



Joint Commission Update 2026: Medical Staff

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• Objectives

Summarize

- 2025 National Data

Identify

- The Top Scored Medical Staff Standards in 2025

Analyze

- The 2025 Medical Staff Scoring Trends

Describe

- Updates for 2026/A360

Examine

- “Frequently Asked Questions” applicable to the Medical Staff



2025 National Data Summary

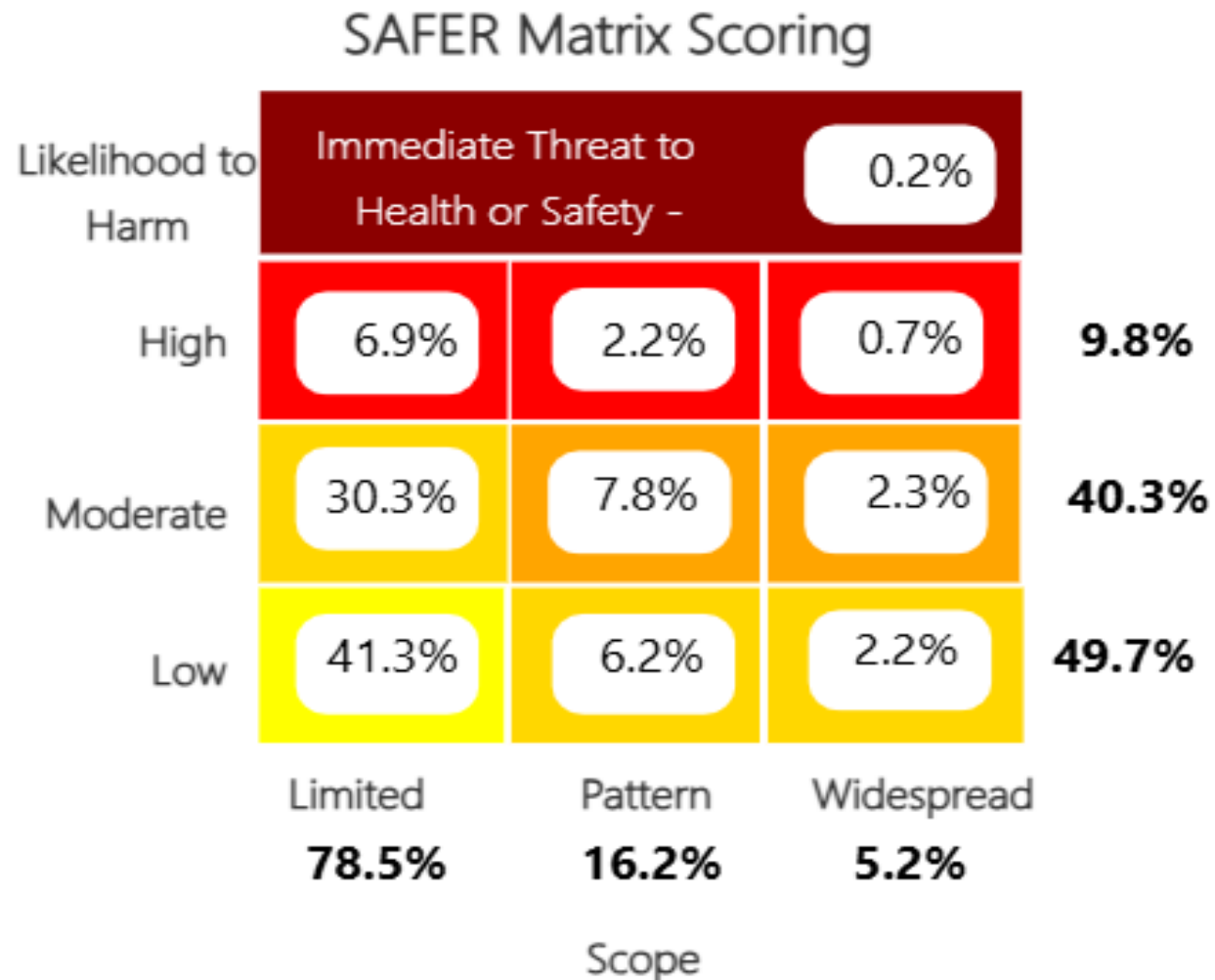
2025 National Scoring Trends Overview

- SAFER[®] Matrix Overview

		Immediate Threat to Life (a threat that represents immediate risk or may potentially have serious adverse effects on the health of the patient, resident, or individual served)		
Likelihood to Harm a Patient/Staff/Visitor	HIGH (harm could happen at any time)			
	MODERATE (harm could happen occasionally)			
	LOW (harm could happen, but would be rare)			
		LIMITED (unique occurrence that is not representative of routine/regular practice)	PATTERN (multiple occurrences with potential to impact few/some patients, visitors, staff and/or settings)	WIDESPREAD (multiple occurrences with potential to impact most/all patients, visitors, staff and/or settings)

National SAFER[®] Hospital Distribution All Chapters Composite

- 1/1/25-12/31/25 Data



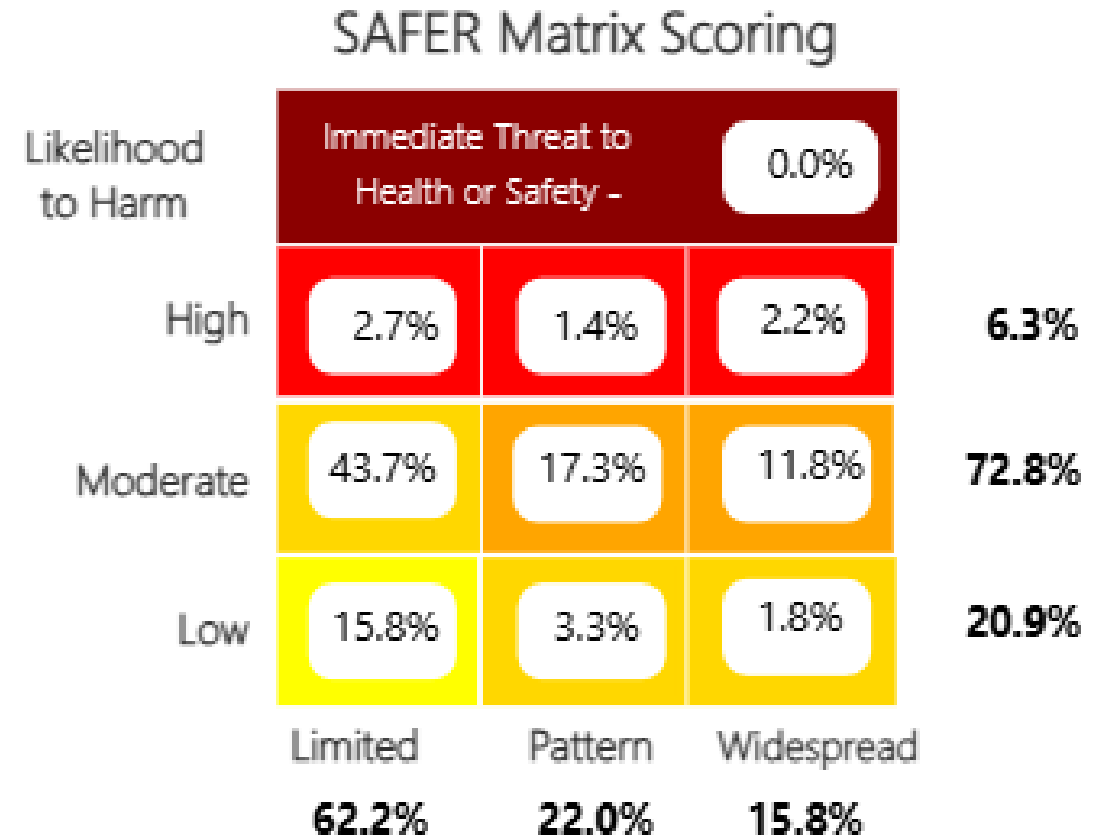
• Immediate Threat to Health or Safety (ITHS)

National Trended Data

2022	2023	2024	2025
54 Total	35 Total	38 Total	34 Total
<ul style="list-style-type: none">• 44 IC related• 1 Abuse/Neglect• 4 Suicide/Ligature• 1 Food Services• 1 Mislabeled Laboratory Specimens• 1 Medical Gas System• 1 IC/construction work• 1 High Risk Compounding	<ul style="list-style-type: none">• 26 IC related• 2 Blood Bank• 1 Lack of adequate anesthesia services• 2 lack of staffing leading to assault• 1 lack of ISO level in compounding hood• 1 lack of lock out tag out system leading to injury/death• 1 Abuse/Neglect• 1 Suicide/Ligature	<ul style="list-style-type: none">• 25 IC related• 2 Resuscitation• 2 Suicide• 1 Chemical restraints• 2 No ICRA construction• Ongoing Work Place Violence• Lack of safe environment for care• 2 inappropriate seclusion• No license provider 30 days (PSYCH)• Lack of governing body	<ul style="list-style-type: none">• 23 IC related• 2 Fire suppression system inoperable• No response to change in patient condition (Psych)• Extensive flooding with mold• Inappropriate seclusion• Unsafe discharge• No RN oversight 2 weeks (Home Care)• 2 Elopement with severe injury/death• Structure integrity

Medical Staff National Trends

Total Surveys Hospital Accreditation Program		
Surveys	Avg RFI Per Survey	Total RFI's
2076	31.57	65,540
Medical Staff Specific RFI's		
Surveys	Avg RFI Per Survey	Total RFI's
973	1.68	1638





The Top Scored Medical Staff Standards in 2025

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)

2025 Top 10 Scored MS Findings: Trends & What's New to the Top 10

2024	2025
MS.01.01.01 EP5 ▬	MS.01.01.01 EP5
MS.08.01.03 EP2 ↓	MS.08.01.03 EP1
MS.08.01.03 EP1 ↓	MS.08.01.03 EP2
MS.08.01.03 EP3 ▬	MS.08.01.03 EP3
MS.08.01.01 EP4 ↓	MS.03.01.01 EP2
MS.08.01.01 EP1 ↓	MS.08.01.01 EP4
MS.03.01.01 EP16 ✘	MS.06.01.05 EP2 NEW
MS.03.01.01 EP2 ↑	MS.06.01.03 EP6 NEW
MS.03.01.01 EP17 ✘	MS.08.01.01 EP1
MS.06.01.03 EP5 ✘	MS.06.01.05 EP7 NEW

• 2025 Medical Staff Scoring Trends

What Improved & What Left the Top 10

Improved Rank Within Top 10	
MS.08.01.03 EP1	OPPE- Process Developed
MS.08.01.03 EP2	OPPE- Data Collection
MS.08.01.01 EP1	FPPE-Initial Privileges
MS.08.01.01 EP4	FPPE-Us Eval Criteria
What Left the Top 10	
MS.03.01.01 EP16	MS Radiology Qual
MS.03.01.01 EP17	MS Nuclear Med Qual
MS.06.01.03 EP5	Provider ID Verification

- **2025 Medical Staff Scoring Trends**
Same, Increased Rank & What's New to the Top 10

Same Rank Finding	
MS.01.01.01 EP5	MS Complies with Bylaws/Policy
MS.08.01.03 EP3	OPPE Data Used
Increased Rank Finding	
MS.03.01.01 EP2	Scope of Privileges
What's New	
MS.06.01.05 EP2	Criteria for Privileging
MS.06.01.03 EP6	Credentials Verification
MS.06.01.05 EP7	NPDB Query

MS.01.01.01 EP 5- SAME

MS Complies with Bylaws/Policy

Trends

- Incomplete or Missing H&P Documentation
- Delayed or Missing Authentication and Timeliness Issues
- Non-Compliance w/Required Consults and Procedure Notes

Solutions

- Bylaws/policies awareness campaigns
- Monitor H&P- in time out process, prior to moving pts to OR's

MS.08.01.03 EP 3- SAME

OPPE Data Used

Trends

- Lack of Practitioner-Specific or Specialty-Specific Data
- Incomplete or Missing OPPE Data at Reappointment
- Failure to Follow OPPE Policies & Documentation Requirements

Solutions

- Ensure provider-specific/specialty specific data
- Ensure all OPPE Data at Reappointment
- Comply with OPPE policies/documentation

MS.03.01.01 EP 2- **INCREASED**

Scope of Privileges

Trends

- Providers performing services or procedures without the required credentials/privileges
- Inadequate/Missing Documentation of Privileges & Credentialing
- Non-compliance w/ Policies/Bylaws re: Privilege Requirements

Solutions

- Processes put in place to randomly audit procedures list by providers and compare to privilege list

MS.06.01.05 EP 2- **NEW** to the Top 10

Criteria for Privileging

Trends

- Lack of Defined or Documented Privileging Criteria
- Insufficient or Missing Credentialing Documentation
- Inadequate Review or Approval Process

Solutions

- Use of checklists/double check processes when privileging

MS.06.01.03 EP 6- **NEW to the Top 10**

Credentials Verification

Trends

- Delayed or Missed PSV of Licenses
- Incomplete Documentation of Credentialing Requirements

Solutions

- Use of checklists/double check processes when verifying credentials

MS.06.01.05 EP 7- **NEW** to the Top 10

NPDB Query

Trends

- Failure to Query NPDB at Privilege Renewal
- Non-Compliance with Medical Staff Bylaws

Solutions

- Use of checklists/double check processes when privileging
- Use of NPDB Continuous Query option (see FAQ)



Transforming Accreditation

Updates for 2026/A360

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



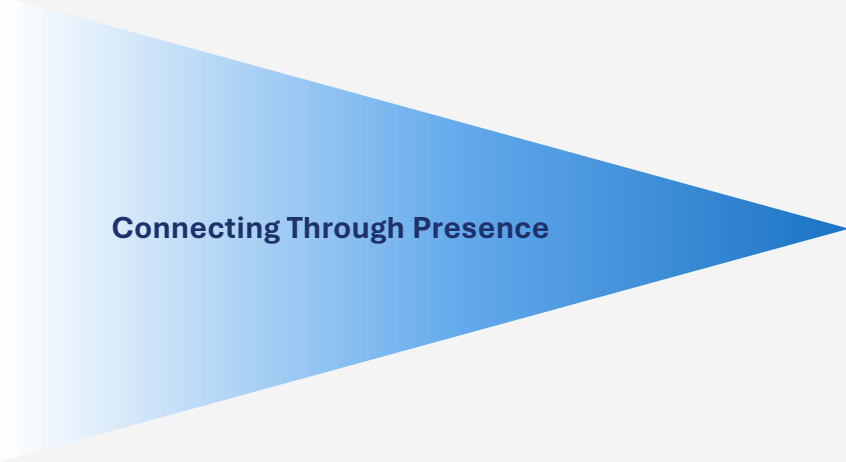
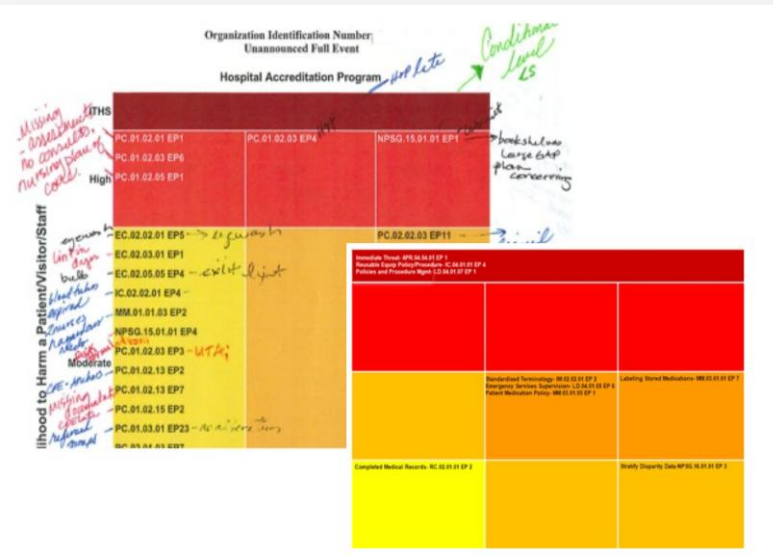
Reducing Burden

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



Engaging Accredited Organizations

Putting the Focus on Relationships and Enhancing/Optimizing Programs



- Days in the Life Of
- Engaged Healthcare Leaders: System and Site Level
- Executive Leadership Site Visits
- Advisory Groups

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

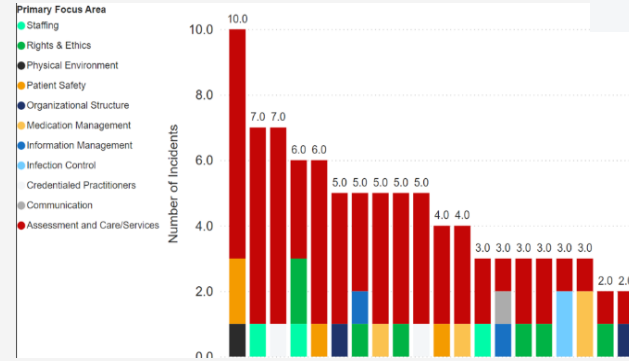
Enabling and affirming the highest standards of healthcare quality and patient safety for all

- 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 Organization Resources for Performance Improvement

SAFER Placement	Standard	EP	EP Text	Observation	Cap and Cop Text
High Risk	IC.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 Activities 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 Risk	IC.01.02.01	8	The hospital's policies and procedures for cleaning, disinfection, and identification of reusable medical and surgical devices and equipment address the following: - Cleaning, disinfection, and identification of reusable medical and surgical devices in accordance with the labeling, disinfection system and manufacturer's instructions. - Use of disinfectants registered by the Environmental Protection Agency for noncritical 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 disinfectants for the processing of critical devices and high-level disinfectants for the processing of semicritical devices in accordance with EPA-obtained label and device manufacturer's instructions. - Required documentation for device reprocessing 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 identification 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 Tracer at new Hospital Site (One Renaissance Blvd, Villa Park, IL) Site. It was noted that the test was not performed on an endoscope during the cleaning, disinfection, and identification process as required by the manufacturer's instructions for use. This observation was noted by the Director of Surgical Services.	SAF.02 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 infections within the hospital and between the hospital and other institutions and settings.

Preliminary Report Availability



Patient Safety Complaint Data

View Standards by Accreditation Program

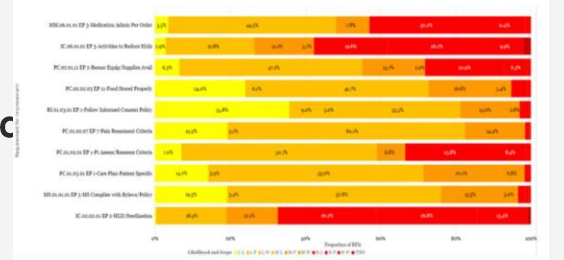
Current effective standards for all Joint Commission accreditation and certification programs are available. Click on your area of interest below.

[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

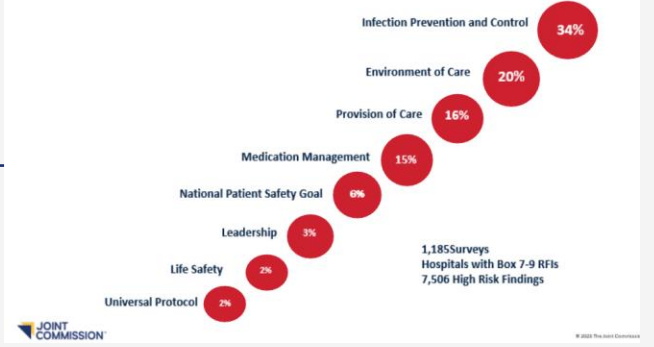


National Trends Clinical Data

Disease Specific Certification Dashboard

High-Risk National Data

High-Risk Requirements for Improvement (RFIs)



Joint Commission 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) (2025)
- 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

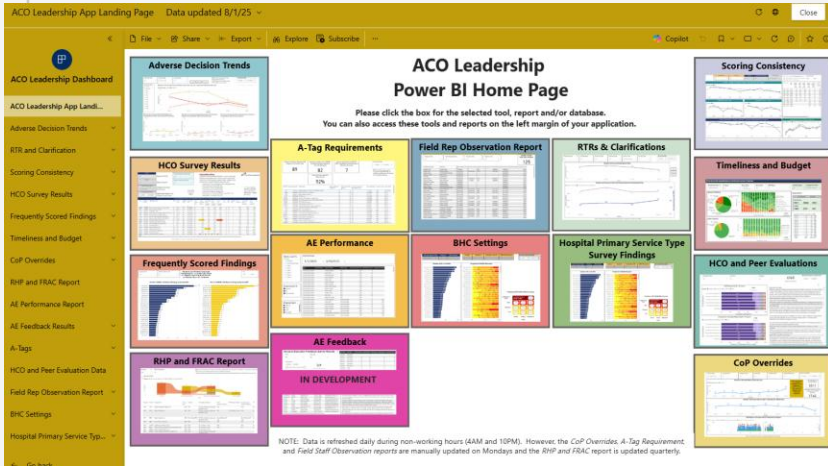
- Standardization of field director observation forms and data collection
- Structured program with incorporated cross-cadre observations within same programs
- Incorporation of CMS Direct Observation Verification (DOV) results



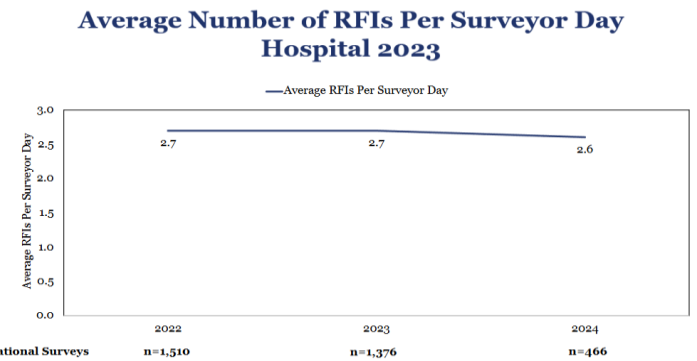
COMMUNICATION

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

Joint Commission Data to Inform Process & Drive Consistency



Internal Operational Dashboard



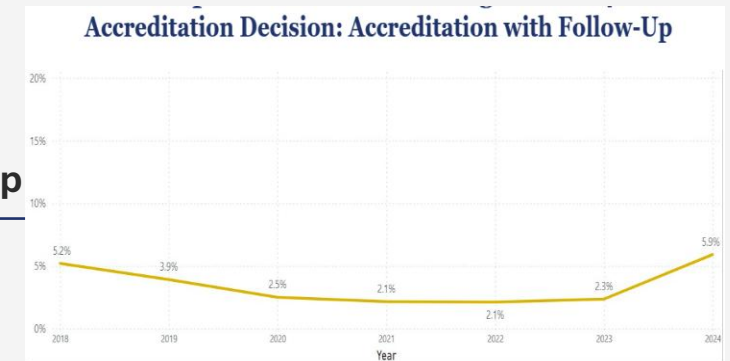
Average Number Requirements/ Surveyor Day

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	0.99	1.41
FT	2	BHC/SW/LPC	BHC	43	6.44	277	0.65	0.50	1.90
FT	6	Nurse	HAP	28	2.54	71	0.50	0.47	1.32
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	0.31	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	12	7.22	211	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	0.03	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

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
4,647	61,988	13.34	77,136	16.60
6,716	4638.00	1895	396	314

Accreditation with Follow-Up



Accreditation 360

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

Moving from Complexity to Clarity



1,551



774

Historical....



Present....

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 dietitian 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.

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Medicare Hospital Requirements to 2024 Joint Commission
Hospital Standards & EPs
Report Generated by DSSM
November 16, 2023
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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.	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.

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Medicare Hospital Requirements to 2025 Joint Commission
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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)

Medical Staff Chapter Overview

Medical Staff Chapter Outline

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, Treat and Svcs (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)

Standards Assistance

Resources for Hospital and Critical Access Hospitals

- **Accreditation Requirements/E-dition**
- **Survey Process Guide (SPG)**
 - Hospital Medical Staff Evaluation Module (482.22)
 - Medical Staff-Related Standards Compliance Evaluation Guides
- **Crosswalks-Medicare Requirements to Joint Commission Standards and EPs**
 - **Medical Staff CMS CoP 482.22**

The following is a link to the above:

<https://www.jointcommission.org/en-us/accreditation/accreditation-360/prepublication-cah-and-hap-requirements-streamlined-to-reduce-burden>

Survey Process Guide (SPG) – Overview

- Replaces Survey Activity Guide (SAG)
- Better reflects State Operations Manual (SOM) related to survey process for the CoPs
- Organized into sections based on the CMS CoP structure
- Same version shared between surveyors and accredited organizations



Hospital Accreditation

Survey Process Guide

Survey Process Guide (SPG)

Hospital Medical Staff Evaluation Module (482.22)

Hospital Medical Staff Evaluation Module (482.22) including Psychiatric Special Staff Requirements (482.62) (b)

Joint Commission Standards / EPs	Hospital CoP	Hospital Survey Process
<p>MS.16.01.01, EP 1: The hospital has an organized medical staff that operates under bylaws approved by the governing body and that is responsible for the quality of medical care provided by the hospital.</p>	<p>§482.22 Condition of participation: Medical Staff. The hospital has an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital.</p>	<p>Interview Leaders (senior leaders and medical staff leader(s)) to confirm there is one medical staff for the entire hospital (including all campuses, provider-based locations, satellites, remote locations, etc.) The organized medical staff is responsible for the quality of medical care provided to patients by the hospital. Note: If this is a hospital system, it can have a unified and integrated medical staff ("unified medical staff") for multiple, separately certified hospitals. The medical staff is organized and integrated as one body that operates under one set of bylaws approved by the governing body. These medical staff bylaws apply equally to all practitioners within each category of practitioners at all locations of the hospital and to the care provided at all locations of the hospital.</p>
<p>MS.14.01.01, EP 2: The medical staff bylaws include the qualifications for appointment and reappointment to the medical staff. Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff is composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also include other categories of physicians as listed at 42 CFR 482.12(c)(1) and other licensed practitioners who the governing body determines are eligible for appointment. Note 2: Gender, race, creed, and national origin are not used in making decisions</p>	<p>§482.22(a) Standard: Eligibility and process for appointment to medical staff. The medical staff must be composed of Doctors of Medicine or osteopathy. In accordance with State law, including scope-of-practice laws, the medical staff may also include other categories of physicians (as listed at § 482.12(c)(1)) and non-physician practitioners who are determined to be eligible for appointment by the governing body.</p>	<p>Interview</p> <ul style="list-style-type: none"> <input type="checkbox"/> Who can be members of the medical staff or who may be granted medical staff privileges (MDs, DOs, other licensed practitioners such as CRNA, APPs?). <input type="checkbox"/> Does state law include other licensed practitioners such as PT/OT/SLT <input type="checkbox"/> If the hospital grants medical staff privileges and/or membership to physicians who are not MDs/DOs, ask about the process the used to ensure that any privileges granted are consistent with state law. <input type="checkbox"/> What is the oversight process for non-physician practitioners? <p>Document Review General</p> <ul style="list-style-type: none"> <input type="checkbox"/> Determine whether the documentation of the categories of practitioners who are members of

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Hospital Accreditation Survey Process Guide

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New Standard/EP

CoP

Survey Process Guidance
(Interview, Document Review, Observation)

Survey Process Guide (SPG)

Medical Staff-Related Standards Compliance Evaluation Guides

Medical Staff-Related Standards Compliance Evaluation Guides

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

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

2025 Top 10 Scored MS Findings- Where are they now in 2026?

2025
MS.01.01.01 EP5
MS.08.01.03 EP1
MS.08.01.03 EP2
MS.08.01.03 EP3
MS.03.01.01 EP2
MS.08.01.01 EP4
MS.06.01.05 EP2 NEW
MS.06.01.03 EP6 NEW
MS.08.01.01 EP1
MS.06.01.05 EP7 NEW

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.
- **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.
- **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.

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 healthcare 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.

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.



FAQs Applicable to the Medical Staff

Joint Commission FAQs

- Search the above via Google or

<https://www.jointcommission.org/standards/standard-faqs/>

Find Answers to Frequently Asked Questions

Please use the tool below to search our FAQ database to find answers to common questions regarding our standards.

Browse our standards FAQs

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Results 1-10 of 12 for History and Physical

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STANDARDS FAQ

Manual: Hospital and Hospital Clinics

Chapter: Medical Staff (MS)

Topic: History and Physicals - Understanding the Requirements

Question: What are the key elements organizations need to understand regarding History and Physical Requirements?

Last updated on July 12, 2022

FAQ's Applicable to the Medical Staff:

- Use of NPDB Continuous Query for Re-privileging
- Peer Recommendations at Reappointment
- OPPE-Low Volume Practitioners
- FPPE Requirements
- History and Physicals

FAQ: Can NPDB Continuous Query Be Used for Re-privileging

Yes. After the organization obtains an initial NPDB query for each practitioner, use of [National Practitioner Data Bank's "Continuous Query"](#) (aka Proactive Disclosure Service) is acceptable for the ongoing NPDB information.

To demonstrate compliance, the organization would need to have record of a baseline query and then share with the surveyors that no updates have been received from the NPDB. There does not need to be documentation in the record that no further communication has been received.

[Privileging - National Practitioner Databank | Joint Commission](#)

FAQ: Peer Recommendations at Reappointment

Peer recommendations are not required at the time of reappointment if there is sufficient practitioner data available to determine if privileges will be renewed, limited or denied. Peer recommendations would be an organization decision.

See MS.17.02.01 EP1

Credentialing and Privileging-Peer Recommendations <https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-faqs/000001368>

FAQ: OPPE & Low Volume Practitioners

Low-volume Practitioners

When practitioner activity at the ‘local’ level is low or limited, supplemental data may be used from another CMS-certified organization where the practitioner holds the same privileges. The use of supplemental data may NOT be used in lieu of a process to capture local data. Organizations choosing to use supplemental data should assess and determine the supplemental data’s relevance, timeliness, and accuracy.

Examples where supplemental data could be used may include, but are not limited to:

- activity is limited to periodic on-call coverage for other physicians or groups
- occasional consultations for a clinical specialty

Consistent with the “Medical Staff” chapter, the medical staff must develop policies and procedures which ensure oversight of local data and the use of supplemental data.

<https://www.jointcommission.org/standards/standard-faqs/hospital-and-hospital-clinics/medical-staff-ms/000001500/>

FAQ: FPPE Requirements

Intent-(FPPE) is a process whereby the medical staff evaluates the privilege-specific competence of the practitioner that lacks documented evidence of competently performing the requested privilege(s) at the organization. This process may also be used when a question arises of a currently privileged practitioner's ability to provide safe, high quality patient care.

Design-The FPPE process must be pre-defined and consistently implemented for all newly requested privileges. There is no exemption based on board certification, documented experience, or reputation. The period of FPPE begins at the time privileges are granted (e.g., temporary, expedited, full privileges, etc.).

Data - Both qualitative & quantitative criteria (data) should be considered when designing the process.

Low-volume Practitioners - When practitioner activity at the 'local' level is low or limited, supplemental data may be used from another CMS-certified organization where the practitioner holds the same privileges. The use of supplemental data may NOT be used in lieu of a process to capture local data.

https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-faqs/000001485?rfkid_64:content_filters=

FAQ: History & Physicals

Content-It is the responsibility of the organized medical staff to determine the minimum required content of medical history and physical (H & P) examinations.

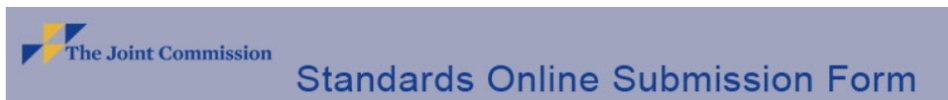
Qualified Practitioners-The H & P must be completed and documented by a qualified and privileged physician or other qualified licensed practitioner privileged to do so in accordance with state law and organizational policy.

Medical Students-A medical student has no legal status as a provider of health care services, therefore, a medical History and Physical (H&P) conducted by a medical student would not fulfill the requirements.

https://www.jointcommission.org/en-us/knowledge-library/support-center/standards-interpretation/standards-faqs/000002272?rfkid_64:content_filters=

JC On-line Question Submission

- Search the above via Google (SIG Online Submission Form) or
- <https://web.jointcommission.org/sigsubmission/sigquestionform.aspx>



Please consider reviewing the [Standards Interpretation FAQs page](#) prior to submitting a question. If you are Joint Commission accredited, click [Login](#) and then click "Joint Commission Connect". Then go to Resources and Tools, Standards Interpretation, and click on the online form link to submit your question. If you prefer to use this form, please complete Steps 1-3 below:

Joint Commission accredited? Yes No

Health Care Organization Information
Complete the three steps below. In Step 3, only health care organizations accredited/certified by The Joint Commission are included in the list. Step 3 is required if you selected Yes to the Joint Commission accredited question above.

Step 1. Select the state/territory: **Step 2.** Select the city: **Step 3.** Select the health care organization:

If you DID NOT find the name of the health care organization from the list in Step 3 above or the state/city is incorrect, please select "No" to "Joint Commission accreditation?" and complete the information below the question. If you are in the process of applying for accreditation, please select "Yes" to the "Are you in the process of becoming TJC accredited?" question and continue to fill out the rest of the information below.

Prefix First Name Last Name Title Professional Credentials

Phone Phone Extension

E-Mail Address

Please respond to my Question via: Email Phone

Questions

Select Accreditation/Certification Manual or Health Care Setting

Select the appropriate chapter/topic. (Must select manual or setting first)

Enter Subject (Include standard if known, Limited to 80 characters)

Please enter your question below. (Limited to 4000 characters)

Please submit only questions that apply to the associated Manual/Chapter in each form. You may select "Submit & Add New Question" for questions regarding an unrelated topic. Your contact information above questions will be prepopulated on the form for these additional submissions.

A Question is Required.

[Submit Question](#)

[Submit & Add New Question](#)

Review “JC News” Monthly for Med Staff Updates

- Formerly known as Joint Commission Perspectives
Final Issue February 2026
“Joint Commission News” as of March 2026

MARCH 2026

Welcome to Joint Commission News™!

We are pleased to bring you the first issue of Joint Commission News™—your new official newsletter about Joint Commission requirements, policies, and procedures. JC News replaces Joint Commission Perspectives as your source for information that affects Joint Commission–accredited, –certified, and –verified organizations.

Every issue of JC News is delivered via e-mail, so you can skim and easily click on articles of interest to you. Most important, the must-read information appears at the top—under “Official Notifications”—and anything related to Joint Commission requirements will be labeled as “REQUIRED.”

The rest of the newsletter features at-a-glance information in the following sections:

- **News Roundup**—highlights from Joint Commission and partner organizations
- **Reminders**—deadlines for submitting data and other notices
- **Spotlight Series**—profiles showcasing quality and patient safety leaders and organizations
- **MythBusters**—explanations that dispel common misconceptions about Joint Commission requirements
- **FAQs**—answers to trending questions from organizations
- **Upcoming Events**—details on in-person and virtual education and events that organizations may want to attend

We look forward to delivering a more streamlined, accessible experience through Joint Commission News—the official home for all Joint Commission notifications.

Take-Aways & Next Steps-Use Your Resources-

Accreditation Requirements/E-dition

Survey Process Guide (SPG)

Hospital Medical Staff Evaluation Module (482.22)

Medical Staff-Related Standards Compliance Evaluation Guides

Crosswalks-Medicare Requirements to Joint Commission Standards/EPs Medical Staff CMS CoP 482.22

The following is a link to the above:

<https://www.jointcommission.org/en-us/accreditation/accreditation-360/prepublication-cah-and-hap-requirements-streamlined-to-reduce-burden>

Joint Commission News Publication

Joint Commission FAQ's

Standards Interpretation Group (SIG) Online Question Form



Thank You