March 2010 Vol. 20, No. 3

Medical Staff Briefing
A TRAINING RESOURCE FOR MEDICAL STAFF LEADERS AND PROFESSIONALS

Joint Commission spotlights conflict resolution in latest draft of MS.01.01.01

In December 2009, The Joint Commission opened the latest chapter in the continuing saga of MS.01.01.01 (formerly MS.1.20). The accrediting organization sent its latest draft of the infamous proposed standard to the field for review, and Joint Commission–accredited hospitals had until January 28 to respond with their feedback.

Although The Joint Commission (formerly JCAHO) had not reached a verdict as of presstime, this latest version of the standard is likely to become official, says **Michael Callahan, Esq.,** partner at Katten Muchin Rosenman, LLP, in Chicago. "It is not a perfect document, but people are tired of dealing with it and want to move on," Callahan says.

One of the most notable changes is the addition of a requirement that the medical staff and the medical executive committee (MEC) design a process for resolving disputes. Leadership standard LD.02.04.01 requires the MEC and the hospital governing board to develop a conflict resolution process. However, the requirement to develop a process between the medical staff and the MEC is new. "Everyone is going to have to change their bylaws to accommodate this change," says Callahan.

Need it or not, here it comes!

According to The Joint Commission's "Frequently Asked Questions Regarding Standard MS.01.01.01 (formerly MS.1.20)," available at *http://tinyurl.com/MS010101FAQ,* the accreditor created a task force that consisted of physicians, hospital CEOs, trustees, and healthcare attorneys. It met 12 times between January 2008 and March 2009.

> **"If you don't interpret it too severely, all it says is that we have to have some mechanism to let medical staff members talk to the MEC."**
>
> *—Joseph Cooper, MD, CMSL*

The task force sought to include a conflict resolution requirement to address a perceived tension between the medical staff and MEC. "There is a perception held by some that medical staff leadership is getting a little co-opted by hospital administration, partly attributable to the fact that hospitals are entering into more contracts with physicians," says **Ann O'Connell, Esq.,** partner at the Sacramento, CA, office of Nossaman, LLP. O'Connell has served for the past year and a half on the MS.01.01.01 task force.

Some in the field think that the requirement will only apply to a small minority of medical staffs. "My guess is that this is going to be an infrequently used element of performance because most medical staffs aren't that far off track with their medical executive committees," says **Carol S. Cairns, CPMSM, CPCS,** senior consultant at

> *continued on p. 2*

IN THIS ISSUE

HCPro

MS.01.01.01

< continued from p. 1

The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, and president of PRO-CON, an Illinois-based consulting firm.

O'Connell agrees that conflict resolution between the medical staff and MEC might not be a hot-button issue for many medical staffs. "In a well-managed hospital, maybe you'd never have to invoke the [conflict resolution] process," she says. However, she notes that it is better to have a plan in case conflicts occur than to try to plug the dam after a leak has sprung.

Start now to create a conflict resolution policy

In "Frequently Asked Questions Regarding Standard MS.01.01.01 (formerly MS.1.20)," The Joint Commission states that many medical staffs will only need to revise small portions of their bylaws, if they need to make any revisions at all. But as with most accreditation changes, doing so might not be that easy.

The Joint Commission has not provided guidance as to what steps need to be included in the medical staff-MEC conflict resolution process, so medical staffs will have to develop an adequate process that addresses their individual cultures.

"These are things The Joint Commission has tried not to prescribe because I think you'd find that the dynamics at every organization are different," says O'Connell.

Medical staffs will first need to decide what circumstances will trigger the conflict resolution process. They may choose to require a certain percentage of medical staff members to present a written request or petition to meet with the MEC to hash out a problem. "I'm thinking no less than 10%," says O'Connell.

But it depends on the medical staff. "If you have a medical staff with only 10 members on it, I don't think one person should be able to invoke the process," O'Connell says.

By setting a minimum threshold, medical staffs will be better able to differentiate between issues that affect the entire medical staff, such as a mandatory ED call schedule, and chips on individual members' shoulders.

Once the standards for invoking the conflict resolution process are set, medical staffs need to decide exactly what the process will entail.

The good news is that it doesn't have to be complicated, says **Joseph Cooper, MD, CMSL,** a consultant at The Greeley Company. "If you don't interpret it too severely, all it says is that we have to have some mechanism to let medical staff members talk to the MEC."

O'Connell adds, "I don't think anyone [on the task force] thinks that it should be as complex as, say, a formal hearing where everyone has an opportunity to be heard."

Rather, drawing from Joint Commission leadership standard LD.02.04.01, which requires the MEC and governing board to establish a conflict resolution process, O'Connell says that the key elements should be:

- Meeting with the involved parties as early as possible

Medical Staff Briefing (ISSN: 1076-6022 [print]; 1937-7320 [online]) is published monthly by HCPro, Inc., 200 Hoods Lane, Marblehead, MA 01945. Subscription rate: $389/year or $700/two years; back issues are available at $25 each. • **MSB,** P.O. Box 1168, Marblehead, MA 01945.

- Gathering information about the conflict
- Working with the parties to manage the conflict
- When possible, resolving the conflict

Using this approach, medical staffs don't have to reinvent the wheel. If a medical staff's bylaws already comply with LD.02.04.01, that language can serve as the foundation for the medical staff–MEC conflict resolution policy. (See "Sample bylaws language: Conflict resolution" on p. 4.)

According to the proposed standard, the conflict resolution process applies to "issues including, but not limited to, proposals to adopt a rule, regulation, or policy, or an amendment thereto."

Because the standard allows for the conflict resolution process to apply to a broad range of issues, medical staffs should adjust their process depending on the significance and complexity of the issue at hand.

For example, small issues, such as whether to include WiFi service in the physician lounge, may be resolved in a single meeting. Weightier disputes, such as whether to transition from laundry list privileges to core privileges, may require the medical staff and MEC to meet, summarize their differing viewpoints in writing, and send their opinions to the governing board to review.

O'Connell says that although the standard somewhat checks the MEC's authority by allowing the medical staff to petition directly to the board, the standard recognizes that the ultimate decision-making authority still rests with the governing board. The governing board, she says, should make decisions with the differing opinions in mind.

Even if this latest version of MS.01.01.01 does not become an official Joint Commission standard, it is best practice to improve communication channels and develop a conflict resolution process between the medical staff and MEC. Doing so will promote a spirit of collegiality and collaboration that will be felt throughout the medical staff, the MEC, and the governing board. ■

Revised standard highlights

The highlights of the December 2009 version of proposed standard MS.01.01.01 as compared to previous versions are:

- **Bylaws:** Most medical staff processes and procedures need to be mentioned in the bylaws, but their associated details, which are often lengthy, can be incorporated into rules, regulations, policies, and procedures. Previous versions of the proposed standard would have required the associated details to be included in the bylaws. "The adoption of revisions to the associated details that reside outside of the bylaws has a process of approval that doesn't take the whole medical staff. In previous versions, that was not always clear or allowable," says **Carol S. Cairns, CPMSM, CPCS,** senior consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, and president of PRO-CON, an Illinois-based consulting firm.
- **Communication:** Like the previous draft of the standard, the new standard permits the medical staff to go directly to the governing board to amend or adopt a rule, regulation, or policy. However, the latest draft of the standard requires the medical staff to communicate its intention with the medical executive committee (MEC) first. On the same note, if the MEC wishes to adopt or amend a rule, regulation, or policy, it must also communicate that to the medical staff. In the case that a policy, rule, or regulation needs immediate change to comply with a law or regulation, the MEC may make a provisional change and notify the medical staff, which retains the right to review and comment on the change retrospectively. "Wider communication is always better, but sometimes it creates additional dissent that has to get worked through," says Cairns.
- **Conflict resolution:** The medical staff and the MEC must design a process for resolving disputes regarding rules, regulations, policies, and procedures. Leadership standard LD.02.04.01 already requires the medical executive committee and the hospital governing board to develop a conflict resolution process. However, the requirement to develop a conflict-resolution process between the medical staff and the MEC is new.