

**JOINT COMMISSION PROPOSED REVISIONS
TO ITS MEDICAL STAFF STANDARDS M.S. 1.20
January 17, 2008**

**Teleconference Presented by Maureen Demarest Murray, Esq.
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AGENDA

1. Introduction
2. Overview of changes proposed by the Joint Commission to Medical Staff Standard 1.20
3. Controversy Concerning the Proposed Changes
4. Practical Steps and Considerations for Implementation of the Proposed Revisions
5. Questions

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OUTLINE

1. Agenda, outline and source references are available on our website <http://www.healthcarelawnote.com/Seminars.asp>.
2. Agenda:
 - (a) Overview of changes proposed by the Joint Commission to Medical Staff Standard 1.20
 - (b) Controversy Concerning the Proposed Changes
 - (c) Practical Steps and Considerations for Implementation of the Proposed Revisions
 - (d) Questions

**OVERVIEW OF CHANGES PROPOSED BY THE JOINT COMMISSION TO
MEDICAL STAFF STANDARD 1.20**

1. According to the Joint Commission, the overall stated intent of the revisions is to “support and reinforce a productive working relationship between the medical staff and the governing body while minimizing disruptions to the hospital, including its medical staff.”
2. Proposed to be effective July 1, 2009. So accredited providers must achieve compliance by that date.
3. Joint Commission announced formation of a Task Force on January 3 2008. Joint Commission contemplates that Task Force will report at the Joint Commission Board meeting on February 29-March 1, 2008. Very tight time frame. Although the Joint Commission has publicly reiterated a number of times strong support for these revisions, the formation of the Task Force signals that the proposed revisions could be withdrawn or changed. Revisions have been under consideration since at least prior to 2004. The consideration process may still be underway.
4. Two broad categories of changes:

- a. What must be addressed in the Bylaws proper and what can be addressed in the rules, regs and policies. Eliminates and does not recognize the option of using separate credentialing or fair hearing manuals.
 - b. How the full medical staff and the MEC relate to each other and to the governing body.
5. Both categories impact the Bylaws revisions that each hospital and medical staff will want to consider. Will address a checklist for Bylaws revisions in the Practical Steps and Considerations. Here just outline the Joint Commission revisions.
6. First, everything substantive or related to “process” must be included in the Bylaws proper. A “process” is “a series of steps taken to accomplish a goal.”
7. Second, a “procedural detail” can be addressed in the rules, regs and policies. “A procedural detail describes in detail how each step in the process is to be carried out.”
8. Other than these two brief descriptions, the Joint Commission does not define the difference between a “process” and a “procedural detail.”
9. The Joint Commission does give an example related to credentialing. The credentialing steps of requiring applications, collecting information, evaluating information and making decisions must be addressed in the Bylaws. The details concerning who collects the information, where files are kept, how references should be checked, etc. can be in the rules, regs and policies.
10. Certain performance standards must be addressed in the Bylaws: EPs 1-33. Procedural details related to 26-33 can be either in the Bylaws or rules, regulations and policies.
11. Requirements for histories and physicals must be in Bylaws. This means putting a lot of details in the Bylaws that are drawn from the Medicare conditions of participation and possibly many licensure rules.
12. Bylaws must be approved by the entire medical staff. Approval of rules, regs and policies can be delegated to the MEC.
13. Second broad category of Joint Commission revisions concerns how the full medical staff relates to the MEC, the reasons seek to increase the role of the full medical staff and impose checks on the MEC’s authority.
14. These changes require Bylaws to address:
 - a. How the full medical staff can remove the MEC;

- b. What authority can be delegated to the MEC;
- c. How the MEC's authority can be removed;
- d. How the medical staff can act if there is disagreement in or failure to act by the MEC; and
- e. How the full medical staff can propose bylaws, rules or regs directly to the governing body.

CONTROVERSY CONCERNING THE PROPOSED CHANGES

1. A number of commentators have criticized the revisions as unworkable, unrealistic and contrary to the stated goal of a cohesive medical staff that works cooperatively with the hospital administration and governing body. The commentators also contend that the revisions will create unnecessary expense with little benefit and impose a time consuming burden on already stretched hospital and medical staffs. See sources.
2. Break down key issues into the same two broad categories.
3. **Bylaws redrafting:**
 - a. Confusion—what is a process and what is a procedural detail? How will organizations determine this?
 - b. Will spend unnecessary time deciphering this.
 - c. A hospital will risk accreditation deficiencies if the medical staff does not decipher this correctly.
 - d. Surveys will depend upon the subjective determination of the particular surveyor on whether a particular provision is a “process” or “procedural detail.”
 - e. If err on the side of caution and put everything in the Bylaws to avoid an issue, then creates practical future problems because every change has to be a major Bylaw change. This is time consuming, burdensome and cumbersome for medical staff and governing body.
 - f. Not much practical benefit to medical staff or hospitals from making this process versus procedural detail distinction.
 - g. Have to stop using credentialing manuals or fair hearing plans with which medical staffs have become familiar and move these to the Bylaws.
4. **Relative authority of medical staff and MEC.**

- a. Puts more authority in the medical staff and limits the ability to delegate authority to the MEC to act without the medical staff.
- b. Presumes medical staff has authority unless specifically delegated to MEC.
- c. Requires procedure for medical staff to override MEC or to remove delegated authority from MEC.
- d. Requires procedure for medical staff to remove MEC members.
- e. Requires procedure for medical staff to act if disagrees with MEC or MEC fails to act.
- f. Requires that medical staff be able to propose directly to governing body without having to go through MEC:
 - (1) Bylaws.
 - (2) Amendments to Bylaws.
 - (3) Veto of Bylaws.
- g. The positive of this approach is that it prevents an out of touch, dominating MEC from running over the medical staff.
- h. However, if there is any disagreement, no matter how much in the minority, among the medical staff, the disagreement can stymie action and result in two opposing or differing proposals being submitted to the governing body.
- i. The revisions seem to encourage fracturing of medical staff and perpetuating disagreement up to the Board level rather than the medical staff resolving its own differences first.
- j. Seems to be an effort to go back to the “good old days” where all the medical staff would regularly attend and participate and everyone would be equally vested in spending their time together addressing medical staff issues, which is different than what most hospitals have been experiencing.
- k. Likely to make it even more difficult to get physicians to volunteer for medical staff leadership positions since they are subject to being attacked and undercut.

PRACTICAL STEPS AND CONSIDERATIONS FOR IMPLEMENTATION OF THE PROPOSED REVISIONS

1. See sources. Some of the suggestions in this outline are drawn from those sources. Some are our thoughts.

2. When to take any action concerning your Bylaws?
 - a. Suggest waiting for report of Task Force and reaction of Joint Commission because revisions could change again.
 - b. May even want to wait longer such as until end of summer 2008 if your process and organization is such that you can still accomplish revisions in Bylaws by July 1, 2009.
3. If disagree with proposed revisions, suggest you send comments to the Task Force and to Joint Commission. It may not be too late.
 - a. If you are a physician, you may also want to comment to state association or society and AMA.
 - b. If you are a hospital, may also want to comment to state association and AHA.
4. Unless see real benefit to detailed, time consuming analysis of Bylaws regarding what is a process and what is a procedural detail, probably better just to move everything to the Bylaws, particularly anything in a credentialing plan or fair hearing manual.
 - a. Likely easier to work with if all in one place.
 - b. Have to move enough to the Bylaws anyway that may not escape much of the cumbersome Bylaw process to make it worth putting some items into rules, regs and policies at least until Joint Commission provides more clarification.
 - c. Multiple people have recommended this approach including Horthy Springer, Bricker & Eckler, and Katten Muchin as evident from the BNA article on Sept. 27 and the Bricker & Eckler Health Care Client Bulletin cited in the sources.
5. Be sure already have history and physical requirements in Bylaws and, if not, include that change in revisions.
6. Be sure Elements of Performance 1 through 25 are in the Bylaws.
7. Be sure the process for each Element of Performance 26 through 33 is in the Bylaws.
8. Move any manuals or fair hearing plans to the Bylaws. Brickler & Eckler in its Health Care Client Bulletin recommends changing the cover pages to state that these are part of the Bylaws.
9. Check the amendment process in your Bylaws and change if needed to eliminate any ability of MEC to make changes to sections that had been

covered in manuals adopted without vote of medical staff. Medical staff must have right to vote on everything required to be in the Bylaws.

10. Check the amendment process in Bylaws and change if needed to only allow MEC only to make changes to procedural details without vote of medical staff.
11. Review quorum provision and consider whether quorum is too high. May be difficult to gather a quorum the number of times needed to address the likely multiple times Bylaw changes may be needed in the future. Consider whether quorum can be obtained through electronic voting.
12. Evaluate whether voting procedures for medical staff are workable if more frequent votes may be needed.
 - a. Voting rights should be limited to the active medical staff and perhaps even active medical staff that have a certain minimum number of hospital encounters, admissions or procedures and are more vested in what occurs at the hospital.
 - b. Explore use of technology for voting electronically during a certain announced time period.
 - c. Consider how to communicate with medical staff concerning Bylaws revisions. In a HealthLeaders Media article in Sept 2007, Maureen Coler quotes Christina Giles, president of Medical Staff Solutions, as suggesting a chart or table form to show the key elements of an existing Bylaw provision compared to a proposed Bylaw change and e-mailing such materials to the medical staff or posting them electronically where the medical staff can access them.
 - d. Same considerations apply regarding any matter for vote. Think through how to present and communicate information, proposals and alternative positions.
 - e. Giles also recommends a vote process where a failure to return a ballot is presumed to be a “yes” vote and the ballot clearly states this presumption as well as where all the materials can be accessed electronically
 - f. It will be very important to give ample advance notice of proposed changes and opportunity for physicians to access information to ensure against claims that no notice was given.
 - g. Consider information sessions through department meetings where attendance and participation may be much better.
 - h. Consider use of video on web where physician can listen at his or her convenience to presentation on the Bylaws changes and register attendance in this way.

- i. May want to develop general voice mails or e-mails about targeted topics.
- 13. View revised standards as instituting more of democracy and checks and balances.
 - a. Could give constructive vehicle for expressing differing views rather than have undercurrents or coups.
 - b. Could help prevent acrimony when have significant number of employed physicians and non-employed physicians perceive favoritism toward employed physicians.
- 14. Also devise structure to prevent inaction due to apathy.
 - a. Possible requirement that physician attend certain minimum number of medical staff meetings to be eligible to renew privileges.
 - b. Possible requirement that physician access information and/or electronically vote on certain minimum percentage of matters raised for vote to renew privileges.
 - c. Track participation like tract quality measures and be a peer review factor.
- 15. Consider mechanisms for the medical staff to override an MEC action such as:
 - a. a waiting period before the MEC action becomes effective and placing a moratorium on the MEC action if a certain number or percentage of the medical staff vote against it or vote for a moratorium.
 - b. Brickler & Eckler proposes a process whereby a certain percentage of the active medical staff could petition either to change MEC action or to present a matter to the MEC or governing body.
- 16. Assess procedures to allow medical staff input before a vote to prevent overrides after MEC action.
 - a. More constructive and less divisive.
 - b. Establish advance notice and comment period where comments are available to all electronically.

- c. Require alternative or negative proposals to be communicated before a medical staff meeting or vote to allow possible compromises.
 - d. Establish super majority vote to defeat MEC action or to approve alternative proposal.
- 17. Evaluate possible mechanisms for removal of MEC members that would lessen the negative impact.
 - a. Need petition by certain minimum percentage of active medical staff to remove a MEC member.
 - b. Establish advance notice and comment period where comments are available to all electronically.
 - c. Consider requiring super majority vote.
 - d. Evaluate possible requirement that medical staff can only remove 25% or some other maximum percentage of members of MEC in any one year to prevent wholesale replacement and lack of continuity.
 - e. Perhaps replacement cannot be from same practice group as physician sponsoring motion to remove existing MEC member.
- 18. Prepare governing boards for possibility for alternate proposals rather than unified voice or medical staff akin to labor and management positions.
- 19. Review and take into account provisions in state licensing rules and Medicare conditions of participation.

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SOURCES

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