Sweat the details
Avoid steep Stark Law and anti-kickback statute penalties with education and documentation

Although the Stark Law and federal anti-kickback statute have been around longer than many of us care to remember, many organizations are still tripping over the details of the complex requirements.

The Joplin Globe reported on November 5, 2012, that Missouri-based Freeman Health System agreed to pay $9.3 million to settle allegations that it violated the Stark Law and False Claims Act when it provided incentive pay to physicians based on referrals. The health system discovered the errors during a 2009 internal review and self-reported.

In April of 2012, the 4th U.S. Circuit Court of Appeals, based on procedural grounds, overturned a district ruling that required Tuomey Healthcare System in South Carolina to pay more than $45 million for allegedly violating the Stark Law. The court is still reviewing two Stark issues that arose during the appellate review, according to the July 2012 issue of Compliance Today.

In September 2012, the Tampa Bay Times reported that a whistleblower accused All Children’s Hospital in St. Petersburg, Fla., of overpaying its physicians by $5 million in 2010.

You get the picture. Due to the physician shortage, hospitals are often caught in the middle between needing to incentivize physicians to join their medical staffs and stringent federal standards that regulate those incentives. Given the complexity of the standards, it’s easy to make a mistake.

“As long as there is pressure on keeping expenditures on Medicare and Medicaid down, there is going to be constant pressure to comply with these statutes to prevent perceived or actual fraud and abuse,” says Bruce Armon, Esq., partner at Saul Ewing, LLP, in Philadelphia.

The best thing hospitals can do is fully understand the Stark Law and anti-kickback statute to ensure their practices fall within acceptable guidelines.

Stark law
Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians, published by CMS, defines the Stark Law as follows:

The Physician Self-Referral Law (Stark Law) prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or an
immediate member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies. Penalties for physicians who violate the Physician Self-Referral Law (Stark Law) include fines as well as exclusion from participation in all Federal health care programs.

Stark can often rear its ugly head around nonmonetary compensation, says Ethan Rii, partner at Katten Muchin Rosenman in Chicago. At hospitals where both employed and community physicians are on staff, the community physicians often feel that the employed physicians are compensated more—even if it is not the case. The medical staff leaders, walking a tightrope, often try to appease this feeling with nonmonetary compensation arrangements.

“The Stark Law has an exception that allows for a certain nominal sum that a designated health services provider (in this case, a hospital) can give to a referring physician,” says Rii.

Nonmonetary compensation might include a medical staff leader taking a physician out to dinner or a day of golf. It can also include a bouquet of flowers sent to a grieving physician’s office after the death of a loved one or a donation of goods, such as waiting room furniture for a physician’s new office practice.

For 2013, CMS’ annual cap for nonmonetary compensation is $380. With such a nominal sum, small gifts add up quickly—a nice dinner for four can eat up most, if not all, of the annual allowance.

“Typically, nonmonetary compensation applies more to the independent physicians. For physicians who are employed, items that are typically considered nonmonetary compensation would fall within the employment exception under Stark Law. “Given the broad nature of the exception, you have a lot of leeway in the direct-employment setting,” says Rii.

The best thing medical staffs can do is create a system for keeping track of expenses. Even a simple spreadsheet is better than nothing. When physicians submit receipts for reimbursement, the dollar amount should be tracked. If the amount for the year already exceeds no more than 50% of the limit ($570), the physician has to give back the difference by the end of the year or within 180 days, whichever is earlier. “If the gift exceeds this amount, you are out of compliance and the return option is not available,” he says. This exception can only be used once every three years.

Medical staffs also need to watch out when it comes to making donations or large gifts to physician groups. Rii offers this example: If the medical staff leaders at a hospital wish to donate a painting to a new office practice in town that they hope will refer patients to the hospital, they can’t divide the cost of the painting among

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**Medical Staff Briefing**

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the number of physicians in the practice. But the medical staff can send a basket of fruit, which can be taken apart and divided among staff members. “Conversations about Stark can get down to minutia,” says Rii.

Medical staffs don’t need to count the annual holiday party as long as it is open to the entire medical staff. However, any gifts or gratuities provided in connection with the event would be subject to the $380 cap. Of course, while these rules require strict compliance, CMS is more concerned about gift-giving when physicians are singled out. “It is not the normal everyday stuff that the government is concerned about, unless the normal everyday stuff has an abusive streak,” says Armon.

Hospitals also don’t have to worry about the small little perks that physicians receive on the job, such as a pager or Internet access, as CMS has established a separate Stark Law exception for that, called the Medical Staff Incidental Benefits exception. For this exception to apply, the perks must be available to all members of the medical staff, and the benefit can only be used on the campus of the hospital and be of low value (i.e., less than $32 for 2013). “This exception applies only if it is directly related to a physician providing medical services at the hospital,” says Rii.

Adding another loophole, hospitals can subsidize up to 85% of the purchase of a physician practice’s electronic health record software under Stark’s EHR Items and Services exception, and it won’t violate Stark Law. Rii stresses that this subsidy is for the software and related items or services (i.e., training) only—no printers, keyboards, or computers. This particular exception will no longer be valid at the end of 2013.

One important issue to note is that the Stark Law does not take intent into consideration. Even if an institution does not intend to violate it, it can still be found at fault. And because fines can include denial of payment, refunds, up to $15,000 in civil monetary penalties for each claim submitted in violation of the law, and exclusion from participation in the Medicare program, it’s all the more reason to ensure strict adherence.

Given the numerous loopholes and exceptions of Stark, in addition to creating a system to keep track of dollars spent on physicians, hospitals would also be wise to include information and updates on the Stark Law during annual physician education. Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians, available at www.cms.gov, is a succinct resource with links to further information.

**Anti-kickback statute**

Avoiding Medicare Fraud & Abuse: A Roadmap for Physicians describes the anti-kickback statute as follows:

The Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program. Where remuneration is paid, received, offered, or solicited purposefully to induce or reward referrals of items or services payable by a Federal health care program, the Anti-Kickback Statute is violated. If an arrangement satisfies certain regulatory safe harbors, it is not treated as an offense under the statute.

“Under Stark, there is a prohibition on physician referrals in which the referring physician has a financial relationship. The Stark Law is focused on referral relationships. In comparison, the anti-kickback statute is much broader and deals with payment, solicitation, or receipt of anything in exchange for a patient referral or a referral of other business,” says Armon.

Whereas Stark prohibits referrals from physicians to another physician or institution for designated health services, the anti-kickback statute prohibits anyone (not just physicians) from offering, paying, soliciting, or receiving anything of value to induce referrals.

For a full comparison of Stark versus anti-kickback, visit oig.hhs.gov/compliance/provider-compliance-training/files/StarkandAKSChartHandout508.pdf.
Under the anti-kickback statute, criminal fines are upward of $25,000 per violation, while civil fines can reach $50,000. Although the fines are steep, the anti-kickback statute offers voluntary safe harbors, including the following:

➤ Investment interests
➤ Safe harbors
➤ Equipment rental
➤ Personal services and management contracts
➤ Sale of practice
➤ Referral services
➤ Warranties
➤ Discounts
➤ Employees
➤ Group purchasing organizations
➤ Waiver of beneficiary coinsurance and deductible amounts
➤ Increased coverage
➤ Reduced cost-sharing amounts, or reduced premium amounts offered by health plans
➤ Price reductions offered to health plans
➤ Practitioner recruitment
➤ Obstetrical malpractice insurance subsidies
➤ Investments in group practices
➤ Cooperative service hospital organizations
➤ Ambulatory surgical centers
➤ Surgeon-owned ambulatory surgical centers
➤ Referral arrangements for specialty services
➤ Price reductions offered to eligible managed care organizations
➤ Price reductions offered by contractors with substantial financial risk to managed care organizations
➤ Ambulance replenishing
➤ Health centers
➤ Electronic prescribing items and services
➤ Electronic health records items and services

For a detailed list of the exceptions, see the Code of Federal Regulations at 42 CFR § 1001.952 (exceptions).

The anti-kickback statute is intent-based, meaning that a judge would determine whether the institution’s intent was to knowingly violate the statute.

“A helpful guide with respect to the kickback statute is the safe harbors. One thing to note: Just because you don’t follow a safe harbor doesn’t mean you violated the anti-kickback statute. You should, however, try to fit the business arrangement into a safe harbor,” says Armon.

Anti-kickback violations are often reported by whistleblowers, but individuals can self-disclose to the Office of Inspector General (OIG) to avoid the cost and hassle of a government investigation. The OIG is currently seeking feedback regarding the self-disclosure process.

Keeping up with OIG advisory opinions (at https://oig.hhs.gov) on the subject may help your organization stay out of hot water, as the advisory opinions may apply to a situation similar to one your organization is facing. For example, in November 2012, the OIG issued an advisory opinion that states that although it’s illegal to induce or reward referrals for services the government reimburses for, offering per diem payments to emergency doctors who see Medicare patients may be admissible, as long as the hospital follows the Social Security Act, the civil monetary penalty provision, and the federal anti-kickback statute.

Ensuring that an organization abides by the Stark Law and anti-kickback statute at all times can feel like a full-time job, especially given the complex relationships that physicians and hospitals have these days, but organizations have a lot to save by staying ahead of the game.
Adding clinicians to the medical staff department can improve the privileging process and streamline responsibilities

Medical staff services isn’t what it used to be, and no MSP would argue with that. What was once an administrative job has become a highly technical career, and it’s getting more specialized by the day.

According to Wendy Crimp, BSN, MBA, CPHQ, consulting practice director for The Crimp Resource Group, one emerging trend is the separation of privileging and credentialing duties. She explained that years ago, the MSP’s role was to ensure that the list of privileges was accurate, but as more emphasis was placed on criteria, the job got more complex. Now, privileging entails determining whether physicians need to acquire specific training and certificates and perform a certain number of procedures to be deemed competent. Thus, MSPs have had to tap into physician’s knowledge and experience to get the job done.

“It has become harder for non-clinicians to administer privileging programs,” says Crimp.

FPPE has added another wrinkle. For facilities that are Joint Commission–accredited, confirmation of clinical competence via either case review or concurrent proctoring is part of the privileging process, and creating a thorough FPPE form for any given specialty requires a clinician’s touch.

“We have more and more clinical activities moving into this previously administrative realm,” says Crimp. “It is hard because although the MSPs have been trained in medical terminology, they frequently have not been trained in clinical nomenclature. A clinical procedure can be named five different ways.”

Given the complexity of the privileging and peer review processes, Crimp recommends that the medical staff office integrate individuals with a clinical background, such as a nurse or respiratory therapist, if not into the department, then at least into the process.

Do what you do best

Hiring an individual with a clinical background into the medical staff department has several advantages. First, if a nurse looks at a cardiac surgery privilege form, he or she will be better able to identify areas that overlap or items that are missing.

Second, when that nurse sits down with a physician to review the privileging form, he or she will have the clinical expertise to ask the right questions.

Third, when it comes time to develop FPPE forms for physicians to use during a review, an MSP with a clinical background will be able to create specific questions.

“If you leave the forms generic, you will get generic responses. If you use good clinical background and understand standard of care for that type of patient, you will be able to put together a meaningful form,” says Cynthia Smeenge, manager of the credentialing department at Spectrum Health in Grand Rapids, Mich.

An alternative to hiring a nurse or other clinician into the medical staff office is to hire a certified medical coder. “Frequently we are hiring people who have never done credentialing and privileging before and training them from scratch. If we are going to train someone from scratch, let’s try to get someone with a secondary skill set. Then when physicians turn in their case logs and there are questions, there is someone besides a physician to answer them,” says Crimp.

If hiring a clinician or medical coder isn’t an option, MSPs can also boost their performance by going back to school. A medical staff coordinator in Smeenge’s department is returning to school to get her RN. “She isn’t going into clinical practice as much as she wants the clinical background to support her in her role,” says Smeenge. “You can’t help them develop threshold numbers if you don’t understand what the jargon and different procedures are.”
Sherry Mehler, CPMSM, manager of privileging systems at Cedars-Sinai Medical Center in Los Angeles, took advantage of a medical terminology course her organization offered in 2009, just before diving into a two-year effort with all medical staff departments and divisions to ensure that the privileging forms in each of the 57 specialties met prevailing standards, reflected contemporary practice, and were compatible with online credentialing. The course helped Mehler transition into her new management role, which focuses solely on privileging.

Privileging professionals with a deep understanding of the various procedures can create streamlined privileging forms. For example, on the surface, it might make sense to lump the insertion, management, and pulling of central lines onto one privileging form, but the reality is that inserting a central line is far more complex than pulling it.

“By putting them together, you are requiring people to request the higher-level procedure for a lower-level procedure,” says Smeenge. By grouping together the pulling of all of the various central lines into one privileging form and the insertion and management of central lines into another, the medical staff services department can streamline the process and ensure that the appropriate clinicians are performing the appropriate procedure.

“It is that kind of understanding of the complexity of different procedures, treatments, or protocols that helps you develop privileges that make sense in the real world,” says Smeenge.

How to make it happen

In the past, medical staffs have tried partnering with the quality department, but that doesn’t often work well, says Crimp. Both the quality and the medical staff departments are often so overwhelmed with their own initiatives that they struggle to help each other out.

“If you just expect them to help when you call, they will be busy doing other things. If you go with the partnering option, it has to be a structured approach where you have once-a-week meetings to discuss business with them or they own a piece of your process—maybe they are going to the physician review meetings with the department chairs and doing interpretations of case logs,” says Crimp.

Ideally, in a partnering situation, the quality and medical staff departments report to the same person who sets the priorities and agendas for both.

“If it isn’t super structured, it won’t happen, and you need to go to plan B, which is to bring the expertise into your department,” says Crimp.

According to Crimp, most of her clients convert an existing position rather than adding staff. One mistake that medical staff departments make when adding an individual with a clinical background to the mix is that they keep the work flows separate. Yes, it makes sense for the nonclinical folks to focus on application management and primary source verification while the individual with a clinical background can focus on the technical aspects of privileging, but that doesn’t mean that the folks with a clinical background can’t do credentialing work, too, says Crimp. Perhaps the individual with a clinical background facilitates review with the department chair and credentials committee.

If an organization is financially strapped, Crimp suggests waiting until the department has a vacancy.

“It is easier to upgrade a position than create a whole new one,” she says.

According to Smeenge, recruiting for the position may be a challenge because so few people understand medical staff services or, quite frankly, know that the department exists. “I find that if I want to hire clinical people, I’m going to have to really recruit and mentor someone because it is not a well-known area of health-care administration,” she says.

Crimp admits that MSPs haven’t always been open to the idea of inviting clinicians into the medical staff department, but given how overwhelming their jobs have become, many would appreciate the assistance and the ability to focus their efforts and talents in the credentialing arena and leave the technical stuff to the experts.
When physicians and patients sue

The medical staff’s guide for legal issues surrounding FPPE

Although The Joint Commission and other regulators require institutions to have credentialing, privileging, and peer review processes in place, there are legal concerns associated with each process. Negligent credentialing and antitrust concerns are a few legal issues that medical staff leaders and MSPs must keep in mind when developing and carrying out FPPE activities. Maintaining consistency and fairness throughout the credentialing and privileging processes, which include FPPE, is critical to avoiding legal situations. Each institution must strive to consistently apply its FPPE program to:

➤ All new applicants or individuals requesting new privileges, referred to as initial practitioner performance evaluation
➤ Individuals who have been identified as requiring a focused review

Although the components of the FPPE review may differ by specialty, the representatives from the specialty, medical staff leaders, and quality and medical staff service professionals must apply FPPE in a standardized way and document the process. This helps avoid legal issues commonly associated with FPPE. Lawsuits related to FPPE may be initiated by practitioners subject to FPPE as well as by patients.

Practitioners who sue

Practitioners who were subject to an FPPE review may bring legal action if they feel there is a bias within the FPPE process. This may include a conflict of interest with the proctor or others involved in the evaluation. They may also sue if they believe the FPPE was required for reasons other than concerns with their quality of care.

Practitioners who undergo FPPE may bring suits in which they claim there was a conflict of interest during the review. They may believe that the FPPE process itself was biased, or that an involved individual or group was biased or performed the task with malice. Organizations should develop an FPPE process that mitigates conflict-of-interest issues and ensures that reviewers have minimal or no conflicts of interest. This may be difficult in small organizations that only have a handful of practitioners practicing in each specialty. In these cases, the medical staff should consider using external reviewers. Many companies provide this service and will be able to review patient files for the practitioner in question. Alternatively, the medical staff may contact a nearby academic center and ask specialty representatives there to conduct the review. Large organizations may also consider using external reviewers. A practitioner under review will most likely find fault with the process if the specialists performing the review are direct competitors.

It may not be possible to avoid all conflicts of interest, but many safeguards should be built into the FPPE and corrective action processes to provide checks against biased assessments. Where a potential conflict of interest exists, consider obtaining the consent of the practitioner under review to use a particular proctor or reviewer. Having that consent makes it more difficult for the practitioner to raise a conflict-of-interest concern for systematic bias or unfairness intended to harm his or her practice. Additionally, design the FPPE process so that if a conflict of interest arises during a review, there is a mechanism to remove the potentially biased practitioner reviewer from the process. The FPPE policy could include a section regarding potential bias and how the situation will be resolved. One drawback to including such language is that it highlights the fact that a bias may exist. Consider a statement such as, “If the practitioner under evaluation can provide substantiated evidence that a reviewer has shown bias, the practitioner will have the opportunity to present his or her concerns to a particular medical staff officer for discussion and resolution.”
Sample conflict-of-interest language

The following is sample conflict-of-interest language that organizations may use as a starting point for developing their own policies:

A practitioner requested to perform focused review may be considered to have a conflict of interest if he or she is unable to render an unbiased opinion. An absolute conflict of interest would result if the practitioner is a first-degree relative or spouse to the individual being reviewed. Additional potential conflicts of interest could result if the practitioner was 1) directly involved in the patient’s care but not related to the issues under review, 2) a direct competitor, partner, or key referral source, or 3) involved in a perceived personal conflict with the practitioner under review.

Conflict-of-interest procedure

It is the obligation of the reviewer to disclose to the appropriate committee the potential conflict. It is the responsibility of the peer review body to determine on a case-by-case basis whether a relative conflict is substantial enough to prevent the individual from participating.

When a potential conflict is identified, the committee chair will be informed in advance and determine whether a substantial conflict exists.

When either an absolute or a substantial potential conflict is determined to exist, the individual may not participate in or be present during peer review body discussions or decisions other than to provide specific information requested as described in the focused review process.

In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described here, the committee or the medical executive committee will replace, appoint, or determine who will participate in the process so that bias does not interfere in the decision-making process.

Initiating the FPPE process

A practitioner may consider suing medical staff leaders for imposing an FPPE requirement if he or she feels that the review is being conducted for reasons other than concern about quality of care, such as for financial retribution. These claims may raise allegations of discriminatory motive, malice, tortious interference with the practitioner’s business opportunities, or other causes of action. Medical staff leaders who determine a need for focused review should carefully document their reasons for imposing the requirement. The reasons should clearly establish the following:

➤ The connection between the focused review requirements
➤ The difference between the practice or outcomes of the practitioner in question and other like practitioners
➤ A concern for patient safety/quality of care

The FPPE policy should specify the exact situations that will initiate a focused review. Examples of scenarios that may trigger FPPE include:

➤ Information obtained from ongoing evaluation/peer review activities that indicate a performance issue
➤ Comparison of the practitioner’s practice to that of like practitioners shows a difference in outcomes, or higher infection or complication rates
➤ Lack of compliance with established clinical practice guidelines
➤ Failure to comply with the medical staff’s/hospital’s code of conduct
➤ A documented trend of change in the practitioner’s clinical practice patterns

The policy should also stipulate that a focused review may be triggered by a specific or single incident, a sentinel/adverse event, complaints from other healthcare providers, longer patient stays compared to other like practitioners, noncompliance with clinical guidelines/pathways, repeated admissions for the same issue, a pattern of unnecessary use of diagnostic testing or treatment, evidence of unfavorable trends or patterns in clinical practice or deportment, or other circumstances indicating that patient safety may be compromised.
**Patients who sue**

Legal issues also arise when patients believe inadequate physician monitoring by the medical staff or hospital led to a bad outcome in their care. Such suits are generally corporate negligence complaints brought against the hospital for inadequate peer review and improper retention of a physician on the medical staff, or inappropriate granting of privileges. Plaintiffs may claim a lack of proctoring to strengthen such allegations. They may make such claims in cases where there was no FPPE or where the focused review process appears to have been defective in some way so that it did not detect substandard practice.

Some plaintiff attorneys argue that all physicians should undergo a period of proctoring when they initially receive medical staff privileges. How else, they argue, can an institution truly know whether a physician is competent to exercise the privileges granted? These lawyers use the fact of a bad outcome (which has led to a malpractice suit) as proof of the need for proctoring. If proctoring had been properly undertaken, they say, the patient might never have been injured. The hospital has therefore been negligent in its duty to protect patients.

These claims aside, The Joint Commission requires that every physician new to the organization or requesting new privileges must undergo a focused review process. The determination of competence is typically made through various vetting techniques, and proctoring is only one of the available methods. Therefore, when creating credentialing policies and procedures, the medical staff should be careful not to imply that all newly privileged clinicians will be proctored if this is not the uniform practice at the institution. The FPPE process may also require chart review, discussion with other practitioners involved in the case, or a simulation experience in which the practitioner may be observed and outcomes measured.

Some medical staffs use a provisional status for new members; however, The Joint Commission no longer requires such a status. In fact, the FPPE process may be substituted for the provisional status process. Retaining the provisional status provides an opportunity for a plaintiff attorney to assert that the failure to proctor a physician during provisional status is evidence of hospital or medical staff negligence as demonstrated through a failure to comply with its own bylaws. Thus, many medical staffs are doing away with provisional status and substituting the FPPE process instead.

Besides allowing for claims of corporate negligence, if the FPPE process includes or requires concurrent proctoring (direct observation), a plaintiff patient may name the proctor as a party to malpractice for failing to intervene in the substandard practice of the practitioner the proctor was observing. Although in general such claims fail because the proctor has no duty to the patient under most proctoring protocols, these claims can still be troublesome for proctors and hospitals. If an organization requires or allows for concurrent proctoring as a mechanism to perform FPPE, the FPPE policy or separate policy should outline the responsibilities of the proctor and the practitioner being proctored. This policy should also outline the facility’s expectation of proctors regarding intervention. Include the following proctor responsibilities in this policy:

- The proctor’s role is that of an evaluator—to review and observe cases—not a supervisor or consultant
- The proctor is an agent of the hospital
- Outline what the proctor should do when he or she has concerns about the practitioner’s competence

*Editor’s note: This article was excerpted from The Complete Guide to FPPE by Valerie Handunge, MA; Christina W. Giles, CPMSM, MS; Jonathan H. Burroughs, MD, MBA, FACPE; and Evalynn Buczkowski, RN, BSN, MS, published by HCPro, Inc. The book is available at www.hcmarketplace.com.*

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**Next issue!**

Stay tuned for next month’s issue of Medical Staff Briefing for a redesigned look and feel. Enjoy the new format, and thanks for being a loyal reader.
Patient empowerment and engagement changes the traditional doctor-patient relationship

Patients are becoming increasingly involved in their own care, often doing Internet research and coming to office visits or the hospital armed with questions and their own ideas about what constitutes appropriate care. It’s a good thing.

To find out the best way for physicians to jump on the patient empowerment train, MSB spoke with Kevin Pho, MD, an internal medicine physician practicing in Nashua, N.H. Pho is known through his blog (www.kevinmd.com) and speaking engagements as Kevin, MD.

**MSB: What do you tell your patients about using the Internet to find healthcare information?**

**Kevin MD:** I talk to a lot of my physician colleagues, and some of them tell their patients, “Don’t go online. Be careful about what you read.” But realistically, I don’t think that is possible because if you look at the latest statistics, eight out of 10 Internet users use the Web to look for health information. Regardless of what doctors say, patients are still going online, and the reason for that is access issues. It is difficult to get an appointment or get a physician on the phone. That said, there is a lot of bad information on the Web from companies trying to sell products or organizations that are trying to push agendas.

I think one of the most important things that doctors can do is give patients some basic online health information tips. I certainly encourage my patients to go online. I try to give them guidelines:

- Be careful about websites that try to subtly push a product
- Trust websites that end in “.edu,” academic medical center websites, and government websites

**MSB: How do you get patients to engage more fully during a hospital or office visit?**

**Kevin MD:** Despite the trend of patients wanting to be more empowered, there are some patients who want to continue with the traditional paternalistic doctor-patient relationship. There are going to be some patients who want to be told what to do, and as a physician, you need to customize your management style to fit what each patient wants. So in talking to the patient and developing a relationship with them, I’ll know generally how much guidance and involvement they want going forward. You can’t force everyone to become more empowered.

**MSB: What are your thoughts on patients being able to reach physicians via email or other online venues?**

**Kevin MD:** I think the movement from that will come not from the individual physician, but from up above, whether it is from insurance payers, Medicare, or large hospital systems themselves. I don’t think it is physicians’ fault that they can’t be reached via email or telephone. It is the rules that govern it. Physicians only get paid when they see a patient in the office, so they don’t get compensated for communicating with patients via email or phone. I would love nothing more than to communicate that way. Eventually it is going to happen. With healthcare reform, we will move from the traditional fee-for-service payment model to something more globally capitiated, where the time spent on communications is valued.

**MSB: Is the patient empowerment trend more difficult for older, more traditional physicians?**

**Kevin MD:** In general, doctors are pretty conservative and set in their ways. When I talk about social media with older physicians, I do encounter a little more resistance. But I think a lot of doctors aren’t going to have a lot of choice because patients are becoming more empowered every day. The traditional doctor-patient relationship isn’t going to be viable anymore, whether physicians like it or not. I think the good news is that a lot of younger physicians have grown up with social media, using mobile devices, and having that type of communication at hand, and it is up to us as a medical profession to change our model to fit this new generation and adapt to the fact that people are used to communicating differently.
**APPs: Distinctions that make a difference**

*Understanding the roles of the physician assistant and nurse practitioner*

by Samuel J. Furci Jr., MPA, and Patricia A. Furci, RN, MA, Esq., principals at Furci Associates, LLC, in West Orange, N.J.

To keep up with today’s complex privileging requirements, MSPs need to understand the growing roles of APPs and how they integrate with the medical staff. Pursuant to 21 CFR § 1300.01(b28), the term “mid-level practitioner” (otherwise known as APP), specifically means an individual healthcare practitioner, other than a physician, dentist, veterinarian, or podiatrist, who is licensed, registered, or otherwise permitted by the United States or the jurisdiction in which he or she practices, to dispense a controlled substance in the course of professional practice. Some examples of mid-level practitioners include (but are not limited to) nurse practitioners (NP), nurse-midwives, nurse anesthetists, and physician assistants (PA).

This series of articles will focus on advanced nurse practitioners (ANP or ARNP), PAs, midwives (also known as CNM, CM, CPM and ANP-Midwifery), registered nurse first assistant (RNFA), and certified registered nurse anesthetist (also known as CRNA or ANP-Anesthesia).

**Dependent vs. independent practitioners**

The first step in sorting out this group of “cousins” comes with identifying the difference in their state licensure, and thus their role in the delivery of care. A dependent practitioner is one who is dependent on or overseen by another practitioner, such as a physician or other licensed independent practitioner (LIP), to perform certain functions. This dependence or supervision requirement is usually described within specific state law. An LIP does not require this level of guidance or dependence.

According to the American Academy of Physician Assistants, a PA is considered a healthcare professional who is authorized by the state to practice medicine as part of a team of physicians. The PA is a graduate of an accredited educational program and is nationally certified and state-licensed to practice medicine with the supervision of a physician. PAs can perform physical examinations, diagnose and treat illnesses, order and interpret lab tests, perform procedures, assist in surgery, provide patient education and counseling, and make rounds in hospitals and nursing homes. All 50 states allow PAs to practice and prescribe medications.

The educational program for PAs is modeled on the medical school curriculum, with a combination of classroom and clinical instruction. The PA course of study is rigorous; the average length of a PA education program is 27 months.

NPs have been providing primary, acute, and specialty healthcare to patients for nearly half a century. According to the American College of Nurse Practitioners, NPs assess patients, order and interpret diagnostic tests, make diagnoses, and initiate and manage treatment plans, including prescribing medications. After completing master's degree programs, graduates are eligible to obtain professional certification as NPs. NP programs generally focus on one specialty area of nursing, and graduates generally choose to seek certification in the same specialty. The American Academy of Nurse Practitioners and the American Nurses Credentialing Center are two credentialing bodies that offer certifications in nursing. These certifications must be renewed every five years to continue development within the profession.

Although these practitioners may seem to be fulfilling the same role, the focus of their education is miles apart. Moreover, the PA requires supervision in accordance with state law while in many states, the NP can practice independently. This is important to note especially in the credentialing and privileging of these providers. We have found that hospitals do not always clearly distinguish between NPs and PAs. They may be “cousins,” but they are really “distant cousins” in both their roles and scopes.

Future installments of this series will discuss various issues the medical staff department may face or have questions about, including state laws, the FPPE and OPPE for APPs, and their relationship with physicians.
Myth #2: Department chairs must serve on the MEC

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Author’s note: Over time, many medical staff governance decisions have become commonplace, even the ones that are unnecessary. This series examines some of the more prevalent myths and misconceptions, delineates what is required and what is not, and offers trends and best practices for medical staff leaders.

One of the prevailing medical staff myths still floating around is that medical staff department chairpersons must serve on the medical executive committee (MEC). Because there is no absolute requirement for a MEC (as we discussed last month) or even for medical staff departments (as we’ll cover next month) there is no basis for this myth. So, where does it come from?

Most medical staffs historically organized themselves around clinical departments probably because academic training centers are organized that way, and it seemed a logical carryover. Under this model, the department chair, as leader of the clinical department, would represent the department on the MEC. When there were relatively few departments, this structure worked well, but as specialties arose and departments grew larger or, to the opposite effect, split into several specialty-specific departments, a whole new set of dynamics came into play. As specialties developed, so did differences of opinion about credentialing and privileging and diverse views about prioritization of hospital dollars, services, staffing, and equipment. Now, it’s common for hospitals to have between 10 and 20 medical staff departments, regardless of the hospital’s or medical staff’s size, accompanied by a bloated and generally ineffective MEC.

In this scenario, the MEC functions more like a house of representatives than an executive branch of medical staff governance. While this might be great for advocacy of special interests, it is not so great for decision-making.

Studies show that five to seven people is the most effective group size for decision-making. Even allowing a little fat—a group larger than 11 members—hinders effective decision-making. Seven to 11 members is large enough to gather a variety of opinions but is not so large as to shut down constructive give-and-take communication.

With all this in mind, we need to return to the question of why the MEC exists in the first place. The primary purpose is to have a body that can carry out the medical staff functions and make recommendations to the governing body regarding credentialing, privileging, and quality of care. This is the “executive” function. The “advocacy” function belongs elsewhere, and many new medical staff models are being developed to address these concerns (more next month).

To effectively restructure, leaders must engage in thoughtful and guided discussions about the requirements for an MEC and examples of emerging best practices. The requirements are easy. CMS does not require a MEC. The Joint Commission (MS.02.01.01) does require a MEC, but it states only that the majority of voting MEC members need to be physicians actively practicing at the hospital and that all members of the organized medical staff are equally eligible for membership on the MEC.

As for emerging best practices, there is a general movement toward a smaller and more efficient MEC (seven to 11 members). Members may be key department chairs or members-at-large from diverse specialties. Also, the chairs of key committees, such as the credentials and peer review committee, may be members with or without a vote. Some alternatives to clinical departments, such as clinical sections, clinical service lines, or dedicated paid physician leaders will be explored next month. Until then, be the best that you can be.