

**THE JOINT COMMISSION TELECONFERENCE  
REVISED LEADERSHIP STANDARDS  
OCTOBER 25, 2007**

**CATHY BARRY-IPEMA:** Welcome to today's telephone conference call with Joint Commission Officers Dr. Paul Schyve, senior vice-president; Dr. Robert Wise, vice-president of Standards and Survey Methods; and Hal Bressler, general counsel. I'm Cathy Barry-Ipema, chief communications officer for The Joint Commission.

Dr. Schyve will discuss new leadership standards that take effect January 1, 2009, with a brief introduction to the revised Medical Staff Standards. You all should have received the discussion brief that is posted to the extranet site. This discussion brief will be posted to the Internet site immediately after this call, in addition to the play-back number for today's call.

We strongly encourage you to participate in the second call that is scheduled on Thursday, November 1, which will include an in-depth look at the revised Medical Staff Standard, MS.1.20, that takes effect in July 2009.

It is now my pleasure to introduce Dr. Paul Schyve, senior vice-president of The Joint Commission.

**DR. PAUL SCHYVE:** Thank you, Cathy. Good afternoon or good morning, depending on where you are. I'd like to just briefly describe the background that led to these new leadership standards and what they contain, and finally what the relationship of those standards are to the Medical Staff bylaws. The specifics of MS.1.20, as Cathy described, will be primarily the focus of next week's teleconference.

The Joint Commission has had a Leadership Chapter since about 1995. And from the beginning we described the leaders of the health care organization as the leading

clinicians obviously in hospitals, and that would be the leaders of the organized medical staff; the governing body; and the CEO and other senior managers in the organization. And those three groups are what we mean when we refer to the leaders of the organization. What we found was that we were increasingly getting reports from all of those leadership groups about conflicts over their relative authorities. And that led to a decision to undertake a revision of the Leadership Chapter. At the same time, we were updating the Medical Staff Chapter and decided to pull into a single standard all the references to what was supposed to be found in the Medical Staff bylaws or other documents that were approved jointly by the organized medical staff and the governing body.

The process was essentially a staff process to pull together those things that were in the Medical Staff chapter without changing the requirements. But with regard to the leadership, we put together a Leadership Task Force of experts and people who were in the field and represented these different leadership groups, as well as some consumer representation. The result was a Leadership Chapter which has now been adopted and will take effect on January 1, 2009, which focuses on, instead of the relative authorities of these different groups, focuses on their accountabilities for the quality and safety of care. The chapter does recognize that the ultimate responsibility for the quality of safety of care relies with the governing body. But there was great stress on the collaboration that must occur among these leadership groups.

Secondly, given the theme of collaboration, there was a focus on the orientation of the leaders to how, in fact, would they serve well as leaders, both collaboratively, as well as representing the particular perspectives that they would bring to discussions.

A third factor was that the leaders of the organization are the ones who are most influential in establishing the culture of the organization. And as we all know, it's become clearer and clearer that a culture of safety is necessary if we're going to have safe care for

our patients in hospitals and other health care organizations. And as a result, there's an emphasis on the leaders creating a culture of safety.

One of the things that occurs within a culture of safety is that people treat each other with respect, and so there's also a new section that deals with the idea of how do you prevent disruptive behavior and how do you respond to disruptive behavior in the health care organization.

From time to time, there will be conflicts of interest among the leadership groups, so there's a new section that deals with how do you address conflicts of interest when they arise in the decisions being made collaboratively by leadership groups.

And finally, whenever there are people or groups, there will be conflicts that occur in terms of disagreements. And so one of the final major issues that was added to the chapter was that the organization has the capability of managing conflicts.

So those issues—the focus on collaboration, orienting the leaders to their roles, creating a culture of safety, addressing disruptive behavior, addressing conflicts of interest among leadership groups, and managing conflicts that occur—all were issues that were addressed in this new Leadership chapter.

Let me now just take a moment to explain the relationship of that to the role of the medical staff. It's very clear that the medical staff has historically and continues to be held accountable to the governing body for the quality and safety of care that's provided by licensed independent practitioners, such as physicians. Why is that? Because the licensed independent practitioner—I'll use the word physician at this point—the physician is authorized by law to direct a patient's care without clinical supervision. In fact, that direction of care even controls much of the use of hospital resources. But at the same time, that direction of care occurs within hospital systems, work processes, and the treatment team. So the medical staff needs collectively to have sufficient independent judgment to carry out

its accountability to the governing body for overseeing the quality and safety of care provided by licensed independent practitioners. And secondly, they need to have the ability to define the specific activities that they carry out in order to accomplish things like credentialing and peer review. And finally, now that we recognize increasingly the importance of teamwork and the systems that we work in as contributing in a major way to the quality of safety of care, we also have to, in fact, describe how the organized medical staff is going to participate with others in the organization to create safety in the systems of the organization.

That's what the Medical Staff bylaws are designed to do. It's designed to codify the processes that allow that independent judgment and for which the medical staff is accountable to the governing body. And it also defines the specific activities that they are expected to carry out, in order to fulfill that accountability. And finally, it defines how they're going to work with others collaboratively to create the systems of safety and quality in the organization. And the purpose of MS.1.20 is just to lay out these issues as they are going to be defined in the Medical Staff Bylaws—the independent judgment, the accountability—and at the same time providing the medical staff and the governing body flexibility to adjust to their own needs for quality of safety, both up front, as well as over time as changes in circumstances occur.

We know that there are many questions about the details of MS.1.20, and as Cathy said, we hope to focus next time on answering those questions and clearing up some of the misperceptions about the prescriptiveness of those expectations. I hope this background gives you some basis for the questions that we would now like to try to answer.

**CATHY BARRY-IPEMA:** Thank you very much, Paul. We would now like to take questions from our listeners. We ask that you please state your name and the name of your organization prior to asking your question.

**QUESTION:** Okay. Wondering if you could go into a little bit more detail about the actual changes to the Leadership chapter? Not all of them have changed, I'm sure.

**DR. ROBERT WISE:** Actually, there are a number of things that have changed, and they're in certain sections. Dr. Schyve went over some of the major areas. We did not get into the specific standards and Elements of Performance. That question is going to get pretty extensive. Here are the areas with the biggest changes: LD.1.70, LD.2.20, LD.2.40, and LD.3.10.

**DR. PAUL SCHYVE:** Let me add to what Bob Wise just said. Actually, it's an interesting question, because it adds a piece of emphasis to something that perhaps wasn't clear in my overview. And that is, who are the leaders that we're talking about? And the requirement for them to work together has been part of the Leadership chapter all along, so it is important to note that it's not as if all of a sudden the old Leadership chapter is gone and we now have something entirely new. The issues that I outlined are the ones, however, which are added in as new things in the chapter. So one was the issue that there's considerably more emphasis on the collaboration that occurs as they're accountable to each other. And then those issues that really weren't addressed in the existing chapter were the leader orientation; the expectations that create a culture of safety; addressing disruptive behavior; addressing conflicts of interest; and addressing management of conflicts that occur between leadership groups.

**QUESTION:** Hi. I'm curious about the use of the term medical staff as a whole, regarding the need to review bylaws and policies. And I'm concerned that the entire organized medical staff could usurp the Medical Executive Committee's authority and overrule them. How do you respond to that?

**DR. ROBERT WISE:** The issue that you're bringing up has to do with the relationship of the medical staff as a whole versus the MEC. So, while I won't go into a lot of detail on that today, let me try to answer the first part of the question, which is the medical staff as a whole. One of the areas that we're going to clarify is exactly what we mean by that. What we did not mean was that every single person who has been given privileges would then be, by our standards, required to have an opinion. Most medical staff have an active group, and it is that group who they decide to give the right to vote on bylaws. What that ends up meaning, the medical staff as a whole would be the group of people in the medical staff that has been determined by the medical staff to have the right to vote on bylaw issues. So it's a much smaller group. And it would be up to that medical staff to make that determination.

The other part, which had to do with relationship of the MEC and the medical staff, really requires a much more in-depth discussion than what we will be doing here today.

**HAL BRESSLER:** I agree with that. We need a more in-depth discussion, and we can do that next week. Let me say that in this area, I think there may be the most misunderstandings or misperceptions. There appears to be an assumption, for example, that the standard requires the medical staff to have a veto power over what the Medical Executive Committee does. That is absolutely not true. The standard does not require that. There is a lot of misunderstanding about the issue that you asked about, and next week we'll go into it in much more detail.

**QUESTION:** I'm concerned about the very broad language of the EPs, LD.3.10 through 4.190. The language in those Elements of Performance are open to broad interpretation. For example, what is a valid and reliable tool for assessing culture of safety? Is there any plan to narrow the language or drive more transparencies into these Elements?

**DR. ROBERT WISE:** You've actually named a lot of standards, but the one that you have brought up comes up frequently. And for people who have the document, it is LD.3.10, EP 1, which says, "Leaders regularly evaluate the culture of safety and quality using a valid and reliable tool." This was actually one of the areas that was under enormous debate. While there are a handful of valid and reliable tools, there was significant discussion that to end up limiting the tools just to these few was really at this point way too restrictive. And so what we're allowing here is that the leaders can make their own determination of what a valid and reliable tool is. What's more important here than the tool is that the leaders need to be looking at their culture and evaluating it on a regular basis. This is really the first time that this requirement has been required and therefore, we're leaving it reasonably open for an organization to do it as they see best. I think in the years to come, as we get a sense of how organizations are doing that and how the science itself on evaluation of culture changes, we may end up becoming more specific. But right now, it's being left pretty broad.

**CALLER:** I just simply provide that as an example. There are several EPs throughout those dozen or so standards that appear to give an awful lot of room for interpretation.

**DR. PAUL SCHYVE:** Let me add that when we set standards like this, if we are too prescriptive, organizations follow it and say okay, this is the tool that I use. But in fact, it may not be the most useful tool for that organization. So let me focus in on that specific example,

because the principle applies to others, also. The concept of validity actually is the question of, does this address and answer the question that I have? So, for example, a tool may be valid for one purpose but not valid for another. It literally may mean that a specific tool is valid in one organization, considering what its issues are, and not valid in another. It's a question that has to be essentially thought through by the organization. I know that we already have been providing some educational information about what kind of tools are available that people could use, but at this point we literally did not want to say you must do it this way. That also means that when the surveyor comes, the surveyor's question will not be, have you used this tool? The surveyor's question will be: I see you're using this tool. How have you tried to look at whether that's going to be a valid tool for use in your organization? The same thing will apply in other standards. How have you gone about trying to achieve this particular end, which is described in the Standards? So, in some cases, there's literally a deliberate choice not to create something that's so prescriptive that it actually inhibits your ability to design something which will help you create better quality and safety in your organization.

**QUESTION:** How do these standards apply when we have physicians that are employees?

**DR. PAUL SCHYVE:** In my introduction and also, obviously, in the chapter, we refer to licensed independent practitioners. That usually means physicians—the majority of them are physicians—but it also can include others who essentially are authorized both by law and the organization to make decisions about patient care without clinical supervision. Now I emphasize the word clinical, because people may be employed—they may be, in fact, under administrative supervision for a number of things—but they're not being supervised. Aside from the organized medical staff, they're not being supervised in terms of their clinical

decision-making. They are, in fact, for example, as a physician, licensed to practice medicine. A hospital as a hospital is not licensed to practice medicine. A governing body is not licensed to practice medicine. Frankly, even if every member were a physician, it's not licensed to practice medicine. So the issue is, who is authorized by law to make those decisions? Once we recognize that that's the licensed independent practitioner, whether employed or not, we need to talk about how do we create the kind of relationships and structures and participate in the design, redesign, the evaluation of the work processes that people work in, which we now recognize is actually probably the major contributor to creating safety.

**DR. ROBERT WISE:** In Dr. Schyve's opening remarks, he used the term independent judgment. And independent judgment is an important word here in that when we talk about independent medical staff, one of the things that we would expect of them is to be able to maintain this concept of independent judgment. Whether somebody is employed by the hospital, or employed by a medical group, or is there by themselves, the accountability of the medical staff remains the same. We do appreciate that there have been some concerns for the members of the medical staff who are completely employed, that in fact, there could be a loss of independence. But from The Joint Commission's point of view, if the independent judgment around issues of quality and safety of what licensed independent practitioners are doing is lost, we would view that as a concern. But there certainly is nothing about an employment relationship per se that would disrupt the ability to be accountable for that type of judgment.

**QUESTION:** If a hospital is in the midst of revising its Medical Staff bylaws, say between now and over the next three months, and it relies on the MS.1.20 that was approved at the

June Board of Commissioner's meeting, would that hold them in good stead, or would they be violating anything in the existing MS.1.20 that's in the January 2007 accreditation manual?

**DR. ROBERT WISE:** That's a great question. There is nothing in the new MS.1.20 that would violate what is currently in MS.1.20. I do want to make sure you understand, though, that it's clear from all the letters that we've been getting is that there is a lot of misunderstanding of exactly what was meant and of some of the implementations of MS.1.20. We will go over those next week, so hopefully you don't complete everything before the November 1 call.

**CALLER:** No, and I look forward to next week, because I actually saw in some instances some greater flexibility about putting some of the procedural details in policies and procedures outside the bylaws as opposed to the existing MS.1.20.

**DR. ROBERT WISE:** You actually understood correctly. Your point will be one of the areas that is discussed on November 1.

**QUESTION:** We're being surveyed in 2008. What, if anything, would the surveyors expect to see in terms of moving toward implementing these Leadership standards, or if we've already implemented some of them, if there are any conflicts?

**DR. ROBERT WISE:** If a surveyor comes any time before January 2009, there would be no expectations. There's nothing that creates an expectation that you'd be making changes

prior to the date of January 2009, nor is there anything in the current standards if, in fact, you have made those changes, that would be in conflict to what currently exists.

**DR. PAUL SCHYVE:** The Leadership Standards, under normal circumstances, would have become effective January 1, 2008. The field actually came back to us and said they actually very much like the new Leadership chapter. We think that these expectations really do describe how we should be working together as leaders, et cetera. But this is not an easy thing, to make the change, at least for some organizations. So we need some additional time to make the change. And the Board of Commissioners agreed and said all right, let's make it effective January 1, 2009. So, I guess, that from the point of view of what would the surveyors expect to see, what Bob said is absolutely correct. You would be expected only to be complying with the current Leadership chapter, not with the new one that becomes effective January 1, 2009. But, given the argument that people made about why it will take some effort to make these changes and they needed some time to do it, I would personally say I'd be surprised if I were to walk in and see that you weren't on the road. Otherwise, how are you going to do this suddenly between December 31 and January 1? So it's a difference between what's a surveyor looking for in terms of, is there a finding here or not, are you in compliance with the current standards, versus what you probably want to do in order to make those changes.

**QUESTION:** Our question is about LD.3.70. Did that section get moved to another part of the standards?

**DR. PAUL SCHYVE:** The standard being referred to says that the leaders define the required qualifications in confidence that those staff will provide care, treatment, and

services and recommend a sufficient number of qualified staff. And that is now under Leadership Standard 3.60 in the new chapter, in which one of the Elements of Performance has to do with a sufficient number of individuals to support the services provided by the hospital. And another EP is that those who work in the hospital are competent to complete the assigned responsibilities. This is part of the Leadership chapter. In the new chapter, it's LD.3.60.

**CALLER:** It looks like that the detail that was in the prior EP 3.7, number 3, we're talking about the competence of a non-employee individual. Does that remain? Because what I'm seeing is a lot less verbiage that spells that out. So are we supposed to know that we're supposed to do this? I mean is this still part of the standards?

**DR. PAUL SCHYVE:** Yes, it is. But that was moved to the HR chapter.

**CALLER:** Okay, that was our question. Thank you.

**QUESTION:** I'm looking at LD.2.20 and 4.100. They seem repetitive, as they both deal with conflict of interest. I'm wondering if there was a reason why they're separated out, or is there a substantial difference that I'm missing?

**DR. PAUL SCHYVE:** I'm glad you asked this, because many times people have asked the same question. LD.2.20 deals with the conflicts of interest between and among leadership groups. That kind of conflict of interest, obviously, may occur. For example, one that has come to our attention is when the medical staff has chosen the physician that they'd like to participate in the governing body, meaning with voice—not necessarily with vote, but with

voice—and the governing body concludes that that individual in a particular discussion has a conflict of interest because they're also an investor or owner of a potentially competing specialty hospital. LD.2.20 deals with addressing conflicts of interest between the leadership groups.

LD.4.100 deals with conflict of interest throughout the organization. It's the leaders who are responsible for establishing the policy and procedures for how to address the conflicts of interest that occur throughout the organization; not specifically between the leadership groups.

**QUESTION:** Is there a possibility of developing a crosswalk between the old standards and the new standards, at least by the end of the year or the beginning of next year?

**DR. ROBERT WISE:** In front of each chapter there will be a crosswalk where people can follow what has been and where it will go. I will take from your comment to remind us that the field is very interested in this, so we will move as quickly as possible. But it is a planned piece of the new manuals.

**DR. PAUL SCHYVE:** I think your point is how quickly can we have it to you, which is probably before the new manuals are published. But I think that we should be able to do that, whether it's literally by the end of the year I'm not sure. I don't think we need to wait until the new manuals are published to provide it to you.

**DR. PAUL SCHYVE:** Yes, just in case anybody didn't realize this, normally once we've published a chapter, we don't leave it on the website. But we specifically did that for the

Leadership and for MS.1.20, so those are on the website. We should put that crosswalk on the website with that.

**QUESTION:** As we were looking over the new standards, we found some differences in the way they're shown for LD.3.50 and LD.3.60. The differences we found under the Elements of Performance were you had design, implementation, and results, which are pretty well laid out for us looking at that standard. And the other ones didn't have that under the Elements of Performance.

**DR. ROBERT WISE:** While we attempted to create that triad of design, implementation, and results, we did find that there were some standards where it was artificial, and it really could not be created in that way. So if you don't see that break-out, it just meant that we felt that it really didn't make sense to create that type of format.

**CALLER:** So just to continue the question, let's look at LD.3.50. It's 1 through 3 in the design, 4 and 5 under implementation, and 6 and 7 under results. So all those Elements of Performance we need to address.

**DR. ROBERT WISE:** Yes. The only thing we're doing is we're grouping them so that there's some internal logic to the way they're being presented.

**DR. PAUL SCHYVE:** Actually, if you look through you'll find others, like LD.3.20 has the same thing. The design, implementation, results are words only to help people understand. They're not part of the requirements.

**QUESTION:** For Standard LD.3.60, where it talks about sufficient number of individual and support services, is the staffing effectiveness still in the PI Standards, or is there not that expectation any longer?

**DR. ROBERT WISE:** There has been lots of discussion nationally about that, if it is as effective as we want it to be. And so while there will be changes coming up with that, it currently is still in the manual unchanged.

**QUESTION:** I have a question with respect to MS.1.20 in terms of what type of training are you doing to assure that surveyors are going to be able to be consistent in distinguishing between what constitutes a process versus what constitutes a procedure? Even with all the explanation that you have given, it is still a very subjective determination, and I'm just concerned how there's going to be able to be any type of consistency on that.

**DR. ROBERT WISE:** You're actually asking once it's clear what those things mean, what training will we give. We want to first make sure there's clarity of what those are, and once again, we will talk about those in more detail next time. We believe that after we have talked in detail, it will be a whole lot clearer of what falls in each of those groups. As for surveyor training, there is a huge amount of surveyor training that goes on, including an annual conference where whenever we find areas that seem to be confusing or more open to a lot of variability, we will tend to focus there. We believe that both Leadership and MS.1.20 will be areas that we'll spend a lot of time focusing on with the surveyors.

**HAL BRESSLER:** We'll talk more about this next week too, but again, there's an assumption here that you shouldn't leave with. The assumption of that question is that there

will be a very precise checklist—A) will be procedural detail, B) will be this for every single hospital in the country—a very precise checklist with no traditional reliance on the reasonable discretion of the accredited hospital. That's not an assumption you should leave here with today, and we'll go into more detail next week.

**DR. PAUL SCHYVE:** There will be two implications of this that I would like you just to think about today so that we can deal with it in detail next time. The one implication is that many times the decision about what that something is in terms of is this a requirement, is this a procedural detail, is it something else—that's a decision that's really in the hands of the governing body and medical staff, not the surveyor. And secondly, that means that that decision may actually be different in one hospital from another. This goes back to a point I made at the very end of my introduction, and that was we've tried to build this in a way that actually provides the organization, the governing body and the medical staff, flexibility to make decisions which are in the best interests of the quality and safety of care in the circumstances that they are dealing with in their organization, circumstances that actually even may change over time.

**QUESTION:** Our question is regarding LD.2.20. Would it be considered a conflict of interest when members of the MEC are also the voting majority of elected members of the governing board? Is that considered a conflict of interest?

**DR. ROBERT WISE:** Let me understand what you're saying. Are the members of the MEC also on the voting part of the governing body? Is that what you're asking?

**CALLER:** Yes, we have a five-member board. Three of the members are physicians that are also members of the MEC.

**DR. ROBERT WISE:** Let me answer the question generally without trying to tell you that I know exactly all the circumstances that are going on inside of your hospital. You had heard at the very beginning that it is important that the leaderships have clarity of accountability, and also the term around the issue of the medical staff was independent judgment. If, in fact, the way the voting is done—between the medical staff and the governing body—that the ability to lose an independent judgment or that, in fact, that a separate judgment is lost, then it would not meet the standard of what we are trying to create. If you have the same body who is just voting twice, you obviously know what the outcome is going to be. There would certainly be some question of whether the governing body is truly looking toward the medical staff to get further independent judgment.

**HAL BRESSLER:** It would be an incredibly unusual case, sometimes what I would call an off-the-wall case, where The Joint Commission would be the judge of whether a conflict of interest existed. These standards are like many Joint Commission standards, in which The Joint Commission is saying to you we want you, at least, to think about it in good faith. You asked that question. Now think about that question, and make your own decision on what you think the answer is, and that good faith, evaluation, and judgment on your part will be sufficient to comply with the standards.

**QUESTION:** I wanted to ask you about LD.3.10. And the reason I'm asking this is because we have to deal with regulation from the state and regulation from the federals. Now are those tools comparable with what The Joint Commission usually uses in the Leadership

evaluation with our institution? That would be question number one. And question number two is concerning disruptive behavior, which is number four in this same LD.3.10. Number four says a hospital has a code of conduct to define acceptable or disruptive and the proper behaviors. Concerning the issues of conduct and the code of conduct, is there any way that we should know if HIPAA violations should be included within this code of conduct, or is The Joint Commission going to look into it as part of it? And the reason I'm asking is because at times we have included physicians who might be excluded from one program, that's a state program and they cannot perform in that, because they violated whatever orders and they only stayed with the federal program, even though it's not a HIPAA violation. But there is a violation there, and I was wondering how should we see this within the context of the Leadership program within the boundaries of The Joint Commission and what they want us to do?

**DR. PAUL SCHYVE:** We have certainly had situations over the years in which, for example, a particular state has required that some tool be used within that state, sometimes with or without public reporting. Our position has generally been that if you're required by a regulation or something to use a particular tool, we're not going to be questioning your judgment in having decided to use that tool. So I don't think that you would find yourself having a conflict over which tool you had decided to use if, in fact, that was the rationale for having used it.

With regard to the disruptive behavior, when you asked the question, I realized that in our attempt to emphasize that many people have advised that codes of conduct are best when they focus on desirable conduct, rather than simply being a list of don'ts. We talked about acceptable conduct, which of course would include complying with HIPAA, et cetera. But I would have to say that I think our intent behind number four and number five, where it

talks about disruptive, inappropriate behavior, had to do essentially with interpersonal behavior. Obviously, you're to be in compliance with HIPAA, but that wouldn't necessarily show up here. It wouldn't be what the surveyor would be looking for. The surveyor would be looking for how do you address inappropriate interpersonal behavior, the kind of behavior that, in fact, can work adversely with regard to, say, a culture of safety and so on.

**QUESTION:** I know this is going to seem rather simplistic, but I just want to ask a question about the scoring of these standards. Obviously, we would need to be able to produce and show that we have these policies, processes in place, et cetera. But will this actually be scored out or done similar to like a tracer, where you would actually want to see demonstration of a physician who was held accountable and really show evidence of these policies being enacted?

**DR. PAUL SCHYVE:** Are you referring specifically to the issue around disruptive behavior?

**CALLER:** Yes, really any of them. I mean there's several, but that was the one that seemed to me to be the easiest one to talk about.

**DR. PAUL SCHYVE:** Obviously this could occur in an actual patient tracer. But it also may occur in terms of evaluating the leadership, whether or not they have policies in this particular area.

**CALLER:** I guess I'm not worried so much about having the policies, because a lot of us can have lots of policies. The question is, are we following our own policies? So the only

way that I can see this working is that we would be asked for evidence of enacting the policies.

**DR. ROBERT WISE:** I think it would not be unreasonable that if it was traced to this that the surveyor would say could you describe a situation in which the organization leaders were aware of the disruptive or inappropriate behavior and how they handled that.

**QUESTION:** I can see where an organization would choose to handle this under a peer review process, and once it gets referred to peer review those files are not usually just part of open minutes. So I would assume that would be asked for during survey. I'm curious if you have even gotten that far down the line?

**DR. ROBERT WISE:** The question is are these files and processes under the peer review? I don't think we have answered that question. It's useful for us to hear that, and we can then use that as we're constructing the survey process to understand how we would handle that.

**CALLER:** Okay, thanks very much, because every time I hear the word policy, my next thought is how are we demonstrating we're following our policy.

**DR. PAUL SCHYVE:** Absolutely. That's right.

**QUESTION:** Under LD.3.10, EP 1, I was wondering how you are defining "regularly" evaluating the culture of safety, if that's annually or once within a three-year cycle?

**DR. ROBERT WISE:** We initially had talked about an annual review, and people just thought that was too much. What we decided to do is not to come down with a very specific time, but we would leave it at this point to the leaders to make a decision with some rationale about why they have chosen that.

**CALLER:** And then in relation to that, if you survey for this in 2009 for EP 2, would you expect that we have done an evaluation in '08 so that by '09 we're responding to the results and implementing changes?

**DR. PAUL SCHYVE:** I think the way we want to train the surveyors is truly if you've done number one following January 1, 2009, that number two becomes not applicable. We'd simply score this an A. Unless, of course, you've been doing it, and you've already taken some action. But I think the only sensible thing would be to say no, you can't expect that if you've just done the survey.

**DR. ROBERT WISE:** It also suggests that when you're looking at issues of culture of safety, you're actually looking at broad systems and process issues, not something that you could decide that you're going to fix in the next 30 days.

**CATHY BARRY-IPEMA:** Thank you to everyone who took the time to participate in today's call. We hope it was of value to you. Please remember to visit The Joint Commission website at [www.jointcommission.org](http://www.jointcommission.org) or your secure extranet site for more information on this topic. You will also receive an e-mail with a toll-free phone number that you can call to hear a playback of today's call, and a written transcript will also be available on our website and the extranet site within the next few weeks. Registration for the second part of this call will

be e-mailed to all accredited hospitals and critical access hospitals tomorrow, October 26. That information will also be posted to The Joint Commission Connect, your secure extranet site. The information typically is sent to the CEO of every organization, the Chief Medical Officer, and the Survey Coordinator. There is also a number of you who have asked to be added to the list, and you're on the list, as well.

**DR. PAUL SCHYVE:** We put off some detailed questions about MS.1.20 until next time. And so I would encourage you if you actually have some detailed questions about that, go ahead and also e-mail those to Lynn Berry, because it may help us answer some of the questions up front as we provide some background information. So again, that was [lberry@jointcommission.org](mailto:lberry@jointcommission.org).

**CATHY BARRY-IPEMA:** Thank you very much, everyone.