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Power to the APPs

The case for expanded medical staff membership and leadership opportunities

As physician shortages escalate and demand mounts for broader care access, advanced practice professionals (APP) are increasing in number and significance across the healthcare continuum. Over the past three years, the population of nurse practitioners (NP) climbed 23%, reaching 222,000 this year, according to the American Association of Nurse Practitioners. In a similar trajectory, the roster of certified physician assistants (PA) soared nearly 36% between 2010 and 2015, topping 108,000 at the end of last year, the National Commission on Certification of Physician Assistants reports.

Despite this tremendous growth, APPs' presence in the workforce often surpasses their representation on the medical staff. Some organizations carve out specific membership categories for APPs that allow attendance of staff meetings but little in the way of decision-making power, such as voting rights or eligibility to serve as a medical staff officer or committee member. Others offer no affiliation for these practitioners beyond a grant of clinical privileges.

A leading barrier to medical staff membership and leadership opportunities is the patchwork of state statutes governing APPs' scope of practice and participation on the medical staff.

"The state practice acts … are so incredibly variable," says **Laura Searcy, MN, APRN, PPCNP-BC**, president of the National Association of Pediatric Nurse Practitioners and a pediatric nurse practitioner at Marietta

Welcome to the expanded CRCJ!

Dear CRC member,

As of October 4, the **Credentialing Resource Center (CRC)** is sporting a sleek new look, an assortment of upgraded and expanded membership benefits, and an expedient publishing model for our signature news and analysis.

As part of this exciting upgrade, the **Credentialing Resource Center Journal (CRCJ)** and the **Credentialing & Peer Review Legal Insider (CPRLI)** are now one 16-page publication that reflects the hallmark insights of both classic newsletters.

Heading up the expanded **CRCJ's** new "Legal Insights" section is Son Hoang. Contact Son at *shoang@hcpro.com* with your burning questions and intriguing leads on peer review, negligent credentialing, the Stark Law, EMTALA, the anti-kickback statute, antitrust law, and any other hot legal topics in the medical staff and credentialing world.

This will be the last print version of **CRCJ.** Going forward, articles will be published on the CRC site and announced in **CRC Daily** on a weekly basis. CRC members can continue to download and print high-quality digital PDFs of current issues and peruse several years of back issues in the News & Analysis section of the CRC site.

Read on for the debut issue of the expanded **CRCJ.** We hope you enjoy the broadened access to analysis and best-practice strategy on credentialing, privileging, peer review, and medical staff office management, as well as the legal implications for these core functions. As always, get in touch with any comments or questions.

Best,

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(Georgia) Neonatology in the WellStar Health System. "It makes it very complicated to sort through what types of changes are possible in a given state and where there might be institutional barriers versus statutory barriers versus regulatory barriers."

Culture is another common—yet often more negotiable—stumbling block. Aversion to change can run deep, especially when the exclusivity of a status historically reserved for physicians is on the line.

In today's volatile healthcare climate, however, the incentive to overcome such obstacles is greater than ever.

"We have advanced training, we have a lot of experience with quality improvement, with team based care, with innovative practice models to improve quality, and our voices are valuable," says Searcy. "Medical staffs are selling themselves short when they limit the effectiveness of the voices of all of their qualified professionals."

Statutory limitations

Under CMS' hospital *Conditions of Participation*, a medical staff's membership must include MDs and DOs, but may also encompass "other categories of physicians … and non-physician practitioners who are determined to be eligible for appointment by the governing body," as relevant state scope-of-practice laws permit (42 CFR § 482.22(a)). Under these broad parameters, the following practitioners are potential candidates:

- NPs
- PAs
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Certified nurse-midwives
- Clinical social workers
- Clinical psychologists
- Registered dietitians

Although the federal regulations provide a wide range of viable medical staff recruits, state statutes can whittle down the possibilities considerably, says **Jennifer A. Hansen, JD**, partner at the San Diego office of healthcare law firm Hooper, Lundy & Bookman, PC.

"It's really important to consult with your attorneys when looking at this because you not only have to be in compliance with the federal law but also with the state law," says Hansen.

In addition, organizations that are interested in appointing APPs to the medical staff (or awarding additional rights to members with restricted standing) must adhere to accreditation standards, the specific terms of contracts with third-party service providers (e.g., a group practice that dispatches all of the hospital's affiliated dietitians), and their own bylaws, Hansen says.

To improve navigation in this complex landscape, the medical staff at Arkansas Children's Hospital (ACH) enlists its 120 affiliated APPs in verifying that their privileges and medical staff designations adhere to applicable internal and external requirements. "We have several APRNs [advanced practice registered nurses] here who are just marvelous. They can almost quote you line by line what the national standards are and what the statewide standards are, and it is extremely helpful," says **Becky Foor, RN, BBA, CPMSM**, medical staff administration director at the Little Rock facility. Although ACH hasn't extended full membership rights to APPs, it grants the chief nursing officer (CNO) a seat and partial voting rights at key medical staff committee meetings. It also recently instated an allied health committee to expand non-physician practitioners' involvement in the vetting process.

Self-policing can also help APPs and their advocates stand up against organizational medical staff membership and clinical privilege rules that are more restrictive than state law, Searcy points out.

Cultural barriers

Despite the potential gains in diversifying the ranks of medical staff members and leaders, pioneers of such initiatives should be prepared for pushback.

At Novant Health UVA Health System Culpeper (Virginia) Medical Center, the decision to open medical staff membership to APPs is only one aspect of an ongoing bylaws overhaul, but it's among the most controversial. "This was a portion that hit some buttons," says **Kelli W. Botzer**, medical staff coordinator/liaison at the facility.

Culpeper fashioned a work group of nine physicians—all with full medical staff rights—who, in partnership with a hired consultant, have been envisioning and executing the bylaws revision since January.

Today, affiliated APPs are considered part of Culpeper's allied health staff, a nominal designation that's not

delineated in the current bylaws or accompanied by any rights beyond clinical privileges, says Botzer.

The vast majority of work group participants voted in favor of the initial proposal to appoint APPs to the medical staff, citing as rationale a dwindling physician workforce, the importance of acknowledging the increasingly essential role of non-physician practitioners in and beyond the facility, and the potential to recruit skilled APPs by offering more attractive affiliation options.

Despite this widespread support, two holdouts in the work group expressed concerns that have since been echoed in the broader membership. Currently, the proposed bylaws revisions are under review by the entire medical staff, some of whom have suggested that expanded membership eligibility could jeopardize the caliber of the staff, a sentiment that Botzer chalks up to misplaced "traditionalism."

Summon the spirit of compromise

Currently, Culpeper's proposed bylaws updates are under legal review to ensure that the provisions on APP appointment are in line with Virginia law. In addition, per federal regulations, the proposed bylaws specify that an APP cannot hold the position of medical staff president. To further appease wary members, the new bylaws would also prevent APPs from serving as medical staff officers. Still, these practitioners would be eligible for other important medical staff posts, such as committee chair, Botzer says.

Beyond these built-in compromises, Culpeper's bylaws work group has conceived a backup plan in case their goal of instating full rights falls through: APPs would not be considered members of the medical staff, but they would be allowed to sit on committees with a vote.

ACH has similar, albeit slightly narrower, opportunities already in place for APPs. Non-physician practitioners are granted an affiliated level of membership but are not considered part of the organized medical staff. The CNO is invited to medical executive committee meetings. At credentials committee meetings, she has a seat and a vote on APP files.

Beyond placating parties with opposing stances on APP appointment, such middle-of-the-road constructions preempt administrative burdens that can accompany an expanded medical staff membership, says Hansen.

For example, CMS requires a hospital's medical staff to "examine the credentials of all eligible candidates for medical staff membership and make recommendations to the governing body on the appointment of these candidates in accordance with state law, including scope-of-practice laws, and the medical staff bylaws, rules, and regulations" (42 CFR § 482.22(c)(2)). For medical staffs that wish to appoint APPs who have been vetted exclusively through the HR department, this means outfitting the credentialing and privileging process for a wider pool of practitioners.

"There's a lot of additional cost that can be incurred for oversight and peer review, quality assurance, credentialing, and bringing in additional administrative staff to assist with those types of things," Hansen explains, adding that a decision to extend the fair hearing process to these new medical staff members can carry an even steeper legal price tag.

However, the additional burden will likely be minimal for medical staffs and MSPs who already vet all prospective APP appointees to comply with applicable regulatory and accreditation guidelines. For example, CMS requires medical staffs to credential and privilege any affiliate who provides a "medical level of care," and The Joint Commission specifically names PAs and APRNs among the practitioners who must receive this treatment.

"We credential [our APPs] the same as we do the physicians, so I don't think it will change anything here," says Botzer. If approved as proposed, the revised bylaws would add 15–20 APPs (all PAs and APRNs) to a medical staff that currently comprises roughly 170 physicians.

Provide a voice, if not a vote

Simply put, Searcy believes that APPs deserve full medical staff membership rights within the bounds of applicable laws. "Once you are credentialed, privileged, and functioning in a medical staff role, any professional fulfilling that role ought to be granted the full authority of the medical staff," says Searcy, who currently holds an allied health designation in the WellStar Health System that scores her an invite to pediatric staff meetings but no voting rights.

Still, striving to reshape attitudes and systems that are out of step with the realities of modern healthcare can be more important than securing one-off appointments.

"It's just a matter of the rules and bylaws not evolving as quickly as the scope of the skills of the advanced practice professionals," says Searcy. "I think that just needs to be pointed out."

And productive change doesn't require an all-or-nothing petition for membership rights. "You have to start where you are, and move forward, and realize that medical staff rules where APPs don't have full voting rights have been in place for a long time," Searcy explains.

ACH is a prime example of moderately paced progress. Last year, the medical staff, who has turned down multiple proposals to grant APPs full membership, nonetheless instituted a dedicated outlet for these practitioners to connect and contribute to the vetting process, says Foor. The fledgling allied health committee comprises at least one representative from each nonphysician discipline at the hospital, including advanced practice nursing, PA, psychology, and optometry.

Searcy considers such representation "extraordinarily valuable."

"It's absolutely wonderful to have opportunities, whether they're designated committees with a certain mission or whether they're just regular opportunities for advanced practice professionals to meet together to talk about common issues, to interact with the leadership in the organization, and then to discuss areas where they think some change might be needed and be able to implement a plan to try to achieve that change."

Move the needle

For physicians who have long enjoyed exclusive standing on the medical staff, a proposal to expand the membership benefits of advanced practice professionals (APP) can feel like an unwelcomed shakeup to the status quo rather than an opportunity to learn from and collaborate with a broader pool of capable colleagues. Experts offer the following tips for driving a change in perspective.

Enlist allies early on

To kick off the APP appointment plan, gauge interest in a diversified medical staff membership and, if it's there, recruit respected physicians to the cause, says **Kelli W. Botzer**, medical staff coordinator/liaison at Novant Health UVA Health System Culpeper (Virginia) Medical Center. "Know your medical staff leadership, and find a physician champion," she advises, adding that proponents may be surprised by the number of like-minded colleagues.

Encourage education, not infighting

"Adversarial relationships are never productive," says **Laura Searcy, MN, APRN, PPCNP-BC**, president of the National Association of Pediatric Nurse Practitioners and practicing pediatric nurse practitioner at Marietta (Georgia) Neonatology in the WellStar Health System.

Instead, she advocates a measured and respectful approach to briefing reluctant physicians on the benefits of more inclusive membership and the shared goals of healthcare practitioners across disciplines. "The patient always has to be front forward," says Searcy. "If we are not hearing voices that have something that could help contribute to increased access and increased quality, we're not putting the patient first."

Productive collaboration can also extend beyond the walls of the hospital, says Searcy, who encourages medical staffs and MSPs to therefore turn outward when exploring potential strategies for expanding medical staff membership.

"It's looking at best practices around the country, looking at your institutions that are doing the best job with fully utilizing their advanced practice professionals," she explains. "You find what works, and you replicate it."

Resolve systemic limitations

"Some of the APRNs that I've interacted with … feel like the respect and acknowledgment and utilization of their skills is variable even within their own institution depending on the time of day and who's on the service," says Searcy. To rectify such inconsistencies, reflect on the organization's current administrative chain of command, study medical staff governing documents, and open the floor for a candid conversation on the strengths and opportunities in these structures, she advises. "The power of institutional inertia can never be overestimated."

Indeed, the ACH committee functions as much more than a sounding board. Members review privileging forms for non-physician disciplines, drawing on their expertise to hold detailed discussion on necessary certifications, appropriate privileges, and the criteria for special procedures. So far, their analysis has produced concrete changes to ACH's psychology core privileging form, says Foor. The committee applies this same thoughtfulness in evaluating the actual files of non-physician applicants and reapplicants before the credentials committee conducts its review.

Assigning such tasks to APPs makes practical sense, says Searcy. "No one but nursing professionals are going to understand the different credentials, the certifications, the scopes of practice of the variety of APRNs that may come requesting privileges."

Broaden APP leadership opportunities

Sticking points aside, medical staff membership among APPs is increasing. Likewise, leadership positions among this population are on the rise, and rightfully so, says Searcy. She points to the growing ranks of APPs with advanced degrees reflecting a robust clinical and managerial skill set.

For example, between 2014 and 2015, the number of graduates from Doctor of Nursing Practice (DNP) programs increased more than 25%, according to the American Association of Colleges of Nursing. The DNP credential demonstrates extensive expertise not only in clinical practice, but also in management, informatics, and quality improvement, says Searcy.

"Those skills are becoming more prevalent in the advanced practice community, and they're very valuable in management, which is why more of our advanced practice professionals are finding themselves in C-suite positions," she explains, adding that the number of APPs in vice president and director positions is likewise climbing.

Placing APPs in high-profile, high-power positions also benefits the vetting and peer review processes, says Searcy. Under this organizational model, APPs are directly managed and evaluated by peers with deep insight into the skills necessary for competence and quality care.

"I think it's necessary to have [APPs] actually sitting on the credentialing and privileging committees so they can have some input and evaluate applications and also in leadership so that recredentialing is actually being done by a professional peer or at least that a professional peer is included in the chain of who evaluates an advanced practice professional," she explains. In addition, integrating APPs into the upper echelons can foster greater understanding, familiarity, and comfort with this population's increasing presence across the care continuum.

When exploring additional leadership options for APPs, medical staffs should keep in mind the limits imposed by regulators, accreditors, and their own governing documents. For example, CMS specifies that only a physician (MD or DO), or where permitted by state law, a dentist (DDS or DMD) or a podiatrist (DPM) may be assigned "the responsibility for organization and conduct of the medical staff" (§ 482.22(b)(3)). In many organizations, the medical staff president or chief of staff fills this role.

The road ahead

Of the two Culpeper work group participants who were initially opposed to appointing APPs, one has already come around thanks to compelling collegial discourse.

"The physicians in the group talked it out amongst themselves and actually convinced him that it made sense," says Botzer. "You've got to get some physician champions."

MSPs can also be powerful advocates, says Botzer, who was an early proponent of—and active participant in—Culpeper's APP appointment plan. "I see that they're here, they're in the trenches … they're treating our patients," she says. "So shouldn't we get some feedback from them or make it more of a collaboration?"

Beyond backing a broadened membership, Botzer has been conducting extensive research of medical staff models at other facilities and managing work group meetings. She also tracked down the consultant who has helped guide the entire bylaws revision process.

Such a proactive effort can set the stage for future success in an increasingly integrated healthcare industry, says Searcy. "In this day and age, the ability to increase patient access to care, increase quality of care, and reduce cost of care is critical. Isn't it incumbent upon institutions to ask if they are fully utilizing the skills of all of their team members? And if they're not, isn't it in the best interest of everyone, especially the patients, to look at ways to better do that?"