

Medical Staff Briefing

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INSIDE THIS ISSUE

P5 Social media guidelines

Struggling with what to include in your social media policy? This sample language will get you started.

P7 Criminal background checks

Patricia A. Furci, RN, MA, Esq., and Samuel J. Furci, MPA, talk about the variations between state and health system requirements for criminal background checks.

P10 California employs physicians

With the start of the new year, critical access hospitals in California will have the option to employ physicians.

P12 Naturally becoming a leader

How do the job functions required in medical staff services translate to leadership ability? Kathleen Tafel explains.

Be social, but stay out of trouble



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Last month, **Medical Staff Briefing** discussed how physicians can use social media to enhance their practices by communicating with current patients, attracting new patients, and sharing health tips with a large number of people quickly. But there can also be negative side effects associated with social media. Physicians are now being reviewed by patients online, through websites like Yelp, Healthgrades, and Vital. And unlike other business owners, physicians can get into serious trouble even by responding to reviews to defend themselves. Physicians also have to think twice (maybe three times) about any information they share involving a patient case, even if the information the physician has to share could benefit many other patients. This month, **MSB** asked experts to explain what physicians need to know about sharing health information and responding to reviews online.

Online reviews

Because people are pretty much free to post whatever they want on the internet, physicians are bound to receive some negative online reviews—ones that may or may not be based in fact. And when this happens, the natural human instinct is to defend oneself. However, physicians are advised not to say what they are thinking, even if they know a bad review stems from a misperception.

“It does not benefit a physician or healthcare entity to respond via social media,” says **Fatema Zanzi, Esq.**, partner at Drinker Biddle & Reath, LLP, in Chicago. “The better way to do it is to figure out how to address the situation with the patient directly. In-person interaction is always better than interaction via social media.”

It’s harder to decipher tone and intent in a piece of written correspondence, first of all. Also, responding to a review can put a physician at risk of violating the Health Insurance Portability and Accountability Act (HIPAA). For example, a patient could claim he or she wasn’t given the best medication to treat an illness, and if the physician responds with any information about the patient’s condition, that physician is revealing protected health information (PHI). According to **Lloyd Fisher, MD**, chair of the Massachusetts Medical Society’s Committee on Communications, even if a patient reveals information about his or her own personal health, physicians would still be in violation of HIPAA if they themselves comment on the patient’s health.

“It can be frustrating. ... A patient can say the physician misdiagnosed them, and the physician cannot say anything to set the record straight without violating HIPAA and confidentiality laws,” says Fisher.

What the physician can do is write a simple statement such as, “I am sorry to hear that you had this experience; contact me directly to see how we can remediate the problem.” This shows others reading the review that the physician cares about resolving the issue. As a next step, following up and talking to a patient in person can help the physician understand what part of the care was dissatisfactory and whether the issue is based on a misconception or something the physician actually did wrong. Although it is true that anyone can go online and write a review—patient or not—and that negative reviews are usually overly charged with emotion, physicians should not brush off reviews.

“You have to at least consider that they felt strongly enough to write the post,” says Fisher. “Could you have done anything to prevent that person from feeling the way they did? Sometimes the answer is no. The practice of medicine is about relationships, and some physician-patient dyads work and some don’t.”

To prevent patients from jumping on review sites when they are upset, **Nina Grant**, vice president, agency managing director/corporate partnerships for [Practice Builders](#), a healthcare marketing and

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consulting firm in Irvine, California, suggests health-care organizations create internal feedback systems. This gives patients the opportunity to express their concerns directly with the organization, while keeping the information internal. These feedback systems can also help with course correction. For example, if many patients start to complain about a practice's wait time, the practice probably needs to examine its wait time and see whether changes can be made. This in turn can prevent future negative reviews about the issue.

Physicians should either set up Google alerts for their name/organization or do a manual search on the internet. However, Grant finds that many physicians do not do this and instead choose to ignore online reviews. She warns that ignoring reviews will not make them go away, and even if physicians do not take their reviews seriously, consumers do.

"You can lose a lot of business if you just ignore it," says Grant.

In its [*Physicians' Guide to Social Media*](#), the Massachusetts Medical Society suggests physicians do the following to monitor and manage their online reputation:

- **Examine your current online presence.** Set aside a few hours to search your name and adjust your privacy settings on your social media platforms. It is important to remember that a platform's privacy practices can change often, sometimes without notice to users. Choose the most secure settings offered by each platform. Delete, when possible, any questionable social network posts in which you have been tagged at social events or in unprofessional settings.
- **Create a Google+ account.** Anything you post on a Google+ account will automatically rank higher in a Google search.
- **Set a Google alert.** The easiest and least expensive way to monitor online content about you or your practice is to set up a Google alert for a few key terms. (You need a Google account to set up an alert. If you don't have one, an account with a Gmail address can be created for free.)

You will receive email notifications when new content is published containing these terms.

- **Update your profile on key sites.** You should have an updated profile—including a flattering photo, your practice logo, and a few lines about your education and expertise—on Facebook, Twitter, Google+, and other major hubs and medical review sites. Also, be sure to update your profile and contact information on your state's medical board database and any databases of your specialty society. A large amount of the incorrect data found on the various doctor search directories is taken from publicly available state licensing board records.

Social media policy

Physicians must be aware of any policies their organizations have regarding social media and use of devices. Zanzi says both types of policies are becoming popular among healthcare organizations.

Some of the most common issues addressed in social media policies include:

- Not posting images or circumstances that make a patient identifiable
- Not talking about situations that involve patient care
- Acceptable use of personal social media accounts while at work

To see a sample policy, turn to p. 5.

"It is using common sense in a lot of ways when it comes to social media—not being so quick to use social media when you are at work. It can be a fine balance. You can use social media to do good, to talk about your practice, physician wellness, or other things that are relevant in thought leadership," says Zanzi.

Physicians should also be aware that potential patients or employers might pass over them because of what they see about the physician on social media. And while the use of privacy settings is recommended, keep in mind that no privacy setting is absolute.

“Consider it fair game,” says **Matthew Katz, MD**, member of the Massachusetts Medical Society Committee on Communications. “Hospitals may use [social media posts] to decide who to hire. It’s important for medical students and doctors to make strategic decisions about what to share online, and how to best use privacy settings.”

Another issue is whether it is acceptable to share direct social media connections with patients (e.g., friending a patient on Facebook). Fisher recommends weighing the risk-benefit ratio of doing so.

Tips for blogs

Done correctly, blogs can help your practice share expertise and knowledge with a large audience. Consider the following blogging tips from Practice Builders:

- If you have a niche, focus on it. It will help differentiate your practice and attract your target audience.
- Post entries that provide perspective and insight about your practice. In addition, make posts about current news or events related to healthcare and your specialty. Blog about general health information, patient health tips, new procedures, or anything else related to your practice and specialty.
- Post an assortment of professional and personal entries.
- The AMA’s Social Media Policy recommends using privacy settings to safeguard personal information and content to the fullest extent possible. Remember that any harmful or inappropriate actions or messages online can negatively affect your reputation among patients and colleagues.
- Stay HIPAA-compliant: Don’t post any patient-identifiable information on your practice blog, and maintain appropriate patient-provider boundaries. When interacting with patients online, be sure that patient privacy and confidentiality are respected and enforced.

Source: *Practice Builders* (www.practicebuilders.com).

Physicians should also be leery about commenting on posts that ask medical questions. Fisher points out that in real life, physicians have to be careful not to give medical advice when asked for it by friends and family. Writing out a diagnosis online is an even greater potential liability, even if doing so on social media might seem innocuous.

“When you are doing it online, it increases your liability because now there is a permanent record of that interaction. If someone asks for medical advice, you are establishing a patient-physician relationship and incurring some liability by giving advice,” says Fisher. “You obviously have to weigh the risk-benefit. If a friend asks on Facebook, ‘How can I get my baby to sleep through the night?’ my risk of responding is low. But if they are asking about medication dosage, those conversations should not be online, and you should encourage them to talk to their own physician.”

Remember, once something makes its way to the internet, it is there forever. “Assume anything you make digital is publicly discoverable,” says Katz.

Personal device policies are essential now that physicians can use their own phones, tablets, and computers to log in to their organization’s electronic systems. Organizations have to ensure these personal devices are secure, encrypted, protected with passwords, and able to be wiped remotely if lost. Although it might not seem worth the hassle to do so, the proper use of personal devices can greatly enhance patient care.

“If I am a radiologist, and I need to see an image, and it happens to be on my phone and I am on call, it should not prohibit providing care, but that information needs to be secure,” says Zanzi.

Being a thought leader

Again, physicians have to toe a thin line between being a thought leader and violating HIPAA.


“Doctors are highly respected in the U.S. because people expect us to be professional and conscientious,” says Katz. “Social media are very powerful ways to share stories, but our content is necessarily restricted from stories that involve colleagues or patients.”

Fisher adds that PHI doesn't just encompass a patient's name or date of birth—rather, PHI is any piece of information that would make the patient identifiable by a third party. A physician violates HIPAA simply by stating that a particular person is his or her patient. If a physician has only treated a handful of patients for a condition and lives in a small town, it would be fairly easy for other people in that town to identify whom the physician is referring to when describing a case. However, if a pediatrician sees hundreds of patients a month and discusses an ear infection case, the pediatrician could likely de-identify the case enough to be able to discuss it. Every circumstance is different, says Zanzi, and physicians must consider whether a discussion could allow the public to deduce the identity of the patient involved.

For physicians who don't want to worry about violating HIPAA, they can instead engage in discussions on broader issues such as healthcare policy, liability reform, payment reform, or general health tips. They can also share information about trending issues. For example, Fisher, who is a pediatrician, has been trying to educate the public about vaccinations.

The Federation of State Medical Boards states that

physicians using social media and social networking sites are expected to observe the following ethical standards:

- **Candor:** Physicians have an obligation to clearly disclose any information (e.g., financial, professional, or personal) that could influence patients' understanding or use of the content offered on any website providing healthcare products, services, or information.
- **Privacy:** Physicians have an obligation to prevent unauthorized access to, or use of, patient and personal data and to ensure "de-identified" data cannot be linked back to the user or patient.
- **Integrity:** Information contained on websites should be truthful, not misleading or deceptive. It should be accurate and concise, up-to-date, and easy for patients to understand. Physicians using medical websites should strive to ensure the information provided is supported by current medical peer-reviewed literature, emanates from a recognized body of scientific and clinical knowledge, and conforms to minimal standards of care. The information should clearly be labeled to indicate whether it is based on scientific studies, expert consensus, professional experience, or personal opinion. 

Social media guidelines

The following policy is adapted from the University of Rochester (New York) Medical Center.

Before engaging in blogs, Facebook, and other social networking sites, remember that the basic principles and policies that apply to your professional life also hold true in online forums. The guidelines below offer examples of how existing policies play out in the realm of modern communication platforms:

- Personal use of social networking sites should be limited to non-work time, and should not interfere with your work or the mission of the University.
- Do not share confidential or proprietary information about the University or its affiliates.
- In keeping with HIPAA regulations, never use or disclose Protected Health Information without official, signed consent from the patient or research subject. Even a casual reference—such as the fact that you were a patient's nurse—amounts to a HIPAA violation, since it acknowledges that an individual was or is hospitalized. These rules apply even when a patient was specially profiled on (or if the patient directly posted a comment on) a University blog or Facebook page.
- Also in compliance with HIPAA privacy law, never post or publish photos relating to your patients or their care. Remember, even references to the care of a patient who is not identified by name, but who is identifiable to your coworkers or others in the University community (due to

Social media guidelines (cont.)

knowledge of circumstances), are problematic. In fact, in general, we encourage you to err on the side of caution and refrain from even vague references to patient care duties, given the potential for HIPAA violations.

- Use a personal email address (not your “urmc.rochester.edu” address) as your primary means of registering for entry into social media platforms.
- Personal use of social networking sites should not violate University policy as it relates to coworkers, supervisors, or other members of the University community. For example, social media should not be used to post comments or references to coworkers, supervisors, or patients that are vulgar, obscene, threatening, intimidating, or harassing (i.e., all examples of misconduct under the University’s corrective discipline policy, Policy 154), or a violation of the University’s workplace policies against discrimination, harassment, or hostility on account of a protected class, status, or characteristic (e.g., age, disability, race, religion, sex, etc., under Policy 106). Behavior violating such policies can result in discipline.
- In some instances, the personal opinion of a University faculty and staff member (who directly or indirectly identifies themselves as a member of the University community) could be misconstrued as an official University stance. In those circumstances, we strongly urge you to use this disclaimer: “The views expressed on this [blog; website] are my own and do not reflect the views of my employer.” We suggest including this language in an “About me” section of your online profile.
- If discussing University or University-related matters over the Internet, we encourage you to specify your connection to the University, use good judgment, and strive for accuracy in your communications. Errors and omissions reflect poorly on the University. Again, to avoid confusion, it’s always prudent to distinguish between your personal views and an official University position.

- Clinical caregivers should not provide consultation or medical advice online; in the same vein, we encourage caregivers to avoid muddying professional duties with personal social media accounts by “friending” or connecting with patients online.
- Some of the information you post online may be available more broadly than you expect (social media platforms are often less private than they seem), and could potentially be misconstrued. Since patients and the community see our faculty and staff as extensions of the organization itself, we advise you to exercise good judgment and take personal and professional responsibility for your online behavior. Consider the sage adage of “pausing before posting” to think how your message or photo might be perceived by the general public. Remember, even once comments are deleted, and tweets are “recalled,” it’s practically impossible to completely erase content once it’s been published in cyberspace.
- Do not publish or post false information about the University, its employees, its patients, or its affiliates.
- Be courteous and professional when interfacing with the University’s corporate social media platforms such as our official Facebook sites, Twitter feed, YouTube channels, etc.

A good rule of thumb: If you would not want a broad audience to see comments you share online, you might not want to post them to the Internet.

Please note that nothing in these guidelines is intended to prohibit employees from communicating in good faith about wages, hours, or other terms and conditions of their or their coworkers’ employment.

EDITOR’S NOTE

This is an excerpt from *The Residency Coordinator’s Handbook*, Third Edition, by Ruth Nawotniak, MS, C-TAGME.

Criminal background checks

by Patricia A. Furci, RN, MA, Esq., and Samuel J. Furci, MPA, principals at Furci Associates, LLC, in West Orange, New Jersey. They may be reached at info@furciassociates.com.

Criminal background checks are often conducted by hospitals during the initial hiring process or, in some cases, for specified types of healthcare providers. While many states require criminal background checks as a condition of initial licensure, healthcare organizations may establish policies that go beyond state law.

The Federation of State Medical Boards (FSMB) notes that 45 state medical boards conduct criminal background checks as a condition of initial licensure. Beyond these checks, 39 state medical boards require fingerprints as a condition of initial licensure. Further, 43 state medical boards have access to the FBI database (FSMB, 2016).

In 1998, the FSMB recommended that state medical boards conduct criminal checks on physicians seeking full or partial licensure; however, not all states have followed suit. Further, how information in criminal background checks is handled by states and healthcare organizations can vary.

According to an *American Medical News* article, “Physicians with criminal records may be denied a license, have restrictions placed on their practice, or face no repercussions, depending on the will of the board in a particular state” (“Criminal background checks provide patchwork protection against rogue doctors,” 2012). This disparity is not unlike the variation we’ve spoken about when comparing actions taken by medical boards from state to state.

Although more state medical boards have begun requiring criminal background checks as a condition of initial licensure, organizations such as the AMA and Public Citizen have pointed out that state medical boards do not consistently conduct criminal background checks on all physicians applying for a medical license (Greene, J. (2001, November 5). “Few licensing boards conduct criminal background checks.” *American Medical News; Health Matrix*, 16(335), Summer 2006).

Background

Although state medical boards have increasingly pursued criminal background checks on physicians in the past 15 years, states still do not use this information in a consistent fashion. In some states, those found to have a criminal record may be denied a license; other states may only face restrictions, while still others impose no repercussions. Currently, 39 states require fingerprinting, whereas only seven states required it some 10 years ago (Physicians Weekly (2012, April 3). “Criminal background checks on docs increasing.”).

State medical boards’ websites provide a variety of valuable information on physicians’ activities in that state known as “physician profiles.” These profiles are available at no charge and usually include a physician’s licensure status and disciplinary history; more comprehensive profiles may include full board orders of disciplinary actions, malpractice judgments/settlements, and criminal convictions (FSMB, 2014).

Although physicians are regarded in high esteem by society, there are a number of well-publicized examples of physicians who were engaged in criminal activity. A New York gynecologist was charged with first-degree assault for carving his initials into the abdomen of a woman who had just delivered her baby by cesarean section; he surrendered his license, received five years of probation in a plea agreement, and was barred from applying for a medical license for five years. A Long Island surgeon is serving three life sentences for fatally poisoning three patients who were under his care in a New York City hospital (Public Citizen, 2016).

The inconsistent use of criminal background checks increases the risk of prior criminal activity going unnoticed. In Maryland, for example, a former Catonsville family doctor was charged with sexually assaulting a female patient. *The Baltimore Sun* reported that the doctor had been previously convicted of raping a Florida woman in 1987 at gunpoint, and served four years of a

10-year sentence. Within two years of his release, he was a resident treating patients at the University of Maryland Medical Center. His criminal history was unknown to Maryland, and he was granted a medical license in 1996 (Dance, S. (2014, November 6). “Md. board backs continual monitoring of charges against doctors.”).

Recent Maryland legislation is intended to close this regulatory gap. It calls for criminal history record checks to be required for all reinstatements, renewals, and initial license applications beginning October 1, 2016 (Maryland Board of Physicians, 2016).

To further assist consumers in researching their physicians, the FSMB provides free public access to a national database of physician information, known as Docinfo. This tool provides consumers with a report that includes the following information for a given physician:

- Disciplinary actions taken by state medical boards
- Medical school and year of graduation
- Licensure history, including state name, date issued, and license number
- American Board of Medical Specialties specialty
- Location

Compliance with the Fair Credit Reporting Act (FCRA) is essential when establishing a sound policy for performing criminal background checks. In 1997, the FCRA was modified to regulate the use of consumer reports. Under the FCRA, “consumer report” can refer to any number of reports, including credit reports, driving records, employment reference checks, and criminal court records. The FCRA states that a consumer report cannot be generated without prior written permission from the individual being queried (PreCheck, Inc. (2006). Criminal background checks for physicians and allied health professionals: A guide for healthcare organizations.).

Clearly, conducting criminal background checks on physicians and allied health professionals reduces the risk an organization incurs in providing medical care. Opponents may bristle at the practice: As a Bioethics.net

article argues, “just because physicians (in practice or in training) attend to the public health and interest does not mean the state has an unlimited right to snoop in their personal lives, personal history, and work outside the clinic” (McGee, S. J. (2012, April 3). “Are criminal background checks for doctors justified?”). Keep in mind, though, that if you agree to a criminal background check and to fingerprint collection, your civil liberties are not being infringed on. This is because your agreement is voluntary. You have the right to say no to these measures, but states (and private healthcare organizations) have the right to require them in order to protect the public. A private healthcare organization can go beyond state law requirements for screening physicians and allied health professionals—this is because medical staff or allied health staff membership is a *privilege*.

In terms of Joint Commission standards, if state law requires background checks only on specified types of healthcare providers, The Joint Commission will require such background checks as noted by state law. If a healthcare organization’s policy sets a higher standard than state law, The Joint Commission will require a greater level of compliance to meet the organization’s policy (VerifyStudents.com (2014, March). “The Joint Commission’s requirements for criminal background checks.”). When state law requires background checks on all employees, The Joint Commission encourages organizations to obtain an opinion from the state on what categories of healthcare workers are considered “employees” (VerifyStudents.com, 2014).

In Virginia, for example, certain felony and misdemeanor convictions (barrier crimes) are a bar to employment in hospitals, nursing homes, and home-care organizations. For this reason, state law (§ 32.1-126.01 and 32.1-162.9:1 of the Code of Virginia) requires that each hospital, nursing home, homecare organization, and hospice obtain a criminal record background check on new hires within 30 days of employment. The law requires that these background checks be obtained using the Central Criminal Records Exchange from the Virginia State Police. Further, no employee is permitted to work in a position that involves direct contact with a patient until an

original criminal record clearance or criminal history record has been received—unless that employee works under the direct supervision of another employee for whom a background check has been completed. Direct supervision is defined as the physical presence of the supervising employee within an immediate distance (Virginia Department of Health Office of Licensure and Certification).

The list of barrier crimes in the state of Virginia includes:

- Felony violation of a protective order (§ 16.1-253.2)
- Murder or manslaughter (§ 18.2-30 et seq.)
- Malicious wounding by mob (§ 18.2-41)
- Abduction (§ 18.2-47, subsection A or B)
- Abduction for immoral purposes (§ 18.2-48)
- Assaults and bodily wounding (§ 18.2-51 et seq.)
- Robbery (§ 18.2-58)
- Carjacking (§ 18.2-58.1)
- Extortion by threat (§ 18.2-59)
- Threats of death or bodily injury (§ 18.2-60)
- Felony stalking (§ 18.2-60.3)
- Sexual assault (§ 18.2-61 et. seq.)
- Arson (§ 18.2-77 et. seq.)
- Drive-by shooting (§ 18.2-286.1)
- Use of a machine gun in a crime of violence (§ 18.2-289)
- Aggressive use of a machine gun (§ 18.2-290)
- Use of a sawed-off shotgun in a crime of violence (§ 18.2-300)
- Pandering (§ 18.2-355)
- Crimes against nature involving children (§ 18.2-361)
- Incest (§ 18.2-366)
- Taking indecent liberties with children (§ 18.2-370 or § 18.2-370.1)
- Abuse and neglect of children (§ 18.2-371.1)

Virginia state law serves as an example of how one state addresses barrier crimes. Even if an applicant has been convicted of a barrier crime, in Virginia, this

conviction may not always prevent employment. An applicant who has one misdemeanor conviction specified above may be hired if:

- The criminal offense did NOT involve abuse or neglect; AND
- Five years have lapsed since the conviction occurred

Virginia law also states that other convictions may disqualify an applicant on the basis of a facility's established hiring, personnel, or other policies (Virginia Department of Health Office of Licensure and Certification).

Policy language

There are differing opinions on what constitutes a barrier crime. Beyond state law requirements, the ultimate responsibility for establishing a list of barrier crimes lies with the respective healthcare organization, such as through formal policy development. A generalized list might include the following (PreCheck, 2006):

- Homicide: Murder, manslaughter, negligent homicide, vehicular manslaughter
- Violent crimes: Assault, robbery, aggravated assault, breaking and entering, battery
- Sexual crimes: Sexual assault, sexual misconduct with a minor, prostitution
- Drug-related crimes: Drug trafficking, misuse of prescription privileges, possession with intent to distribute
- Domestic crimes: Spousal abuse, child abuse, elder abuse
- Financial crimes: Embezzlement and fraud

We would add crimes of a similar nature to the above list.

There are some crimes that in isolation may not represent a barrier crime, but that may constitute cause for concern if a repeated pattern has been established. These include (PreCheck, 2006):

- DUI/DWI
- Public intoxication
- Drug possession
- Theft by check
- Tax evasion

Again, we would add crimes of a similar nature to the above list.


States as well as healthcare organizations have a compelling interest to protect public health. Although criminal background checks are viewed by some as a blunt instrument, there is an increasing reliance on these checks as a means to ensure staff integrity. Still, policy language that goes beyond state law in addressing barrier crimes and other crimes of concern requires very careful consideration. A healthcare organization's policy should clearly indicate the importance of the integrity of its professional staff.

When we last spoke about the role of MSPs when reviewing NPDB profiles, we indicated it is important

for MSPs to compare actions from other states against the regulations of their respective state to provide an apples-to-apples comparison of a clinician's infractions, since a minor infraction in one state may be deemed a major infraction in another. The same holds true when reviewing criminal background checks. The MSP should assist in educating the healthcare organization's professional staff and governing body on how states' criteria for licensure can vary.

Conclusion

Most states require criminal background checks for initial licensure. If your state does not, your organization must decide whether to require criminal background checks in order to better protect itself and its patients.

Ultimately, when state law does not require ongoing monitoring of criminal backgrounds, healthcare organizations are faced with another choice: rely on self-reporting as required through the reappointment process, or take the next step and mandate ongoing monitoring of criminal backgrounds as an organizational policy. 

California's critical access hospitals get green light to employ physicians

A new California law lifts a century-old ban on direct physician employment and aims to end a "doctor desert" among the smallest and most remote hospitals.

Gov. Jerry Brown has signed a bill that will allow critical access hospitals in the state to employ physicians starting in 2017. Brown signed off on a number of patient protection bills in September.

Assembly Bill (AB) 2024, authored by assembly member **Jim Wood** (D-Healdsburg), will allow the state's smallest and most remote hospitals to directly employ physicians rather than hire them as independent contractors.

Hospitals in the state are banned from directly employing physicians under a corporate medicine law

designed to prevent hospital administrators from influencing the decisions of physicians.

"Nearly the entire North Coast is a doctor desert," says Wood. "We have to find ways to recruit providers in our rural communities. It is a daunting task for young physicians, who are often tens of thousands of dollars in debt, to move to a small town and build a practice from the ground up."

AB 2024 will apply only to critical access hospitals, small hospitals with 25 or fewer beds typically located in remote areas of the state (35 miles from another hospital), and will go into effect on January 1, 2017. It calls for an eight-year pilot program due to sunset in 2024.

Bills similar to AB 2024 have been considered in the

past, but most of them applied to rural hospitals, which make up a much larger group than critical access hospitals. There are 34 critical access hospitals in California.

“I think this bill succeeded where others failed because assembly member Wood narrowed it down to just critical access hospitals,” says **Peggy Wheeler**, vice president of Rural Health and Governance for the California Hospital Association (CHA). “With rural hospitals, you’re talking about a much larger group of about 67 hospitals.” Wheeler says CHA has been advocating for a bill similar to AB 2024 for more than a decade.

The bill reflects the changing needs and attitudes of young physicians as much as it addresses physician recruitment and retention at critical access hospitals, says **David Perrott, MD**, senior vice president and chief medical officer for the CHA.

“You can look at this as a hospital bill, but it’s also about physicians and what they want,” says Perrott. “Most young physicians would prefer to be employed by a hospital rather than go into a private practice.”

He cites a 2015 survey from research firm Merritt Hawkins that found 92% of final-year medical residents would prefer to be employed directly by a hospital and earn a salary rather than be an independent contractor.

“California is behind the time and is one of only a few states left that do not allow hospitals/health systems to employ. This creates challenges, especially in rural areas, because most residents coming out of training want an employed model,” says **Jack Cox, MD, MMM**, senior vice president/chief quality officer of Providence St. Joseph Health, based in Irvine, California. “For example, in Humboldt county [California] where this hospital is located, we also have St. Joseph Eureka, and they have a very difficult time recruiting physicians because of a lack of an employment model.

“It is good for California that critical access hospitals can employ physicians. I think California will succumb to the pressures of physicians who want to be employed and the corporate practice of medicine law will go by the wayside. It’s a matter of when—not if,” says Cox.

According to a state analysis of AB 2024, the state ban on corporate medicine dates back to the early 20th century, when mining companies in California hired physicians to care for workers. That situation created problems when physicians’ loyalty to the mining companies conflicted with the needs of patients, leading the state to ban corporate medicine.

“This prohibition was more about physician and hospital distrust than it was about patient care,” says **William K. Cors, MD, MMM, FACPE**, chief medical officer of Pocono Health System in East Stroudsburg, Pennsylvania. “If hospitals were allowed to employ physicians, where were the checks and balances? Could not the hospital have an open door to malfeasance and just strip the physicians of any autonomy by telling them how they were to practice? Or so the thinking went.”

However, in California, hospitals are able to form foundations, which are considered separate entities that are able to directly employ physicians. “In a way,” says Cors, “it was always a formality because all you had to do was form a ‘foundation’ and they could employ the doctors. It really put California at a huge disadvantage to recruit physicians to rural critical care access hospitals, which may not be able to form the ‘foundation’ needed to employ the physician.”

New Jersey also has a statute that prohibits the “corporate practice of medicine,” but according to Cors, it is less restrictive than the California law. New Jersey’s statute requires a physician to be the owner of the physician group. Hospitals can meet this requirement by having a physician executive—like the VPMA or CMO, or a designated medical director—as the sole shareholder of a separate physician practice corporation that is still totally owned by the hospital; the hospital can then employ all the physicians through that group.

“It is a silly law with a huge loophole, and it doesn’t really affect patient care much, so it stays on the books, *but* it is another antiquated relic from the good old days of physicians and hospitals distrusting one another,” says Cors. 🏠

EDITOR’S NOTE

This story was adapted from HealthLeaders Media.

Leadership: Are you ready for the next step?

by Kathleen Tafel, credentialing and privileging consultant

Developing your strengths in credentialing and privileging is not an easy task—it takes commitment and loyalty to processes, standards, and policies. Many credentialing and privileging specialists develop a penchant for independently researching and maintaining resources to stay current with the field, which helps them ferret out applicants or reapplicants that could potentially be a risk for their organization.

As MSPs hone those skills, they also develop their leadership ability by becoming the resident expert on credentialing and privileging. This is the foundation for advanced development as an MSP leader.

Leadership as an MSP reaches beyond the foundational work of credentialing and privileging; it requires commitment and passion, plus an ability to see the rainbow through some dark and gloomy days. As you develop as a leader, you may find you have the ability to communicate vital information. Imagine yourself clearly and concisely explaining the results of a credentialing investigation to numerous medical staff leaders and hospital executives, delivering an objective synopsis of a credentialing file and identifying the regulations, standards, or policies that may be impacted should the applicant be recommended to the board of directors.

Developing your leadership skills includes bolstering your courage. An MSP may be one of a few people in the room with the knowledge and understanding of the regulations, standards, or policies affected by a potential decision. Refining your delivery of objective information will raise the level of attention paid to you, but not if you are wavering or timid. Delivering your message in a decisive and calm way will assist the message's receipt as well as your perceived authority.

MSPs seeking to be regarded as a leader in their field understand the importance of humility. As professionals, our duty is to provide the data extrapolated from an exemplary credentialing and privileging review,

even though our recommendations may sometimes be vetoed or questioned. Developing as a leader requires the ability to take criticism well and use it for collaboration and further growth.

Working and developing as an MSP will lead to mastery of foundational management and leadership skills. I can think of no better opportunity to advance your career. The skills honed—commitment, loyalty, courage, decisiveness, presentation, and humility—are the building blocks of managing a medical staff services department (MSSD). Becoming the manager of an MSSD will expose you to numerous hospital committees, physician and hospital leaders, regulatory reviewers, and community representatives.

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This exposure will provide extended education as you interact with these individuals and observe how they develop strategies that impact the mission and goals of the organization. You will increase your net worth by strengthening your skills in staffing, budgets, policy development, negotiation, and acting as a liaison. You'll also better understand the impact of your core passion: ensuring only the most qualified and educated individuals serve your community's patients.

I encourage you to take some time for introspection. Are you ready for the next step? As an MSP, you hold the key to the foundation of our healthcare communities—you may also hold the qualifications and virtues of an exceptional leader.

Until next time, “believe in what you do, and do what you believe.” 🏠