White Paper

Medical Staff Bylaws

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For the sake of this white paper, Advanced Practice Registered Nurses (APRN) that practice in hospital organizations and settings often fall under the scope of Medical Staff bylaws. 'APRN' includes the following practitioners: Certified Nurse Midwife (CNM), Certified Registered Nurse Anesthetist (CRNA), Clinical Nurse Specialist (CNS), and Nurse Practitioner (NP) who are then further designated by population focus (ANCC, 2012; NCSBN, 2008; WNA APRN Coalition, 2019). The medical staff bylaws are a democratic governance set in place and mandated by The Joint Commission. Moreover, many APRNs have no voting privileges on the governing structure or changes. The bylaws are set up to be a form of governance to provide organization, classification, and control of "citizenship" in an organization (Kobernusz, 2012). The bylaws must categorize and define APRNs within the medical staff (ancillary, casual, full, active, licensed independent providers, advanced practice providers) (Gassiot et al, 2011; Kobernusz, 2012). More recently, the Centers for Medicare & Medicaid Services (CMS) has broadened definitions for medical staff to include APRNs based on state regulation and licensure (Fierce Healthcare, 2012). Further CMS conditions of participation (CoP) on medical staff do allow for APRN's to be full members on medical staff. Between 2013 and 2015, the Center for Advancing Provider Practices provided data showing over 60% APRN growth in 37 organizations (Anan & McElroy, 2017). Unfortunately, despite this growth few hospitals have provided APRNs within the medical executive committee (MEC). The absence of an APRN brings delay in policy, evidenced based practice, expertise in scopes of practice and education. The APRNs are necessary to navigate the ever-changing health care systems. The position of the WNA Nurse Practitioner Forum Board of Directors aim of this white paper is to inform, educate, and advocate for all APRN's in positions under medical staff bylaws as to practice definitions, requirements, barriers and limitations to practice.

Education

In many APRN school of nursing programs, a shortcoming of education and understanding on medical staff bylaws in preparation of entering the current health care workforce exists. Graduate programs can utilize the contents of this white paper to further educate students entering the workforce in preparing for credentialling and privileging through health care facilities. Several definitions may be seen such as Advanced Practice Provider (APP), Allied Health Profession (AHP), Licensed Independent Provider (LIP), and Midlevel Provider (MLP) (Kobernusz, 2012). Each health care system will define these titles and which practice professionals are in each of these such as Nurse Practitioner or Physician Assistants.

It is important for students and experienced APRNs to recognize the role in which they have been board certified for but also an understanding of the other APRN roles and state regulations that may be present.

The Institute of Medicine (IOM, 2011) noted four key messages, one specifically recommended a full partnership with physicians and other health professionals to bring evidenced based practice (EBP) from the bedside to leadership, becoming partners in leadership and serving actively in policy making and decisions (Melnyk, 2016). The need for health care systems to change and adapt quickly, providing quality and effective patient care leads to advanced practice empowerment, engagement, and buy-in. The unfortunate lack of this full partnership does not bring diversity of roles, education or expertise (Bidar-Sielaff, 2019).

Additional education focuses on new and existing APRN's to identify and interpret what existing medical staff bylaws state about the citizenship category one may be listed under. Interview preparation for a new role can assist in a better understanding of current identification within the bylaws and what citizenship category you may fall within. A basic understanding of medical staff bylaws can set up APRN's to understand scope of practice from how bylaws are outlined for each specific specialty. Additionally, several health care facilities may be out of date with current state rules, regulation, and terminology of APRN's (Kobernusz, 2011). This provides an opportunity as nursing leaders to become involved in change.

Barriers to APRN participation

Examples of barriers to APRN practice within medical staff bylaws has been the lack of voting rights to the medical staff meetings by APRN's. This directly affects voting on potential bylaws edits or changes that affect and control how APRN's practice in the hospital setting. APRN's may have the ability to sit, lead and chair on numerous hospital committees however none of these groups dictate or managing scope of practice. In Wisconsin, it has been reported several examples of rural critical access hospitals are finding a shortage of physicians interesting in service sitting as medical staff officers and now allow APRN's to sit as medical staff officers.

Stakeholders

Identification of key stakeholders is essential to understand and potential champion any potential changes to medical staff bylaws. The Chief Medical Officer (CMO), Chief Nursing Officer (CNO), Chief Financial Officer (CFO), Chief Operating Officer (COO), medical staff office personal, Specialty Division Chief's (Surgery, Cardiology, Hospitalist Medicine) and APRN leadership if established within the health care facility. Additional supportive stakeholders including but not

limited to patients, the community, public health, county health department, schools, pharmacy, divisions of therapy, and coding/billing leadership. Dr. Jeffrey Bauer (2020) noted how imperative it is for APRN's to get involved at the table as leaders and in leadership in policy and EBP changes.

Bylaw changes

Within each medical staff bylaws, the rules in which changes are to be made along with timing of these changes must be known. This is an essential part not only how to make changes, edits but also through who do the changes need to be reviewed by and eventually voted on (Kobernusz, 2011). Changes to bylaws may fall between annually or biannually depending on the health care facility. The process of bylaws changes can be very time consuming for review, rewrite, review with stakeholders and bring forward to the medical staff voting during annual or biannual meeting.

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