Medical Staff Feedback Q&A
from Survey Monkey tool, Town Halls, emails, personal communications

(most recent questions and responses will be posted at the top of the document)

3.c.4.d Thirty (30) min response from “call” or from when you are gotten ahold of “? What does 45 min for “staff” mean? Why a different response time?
This timeline, which is the standard in our existing bylaws, is interpreted as 30 minutes from the time of the initial attempt to notify the on-call provider. From initial contact, the on-call provider is expected to contact the hospital in response to the hospital’s initial page (phone call, text, present physically) within 30 minutes. If the provider who wanted the consult requests the on-call provider come into the hospital to evaluate the patient, then the on-call provider has a maximum of 45 minutes (after communication between the on-call provider and facility) to physically present to the hospital. The difference in timeframes is that one is centered on communication while the other requires the physical action of coming into the hospital.

Please note these times may be superseded by any existing medical staff or hospital policy that requires the on-call provider must respond sooner. These times represent the maximum timeframes allotted to respond if no other policies are in place to provide guidelines.

In our existing bylaws, which will remain unchanged in the proposed bylaws, the term “STAFF” is defined as follows:

The term “MEDICAL STAFF” or “STAFF” means all PHYSICIANS, dentists, podiatrists and other professionals duly licensed to practice in the State of Alaska and Federally Employed Military Staff who have been granted MEDICAL STAFF membership at the HOSPITAL.

5.c.6 Should the Chief of Staff and CMO alone determine whether to continue processing a file when a misstatement or omission is discovered during the credentialing process? Or would it be better for the Credentials Committee to own the decision of whether the application proceeds?
If the Chief of Staff and Chief Medical Officer make the initial determination on whether or not an application should continue being processed due to omission or misstatements, then there will be no perceived bias or conflict in the Credentials Committee’s recommendation. The Credentials Committee should only review completed files and not have the additional burden of making the determination on whether or not to process an application.

10.c.3 It seems like we should define “works well with others “. What do we mean by “past adverse recommendations “? Seems like lots of good docs have had need for discipline in the past. This doesn’t make them bad for committee work but sometimes it does.
There are a few options to determine if someone “works well with others” such as peer references, review of patient complaints or incident reports, and 360 evaluations. These are the same tools used in the credentialing process to determine if members of the medical staff are meeting their responsibilities outlined in the bylaws of “working cooperatively with members, nurses, Hospital administration and others so as not to adversely affect patient care” and the established ACGME core competencies of professionalism and interpersonal communication.
Having the MEC, which includes the Leadership Council (Officers) who have access to confidential information as those described previously, will allow for a fair evaluation against the established criteria to determine eligibility for those interested in medical staff leadership positions.

The term “Adverse Action” is defined in Article IX but it will be added to the definitions section. The term “Adverse Action” has replaced “Adverse Recommendation” in the Leadership section to provide clarity.

11.e.15 This has old language that says department chairs are voting members on MEC.
This language is not outdated as the department chairs are voting members of the MEC currently. The open MEC session members vote on items such as bylaws, policies, ballots, and funding requests. In 2019, a subcommittee of the MEC, made up of the Officers of the Staff, CEO, and CMO, was formed (through a Bylaws revision) to address the functions of the MEC related to peer review protected information such as credentialing decisions and professional practice concerns. This decision was made in order to protect confidential, sensitive information about medical staff members from being presented to a large body of their peers. A summary report of each closed session is presented to the full MEC each month.

11.a.2 Should MEC hold the power to make and change departments? Should this be a power of the medical staff and not just the committee?
This language is a TJC Medical Staff requirement. Joint Commission standard MS02.01.01 states: “The Medical Executive Committee makes recommendations, as defined in the bylaws, directly to the governing body on, at least, all of the following: The organized medical staff structure”

Since department chairs make up the majority of the voting members of MEC, any decision to add, modify, or eliminate departments/sections would be made by those elected as representatives of said departments and the general medical staff.

Thank you for opening this process to the staff at FMH. I am a CRNA here and love our facility. I would like to see the bylaws accurately depict my role in terms of an independent provider in line with the state board of nursing. There is no need to REQUIRE physician oversight, that said, we happily work together with our fabulous anesthesiologist colleagues. Designating us as independent is simply an accurate representation of our role, especially in covering epidural placement in OB.
The Bylaws Committee is currently reviewing the various Categories of Staff and their prerogatives. The ultimate decision as to the scope of any practitioner providing care in the facility is up to the Board as they are ultimately liable. Your input is valuable as it highlights that the landscape of healthcare is changing and as an institution we need to continually assess and adapt to best meet the needs of our community.

Could you give an example where a consulting physician would need admitting privileges?
There are 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.

Article 10 - I assume that the Leadership Council is terminology regarding officers of the staff?
Leadership Council refers to the Officers of the Staff and is defined in the Definitions section L. The Officers of the Medical Staff will consist of the: Chief of Staff, Chief of Staff Elect, Secretary/Treasurer, Member-at-Large,
and Immediate Past Chief of Staff. The Leadership Council may invite other leaders to participate in their meetings as needed (chairs of departments and/or committees, CEO, CMO).

**Article 12.C.4 (Officers not serving on PRC) - PRC would lose two tenured members who are also officers.**

Not sure if By-laws committee was aware of this.

This will help avoid situations in which the same person is voting twice on professional review matters reported to the MEC. This change 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 also reduce the meeting burden on officers (and committee members) so they can focus on their specific duties.

**Why have Medical Staff Dues?**

The proposal is that all members of the medical staff pay annual dues. These dues will provide funds for the Medical Staff account to be used by the medical staff. 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. One hundred (100) percent of dues would be deposited into the Medical Staff Account. These funds are accessed by the Medical Executive Committee (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 from applying/reapplying for membership. These are practitioners who primarily live outside of our immediate vicinity.

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%), which is why this account is dwindling versus growing.

**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 Medical Staff calendar*). 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.

I missed the town hall. Wonder if there was discussion on eliminating the $ penalty for meeting attendance to instead get $100 off your application for meeting the meeting attendance requirements. Need to change to more positive incentive based system (more supportive) to less punitive (less supportive and antiquated) systems.

Currently, the reappointment fee for a physician is $100 (AHP $50). If this $100 fee were waived, the medical staff and hospital would lose funds. Fifty (50) percent of the money from reappointment fees goes into the Medical Staff account while the other fifty (50) percent goes into the Medical Staff Services account to cover the cost of processing the reappointment file.

This idea was discussed, though not at the town hall, and while we appreciate this shift to an incentive-based system, participation in medical staff meetings is part of the responsibilities that providers agree to when applying to the medical staff. If a reward for participation is offered, it should be for exceeding the required standards, such as 70% meeting attendance rather than 25%. With the option to participate virtually in meetings, having access to the entire year’s meeting calendar in January, and numerous reminders, there are plenty of opportunities to plan ahead to ensure meeting attendance (with the obvious exception of urgent patient care needs).

I would like clarification where certified registered nurse anesthetists (CRNAs) fall in the "independent" and "dependent" advanced practice provider groups of the revised bylaws. If CRNAs are considered to be in the "dependent" category, I find that highly inappropriate. Alaska is a CMS opt-out state and allows for full practice authority with no requirements of physician supervision for CRNAs. In accordance with state BON statutes and insurance reimbursement requirements, there is no need to require physician supervision of CRNAs. Furthermore, it is inappropriate to have bylaws that state a supervising physician is responsible for the actions of a CRNA. This puts other providers in a position of increased liability, and in the event of litigation, unnecessarily increases the number of malpractice policies for lawyers to seek payment from.

CRNAs are currently considered Category I practitioners who work in collaboration with a sponsoring physician. The Hospital Board determines the scope of practice for all practitioners authorized to provide patient care in the Hospital as they are ultimately held liable.

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)

Yes. This verbiage was simply outdated language and has been updated in the draft.
5G - Physicians should have the ability to review their medical staff file on demand and not need the approval of the executive committee.

The section on Credentials files has not changed from the current bylaws in terms of accessing one’s own file. The changes that were made merely reflect that the “files” are no longer referred to as “Active” and “Inactive” and are maintained electronically. This recommendation would require a change in our existing bylaws. The oversight built into this section is to ensure that confidentiality requirements and protections of state and federal law are being observed.

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 still contained in Appendix D of the document. The overall immunity from liability and indemnification protections for providers remains the same.

8.G -6 Suspension of privileges for voluntary exclusion from a Federal Health Care Program is problematic. There are a number of reasons you may choose not to contract with Medicare, Native health org, VA, etc. This may also have consequences down the road for a nationalized health care system that you may choose not to associate with.

This language was targeted at addressing when a provider involuntarily becomes excluded from Federal Health Care Programs. Exclusion is a remedy the government imposes on someone who has done something illegal or egregious and who, as a result, the government no longer allows to participate in federal health care programs. This statement in the draft bylaws has been updated to more adequately address that is does not apply to voluntary but only imposed (involuntary) exclusions.

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.