Proposed Bylaws Revisions

Town Hall

Purpose: To discuss concerns, feedback, and questions from the medical staff regarding the proposed revisions to the Medical Staff Bylaws.
Feedback/Question #1: Why have Medical Staff dues? (2.D. – p. 5)

- The proposal is that all members of the medical staff pay annual dues. The suggested amount is $100 for members and $50 for AHPs.

- The process would involve Medical Staff Services sending out invoices for dues every December, which would be due by the end of January.

- If the revisions are approved, the first dues would not be required until January 2021.

- 100% of dues would be deposited into the Medical Staff Account.

- These funds are accessed by the Medical Staff (via the MEC) for education, equipment, donations, and potential reimbursement for leadership positions in the future.

- Having annual dues may discourage some practitioners who hold privileges but do not contribute to the medical staff. These are practitioners who primarily live outside of our immediate vicinity.

**Background Information:**

- FMH/DC Medical Staff had dues prior to the last bylaws revision.

- Dues are standard practice among medical staffs across the country.

- The only money currently being added to the Medical Staff account comes from 1) delinquency fines (100%) and credentialing fees (50%).
Feedback/Question #2: Can you give an example where a consulting physician would need admitting privileges? (p. 10)

• We have long-term locum tenens, part-time staff and other providers who do not live primarily in the area or have more than one practice location who need to be able to admit to the hospital. (hospitalist; surgical providers who outside our area; long-term locums used to cover call gaps)

• Due to our unique location, it can be challenging to get staff to fill positions. This requires some creative staffing models that work on a practical level but do not align well with our categories in terms of credentialing and bylaws.

• These categories and their privileges need to be aligned with the current composition of the medical staff and our hospital needs (services, coverage). Staff categories will be part of the next steps in the revision process.
Feedback/Question #3: Who makes up the Leadership Council?
(Definitions L.; Article 10 – p. 47)

• Leadership Council refers to the Officers of the Staff and is defined in the Definitions section L.

• The Officers of the Medical Staff consists of the:
  • Chief of Staff
  • Chief of Staff Elect
  • Secretary/Treasurer
  • Member-at-Large
  • Immediate Past Chief of Staff

• The Leadership Council may invite other leaders to participate in their meetings as needed. (i.e. department and/or committee chairs, CEO, CMO)
Feedback/Question #4: Why is it that Officers cannot serve on Peer Review Committee? (12.C.4 – p.52)

- This will help avoid situations in which the same person is voting twice on professional review matters reported to the MEC. This reduces conflicts of interest and legal risk in review processes.

- The same language was also added in regards to the Credentials Committee members.

- There is already language in the bylaws related to Wellness Committee members not serving in certain positions. The bylaws state, “Members of this committee shall not serve as active participants on any Medical Staff or Hospital peer review or quality management, assessment and improvement committee while actively involved in a matter referred to this committee”.

- There is no restriction related to Peer Review Committee members serving as Credential Committee members or vice versa.

- This change will reduce the meeting burden on officers (and committee members) so they can focus on their specific duties.
Feedback/Question #5: I am uncomfortable with the requirement to attend 100% of all meetings and the $100 fine if I fail to do so. (13.C.6.c. – p.58)

- The requirement is for **ACTIVE** members, in which they must attend 25% of the total cumulative meetings within a 2-year period based on their department and committee membership.

- This requirement will apply to Medical Staff, not Hospital, meetings. (*see the next slide for a list that will be evaluated for this requirement*)

- There will no longer be an option of ‘being excused’ from meetings.

- If an ACTIVE member does not meet this requirement, the member is considered to not be contributing to the governance functions of the medical staff. The member will instead contribute to the medical staff functions financially by paying a $100 fee. This fee will be deposited into the Medical Staff account.

- The $100 fee is **not** per each year but rather $100 per two-year reappointment).

- This system is to encourage participation in department and committee meetings. Member attendance is the key to meeting quorums, meaningful discussions (representation) and recommendations, and voting on action items. Without participation by its members, the medical staff cannot successfully accomplish its self-governance duties.

  **EXAMPLE:** An Internal Medicine physician that does not serve on committees attends only three (3) IM meetings and one (1) general staff meeting during his two-year reappointment timeframe. The member could have potentially attended 12 IM meetings and eight (8) general staff meetings during the same timeframe.

  (4 meetings attended divided by the 20 total meetings = .20 or 20% attendance)

  This physician would be required to pay $100 fee for failing to meet the requirement of 25% meeting attendance within two years.
*Medical Staff Meetings that will be evaluated for the 25% meeting attendance requirement

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<th>Department/Section Meetings:</th>
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Feedback/Question #6: Can we change the phrase "drug addicts" on page 72 (at end of paragraph) to "people with drug addiction“ or “substance abuse disorder / alcohol abuse disorder? 

(Rules and Regs – p. 72-73) 

• This verbiage was simply outdated language and has been updated in the draft.
Feedback/Question #7: How did the indemnification section change?

• The indemnification section was streamlined in the Article of the Bylaws but the majority of the details regarding indemnification and immunity from liability are contained in Appendix D of the document.

• The overall immunity from liability and indemnification protections for providers remains the same.
Question #8: Why was there so much added to the suspension and fair hearing sections? (p. 30 thru 42)

- Our external legal consultant recognized these sections were vague and outdated in comparison to other organizations. Our consultant drafted up these sections to align our document with current industry standards.

- Adding more language helps clarify the process and protections for providers and the facility.

- There are now specific explanations as to when items are reportable to the NPDB, which is a frequent question during the professional review discussions.
Next Steps & Feedback

NEXT STEPS: The Bylaws Committee will present the proposed draft to the Medical Executive Committee for discussion and a vote. If approved, the document will be forwarded to the general medical staff for further review and approval. Once the general medical staff approves, the document can be put to a formal vote. After the formal vote, if approved, the document will be sent to the Board for review and a final decision.

FEEDBACK: We greatly appreciate the questions and feedback being sent. As this is an ongoing project, there will remain the opportunity to submit feedback or questions regarding the bylaws (and other documents) by using the survey monkey tool so please continue to be engaged.

Feedback link: [Bylaws Feedback Opportunity](#)

All documents and updates can be viewed on the Medical Staff external website:

[Medstaff External Website Page - Proposed Bylaws Revisions](#)