Greeley Medical Staff Institute Symposium

Preconference Workshops
Medical Staff Bylaws: How to create documents that are clear, compliant, and fair

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How did we get here?

- Ernest Codman, MD, and the American College of Surgeons (1913)
- Minimum Standards for Hospitals (1919)
- Joint Commission on the Accreditation of Hospitals (1951)
- Medicare and the Conditions of Participation (COPs) (1965)
- Democracy to representative republic
Erosion of “the club”

- Audits (1970s)
- DRGs (1983)
- EMTALA (1986)
- Corporate compliance (1990s)
- Patient safety and practice variation (1990s)
- Managed care and capitation (1990s)
More erosion

- HIPAA (1996)
- Balanced Budget Act with sustainable growth rates (SGRs) (1997)
- Pay-for-performance (value-based reimbursement)
- Hospital-physician competition
- Withdrawal from the public sphere
- Advocacy vs. corporate model
- The splintering of medical staff’s “self interest”
Why an “organized” medical staff?

- Oversee and improve the quality of care on behalf of the governing board
- Ensure accountability to the organization and community
- Required to participate in federal and state health reimbursement programs (Medicare/Medicaid)
- Required for accreditation or certification (Joint Commission, CMS)
Why bylaws?

- Binding contract/compact with the governing board to ensure mutual accountability
  - Bylaws as a contract is a double-edged sword
- Defines the purpose of the medical staff
- Specifies the duties and obligations of members and leaders
Why bylaws? (cont.)

• Enhance quality through good credentialing, privileging, and peer review processes
• Set expectations for professional conduct
• Define relationship between organized medical staff and medical executive committee (MEC)
Bylaws components

- Purpose
- Organization name
- Appointment/reappointment process
- Medical staff categories
- Medical staff officers and leaders
Bylaws components (cont.)

- Organizational/committee structure
- Investigations and corrective action
- Fair hearings
- Meetings, quorum, attendance
- Method of adoption/modification
- Confidentiality/immunity provisions
Commonly encountered bylaws weaknesses:

• Anti-trust issues
  • MEC or clinical department taking final action without independent board decision

• Lack of due process for application
  • Previously denied

• Performing consultations without clinical privileges
  • Honorary staff

• Department chair determining qualifications and competence of staff/personnel
Weaknesses (cont.)

- Department shall determine “its own criteria for clinical privileges” (anti-trust)
- Granting privileges within a department without oversight
- Corrective action by MEC without board approval
Weaknesses (cont.)

• HCQIA issues
  • Not offering due process for summary suspension or other potential triggers to state licensing board or National Practitioner Data Bank

• Unnecessary triggers for fair hearing

• Corrective action for potential impairment and peer review
Conflict of interest

• Duty to disclose (not recuse)
  • What information is to be disclosed?
  • What actions are taken if there is a conflict?
  • Can information be used to screen out direct competitors?

• Duty of “body” to appropriately manage

• Mitigate bias and economic/political conflict
Member’s rights

• Be realistic
• Don’t implement if you cannot enforce
• Leaders vs. busy practitioners
• Right to appear before MEC, challenge MEC rule/policy, recall an officer/leader
• Vote
• Serve on committees
Medical staff prerogatives/rights

- Fair process
- Audience with peer review committees and MEC
- Initiate a recall election of a leader
- Call a special meeting of the medical staff
- Challenge a rule/policy
- Call department meetings
- Give and remove authority of MEC
- Bypass MEC and make bylaws/rules/policy recommendations directly to the board
Mission/purpose statement

- Make it short and sweet
- Don’t promise anything you cannot deliver!
- Incorporate Joint Commission language
Membership

• Licensed independent practitioners
  • Physicians
  • Podiatrists
  • Dentists
  • Oral/maxillofacial surgeons
  • Psychologists
  • Advanced practice providers

• Depends on state law limitations
Membership requirements

• Criteria for membership
  • Training, background, experience, current clinical competency, professional conduct, ethics, health status

• Optional: “unrestricted license,” ABMS/AOA boards, certification, and re-certification
Membership requirements (cont.)

- ED call
- Maintain required insurance
- Complete records
- Report certain events
Medical staff categories

• Active
• Associate
• Honorary
• Affiliate
  • Membership but no clinical privileges
Categories (cont.)

• Miscellaneous
  • Consulting, courtesy, provisional, managed care, non-physician
    • But how do you measure quality if there’s no activity?
    • Do you require utilization standards as a condition of reappointment?

• Beware of loop holes for call requirements!

• Credentialing vs. privileging
  • FPPE and OPPE requirements
Medical staff officers

- Officers
  - President, president-elect, secretary/treasurer, past president
- Chairs
  - Department
  - Credentialing committee
  - Peer review committee
    - Elected or appointed?
- Term/duties of office
Medical staff officers (cont.)

- Qualifications/selection criteria
- Nomination committee
- Election of officers
  - Elected/appointed/ratified by medical staff or board?
Leadership development

• Leadership succession planning
  • Background, training, and experience

• Supportive resources
  • Compensation, administrative support, protected time and practice, ongoing training
Credentia ling and privileging

• Credentials committee succession plan
  • Who serves on your credentials committee?
  • What about a board member?

• Eliminate unnecessary “denials”
  • Pre-application letter with comprehensive eligibility requirements for membership and privileges

• Core privileging, competency clusters, or laundry list?
Pre-application letter

- Criteria for completed application
- Criteria for eligibility for membership
- Criteria for eligibility for privileges
Pre-application letter (cont.)

- Grounds for termination of the application process
  - Inaccuracy, omission, misrepresentation, etc.
- Use as a screening device
  - No application for closed departments
  - No application if eligibility criteria are not met
  - No application if purpose is to join a managed care plan
- No hearing if a pre-application is not completed due to ineligibility
Special issues

- Low-volume/no-volume
- New privileges/technology
- Advanced practice professionals
- Telemedicine
- Credentialing by proxy with privileges
- Contracted services
Special issues (cont.)

- Emergency privileges
- Leave of absence
- Aging physicians
- Employed physicians
- Direct competitors
- Evaluation of profiling data,
  - Morbidity, mortality, outcomes, and utilization information
Overall committee structure

- MEC
  - Must have

- Credentials, peer review
  - Should have

- Cancer, trauma, CME, IRB
  - May need to have

- PIC = pharmacy & therapeutics, IC, ethics, medical records, OR, UR, RM
Committee structure (cont.)

- Ad hoc = bylaws, physician health, judicial
- Dispute resolution committee
  - When organized medical staff disagrees with MEC (MS.01.01.01)
  - As required under Joint Commission leadership standards (at least in corporate bylaws)
Medical staff departments vs. clinical services

• Note Joint Commission medical staff department director responsibilities!
• Who will do this job?
• No longer a political appointment
• Create a leadership structure that is realistic and sustainable
• Paid or not and by whom?
• Should there be eligibility criteria?
  • No pending quality investigation, no direct competition, no officer position at another medical staff?
Required by Joint Commission to meet accreditation standards:

“The organized medical staff delegates authority to the MEC to carry out medical staff responsibilities.”

MS.02.01.01
**MEC**

- **Key roles**
  - Governance, recommend appointment, monitor and improve quality

- **Members**
  - Department chairs, at large, officers, specialty balance, management as ex officio non-voting

- **Optimum size**
  - 7-12 members

- Represents the interests of the entire medical staff, not political constituencies!

- New MS.01.01.01 standard
Investigations (clear-line definition)

- Carried out by organization, not an individual
- “Investigation” is a NPDB buzzword regarding reportability
- Inform individual and give him/her the opportunity to respond
- Address concerns about competence or conduct
- Precursor to professional review action
- Clearly specified in bylaws
  - When, by whom, what grounds, documentation, obligation to report, difference from routine peer review
Corrective actions/fair hearing

• Eliminate unnecessary triggers
  • Automatic relinquishment, monitoring, proctoring, mandatory consultations, and other actions that are not reportable to the NPDB or state

• Precautionary suspension prior to summary suspension but hearing still required

• Administrative “time outs”
  • Behavioral issues, failure to comply with policies, etc.

• Pre-hearing conference
  • Maintains collegial environment and reduces red tape

• State and federal requirements
Corrective actions/fair hearing (cont.)

- Consider language that treats hearing as an “intra-professional conference” to de-legalize the process
- Consider limiting the role of legal counsel to that of advisors
- Summary suspensions should be limited to those situations where there is an imminent threat to patients, employees, and/or the general public
- Consider using hearing officers
Criteria for peer review: bylaws or procedure manual

• External
  • Lack of expertise, irreconcilable conflict, potential governance action/fair hearing, irreconcilable difference of opinion, audit
  • Physicians should have opportunity to review and comment on any external review

• Internal
  • Sentinel events, critical threshold for rates and rules
Precautionary suspensions

• By whom
  • Chief of staff, CEO, department chairs?
• Not reportable unless >30 days
• Concern about competence or conduct
• Result from professional review action
• Provider resigns while suspended (under investigation)
• Medical staff should grant hearing/appeal rights unless waived
• Consider a “voluntary relinquishment” pending review
Administrative suspension

• Often called “automatic relinquishment”

• Common triggers
  • Medical records
  • Lack of current DEA/liability policy/license
  • Sanction by OIG
  • Failure to pay dues/maintain certification/attend special appearance
  • Felony indictment/conviction
Hearing or no hearing? Limited scope is given hearing rights (i.e., did you complete your records?)
Avoid unnecessary triggers for fair hearings

• Failure to meet eligibility for privileges or membership
• Administrative lapses
• Failure to complete an application or produce all required information
• Misrepresentation on an application
• Denial of LOA
• Closure of specialty opening
• Proctoring/monitory/consultations
Avoid unnecessary triggers for fair hearings (cont.)

- Voluntarily reduce privileges
- Expiration of membership/privileges
- Grant of conditional appointment for a limited period
- Denied application unless reportable
- Denial or termination of ED call
- Denial of requested privileges
Hearings

• Adequate notice and circumstances to trigger
  • List of witnesses

• Right to review and have copies of all information relied on by medical staff/hospital when imposing corrective action

• Who appoints the hearing committee?

• Consider using hearing officer

• Waiver of hearing

• Impartial participants
  • Arbitrator, hearing officer, hearing panel
Hearings (cont.)

- Time frames
- Burden of proof required
  - Give right to abject preponderance on substantial evidence?
- Presentation and admissibility of evidence
  - Rule of relevance
- Role of attorneys
- Consider de-legalizing the hearing process
- Committee should issue findings and explanation of decision
Appellate review by board

- Mandated by Joint Commission (MS.10.01.01)
- Appeal right should be given to all parties
- Limited to new or relevant evidence; otherwise focus on fairness of hearing and compliance with bylaws
- No report to NPDB until all due process remedies are exhausted
- Should affirm hearing committee recommendation unless “arbitrary and capricious”
Peer review (OPPE) manual

- Peer review charter/policy
- Performance framework
- Procedure for creating measurable indicators with benchmarks from performance expectations
- Peer review procedure
- Performance improvement plan procedure
- Triggers and criteria for FPPE
Quorum/attendance/meetings

• How often?
  • MEC, credentials, peer review, PIC, and clinical departments often
  • Medical staff quarterly
  • Ad hoc infrequently as needed

• Quorum
  • MEC, credentials, peer review = some
  • Medical staff/departments = present and voting with proxy
Quorum/attendance/meetings (cont.)

• Attendance
  • MEC, credentials, peer review = 50-75%
  • Medical staff/departments = ?

• Voting process
  • Proxy or not for general meetings?
  • Secret ballots?
Amendment process

- Bylaw committee, MEC, medical staff, board of trustees
  - Must pass by full medical staff

- Voting process
  - 20-25% required to vote “no”
Operational issues

• Confidentiality/immunity/releases
• Special appearance requirement
• Contract?
• Affect of Patient Safety Act and PSOs
Corporate negligence

- Any deviation in practice from that detailed in the bylaws, rules, regulations and policies; accreditation standards; peer practices; Medicare Conditions of Participation; clinical pathway; etc.
Critical principle

“FORM FOLLOWS FUNCTION.”
(Horatio Greenough/Louis Sullivan)

• Constitutional document with associated manuals
  • Credentials, peer review, fair hearing, etc.
  • MS.01.01.01
Communication of change strategy

- MEC input
  - In sequence or as a package?
- Full medical staff input
  - Town hall meeting?
- Newsletter from chair?
- Individual discussions with covert leaders?
Questions?
Thank you for joining us!