

JCAHO 2007 CREDENTIALING AND PEER REVIEW STANDARDS

| Key | |
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| | Grey shading = JCAHO standard |
| | Red type = new, substantially revised, or reorganized standard or element of performance |
| | Green shading = current substantial compliance |
| | Yellow shading = minor changes needed to existing policies |
| | Orange shading = significant implications for current policies or practice |
| | Blue shading = delayed implementation |

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| 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. | <i>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.</i> |
| 4.00(1) | | [B] | 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. | |
| 4.00(2) | | [B] | The organization consistently determines the resources needed for each requested privilege. | |
| 4.10 | | | The hospital collects information regarding each practitioner's current license status, training, experience, competence and ability to perform the requested privilege. | <i>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.</i> |
| 4.10(1) | | [A] | The hospital credentials applicants using a clearly defined process. | |
| 4.10(2) | | [A] | The credentialing process is based on recommendations by the organized medical staff. | |
| 4.10(3) | | [A] | The credentialing process is approved by the governing body. | |
| 4.10(4) | | [A] | The credentialing process is outlined in the medical staff bylaws (<i>see also Standard MS.1.20</i>). | |
| 4.10(5) | | [A] | The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents | |

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| | | | by viewing any of the following: <ul style="list-style-type: none"> • A current picture hospital ID card • A valid picture ID issued by a state or federal, agency (e.g., drivers license or passport) | |
| 4.10(6) | | [A] | 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: <ul style="list-style-type: none"> • 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 | |
| 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. | |
| 4.15(1) | | [B] | 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: <ul style="list-style-type: none"> • 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. • 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. | |
| 4.15(2) | | [B] | Each of the criteria used are consistently evaluated for all practitioners holding that privilege. | |
| 4.15(3) | | [A] | 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. | |

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| 4.15(4) | | [A] | <p>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.</p> <p><i>Note: 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.</i></p> | |
| 4.15(5) | | [A] | <p>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.</p> | |
| 4.15(6) | | [A] | <p>Peer recommendation includes written information regarding the practitioner's current:</p> <ul style="list-style-type: none"> • Medical/Clinical knowledge • Technical and clinical skills • Clinical judgment • Interpersonal skills • Communication skills • Professionalism | |

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| 4.15(7) | | [B] | <p>Before recommending privileges, the organized medical staff also evaluates the following:</p> <ul style="list-style-type: none"> • 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 <p><i>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.</i></p> | |
| 4.15(8) | | [A] | 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. | |
| 4.15(9) | M | [C] | Completed applications for privileges are acted on within the time period specified in the medical staff bylaws. | |
| 4.15(10) | M | [C] | Information regarding each practitioner's scope of privileges is updated as changes in clinical privileges for each practitioner are made. | |
| 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. | |
| 4.20(1) | | [B] | The information review and analysis process is clearly defined. | |
| 4.20(2) | | [B] | 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. | |

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| 4.20(3) | M | [C] | The organization completes the credentialing and privileging decision process in a timely manner. | |
| 4.20(4) | | [A] | The organization's privilege granting /denial criteria are consistently applied for each requesting practitioner. | |
| 4.20(5) | M | [C] | Decisions on membership and granting of privileges include criteria that are directly related to the quality of health care, treatment, and services. | |
| 4.20(6) | M | [C] | 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. | |
| 4.20(7) | | [A] | The governing body or delegated governing body committee has final authority for granting, renewing, or denying privileges. (See Standard MS.1.20) | |
| 4.20(8) | | [A] | Privileges are granted for a period not to exceed two years. | |
| 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. | |
| 4.25(1) | | [A] | Requesting practitioners are notified regarding the granting decision. | |
| 4.25(2) | | [A] | In the case of privilege denial, the applicant is informed of the reason for denial. | |
| 4.25(3) | | [B] | 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. | |
| 4.25(4) | | [B] | 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. | |

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| 4.30 | | | The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance. | <i>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.</i> |
| 4.30(1) | | [B] | A period of focused professional practice evaluation is implemented for all initially requested privileges. (Effective January 1, 2008.) | |
| 4.30(2) | | [A] | 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. | |
| 4.30(3) | | [A] | The performance monitoring process is clearly defined and includes each of the following elements: <ul style="list-style-type: none"> • 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 | |
| 4.30(4) | | [B] | Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff. | |
| 4.30(5) | | [A] | The triggers that indicate the need for performance monitoring are clearly defined. | |
| 4.30(6) | | [B] | 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. | |

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| 4.30(7) | | [A] | Criteria are developed that determine the type of monitoring to be conducted. | |
| 4.30(8) | | [A] | The measures employed to resolve performance issues are clearly defined. | |
| 4.30(9) | | [B] | The measures employed to resolve performance issues are consistently implemented. | |
| 4.35 | | | An expedited governing body approval process may be used for initial appointment and reappointment to the medical staff and when granting privileges when criteria for that process are met. | |
| 4.35(1) | | [B] | The organized medical staff develops criteria for an expedited process for granting privileges. | |
| 4.35(2) | | [C] | The criteria provide that an applicant for privileges is ineligible for the expedited process if any of the following has occurred: <ul style="list-style-type: none"> • The applicant submits an incomplete application • The medical staff executive committee makes a final recommendation that is adverse or has limitations | |
| 4.35(3) | M | [C] | 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. | |
| 4.35(4) | M | [C] | 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. | |
| 4.35(5) | M | [C] | 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. | |
| 4.35(6) | M | [C] | 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. | |
| 4.35(7) | M | [C] | The organized medical staff uses the criteria developed for the expedited process when recommending privileges. | |

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| 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. | |
| 4.40(1) | | [A] | There is a clearly defined process in place that facilitates the evaluation of each practitioner's professional practice. | |
| 4.40(2) | | [B] | The type of data to be collected is determined by individual departments and approved by the organized medical staff. | |
| 4.40(3) | | [B] | Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s). | |
| 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. | <i>A well-structured internal reporting process supports the ongoing professional practice evaluation and enhances the quality of care and patient safety.</i> |
| 4.45(1) | | [A] | 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. <i>(See Standard RI.1.120 regarding complaints received from patients and families.)</i> | |
| 4.45(2) | | [B] | Reported concerns regarding a privileged practitioner's professional practice are uniformly investigated and addressed, as defined by the organization and applicable law. | |
| 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. | <i>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.</i> |
| 4.50(1) | | [B] | 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. | |

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| 4.50(2) | | [B] | 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. | |
| 4.50(3) | | [B] | 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. | |
| 4.50(4) | | [B] | 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. | |
| 4.50(5) | | [B] | 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. | |
| 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. | |
| 4.60(1) | | [A] | The organized medical staff develops criteria for medical staff membership. | |
| 4.60(2) | M | [C] | The professional criteria are designed to assure the medical staff and governing body that patients will receive quality care, treatment, and services. | |
| 4.60(3) | M | [C] | The organized medical staff uses the criteria in appointing members to the medical staff and appointment does not exceed a period of two years. | |
| 4.60(4) | M | [C] | Membership is recommended by the medical staff and granted by the governing body. | |

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| 4.70 | | | 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. | <p><i>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.</i></p> <p><i>Sources for peer recommendations may include the following:</i></p> <ul style="list-style-type: none"> • <i>An organization performance improvement committee, the majority of whose members are the applicant's peers</i> • <i>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</i> • <i>A department or major clinical service chairperson who is a peer</i> • <i>The medical staff executive committee.</i> |
| 4.70(1) | M | [C] | Recommendations from peers are obtained and evaluated for all new applicants for privileges. | |
| 4.70(2) | M | [C] | Upon renewal of privileges, when insufficient practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations. | |
| 4.70(3) | M | [C] | Peer recommendations include the following information: <ul style="list-style-type: none"> • Relevant training and experience • Current competence • Any effects of health status on privileges being requested | |
| 4.70(4) | M | [C] | 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. | |

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| 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. | <p><i>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.</i></p> <p><i>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.</i></p> |
| 4.80(1) | | [B] | 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). | |
| 4.80(2) | | [A] | Process design addresses the following issues: Self referral by a licensed independent practitioner. | |
| 4.80(3) | | [A] | Process design addresses the following issues: Referral by others and maintaining informant confidentiality. | |
| 4.80(4) | | [A] | 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. | |

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| 4.80(5) | | [A] | 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. | |
| 4.80(6) | | [A] | Process design addresses the following issues: Evaluation of the credibility of a complaint, allegation, or concern. | |
| 4.80(7) | | [A] | 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. | |
| 4.80(8) | | [A] | Process design addresses the following issues: Reporting to the organized medical staff leadership instances in which a licensed independent practitioner is providing unsafe treatment. | |
| 4.80(9) | | [A] | Process design addresses the following issues: Initiating appropriate actions when a licensed independent practitioner fails to complete the required rehabilitation program. | |

N.B. No significant changes in MS 4.100 – MS 5.10.