Consider these different approaches to amending bylaws and documents

**Decide what's most effective and efficient**

How does your hospital go about amending its medical staff bylaws and any separate documents, such as those for credentialing and privileging processes?

The traditional approach—which calls for a general medical staff meeting with a required number of members in attendance to adopt any changes—may not be the best way, according to some industry experts.

When it clarified bylaw requirements for 2004, the JCAHO discussed the approval of a hospital's core medical staff bylaws and the policies and procedures organizations can include in separate documents.

However, the JCAHO leaves it up to hospitals to decide an approval process for those bylaws and separate documents.

**Consider your amendment process**

You'll recall that in a December 2003 clarification of standard **MS.1.20**, the JCAHO said it will allow hospitals the option of continuing to only reference four specific medical staff functions—credentialing, privileging, appointment, and fair department chairs—she convinced the JCAHO surveyor of the adequacy of the hospital's privileging process, she probably kept University Health System from receiving a Type I recommendation. (In 2004 surveys, the JCAHO has eliminated Type I's.)

A privileging problem

The professional staff services office that Flowers heads up is responsible for credentialing and privileging physicians at the large hospital and five ambulatory clinics.

**JCAHO survey review: Don’t be afraid to speak your mind**

**Stand up for your facility when you’re doing the job right**

Betty Flowers, CPMSM, director of professional staff services at University Health System in San Antonio, learned an important lesson during her hospital's JCAHO survey in December 2003. If you believe you're doing the job right, don't be afraid to stand up and make your case to surveyors, Flowers says.

Flowers believes the fact that—backed up by staff from the quality, legal, and accreditation departments, and several of the department chairs—she convinced the JCAHO surveyor of the adequacy of the hospital's privileging process, she probably kept University Health System from receiving a Type I recommendation. (In 2004 surveys, the JCAHO has eliminated Type I's.)

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**Success with hospitalists**
Learn about ways hospitals credential and privilege the growing number of hospitalists on p. 6.

**News briefs**
Amending bylaws

hearing and appeal processes—in the bylaws, as long as those procedures are detailed in separate documents. (See the February BOC and this issue’s special report for more details.)

The clarification stated that the medical staff and governing body must jointly approve those separate documents. However, the JCAHO also said the process for medical staff approval and amendment of these separate documents may be different than the process followed to approve the bylaws. That approval is typically a percent approval of the entire medical staff, the JCAHO said, implying the process for dealing with the separate documents may be less stringent. But don’t forget to set forth that alternative approval process in the bylaws.

The JCAHO clarification raised the broader issue of how hospitals should go about amending or changing their bylaws. Now is a good time for medical staff services professionals (MSSPs) to consider the best way to approve and amend those separate documents dealing with credentialing, privileging, appointment, and fair hearing and appeal processes.

“If you go about a review of your bylaws, obviously you are going to find opportunities to make some changes and do things differently,” said Todd Sagin, MD, JD, national medical director for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. “This can be very challenging for many medical staffs because they have created a significant burden to changing bylaws,” he said during the December 2003 audioconference, “How to fix your bylaws: Physician rights, medical staff responsibilities, and new JCAHO standards.”

Some drawbacks to tradition

The typical and traditional method most hospitals use to change their bylaws is to require after one or two readings of a proposed amendment that there be a general medical staff meeting that a quorum of members must attend, Sagin said. A quorum is often a fairly significant number of medical staff members and approval of a change often requires a two-thirds majority or sometimes even 80%.

“This can be fairly daunting,” Sagin said. “We all know it’s gotten much more difficult to get folks to attend general staff meetings than it has been in the past. It can be difficult to achieve that quorum, and then the organization is paralyzed when it needs to make bylaws changes, especially if it needs to make them promptly.”

Many medical staffs do break up their bylaws into one essential core document and have separate documents that, for example, detail credentialing and privileging processes. That essential core document, often called the bylaws, may only be 15–20 pages and contains fundamental principles that the medical staff would rarely want to see changed, Sagin said.

Remember that your core bylaws should speak to the amendment process that is applicable to each of your separate documents or manuals, he said. “You can have somewhat different approaches with lower thresholds [for approval] than you might for your core bylaws.”

How hospitals amend bylaws

During the HCPro, Inc., audioconference “How to fix your bylaws: Physician rights, medical staff responsibilities, and new JCAHO standards,” the audience was asked whether their hospitals’ bylaws are currently amendable only through a general medical staff meeting with a quorum present, or whether they can be amended by some other mechanism that does not require a general medical staff meeting. The results were as follows:

General medical staff meeting with a quorum: 77%
Another mechanism rather than a meeting: 23%
“The great advantage to this approach is that you can have lower thresholds for making changes to these documents, such as your credentials document, that might need to be changed quickly in reflection of changes in policy, changes in regulation, or changes in common practice,” Sagin said.

**Consider your options**

What are some of the different approaches hospitals might consider for amending these separate documents?

- Some hospitals still call for a general medical staff meeting, but require only a simple majority of those in attendance to approve a change to bylaws, Sagin said. A quorum is not necessary, so this method helps address the problem of low attendance at meetings.

- Other hospitals have eliminated meetings, and now use a balloting process to measure approval of bylaws changes. Hospitals can distribute that ballot either by mail or by posting it on the medical staff Web site, Sagin said. When the ballots are returned, the vote of the medical staff—perhaps either a two-thirds approval or a simple majority, depending on the hospital—can change the bylaws.

- Some hospitals have taken this even further, designating that a nonreturned ballot is considered a “yes” vote to approve a proposed change. “This recognizes that many on the medical staff simply don’t take the time to express their opinion one way or the other, or to register a ballot. But they have confidence in the medical staff leaders they elected, and proposed amendments—which should always come at the recommendation of the medical executive committee [MEC]—would be considered appropriate since it comes from the elected officials they put in place,” Sagin said.

Various hospitals have come up with methods that suit their needs, said Hugh Greeley, founder of The Greeley Company, who also spoke during the audioconference.

That’s the case of a Denver hospital with a large medical staff, Greeley said. The medical staff there voted to amend its bylaws to permit the MEC to create amendments and recommend them directly to the board without a review and vote by its members.

The medical staff elects the MEC, and that cannot be changed by the MEC, Greeley said. So the MEC has responsibility and authority to maintain the medical staff bylaws, amend them, and recommend changes to the board of directors. Once approved, those amendments must be circulated to the staff on its Web site.

“This is an evolution,” Greeley said, from bringing the entire medical staff together in one room to approve a change, to having a small group of physician leaders come together to review the bylaws and make recommendations.

“I think we’re going the full gamut here depending on the size of the hospital and its evolution,” Greeley said.

Both Greeley and Sagin cautioned hospitals that have amended the quorum requirement to make it a very small percentage of the medical staff, that this subsequently allows a small number of physicians to change bylaws. A small number of members who show up at a meeting may be motivated by a single issue, Sagin said. A downside is that a hospital could get a very one-sided set of opinions driving bylaws changes.

“I’m absolutely convinced in today’s environment where medical staffs are trying to reach out to their medical staff members and involve them in critical medical staff processes that the MEC should search for a mechanism that gets maximum participation in amending the medical staff bylaws and electing staff officers,” Greeley said, a measure accomplished with a very well-attended general meeting or through a ballot.

**Editor’s note:** Go to www.hcmarketplace.com if you are interested in ordering a tape of the audioconference “How to fix your bylaws: Physician rights, medical staff responsibilities, and new JCAHO standards” or call customer service at 800/650-6787.
that comprise University Health System. JCAHO surveyors spent five days at those facilities in December 2003.

The privileging controversy arose when the surveyor, who focused on the credentialing and privileging review, was unhappy with the amount of information contained in University Health System physician profiles—data that department chairs look at when recommending approval to reappoint physicians to the medical staff.

When the professional staff services office provides the information in the physician profile—the physician performance reports for reappointment data or feedback—it only shows the top five procedures for that physician, Flowers says. The surveyor wanted more, and Flowers says it looked like the health system was headed toward receiving a Type I, which indicates a facility is not adequately addressing JCAHO standards.

It took some convincing to explain the privileging process to the surveyor, who didn’t cite the hospital with a Type I, but also didn’t back down from his position. Therefore, based on consultation with the JCAHO surveyor, professional services staff will expand the physician profiles and show data on all the practitioner’s procedures, she says.

Explain the logic
Explain the rationale for its profiling process kept the health care system—made up of the University Hospital and its five ambulatory clinics—from receiving recommendations for credentialing/privileging issues during this survey. The health system received accreditation with requirements for improvement. Flowers says the system received three Type Is, but none involved credentialing or privileging issues.

“The problem we [ran] into is that we decided as a health system that we would only show the top five procedures [on physician profiles]. The surveyor wasn’t real pleased to see that. He thought we needed to expand on that and show all of those data,” Flowers explains.

“We had the data. All that information was available in our office,” continues Flowers, who has participated in six JCAHO surveys since taking over the job in 1988. She made it clear to the surveyor that during reappointment meetings, she stipulates to department chairs that if they need more information to recommend approval, it is available in the professional staff services office.

She also explained the health system’s reasoning behind its profiling process. “One of the reasons for this is we’re a teaching institution,” says Flowers, of University Hospital, which is the primary teaching facility for the University of Texas Health Science Center.

“Our department chairs are not [appointed] on a rotating basis. Some of our chairs have been here for 20 years, and most of our medical staff are faculty members of the University of Texas Health Science Center. So for every physician in a department, the chair is well aware of his or her performance because he has to evaluate these practitioners over at the university side. It was very hard to convince the surveyor that this carries over to the hospital side,” she says.

In fact, it took two meetings with the surveyor to convince him that their procedures were in compliance. “We invited a couple of chairs to give their point of view as far as what information they have. It’s an ongoing process. The reappointments do occur every two years, but the chairs review data on a monthly basis,” she says.

About the facility

Name: University Health System
Location: San Antonio
Hospital size: Approximately 600 beds
Additional facilities: Five ambulatory clinics
Active medical staff size: 610 physicians with admitting privileges
Total medical staff size: 1,050 physicians
The surveyor also explained his position. “He was concerned they weren’t data-driven appointments. The more data you have about your practitioners, the better off you are,” she says.

The feedback from the surveyor will mean future changes. “This is something we have taken as consultative advice, and we are going to provide more of a detailed profile to the department chairs next time,” she says.

If a delineated privilege form lists certain procedures, the hospital will now ensure that it includes information about all procedures done by the practitioner in the last two years in the profile, in order for the chair to recommend approval for reappointment.

**A broad review**

During the credentialing and privileging review, the surveyor began by asking for a medical staff roster with the names of physicians and specialties. “He circled the files he wanted,” Flowers says, choosing about 25 files from different specialties. The surveyor reviewed files that included a physician assistant, a research nurse, a nurse practitioner, and a certified registered nurse anesthetist.

“I think they are looking more and more at how we credential and privilege the physician extenders. They want to make sure that they are credentialed and privileged in the same way we do the medical staff,” she says. In this survey, the surveyor divided the review into two segments—first looking at the credentialing process and then the privileging process.

In terms of credentialing, the surveyor reviewed files to make sure the professional staff had carefully completed all of their primary source verifications and that all pertinent documents were in the practitioner’s file. In terms of privileging, the surveyor ensured that the privileges each practitioner requested matched his or her experience and training.

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**Survey survival tip**

*Editor’s note: The following advice comes from Betty Flowers, CPMSM, director of professional staff services at University Health System in San Antonio.*

If you know you’re doing a good job, it’s worth the fight to convince JCAHO surveyors, says Flowers.

During her JCAHO survey in December 2003, it became clear to Flowers that her facility was in trouble when a surveyor was not happy with the way the medical staff services office did its physician profiling (see story on p. 1). “When he really started looking at the privileging part of the process, I was pretty panicky. It was hard for me to convince him that we were doing a good job,” she says.

Although it would have been easy to take the surveyor’s criticism without argument, Flowers says she wanted him to understand the hospital’s rationale for its physician profiling. “If you feel like you’re going toward a Type I [recommendation], and you feel strongly that you are doing a good job, then don’t let it go. Fight for it,” she says.

“We did not let it go. We made sure he understood that we were doing a good job by tag-teaming the surveyor with all our resources,” Flowers continues. In a second meeting with the surveyor to explain the hospital’s position, “We invited staff from quality, legal, and accreditation, as well as chairs from two of the clinical departments. We wanted to ensure that the surveyor understood our complete process.”

“I could have probably just given up on that first basis. My advice is don’t back down. Challenge, challenge, challenge, and keep driving your point home. I believe [our assertiveness] avoided a Type I,” she says.
The hospitalist movement in the United States has grown tremendously since the late 1990s.

Your hospital may already have launched a hospitalist program or may be thinking of starting one. Because of the increasing presence of hospitalists in health care organizations across the country, credentialing professionals need to familiarize themselves with these practitioners.

The influx of hospitalists has raised questions about how hospitals should credential and privilege these practitioners.

For example, one credentialing problem around hospitalists is that they are employed by a number of entities besides hospitals, including medical groups and insurance companies.

“The most common employment structure is for a large private medical group to sponsor a hospitalist program,” says Jeffrey Dichter, MD, FACP, currently the president of the Society of Hospital Medicine and director of the hospitalist program at Ball Memorial Hospital in Muncie, IN. Dichter is coauthor of the book *The Hospitalist Program Management Guide*, brought to you by BOC’s publisher HCPro, Inc.

The bottom line is that to be valuable, a hospitalist program must be of high quality and satisfy all parties—physicians, staff, and patients—as well as be cost-efficient, Dichter says.

**Credentialing considerations**
Industry insiders suggest credentialing hospitalists as you would any other physician.

For example, hospitalists haven’t created credentialing challenges at Slidell (LA) Memorial Hospital. They have been providing patient care at the facility for more than three years, and are employed either by other area hospitals or physician groups.

“[The hospitalists] are credentialed following the same process used for every other physician that applies for medical staff membership and privileges [at this hospital],” says Brenda Borland, CPCS.

“They are members of the medical staff and

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<th>Is a hospitalist program right for your organization?</th>
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<td>It takes more than quality hospitalists to make for a quality hospitalist program.</td>
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<td>There are some key characteristics that can help your administration assess the effectiveness of a program, says Jeffrey Dichter, MD, FACP. These same factors can also determine whether a hospitalist program is a good fit for a facility and whether it might be a cost-effective addition.</td>
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<td>Dichter says hospitals can look at the following seven factors to assess a hospitalist program:</td>
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<td>✔ Quality of care</td>
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<td>✔ Nursing satisfaction and satisfaction of other inpatient professionals</td>
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<td>✔ Accessibility/availability of hospitalists</td>
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therefore must abide by our medical staff bylaws.”

Borland equates a primary care physician’s use of a hospitalist to that of a traditional practitioner called in for a consult.

“The attending physician who calls in a consult is responsible for whatever that practitioner does to the patient. The same holds true in regard to hospitalists,” Borland says.

At Saratoga Hospital in Saratoga Springs, NY, the hospital’s contracted emergency department employs hospitalists who are credentialed just as “any other active or affiliate staff practitioner,” says Mary Branson, medical staff service professional.

Branson says the only difference she has noticed between hospitalists and traditional physicians is that hospitalists are invited to multiple department meetings. For example, hospitalists often attend family practice and pediatric department meetings.

“The inpatient physician group is the second-largest group in contact with pediatric patients. If the department wants to change a policy pertaining to pediatric patients, the department would like a representative to relay pertinent information back to the hospitalist group,” Branson says.

**Privileging practices**

Many hospitalists are internal medicine specialists, general internal medicine specialists, or internal medicine subspecialists.

Hospitalist is a job description, not a distinct specialist, says Steven Nahm, MBA, chief executive officer and senior partner at InCare Strategies in Laguna Beach, CA. Privileges should be based on each hospitalist’s experience, but some hospitalists may be eligible for advanced privileges. Consider the following guidelines when granting hospitalists privileges at your facility, Nahm says. Hospitalists should possess

- **board certification** in internal medicine
- **skills and experience** to care for intensive care unit patients
- **core procedural skills**, including urinary bladder catheterization, intravenous catheterization placement, and nasogastric intubation
- **advanced procedural skills**, including mechanical ventilation, intubation, pulmonary artery catheterization, and thoracentesis

*Editor’s note: To learn more about hospitalists, purchase the new book *The Hospitalist Program Management Guide*. Go to [www.hcmarketplace.com](http://www.hcmarketplace.com) for a description or call customer service at 800/650-6787.*
New York governor wants tougher screening
The case of a New Jersey nurse who has been charged with murder and claims to have killed 30–40 patients in a nursing home and nine hospitals led New York Governor George Pataki to propose stronger credentialing laws. The legislation is aimed at better protecting patients by requiring health care institutions to credential all licensed medical professionals who provide direct patient care in that state’s facilities, according to the Healthcare Association of New York State (HANYS). The proposal will also give providers statutory authority to disclose information regarding former employees, HANYS said.

Pataki’s proposal would require credentialing of nurses, pharmacists, respiratory therapists, and others specified by the health commissioner—in addition to the physicians, physician assistants, dentists, and podiatrists currently covered by New York law. The proposal would expand the ability of the state health and education departments to share information with each other and with health care providers.

Check the FAQs
Credentialing professionals will find some updated and revised frequently asked questions (FAQs) for hospitals on the JCAHO’s Web site. The accreditor updated several questions and answers that relate to the medical staff standards found in the Comprehensive Accreditation Manual for Hospitals. The JCAHO updated several credentialing and privileging FAQs as of January 1. Find the latest information on the Joint Commission’s Web site at www.jcaho.org by clicking on “standards FAQs—ask a question.”

Correction
Because of an editing error, the hospital dentistry White Paper included with the February BOC was incorrectly printed under the category of “Procedure” 130. The correct category for this White Paper is “Practice Area” 130. BOC apologizes for the error.