# Introduction to Medical/Professional Staff Bylaws

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## Purpose

CRNA practice is governed by federal, state, and local law and regulations, accreditation standards, if accredited, and medical or professional staff bylaws,[1] rules and regulations, policies, and procedures. Many facilities also have anesthesia department rules and regulations, policies, and procedures.

Medical staff bylaws generally describe the relationship of CRNAs to, and within, the medical staff. They describe CRNA rights, responsibilities, and prerogatives, including important issues, such as criteria for clinical privileges, whether CRNAs have voting rights and are eligible to serve as officers or on committees, and what type of disciplinary and fair hearing procedures apply to CRNAs. They also describe the qualifications for directors of anesthesia departments or service areas. Medical staff bylaws may be more restrictive than applicable law or accreditation standards. Therefore, it is important for CRNAs to understand how they are categorized in medical staff bylaws, what to look for in the bylaws to support CRNA practice, and how to impact bylaw changes.

The purpose of this document is to supplement and provide an overview of the AANA Medical/Professional Staff Bylaws Framework, which recognizes CRNAs as medical staff members who have the same rights as other medical staff members, including due process and fair hearing and appeal rights.

Applicable law or other requirements may restrict CRNA status on the medical staff or may impose limitations not reflected in the AANA Medical/Professional Staff Bylaws Framework, as indicated in the checklist below. Please review this checklist prior to use of the AANA Medical/Professional Staff Bylaws Framework.

## Disclaimer

- This information is provided as a member benefit and does not constitute legal advice. Consult with knowledgeable legal counsel in the applicable state for review of and legal advice concerning Federal, state, and local laws, regulations, and legal considerations relating to bylaws preparation.
- AANA cannot provide a model or ideal set of bylaws as any set of bylaws must be tailored to each individual facility and medical staff needs and circumstances, legal considerations, and applicable law. There is no one-size-fits-all strategy or best practice that every medical staff should adopt. This bylaws outline is not appropriate in every circumstance and is not complete. The bylaws outline does not encompass the full range of medical staff governance, structure, or process options that exist.
- The bylaws outline was developed as a guide to prompt CRNAs to review their medical staff bylaws, analyze those bylaws, and consider potential positive revisions to the bylaws. CRNA's should work with their facility and legal counsel to (1) identify gaps between this outline and actual practice and between this outline and the current medical staff bylaws, and (2) consider whether this outline's provisions, or similar bylaw provisions, could apply to CRNA practice within that facility in accordance with applicable law and external requirements. Consider the level of detail necessary in the bylaws to reflect the facility's patient population and needs.

[1] Subsequent references to "medical or professional staff" are simplified to "medical staff."



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## AANA Recommendation

AANA recommends active medical staff appointment for CRNAs, if allowed by state law, to provide CRNAs with a voice on medical staff and patient care quality matters and to protect CRNAs against arbitrary privileging decisions.

## How to Use This Document

- This document and the bylaws framework provide a basic orientation to considerations for medical staff bylaw language and structure.
- Each medical staff has unique considerations. Do not simply copy and paste sample bylaw language into your bylaws. Tailor bylaws to accommodate varying circumstances. Careless adoption of sample medical staff bylaw language can get an organization in trouble.
- Consult with legal counsel at the beginning of the drafting stage to address legal considerations in bylaw development and revision and to carefully review federal, state, and local laws and regulations and accreditation standards, as they may have changed since the last bylaw revision.
- Terms used in this bylaw outline may differ from those used in your facility. The outline has many placeholders, prompting users to determine their own language or provisions.

## Getting Involved at the Facility

*Prehire/Precredentialing Interview Process*

- Request a copy of the bylaws. (Typically, the bylaws are included in your credentialing application packet.)
- Understand how CRNAs are classified in the medical staff bylaws.
- Ask about medical staff rights and responsibilities applicable to CRNAs.
- Consider whether the bylaws more restrictive than applicable federal and state law?
- The information gathered will help you decide if this is the right organization for you.

*Once Employed/Privileged* (either a facility employee or independent contractor)

- Develop and sustain leadership relationships.
- Develop a network for information sharing across various departments.
- Seek out leadership opportunities.
    - Participate in the development of policies and procedures.
    - Participate on taskforces and committees.
- As you identify barriers for CRNAs, use your networking, resources and supporting materials to influence bylaw changes.
- If CRNAs are new to the medical staff, the bylaws, rules and regulations, policies and procedures may not accurately reflect CRNA practice. This provides an opportunity to educate leadership, show CRNA value, and advocate for the profession to amend existing facility documentation.



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**Developing or Updating Medical Staff Bylaws**

A facility/organization may consider the following process for developing or updating medical staff bylaws.

- Review and modernize bylaws on a periodic basis:
  - Review annually.
  - Work with legal counsel to update bylaws as needed to reflect changes in federal and state law, accreditation standards, or other applicable standards.
  - Perform comprehensive analysis less frequently (e.g., three to five years) or earlier if considering revising medical staff structure and processes.
- Team members involved in bylaw review and revision may include:
  - Medical staff professionals and leadership.
  - Facility leadership/management.
  - Standing or ad hoc bylaws committee/task force.
  - Medical executive committee (MEC).
  - Consultants.
  - Legal Counsel/Risk Management.
    - Generally, facility/organization legal counsel or medical staff legal counsel participate in reviewing and drafting medical staff bylaws for compliance with applicable legal requirements (e.g., scope of practice).
- Qualities of team members include medical staff knowledge and relationships, drafting ability, strong oral communication skills, diplomacy, and ability to help achieve medical staff buy-in.
- Medical staff bylaws should reflect how the medical staff wants to function; however, it is important to include provisions that can be realistically implemented.
- Aim to reduce bureaucracy, eliminate provisions that do not add value, and create a streamlined organization.
- Create clear, user-friendly, streamlined bylaws.
  - Review bylaws for clarity. Eliminate unnecessary use of complex legalese, jargon, definitions and terms. Ambiguous language is difficult to interpret and may lead to disputes and lawsuits.
  - Reflect clear organization.
  - Define effective, efficient medical staff structures and processes.
  - Describe medical staff good citizenship obligations.
  - Describe credentialing, privileging, and performance improvement processes to promote and advance quality care.
  - Describe clinical and professional conduct obligations.
  - Protect medical staff members' self-governance and due process rights.
  - Delineate investigation and fair hearing processes.
  - Define a conflict management process for conflicts among leadership groups without including overly burdensome provisions.
  - Consider keeping valuable provisions and modernizing outdated provisions to reflect current best practices and current structures and processes.
- Review and update bylaws to eliminate and resolve contradictory provisions.
- Review other pertinent and related documents (e.g., medical staff rules and regulations, policies and procedures and department rules and regulations, policies and procedures) for consistency with medical staff bylaws.
- Obtain medical staff consensus and disseminate information



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- Educate leadership on the proposed revised bylaws, including purposes, provisions revised, and rationale for increased effectiveness and efficiency.
- Develop a multifaceted program to educate the medical staff after receiving leadership buy-in.
  - Consider town hall meetings, newsletters and other publications, department meeting presentations, or meetings with individual medical staff members who do not desire change.

**Bylaws Overview**

*What is the Medical Staff?*

- A medical staff is a voluntary association of independent and employed physicians and may include other Advanced Practice Professionals (APPs) (e.g., Advanced Practice Registered Nurses (APRNs), including CRNAs; physician assistants) in compliance with state law.
- Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs) require hospitals to provide a statement of the duties and privileges of each category of medical staff.
  - CMS Hospital CoPs and Interpretive Guidelines
  - CMS Critical Access Hospital CoPs and Interpretive Guidelines
  - CMS Ambulatory Surgical Center Conditions for Coverage
- In addition to meeting CMS CoPs and applicable state law, most medical staffs create categories for two reasons.
  - To assign specified rights to certain categories: A member category indicates whether a practitioner can vote in general medical staff elections or on bylaw amendments, serve as an officer of the organization, sit and vote on committees, and so forth.
  - To assign specified responsibilities to certain categories (e.g., emergency department and clinic coverage).
- The bylaws should embody/reflect the organization's culture.
  - Once a medical staff decides how it wants to function, those decisions should be incorporated into the medical staff bylaws.

*Bylaws Purpose*

- Establish an effective, collaborative, and appropriate legal and professional relationship between the medical staff and the healthcare organization.
- Serve as blueprint and road map for medical staff exercise of powers delegated by governing body.
- Reflect compliance with federal, state, and local laws and regulations, accreditation standards, and any other applicable requirements.
- Promote efficiency and quality healthcare.
- Mitigate conflict by establishing medical staff processes.
- Minimize administrative burdens.

*Bylaws Compliance*

Bylaws should be drafted and updated to ensure compliance with various legal requirements and accreditation standards. Below is a list of items that should be considered by legal counsel in developing and updating medical staff bylaws.



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- Federal law/regulations/case law
  - CMS (see links above)
    - 42 CFR 482.12: governing body CoP
    - 42 CFR 482.22: medical staff CoP
      - Bylaws are approved by a governing body
  - Health Care Quality Improvement Act (HCQIA) of 1986 / National Practitioner Databank (NPDB), Title IV of HCQIA, 42 USC 11101 *et seq.,* implementing regulations, 45 CFR Part 60, Section 5 of the Medicare, and Medicaid Patient and Program Protection Act of 1987, and Section 221(a) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
    - Two prongs:
      - Immunity for good-faith professional peer review action taken against physicians and dentists/does not create immunity for actions taken against CRNAs; 42 USC 1112(a) sets forth four-part test for immunity.
      - Created NPDB (42 USC 11133(a)).
    - Purpose:
      - Encourage meaningful peer review of quality of care of physicians and dentists.
      - Provide immunity to physicians and dentists and professional review bodies who engage in effective professional peer review.
      - Require or encourage reporting adverse actions reflecting on professional competency and conduct of healthcare practitioners to inform other healthcare providers and facilities.
    - Immunity - Provides immunity from monetary damages in civil lawsuits under federal (e.g., antitrust) and state law (e.g., defamation, breach of contract, tortious interference with business relations). Applies when professional review responsibilities and procedures are conducted with the reasonable belief of furthering the quality of healthcare and when due process is provided to the affected *physician or dentist*. There are exceptions for discrimination/civil rights actions and antitrust actions brought by federal and state governments.
    - This immunity does not apply to professional peer review actions taken against other practitioners, including CRNAs, who are not physicians.
      - This absence of federal immunity protection may be a factor in medical staffs offering less rigorous due process protections to CRNAs and other APPs in medical staff bylaws.
    - NPDB
      - Reporting requirements
        - Adverse actions against clinical privileges of physicians and dentists meeting specified NPDB criteria (e.g., lasting more than 30 days) must be reported to the NPDB, but reporting these actions against clinical privileges of other practitioners, including APPs, is optional. (NPDB Guidebook, Chapter C Table C-3, E-30)
        - Denial of initial credentialing applications are reportable, but not if the denial was based on failure to meet threshold



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credentialing criteria.
    - Actions unrelated to professional competence or conduct are not reportable to the NPDB.
    - Provides immunity for reporting to NPDB unless the reports are made with actual knowledge that the information reported is false.
    - Information reported to the NPDB is confidential and may not be disclosed except to other healthcare entities querying the NPDB, through practitioner self-query, and as specified in NPDB regulations (45 CFR part 60).
        - Note: If adverse actions against APPs or CRNAs are reported, they may have the same or similar hearing and appeal rights as medical staff members, given the significance of an NPDB report.
- Querying requirements
    - Hospitals must query information regarding APPs, including CRNAs, during the medical staff appointment or credentialing process.
        - For more information, see the National Practitioner Data Bank (NPDB) Guidebook.
        - Patient Safety and Quality Improvement Act of 2005 (PSQIA) 42 U.S.C. § 299b- 21 *et seq.*
    - Creates a national system for voluntary reporting of medical errors, near misses, and other quality and patient safety information to designated Patient Safety Organizations (PSOs).
    - Creates privilege and confidentiality protections in federal and state civil, criminal, and other proceedings for "patient safety work product" as defined in the statute.
- Emergency Medical Treatment and Active Labor Act (EMTALA), 42 USC 1395dd
    - EMTALA was enacted to ensure public access to emergency services regardless of ability to pay. Section 1867 of the Social Security Act imposes specific obligations on Medicare- participating hospitals that offer emergency services to provide a medical screening examination (MSE) when a request is made for examination or treatment for an emergency medical condition (EMC), including active labor, regardless of an individual's ability to pay. Hospitals are then required to provide stabilizing treatment for patients with EMCs. If a hospital is unable to stabilize a patient within its capability, or if the patient requests, an appropriate transfer should be implemented.
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
    - Provisions include mandating industry-wide standards for healthcare information on electronic billing and other processes and requiring the protection and confidential handling of protected health information.
- Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH)
    - Provides the US Department of Health and Human Services (HHS)



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with the authority to establish programs to improve health care quality, safety, and efficiency through the promotion of health IT, including electronic health records and private and secure electronic health information exchange.

- Americans with Disabilities Act (ADA), Title VII of the Civil Rights Act of 1964 (Title VII), and other discrimination laws
  - ADA prohibits private employers, state and local governments, employment agencies and labor unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions, and privileges of employment.
  - Outlines requirements for self-evaluation and planning; including making reasonable modifications to policies, practices, and procedures where necessary to avoid discrimination and communicating effectively with people with hearing, vision, and speech disabilities.
  - Prohibits places of public accommodation from discriminating against individuals with disabilities. Public accommodations include privately- owned, leased, or operated facilities, such as private hospitals.
  - Title VII prohibits discrimination in employment on the basis of race, color, sex, national origin and religion. It also is unlawful under the Civil Rights Act of 1964 for an employer to take retaliatory action against any individual for opposing employment practices made unlawful by Title VII or for filing a discrimination charge, testifying, assisting, or participating in an investigation, proceeding, or hearing under Title VII.
- Accountable Care Act (ACA) - ACOs/Medicare Shared Savings Program, Value- Based Purchasing
  - Accountable Care Organizations (ACOs)/Medicare Shared Savings Program
    - ACOs are groups of doctors, hospitals, and other healthcare providers, who come together voluntarily to give coordinated high quality care to Medicare patients. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.
    - Established by the ACA, the Medicare Shared Savings Program is a new approach to the delivery of healthcare. The Medicare Shared Savings Program facilitates coordination and cooperation among providers to improve the quality of care for Medicare Fee- For-Service beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Medicare Shared Savings Program by creating or participating in an ACO.
  - Hospital Value-Based Purchasing (VBP)



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- The VBP Program is a CMS initiative that rewards acute-care hospitals with incentive payments for the quality of care they provide to Medicare beneficiaries.
- CMS rewards hospitals based on:
  - The quality of care provided to Medicare patients;
  - How closely best clinical practices are followed; and
  - How well hospitals enhance patients' experiences of care during hospital stays.

- Other CMS requirements related to quality of care
  - Provider Preventable Conditions
  - Readmissions Reduction Program
  - Hospital-Acquired Conditions

- State statutes/regulations/case law
  - Nursing/Medical/Allied health/other (e.g., scope of practice, supervision, collaboration)
  - Facility licensing (hospital, ASC) (often addresses APP and CRNA services)
  - Peer review process, including immunity from civil liability and confidentiality/protection from legal discovery/privilege protection (peer review statutes and regulations may or may not apply to APPs and CRNAs)
    - Laws/regulations affecting right to a fair hearing and appeal
  - Reporting requirements for adverse actions to state agencies or databases
- Accreditation standards
  - The Joint Commission (e.g., Medical Staff standard MS.01.01.01)
    - Credentialing and privileging process for CRNAs must be the same medical staff process as for physicians.
  - Accreditation Commission for Health Care (ACHC)
  - DNV GL
  - Center for Improvement in Healthcare Quality (CIHQ)
  - Institute for Medical Quality (IMQ)
  - American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
  - Accreditation Association for Ambulatory Health Care (AAAHC)
  - National Committee for Quality Assurance

*Legal Considerations*

- Bylaws have legal implications. Legal counsel should review underlying legal and business issues that may arise in medical staff bylaws.
  - Corporate negligence
    - Hospital has legal duty to patients to make sure that every practitioner with privileges has the background, experience, education and training to exercise those privileges.
  - Apparent agency
    - Potential liability of a facility for negligence of an independent contractor provider (e.g., contracted anesthesia personnel employed by a separate group) when patient believes provider is facility employee.
  - Bylaws as contract between medical staff and hospital or organization (varies by state law)
  - Bylaws compliance and uniform application



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- Antitrust
  - Restraint of trade
  - State mandated peer review defense/state action doctrine
- Economic credentialing
- Exclusive contracts
- Geographic proximity requirements
- Procedure number requirements
- Responses to credentialing inquiries from other facilities

**Bylaw Structure and Content**

Outlined below is a proposed structure for medical staff bylaws, as well as a summary of pertinent content. Please note that this summary is not all inclusive, and a facility/organization's medical staff bylaws should be tailored to the needs of the facility, and should address federal, state, and local law.

*Introduction*

- Include term definitions.
- Define the medical staff purpose and authority.

*Medical Staff Governance Structure*

- Define the process to adopt and amend bylaws, rules and regulations, and policies (may depend on state law and accreditation standards).
- Governing body approves bylaws.

*Medical Staff Organization and Function*

- Determine how inclusive the active medical staff will be. Will the medical staff be exclusive (e.g., reserving active status for practitioners who have a high number of patient contacts at the facility), or will it be inclusive (e.g., including practitioners who may not provide direct patient care at the facility, but refer many patients to the facility, or are otherwise actively engaged in the medical staff, such as attending medical staff meetings)? Determine the approach that is most applicable to the facility/organization's needs, which may include a hybrid approach.
- Appointment categories
  - Determine categories of clinicians who qualify for membership.
  - Set forth qualifications for appointment for each category (e.g., active, provisional, affiliated, consulting, courtesy, telemedicine, honorary and retired).
  - Describe duties and privileges of each category.
  - Describe members who are eligible to vote.
    - Typically, active medical staff allows for full voting privileges and more rigorous due process protections. AANA recommends active medical staff appointment for CRNAs, if allowed by state law, to provide CRNAs with a voice on medical staff and patient care quality matters and to protect CRNAs against arbitrary privileging decisions. (If active medical staff status is not possible, seek voting positions on facility, medical staff or department committees (e.g., credentialing) in accordance with state law.)
      - Although CMS requires that medical staff must be composed of MDs/DOs, the CMS CoPs permit CRNAs to serve as active members of the medical staff, but do not require it (Hospital CoP, 42 C.F.R. 482.22)



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        - State law may address whether CRNAs may be on medical staff.
    - Benefits of active medical staff and committee membership for CRNAs:
        - Adds CRNA and APRN perspective.
        - Educates regarding CRNA research, outcomes, and scope and standards of practice/address and corrects misperceptions.
        - Broadens CRNA perspective.
  - Consider whether to include a provisional or similar status category.
    - Should members be on the medical staff for a certain period of time (e.g., 1-2 years) before they are eligible for active status with voting rights or should members be given active status and voting rights immediately?
  - Describe the appointment and reappointment process.
  - Describe medical staff officer positions, including process to select and remove.
  - Identify the qualifications, roles and duties of each medical staff department chair, including selection and removal process.
- A delineated list of all medical staff responsibilities is generally not found in the bylaws. The bylaws often provide broad categories of responsibilities and leave details in associated documents, such as rules and regulations, policies, and procedures.

*Credentialing, Privileging, and Reappointment Processes*

- May have a standing credentials committee. The MEC may also perform the credentialing role. The bylaws should identify the responsible committee.
- Credentialing process is objective and documented within the bylaws.
  - Consider broadly describing the credentialing process in the bylaws (required by some accreditation organizations) and including related details in flexible medical staff policies that are easier to revise and amend, typically by another committee, such as the MEC.
- Bylaws are typically difficult to amend, possibly taking many months depending on the frequency of medical staff meetings, and often require a majority or greater vote. This means they are less flexible than related documents that are easier to revise as details change in the rapidly evolving healthcare and compliance environments. The reappointment process, documented in the bylaws, should include an evaluation of the practitioner's ongoing medical staff membership and privileges. The practitioner must update information submitted on the original application and reapply for clinical privileges.
- Bylaws describe the process and criteria for requesting new privileges.
- Bylaws describe the process and criteria for temporary, emergency and disaster privileges.

*Peer review/FPPE/OPPE*

- The credentials committee may also serve as a peer review committee if state law allows.
- Bylaws for Joint Commission or HFAP-accredited facilities may address ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE).
- OPPE is designed to continuously evaluate the practitioner's performance, with the goal of identifying and resolving potential issues as soon as possible. There are two types of FPPE.
  - FPPE required for initial privilege request or new privilege request of a currently privileged practitioner.
  - FPPE evaluates the practitioner's performance when a question arises



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regarding the practitioner's ability to provide safe, high-quality patient care.

*Fair Hearing and Appeal Procedures/Due Process Rights and Protections*

- Clearly define medical staff members' fair hearing rights and protections.
- APPs should have the right to dispute any actions negatively affecting their clinical privileges, preferably with the full hearing and due process rights afforded to physicians.
- The Joint Commission requires a fair hearing and appeal process for practitioners with clinical privileges subject to corrective action. However, if the practitioner with clinical privileges is not a medical staff member, The Joint Commission allows the hearing and appeal process to differ from the hearing and appeal process for medical staff members.
- Check state laws and regulations relating to hearing and appeal rights.
- The fair hearing process should include at a minimum:
    - Events that trigger a hearing
    - Hearing procedure (e.g., notice, eligible participants, timeframe, burden of proof, role of attorneys, etc.)
    - Right to waive fair hearing
    - Composition of fair hearing panel
    - Appeal procedures in the case of an adverse determination by the fair hearing panel

*Medical Staff Committees*

- Medical Staff Officers/Leadership
    - Determine which medical staff officer positions are necessary.
    - Address medical staff leadership including number of medical staff officers, role description, term duration, qualifications, nomination/election process, and conditions for removal.
- CMS does not require particular committees. Accreditation agencies vary in their requirement for an MEC. Consult with your facility accreditor for specific requirements.
- Designation of medical staff committees, including size, function, composition and authority, selection and removal process for chairs.
    - Varies by complexity of the organization and most efficient structure for the particular medical staff.
    - Trends indicate that medical staff members have less time and desire for burdensome committee participation and responsibilities. Streamlining infrastructure as much as possible responds to this trend.
    - Streamlined structure might include:
        - Committees required by law, regulations, accreditation or professional standards
        - MEC
        - Credentials Committee
        - Interdisciplinary Quality/Peer Review Committee
        - Leadership and succession committee
        - Other committees that add value
            - Consider whether an APP committee adds value and supports CRNA roles within the organization.
            - Consider whether medical staff committees could be hospital committees that include healthcare professional medical staff leadership and participation (e.g., medical records, ethics, pharmacy, infection control, wellness)



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- Consider use of healthcare professional liaisons, advisors, experts in place of committees
- Consider ad hoc committees or committees that meet only when needed in place of standing committees

*Departments*

- Number and identification of departments/service areas.
- Qualifications of department/service chairs.

*Confidentiality and Immunity*

- This bylaw section addresses confidentiality issues as well as immunity provisions provided to practitioners when performing medical staff duties.

**AANA Resources**

- www.aana.com/PracticeManagement
- www.aana.com/ProfessionalPractice
- CRNA Employment/Practice Setting Considerations*
- Medical/Professional Staff Bylaws Framework*
    - Professional Practice Division
        - practice@aana.com
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        - *Topic area: general practice, bylaws, and facility accreditation*
    - State Government Affairs
        - sga@aana.com
        - 847- 655-1130
        - *Topic area: CRNA scope of practice, supervision, collaboration, or state law*

**Member Login Required*

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