Pennsylvania Bar Institute

Hot Medical Staff Topics for Medical Staff Leaders and Counsel who advise them

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I. Medical Staff Unification within Systems

II. Trends in Peer Review – the Impact of *Reginelli*

III. October 2018 Revisions to National Practitioner Data Bank Guidebook

IV. The Expanding Role of Advanced Practice Clinicians within Medical Staffs

V. Dealing with Sexual Harassment Allegations in Medical Staffs in the #Me Too Era

VI. Strategies for Understanding and Alleviating Physician Burnout

I. Medical Staff Unification within Systems

Medicare Conditions of Participation ("CoPs") revised in 2014 to allow a "unified"

(42 C.F.R. §482.22(b)(4))

Interpretive Guidelines

- CMS State Operations Manual
- The Medical Staff members of each separately certified hospital in the system voted by majority

COPs:

- Election of the unified Medical Staff option by the hospital's governing body
- Opt out

COPs:

- A hospital that is part of a hospital system is expected to have Medical Staff bylaws, rules and requirements that address the regulatory regulations related to a unified Medical Staff
- Flexibility to determine the details of the voting process

Pennsylvania Department of Health

- Hospitals must seek an exception
- One set of exceptions was granted in 2018
- DOH regulates hospitals, not systems; believes current regulations do not allow unification

Key points for DOH

- A DOH surveyor must be able to readily see that each hospital can demonstrate compliance with all DOH regulations and CoPs
- Any benefits of a system would need to be balanced with concern about “unique circumstances” (local interests)

Key points for DOH

- An exception request must clearly lay out how all system hospitals will meet all of the requirement
- Demonstration that each local Medical Staff has opted in by majority vote and has right to opt out

Most other states' statutes, regulations silent – Illinois specifically allows unification.

Work-arounds?

- Uniform documents, different cover pages
- Meetings – separate minutes

Practical Considerations

- Advantages: Stronger peer review, systems can aid quality, safety initiatives (and better ability to protect information in light of Reginelli?)
- The larger the system (number of hospitals), the greater the disparity in size, teaching status, rural vs. urban, with less existing overlap, the harder it may be to obtain significant advantages or physician buy-in

II. Trends in Peer Review – the Impact of *Reginelli*

Peer Review Privilege

Reginelli v. Boggs, 181 A.3d 293 (2018)

Performance file of emergency physician not protected.

Court:

- No peer review privilege for file created by Medical Staff Dept. Chair (who headed ED group)
- Group not a review organization or review committee

Open question –

Is review conducted by external committee of health care professionals under a contract protected?

Yes –

In Re: Westmoreland Hospital Cardiac Stent litigation (Ct. Com. Pl. Westmoreland Cty. Dec. 18, 2018)

Manage risk by language in hospital-based physician contracts and Bylaws?

III. October 2018 Revisions to National Practitioner Data Bank Guidebook — no comments sought

- **Voluntary temporary agreement not to exercise privileges – reportable if more than 30 days**

- **LOA? Potential ADA claims?**

Legal authority questionable (subregulatory guidance)—develop a policy designed to demonstrate compliance, using language from Guidebook

IV. The Expanding Role of Advanced Practice Clinicians within Medical Staffs

Issues

- Credentialing
- Privileging
- Peer Review
- Procedural Rights

Categories

- Licensed Independent Practitioners
- Advanced *Dependent* Practitioners ("mid-level")
- Dependent Practitioners
- Alternative/Complementary

1. Licensed Independent Practitioners (LIPs)

Individuals who by license and hospital protocol are permitted to practice independently without physician supervision or direction

LIPs

- Psychologist
- Podiatrist?

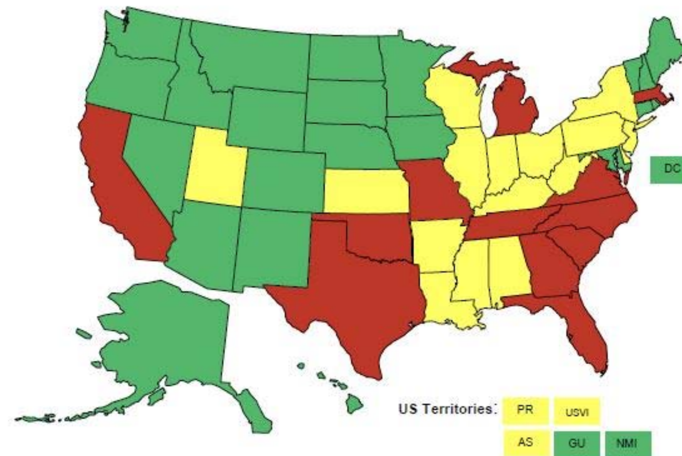
(Usually members of the medical staff today, but still need DOH exception)

2. **Advanced *Dependent* Practitioners - PAs, APRNs**

Individuals who practice under the supervision of or in collaboration with a physician and are granted clinical privileges; "Advanced Practice Clinicians"

AANP | American Association of NURSE PRACTITIONERS™

2018 Nurse Practitioner State Practice Environment



Full Practice
State practice and licensure laws provide for nurse practitioners to evaluate patients, diagnose, order and interpret diagnostic tests, initiate and manage treatments—including prescribe medications and controlled substances—under the exclusive licensure authority of the of the state board of nursing. This is the model recommended by the National Academy of Medicine, formerly called the Institute of Medicine and National Council of State Boards of Nursing.

Reduced Practice
State practice and licensure law reduces the ability of nurse practitioners to engage in at least one element of NP practice. State requires a career-long regulated collaborative agreement with another health provider in order for the NP to provide patient care or limits the setting of one or more elements of NP practice.

Restricted Practice
State practice and licensure law restricts the ability of a nurse practitioner to engage in at least one element of NP practice. State law requires career-long supervision, delegation or team-management by another health provider in order for the NP to provide patient care.

Source: State Nurse State Practice Acts
And Administration Rules, 2017
©American Association of Nurse Practitioners, 2017

Update: 1.2018

3. Dependent Practitioners (DPs)

Individuals who practice under the supervision (and direction) of a physician and are granted a scope of practice, or “clinical functions”

DPs

- RN First Assistant
- Surgical Technician

4. Alternative/Complementary Practitioners

- Massage Therapist
- Aromatherapist
- Hypnotherapist
- Acupuncturist

Issues

- Employed by hospital?
- Employed by staff physicians?
- Independent?

The rules come from different sources:

- State licensing laws and regulations – for individuals and hospitals
- Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs)
- Accreditation Standards

CMS

- **Credentialing and privileging for those providing "medical level of care"** ***through Medical Staff process*** **required by CMS**
- **What about RNFAs? — see CoPs — § 482.51(a)(4)**

Framework - CMS
"Evidence-based" Privileging

- Education
- Special training
- Quality of specific work
- Patient outcomes
- Current work practice
- Maintenance of continuing education
- Certifications
- Licensure

Physician Assistants

- Eligibility criteria for initial privileges
- Scope of privileges by specialty
- Level of physician supervision
- OPPE/FPPE, reappointment

AAPA "Accreditation Standards for Clinical Postgraduate PA Programs"

- Structured specialty training is not required for physician-PA teams
- "Should not be mandated"
- Average PA — 3 specialties in career

Can or should advanced training or a defined period of specialty practice be required for eligibility for certain privileges?

Is “on-the-job” training for PA specialty practice in hospitals acceptable?

Can a hospital develop its own training and guidelines for physicians to train PAs?

Consider a Task Force, work group or subcommittee of the Credentials Committee

PAs – Sources of guidance

- AAPA, other professional bodies – e.g., American Association of Surgical Physician Assistants
- Literature
- Examples from other hospitals

When a hospital is Joint Commission-accredited, if PA or APRN privileges are revoked or terminated, the hospital must provide a hearing and appeal mechanism, may differ from medical staff hearing.

What is a “Medical Level of Care”?

“Medical Level of Care”

- Is the APRN or PA performing a task that has historically (within the last 20 years) been performed by physicians?
- Could the task “kill or cause significant harm” to the patient?

PA Department of Health
Specified professional personnel

The use of CRNPs, PAs and CNMs in hospitals

A physician member of the medical staff has the ultimate responsibility.

Agreement in writing between the physician and the CRNP, PA or CNM

Hospital should maintain a copy of each written agreement.

In the case of multiple supervising physicians, one agreement may be used as long as each physician is named in and signs the agreement and other applicable requirements of the State boards are met.

The physician with whom the CRNP, PA or CNM has an agreement shall be onsite or readily available for consultation by telephone, radio, or telecommunications.

Writing of orders and recording of reports and progress notes in medical records of patients - within the limits established by the medical staff.

EMTALA -

Can PAs, APRNs be included on the on-call schedule?

Contact must still be made by ED with on-call physician. ED physician has ultimate authority to decide who responds.

Who Can Perform a Medical Screening Examination?

Qualified Medical Personnel

EMTALA authorizes MSE to be performed by QMP "as determined by hospital bylaws or rules and regulations."

The hospital's Board must approve, in writing, the category or categories of QMPs who will be performing MSEs.

Services provided by the QMPs must fit within the state's licensing regulations and the hospital's scope of practice.

CMS

Nurse midwife can make the determination of false labor.

In Pennsylvania, OB nurse can perform the MSE, but then must call the OB to make the diagnosis.

V. Dealing with Sexual Harassment Allegations in Medical Staffs in the #Me Too Era

V. Best Practices

- Anti-Harassment Policy –
  - Minimizes liability, promotes culture of respect
- Enforcement
- Orientation for new Medical Staff members and APCs

Have a policy,
teach it, and
follow it.

Policy Elements

- Define appropriate and inappropriate conduct

I. POLICY STATEMENT

1. All Medical Staff members practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.

2. This Policy outlines collegial and educational efforts to be used by Medical Staff leaders in order to address conduct that does not meet this standard. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve the concerns that have been raised, and thus avoid the necessity of proceeding through the disciplinary process in the Credentialing Policy.

3. This Policy is also intended to address sexual harassment of employees, patients, other members of the Medical Staff, and others, which will not be tolerated.

4. In dealing with all incidents of inappropriate conduct, the protection of patients, employees, physicians, and others in the Hospital and the orderly operation of the Medical Staff and Hospital are paramount concerns. Complying with the law and providing an environment free from sexual harassment are also critical.

II. DEFINITION AND EXAMPLES OF INAPPROPRIATE CONDUCT

To aid in both the collegial education of Medical Staff members and in the enforcement of this Policy, examples of "inappropriate conduct" include, but are not limited to:

- threatening or abusive language directed at patients, nurses, Hospital personnel, or other physicians (e.g., belittling, berating, and/or threatening another individual);

- degrading or demeaning comments regarding patients, families, nurses, physicians, Hospital personnel, or the Hospital;

- profanity or similarly offensive language while in the Hospital and/or while speaking with nurses or other Hospital personnel;

- inappropriate physical contact with another individual that is threatening or intimidating;

MEDICAL STAFF CODE OF CONDUCT POLICY

I. POLICY STATEMENT

1. All Medical Staff members practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.

"sexual harassment"… any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those who are subjected to it or witness it. Examples include…

- inappropriate physical contact with another individual that is threatening or intimidating;

Examples:

- Sexual advances
- Verbal sex-oriented abuse
- Pictures, images
- Dirty jokes, innuendo
- Touching

MEDICAL STAFF CODE OF CONDUCT POLICY

I. POLICY STATEMENT

1. All Medical Staff members practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.

Because of the unique legal implications surrounding sexual harassment, a single confirmed incident requires action…

speaking with nurses or other Hospital personnel;

- inappropriate physical contact with another individual that is threatening or intimidating;

Policy Elements

- Reporting
- Fact-finding
- Meeting
- Resolution
- Follow-up

Progressive Steps for Harassment Concerns

- Fact-finding to confirm
- First incident or pattern?
- Is collegial intervention strong enough?
- Warnings, reprimands – document! (Allow response)
- Require participation in program
- Conditional reappointment, behavior agreement
- If adverse action is necessary – it is due to practitioner's choice!

Who Should Handle? Options:

- Professionalism Committee
- Peer Review Committee
- Department Chief – be careful!
- Leadership Council (small group – officers plus – CMO of hospital and affiliated group?)
- MEC – egregious conduct, pattern
- Human Resources?

Referral to MEC

- Summary/Precautionary Suspension? (HCQIA immunity: imminent danger standard)
- Should employed practitioners be handled differently? Are there any issues with sharing information?
- Work with counsel on information-sharing between HR and MEC, and employer group

Prevention: Code of Conduct

- Provide expectations at initial interview
- Provide with letter of appointment, ask for signature
- Orientation should emphasize culture of respect
- Emphasize at reappointment
- Use in all interventions and communications

VI. Strategies for Understanding and Alleviating Physician Burnout

- Why Burnout? New and Old Stressors
- Effects of Burnout
- Strategies to Minimize

Health Affairs Blog

Physician Burnout Is A Public Health Crisis: A Message To Our Fellow Health Care CEOs

March 28, 2017

The Quadruple Aim recognizes that a heal… …, and resilient physician workforce is essential to achieving national health goals of … …ity, more affordable care and better health for the populations we serve. Yet in a recent study of U.S. physicians, more than half reported experiencing at least one symptom of burnout—a substantial increase over previous years—

Why Burnout?

EMR

CPOE

Privacy/Security Risks

Stolen devices

Ransomware

OIG

MACRA

HCAHPS

Bundled payment/VBP

Yelp

O M G

Effects of Burnout

Increased

- Medical Errors
- Turnover
- Suicidal Ideation
- Impairment

Decreased

- Professionalism
- Patient Satisfaction
- Productivity
- Safety Culture

PRACTICE SUPPORT | RESOURCE LIBRARY | CONTACT US | SHARE

STEPS*forward*

HOME | MODULES | EVENTS | HOW IT WORKS

Improve patient satisfaction, quality outcomes and provider recruitment and retention.

Preventing Physician Burnout

Mark Linzer MD, FACP Hennepin County Medical Center

Laura Guzman-Corrales, MPH Hennepin County Medical Center

Sara Poplau Hennepin County Medical Center

AMA IN PARTNERSHIP WITH

CME CREDITS: 0.5

How will this module help me successfully eliminate burnout and adopt wellness approaches in my practice?

1. Seven key steps to help you prevent provider burnout
2. Ten-item survey designed to assist you in assessing burnout
3. Examples of successful burnout prevention programs in a variety of practice/organization settings

Share

Download module as PDF

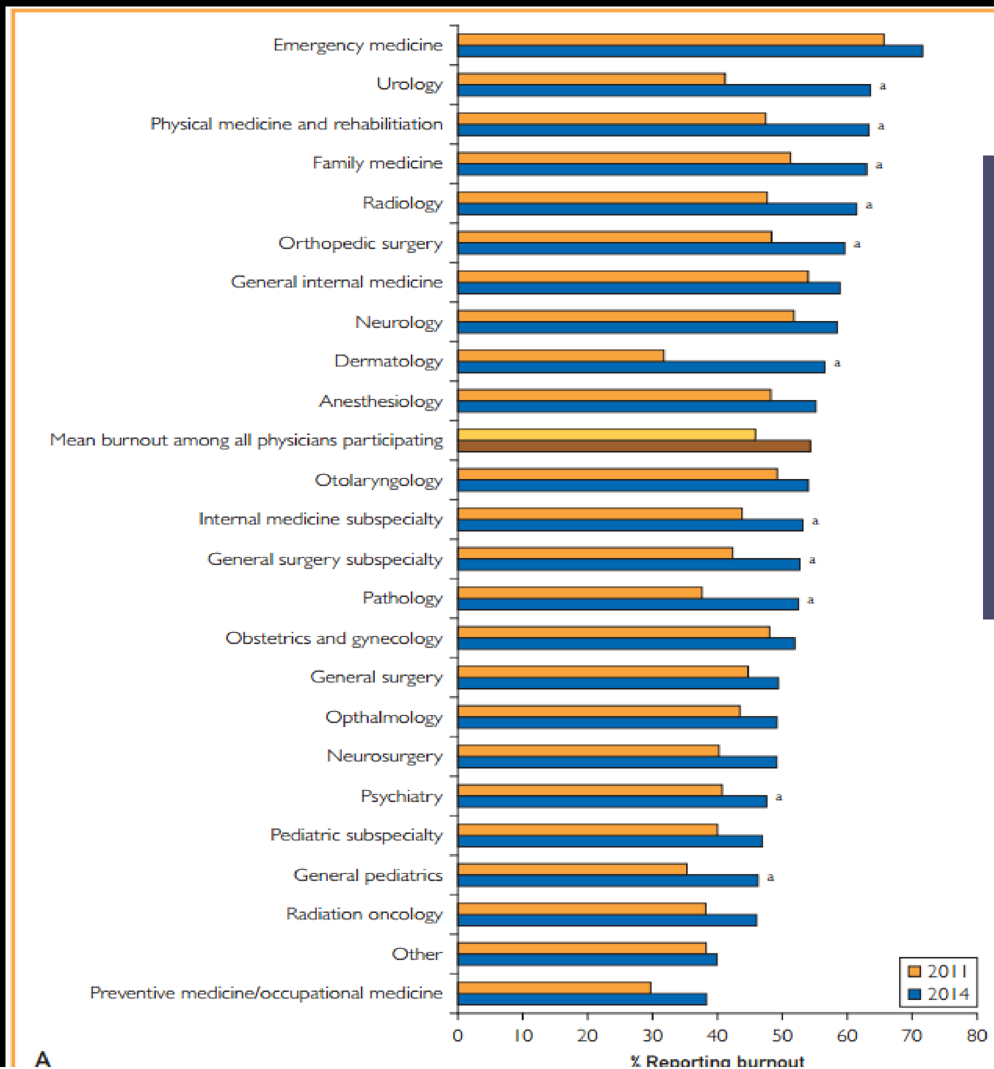
Download module PowerPoint

Online module | STEPS in practice | Downloadable tools | Implementation support

Counseling medical staff leaders:

- Identify signs and symptoms of stress and burnout
- Develop strategies and options for policies to proactively help colleagues avoid burnout
- Design leadership interventions to mitigate burnout
- Implement best practices for collegial steps, counseling and mentoring practitioners

Mean Physician Burnout Score Rises to 54.4%



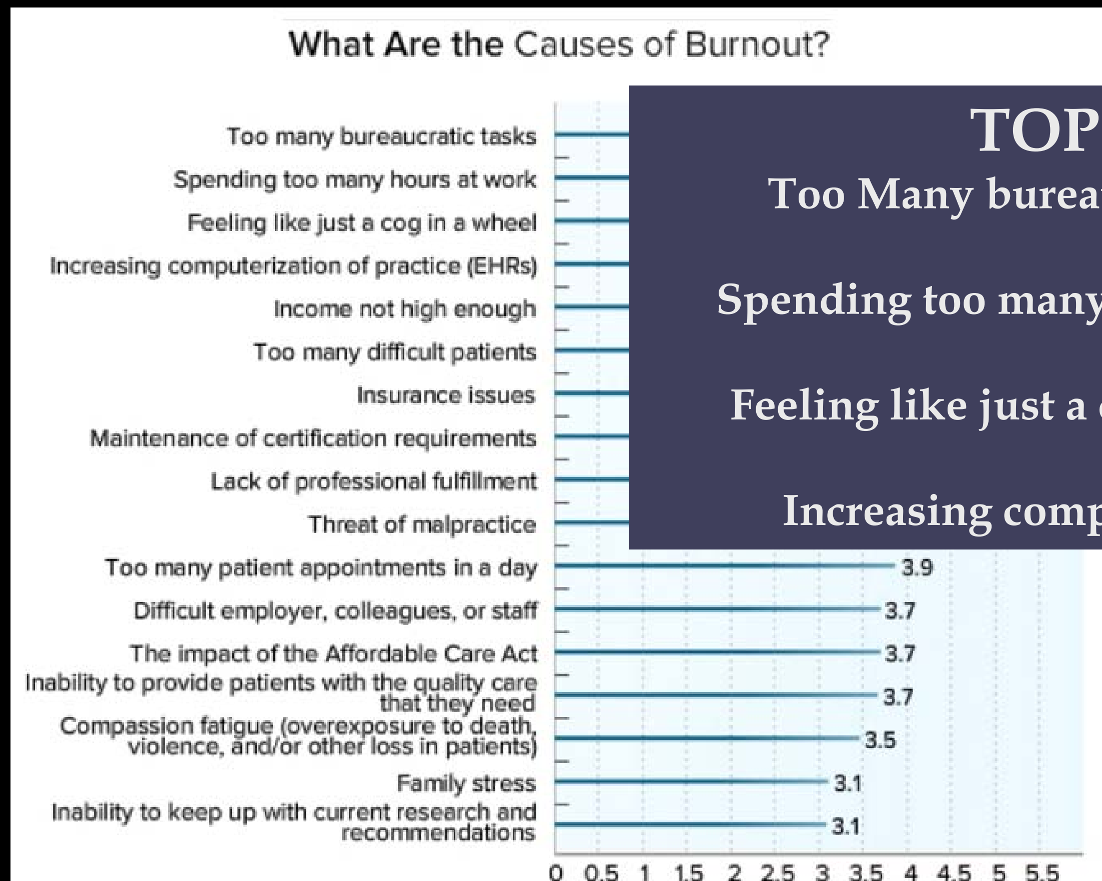
Depersonalization

Low Personal Accomplishment

Emotional Exhaustion

Shanafelt, T et al. Mayo Clin Proc. Dec. 2015;90(12):1600-1613

What Contributes to Burnout?



TOP 4

Too Many bureaucratic tasks

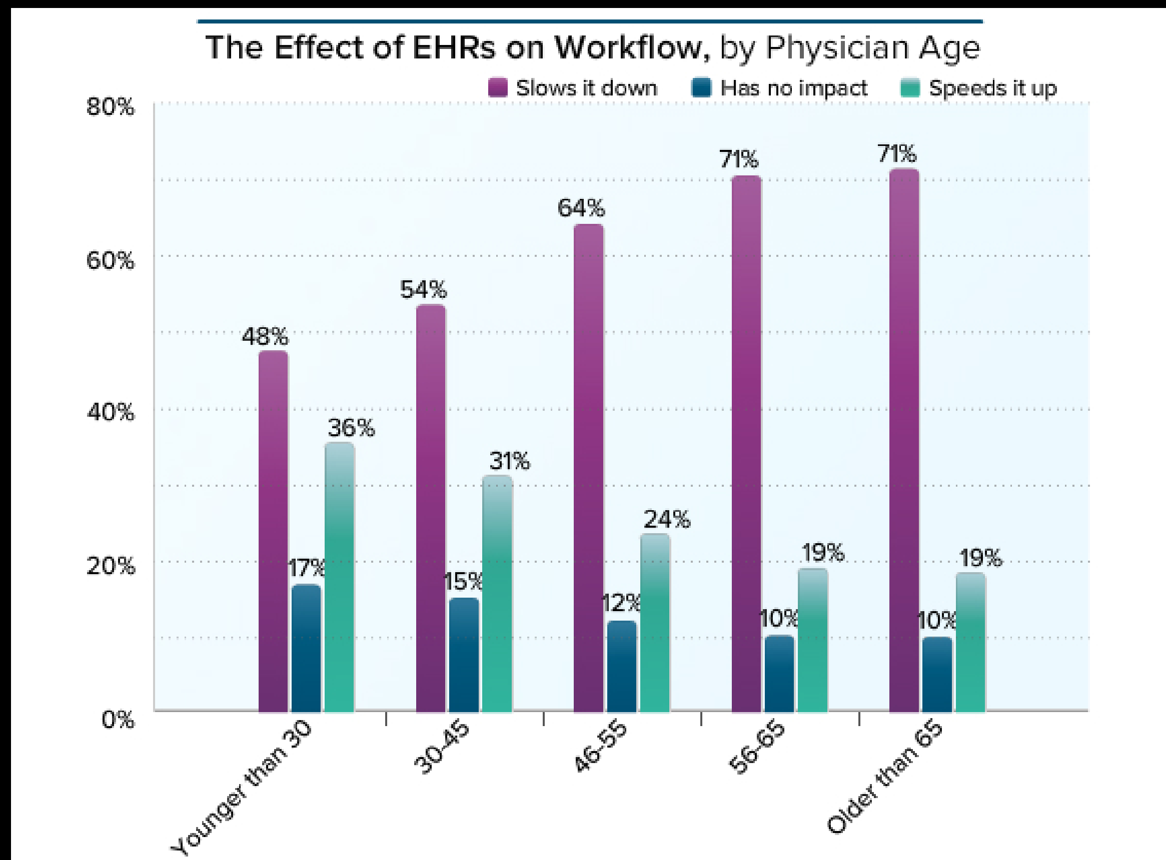
Spending too many hours at work

Feeling like just a cog in a wheel

Increasing computerization

Medscape Lifestyle Report 2017

EHRs have had a severe impact on workflow



Medscape EHR survey of 15,300 physicians across 25 specialties
August 2016

Use of CPOE was an independent factor associated with burnout.

Shanafelt, T. et al. Mayo Clinic Proceedings 2016: 91 (7) pp. 837-848

National Academy of Medicine Initiative

- nam.edu/ClinicianWellBeing

Investing in leadership is a key vaccination for burnout.

Strategies:

- Well-being committee
- Leadership development, succession planning, role in governance, management