Do your bylaws reflect what you are doing?

A regular review of your medical staff bylaws not only ensures you are compliant with accreditors’ and regulators’ standards, but also verifies that the current actions of your medical staff members do not conflict with what is written in your bylaws.

Medical staff bylaws should conform with regulatory and accreditation requirements, but they also need to accurately reflect the way things are done at your organization, says Sandra DiVarco, BSN, RN, JD, an attorney with McDermott Will & Emery, LLP, in Chicago. However, if no one at your organization reviews the bylaws on a regular basis, language can become outdated and no longer reflect what is happening at your organization; alternatively, established mechanisms for important processes may be forgotten with time.

For this reason, DiVarco encourages medical staffs to review their bylaws on a regular basis—not just when a new regulation comes out. It can also be helpful to have a fresh set of eyes review the bylaws—for instance, when a new MSP or chief medical officer (CMO) joins the facility.

Eight months ago, Christine Hearst, CPMSM, became the director of medical staff services of Mission/Mission Laguna Beach/CHOC Children’s Mission Hospital in Mission Viejo, California. She is now undertaking a complete bylaws review and is using her outsider perspective to look for confusing or outdated language.

In general, Hearst likes to review the bylaws of her organization on an annual basis. Even if nothing needs to be changed, the review makes sure the bylaws are compliant when it’s time for an accreditation visit. Beyond ensuring your bylaws address any regulatory/accreditation requirements, accreditors will also look to make sure you are following any additional requirements in your bylaws. That means if you choose to go beyond the accreditors’ requirements, they will judge you against what is written in your bylaws—not what their minimum requirement states.

“If you don’t pay attention to your bylaws, you are going to get bitten when surveyors show up. They
know exactly where to look. Don’t give them any low-hanging fruit,” says Hearst. “Always stay on top of your bylaws because these are what you are governed by.”

With this in mind, organizations should evaluate whether their bylaws are too narrowly focused and prescriptive. For example, Hearst’s hospital is part of a large health system. The medical staff bylaws at her hospital state that the hospital will accept proctoring information from other Joint Commission–accredited hospitals in the health system. However, one of the sister hospitals is now accredited by DNV. So according to the bylaws, her hospital should not accept proctoring information from the other hospital.

“You have to look at the language you use to make sure you are not boxing yourself in too much,” says Hearst.

On the flip side, bylaws provisions can also be crafted so broadly that they are left open to interpretation, which can cause inconsistent application of the bylaws from case to case. DiVarco experienced this with a client. The healthcare facility did not like the way the fair hearing process actually worked, based upon certain broadly drafted provisions in the relevant sections of the bylaws, and wanted to handle the process differently in a subsequent case that arose almost immediately after the first. However, DiVarco advised the client that maintaining a consistent approach—at least until the bylaws were updated to reflect streamlining of the process—was more prudent. “Given the inherent importance of following the bylaws, there is value to acting consistently from one incident to the next so it does not look like the facility or medical staff is being unreasonable or capricious.”

Who to involve

When reviewing the bylaws, medical staffs should create a bylaws review committee, including individuals such as:

- Vice president of medical affairs (VPMA)/CMO
- Medical staff leaders
- Past chiefs of staff
- Medical staff members
- MSPs
- Legal counsel
It is important to include seasoned medical staff leaders who, by their use of the bylaws, know the strengths and weaknesses of the current documents. Past chiefs of staffs can also weigh in on what worked and didn’t work in the past.

Most medical staff leaders do not keep new CMS regulations or accreditation standards top of mind; they also struggle to keep up with legal cases that could affect the organized medical staff. Therefore, it is also important to include administrative personnel, such as the VPMA/CMO and MSPs, on the review committee. These individuals facilitate medical staff operations and have a better day-to-day understanding of the bylaws than most individuals within the organization.

In addition, include one or two medical staff members who have the respect of other medical staff members and who are not afraid to speak up. The medical staff knows that these individuals will question the process thoroughly and vet the bylaws revisions from top to bottom, so if they agree to the revisions, other members of the medical staff are likely to buy into the changes. It is better to involve these individuals so that they can have substantive input into the resulting product, then be your best advocate for the proposed changes.

When reviewing the bylaws, ask yourself whether they accomplish the following:

- Accurately reflect the structures and processes used by the medical staff
- Incorporate recognized leading practices for medical staff functioning and structure
- Are organized into a user-friendly and flexible set of documents
- Adequately address potential future conflicts
- Comply with regulatory standards

Keep in mind that it is not the job of the bylaws committee to approve or deny bylaws. This process starts with the medical staff, moves to the medical executive committee (MEC), and ends with the governing board. With this in mind, organizations should determine the best approach for them: revising the bylaws a few sections at a time or conducting a complete revision all at once.

**Complete overhaul?**

Although it seems like the better option from a bookkeeping standpoint, revising all of your bylaws at once can cause an uproar and pushback from the medical staff. This is for two reasons:

- It is too much information for busy medical staff members to read and digest, so they won’t read any of it
- It will likely be viewed by the medical staff as administration trying to make sweeping changes and take away their rights

“I recommend chunks at a time,” says Hearst. “It is better digested by medical staff. It scares them [when it is the whole document], and it is too much to read and understand.”

For organizations that want a complete review on a regular basis, DiVarco recommends writing the review into the bylaws or a policy. “If you have it built into your process, it is less threatening to the medical staff because it is simply part of the process.”

She also advises organizations who take the section-by-section approach to be mindful of how different sections of the bylaws could be affected by a change. For example, are investigations and disciplinary processes addressed in separate sections of the bylaws? If you change your section on investigation, this could affect your section on disciplinary process, and you will then need to review the disciplinary process for consistency. “You don’t want to have inconsistencies that you have to explain when you are in crisis mode in court,” says DiVarco.

**Move out of bylaws**

According to Hearst, her hospital is beginning to pull items out of the bylaws and move them into policies and procedures or rules and regulations—all of which are easier to update than bylaws. She recommends making the policies and procedures/rules and regulations department-specific so each department can change the documents to fit its evolving needs. You might also find it easier to get one department to sit down and review the documents it cares about. For example, Hearst’s hospital has started letting departments decide if they will accept the National Board of Physicians and Surgeons certification.
When deciding what to keep in the bylaws, Hearst suggests focusing on issues that affect the entire medical staff. Most medical staffs require a majority vote from the medical staff to amend a bylaw, which in this day and age can be a challenge as physicians separate themselves from nonclinical duties. Do you want to have to obtain a 75% vote of the medical staff for something as simple as combining two medical staff committees into one? By only having the committees that are required by your accreditor in the bylaws and moving the rest into a policy, you avoid having to go through the bylaws amendment process to alter when a committee meets or update a committee’s function.

**Challenging sections**

When reviewing the bylaws, the following are the areas that usually need to be addressed:

- **Membership**
  - What types of practitioners qualify for membership
  - Membership responsibilities
  - Membership rights
- **Leadership**
  - Which medical staff officer positions are necessary for a smoothly functioning medical staff
  - Qualifications of leaders
  - Election and removal process
- **Department**
  - The necessary number of departments
  - Which medical staff members qualify to be department chairs
- **Committees**
  - Medical staff versus hospital committees
  - MEC/credentials/medical staff quality
  - Composition of committees
  - Functions of committees
- **Meetings**
  - Attendance
  - Quorum
  - Voting

According to Hearst, the issue her hospital—and many others—struggle with is categories of practitioners. “Courtesy, provisional, associate, consulting—how many categories do you really need to make your bylaws work, and where do you put those people?” She suggests fewer categories, but says there needs to be something in the middle of active and non-active staff. See page 5 for sample bylaws language addressing medical staff categories.

CMS’ *Conditions of Participation* require hospitals to provide a statement of the duties and privileges of each medical staff category. In addition to meeting this requirement, most medical staffs create categories for a couple of reasons. The first reason is to determine the citizenship status of various members of the medical staff. A member category indicates whether a practitioner can vote in general medical staff elections or on bylaws amendments, serve as an officer of the organization, sit and vote on committees, etc. The second reason is to assign certain responsibilities—such as ED or clinical coverage—to practitioners based on their category.

Other recent bylaws challenges are board certification/Maintenance of Certification and the National Practitioner Data Bank Guidebook’s new definition of investigation. But again, depending on where you address these issues, you might not need to overhaul your bylaws. As previously mentioned, Hearst’s hospital moved some elements out of its bylaws. For example, the hospital’s bylaws simply state that OPPE and FPPE are conducted and direct the reader to the medical staff policy and procedure. They have OPPE and FPPE policies that describe the meat of the processes. This makes it easier for the medical staff to address OPPE and FPPE when regulatory changes come about. As you review your bylaws, consider what elements could be pulled out into policies and procedures/rules and regulations.

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Common medical staff categories

If your organization is struggling with where to place a practitioner in one of your medical staff categories, you either have too few or too many medical staff categories. Consider arranging your medical staff categories into these four common categories.

**Active**
This category typically includes members who have been on the medical staff for a reasonable time period and who are active and interested in the institution’s clinical affairs, as noted by clinical activity, engagement in medical staff affairs (i.e., meeting attendance), or other parameters. Establishing clear criteria for inclusion in this category minimizes the complexity and confusion that occasionally surrounds the issue.

Physicians in this category are allowed to do the following:
- Members can attend medical staff or department meetings of which they are a member, as well as any medical staff or hospital education programs
- Members vote on all matters presented by the medical staff, department, or committee(s) to which the members are assigned
- Members [can/cannot] hold office and sit on or be the chair of any committee in accordance with any qualifying criteria set forth elsewhere in the medical staff bylaws or medical staff policies

**Associate**
Associate staff members are typically interested in remaining members of the medical staff but do not meet the requirements for the active category. Often, physicians who are new to the medical staff are made associate members. In addition, longtime medical staff members who are not active (and are non-voting members) or who are not interested in participating in the organization’s affairs can be placed in this category.

The prerogatives of this category could include the following:
- Members can order noninvasive outpatient diagnostic tests and services; visit patients in the hospital; review medical records; and attend medical staff or department meetings, continuing medical education (CME) functions, and social events
- Members cannot be eligible for clinical privileges and cannot manage patient care in the hospital
- Members [can/cannot] vote on medical staff affairs or hold office depending on the decision the medical staff has made regarding inclusiveness or exclusiveness of the medical staff

**Honorary**
Physicians who the staff and board wish to honor for past services are frequently appointed to the honorary medical staff category.

The prerogatives of this category could include the following:
- Members may attend medical staff or department meetings, as well as CME activities
- Members may be appointed to committees, but they shall not hold clinical privileges, hold office, or be eligible to vote

Variations among state medical board actions

by Patricia A. Furci, RN, MA, Esq., and Samuel J. Furci, MPA, principals at Furci Associates, LLC, in West Orange, New Jersey. They may be reached at info@furciassociates.com.

Physician disciplinary actions by states have been recorded for many years following the opening of the U.S. Department of Health and Human Services’ National Practitioner Data Bank (NPDB) on September 1, 1990.

The first nationwide academic study of physician disciplinary actions and malpractice claims rates, however, wasn’t published until this year. The data for the study came from the NPDB, which covers all 50 states and the District of Columbia. Researchers John Harris, MD, and Elena Byhoff, MD, focused on the most recent data available—2010 through 2014.

For the U.S. as a whole, the study found that there were 3.75 disciplinary actions each year for every 1,000 practicing physicians; this included 1.15 major disciplinary actions. However, of particular concern was the range among states. For example, the study noted 7.93 disciplinary actions of any type per 1,000 physicians in Delaware, down to 2.13 per 1,000 in Massachusetts, and from 2.71 major actions per 1,000 physicians in Delaware down to 0.64 in New York.

MSPs routinely collect individual practitioner disciplinary actions and malpractice claims data through the NPDB and insurance carriers. However, hospitals often do not compare trends in the aggregate data for specific states. In this article, we take a look at some of the data trends, the sources for this information, what the implications may be for MSPs, and suggestions for future insights.

Background

Historical data regarding disciplinary actions as well as malpractice payments reflect some interesting facts.

From 1990 to 2004, only 5.5% of physicians accounted for 57.3% of medical malpractice payouts. Further, only 11.4% of physicians who had made three or more malpractice payments were ever disciplined (Rieders, C. A. (n.d.). Discipline of bad doctors and medical malpractice insurance premiums. Williamsport, PA: Rieders’ Travis Law Firm.).

Data from the Federation of State Medical Boards on the number of serious disciplinary actions taken against physicians from 2002 to 2004, as calculated by Public Citizen’s Health Research Group, reflected a very low rate of serious disciplinary actions. The rate is based upon the number of actions per 1,000 physicians.

From 2002 to 2004, the states with the most vigorous disciplinary enforcement included:
1. Wyoming
2. Kentucky
3. North Dakota
4. Alaska
5. Oklahoma
6. Arizona
7. Ohio
8. Montana
9. Colorado
10. West Virginia

Of note are some states which saw a drastic change (either higher or lower) in their ranking from 2002 to 2004: these included New York, which went from 29th to 17th, New Jersey, which went from 19th to 29th, and Pennsylvania, which went from 47th to 36th. Hawaii ranked as the lowest state in the country in disciplining physicians (Rieders, n.d.).

In 2004, there were 3,296 serious disciplinary actions taken by state medical boards as compared to 2,992 serious actions taken in 2003 (Rieders, n.d.).

Eighty-three percent of doctors never had a medical malpractice payout since the NPDB was established in 1990, as reported by the Health Research Group in 2004. Further, less than 33% of doctors who made 10 or more malpractice payouts were disciplined by a state medical board during this same time period.

In 2011, rankings for the above-noted states, as based upon the number of serious actions per 1,000
From 2010 to 2014, medical boards reported a total of 21,647 disciplinary actions, of which 5,137 (23.7%) were major disciplinary actions involving revocation, suspension, or surrender of license.

Data trends
The Health Research Group reported that the rate of serious disciplinary actions taken against physicians increased from 2.97 in 2010 to 3.06 in 2011, although that number was 18% lower than the peak rate in 2004 of 3.72.

From 2009 through 2011, the states and districts with the lowest number of serious actions by their respective medical boards included those with small populations and those with large populations. In addition, three states (Minnesota, South Carolina, and Wisconsin) were consistently among the lowest 10 states for serious board actions across nine three-year periods (Health Research Group). The academic study points out that the percentage of clinicians who are disciplined or have to pay a medical malpractice claim is four times more in some states than in others.

Figure 1: Annual rate of serious disciplinary actions* by state medical boards, 2001–2011

*Rate of serious actions per 1,000 physicians

Source: Public Citizen’s Health Research Group, June 2012.
Here, then, is an opportunity for MSPs to clarify the interpretation of NPDB and malpractice data to their respective medical staff leadership and governing boards.

**Conclusion**

As the Public Citizen Health Research Group points out, states that provide adequate funding from licensing fees to support state medical board activities tended to do a better job disciplining physicians. Boards also tend to do better when they have adequate staffing and initiate proactive investigations rather than taking reactive action. To ensure a fully functioning medical board, excellent leadership is important as well.

The legal community and patient advocates suggest that the 5% of bad doctors who are responsible for the most medical malpractice should be disciplined vigorously (Health Research Group).


Given the fourfold variation by state in the annual rate of medical board physician disciplinary actions across the country, state medical boards should consider policies aimed at improving standardization and coordination to provide consistent supervision to physicians and ensure public safety.

Until there is an improved standardization of disciplinary actions across states, MSPs should explain this variation to medical staff leadership so that governing board members are also aware of such discrepancies.

Further, when reviewing NPDB profiles, MSPs should seek to compare actions from other states against the regulations of their own state to provide an apples-to-apples comparison of a clinician’s infractions, since a minor infraction in one state may be deemed as a major infraction in another, or vice versa. This is a fair assessment for both the clinician and the governing body.

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### Figure 2: 10 states with the lowest number of serious actions, 2009–2011

<table>
<thead>
<tr>
<th>State/district</th>
<th>Serious actions/1,000 physicians 2009–2011</th>
<th>Times in bottom 10 since 2001–2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Carolina</td>
<td>1.33</td>
<td>9</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>1.47</td>
<td>2</td>
</tr>
<tr>
<td>Minnesota</td>
<td>1.49</td>
<td>9</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>1.66</td>
<td>3</td>
</tr>
<tr>
<td>Connecticut</td>
<td>1.82</td>
<td>6</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>1.90</td>
<td>9</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>2.02</td>
<td>4</td>
</tr>
<tr>
<td>Nevada</td>
<td>2.07</td>
<td>5</td>
</tr>
<tr>
<td>New Jersey</td>
<td>2.26</td>
<td>2</td>
</tr>
<tr>
<td>Florida</td>
<td>2.28</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: Public Citizen’s Health Research Group, June 2012.

### Figure 3: 10 states with the highest number of serious actions, 2009–2011

<table>
<thead>
<tr>
<th>State/district</th>
<th>Serious actions/1,000 physicians 2009–2011</th>
<th>Times in bottom 10 since 2001–2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wyoming</td>
<td>6.79</td>
<td>7</td>
</tr>
<tr>
<td>Louisiana</td>
<td>5.58</td>
<td>4</td>
</tr>
<tr>
<td>Ohio</td>
<td>5.52</td>
<td>9</td>
</tr>
<tr>
<td>Delaware</td>
<td>5.32</td>
<td>1</td>
</tr>
<tr>
<td>New Mexico</td>
<td>5.28</td>
<td>3</td>
</tr>
<tr>
<td>Nebraska</td>
<td>4.70</td>
<td>4</td>
</tr>
<tr>
<td>Alaska</td>
<td>4.69</td>
<td>9</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>4.65</td>
<td>9</td>
</tr>
<tr>
<td>Washington</td>
<td>4.45</td>
<td>1</td>
</tr>
<tr>
<td>West Virginia</td>
<td>4.32</td>
<td>2</td>
</tr>
</tbody>
</table>

Source: Public Citizen’s Health Research Group, June 2012.
Medical staff leadership positions

Part 2: Job descriptions?

by William K. Cors, MD, MMM, FACPE, chief medical officer, Pocono Health System, East Stroudsburg, Pennsylvania

Last time, the proposition that medical leadership positions are actually “jobs” was explored. Essential to this understanding is that the medical staff has clear accountabilities to the governing board for quality of care. To fulfill these responsibilities, the medical staff must perform work through defined structures and processes to ensure the competency and quality of care delivered primarily by individuals holding privileges in the organization. This work can be divided in multiple different ways as no one size fits all. But as with any work, it can be broken down into jobs, and each job carries a position description.

Job description

If these positions are truly viewed as jobs, then we need to begin the discussion with a couple of questions:

- Would you accept a job without knowing the responsibilities of the position you are fulfilling?
- Would you accept a job without knowing in advance how much time the job will require?
- Would you accept a job without knowing the level of compensation, benefits, and reporting relationship?

The answer to these questions is, of course, a resounding “no.” Yet, very often that is exactly what happens when accepting a medical staff leadership position. Too often, physicians accept a medical staff leadership position without a thorough understanding of the actual requirements, skills, time, and abilities needed to be successful in their role.

We need to begin with the simple premise that physicians are generally committed to doing a good job at everything they do. This is part of the self-selection process to medicine in the first place. Once a physician understands what is expected of him or her, that physician generally strives to meet (or exceed) those expectations, provided that he or she buys into those expectations. There is little chance that a physician leader will comply with expectations if he or she does not support the established expectations, or if he or she was never informed of those expectations. A failure to understand or buy in to the expectations of the position could be a recipe for failure or poor performance, which are both anathema to most physicians.

Would you accept a job without knowing the responsibilities of the position you are fulfilling?

Clear expectations for leadership roles are important for encouraging medical staff members to volunteer or apply for such a position (depending on how your medical staff is structured). Increasingly, key leadership positions come with financial compensation from the hospital/medical staff. Under these circumstances, a formal job description and time log is mandatory to ensure compliance with federal regulations concerning fair market value and legitimate payment to physicians for services rendered. A well-developed job description is one way of establishing and communicating clear expectations and simultaneously meeting compliance regulations. Elements of a good medical staff leader job description include the following:

- A reporting relationship that identifies to whom the medical staff leader is accountable
- A position purpose that lists the medical staff leader’s responsibilities in that position
- Accountability and functions that define the expectations of the medical staff leader for each responsibility
- Position requirements that identify the mandatory prerequisites of the position, including all necessary education, skills, experience, and other criteria
- Recognition and benefits that enumerate the financial and nonfinancial rewards and recognitions associated with the position
- Occupational hazards that outline the burdens, challenges, time commitment, and risks of the position
Sample job descriptions for key medical staff leadership positions are available from multiple resources, including the HCPro book *The Medical Staff Leader's Survival Guide* (2014). The following is one example of how constructing a job description might look.

**Sample job description: Credentials committee chair**

The credentialing and privileging of practitioners is a fundamental accountability of the medical staff to the governing board. Many medical staffs organize a credentials committee to perform this work. The committee chair holds a key role in ensuring that this responsibility is carried out well. Using the above outline, the job description elements might include:

- **Reporting relationship:** This position reports directly to the medical executive committee and the governing board.
- **Position purpose:** This position organizes, administers, and directs the organization’s credentialing program in conformance with all applicable regulatory and accreditation standards.
- **Accountability and functions:** Create and maintain, on behalf of the board, a fully documented policy and procedure manual outlining forms used, privilege criteria, and timelines for processing applications. Work with candidates, the medical staff president, medical staff professionals, and others to maintain accurate and complete documentation of the entire credentialing process.
- **Position requirements:** The credentials chair shall be an active staff member for at least five years, with preference given to those physicians who have held other leadership positions or have served on the credentials committee. The physician shall have significant experience and knowledge of all aspects of medical staff credentialing.

**Recognition and benefits:** This might include a monthly stipend, paid attendance at subject-specific continuing medical education conferences, and administrative support.

**Occupational hazards:** There is a risk of antitrust, corporate negligence, or malpractice litigation, and the organization indemnifies the physician in this role and covers him or her with the directors’ and officers’ insurance of the organization.

The full sample job description is available below and on p. 11.

**There is little chance that a physician leader will comply with expectations if he or she does not support the established expectations, or if he or she was never informed of those expectations.**

**Future considerations**

All things considered, developing the job description may actually be the easy part—as always, the devil is in the details. Where do the job accountabilities and requirements come from? How are they developed and by whom? And how are physicians identified who may have both the interest and the abilities to perform the job? This will be the topic of the next column. Further installments will address how to prepare for the job if you don’t meet the requirements; whether the position is appointed or elected; and whether it is voluntary or paid. Until next time, be the best that you can be.

### Position description: Credentials committee chair

**Reporting**

The credentials committee chair reports directly to the medical executive committee (MEC) and the board of directors. Most often, reporting will be needed regarding applicants for medical staff appointment and staff members eligible for reappointment. The credentials committee chair might need to make additional reports when necessary, such as when questions regarding a physician’s competence and qualifications arise. Additionally, the credentials committee chair is expected to interact with and report to each department chair as necessary.
Position description: Credentials committee chair (cont.)

Position purpose
The credentials committee chair organizes, administers, and directs the organization’s credentialing program. The credentials committee chair must ensure that credentialing activities are in compliance with the organization’s credentialing policies, accreditors’ standards, and applicable laws. Ideally, credentialing functions should minimize the inconvenience to new applicants during the credentialing process, minimize potential liability, enhance the quality of patient care, and eliminate the influence of competition in the credentialing process.

Accountability and functions
The credentials committee chair must:

- Create and maintain, on behalf of the board, a fully documented credentialing policies and procedures manual, complete with all forms, form letters, and criteria for clinical privileges used in the credentialing process
- Ensure that all new applicants for medical staff appointment and existing staff members receive summaries of policies that may affect their practice at the institution
- Supervise MSPs’ credentialing activities (except where otherwise arranged), ensuring that policies and procedures are followed and that applications, reaplications, and requests for clinical privileges are processed thoroughly and expeditiously
- Monitor the processing of all applications for appointment, reappointment, and clinical privileges to ensure that applicable policies and procedures are followed
- Assist the MSP in certain credentialing activities and issues, such as reviewing preapplications for medical staff appointment
- Work with the president of the medical staff in assembling a credentials committee of no more than seven individuals to assist in all aspects of the credentialing program
- Maintain accurate and complete documentation concerning the entire credentialing process, including establishment, maintenance, storage, security, and retrieval of credentials files, credentials committee minutes, and other documents pertaining to the processing of individual applications for appointment and clinical privileges and to the credentialing program in general

Position requirements
The credentials committee chair must be an active member of the medical staff, having held that position for at least five years. Preference is given to those candidates who have served as a credentials committee member, as medical staff president or vice president, or as a board advisor or board member. The physician must have significant expertise in all aspects of medical staff credentialing activities. Participation as a physician leader at any other institution is not permitted during the individual’s term of office.

Recognition and benefits
The benefits of this position include participation in up to three position-related conferences per year. Due to the extremely important nature of this position and the possibility for significant family and practice disruption, the organization will reimburse the credentials committee chair for participation and expenses—including spousal expenses, if applicable—in the conferences.

Other benefits include a monthly stipend, professional liability insurance, a home fax machine, secretarial/administrative support, educational tuition and expenses, and subscriptions to leading medical staff publications.

Occupational hazards
This position carries a slight risk of involvement in antitrust, corporate negligence, and malpractice litigation. Should the organization be sued for violation of the Clayton and Sherman Acts (based upon actions taken as a result of the credentials committee’s recommendations), the indemnification provisions of the board and the organization’s pledge to stand behind its physician leaders in such circumstances protect the credentials committee chair.
Secure support for converting to core privileges

Editor’s note: The following is an excerpt from Criteria-Based Core Privileging: A Guide to Implementation and Maintenance, © 2016 HCPro.

The benefits of a criteria-based core privileging system need to be emphasized and demonstrated from the start. It is absolutely essential to be able to quantify the benefits that your organization would gain by transitioning from the current privileging system to a criteria-based core privileging model. Education helps solidify prior conceptual approval of any project and provides a great opportunity for individuals to raise questions that will demand answers at a future date. By providing opportunities for education, organizations can avoid embarking on a project that may ultimately be abandoned due to a lack of understanding about the benefits of the project or a lack of commitment to it.

Most individuals are more impressed by demonstrations than by words. Prepare a detailed presentation about the specifics: the benefits of core privileging, the process that will be used, the level of involvement, and a general timeline for the project. This presentation should be made first to the credentials committee and the medical executive committee in order to ensure their continued support for the project. Once this is ensured, the medical staff should also be educated about the specifics of the project. This can be done to the entire medical staff or by department. Despite the extra time involved, it is preferable to make the presentation to each department and customize it for each department’s specific concerns.

Begin the presentation by explaining that the current privileging process has become overly complex with examples such as requiring the following:

- Family physicians to request privileges to treat pneumonia patients
- Cardiologists to request privileges to treat myocardial infarctions, myocardial infarctions with arrhythmia, and myocardial infarctions without arrhythmia

To help illustrate the complexity of the traditional privileging process, try to find your organization’s most complex privilege delineation form—often general surgery.

Show the complexity of your current privileging process by demonstrating the traditional mechanism used by a department chair when he or she reviews a request for privileges. In most institutions, the department chair first will determine whether the practitioner requesting privileges is well trained and experienced. If the department chair decides that the practitioner has adequate training and experience, he or she might then put a check at the top of the privilege request form, draw a line with an arrow to the bottom of the form, and place another check at the bottom of the line to signify that he or she has recommended each privilege individually. Hopefully the department chair hasn’t missed a checkbox or noted that one of the boxes was not checked and therefore not requested by the physician.

Return to the example of general surgery privileges and show how the lengthy laundry list can be reworked into a fairly simple and straightforward core description using the following language:

“Admit; evaluate; diagnose; consult; provide pre-, intra-, and postoperative care to and perform surgical procedures on patients of all ages; correct or treat various conditions, diseases, disorders, and injuries of the alimentary tract, skin, soft tissues, breast, endocrine system, head and neck; be familiar with surgical oncology, trauma and nonoperative trauma, and the vascular system. These core privileges in general surgery include the procedures defined on the following procedure list and such other procedures that are extensions of the same techniques and skills.”

Demonstrate how any general surgeon would request that core and the core procedures list with a single check mark and how the department chair, after confirming the physician’s qualifications, would then indicate his or her recommendation to grant that core.

The limitations of the current privileging process and the benefits of the new system to physicians as well as to the organization should be highlighted. Ideally, the medical staff leadership has already discussed the general concepts of the project to their departments. It should be made clear that the project has been approved by the medical staff leadership, administration, and the governing board.