HCPro
a division of BLR

Please note: Starting 30 minutes before the program begins, you should hear hold music after logging in to the webinar room. The room will be silent at other times. If you experience any technical difficulties, please contact our help desk at 877-297-2901.

Writing Medical Staff Bylaws (WT)

AN HCPRO WEBINAR PRESENTED ON JULY 19, 2017

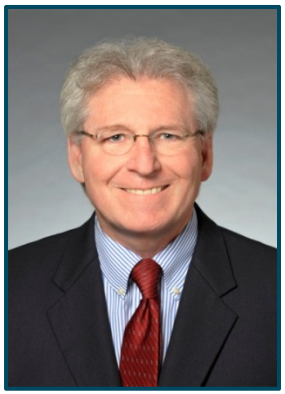
We will begin shortly!

HCPro
a division of BLR

Writing Medical Staff Bylaws: How to Avoid Compliance Gaps and Implement Best Practices

AN HCPRO WEBINAR PRESENTED ON JULY 19, 2017

Presented By



Michael R. Callahan

Michael R. Callahan assists hospital, health system and medical staff clients on a variety of health care legal issues related to accountable care organizations (ACOs), patient safety organizations (PSOs), health care antitrust issues, Health Insurance Portability and Accountability Act (HIPAA) and regulatory compliance, accreditation matters, general corporate transactions, medical staff credentialing and hospital/medical staff relations.

Michael's peers regard him as "one of the top guys […] for credentialing—he's got a wealth of experience" (*Chambers USA*). Additionally, his clients describe him as "always responsive and timely with assistance," and say he is "informed, professional and extremely helpful" and "would recommend him without reservation" (*Chambers USA*). Michael's clients also commend his versatility, and say "He is willing to put on the hat of an executive or entrepreneur while still giving legal advice," according to *Chambers USA.*

He is a frequent speaker on topics including ACOs, health care reform, PSOs, health care liability and peer review matters. He has presented around the country before organizations such as the American Health Lawyers Association, the American Medical Association, the American Hospital Association, the American Bar Association, the American College of Healthcare Executives, the National Association Medical Staff Services, the National Association for Healthcare Quality and the American Society for Healthcare Risk Management.

Michael was recently the past chair of the Medical Staff Credentialing and Peer Review Practice Group of the American Health Lawyers Association. He also was appointed as the public member representative on the board of directors of the National Association Medical Staff Services.

He was an adjunct professor in DePaul University's Master of Laws in Health Law Program, where he taught a course on managed care. After law school, he served as a law clerk to Justice Daniel P. Ward of the Illinois Supreme Court.

Learning Objectives *[to be completed by HCPro]*

- **At the completion of this educational activity, the learner will be able to:**
  - First
  - Second
  - Third
  - Fourth (optional, but must have at least 3)
  - Fifth (optional)

Background

- **Hospitals and their affiliated entities are participating in one of the most heavily regulated industries in the country**
- **Some of the relevant regulatory standards that apply to medical staff professionals include:**
  - Medicare/Medicaid Conditions of Participation
  - Hospital Licensing Act
  - Medical Practice Act
  - Nurse Practice Act
  - Acts applicable to all other credentialed practitioners
  - State Peer Review Statute
  - Patient Safety and Quality Improvement Act of 2005
  - HIPAA/HITECH
  - EMTALA

Background (cont'd)

- ADA, Title VII and other discrimination statutes
- HCQIA
- Data Bank
- The Joint Commission, HFAP, DNV, NCQA
- Accountable Care Act – ACOs/Medicare Shared Savings Program, Value Based Purchasing
- CMS standards on never events, hospital acquired conditions, readmissions
- County and city statutes and ordinances
- Applicable case law

Background (cont'd)

- Failure to comply with these standards and/or your Bylaws can have the following adverse implications
  - Loss or restriction of licenses
  - Accreditation watch or loss of accreditation
  - CMS determination of "immediate jeopardy" or loss of Medicare eligibility
  - Professional liability under respondent superior, apparent agency and corporate negligence theories
  - Civil, criminal fines
  - Loss of insurance or significant increase in premiums
  - Loss of managed care contracts, MSSP and other performance based payments
  - False Claims Act liability
  - You lose your job

Background (cont'd)

- Evidence of compliance is largely demonstrated in corporate and medical staff governance documents including
  - Corporate Bylaws, Rules, Regs and Policy
  - Medical Staff Bylaws, Rules, Regs and Policies
  - Code of Conduct/Disruptive Behavior Policy
  - Appointment/Reappointment applications
  - Peer review policies
  - Credentialing manual
  - Fair hearing procedures
  - Medical staff development plan

Background (cont'd)

- Impaired physician/allied professional policy
- Leave of absence and reinstatement policy
- Conflict of interest policy
- Anti-harassment policy
- ED Call Policy
- Department policies

– A single set of Medical Staff Bylaws cannot demonstrate compliance with all relevant requirements

Definitions

- **Compliance Gaps**
  - Definitions inconsistent when referenced in Bylaws
  - Definition of “medical staff” not consistent with state law
    - Podiatrist considered an allied health professional and not a physician
- **Best/Evolving Practices**
  - Include definitions for “peer review” and “peer review committee” consistent with state confidentiality protections in order to maximize confidentiality/privilege protections (see attached examples)

Definitions (cont'd)

- If participating in a PSO, consider adding definitions for "patient safety evaluation system" and "patient safety work product" (see attached examples)
- Definitions of "adverse" decisions should be limited to actions that require a state or Data Bank report or limited to what triggers a hearing under the Bylaws

Medical Staff Membership

- **Compliance Gaps**
  - Not required to provide applications to all interested practitioners.
  - Membership extended to ineligible practitioners – i.e. chiropractor. See state statute.
  - Membership denied to eligible practitioner – i.e., podiatrist.
- **Best/Evolving Practices**
  - Physicians and other licensed practitioners as a general matter, have no legal, statutory, constitutional right to medical staff membership/privileges. Therefore, hospitals can develop initial screening/eligibility criteria on front end to deny applications/appointment to "non-qualifying practitioners" including decisions based on economic factors such as whether physician is employed by a competitor or has a financial interest in a competing facility, i.e., surgicenter. See comments re: Pre-Application Process.

Medical Staff Membership (cont'd)

- Aside from the standard language which states that licensure does not guarantee Medical Staff membership, many hospitals are requiring a higher degree or evidence of loyalty or demonstrated history of meeting quality/utilization standards consistent with hospital standards
- Bylaws should not limit Hospital's discretion and authority to develop Medical Staff Development/Needs policies which establish areas of need or which limit access to membership
- Lack of available personnel, resources, equipment, etc., are legitimate reasons for denial.
- Consider unified medical staff if eligible under Medicare CoPs

Qualifications for Membership

- **Compliance Gaps**
  - Should reference obligation to comply with applicable Code of Conduct/Disruptive Behavior Policies
  - Should reference requirement to comply with reporting requirements concerning malpractice suits, sanctions, loss of privileges, licensure, and other regulatory requirements
  - Should reference requirement to participate in ED call
  - Board certification/recertification
    - Board certification is not a legal condition of membership although required by managed care organizations

Qualifications for Membership (cont'd)

- Do the Bylaws refer to re-certification?
- Are privileges and membership revoked/reduced?

- **Best/Evolving Practices**
  - Board can grant board certification exceptions where physician filling specialized need
  - Consider granting an extension of time
    - Consider reducing membership category instead of termination albeit under some form of continuous review
    - Consider grandfathering option
    - Need to justify any exception and apply standard uniformly

Insurance Requirements

- **Compliance Gaps**
  - Privileges to admit/treat automatically suspended – should not be allowed to co-admit
  - Physician should report reductions or loss of coverage
  - Should report new medical malpractice lawsuits or change in insurance carrier

Insurance Requirements (cont'd)

- **Best/Evolving Practices**
  - Obtain coverage schedule in addition to certificates of insurance – includes limits and exclusions
  - Obtain five (5) year coverage history
  - Find out if coverage schedule applies at multiple hospitals and if claims made/occurrence coverage
  - Get insurance company rating and make sure company is certified by the State
  - Consider requiring tail or prior acts coverage if they leave Medical Staff or if coverage is terminated while still on staff
  - Require report if coverage reduced to explain basis of reduction

ED Coverage

- **Compliance Gaps**
  - Bylaws, Rules and Regs do not reflect ED response times and on call responsibilities consistent with EMTALA, trauma center and other statutory requirements
  - Physician does not identify back up coverage if not available
  - Physician does not contact back up in advance of being unavailable
  - Physician should be qualified to handle all ED cases consistent with existing clinical privileges.

ED Coverage (cont'd)

- Post ED obligation to provide follow up care – patient abandonment issue
- Non-compliance can lead to EMTALA violations with resulting fines and possible litigation against the hospital and therefore violations need to result in remedial action

- **Best/Evolving Practices**
  - Need to decide what Medical Staff categories have ED coverage responsibilities
  - Place requirement in Bylaws
  - Delegate coverage schedule to Department Chair BUT subject to MEC review and approval

ED Coverage (cont'd)

- Remember that ED call is a duty and not a privilege. Can be removed without triggering hearing rights
- If patients who are admitted or are referred out of hospital for no justifiable reason, ED call duty can be revoked – no hearing rights
- ED call can be provided to an exclusive group for pay consistent with regulatory standards
- Make sure that physician identifies back up in advance of going out of town

Ability to Work with Others/Health Status

- **Compliance Gaps**
  - Need to have a Code of Conduct/Disruptive Behavior Policy in place that applies to physicians/practitioners as well as Board members and all hospital employees
  - Need to uniformly enforce your policies
  - Physician Wellness Committee cannot recommend or impose disciplinary action
- **Best/Evolving Practices**
  - Establish separate Physician Wellness Committee
  - Avoid use of corrective action/disciplinary procedures
  - Be mindful of reporting requirements re: state and Data Bank

Ability to Work with Others/Health Status

(cont'd)

- Implement progressive remedial action standards
- Implement a Bylaw standard to require evaluation if there is a reasonable suspicion of impairment
- Refusal to be evaluated can result in recommendation for remedial action
- Consider adding a requirement for physical/fitness for duty evaluation for practitioner 65 years or older on yearly basis

Compliance with Quality/Utilization Metrics

- **Compliance Gaps**
  - Failure to incorporate private, governmental and accrediting quality and utilization metric/outcome standards into appointment/reappointment procedures
- **Best/Evolving Practices**
  - Need to identify ACO, P4P, Value Based Purchasing, MACRA and other metrics
  - Has a direct impact in liability, compliance and reimbursement standards
  - Standards need to be incorporated into privileging/credentialing standards as a condition of appointment/reappointment on Medical Staff and/or ACO/CIN

Compliance with Quality/Utilization Metrics (cont'd)

- **Best/Evolving Practices**
  - Ask for quality/utilization scorecard at time of appointment/reappointment
  - Prepare and send quarterly reports which compare physician's practice to peers based on utilization and quality metrics standard BUT make sure reports are created in a way to maximize confidentiality and privilege protections under state and/or federal law

Medical Record Completion

- **Compliance Gaps**
  - Medicare CoPs require that Bylaws include standard for conducting histories and physicals
  - Medical record completion requirement is not followed or is not enforced
  - Physician not trained in or is not compliant with EMR standards and policies and/or compliance is not enforced

Medical Record Completion (cont'd)

- **Best/Evolving Practices**
  - Physician not reappointed and privileges lapse if records not completed – has to reapply
  - Repeat offenders could be reported to Data Bank
  - Where incompletions relate to lack of H&P, discharge summary, treatment plan or other substantive portion of record, as opposed to a missing signature, physician can be reported according to the Data Bank
  - These potential Data Bank outcomes should be referenced into the Bylaws

Medical Staff Categories

- **Compliance Gaps**
  - Wrong treatment of podiatrists as allied health practitioners
  - Utilization and similar requirements as a condition of Active Staff membership is not defined or uniformly enforced or is out of date
  - Credentialing process not the same for all categories
  - Standard on geographic distance or response time to treat patients not uniformly enforced or is overly restrictive
  - Failure to query the Data Bank for all staff categories, i.e., Emeritus and Honorary

Medical Staff Categories (cont'd)

- **Best/Evolving Practice**
  - Creation of new category where physician is a Medical Staff member but has no clinical privileges – need not go through formal appointment/reappointment process
  - Creation of Telemedicine Staff
  - Creation of Hospitalist Staff
  - Adding APN, PAs to medical staff if permitted by state law and Board

Telemedicine

- **Compliance Gaps**
  - Under CoPs, hospital and distant site hospital where telemedicine physician is credentialed and privileged fail to enter into a formal written agreement that satisfies all requirements
    - Provide list of credentials and privileges at distant site hospital
    - Applies internal peer review process to practitioner and informs hospital of any adverse events and complaints
    - Appointment/reappointment process not consistent with Medicare CoPs or accreditation requirements
  - Telemedicine practitioner must be licensed in your state
  - Failure of both parties to report quality and behavioral problems
- **Best/Evolving Practices**
  - Don't rely on credentialing by other hospital or accredited entity
  - Extension of telemedicine services to multiple specialties

Allied Health/Advanced Practice Professionals

- **Compliance Gaps**
  - Practicing outside scope of license/certification
  - Not utilizing collaborative agreement when required
  - Physicians not letting them practice to full extent of license
  - Not reporting impaired or disciplined professional to the state – reporting to Data Bank is optional
- **Best/Evolving Practices**
  - Let them practice within full scope
  - Query Data Bank for all who obtain clinical privileges
  - Allow to participate on certain Medical Staff committees
  - Participation in appointment/reappointment process

Pre-Application Process

- **Compliance Gaps**
  - Process not reflected in Bylaws as required
  - Failure to provide written explanation for denying an application including whether decision was based on economic factors
  - Physician or physician committees are improperly given the right to decide who is given or not given an application thereby raising antitrust/discrimination claims

Pre-Application Process (cont'd)

- **Best/Evolving Practices**
  - Require signed waiver form
  - Include in pre-app form whether they are employed by or had their practice purchased by a competitor have a financial interest in a competing entity or otherwise have a financial conflict of interest
  - Require disclosure of whether they are an officer, director, medical staff leader, department chair in a competing hospital, ACO, ACE or other competing or similar entity.
  - Include other questions the answers to which will decide whether or not to give them an application

Appointment

- **Compliance Gaps**
  - Giving veto authority to a Department Chair or physician committee over who does or does not receive an application
  - “Sitting on” applications
  - Processing before all information received and/or not following up on incomplete or “red flag” responses
  - Relying on outdated information on older application used by physician for another hospital
  - Use of waiver of liability forms and Bylaws language which uses “in good faith and without malice” standard

Appointment (cont'd)

- Not reporting to Data Bank when required
- Health status information not updated
- Not requesting quality/utilization information

- **Best/Evolving Practices**
  - Language which places burden on applicant to produce any and all information requested at any time during the process
    - Failure to produce information results in withdrawal of application
    - No hearing rights
    - Cannot reapply for one year
  - No hearings for denied applicants unless decision reportable to State or Data Bank

Appointment (cont'd)

- Use "absolute waiver of liability" standard in Bylaws and waiver forms (see attached example)
  - Fall back is reference to the state immunity standard
- Require physician to attest that information provided is current and accurate – "my assistant prepared the application" is not acceptable
- Peer references should include physicians who are not partners or members of group practice
  - Department chair
  - CMO/VPMA
  - Other?
- Criminal background checks becoming more common
- Application should income language which authorizes sharing of peer review information throughout the system

Reappointment

- **Compliance Gaps**
  - Failure to have Department Chair/Credentials Committee review all relevant peer review, quality information generated over the past two years
  - Failure to update eligibility criteria when reviewing “current competency”
  - Failure to apply “current competency” standard to all existing/requested privileges
  - Having Department Chairs serve on Credentials Committee
  - Allowing physicians to “accumulate” privileges
  - Failure to obtain health status information, especially for physicians older than 65 years

Reappointment (cont'd)

- Failure to follow up with all facilities where physician has membership and/or clinical privileges
- Failure to query Data Bank when physician requesting new privileges
- Reappointment exceeds two year standard

- **Best/Evolving Practices**
  - See Appointment Best Practices
  - Required disclosures through conflict of interest forms or activities with competitors
  - Request Quality/Utilization Scorecard
  - Request information on loss of membership in ACO, PHO, IPA, professional societies

Exclusive Contracts

- **Compliance Gaps**
  - Failure to give required notice of hearing opportunity and hearing
  - Failure to review impact on privileges of existing Medical Staff member
  - Failure to support with Board review and approval which cites to benefits of the exclusive arrangement
  - Failure to consult with Medical Staff/MEC in advance of new arrangement

Exclusive Contracts (cont'd)

- **Best/Evolving Practices**
  - Incorporate right to enter into exclusive contracts and applicable hearing rights, if required, into Bylaws
  - Incorporate a provision which states that when Bylaws conflict with exclusive/employment contract, then contract prevails
  - Determine whether to include a "clean sweep" provision, i.e., no hearing rights if contract terminated

Exclusive Contracts (cont'd)

- Consider adding the ability to offer a hearing if termination decision should be reported to Data Bank
  - Joint Commission has taken the position that termination based on quality/competence/conduct issues requires a hearing even if employed
  - Providing a hearing gives you HCQIA immunity protections
  - Fairness dictates that if reporting a physician they should be offered a hearing opportunity
- Provide advance notice to MEC regarding the proposed exclusive arrangement and Board's reasoning

Remedial/Corrective Action

- **Compliance Gaps**
  - Failure to comply with HCQIA and state procedural requirements
  - Not clear when an investigation is triggered
  - Process is unfair
- **Best/Evolving Practices**
  - Collegial intervention approach (See attached example “collegial intervention” provision)
    - Goal is to address quality/behavioral issues and attempt to resolve as early on as possible.
    - Department Chairs/Section Chiefs are required to engage in one on one discussions, “coffee cup communications”, with the physician to identify issues so as to avoid/prevent future problems.

Remedial/Corrective Action (cont'd)

- Must be attempted and documented before considering request for remedial action.
- Collegial Intervention is not a substitute for established peer review process – it is part of the process.
- Remedial action should only be requested when other measures have failed as part of the peer review process.
  - Collegial intervention
  - FPPE
  - Monitoring, proctoring, mandatory consultations
  - Re-education
  - Other actions which do not trigger hearing or state or Data Bank reports
- A resignation which occurs during the peer review process, as opposed to when remedial/corrective action is requested, is not reportable.

Remedial/Corrective Action (cont'd)

- Peer review process should not be defined or treated as an investigation.
- Should define the term "investigation" in Bylaws to commence only when MEC agrees that a request for corrective action warrants an investigation by MEC or appointed ad hoc committee
- Only Department/Committee Chairs, Medical Staff President and CEO should be able to request remedial action.
- Request should not specifically request a particular action.
- If MEC believes the request has merit, meaning the record shows that collegial intervention and other non-reportable remedial measures have not succeeded in addressing the problem, then request can go forward and you are now in the investigation stage.
  - Physician's resignation at this stage is reportable.

Remedial/Corrective Action (cont'd)

- MEC should appoint an Ad Hoc Committee rather than conduct investigation on its own.
- Ad Hoc Committee should be composed of members from same Department or who have similar expertise.
- Members should not have had a role in peer review process leading up to remedial action request.
- Where possible, avoid appointing a direct competitor or someone with a known bias as a Committee member.
- Whatever information is collected to support the request should be shared with the Committee AND the physician sufficiently in advance of physician's meeting with the Committee.
- Physician meeting should be required before Committee makes a recommendation.

Remedial/Corrective Action (cont'd)

- Committee should not be limited in the form of remedial action requested even if such action was not previously successful.
- Committee should attempt to engage the physician in the design of any action plan.
  - This effort is a good way to evaluate physician's judgment and acceptance of whether to accept responsibility and commitment to improve.
- Committee should prepare written report to explain basis and reasons for recommendation. If recommending action which triggers hearing rights, i.e., suspension, termination, report should detail and explain why lesser forms of remedial action, in the opinion of the committee, will not suffice.

Remedial/Corrective Action (cont'd)

- MEC, before making final recommendations, should consider meeting with the Physician.
- MEC not limited in the form of recommended action.
- MEC should clearly describe in writing its rationale based on the information presented.
- If recommendation triggers hearing rights then proceed to a hearing – recommendation should not go to Board because it ultimately will make final decision on appeal.

Fair Hearing

- **Compliance Gaps**
  - Hearing procedures do not comply with state law and/or HCQIA.
    - Physician not given 30 days within which to request hearing.
    - Notice is defective and incomplete as to basis of decision, reference to relevant patient charts and citation to standards.
    - Failure to provide reasonable and timely access to information on which the decision was based.
    - Failure to follow statutory or Bylaw process for selection of hearing committee members.
    - Summary suspension is imposed even though imminent danger to patient standard is not met.
    - Physicians who are competitors or have a known bias or who had an active role in the process leading up to adverse decision are appointed as members.

Fair Hearing (cont'd)

- Burden of proof standard placed on physician is inherently unfair - "adverse recommendation to be upheld if there is any basis in the record to support it".
- Failure to follow Bylaws/Fair Hearing procedures.
  - Courts do not interfere with disciplinary decisions as long a hospital and medical staff comply with stated procedures and the proceedings are fair.

Fair Hearing (cont'd)

- **Best/Evolving Practices**
  - Hearing Committee
    - To avoid the appearance of a conflict of interest, consider not appointing employed physicians or physician under contract with the Hospital.
  - Appointment of Hearing Officer
    - Given the high stakes at issue for both sides, an experienced hearing officer can greatly facilitate the hearing particularly if attorneys are given the right to direct and cross examine witnesses.
    - Hearing officer should not have any conflicts of interest, i.e., should not have previously represented the hospital, the physician or the medical staff.

Fair Hearing (cont'd)

- Should offer to have physician pay half of the fee although this suggestion usually is declined.
- Hearing officer should sign a HIPAA business associate agreement.

– Pre-Hearing Procedures
  - Bylaws should require that there be a pre-hearing process to address procedural issues and disputes so as to facilitate a smooth hearing.
  - There should be a record of these proceedings and the hearing officer should prepare a written decision.
  - Challenges to hearing committee members through a voir dire or similar process should be addressed at this time – no automatic challenges to proposed members should be provided to either side.

Fair Hearing (cont'd)

- Role of legal counsel
  - Consider limiting role of legal counselor to acting as an adviser to his/her client with the right to make procedural objections but no right to direct/cross examine witness.
  - Role can be expanded by hearing committee if physician not able to handle.
- Burden of proof – hearing
  - Burden should be on the medical staff to show that the adverse recommendation is supported by a preponderance of the evidence – i.e., a majority of the evidence.

Fair Hearing (cont'd)

- Hearing committee should be required to make written findings of fact and detailed explanation to support recommendation.
- Both parties should be given the right to appeal hearing committee recommendation.
- Appellate Procedures
- Burden of proof – appeal
  - Is the hearing committee recommendation supported by a preponderance of the evidence?
  - Was the adverse recommendation arbitrary or capricious?
  - Did hospital and medical staff substantially comply with its bylaws/fair hearing plan?

Fair Hearing (cont'd)

- Board should appoint an appellate committee of the board which has at least one physician member rather than have the entire board participate.
- Any board member, including hospital administrators who had a role in the recommendation and process leading to the adverse decision, should recuse themselves and not participate on the committee or when the board renders its final decision.
- Oral argument should be at the discretion of the board and not a matter of right.
- Parties should be required to submit written memos setting forth the basis for accepting or contesting the hearing committee's recommendation.

Fair Hearing (cont'd)

- Committee should have access to the complete administrative record and be required to review it in advance of its recommendation to the Board.'
- Committee should be required to prepare written findings to support its recommendation tied to burden of proof standard.
- Remaining Board members should at least review hearing committee recommendation, memos from the parties and Appellate Committee recommendation and report before rendering final decision.

Meetings/Voting

- **Compliance Gaps**
  - Medical staff does not fully comply with its own meeting, voting, quorum and notice requirements.
  - Can lead to an argument that recommendation/decisions are invalid.
- **Best/Evolving Practices**
  - Quorum and voting requirements modified to reflect realities of actual attendance.
  - Telephone participation is considered being physically present for quorum and voting at committee meetings, but not for general or special meetings of the medical staff.

Meetings/Voting (cont'd)

- Proxy voting at all meetings, except for Core Committees, becoming more acceptable.
- Voting by email?

Bylaw Amendments

- **Compliance Gaps – The Joint Commission**
  - Organized medical staff not given right to propose bylaws, rules, regs and policies directly to the Board.
  - Must first be submitted to MEC.
  - Bylaws, rules, regs or policy do not contain a conflict management process when there is a dispute between the organized medical staff and the MEC or between OMS/MEC and Board.
  - Bylaws, rules, regs or policy does not reflect a process allowing an urgent amendment to rules and regulations.
  - Applies when rule or reg cannot be amended in timely manner consistent with current amendment process.

Bylaw Amendments (cont'd)

- No reference to corporate and medical staff bylaws being compatible and that neither the medical staff nor the board can unilaterally amend the Bylaws.
- BUT CMS just approved accreditation standards for the Center for Improvement in Healthcare Quality which allows a unilateral amendment if needed to "comply with law, regulations, accreditation standards or situations that pose a serious and direct threat to the safety of patients" after notice given to medical staff and it refuses or is unable to make necessary amendments.

Rules and Regulations

- **Compliance Gaps**
  - MEC cannot adopt or amend rules and regulations without the approval of voting members of the OMS unless permitted to do so under the bylaws – even if permitted MEC must first communicate change to Medical Staff.
  - Standard for conducting histories and physicals cannot only be in the rules and regulations – must be in the bylaws.
  - Basic steps of Elements of Performance 12-36 in MS.01.01.01 that require a process must be in the bylaws and cannot be in the rules and regulations.

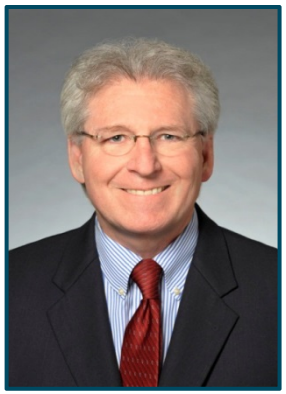
Immunity Provision

- **Compliance Gaps**
  - Language regarding what activities, recommendations and decisions are protected from liability claims is too narrowly drawn or is not consistent with state immunity statute.
  - Should cover at a minimum pre-screening, appointment, reappointment, peer review, OPPE/FPPE, investigations and hearings and all employees, physicians and consultants involved in these processes.

Immunity Provision (cont'd)

- **Best/Evolving Practices**
  - Should consider using "absolute waiver of liability requirement even if it exceeds state/HCQIA immunity protections.
  - At least one federal circuit court of appeals believed that such language was acceptable although resident's lawsuit against a hospital based on alleged disclosure about prior disciplinary action was dismissed on other grounds.
  - Language should require that physician must first exhaust all internal hearing and appeals procedures under the Bylaws before filing suit.
  - Physician should be required to agree that peer review information be shared with other facilities within the system where they have membership/clinical privileges.

Questions & Answers



Michael R. Callahan
Partner
Katten Muchin Rosenman LLP
Chicago, IL

Submit a question:
Go to the chat pod located in the lower left corner of your screen. Type your question in the text box then click on the “Send” button.

Thank you for attending!

Please note: Continuing education credits are available for this program. For instructions on how to claim your credits, please visit the materials download page at *http://hcproevents.hrhero.com/materialsXXXXXXXXXXXXXXXXX*

For more information on programs HCPro offers please visit http://www.hcmarketplace.com.

Be sure to register for HCPro's program:

insert next future program title

Insert next date at 1:00pm Eastern

http://www.hcmarketplace.com/prod-SAMPLE.html

This concludes today's program.

Please complete and submit the program evaluation, which has been sent to the person who registered for this event at your facility. *We kindly request that they forward it to everyone in your group.*

Copyright Information

- **Copyright © 2017 HCPro, a division of BLR.**
- **The "**Writing Medical Staff Bylaws **" webinar materials package is published by HCPro, a division of BLR.**
- **Attendance at the webinar is restricted to employees, consultants, and members of the medical staff of the Licensee. The webinar materials are intended solely for use in conjunction with the associated HCPro webinar. The Licensee may make copies of these materials for internal use by attendees of the webinar only. All such copies must bear the following legend: Dissemination of any information in these materials or the webinar to any party other than the Licensee or its employees is strictly prohibited.**
- **In our materials, we strive to provide our audience with useful and timely information. The live webinar will follow the enclosed agenda. Occasionally, our speakers will refer to the enclosed materials. We have noticed that non-HCPro webinar materials often follow the speakers' presentations bullet by bullet and page by page. However, because our presentations are less rigid and rely more on speaker interaction, we do not include each speaker's entire presentation. The enclosed materials contain helpful resources, forms, crosswalks, policies, charts, and graphs. We hope that you will find this information useful in the future.**
- **Although every precaution has been taken in the preparation of these materials, the publisher and speaker assume no responsibility for errors or omissions, or for damages resulting from the use of the information contained herein. Advice given is general, and attendees and readers of the materials should consult professional counsel for specific legal, ethical, or clinical questions.**
- **HCPro, a division of BLR, is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks; the Accreditation Council for Graduate Medical Education, which owns the ACGME trademark; or the Accreditation Association for Ambulatory Health Care (AAAHC).**
- **Magnet™, Magnet Recognition Program®, and ANCC Magnet Recognition® are trademarks of the American Nurses Credentialing Center (ANCC). The products and services of HCPro are neither sponsored nor endorsed by the ANCC. The acronym MRP is not a trademark of HCPro or its parent company.**
- **Current Procedural Terminology (CPT) is Copyright © 2016 American Medical Association (AMA). All rights reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. [*NOTE TO PRODUCER: This bullet for use on coding shows only, and copyright within stays as 2015 until Nov 2016 because of when book was published.*]**
- **For more information, please contact us at:**