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About The Greeley Company

The Greeley Company's consultants and educators are physician leaders and senior healthcare professionals with hands-on experience in hospital, ambulatory, physician practice, and managed care settings. Our approach is to provide consultation, education, and training that is timely and cost-effective and to partner with our clients to produce high-impact results that serve the best interests of your organization, your patients, and the communities you serve.

We’re dedicated to helping healthcare leaders succeed in the face of today’s toughest challenges. We know how hard your job is. We have years of experience doing your job and helping others across the country do their jobs. From that experience, we know you don’t always have all the talent, resources, or time available within your organization to tackle the issues most important for your success and sometimes even for your organization’s survival. So when you need help, we’ll be there with just the customized, effective solution you need.

Contact us at:
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Seminars:  800/801-6661  800/738-1553 (fax)

About The Greeley Medical Staff Institute

The Greeley Medical Staff Institute is a unique membership organization dedicated to serving the needs of hospital and medical staff leaders who recognize the importance of effective physician relationships to their hospital's success. Members of the institute receive exclusive access to high-level, nationally renowned consulting experts—all physicians and former hospital leaders—who work closely with you and members of your staff to develop and implement a multifaceted relationship-building program. Each customized program is designed to reduce hospital costs, build effective medical staff leadership, develop a succession strategy, comply with regulatory requirements, meet public accountability for quality, and train staff members to practice safe and effective medicine.
Speaker profiles

Jonathan H. Burroughs, MD, MBA, FACPE, CMSL

Dr. Jon Burroughs is a senior consultant with The Greeley Company working with medical staffs and boards throughout the country in the areas of governance, credentialing, privileging, peer review and performance improvement, medical staff development planning, strategic planning and physician performance and behavior management.

Board certified in medical management, Dr. Burroughs is a past medical staff president, past president of the New Hampshire chapter of the American College of Emergency Physicians, and most recently served as an emergency department medical director. As a member of the governing board of Memorial Hospital in New Hampshire, he chaired the ethics, succession planning and bylaws committees and sat on the joint conference, strategic planning, and medical executive committees.

Dr. Burroughs’ passion for the outdoors has led to his serving as a physician on mountaineering expeditions throughout the United States, Mexico, South America, Europe, Africa, and Russia and he is the co-editor of the 26th edition of the White Mountain Guide and the 1st edition of the Southern New Hampshire Trail Guide. He has reached the summits of Mts. McKinley (Alaska), Grand Teton (Wyoming) Blanc (France/Italy), Elbrus (Russia), Kilimanjaro (Tanzania), Orizaba (Mexico), Rosa (Switzerland), and Rainier (Washington), to name a few.

Dr. Burroughs received his BA degree at Johns Hopkins University and his MD from Case Western Reserve. He previously served as a member of the clinical faculty of Dartmouth Medical School where his research interests included introducing EMT defibrillation and automatic defibrillation into the field. Dr. Burroughs is a certified physician executive, a fellow of the American College of Physician Executives, and completed his healthcare MBA at the Isenberg School of Management. He currently serves on the national faculty of the American College of Physician Executives.

HCPro, Inc. has confirmed that none of the faculty/presenters or contributors have any relevant financial relationships to disclose related to the content of this educational activity.
Carol S. Cairns, CPMSM, CPCS

Ms. Cairns has participated in the development of the medical staff services profession for more than 35 years. She is a senior consultant and frequent presenter with The Greeley Company, based in Marblehead, MA and serves as president of PRO-CON. A recognized expert in the field, Ms. Cairns presents frequently for healthcare entities as well as at state and national seminars.

Ms. Cairns began her career in medical staff services in Joliet, IL, where she coordinated and directed medical staff services for Provena Saint Joseph Medical Center and Silver Cross Hospital. In 1991, she became clinical faculty member and author for The Joint Commission by collaboratively developing an educational program entitled “Credentialing and Privileging Medical Staff and Allied Health Professionals.” She served as clinical faculty for this program from 1991 to 2000. Ms. Cairns coauthored The Medical Staff Handbook: A Guide to Joint Commission Standards, which focuses on medical staff credentialing and privileging standards, and authored The LIP’s Guide to Credentials Review and Privileging, both published by The Joint Commission.

In addition, Ms. Cairns has been a faculty member with the National Association Medical Staff Services (NAMSS) since 1990. She presents at numerous state and national seminars on subjects such as basic and advanced credentialing and privileging, the Centers for Medicare & Medicaid Services' Conditions of Participation, The Joint Commission standards and survey preparation, National Committee on Quality Assurance (NCQA) standards, Healthcare Facilities Accreditation Program Standards, AHP credentialing, core privileging, risk management, and meeting management and documentation. In 1995, Ms. Cairns coauthored the NAMSS educational program for certification of provider credentialing specialists (CPCS), for which she also currently serves as faculty.

In 1996, NCQA appointed Ms. Cairns as a surveyor in its certification program for credentials verification organizations (CVO). She surveyed CVOs for the NCQA and was a clinical faculty member for the NCQA on credentialing and CVO certification until 2006. In 2003, Ms. Cairns provided input to the American Osteopathic Association 2004 Healthcare Facilities Accreditation Program relative to the medical staff and allied health professionals credentialing and privileging standards. In 2005, the Illinois State Association Medical Staff Services recognized Ms. Cairns by presenting her with a Distinguished Member award. To date, she is one of only two recipients.

Key 2009 Joint Commission Leadership Standards
What Medical Staff Leaders Need to Know

Jonathan Burroughs, MD, MBA, FACPE, CMSL
Carol Cairns, CPMSM, CPCS
March 13, 2009

Why New Leadership Standards?
Leadership standards in 2009

- Leadership standards completely rewritten and emphasize collaboration among the “three leadership groups:”
  - The governing body (GB)
  - Senior managers (SM)
  - The organized medical staff (MS)

Overview statement

- Leaders shape the hospital’s culture, and the culture, in turn affects how the hospital accomplishes its work.

- Leaders have an obligation to set an example of how to work together to fulfill the hospital’s mission...leaders model to others how to collaborate, communicate, solve problems, manage conflict, and maintain ethical standards, essential practices that contribute to safe health care.
Overview statement (cont)

- Three leadership groups:
  - Senior managers—Direct the day-to-day operations of the hospital
  - Governing body—Determines what resources the hospital needs and then secures those resources
  - Organized medical staff—Make independent decisions about the diagnosis and treatment of their patients and, in doing so influence the choice and use of many of the hospital’s resources

Emphasis on governing body accountability

- LD Overview
  - Final decisions are always the ultimate responsibility of the GB

- LD Standards (LD.01.05.01) relocated from MS
  - There is a single organized medical staff…
  - The organized MS is self-governing
  - The GB approves the structure of the organized MS
  - The organized MS oversees the quality of care, treatment, and services provided by those with clinical privileges
  - The organized MS is accountable to the GB
Leadership standards in 2009

- Highlights of major areas:
  - Senior managers and MS work with governing body to define shared and unique responsibilities and accountabilities (LD.01.02.01)
  - GB establishes process for making decisions when leadership group fails to fulfill its responsibilities and/or accountabilities (LD.01.02.01)
  - GB, SM, MS annually evaluate hospital’s performance in relation to mission, vision, goals (LD.01.03.01)

Leadership standards in 2009

- Individual members of GB, SM, MS are oriented to all of the following related to the hospital:
  - Mission & vision
  - Safety and quality goals
  - Structure and decision-making process
  - Development of budget & interpretation of financial statements
  - Population served and issues related
  - Individual and interdependent responsibilities and accountabilities of GB, SM, MS relating to supporting the mission and providing safe and quality care
  - Applicable law and regulation

- GB provides leaders with access to information and training in areas of needed skills or expertise
Leadership standards in 2009

- The hospital manages conflict between leadership groups to protect quality and safety of care (LD.02.04.01)

- Leaders create and maintain a culture of safety and quality throughout the hospital (LD.03.01.01)

- The leaders address any conflict of interest involving licensed independent practitioners and/or staff that affects or has the potential to affect the safety or quality of care treatment and services (LD.04.02.01)
Key leadership structures, responsibilities, and relationships

- Governing Board (LD.01.03.01): responsible for overall quality and safety and must establish a conflict resolution mechanism
- CEO (LD.01.04.01): accountable to governing board
- Medical Staff (LD.01.05.01): accountable to governing board

Board, administration, and medical staff relationships

Board of directors
  - CEO (System Quality)
  - MEC (Individual Quality)
Creating a Culture of Safety

Why a Culture of Safety?

- Errors are inevitable
- Error prone situations are predictable
- We cannot get there alone
- We must work together to create a “system of safety” that enables individuals to excel
What is a Culture of Safety?

- Teamwork within units
- Leadership actions and expectations promoting and supporting safety
- Organizational learning and continuous improvement

Culture of Safety (cont)

- Overall perception of patient safety
- Feedback and communication about error
- Communication openness
Culture of Safety (cont)

- Frequency of events reported
- Teamwork across units
- Adequate staffing to reduce errors

Culture of Safety (cont)

- Standardized handoffs and transitions
- Non-punitive response to errors (re-frame as learning)
- Culture of safety becomes a normative value
LD.03.01.01: Leaders create and maintain a culture of safety throughout the organization

- EP1- Leaders regularly evaluate the culture of safety and quality using valid and reliable tools

- EP2- Leaders prioritize and implement changes identified by the evaluation

- EP6- Leaders provide education that focuses on safety and quality for all individuals

- EP7- Leaders establish a team approach among all staff at all levels

- EP8- All individuals who work in the hospital...are able to openly discuss issues of safety and quality
Conflict Management and Managing Conflicts of Interest

Conflict management

- Differs from “conflict of interest”
- Implications of conflict

Must have process for addressing:
1. Conflict between leadership groups that jeopardizes patient quality/safety (LD.02.04.01)
2. Adverse conflict between others in the organization (LD.01.03.01 EP7)
3. Disruptive behavior (LD.03.01.01 EP 4, 5, 7)
**LD.02.04.01: Conflict between leadership groups**

- **EP1**- Ongoing process for managing conflict between leadership groups
- **EP2**- Board approves
- **EP3**- Process engages individuals who are skilled in conflict management

**LD.02.04.01: Conflict between leadership groups**

- **EP4**- Process expectations (meet with others ASAP to understand conflict, gather information, work with parties to address conflict, protect patients from inadvertent harm)
- **EP5**- Implement!
Conflict resolution process

- Open door (structured access)
- “Peer Review” (peers adjudicating peers)
- Joint Conference Committee
- Mediation
- Non-binding arbitration
- Binding arbitration

LD.01.03.01: Conflict between others in the organization

- EP7: The governing body provides a system for resolving conflicts among individuals working in the hospital
**LD.03.01.01: Disruptive Behavior**

- EP4- Code of Conduct defines acceptable, disruptive, and inappropriate behaviors
- EP5- Leaders create and implement a process for managing disruptive and inappropriate behaviors
- EP7- Physician responsible for organization and conduct of the medical staff (effective July, 2009)

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**Sentinel Event Alert #40: Intimidating and Disruptive Behaviors cause...**

- Medical errors/deaths
- Increased costs (complications, re-work, liability, staff turnover, loss of confidence)
- Breakdown in communication/teamwork (leading cause of sentinel events)
So what’s the problem?

- History of tolerance and indifference
- Fear of retaliation (financial and legal)
- Fear of confrontation and conflict
- Professional and social stigma
- Some physicians are “more equal” than others

In other words: inadvertent and indirect promotion

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The power of the pyramid
Achieving great physician performance

- Appoint excellent physicians
- Set, communicate, and achieve buy in to expectations
- Measure performance against expectations
- Provide periodic feedback

30
LD.02.01 and LD.04.02.01: Conflicts of Interest

- Define conflicts of interest that can adversely affect patient safety or quality of services
- Written conflict of interest policy
- Culture of open “disclosure”
- Review relationships with external entities (legal and regulatory requirements)
- By request, respond to relationships between care/treatment and financial incentives
LD.2.30: Board, medical staff, and management communication

- Regular communication
- Focus on quality and safety
- Generate trust and mutual respect

Elements of trust and mutual respect

- Explore inadvertent judgment of differing perceptions
- Find shared goals to commit to
- Understand each other
- Assume responsibility for “self”
- Maintain integrity
- “Walk the talk” consistently
- Share sensitive issues
- Forgive and reconcile
In summary, new leadership standards want us to build a culture of

- Safety
- Collaboration
- Forgiveness and reconciliation
- Trust and mutual respect
- Care and compassion
EXHIBIT B

AHRQ 2008 Patient Safety Culture Composite Results
AHRQ 2008 Patient Safety Culture Composite Results

1. Teamwork Within Units 100%
2. Supervisor/Manager Expectations & Actions Promoting Patient Safety
3. Management Support for Patient Safety
4. Organizational Learning-Continuous Improvement
5. Overall Perception of Patient Safety
6. Feedback & Communication About Error
7. Communication Openness
8. Frequency of Events Reported
9. Teamwork Across Units
10. Staffing
11. Handoffs & Transitions
12. Nonpunitive Response to Error

EXHIBIT C

Sample Policy and Procedure
Medical Staff Professional Conduct Policy
Sample Policy & Procedure
Medical Staff Professional Conduct Policy

Objective
The objective of this policy is to ensure optimum patient care by promoting a safe, cooperative, and professional healthcare environment, and to prevent or eliminate, to the extent possible, conduct that:

- disrupts the operation of the hospital;
- affects the ability of others to do their jobs;
- creates a hostile work environment for hospital employees or other medical staff members;
- interferes with an individual’s ability to practice competently; or
- adversely affects or impacts the community’s confidence in the hospital’s ability to provide quality patient care.

Policy
It is the policy of the medical staff that all individuals within the hospital’s facilities will be treated with courtesy, respect, and dignity. To that end, the medical staff requires that all members of the medical staff as well as advanced practice professionals granted privileges conduct themselves in a professional and cooperative manner in the hospital. The medical staff intends to enforce this policy in a firm, fair, and equitable manner.

The medical staff is accountable to the board of trustees for effectively addressing disruptive behavior by physicians and other advanced practice professionals with privileges consistent with this policy. As a result, individual incidents of severe disruptive behavior or persistent patterns of disruptive behavior not addressed by the medical staff in an effective and timely fashion shall be definitively addressed by the governing board.

The medical staff will interpret and enforce this policy as its sole process for dealing with egregious incidents and persistent patterns of disruptive behavior. No other policy or procedure shall be applicable to disruptive behavior except as designated by the medical staff and governing board.

Definition
Consistent with the objective above, unacceptable, disruptive conduct may include, but is not limited to, behavior such as the following:

- Attacks—verbal or physical—leveled at other appointees to the medical staff, hospital personnel, patients or patients’ families that are personal, irrelevant, or beyond the bounds of appropriate, professional conduct;
- Impertinent and inappropriate comments or illustrations made in patient medical records or other official documents that impugn the quality of care in the hospital or attack particular physicians, nurses, or hospital policies;
- Criticism leveled at the recipient in such a way that it intimidates, undermines confidence, belittles, or implies stupidity or incompetence;
• Behavior in committee, department, or other medical staff or hospital affairs that is rude, disrespectful, threatening, or otherwise unprofessional or inappropriate.

Disruptive behavior shall not include constructive concerns regarding patient care and the system of care that are communicated through appropriate channels in a good faith effort to improve the quality of care and services throughout the organization.

Procedure
This policy will be implemented in a manner that carries out the following activities:

• Set, communicate, and achieve “buy in” to clear expectations of behavior, including wide dissemination of this policy;
• Measure performance of individuals compared to these expectations;
• Provide constructive timely and periodic feedback of performance to individuals;
• Manage poor performance when patterns of disruptive behavior persist in an effort to improve performance;
• Take corrective action to terminate or limit a provider’s medical staff membership or privileges following a single egregious incident or when the problem cannot otherwise be resolved in a timely and supportive manner.

Any physician, advanced practice professional, employee, patient, or visitor may report conduct that they deem disruptive. Individuals may submit a report to the [chief medical officer or a member of hospital management], who will then forward the document to the CMO or the president of the medical staff.

Once it is received, the [chief medical officer, in consultation with the president of the medical staff,] will investigate the report. The chief medical officer may dismiss any unfounded report and will notify the individual who initiated the report of his or her decision. A confirmed report will be addressed as follows:

1. It shall be made clear to the offending individual that attempts to confront, intimidate, or otherwise retaliate against the individual(s) who reported the behavior in question is a violation of this policy and grounds for further disciplinary action.

2. A single confirmed incident warrants a discussion with the offending individual. The [chief medical officer/chief of staff] or designee shall initiate such a discussion and emphasize that such conduct is inappropriate and must cease. The [chief medical officer/chief of staff] or designee will provide the offender with a copy of this policy and inform the individual that the board of trustees requires compliance with this policy. The approach during such an initial intervention should be collegial and helpful to the individual and the hospital.

3. Further incidents that do not cluster into a pattern of persistent disruptive behavior will be handled by providing the individual with notification of each incident and a reminder of the expectation that the individual comply with this policy, i.e. as a rule violation.

4. If the chief medical officer, the president of the medical staff, or department chair determines the individual is demonstrating persistent disruptive behavior, the [chief medical officer/president of the medical staff] or designee shall discuss the matter with the individual as outlined below:
As with the single confirmed incident, the [chief medical officer/president of the medical staff] or designee will provide the offending individual with a copy of this policy and inform the individual that the medical executive committee (MEC) and board of trustees require compliance with this policy. Failure to agree to abide by the terms of this policy shall be grounds for summary suspension or precautionary suspension.

The [chief medical officer/president of the medical staff] or designee will inform the offending individual that if the disruptive behavior recurs, the MEC and/or board will take more formal action to stop it. The MEC and CEO will also receive notification about the recurrence of the behavior.

Because documentation of each incident of disruptive conduct is critical as it is ordinarily not one incident alone that leads to corrective action, but rather a pattern of inappropriate conduct, the [chief medical officer/president of the medical staff] or designee shall document all meetings regarding professional conduct in writing through at least a follow-up letter to the offending individual. The letter will document the content of the discussion and any specific actions the offending individual has agreed to perform. The letter shall include all of the following:

a) The date and time of the questionable behavior
b) A statement of whether the behavior affected or involved a patient in any way, and, if so, information identifying the patient
c) The circumstances that precipitated the situation
d) A factual and objective description of the questionable behavior
e) The consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations
f) A record of any action taken to remedy the situation, including the date, time, place, action, and name(s) of those intervening and follow up action steps agreed to by the individual involved and the individual(s) performing the intervention.

The chief medical officer will keep a copy of this letter on file.

The involved practitioner may submit a rebuttal to the charge. The rebuttal will become a permanent part of the record.

If the offending behavior continues, it is the responsibility of the president of the medical staff to ensure that it stops. To do so, the president of the medical staff [or designee] will collaborate with [the chief medical officer and CEO] in holding a series of meetings with the offending individual until the behavior stops. The intervention involved in each meeting will progressively increase in severity until the behavior in question ceases.

If, in spite of these interventions, the behavior in question continues, the president of the medical staff and [the board chair, or designee] shall meet with and advise the offending individual that such conduct is intolerable and must stop. The individuals carrying out this intervention will inform the individual that a single recurrence of the offending behavior within a specified time period shall result in loss of medical staff membership and privileges. This meeting is not a discussion, but rather constitutes the physician’s final warning. The offender will also receive a follow-up letter that reiterates the final warning.
6. If, after this final meeting, the offending behavior recurs within the specified time period, the individual’s medical staff membership and privileges shall be summarily suspended consistent with the summary suspension terms of the medical staff bylaws and policies and procedures. The MEC and board will then take action to revoke the individual’s membership and privileges. The individual will be ineligible to reapply to the medical staff for a period of at least one year.

7. If a single incident of disruptive behavior or repeated incidents of disruptive behavior are determined to place patient care or the liability and reputation of the hospital at risk, the offending individual may be summarily or precautionarily suspended, and the medical staff and hospital policies for addressing summary suspension will be followed.

Note: Hospitals must seek expert legal advice when implementing this policy and procedure. Provisions of this recommended policy might conflict with medical staff bylaws or fair hearing procedures. Hospitals must address such conflicts before finalizing this policy. In addition, medical staffs may choose to adopt this policy as a medical staff policy rather than a board policy. In such case, appropriate changes to the policy language will have to be made.
EXHIBIT D

Sample Policy and Procedure
Joint Board, Hospital and Medical
Staff Professional Conduct Policy
Sample Policy and Procedure

Joint Board, Hospital and Medical Staff Professional Conduct Policy

Objective
The objective of this policy is to ensure optimum patient care by promoting a safe, cooperative, and professional healthcare environment, and to prevent or eliminate, to the extent possible, conduct that:

- disrupts the operation of the hospital;
- affects the ability of others to do their jobs;
- creates a hostile work environment for hospital employees or other medical staff members;
- interferes with an individual’s ability to practice competently; or
- adversely affects or impacts the community’s confidence in the hospital’s ability to provide quality patient care.

Policy
It is the policy of [HOSPITAL NAME, hereinafter hospital] that all individuals within the hospital’s facilities will be treated with courtesy, respect, and dignity. To that end, the hospital requires that all individuals working and/or providing patient care within the hospital, including all members of the medical staff as well as allied health practitioners granted privileges, conduct themselves in a professional and cooperative manner in the hospital. The board of trustees, hospital management, and medical staff will enforce this policy in a firm, fair, and equitable manner.

All employees of the hospital as well as individuals providing services through contracts with the hospital are accountable to the hospital chief executive officer (CEO) for their conduct within the hospital. The CEO is accountable to the board for effectively addressing unprofessional conduct by these individuals consistent with this policy. All practitioners granted privileges are accountable to the medical staff for their conduct within the hospital. The medical staff is accountable to the board of trustees for effectively addressing unprofessional conduct by these individuals consistent with this policy. Individual incidents of severe unprofessional conduct or persistent patterns of unprofessional conduct not addressed by the CEO or medical staff in an effective and timely fashion shall be definitively addressed by the governing board.

Individual members of the board are accountable to the board as a whole for their conduct within the hospital and for complying with this policy.

All patients, visitors, and guests are required under Title VII of the Civil Rights Act of 1964 as amended in 1991 to treat all individuals within the healthcare organization with dignity and respect and will be accountable to senior management and the governing board to assure compliance.

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Human resource policies shall be implemented as applicable in addressing unprofessional conduct by hospital employees. In the event of a conflict between a human resource policy and this policy, the terms of [the human resource policy/this policy] shall prevail.

The medical staff will interpret and enforce this policy as its sole process for dealing with egregious incidents and persistent patterns of unprofessional conduct. No other policy or procedure shall be applicable to unprofessional conduct by individuals granted privileges except as designated by the medical staff and governing board.

**Definition**
Consistent with the objective above, unacceptable, disruptive conduct may include, but is not limited to, behavior such as the following:

1) Attacks—verbal or physical—leveled at other appointees to the medical staff, hospital personnel, patients or patients’ families that are personal, irrelevant, or beyond the bounds of appropriate, professional conduct;

2) Impertinent and inappropriate comments or illustrations made in patient medical records or other official documents that impugn the quality of care in the hospital or attack particular physicians, nurses, or hospital policies;

3) Criticism leveled at the recipient in such a way that it intimidates, undermines confidence, belittles, or implies stupidity or incompetence;

4) Behavior in committee, department, or other medical staff or hospital affairs that is rude, disrespectful, threatening, or otherwise unprofessional or inappropriate.

**Procedure**
This policy will be implemented in a manner that carries out the following activities:

- Set, communicate, and achieve “buy in” to clear expectations of behavior, including wide dissemination of this policy;
- Measure performance of individuals compared to these expectations;
- Provide constructive timely and periodic feedback of performance to individuals;
- Manage poor performance when patterns of disruptive behavior persist to improve performance;
- Take corrective action as applicable to terminate or limit employment, a contract, or a provider's medical staff membership or privileges following a single egregious incident or when the problem cannot otherwise be resolved in a timely manner.

Any physician, allied health practitioner, employee, patient, or visitor may report conduct that they deem unprofessional. Individuals may submit a report to the [chief medical officer or a member of hospital management], who will then forward the document to the chief executive officer (CEO), chief medical officer, or the president of the medical staff as appropriate.

Once it is received, the report will be investigated to determine validity. This investigation will be carried out by the appropriate manager for employees and contracted individuals and by the [chief medical officer, in consultation with the president of the medical staff] for providers granted privileges. The investigating individual may dismiss any unfounded report and will notify the individual who initiated the report of his or her decision. A confirmed report will be addressed as follows:
1. It shall be made clear to the offending individual that attempts to confront, intimidate, or otherwise retaliate against the individual(s) who reported the behavior in question is a violation of this policy and grounds for further disciplinary action.

2. A single confirmed incident warrants a discussion with the offending individual. For employees, patients/visitors, and contracted individuals, this shall be carried out by the appropriate manager. For providers granted privileges, this shall be carried out by the [department chair/president of the medical staff] with the support of the [chief medical officer/CEO]. This initial discussion shall emphasize that such conduct is inappropriate and must cease. The person(s) conducting the discussion will provide the offender with a copy of this policy and inform the individual that the board of trustees requires compliance with this policy. The approach during such an initial intervention should be collegial and helpful to the individual and the hospital.

3. Further incidents that do not cluster into a pattern of persistent disruptive behavior will be handled by providing the individual with notification of each incident and a reminder of the expectation that the individual comply with this policy, i.e. as a rule violation.

4. If is determined that the individual is demonstrating persistent unprofessional conduct, this will be addressed with the individual as outlined below. For an employee or contracted individual these steps will be carried out by the appropriate manager with the support of the human resources department. For a provider granted privileges, these steps will be carried out by the president of the medical staff with the support of the [chief medical officer and CEO] or their designees.

   • As with the single confirmed incident, the individual(s) conducting the intervention will provide the offending individual with a copy of this policy and inform the individual that the board of trustees requires compliance with this policy. Failure to agree to abide by the terms of this policy shall be grounds for loss of employment, contract, or summary suspension of medical staff membership and privileges, as appropriate to the individual’s status.

   • Patients and their families, visitors and guests will be counseled by an appropriate member of management to inform them of the organization’s policy and if the behavior continues, families, visitors and guests may be asked to leave the premises and if the behavior is egregious, the police department may be called to restore order and restrict conduct that may place the patient care environment at risk.

   • The individual(s) conducting the intervention will inform the offending individual that if the unprofessional conduct recurs, the management, the medical executive committee (MEC) and/or board will take more formal action to stop it. For providers granted privileges, the MEC and CEO will receive notification about the recurrence of the behavior.

   • Because documentation of each incident of unprofessional conduct is critical as it is ordinarily not one incident alone that leads to corrective action, but rather a pattern of inappropriate conduct, the individual(s) conducting the intervention shall document all meetings regarding unprofessional conduct in writing through at least a follow-up letter to the offending individual. The letter will document the content of the discussion and any specific actions the offending individual has agreed to perform. The letter shall include all of the following:

      a) The date and time of the questionable behavior
      b) A statement of whether the behavior affected or involved a patient in any way, and, if so, information identifying the patient
c) The circumstances that precipitated the situation

d) A factual and objective description of the questionable behavior

e) The consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations

f) A record of any action taken to remedy the situation, including the date, time, place, action, and name(s) of those intervening and follow up action steps agreed to by the individual involved and the individual(s) performing the intervention.

The hospital will keep a copy of this letter on file.

The involved individual may submit a rebuttal to the charge. The rebuttal will become a permanent part of the record.

• If the offending behavior continues, for employees and contracted individuals, it is the responsibility of the CEO to ensure that it stops. To do so, the appropriate manager will collaborate with the CEO or designee in holding meetings with the offending individual until the behavior stops. For providers granted privileges, it is the responsibility of the president of the medical staff to ensure that it stops. To do so, the president of the medical staff [or designee] will collaborate with [the chief medical officer and CEO] in holding a series of meetings with the offending individual until the behavior stops. Regardless of who is carrying out these meetings, the intervention involved in each meeting will progressively increase in severity until the behavior in question ceases.

5) If, in spite of these interventions, the behavior in question continues, the offending individual will receive a final warning. The individuals carrying out this intervention will inform the offending individual that a single recurrence of the offending behavior within a specified time period shall result in separation from the hospital through termination of employment or contract or through loss of medical staff membership and privileges, as appropriate. This meeting is not a discussion, but rather constitutes the physician’s final warning. The offender will also receive a follow-up letter that reiterates the final warning.

6) If, after this final meeting, the offending behavior recurs within the specified time period, for employees or contracted individuals, their employment or contract will be terminated. For providers granted privileges, the individual’s medical staff membership and privileges shall be summarily suspended consistent with the summary suspension terms of the medical staff bylaws and policies and procedures. The MEC and board will then take action to revoke the individual’s membership and privileges. The individual will be ineligible to reapply to the medical staff for a period of at least one year.

7) If a single incident of disruptive behavior or repeated incidents of disruptive behavior are determined to place patient care or the liability and reputation of the hospital at risk, the offending individual may be immediately fired or their contract terminated. For providers granted privileges, the individual will be summarily suspended, and the medical staff and hospital policies for addressing summary suspension will be followed.

8) For governing board members exhibiting unprofessional conduct, the steps outlined above will be implemented by the chairman of the board. In the event the offending
individual is the chairman, the board shall appoint one or more individuals to carry out the steps outlined above.

Note: Hospitals must seek expert legal advice when implementing this policy and procedure. Provisions of this recommended policy might conflict with medical staff bylaws or fair hearing procedures. Hospitals must address such conflicts before finalizing this policy. In addition, medical staffs may choose to adopt this policy as a medical staff policy rather than a board policy. In such case, appropriate changes to the policy language will have to be made.
EXHIBIT E

Sample Policy and Procedure
Medical Staff Conflict of Interest Policy
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Medical Staff Conflict of Interest Policy

Policy:
It is the policy of [______ hospital/healthcare system] that all practitioners serving in an elected or appointed position in the organized medical staff (such as an officer, department chair, or a member of the medical executive, peer review, or credentials committees), or otherwise carrying out a function of the organized medical staff (such as peer review), shall act in good faith to fulfill their responsibilities under the medical staff’s bylaws, rules and regulations, and policies. In order to achieve this goal, practitioners shall fully and openly disclose any actual or potential conflicts of interest at the time they arise in the course of serving in such a position or fulfilling such a medical staff function. At the time of disclosure, it is the responsibility of the medical staff, through its self governing structure, to determine whether and to what extent such conflict of interest should limit the practitioner’s participation in their position, medical staff function, or the particular issue under consideration.

Procedure:
1. At least annually, each practitioner serving in an elected or appointed position in the organized medical staff shall complete a conflict of interest disclosure form identifying any activities, interests, relationships or financial holdings that create or have the potential to create a conflict of interest for the practitioner in carrying out the responsibilities of that position.

2. When an issue comes before the individual practitioner as a result of serving in a position in the organized medical staff, such as a department chair or member of a committee, to which an actual or potential conflict of interest may be relevant, the practitioner shall disclose the conflict of interest prior to participating in consideration of that issue. Such disclosure shall include any conflicts of interest that may have developed since the practitioner’s previous completion of the conflict of interest disclosure form.

3. If the practitioner’s position to which the conflict applies is membership of a committee, such as the credentials or medical executive committee, the disclosure shall be made to the committee as a whole. The practitioner may then remove him or herself from the committee while the committee determines whether and to what extent the practitioner may participate in consideration of the issue.

4. If the practitioner’s position to which the conflict applies is an elected or appointed leadership role, such as a medical staff officer or department chair, the practitioner shall make the disclosure to the individual or committee to which that position is accountable in the organized medical staff governing structure. It shall be the responsibility of the individual or committee to which the disclosure is made to determine whether and to what extent the person making the disclosure may participate in consideration of the issue. For example, a department chair considering a privileging issue for a direct competitor shall disclose the potential for a conflict of interest to the credentials committee. The credentials committee shall then determine if the department chair should make any recommendations concerning the competitor’s privileges or not. If it is the [chief of staff/president of the medical staff] to whom a conflict applies, disclosure shall be to the medical executive committee which shall be responsible for determining the degree to which the practitioner may participate in consideration of the issue.
Sample Policy & Procedure
Conflict Resolution

Unless otherwise set forth in the Medical Staff Bylaws or Hospital Articles of Incorporation or Bylaws, the Medical Staff, in partnership with the Board of [Hospital], establishes the following process for addressing conflicting recommendations made by the Board and the Medical Staff:

1. The Medical Staff, in partnership with the Board will make best efforts to address and resolve all conflicting recommendations in the best interests of patients, [Hospital], the communities we serve, and the members of the Medical Staff.

2. When the Board plans to act or is considering acting in a manner contrary to a recommendation by the MEC, the Medical Staff Officers shall meet with the Board or a designated committee of the Board and management and seek to resolve the conflict through informal discussions.

3. If these informal discussions fail to resolve the conflict, the Medical Staff President or the chairperson of the Board may request initiation of a formal conflict resolution process.

4. The formal conflict resolution process will begin with a meeting of the Joint Conference Committee within thirty (30) days of the initiation of the formal conflict resolution process to address the conflict.

5. The Joint Conference Committee shall be comprised of an equal number of representatives of the MEC and the Board, and the CEO or designee. Membership shall be the three officers of the Medical Staff, the at large elected MEC member, the chairperson(s), vice-chairperson and secretary of the Board or other designees of the board, and the CEO or designee.

6. If the Joint Conference Committee cannot produce a resolution to the conflict acceptable to the MEC and the Board within thirty (30) days of this initial meeting, the Medical Staff and the Board may enter into mediation facilitated by an outside party.

7. The MEC and Board shall agree upon the selection of the third party mediator.

8. The MEC and Board shall make best efforts to collaborate together and with the third party mediator to resolve the conflict. The Board and the MEC shall each designate at least three people to participate in the mediation. Any resolution arrived at during such meeting shall be subject to the approvals of the MEC and the Board which are set forth in the Medical Staff Bylaws and the Articles of Incorporation and Bylaws of the Hospital.

9. If, after ninety (90) days from the date of the initial request for mediation from an outside party, the MEC and Board cannot resolve the conflict in a manner agreeable to all parties, the Board shall have the authority to act unilaterally on the issue that gave rise to the conflict.

10. If the Board determines, in its sole discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process.
in order to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance or other critical obligations of the hospital, the Board may take action which will remain in effect only until the conflict resolution process is completed. Actions taken which are not susceptible to change will not be changed.

11. In addition to the formal conflict resolution process herein described, the chairperson of the Board or the president of the medical staff may call for a meeting of the Joint Conference Committee at any time and for any reason in order to seek direct input from the Joint Conference Committee members, clarify any issue, or relay information directly to medical staff leaders, the governing board or management.
RESOURCES
Contacts

The Greeley Medical Staff Institute
Stacey Koch
Director of member relations
200 Hoods Lane
P.O. Box 1168
Marblehead, MA 01945
Telephone: 888/749-3054 ext. 3193
Fax: 978/531-5601
E-mail: skoch@greeley.com

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a 60-minute audio conference

Rick Sheff
Chairman and Executive Director
The Greeley Company