Executive Summary – Bylaws Draft

**Definitions (Revision/Addition)**

Several definitions were added or revised to accurately reflect current terms, and future terms, that will be used. (Revision/Addition)

**Article 1 – Name and Purpose (Revision)**

1.A. Denali Center was removed from the name of the institution per the request of administration as it is considered a separate entity. (Revision)

**Article 2 – General (Addition)**

2.A. Addition of statement explaining that time limits are guidelines, unless explicitly stated, to allow for flexibility when governing. (Addition)

2.B. Addition of a statement explaining that employment practices are separate, and do not influence, Medical Staff processes. This will help inform providers, and employers, that the medical staff process is standardized for all practitioners regardless of employment arrangements. (Addition)

2.C. Addition of a statement explaining that leaders may delegate, and at times perform, functions of the Medical Staff that are not being accomplished by the individual responsible. This will allow for the Medical Staff to meet their responsibilities to the Hospital and Board by providing flexibility in who may fulfill the function. (Addition)

2.D. Addition of Medical Staff dues to help ensure funding for activities for the Medical Staff activities they want to engage in. It may also be a means to pay leadership positions. Furthermore, it may help deter providers who have no intention in participating or contributing to the Medical Staff function to not seek membership. (Addition)

**Article 3 – Nature of Staff Membership**

3.C.4. Changes to language regarding on call participation were added to provide clarity regarding the Executive Committee providing oversight in ensuring call coverage is managed appropriately for the hospital. (Revision)

3.C.4.a. Addition of a requirement for departments to develop call policies that include the expected response times. Policies should be based on patient need and number of physicians available to take call. (Addition)
3.C.4.d. Additional language to the response time section to clarify the expectations that the on-call provider will respond by the lesser of either the approved call/hospital policies, or if no policy exists, by the maximum allotted time set forth in this bylaws section. 
(Revision)

Article 4 – Categories of Staff

4.B. Changes in this article are mostly related to updating the term “Allied Health Provider” to “Advanced Practice Provider”. Some advanced practice practitioners find the terms “AHP” or “mid-level” demeaning. This updated term is the current industry standard for describing midlevel practitioners. (Revision)

4.B.9. Removal of the limitations on Consultant Staff regarding not serving as the admitting, attending, or surgeon of record. This section was replaced with language indicating that Consultant Medical Staff may exercise their clinical privileges, including admission to the hospital, with the understanding that any inpatient they attend requires the provider to remain in the geographic area during their stay or have appropriate cross coverage. The current situation is an example of why membership and clinical privileges should not be linked as most providers have “admit or admission to the hospital” on their delineated privilege forms. Furthermore, Fairbank’s location create ongoing challenges for employers in recruiting providers so there needs to be some flexibility to credential providers willing to remain in the areas, or establish appropriate cross-coverage, in order for our community to benefit from their services either through ED on call coverage or subspecialist for specific populations. (Revision)

Article 5 – Procedure for Staff Membership and Membership Renewal

5.A.2. Updated language describing how appointment and reappointment dates are determined with Board approval. This change explains the current process, not the Banner process, for assigning renewal dates. TJC requires provider privileges not be granted for a period to exceed 24 months. (Revision)

5.B.1. Expanded the criteria to allow for those providers who have submitted an application to the Alaska State Medical Board to be eligible to receive an application. This is already done by Medical Staff Services (MSS) because of the delays typically associated with obtaining a license. This change would simply bring the bylaws in alignment with current practices. Significant delays in credentialing, which impacts employers, would occur if MSS could not provide an application to start the credentialing process until the license is obtained. (Revision)

5.B.7. Expanded the criteria to allow for residents, who are under contract to work in Fairbanks after graduation, to be eligible to receive an application if they are within the last two months of completing their residency. This is a process MSS already practices as it would cause delays in the credentialing process for employers. (Revision)

5.C.6. This addresses instances when information an applicant should have disclosed was not provided during the credentialing process. Addition of potential consequences for misstatements and/or omission during the credentialing process and who will make the determination as to whether to continue processing the application. (Addition)
5.F. These main changes to this section are the removal of the descriptive terms “Active” and “Inactive” related to Credentials Files. This practice is outdated. The credential files are primarily housed in an electronic system so there is only one file. The peer review information is also housed in the same electronic system. (Revision)

5.F.2. Removed language from a section that describes what providers may look at related to peer review information as the peer review information is housed within the same system as the credentialing information. The main content is unchanged. (Revision)

Deletion Removal of a section that stated the Credential Committee could place unwarranted information into the inactive credential file. This entire section is outdated and no longer takes place. Providers always have the right to add statements to their file regarding issues and also the performance review processes address validity of information prior to it reaching the Credentials Committee. (Deletion)

Article 6 – Privileges
6.F.3.a. Expanded timeframe and patient type that a provider granted temporary privileges for urgent patient needs. This change allows a provider to now see a patient group, not just a singular patient, for a longer period of time. This is a direct change due to the COVID crisis and having to work within the Bylaws to determine the type of privileges to grant practitioners. (Revision)

6.F.3.b. Updated the temporary privilege timeframe from 90 to 120 days to align with TJC language. This section may not be necessary as MSS does full credentialing on locum tenens providers. (Revision)

ARTICLE 8 - PROFESSIONAL REVIEW PROCEDURES AND CORRECTIVE ACTION
8.F. Additional language to the Summary Suspension was added to provide clarity regarding summary suspensions. This includes specific details on the initiation, process, rights to parties, and reporting requirements related to summary suspensions. (Revision)

8.G. The changes made to the automatic suspension/relinquishment of privileges section reflect that there are situations when the basis for a member’s eligibility for medical staff privileges will automatically change, whether due to federal or state law, hospital policy, or otherwise. These include things that are serious enough to go to the basic eligibility for serving on the medical staff, such as licensure, exclusion from federal programs (Medicare), insurance coverage, compliance with the medical records policy, but yet are factual matters that do not require a peer review hearing (as opposed to professional behavior/competence matters which would more appropriately be evaluated through the peer review process). As a result, upon their occurrence, a member automatically loses their privileges to practice for the period of time when the factual matter has occurred (e.g., for as long as their DEA registration is suspended). These actions are administrative in nature and not the type of actions or situations that give rise to professional review actions or would otherwise merit a professional review action. (Revision)

Deletion Removal of current Limited Suspension section as its content is now included in the automatic suspension/relinquishment section. (Deletion)

ARTICLE 9 - HEARING AND APPELLATE REVIEW PROCEDURES
9. The changes made with respect to the fair hearing requirements were based on our experience working through that section. As previously written, the fair hearing requirements were confusing, missing information, and unclear at times. For example, there was no explicit right of the Medical Executive Committee to have an attorney (although the physician under review has that right); it was unclear what process would be followed if the Board was the body who took certain actions thereunder; and the appellate review provisions did not set out the clear options for the appellate review committee. There are very few laws that govern the types of
information that need to be in these types of sections (namely, the Health Care Quality Improvement Act is the main law that applies to grant immunity for those who participate, but that law has very few requirements). In revising the fair hearing requirements, we used standard provisions from other medical staff bylaws in our files. We also added language making it clear that members only get a fair hearing for things which are reportable to the National Practitioner Data Bank. Overall, we sought to make the process more robust while also streamlining it and making it easier to reference and implement. (Revision)

<table>
<thead>
<tr>
<th>Article 10 – Medical Staff Leaders (Revision)</th>
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<tr>
<td>10.A. Removed the Committee Chairs as current officers of the Medical Staff. This change was done to align with all the other changes in the document. This would reduce issues around having to be excused from voting due to the overlap in positions and aligns with the Leadership Council selecting the chairs of committees. The Medical Staff should not elect the chairs of these performance improvement committees as the chairs should be staff with leadership experience and understanding of the committees functions. A Member-at-Large was added to the group which allows a medical staff member who meets criteria to participate in governing. This will allow to train those members who may want to be Chief of Staff in the future and may also be seen as a member who balances out those who have been in leadership for extended periods. Vice Chief of Staff was retitled to be Chief of Staff Elect. (Revision)</td>
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<td>10.B. This change allows for all elected officers to serve a two-year term with an option to continue if elected. This change eliminates the need to vote on an annual basis and provides flexibility to maintain leaders if the medical staff chooses. (Revision)</td>
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<td>10.C. Increased the qualifications that are required to be a medical staff leader. All leaders will be held to these criteria. This is to eliminate candidates who do not model the expectations of a medical staff members, either through their behavior or patient care. This change will impact the department chair position the most. It also ensures leaders have experience in the areas they will be responsible for. (Revision)</td>
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<td>10.D. Revised the nomination and election of officers. This change eliminates the need for the Nominating Committee but rather includes the Leadership Council for candidates. The Leadership Council would have a solid understanding of whether or not the candidates would be good for leadership and meet the qualifications. The process still requires the general approval of the candidates by the MEC and for the medical staff to put forth candidates. The changes to the voting process allows for a more flexible, streamlined process. It eliminates proxy voting or nominations from the floor. (Revision)</td>
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<td>10.E. These changes create a more thorough explanation of why and how staff leave office through removal or resignation. The changes align with other section of the bylaws. Currently, the grounds for removing a leader is not explicitly stated so this adds a level of accountability to hold leaders to. (Revision)</td>
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<td>10.E.1.a. The numbers for removal was changed from 2/3 to ¾ for the MEC due to the size of the group. (Revision)</td>
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<td>10.E.3.b. Revised the language for filling vacancies so that only the Chief of Staff position is automatically filled. All other positions will need to be voted on. With such a small officer group, the medical staff should be allowed to elect the replacement of the positions. (Revision)</td>
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10.F.1. Revisions were made to the Chief of Staff duties though they are primarily the same. A few additions and deletions were made but mostly just rewording existing duties the Chief section to align with other changes or current practices. (Revision)

10.F.2 The title of the Vice Chief of Staff was changed to Chief of Staff Elect. The Chief of Staff Elect will automatically succeed the Chief of Staff after his/her two-year term. This creates a succession plan in which the Chief of Staff Elect will be mentored and gain experience for when he/she takes over the position. Creating a succession system allows for seamless transitions among the officers. This will lead to an engaged, well-informed medical staff leadership team that can continue medical staff initiatives and projects without losing any ground when transitions in position occur. (Revision)

10.F.2-5 Revisions were made to the other officer roles. (Revision)

Deletion Deletion of the order of succession section as it is not needed with a small officer group. (Deletion)

Article 11 – Departmentalization of the Staff

11.A.2. Added explicit language related to creating, eliminating or changes departments or sections to and their purpose to match up with TJC language. (Addition)

11.B.2. Revision of the section regarding how providers are appointed to departments. Written to align with TJC language. (Revision)

11.D.1. Added additional language for eligibility requirements to be chair. This change will in making sure candidates are able to appropriately serve their departments. This will hopefully reduce departments simply allowing members whose “turn it is” govern the department, even if the member doesn’t meet the behavior or quality standards expected of a member of the Medical Staff. (Revision)

11.D.2.c. Term of office was aligned so that any leader can be re-elected after a two-year term. If a department chair is willing and meets qualifications there is no reason for that member to step down if the department feels they are being represented appropriately. This may help eliminate issues with departments who do not have a large body to draw from for leadership. It may also help keep some continuity in projects or addressing issues when the chair elects to remain in office. (Revision)

11.D.2.b. Language was added to clarify how and when vacancies of the department chair or vice chair position will be filled if the vacancy occurs during the leadership term. (Revision)

11.D.2.c. Language was added regarding the voting process for departments and how ties will be determined. This would eliminate a need to vote every year and there was not previously language specifically about how to decide a tie. (Revision)

11.D.3.a. Revision to the removal section to change the number from 2/3 to ¾ of the department and MEC for removal. This would ensure a more fair removal process due to the size of some of the departments. Also, the grounds for removal were included as it was not previously stated. The process for removal and filling vacancies now align with the Article X with the additional component of including the department. (Revisions)
11.E. Revisions to this section represent the TJC requirements. Most of the general responsibilities were simply rewording but there were some that were added or deleted. Department chair positions are responsible for a plethora of activities. This must be included in their orientation to the position. There is a need to review this list to ensure the department chairs are involved or have delegated these duties. There may be some that are being handled by the medical director roles in the hospital so it would be important to identify who, and how we demonstrate, that we are in compliance with the TJC. (Revision)

11.F. Streamlined vice Chair qualifications, selection and tenure, and duties information into more succinct statements. It is not a requirement to have vice chairs or sections so it may be worth removing these positions/groups. (Revision)

Deletion Deletion of several sections in the current bylaws as the information is either captured in other sections or no longer relevant. (Deletions)

Article 12 – Committee

12.A.1. Addition of a statement stating specifically what the function of committees are as stated by TJC. (Addition)

12.A.2 & 3. Changes to who makes appointments to committees, how committee chairs are appointed, and the term of committee positions. (Revision)

12.B. Changes to the Executive Committee composition were made to reflect the changes in leadership and align with the TJC. Addition of confidentiality statement for the entire MEC group and its guests. (Revision)

12.B.2. Duties were revised to align specifically with TJC standard. Addition of a statement that the authority designated to the MEC may be removed if the bylaws are amended. This is a TJC and was simply moved into this section from a different section. Addition that the meeting shall be recorded and meet monthly. (Revision)

12.C.1. Addition of language regarding why and how standing committees are created or dissolved. This is needed to demonstrate that committees should have a specific purpose and that ultimately the MEC is responsible for the functions assigned to the medical staff. (Addition)

12.C.2. Addition of language regarding why and how special committees are created or dissolved. It explains that special committees are accountable to the MEC. (Addition)

12.C.3 Removal of the terms of office and appointment by the Chief of staff were deleted from most of the standing committees. This aligns with the revision that the Leadership Council will be making appointments and removals from committees. Also, the phrase “in Good Standing” was added to those committees who perform physician performance reviews to align more with the requirements expected of those who serve in medical staff positions.
12.C.3.b. The Bylaws Committee would now serve as needed when the MEC wants them to review proposed amendments. This is due to a change in the process for proposing amendments. They would still be responsible for the annual review of the governing documents.

12.C.4.a. Language added that allows for Officers of the staff to serve on the Peer Review Committee only if approved by the Medical Executive Committee. This guideline is to avoid any potential overlap in voting on recommendations related to provider issues that would cause an Officer to recuse him/herself at the MEC level, while still recognizing the challenges of a small medical staff in which providers sometimes need to serve on multiple committees. (Revision)

12.C.5.a. Language that does not allow for the Officers of the Staff to serve on the Credentials Committee to avoid double voting on the recommendations related to credentialing matters.

12.C.11.b. Addition of the words “performance improvement” to describe the functions of the QI committee. Removal of the election component to align with the change in officers. Also added the phrase “related to” as the QI committee doesn’t directly do the monitoring, assessing and improving of all of the items in the list but rather should be receiving reports on them from the groups that are.

**Deletion** Details related to committee meeting items (quorum, minutes, agendas, etc.) were removed from this section because they are contained in another article of the bylaws.

**Deletion** Nominating Committee was deleted due to change in voting process.

**Deletion** Deletion of the statement that the Care Management Team shall manage the meeting from the Bioethics Committee.

### Article 13 – Staff Meetings

**13.A.1.** Reduces the number of required general staff meetings from four to two meetings per year. The reason for the reduction is that situations arise in which four meetings are not feasible or necessary. This provides flexibility in when the meetings can be held and reduces associated costs. This change still allows the Chief of Staff, MEC, or CMO or medical staff to call for meetings of the staff. Other changes are to the meeting notification and details. This changes allow some flexibility for meetings as well. (Revision)

**13.B.1.** Changes eliminate a required number of meetings and instead allow for departments or committees to meet as often as necessary. This will reduce meeting for no specific purpose. This also outlines how to call special meetings. (Revision)

**13.C.** Update and standardization of what the chair is responsible for as the leader of the meeting. This also includes not formally using Robert’s Rules of Order since most don’t know the rules and we do not apply them consistently. (Revision)

**13.C.2.** Revisions to when and how notices for meetings are distributed to the medical staff aligns with current practices. (Revision)
13.C.3. Quorum requirements for voting by the MEC, Credentials Committee and Peer Review Committee were changed to 50% of the group must be present. Considering these bodies vote on topics that could potentially affect a provider’s membership and or clinical privileges it is important multiple staff are present. (Revision)

13.C.4. Details regarding meeting documentation which were previously in different sections were standardized in this section. (Revision)

13.C.6. Attendance requirements for Active staff were changed from 50% of committee meetings to 25% of all meetings. This will hold Active staff accountable for attending department, regular meetings of the staff, special, and committee meetings. The addition of a penalty of a fine ($100) at reappointment was added to encourage Active staff to attend their assigned meetings. It is important that the Active voting staff be engaged and informed in medical staff affairs. To do this, they need to participate in meetings. (Revision)

13.C.6.d. Addition of language regarding mandatory meetings and the potential outcomes of failure to present at the meeting. This is needed in order to delete Article 15. Once the other documents (Credentialing policy) is in place, this requirement may be appropriate in that document and removed from this section. (Addition)

Deletion Since the attendance was standardized and included in this Article, Article 15 of the current bylaws is being removed completely. (Deletion)

Article 14 – Conflict Resolution

14.D.2. Removal of language regarding submitting the unresolved controversy to arbitration. (Revision)

14.D.3 Removal of arbitration word related to costs of conflict resolution. (Revision)

Article 15 – Chief Medical Officer (Addition)

15.A. This adds the Chief Medical Officer role formally to the bylaws. Right now this information lives in the Rules and Regulations. (Addition)

15.B. The duties were revised to include participation in the Leadership Council, assisting all medical staff leaders, and performing other functions. This formalizes the CMO position and adds some clarify regarding the position’s integration with Medical Staff leadership. (Revision)

ARTICLE 16 - IMMUNITY FROM LIABILITY AND INDEMNIFICATION

16. The contents of this article were moved almost entirely to the Appendix D. These two statements simply state that physicians have immunity and indemnification when acting on behalf of the medical staff in certain situations. (Revision)

Article 17 – Amendments
17.A. Statement added regarding the MEC and the Board are not allowed to unilaterally amend the bylaws. This is a TJC requirement. (Addition)

17.B. & C. These changes make proposing changes and presenting bylaws a faster process by eliminating the required role of the Bylaws Committee as the first approval body. The Bylaws Committee can asked to convene by the MEC to review proposals as needed. (Revision)

17.C. The changes to the process of adopting bylaws makes it a more efficient process. (Addition)

**Article 18 – Other Medical Staff Documents (Revision)**

| 18.A. | The language explains that the governing documents include Rules and Regulations, policies, and other procedures. It adds policies and procedures to the existing Rules and Regulations section which used to have its own Article regarding amendments. This is in line with TJC and prepares for future revisions. (Revision) |
| 18.B. | Revisions to proposing and adopting the rules and regulations make this a more streamlined process. The changes also include how to adopt urgent amendments by the MEC and Board. (Revision) |
| 18.C. | Addition of language regarding how other policies or procedures are approved by the MEC and then the Board. This is a small change which may need to be altered because the Board doesn’t currently approve all of the medical staff policies. (Addition) |
| 18.D. | Notification of amendments was revised to be aligned with current practices. (Revision) |

*Deletion* Removal of the Department and Section Rules and Regulations as these do not exist currently. These may be referring to different policies that the medical staff departments or sections have. (Deletion)

**Article 19 – Adoption and Implementation of Bylaws**

| 19. | Updated names to reflect current leaders and organization. (Revision) |

**Appendix C – Rules and Regulations**

<p>| 1.B Staff Privileges | There were several updates of the term “Allied Health Providers” to “Advanced Practice Providers”. (Revision) |
| 1.B Staff Privileges | Updating of the term “sponsoring physician” to “supervising/collaborating” physicians in relation to Allied Health Staff. (Revision) |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.B Staff Privileges</td>
<td>Revisions to this section do not change the existing obligations of Advanced Practice Providers (APPs); however, it does remove specific requirements (72 hour co-signature) and replaces them with reference to policy. Details related to medical record requirements for APPs, and their sponsors, are already defined in multiple policies. The intent of the passage is to state that APPs must adhere to the parameters as authorized by the Board in terms of their scope of practice. The updated language provides the flexibility to alter those parameters as needed. (Revision)</td>
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<tr>
<td>9. Special Categories of Patients</td>
<td>Updating the terms “alcoholic”, “alcohol abuse”, and “alcoholism” to “alcohol use disorder”. Updating the terms “addicted to drugs” and “drug addict” to “substance abuse disorder”. (Revision)</td>
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<tr>
<td>10. Standing Orders</td>
<td>Change from “associate” to “courtesy” staff regarding who can initiate standing orders. The associate category is no longer in the bylaws. This may need to be discussed further (Revision). Also, the section was updated to reflect that records are now accessible electronically. (Revision)</td>
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<tr>
<td>Deletion</td>
<td>Removal of the Chief Medical Officer section as it was relocated to Article 15 of the bylaws. (Deletion)</td>
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**Appendix D – Immunity From Liability and Indemnification Policy and Procedure**

Appendix D | This appendix combines the information previously located in Article 16 and the indemnification agreement (previously in this appendix). (Revision)