

## Frequently Asked Questions Regarding Standard MS.01.01.01 (formerly MS.1.20)

1. **Why was the MS.1.20 Task Force formed?** Standard MS.1.20 (currently MS.01.01.01) was created in 2004 and revised in June 2007. Since that time, the field has raised questions about the intent of its requirements. These concerns centered on requirements for details in the bylaws; the cost and burden associated with changing bylaws; the potential for disrupting relationships between the medical staff and governing body; and the role of the medical executive committee. Accordingly, the MS.1.20 Implementation Task Force was convened by The Joint Commission in December 2007 to analyze the potential impact of implementing the revised standard. The Task Force concluded that a revision of the June 2007 standard was necessary to address the concerns of the field.
2. **Who was on the Task Force and for how long did they meet?** The Task Force membership included representatives from seven professional organizations: American College of Physicians; American College of Surgeons; American Dental Association; American Hospital Association; American Medical Association; Federation of American Hospitals; and National Association Medical Staff Services. The Task Force included physicians, hospital CEOs, trustees, and healthcare attorneys with extensive experience with medical staff bylaws and related issues. The Task Force met 12 times between January 2008 and March 2009.
3. **How does MS.01.01.01 support patient safety and quality of care?** Decisions about patients' diagnoses and treatments are made by physicians and other "licensed independent practitioners" (that include, for example, dentists and podiatrists) who have been licensed by the state to diagnose and treat patients *without clinical supervision*.

This role of physicians and other licensed independent practitioners within a hospital has two implications:

- Legally, these physicians and other licensed independent practitioners can be *clinically* overseen only by others who are licensed independent practitioners.
- Their *clinical* decisions drive much of the rest of the hospital's activities—from nursing care to diagnostic imaging to laboratory testing to medication use—that powerfully affect the hospital's ability to provide high-quality, safe care to the patients it serves.

Therefore, the physicians and other licensed independent practitioners in the hospital form an "organized medical staff" that has both the technical knowledge and the legal standing to provide *clinical* oversight of the *clinical* care and performance of those with clinical privileges, and to evaluate and establish

direction for their *clinical* care and decision making. Standard LD.01.05.01 in the “Leadership” chapter specifically requires that this organized medical staff be “accountable to the governing body” to “oversee the quality of care, treatment, and services provided by those individuals with clinical privileges.”

For this reason, Joint Commission standards for hospital leadership describe three groups—the governing body, the chief executive and other senior managers, and the *organized medical staff*—that must work together if the hospital is to reliably achieve high-quality, safe patient care. To enable this collaboration, the governing body and the organized medical staff must *mutually* agree on rules, procedures, and parameters that will guide their interactions. That is the rationale behind proposed Standard MS.01.01.01, which requires that these rules, procedures, and parameters be in a set of medical staff bylaws and rules and regulations that are *adopted by the medical staff* and *approved by the governing body*.

Within this context, the medical staff’s oversight for which it is accountable includes collecting, verifying, and evaluating each licensed independent practitioner’s credentials, and recommending to the governing body that an individual be appointed to the medical staff and be granted clinical privileges, based on these credentials. Other medical staff and governing body activities related to the quality and safety of care include setting requirements for medical histories and physical examinations, terminating or suspending a practitioner’s medical staff membership or clinical privileges (including a process for challenging such action based on quality of care considerations), and directing medical staff departments.

How these activities are to be conducted, and the respective roles of the organized medical staff and the governing body, are part of the agreement between the governing body and the medical staff that is specified in the medical staff bylaws and rules and regulations.

4. **How is the working draft MS.01.01.01 an improvement over the June 2007 version of MS.1.20?** The working draft provides more flexibility for governing bodies and medical staffs to determine what will be placed in the medical staff bylaws and what will be placed in other documents. The working draft also provides for notification by the medical staff to the medical executive committee (MEC) when it wishes to propose a change to a rule, regulation, or policy directly to the governing body. At the same time, the MEC must provide notice to the medical staff concerning proposed changes to rules or regulations (policy changes by the MEC do not require notification). While disagreements in well-functioning organizations would be rare, the proposed standard calls for a process to manage conflict that might occur.
5. **All “requirements” for EPs 12-36 must now be in the bylaws. For those EPs 12-36 that require a process, the medical staff bylaws must include a**

**minimum the basic steps, as determined by the organized medical staff and approved by the governing body. The “associated details” for EPs 12-36 may reside in the medical staff bylaws, rules and regulations, or policies. The organized medical staff adopts what constitutes the associated details, where they reside, and whether their adoption can be delegated to the medical executive committee. EP 14 refers to the process for privileging and re-privileging licensed independent practitioners. Does this mean that all of the associated details to obtain privileges, such as the need to have successfully performed “x” number of laparoscopic cholecystectomies, must now be in the bylaws? Exactly what details or criteria must be in the bylaws and what should be in other documents?** Each hospital’s medical staff and governing body must decide what degree of detail needs to be in the bylaws—the critical issue being what must be jointly approved by the governing body and the organized medical staff. For example, a medical staff and governing body may wish to set a critical level of requirements that must be listed in the bylaws (with respect to credentialing or privileging)—such as board certification, valid license, and National Practitioner Data Bank query. As for the number of times a certain procedure must be performed before privileges are granted (for example, the number of times a laparoscopic procedure is performed), this requirement would be the type that might better be met by an individual department (e.g., surgery, family practice, etc.) and thus kept in rules and regulations or other documents—but this is up to each organization’s medical staff and governing body. With respect to a practitioner performing a new procedure (e.g., laparoscopic bariatric surgery), the bylaws could set a “bright line” that needs to be met—for example, that the physician be trained in a recognized program; that the physician successfully complete the program; that recommendations from peers be sent to the hospital; and that the physician be competent. The more specific details, such as the number of procedures to be performed, might then be determined by the particular department and placed in rules, regulations, or policies. Again, this is up to each medical staff and governing body.

- 6. What’s new in the working draft of Standard MS.01.01.01?** Draft Element of Performance (EP) 3 now provides flexibility to place associated details in medical staff bylaws, or rules and regulations, or policies. However, where an EP requires a process, the basic steps (of the process) need to be in the bylaws. The thinking of the Task Force was that all medical staff members need to participate in the adoption of the basic steps of processes since they have a direct bearing on quality and safety of care. At the same time, minor process details, which may be subject to frequent modification, can be placed in rules, regulations, or policies if so desired by the medical staff and governing body. The draft standard recognizes that conflicts regarding medical staff bylaws, rules and regulations, and policies may arise between the medical staff and the medical executive committee. EP 10 proposes that if a conflict should occur, a conflict management process is implemented. There is also a process for provisionally adopting and approving urgent amendments to rules and regulations until the medical staff has the

- opportunity to review and comment on the provisional amendment and the governing board approves the provisional amendment.
7. **The Joint Commission has received hospital deeming authority from the Centers for Medicare & Medicaid Services (CMS). CMS requires certain EPs to be contained in the medical staff bylaws. What EPs within the working draft of MS.01.01.01 are required by CMS to reside within the medical staff bylaws?** According to the CMS Conditions of Participation, the following requirements must reside within the medical staff bylaws: EP 12 (The structure of the medical staff); EP 13 (Qualifications for appointment to the medical staff); EP 14 (The process for privileging and re-privileging licensed independent practitioners, which may include the process for privileging and re-privileging other practitioners); EP 15 (A statement of the duties and privileges related to each category of the medical staff (for example, active, courtesy)); and EP 16 (The requirement for completing and documenting medical histories and physical examinations). It is important to note that anything in Standard MS.01.01.01 that is found to be in conflict with CMS Hospital Conditions of Participation either now or in the future, and consequently could threaten The Joint Commission’s hospital deeming authority, will be changed to align with the CMS requirements.
  8. **EP 16 provides that the “requirements” for performing histories and physicals (H&P) must be in the bylaws. Does that mean that the bylaws must now contain all the details regarding the required contents of an H&P, which are commonly found in medical staff rules or a medical record policy?** CMS CoPs (Section 482.22 (c) (5)) require that the medical staff bylaws contain the requirements for completing and documenting an H&P that must be completed for each patient. EP 16 was included to align Joint Commission requirements with CMS requirements which include information on who can perform an H&P and the time frame (e.g., not more than 30 days prior to and within 24 hours after admission; requirements for H&P updates; requirements for H&P outpatient procedures; and any countersignature requirements). Requirements for other information or details, such as the medical history, psychological history, body systems review, etc., can be placed in other documents (rules, regulations, or policies) if desired.
  9. **If the “requirements” of what must be included in an H&P are to be changed, does the medical staff have to go through the entire bylaw amendment process?** Yes; if requirements must be moved from the rules, regulations, or policies to the bylaws, and if the requirements were not originally voted on by the organized medical staff, the requirements must now be voted on by the organized medical staff before they are moved to the bylaws. Obviously, if the requirements are in need of being amended, the organized medical staff must vote on the amendments.

- 10. In EP 8, the organized medical staff has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments, and propose them directly to the governing body. Thus, the medical staff's ability to override an MEC action would appear to be very broad. Does this mean that there should be a process for the organized medical staff to review, and potentially reverse, any action of the MEC, including a recommendation concerning approval or denial of a particular practitioner's application for appointment or reappointment, or a recommendation related to some disciplinary action in an individual case?** It is up to the governing body and the organized medical staff to decide whether they want to have a process for the organized medical staff's review and potential reversal of such actions of the MEC. However, the general sense of the Task Force members was that this provision is meant to apply to bylaws, rules, regulations, and policies and not to decisions about individual practitioners taken pursuant to those bylaws, rules, regulations, and policies.
- 11. How does MS.01.01.01 promote efficiencies and a smoothly operating medical staff?** In a majority of cases, the organized medical staff and the governing body work together, reflecting clearly recognized roles, responsibilities, and accountabilities, to enhance the quality and safety of care, treatment, and services provided to patients. In well-functioning organizations, the Task Force anticipates little change to the bylaws will be needed, other than including the specific CMS requirements (if they are not already) and specifying basic steps of processes (which are already in many medical staff bylaws). In less well-functioning organizations, where there has been conflict, the proposed standard should help to reduce conflict by promoting discussion between the medical staff and governing body. In addition, the conflict management process could be implemented where there are disagreements between the medical staff and the MEC.
- 12. MS.01.01.01 appears to diminish the responsibility and authority of the Medical Executive Committee to act on behalf of the medical staff.** Proposed Standard MS.01.01.01 does not diminish the responsibility of the MEC to act on behalf of the medical staff. The proposed standard allows the medical staff (with the approval of the governing body) to determine what constitutes associated details (related to each EP), where they reside, and whether their adoption can be delegated to the MEC. If those details reside in rules, regulations, or policies and the medical staff delegates their adoption and amendment to the MEC, the MEC will continue to function much as it has in the past. The MEC will need to notify the medical staff about proposed amendments to rules and regulations, but such notification is easily accomplished through email or posting on the organization's intranet. It is important for medical staff members to be aware of proposed changes so that they can make suggestions for modification and be more aware of changes they may need to make in their activities. Standard MS.02.01.01 further defines the role of the MEC. The MEC acts on behalf of the organized medical

staff between medical staff meetings; has a mechanism to recommend medical staff membership termination; and makes recommendations directly to the governing body (as defined in the medical staff bylaws) regarding medical staff membership, the organized medical staff's structure, the process used to review credentials and delineate privileges, and the delineation of privileges for each practitioner privileged through the medical staff process. The MEC authority remains; it is just more clearly defined.

13. **What is the need for a conflict management process between the medical staff and MEC? Doesn't this assume that there is unnecessary friction between the medical staff and the MEC?** Given the current economy and stresses facing hospitals, it is possible that conflicts will arise between medical staffs and MECs. The conflict management process is a means by which these groups can recognize and manage conflict early and with minimal impact on quality of care and patient safety. Conflict management is important in any organization and similar procedures are required by the "Leadership" chapter with respect to conflicts among the medical staff, governing body, and senior management.
  
14. **Isn't MS.01.01.01 going to require excessive, time consuming, and costly revisions of medical staff bylaw?** The Joint Commission does not believe that this will be the case. For those medical staffs and governing bodies who have engaged in robust discussion regarding what is to be placed in medical staff bylaws, rules and regulations, and policies, there is no need to totally revise their medical staff bylaws. Given the proposed flexibility provided for in the draft standard, a limited amount of revision is all that may be needed. In some cases, no revisions will be required.