American Hospital Association

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Robert Wise, M.D.
Vice President
Division of Standards and Survey Methods
The Joint Commission
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

Dear Dr. Wise:

On behalf of our 3,200 member hospitals, health care systems and other health care organizations that are accredited by The Joint Commission, the American Hospital Association (AHA) appreciates this opportunity to comment on the proposed standard for conflict management (Standard LD.2.40). The Joint Commission has made some important changes in the proposed standard to bring it into greater alignment with the operational authority of the hospital's governing body, and we thank The Joint Commission for these improvements.

We believe the proposed standard can be improved by further refinements to ensure that it consistently reflects the governing body's authority and clearly indicates a direct link to improving quality of care and patient safety. Our specific recommendations for achieving these results are outlined below.

Continue to Specify Individual Responsibility
Elimination of the "leadership components" framework used throughout the previous draft of the Leadership Chapter is a welcome change. The "leadership components" framework appeared to blur the lines of authority for hospital governance by equating the roles and responsibilities of the governing board, hospital administration and organized medical staff leadership. As revised, the proposed standard is more consistent with the ultimate authority of the hospital's governing board.

Specifically, the proposed standard's sparing use of the more general term "leadership groups" and its more frequent identification of precisely which leadership group (i.e., governing body, senior managers and/or leaders of the organized medical staff) has the identified responsibility properly recognizes the governing board's ultimate authority for

authorizing hospital leadership and medical staff to carry out specific responsibilities and establishes collective accountabilities for ensuring the quality and safety of patient care.

Explicitly State Governing Body Decision-making Responsibility/Authority
EP 2 explicitly requires that the governing body approve the process for conflict management. Its corollary, EP1 seems consistent with this in concept, but we recommend modifying the language slightly to provide a clearer articulation of the responsibility:

> Senior managers and leaders of the organized medical staff work with the governing body to propose ~~develop~~ an ongoing process for managing conflict among leadership groups that threatens health care quality and safety. (*Underline indicates addition and strikethrough indicates deletion.*)

The proposed standard, however, does not seem to recognize explicitly the authority of the governing body to make final decisions when conflicts cannot be resolved as The Joint Commission, in the notice of field review, suggests it does. EP 7, where such recognition should logically be found, states only that:

> At a minimum, the conflict management process includes:
>
> 7. Working with the parties involved to address, and when possible, resolve the conflict.

While this language clearly and appropriately suggests that not all conflicts among leadership groups can be resolved, EP 7 includes no explicit statement of the governing body's authority to make a final decision when conflicts cannot be resolved. EP 7 should be modified to include specific language about such authority of the governing body.

Tie Standard Closely to Safety and Quality
The Joint Commission suggests that the proposed standard addresses the need to mange conflict among leadership groups so that it does not compromise the delivery of safe, high quality care, but the standard's Elements of Performance as drafted include largely ambiguous language linking conflict management among leadership groups to the need to ensure the delivery of high quality and safe patient care. The statement of Standard LD.2.40 itself and discussion in the Rationale appear to be a more straightforward statement of the linkage. Because the reference is not in the Elements of Performance, the EPs seemingly suggest a much broader scope of application that would require mediation of all relationships among hospital boards, management and medical staff.

EP 1, for example, calls for development of an ongoing process for managing conflict among leadership groups generally and without qualification. In identifying protecting the safety and quality of care as one of the minimum requirements for the conflict management process, EP 8 also suggests broader purposes for the conflict management

process. Finally, EP 3 states only that the conflict management process is "implemented when needed," without explicitly linking its use to any demonstrable need to manage conflicts among leadership groups that specifically threaten quality of care and patient safety. The AHA noted in its May 4, 2006 comment letter on proposed changes to the Leadership Chapter that the governing board's mere exercise of its ultimate legal authority may cause disagreement or conflicts with medical staff, but these conflicts do not necessarily hurt the quality of care for patients. Rather the board may appropriately use such conflicts as an effective governance tool to spur creative thinking and enhance organizational commitment to a culture of quality.

The standard's Elements of Performance should not obligate, as the current proposal seems to do, the hospital's governing body to submit all potentially controversial operational decisions to a process of mandated conflict management. Instead, The Joint Commission's proper purview in promulgating an accreditation standard for conflict management among leadership groups is to adopt an approach that facilitates hospitals' establishment and implementation of a conflict management process when it is clear that conflict among leadership groups is the cause of a quality of care or patient safety concern. To do otherwise would diminish the governing board's ability to govern and could interfere with quality improvement efforts. Our suggested sample language in the above section "Explicitly State Governing Body Decision-making Responsibility/ Authority" establishes in EP 1 the necessary link to quality and safety of patient care.

Clarify Obligations for Meeting the Required Skills

The AHA also is concerned about the very general statement in EP 4 that individuals who implement the conflict management process are skilled in conflict management. This proposed standard raises questions about the extent of an accredited hospital's obligations and responsibilities for ensuring that those individuals can and do acquire appropriate conflict management skills. Language in the Rationale appears to answer these questions by stating that accredited organizations may choose to, but do not have to, train leaders, and by preserving the flexibility of accredited organizations that elect to train leaders to use a variety of training methods. The AHA recommends that the language of the Rationale be reflected in the EP itself to eliminate potential confusion over an accredited hospital's specific obligations and responsibilities in meeting the requirement of EP 4.

Link to Additional Leadership Standards

More generally, the AHA is disappointed that The Joint Commission chose to release the proposed standard for conflict management without a simultaneous explanation of any final changes that already have been made as a result of previous field review of the Leadership Chapter. The Leadership Chapter offers a necessary context for hospitals to understand and evaluate the true impact of any proposed revisions to the conflict management standard.

Scheduling of Proposed Standards Review

The Joint Commission's standards are important guideposts for hospitals and health systems in their continuing obligation to serve patients to the best of their ability. When

changes are being proposed, the hospital field places great value on the opportunity to assess the proposed changes and provide thoughtful comments to assist The Joint Commission in promulgating requirements that effectively lay the foundation for high quality, safe, effective care in hospitals. We assume the field's input is equally of value to The Joint Commission. This year and last, a number of standards were released in a cluster at the end of the calendar year. Hospitals' ability to evaluate and comment on these changes is constrained by The Joint Commission's simultaneous release of numerous proposed standards with similar comment deadlines. This is especially true where, as here, the proposed standards were released during the holiday season and the comment deadline was set for a short time after the season ended. The AHA urges The Joint Commission to release standards earlier in the fall so that they do not come out during the end-of-the-year holidays, and to release standards in smaller clusters to facilitate hospitals' ability to provide the thoughtful input that these standards deserve.

Please feel free to direct questions about our comments on LD.2.40 to Lawrence Hughes, regulatory counsel and director, member relations at (202) 626-2346.

Sincerely,

Nancy Foster
Vice President, Quality and Patient Safety Policy