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The New Joint Commission Standards—MS.1.20

The Hospital's Perspective

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MS.1.20 Represents a Reversal of August, 2006 Proposed Standard

- August, 2006 proposed standard deferred to the judgment of the medical staff and hospital about which provisions should appear in the medical staff bylaws as opposed to rules, regulations and policies
- The ability of the medical staff to bypass the MEC was limited to proposed amendments to the bylaws
- The August, 2006 proposed standard was responsive to the significant criticisms by hospitals and various trade associations, i.e, AHA, FAH, NAMSS, which found the 2004 iteration of MS.1.20 to be overly prescriptive and confusing

MS.1.20 Represents a Reversal of August, 2006 Proposed Standard (cont'd)

- An additional comment is that it had nothing to do with improving the quality of patient care services
- The hospital industry, and most medical staff members, accepted the August, 2006 proposal as a balanced response to industry concerns, including the AHA

MS.1.20 Represents a Reversal of August, 2006 Proposed Standard (cont'd)

- For all practical purposes, and despite prior industry objections, MS.1.20 reverts back to the overly prescriptive and confusing 2004 proposed standards and goes further by allowing additional ways to pre-empt or bypass MEC recommendations
- The "final" MS.1.20 has taken everyone by surprise and is generating much of the same confusion and criticisms which were previously voiced

Areas of Concern and Confusion

- **MS.1.20 Based on Faulty Premises**
  - Must review the pre-published Leadership Standards in order to place MS.1.20 into context from a Joint Commission standpoint
  - Leadership Standards represent a significant shift because it views the governing body, hospital management AND leaders of the organized staff as the three equal responsible parties

Areas of Concern and Confusion (cont'd)

- What is the "organized medical staff" and who are the real leaders if the MEC can be pre-empted?

– These leaders are expected to "work together to create the hospital's mission, vision and goals" (LD. 2.10, EPI) which are linked to "the safety and quality of care, treatment and services" (See Rationale for LD. 2.10)

– The governing body is expected to "involve senior managers and leaders of the organized medical staff in governance and management functions" (See Leadership Relationships – Introduction)

Areas of Concern and Confusion (cont'd)

- Recognizes that conflicts of interest among the leaders will arise and requires that these conflicts be addressed through an established policy (see LD 2.20)
- Standard presumes that the medical staff has a sufficient and adequate number of leaders who are willing to become actively involved in "governance and management functions"

Areas of Concern and Confusion (cont'd)

– Most hospitals have trouble, as do medical staffs, in finding qualified physician leaders willing to serve in the positions of medical staff officer, department and division heads, committee chairs and committee members, medical directors, board members and board committee members

– There often times is little turn over in leadership positions

Areas of Concern and Confusion (cont'd)

- Physicians typically serve on multiple medical staffs, with multiple ED call obligations, and cannot afford the time or lost income to serve in these capacities
- Physicians are often times seeking some form of payment or reimbursement for these services
  - Most medical staffs cannot afford to pay
  - If paid by the hospital, are these “leaders” now being co-opted? Is their objectivity now tainted?

Areas of Concern and Confusion (cont'd)

- Standard requires a conflict of interest policy for leaders but rather than incorporate this requirement into MS.1.20, MS.1.20 allows the MEC members to be removed or bypassed. Joint Commission, instead, should have required organized medical staff to adopt conflict of interest procedures
- MS.1.20 presumes that the MEC will, at some point in time, not be representative of the organized medical staff's interests
  - Not clear why Joint Commission has taken this position

Areas of Concern and Confusion (cont'd)

- Appears to be based on a general concern that many MEC representatives are either paid or have a contractual relationship with the hospital and therefore cannot objectively represent the interests of the organized medical staff

- **MS 1.20 Will Create Bylaw Gridlock and Will Have No Positive Impact on the Delivery of Quality Health Care Services**
  - Final standard effectively requires that all substantive provision be placed in the bylaws
  - The concession to allow "procedural details" in rules and regulation is both confusing and of little value because these details are not substantive and most medical staffs will choose to keep the substance and the procedural details in one document rather than split them up

Areas of Concern and Confusion (cont'd)

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Areas of Concern and Confusion (cont'd)

- Where a particular provision is located, whether in the bylaws or rules and regulations, is much less important then its actual content
- If the content complies with Joint Commission, the CoPs, and other requirements, who cares?
  - The concern appears to be that the amendment procedures for hearing plans, credentialing manuals, etc., are usually more streamlined and do not always require a vote by the medical staff as usually would be the case for the medical staff bylaws

Areas of Concern and Confusion (cont'd)

- Note that the Joint Commission does not require that the medical staff bylaws have to be amended in any particular manner. Stated differently, the Joint Commission does not require that the voting medical staff must approve any bylaw amendment before it is submitted to the Board of Directors for review and appointment

Areas of Concern and Confusion (cont'd)

- **Questions**
  - May a medical staff have different amendment procedures for particular bylaw sections if these procedures have been approved by the medical staff, as per the existing bylaw amendment process, and the Board of Directors?
  - If yes, medical staffs can develop or maintain more streamlined measures to amend the bylaws, or for identified portions of the bylaws if this process is approved by the medical staff and Board
  - If no, Bylaw Committees the MEC and the medical staff will be meeting with increased frequency to consider bylaw amendments

Areas of Concern and Confusion (cont'd)

- The Joint Commission will need to provide greater clarity as to the differences between "requirements," "processes," and "procedural details"
- Do the processes and procedures utilized by a hospital and medical staff to determine core, privileging need to be included in the bylaws?
- What level of detail regarding the performance of H&Ps needs to be in the bylaws as opposed to a rule and regulation?
- What about "privileging" and "credentialing"? Do both "requirements and "processes" need to be in the bylaws or can they appear in different documents?

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Areas of Concern and Confusion (cont'd))

– What would be examples of "procedural details" as applied to the hearing and appeals process that could be placed in a rule, regulation or policy?

MS.1.20 Reorders the Existing Governance Relationship Between the MEC and the Medical Staff

- Under most existing bylaws, the members of the MEC are usually the elected department chairs, the elected president and vice president of the medical staff, and the elected at large physician members
- The hospital's CEO and sometimes the VPMA or CMO also are members but usually are ex officio, without vote
- At large academic medical centers, department chairs usually are paid positions either by a faculty foundation or the hospital or an affiliated medical school

MS.1.20 Reorders the Existing Governance Relationship Between the MEC and the Medical Staff (cont'd)

- At suburban/community hospital, it is common for hospital based practices such as anesthesiology, radiology, pathology and the ED to have exclusive provider contracts with the hospital
- MEC members who have a contract or financial relationship with the hospital typically are in the minority

MS.1.20 Reorders the Existing Governance Relationship Between the MEC and the Medical Staff (cont'd)

- There are already conflict of interest and appointment and removal provisions which are available that can remove MEC members if they are not being representative of medical staff interests – new standard is not needed
- Standard presumes that the reorganized medical staff does not engage in a constructive and responsible dialogue with its leaders, and visa versa

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MS.1.20 Reorders the Existing Governance Relationship Between the MEC and the Medical Staff (cont'd)

- Standard "requires" a process for identifying how authority is "delegated and removed" from the MEC
  - How is this promoting a dialogue or resolution of differences between the organized medical staff and its leaders?
  - Introduction "urges" the organized medical staff to "determine what steps it will take if it does not agree with an action taken by the [MEC]. Such steps might include a process that would allow the organized medical staff, at its discretion, to extract and consider an action by the [MEC] prior to the action becoming effective."

Relationship Between the MEC and the Medical Staff (cont'd)

- Questions
  - Who can decide to extract a recommendation or bypass the MEC?
  - Can the medical staff and hospital adopt any process for triggering this bypass procedure?
  - What if the medical staff believes its current procedures for appointment and removal of department chairs and MEC representatives is satisfactory and this process is reaffirmed, will they be cited by the Joint Commission?

Relationship Between the MEC and the Medical Staff (cont'd)

- Questions
  - This bypass option is ostensibly related only to "patient safety and quality of care issues" but what isn't?
  - Can the Joint Commission give some examples where an attempt to bypass the MEC as per the Standard would not be viewed as related to "patient safety and quality of care issues?" What about an appointment reappointment/credentialing/peer review issue?
  - What is the standard by which to measure whether an MEC is adequately representing medical staff interests?

Relationship Between the MEC and the Medical Staff (cont'd)

- The Standard allows the MEC to be bypassed not only with respect to bylaws but also "rules and regulations, and policies, and amendments thereto…."
- Are there any MEC recommendations that are exempt from this bypass procedure?
- Does the Standard focus more on issues relating to "patient safety and quality of care" and less on the form of the bylaw, rule or regulation?