Physician performance improvement: Right framework for peer review

Editor’s note: This article is an excerpt from the new HCPro book, Effective Peer Review: A Practical Guide to Contemporary Design, Second Edition, written by Robert Marder, MD; Mark A. Smith, MD, MBA, FACS; and Richard Sheff, MD. For more information or to order a copy of the book, go to www.hcmarketplace.com.

The Joint Commission has tasked medical staffs with conducting ongoing professional practice evaluations (OPPE). To effectively implement OPPE, the medical staff must first decide how to measure physician competency.

OPPE and effective peer review is not just about measuring competency. It is also about responding to the data to improve patient care.

Measuring physician quality is often viewed as a difficult, if not impossible, task. However, other industries have found ways to measure quality. For example, consumer rating services view quality as the sum of several parts. When a consumer guide rates the quality of an automobile, it creates an overall quality rating by first determining the key performance areas that define a quality car and then rating each area.

Breaking down the vague concept of a “quality” car to comparisons such as engine size, acceleration, interior roominess, seat comfort, exterior design, amenities, warranty, and resale value allows for a more reliable estimate of quality than just a summary opinion.

To measure quality, quality must be defined in a measurable way. This may sound a bit circular, but defining the measurable dimensions of performance for a product or service allows you to measure quality.

Thus, to adequately measure physician performance, a comprehensive physician competency framework is needed. There are three steps to measuring physician competence:

- Select a competency framework
- Set specific competency expectations
- Define measures for competency, based on expectations

Step 1: Selecting a competency framework

The first step in choosing a framework is defining the aspects or dimensions of physician performance that are important to your medical staff.

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mortalities, low infection rates, appropriate medication use, and accurate diagnoses.

However, such expectations represent only one aspect of physician performance: technical quality of care.

A comprehensive framework goes beyond that to the broader definition of physician performance.

There are at least two well-developed frameworks for measuring physician competence. The first is a framework that was originally taught by Howard Kirz, MD, in courses offered by the American College of Physician Executives on managing physician performance in group practices, and later adopted by The Greeley Company, a division of HCPro, Inc., for use by medical staffs. In its current form, the framework is composed of six physician performance dimensions:

- **Technical quality**: Skill and judgment related to effectiveness and appropriateness in performing the clinical privileges granted
- **Service quality**: Ability to meet the customer service needs of patients and other caregivers
- **Patient safety/rights**: Cooperation with patient safety and rights, rules, and procedures
- **Resource use**: Effective and efficient use of hospital clinical resources
- **Relationships**: Interpersonal interactions with colleagues, hospital staff members, and patients
- **Citizenship**: Participation in, and cooperation with, medical staff responsibilities

The second framework, called the general competencies, was developed by the Accreditation Council for Graduate Medical Education (ACGME) and adopted by the American Board of Medical Specialties and The Joint Commission. It was created to define methods for evaluating resident competency during training that go beyond measuring technical skills.

This framework also has six categories, which The Joint Commission has defined as follows:

- **Patient care**: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, for the prevention of illness, for the treatment of disease, and at the end of life
- **Medical knowledge**: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and to apply their knowledge to patient care and the education of others
- **Practice-based learning and improvement**: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care
- **Interpersonal and communication skills**: Practitioners are expected to demonstrate interpersonal and communication skills that enable them
A closer look at competency frameworks

Although it may seem obvious that your medical staff should adopt The Joint Commission framework, particularly if you are Joint Commission–accredited, you actually have a choice as long as your framework is comprehensive and covers the same issues.

How do you decide which framework would be best for your medical staff? In our discussions with medical staffs across the country, the following reasons were identified to use the Joint Commission and Greeley frameworks.

The Joint Commission framework

Telling the medical staff that the framework is a Joint Commission requirement will minimize debate and aid adoption. (Note: Some physician leaders expressed that it would have the opposite effect for their medical staffs.)

Because residents coming out of training programs are familiar with it, this framework will provide better continuity for the future.

Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development and ethical practice, an understanding of and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society

Systems-based practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided and the ability to apply this knowledge to improve and optimize healthcare

The ACGME initially defined six competency categories and subsequently created specific expectations to be measured in each category. The Joint Commission has adopted the six definitions almost verbatim, but has yet to define the measurable expectations.

For hospitals with training programs, the attending physician will at least be familiar with it.

The American Board of Medical Specialties will be looking at the same framework for board recertification.

The Greeley/American College of Physician Executives framework

This framework has been used for more than 10 years with attending physicians on hospital medical staffs.

The categories seem more appropriate and the terms more understandable to many attending physicians.

Many medical staffs have already defined expectations for this framework.

By simply creating a crosswalk of how these categories relate to the Joint Commission framework, you can have a framework that medical staff members understand and you will only have to explain it to the Joint Commission surveyor once every two or three years.

The sidebar above describes the reasons for choosing each framework. This should be done through an active discussion at a medical executive committee meeting, not as a passive rubber-stamp approval of your hospital and medical staff performance improvement plan. Then, this framework should be incorporated into your medical staff policies and measurements. Examples of how to do this are provided in later chapters of this book.

Whichever framework you choose, if you are accredited by The Joint Commission, you must adopt a comprehensive physician competency framework to meet its standards. If you are not Joint Commission–accredited, you still should adopt a physician competency framework because it is a best practice and will provide the basis for rational physician competency measurement.

Step 2: Setting specific competency expectations

Once the framework has been defined, the next challenge is to decide the specific expectations that would

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best help your physicians understand how to achieve excellence in all areas of competency covered by the framework. Instead of creating a laundry list of expectations, use your framework as a differential diagnosis to ensure that you develop expectations for the performance dimensions that are most important.

How do you develop these expectations? In general, expectation statements should be relatively broad. The specific measures will define the expectation more precisely. The most important thing to remember is that most expectations should be measurable.

For example, for The Joint Commission’s patient care competency, or the Greeley Company’s technical quality dimension, one expectation could be as follows:

Achieve patient outcomes that meet or exceed generally acceptable medical staff standards as defined by comparative data, medical literature, or peer review activities.

This expectation could be measured by severity-adjusted outcomes data (e.g., mortality, complications, etc.) or by individual case review for unexpected deaths.

Although every expectation does not need direct measurement, keeping the need for measurement in mind when you are describing your expectations will make them easier to define.

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### Step 3: Defining measures for competency based on the expectations

Once the specific expectations are set, the real challenge is to measure them. Some physicians may use expectation statements to guide their approach to patient care and not require any measurement to spur performance improvement. These physicians are similar to drivers who always follow the posted speed limit.

However, for some (if not most) individuals, measurement is necessary to ensure improved performance. For example, although speed limit signs are posted on most roads, we still have police officers who measure performance (and sometimes provide feedback in the form of a speeding ticket). Otherwise, many individuals would likely not comply. In healthcare, when practice guidelines were first measured regarding prescribing ACE inhibitor medications at discharge for patients with congestive heart failure, most physicians thought they were in compliance. Then they received their performance data. Despite good intentions, many physicians were surprised to find that they were routinely performing at a lower level than they had assumed.

Because of the broad definition of physician competence, the methods for measuring expectations will vary and may go well beyond the traditional use of patient charts.

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Burnout is more than a bad day—or several days—at the office. It is a serious syndrome that can manifest itself through impaired job performance and poor health, including headaches, sleep disturbances, irritability, marital dysfunction, fatigue, hypertension, anxiety, depression, and heart attack. Burnout may also lead to alcoholism, drug addiction, or even suicide. But you can help your medical staff by acknowledging the risk of burnout and helping them take steps to prevent it.

John-Henry Pfifferling, PhD, an applied anthropologist and director of the Center for Professional Well-Being in Durham, NC, describes burnout as a grief process in which physicians typically experience a “death” of expectations. Such losses can include:

- A lack of expected autonomy
- Respect as a professional
- Appreciation from patients or colleagues
- A satisfying personal life

Physicians who suffer from burnout experience stages similar to those of the grieving process, Pfifferling says. “Every individual is different, but there’s some denial, bargaining, anger, and a movement to resolution over time.”

Risk is rising

Although burnout is not a new phenomenon, physicians’ risk increases as medicine becomes more complicated, says Anderson Spickard Jr., MD, medical director of The Center for Professional Health at Vanderbilt University Medical Center in Nashville. Today’s physicians have to fill out more forms, be more conscientious about documentation and regulatory compliance, and attempt to run profitable businesses in the face of decreasing reimbursement, higher overhead costs, and greater patient expectations, he says.

Medicine has become so complex that Spickard says he expects to see more physicians fall out of the healthcare system and retire early—unless hospitals create systems to preserve physician well-being.

“Medical schools and residency programs have to provide a realistic understanding of what [students] are getting themselves into,” he says. “They probably stop short of really defining what the issues are around running a practice.” As a result, the exhaustion, cynicism, and distress of burnout often strike physicians during the prime of their careers.

At the Center for Professional Health, which offers continuing medical education programs for distressed physicians, Spickard finds that physicians who work in small group practices, particularly in rural communities, are especially prone to burnout. “They’re more at risk because of the lack of support systems,” he says. For example, it’s all too common for a solo practitioner in a rural community to be the only physician taking call. In addition, solo providers are more likely to see high numbers of patients (40–50) per day, which also intensifies burnout risk. Physicians in such circumstances owe it to themselves to network with other providers so they can find additional coverage when they need it, Spickard says. That is where medical staff leaders and hospitals can step in.

Complicating factors

However, physicians by nature have difficulty asking for help. Common physician personality characteristics include perfectionism, isolationism, the need for control, and an overdeveloped sense of responsibility, says Larry Vickman, MD, MHA, FACEP, FACPE, director of the professional counseling firm The Vickman Group, a consulting practice focused on physician well-being, burnout, and individual assessments and counseling.

In addition, physicians often aren’t interested in guarding themselves against burnout until they find themselves or colleagues in the midst of it, Vickman says. “We don’t get worried about it until a couple of doctors hit the wall

Help staff members avoid burnout by identifying risk

Keep physicians healthy for longevity and effective care

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and commit suicide.” In addition, many at-risk physicians still believe that burnout can’t happen to them. But the personalities of those who become involved in medicine and their ensuing training and socialization to live up to high expectations add up to a huge “watch out,” says Vickman. “It’s an ongoing risk for those of us who are in [medicine].”

Stay-well strategies
The first step in reducing that risk of burnout is overcoming denial, perhaps by looking at the issue in clinical terms. For example, physicians can vaccinate patients for chicken pox, measles, etc., to protect them from the ravages of disease, Vickman says. Why not devote some attention to education, self-care, and building a support network to protect physicians from losing passion for their work and damaging their personal life? Our experts offer the following strategies to protect your medical staff against work stress and burnout:

1. Take time out. During a physician’s career, he or she probably offers more than a few patients the sage advice to relax. But it’s difficult for physicians to practice what they preach. However, self-care must be a priority, Pfifferling says. Encourage physicians to not let their schedule control and exhaust them. Physicians need a moment of quiet.

One strategy physicians can use to incorporate downtime into their day is to schedule “phantom patients,” says Pfifferling. Physicians can use these 20–30 minutes to recharge, do some unhurried research, or even eat lunch. Of course, “free time” would be a misnomer, because a physician’s livelihood depends on the number of patients he or she sees each day. So physicians should begin by scheduling only one phantom patient per week. Physicians may then find themselves with more energy to take on tasks. After three months, physicians should assess the return on this time investment and decide whether to take time out more or less often.

2. Stop saying sorry. Many specialties, such as obstetrics, require physicians to attend to emergencies at the hospital when they may have patients waiting in the office. If this is the nature of the physician’s practice, he or she should inform patients of this up-front. For example, the physician should provide patients with a letter explaining all of the circumstances in which he or she may be late (e.g., to deliver a baby) for an appointment and thank them for their understanding.

By giving patients this document, the physician saves time that he or she would spend apologizing to waiting patients—and the guilt that comes with this, Pfifferling says. The physician’s staff can help, too. At one obstetric practice he works with, staff members ask patients to provide a phone number where they can be reached three hours before their appointment. Then, if a physician is running late for some reason, the employee can call and explain the situation to the patient and offer the option of coming in a little later or rescheduling. This technique shows patients that the physician respects their time and also alleviates the pressure on physicians.

3. Learn to set limits. It’s easy to get caught up in giving too much. For example, surgeons may take on more cases than they’re comfortable with because referring physicians tell them they’re the only one with the right expertise, etc. Often, this fans physicians’ egos and they give in, Vickman says. Instead, physicians should try saying. “Thank you for the compliment, but I really can’t do it.”

Avoid burnout < continued from p. 5

A number of organizations specialize in counseling physicians and other professionals suffering from burnout. Here are just a few:

- The Center for Professional Health and Well-Being—www.cpwb.org
- Vanderbilt Medical Center for Professional Health—www.mc.vanderbilt.edu
- The Vickman Group—www.thevickmangroup.com
4. **Write about it.** When physicians free-associate—write down their thoughts as they come to them—they are often shocked to see how much is really on their minds, Vickman says. “This stuff swims around in our heads and hearts, and something happens when we put it down on paper and look at it.” Often, journaling can help free physicians from these thoughts, at least during their personal time, to make mental relaxation much more possible.

Reading their journals may also give physicians the perspective to assess their situation objectively, he says. For example, if a physician writes down everything he or she needs to take care of the following day, his or her to-do list might not look as intimidating. Or, the journal may help the physician recognize more serious signs of distress and give him or her the insight to take action.

5. **Take a real break.** If a physician feels work stress mounting to the point where he or she is considering leaving medicine, it’s time to take a step back, Vickman says. “The doctor who says, ‘I’m going to quit OB/GYN and start making pots and weaving baskets,’ is probably doing something pretty reactive. You can’t make a decision when you’re under the heat of the gun.”

Vickman recommends an extended period of time off—perhaps a month or more.

However, simply taking a sabbatical or vacation will not address the underlying problems. “Just stopping doesn’t fix it. You’ve got to come up with a plan and be willing to do some work,” Vickman says. The physician must find help in defining and addressing the problem with the guidance of mentors or counselors (see “Physician wellness resources” on p. 6).

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**Readers share budget figures: MSO survey results**

There’s more than one way to slice up a medical staff office (MSO) budget. That’s what **MSB** found when we asked our readers how much money they have to spend and how they spend it.

**MSB**’s survey shows that most MSO budgets (70%) are higher than $11,000, and that of the 44 MSPs who took part in our online survey, most mentioned four spending items:

- Education (86%)
- Travel (84%)
- Books (86%)
- Seminar attendance (84%)

Audioconferences (73%), leadership training (57%), and doctors’ day events (57%) were also high on respondents’ spending choices. Only 30% spend their money on orientation.

The list of what MSO budgets fund is diverse, including NFL and NBA tickets, on-call pay, and office supplies. In the “other” category of responses for how MSPs spend money, nine (20%) reported expenses for office supplies, six (14%) reported spending some of their budget on food (for meetings, for the doctor’s lounge, etc.), and five (11%) reported using part of their budget for verification and credentialing.

Just three of 44 respondents who took part in the online survey listed an MSO budget of $1,000 or less, and 14% listed a budget between $3,001 and $5,000.

Three respondents reported a budget between $5,000 and $7,000, and one MSP reported a budget between $8,000 and $11,000. However, if you think your budget is small, think about the one respondent who reported no specific MSO budget at all.

**Who holds the purse strings?**

Decision-makers for budget spending are varied, with more than one person or department often involved and several combinations of MSPs, administrators, and boards taking part (which is why the results here add up to more than 100%). More than half (52%) of respondents reported that budget expenses are decided by the director.

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Budget survey  < continued from p. 7

of medical staff services. One-third of respondents reported that the MSP or the vice president of medical affairs (VPMA) makes spending decisions, and 43% reported that hospital administrators are in charge. About 11% reported that credentials coordinators write the checks.

When asked who determines budget levels, MSPs gave varied responses, including the hospital board and chief financial officer (CFO). In more than one case, CEOs or CFOs set the budget. About 44% report that medical staff directors, managers, and coordinators are either in charge of or part of setting budget levels.

In the trenches

At RHD Memorial Medical Center in Dallas, directors set the budget initially, and then administrators approve it, says John Pastrano, BBA, CPMSM, CPCS, director of medical staff services for the hospital. However, the office also funds its activities by charging application fees to staff who will be appointed or reappointed.

“That can help ease the burden on the hospital,” says Pastrano, noting that those funds are usually earmarked for verification and credentialing costs.

Although Pastrano tries to anticipate budget needs, costs usually arise that he didn’t consider, such as a national or regional conference that he didn’t know about or a new software upgrade. In those cases, “you sometimes have to go and beg and plead for the extras,” he says.

However, RHD’s MSO is fortunate “because medical staff services here are recognized as important,” says Pastrano. Joint Commission and Centers for Medicare & Medicaid Services regulations and requirements for medical staff services helps, he says, “since compliance with these standards is important.”

Working within the system

Melissa Walters, BSHA, CPMSM, CPCS, manager of medical staff services at Kettering (OH) Medical Center, says that her MSO budget is set by senior hospital administrators.

Walters’ facility uses the Premier Group’s Operations Outlook productivity benchmarking system to determine how many full-time employees her office needs, based on the number of practitioners they credential. Currently, that level funds four full-time and one part-time employee, she says.

Walters’ budget is spent on travel, education, memberships, physician stipends, books, journals, and supplies, she says. But her department must justify expense requests. First, they build a “wish list” and submit it to the VPMA and the finance department.

The CFO, budget manager, decision-support office, and operational design personnel then review the budget requests, going through the budgets line by line and making adjustments.

Walters says her budgeting process is fair and that her organization is open to hearing arguments on funds that decision-makers may not be keen on allowing.

“We feel like we are heard—and not just by our vice president, but by our CFO. We get face time with him and know that he will be able to present our needs accurately to the corporate organization and the board for approval,” Walters says. “We have won a battle or two. But because medical staff offices are a cost center, not a revenue-maker, it can be hard to get budget increases.”

This year, Walters’ VPMA cut $850,000 from her overall budget, including cuts in Walters’ office. However, because her administration is “very pro-physician,” Walters says she knew physicians would still receive funds to grow their skills, advance their leadership ability, and remain satisfied.

“If I tell them I need something for the physicians, I usually get it,” Walters says, noting that if unanticipated costs come up, she can often find money somewhere.

“As long as I come out on or under budget, I’m okay,” she says. “If the physicians tell me they want to have a guest speaker for something, and I didn’t budget for it, I can go ask. They are happy to do anything for the physicians.”
Improving physician-hospital relations: A step-by-step approach

Step 7: Hold regular meetings and retreats

by William K. Cors, MD, MMM, FACPE, senior consultant, The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

After discussing the concept of social capital in Step 6 last month, it seems appropriate to look now at the importance of social interaction for a healthy medical staff.

In his exploration of the collapse and revival of American community, Harvard academic Robert Putnam describes social capital as the grease that lets the wheels of community advance smoothly. He suggests that people are more trusting and trustworthy when they repeatedly interact with fellow citizens. In turn, the cost of everyday business and social transactions decreases when less time and money are spent to make sure others uphold their end of an agreement. Although the importance of informal communication cannot be dismissed, this type of interaction misses the essential point that trust grows from structured access. This can present a problem for physicians and hospital management, who often conduct business on the fly in the hallways.

Medical staffs must take note that a successful relationship is characterized by thoughtful development and implementation of multiple points of structured access between physicians and a hospital. Like a well-crafted and executed strategic plan, channels and venues of communication must be developed, tested, implemented, and hardwired into the business practices of the organization.

The following communication best practices seen in some organizations should serve as examples as you take steps to formalize communication at your hospital:

➤ A biweekly lunch of the hospital’s “C-suite” (CEO, chief medical officer [CMO], chief nursing officer, and chief operating officer), where key medical staff leaders discuss issues on an ongoing basis.

➤ A biweekly coffee meeting between the hospital CEO and CMO and the president/chief of the medical staff and vice president/vice chief of the medical staff.

➤ The hiring of a director of physician relations who, using the pharmaceutical representative model, reports directly to the CEO and looks for opportunities to improve relations.

➤ A biannual off-site retreat of the hospital board, administration, and medical executive committee, with a portion of each meeting devoted to education on collaboration.

➤ Annually, the hospital sends a board member, a hospital administrator, and a few physicians to a national meeting on medical staff and hospital governance and leadership. After ten years, a pipeline of leaders versed in contemporaneous healthcare issues will emerge.

➤ A leadership training academy developed jointly by hospitals and physicians with a defined curriculum and staffed by expert external faculty.

➤ An annual hospital employee picnic for physicians and their families.

➤ Structured but informal physician-hospital social activities, such as an early evening wine-tasting event, postholiday “cocktail hour,” or nonfundraising day of golf, tennis, or swimming.

Why make this investment? Trust grows from structured access. Social capital allows the resolution of collective problems in an economic fashion. More important, it allows physicians and hospitals to widen their awareness to see myriad ways in which their fates are linked and how they can help one another to achieve their goals.

Until next time, stay well and be the best that you can be.

Questions? Comments? Ideas?

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Confusion over sharing NPIs

**MSPs concerned about compliance**

When the Centers for Medicare & Medicaid Services (CMS) extended the May 23 deadline for National Provider Identifier (NPI) compliance in April, they didn’t stop encouraging health professionals who already had the new identifiers to use them.

Many MSPs wonder if they have the right—or obligation—to disclose physicians’ NPIs to other healthcare entities.

It may seem logical for medical staff offices (MSO) to share NPIs (which are 10-digit identifiers that providers use to process electronic claims and other transactions) with referring hospitals, pharmacies, or other healthcare entities. NPIs will be used in the same way as current identifiers, such as unique physician identification numbers (UPIN). But there is confusion in the industry regarding how staff should share NPIs.

By May 2008, NPIs, which do not contain provider information such as their states or specialties, will replace all other identifiers currently in use. CMS had scheduled strict enforcement of NPI regulations to start by May 23, but announced on April 2 that it would give the industry a year to adjust because of a lack of readiness. The NPI provision will require all insurance claims from providers to include an NPI.

**John Reiss, PhD, JD,** a partner in the Philadelphia law firm Saul Ewing, LLP, says there is no reason why MSOs should not share the NPIs—regardless of whether the physician has signed a release.

“[The MSO] could make it a condition of the medical staff bylaws that the physician consents to the release of NPIs,” says Reiss. “Most physicians I know are reluctant to sign a release about anything, and I don’t see why they should [sign a release for NPIs].”

Reiss says MSPs can simply issue a policy stating that they must release NPIs for patient referrals and billing purposes.

“All they have to do is make a policy statement that if you are a member of this staff or hospital or clinic, then your number is going to be shared when there’s a patient need to do so,” Reiss says.

Reiss suggests that the release of NPIs could require signed consent in some cases, such as when outside agencies request them in conjunction with clinical trials or other research.

“If [MSPs] start releasing the numbers for purposes other than patient care, then yes, they’ve got a problem,” says Reiss. “If there’s a research issue—a clinical trial or that sort of thing—then that might be a reason to get permission, and they better be careful.”

When in doubt, use caution

**Dianne Bryant, CPCS,** medical staff coordinator at Blount Memorial Hospital in Maryville, TN, is cautious about releasing NPIs. When a pharmacy or referring physician calls her for one, she gives the provider’s telephone number instead, so the physician can provide their own NPI.

“To be honest, it’s no different for me to look up a phone number than it is to look up an [NPI],” Bryant says. “If they get the NPI from the physician office, then it looks to me that we’ll all be doing what we’re supposed to be doing.”

Bryant is relying on CMS’ Disclosure of National Provider Identifiers by Health Care Industry Entities to Other Health Care Industry Entities, posted on the CMS Web site (www.cms.hhs.gov/NationalProvIdentStand/Downloads/NPIdisclosures.pdf) in April, to dictate how she handles NPI requests.

“What if I have a CMS auditor who comes in and hands me this disclosure statement?” says Bryant. “I’m only not [sharing NPIs] because of what the disclosure
says. I’m not worried the [physicians] would file a lawsuit. I just want to make sure that if I’m audited, I’m doing it correctly.”

It’s the last paragraph of CMS’ Disclosure that has MSPs such as Bryant taking steps to protect privacy. It reads:

“We encourage healthcare industry entities who plan to make disclosures described above to ensure that the affected healthcare providers are aware beforehand of these plans and that the affected healthcare providers do not object to such disclosures. If disclosures are made without the affected healthcare providers’ knowledge or consent, the entities making the disclosures could be faced with adversarial actions on the part of any or all of the affected healthcare providers.

However, it appears that CMS expects NPIs to be shared with healthcare entities with which providers already work, as well as with health plans that request the NPIs.

Legal interpretations may differ

Vanessa Hosbach, CPCS, medical staff coordinator at Warren Hospital in New Jersey, is also cautious about having physicians sign release forms allowing MSPs to give out their NPIs to any requesting facility or physician.

“[The Disclosure] means you have to let them know first,” Hosbach says. “By having a release on file showing that they agreed to disclose it, we can show that as proof.”

Noreen Sommer, CPMSM, coordinator of medical staff services at St. Clair Hospital in Pittsburgh, has fielded about a dozen requests for NPIs, mostly from nursing homes, insurance providers, and doctors’ offices. Her staff is sharing NPIs without requiring a release form from providers.

“We have talked with our legal counsel and corporate compliance office, and that is what they recommended,” Sommer says.

Sommer’s process for sharing NPIs has been informal, usually by phone or e-mail, but St. Clair has no plans to post the numbers online, despite talk of CMS’ plans to eventually do so.

“Until they start posting [NPIs] on the CMS Web site, we’re not going to put them on our Web site,” Sommer says. “Once they’re available there, we’ll put them on our site. If an entity requests them or a doctor requests them, we make it available.”

Arduous process

Although getting an NPI is easy for healthcare providers, logging the new numbers into a system and retrieving signed releases can be time-consuming.

Warren needs NPIs for 221 physicians and 26 AHPs who are on staff and another 1,200 providers who are not on staff.

As a result, Hosbach says staff members have formed an NPI subcommittee and logged at least 200 hours since...”
NPIs  < continued from p. 11

January entering the numbers in her system and getting signed releases returned.

“Once you get their NPI, you have to look up their specialty, license number, and taxonomy codes in order to put them in the system,” Hosbach says.

Get it, share it, use it

According to CMS’ Web site, providers who are covered entities under the Health Insurance Portability and Accountability Act of 1996 must share their NPIs with any entities that need the numbers for billing, “including those who need them for designation of ordering or referring physician(s).”

“Providers should also consider letting health plans, or institutions for whom they work, share their NPIs for them,” reads an April 24 post on CMS’ NPI Standard site (http://www.cms.hhs.gov/NationalProvIdentStand).

In the Disclosure, CMS also advises healthcare entities to check state law before setting disclosure policies. Brian Annulis, JD, a partner in the Chicago law firm Katten Muchin Rosenman, LLP, says he does not know of any state regulations that would affect the disclosure of NPIs for patient care purposes.

However, Annulis does advise MSPs to work with physicians, billing staff members, administrators, and legal counsel to develop policies about sharing NPIs by considering potential scenarios tailored for their individual institutions.

In its MLN Matters newsletter number MM5595, CMS encourages staff to share NPIs, telling physicians, “You should also make sure that your billing staffs begin to include your NPI on your claims as soon as possible.”

Consultant Vicki Searcy, CPMSM, practice director of credentialing and privileging for The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, also suggests establishing a policy that is approved by the medical executive committee after review by legal counsel and includes the following:

- Confirm that a provider signs a waiver and release when he or she applies for medical staff membership and/or clinical privileges. This waiver and release should cover the release of routine information.
- Describe the data maintained in the credentialing database, including a practitioner’s name, office address, home address, cell phone number, birth date, social security number, and NPI number.
- Specify what information to share (data element by data element) and with whom it can be shared. It may be easier to list information that can be shared only in specific cases, such as a practitioner’s social security number or a copy of the National Practitioner Data Bank report.

MSPs who provide physician NPIs are probably not going to face repercussions from CMS, Annulis says. “If you look at the global spirit of [NPI compliance], it seems to me it would be inconsistent to preclude the disclosure of this information.”

Annulis reiterates, however, that MSPs should follow a policy of judicious disclosure developed for their specific needs. “I wouldn’t counsel or recommend that [MSPs] just provide it willy-nilly to anyone who asks,” he says.

Upcoming audioconferences

July

Tips and tools to train your medical staff office staff—Learn from your colleagues how to train new staff to take on the many tasks assigned to the medical staff office. If you are the sole MSP in your office, learn tips and tools for quickly mastering the ins and outs of your job.

Credentialing software tools: Ensuring your purchase is a future-proof investment—Now that you’ve won approval to purchase credentialing software, you are struggling to understand the differences between the various products on the market. Our credentialing experts give you the tools you need to choose the right software for your office.
Dear MSB subscriber,

As you open this month’s issue, you will notice that Medical Staff Briefing (MSB) is sporting a new look. We hope you’ll agree that it’s a positive change. Our new design aims to allow for easier reading and absorption of information.

We’re committed to making sure that MSB continues to deliver the expert advice medical staff leaders and medical professionals need. Your suggestions and feedback are extremely valuable to us, and we want to hear from you. Please feel free to drop me a line at any time.

In the meantime, enjoy MSB’s brand-new look!

Sincerely,

Erin E. Callahan
Executive Editor
Phone: 781/639-1872, Ext. 3205
E-mail: ecallahan@hcpro.com
How to get the most from your
June 2007 Medical Staff Briefing

Physician performance review
For a dynamic excerpt from the new HCPro book, Effective Peer Review: A Practical Guide to Contemporary Design, Second Edition, written by Robert Marder, MD; Mark A. Smith, MD, MBA, FACS; and Richard Sheff, MD; turn to p. 1.

Physician burnout
The risk of physician burnout is growing. Find out what medical staff leaders can do to keep healthcare providers healthy for the long term on p. 5.

Medical staff office budget survey
Where does your budget rank, and who decides how to spend it? See the results of our online poll on p. 7.

Improve physician-hospital relations
The column by William K. Cors, MD, MMM, FACPE, continues with the importance of holding regular social functions to keep communication flowing. See p. 9.

National Provider Identifiers
A growing number of MSPs wonder if signed consent is needed to release the new provider identifier numbers used in billing and referral processes. Learn more on p. 10.
| **MAY** | **MGM GRAND HOTEL & RESORT | LAS VEGAS, NV** |
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| 2 | Core Privileging Essentials: Advanced course in criteria-based design and implementation |
| 3–4 | Association for Healthcare Accreditation Professionals Conference |
| 3–4 | Hospital Safety Symposium (Sponsored by *Briefings on Hospital Safety*) |
| 3–4 | The 10th Annual Credentialing Resource Center Symposium |
| 5 | Patient Flow Solutions: Five big issues you can tackle today |
| 5 | Physician Competency Data (Cosponsored with ACS MIDAS+) |

| **JUNE** | **THE WESTIN SAVANNAH HARBOR GOLF RESORT & SPA | SAVANNAH, GA** |
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| 14–15 | Medical Executive Committee Institute: The essential training program for medical staff leaders |
| 14–15 | Peer Review for Today: Practical solutions to make peer review effective, efficient, and fair |
| 15–16 | Surgical Chair Forum: Learn the skills to lead surgeons, collaborate with your hospital, and ensure a successful OR |
| 15–16 | Developing and Maximizing Your Hospitalist Program (Sponsored by *Hospitalist Management Advisor*) |

| **JULY** | **HILTON GARDEN INN | SAN FRANCISCO, CA** |
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| 9–12 | Survey Prep Boot Camp™—Long-Term Care Version |

| **SEPTEMBER** | **THE DRAKE HOTEL | CHICAGO, IL** |
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| 6–7 | Infection Control |
| 6–7 | Magnet Resource Center |
| 6–7 | Observation Status |
| 17–20 | Survey Prep Boot Camp™—Long-Term Care Version |

| **OCTOBER** | **INTERCONTINENTAL MARK HOPKINS | SAN FRANCISCO, CA** |
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| 6 | Patient Flow |
| 6–7 | Effective Residency Program Management: Administrators’ workshop |

| **NOVEMBER** | **THE RITZ-CARLTON | PALM BEACH, FL** |
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| 2–3 | Medical Executive Committee Institute: The essential training program for medical staff leaders |
| 3 | Core Privileging Essentials: Advanced course in criteria-based design and implementation |
| 4 | Contemporary Privileging Challenges: How to match privileges with competency |
| 4 | Physician, Hospitals, and ED Call: Effective solutions to shared problems |
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| 5–6 | Advanced Credentialing Retreat: Tackling today’s toughest credentialing challenges |

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