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THE Medical Staff Leader's Practical Guide

Survival Tips for Navigating Your Leadership Role

William K. Cors, MD, MMM, FAAPL

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About the Author

William K. Cors, MD, MMM, FAAPL

William K. Cors, MD, MMM, FAAPL, is an experienced physician executive with a background that includes 15 years of clinical practice and more than 20 years of executive hospital/health system management experience and extensive experience as a healthcare consultant. He currently serves as the chief medical officer (CMO) for Lehigh Valley Hospital-Pocono in Pennsylvania. Formerly, he was the vice president of medical staff services for The Greeley Company, Inc., in Danvers, Massachusetts, and worked with national hospitals and medical staffs.

Cors holds an AB degree from the College of the Holy Cross in Worcester, Massachusetts; an MD from Rutgers New Jersey College of Medicine in Newark, New Jersey; and a master's in medical management (MMM) from Tulane University in New Orleans, Louisiana. He is a fellow of the American Association for Physician Leadership (FAAPL) and is board certified in both neurology and medical management.

In addition to working with medical staffs, hospitals, and boards across the country, he has authored numerous books and articles. Since 2007, he has written a monthly column for HCPro's newsletter *Medical Staff Briefing* on a wide range of medical staff topics. In addition, he coauthored books including *The Medical Staff Leader's Practical Guide,* Sixth Edition (2007), *The Greeley Guide to New Medical Staff Models* (2008), *The Greeley Guide to Physician Employment and Contracting* (2010), and *An Integrated Approach to Marketing Orthopedic and Neuroscience Service Lines* (2013). He was also the author of *The Medical Staff Leader's Survival Guide* (2014) and *The Medical Staff's Guide to Employed Physicians* (2016).

Introduction

Congratulations! You have been appointed or elected to a medical staff leadership position. At some point, though, you have probably realized that what made you a successful clinician may not help much with what is required to be a successful leader. Like many medical staff leaders across the country, you may have arrived at this point ill-prepared and insufficiently trained to carry out the demands of your position. Your experience in this matter is not unique. The skills required for medical staff leadership are just not part of the standard medical training education program. Although only you know why you have chosen this path, this book is designed to help you answer how to succeed now that you have made this choice.

The first edition of this book was released in 2014. Since then, the exponential and unprecedented changes occurring in healthcare have not slowed down one single bit. As a result, many healthcare organizations recognize the value and absolute necessity of having strong physician leaders at the table. And yet, precisely at a time that such leadership is in demand, constraints on physician time and finances have increasingly kept them from stepping forward. You have elected to take this step regardless of constraints, so please consider this book to be a friend and a guide to help you (and other courageous and committed physicians) as you assume your role and responsibilities.

The good news is that, as a leader, you will be able to better influence and guide what is occurring in your organization. The bad news is that, at times, it will be very difficult and overwhelming. This book is designed for medical staff leaders confronting these challenges in real time. It has been extensively rewritten to offer medical staff leaders practical strategies and solutions for challenges in their organizations. Because of the urgency in getting medical staff leaders up to speed rapidly, the book has been re-engineered to serve simultaneously as a road map and a basic source of information.

How This Book Will Help

Practical strategies and best practices have been developed to help medical staff leaders manage the multiplicity of challenges that arise in the natural course of their leadership roles and responsibilities. This book can be utilized in several different ways. Medical staff and hospital leaders can read it from cover to cover to gain a broad overview and insight into the landscape of today's medical

staff environment with, a particular emphasis on the responsibilities and accountabilities of the medical staff within the organization. Alternatively, specific topics and challenges can be easily accessed by chapter and used as a quick and handy reference for practical approaches to specific, real-time challenges faced by medical staff leaders. Whenever appropriate, the reader is directed to further resources to understand and manage today's complex challenges. Cross references to pertinent material in other book chapters are also offered throughout.

How This Book Is Organized

The Medical Staff Leader's Practical Guide is divided into 30 chapters, each of which deals with a very real and specific topic or challenge faced by medical staff leaders. Wherever appropriate, a step-by-step outline of best practices or guiding principles is provided. Throughout the book, accompanying figures/sample forms amplify content in the chapters. They are also designed to make it easier for you to quickly implement and use them in your organization.

Each chapter is designed to stand alone and address a particular principle or challenge in a short and succinct fashion. Chapters are titled in a way that allows the medical staff leader to rapidly identify areas of interest and quickly access the content. Providing online access to forms, policies, and other documents, this book offers a practical set of tools that the leader can deploy.

The Medical Staff Leader's Practical Guide: Putting It All Together

The Medical Staff Leader's Practical Guide is dedicated to helping medical staff leaders achieve their vision of being part of a truly effective medical staff. Hopefully, it will help assist in helping new leaders become good leaders and good leaders become great leaders. In writing this book, I intend to offer practical information, provide useful resources, and identify alternative solutions to ongoing challenges. It is my sincere hope that every medical staff leader will be the best that he or she can be and that this book will be of some value in helping to realize that goal.

Acknowledgments

First and foremost, I must thank my family for putting up with the time and commitment required to prepare this work. Without their support, this would have not been possible. Additional thanks are offered to the hundreds of medical staff leaders with whom I have had the opportunity to interact and from whom I have learned over the years in organizations, large and medium and small, across the country. That experience has been invaluable in preparing this work. And to the users of this book, a special thank you for your willingness to step forward and lead.

—WKC

1 Where to Begin: Principles of Governance

Congratulations! You have just been appointed or elected to a medical staff leadership position. Possibly it is as a medical staff officer, maybe even as the chief/president of the medical staff. Or perhaps you will serve as a department chair or a clinical service line physician leader. Maybe your position is to chair or be a member of a key medical staff team, such as the credentials committee or the peer review committee. As exciting as this news is, you might have a moment (or many moments) when you ask, "Now what?"

Many physicians begin their leadership positions unprepared to carry out its responsibilities. Very often the physician leader is a skilled clinician, well respected by his or her peers; however, it should not be assumed that clinical skills and knowledge will translate into an effective leadership toolbox for the medical staff leader. In fact, very often the skills that drive clinical success may be antithetical to the skills that drive leadership success.

Although many physicians possess considerable natural leadership skills, talents, and abilities, it is a mistake to leave it at that because the skill set necessary to succeed as a physician leader is not taught in medical school or residency. Yet organizations are increasingly looking for skilled physician leaders to help guide their organizations through the significant upheavals and challenges facing the healthcare system today and for the foreseeable future. Learning "on the job" is not a good option for either the physician leader or their organization. Physician leaders must be offered formal and structured opportunities to participate in a phased leadership training and development program. Such opportunities ensure that, over time, those leaders will learn the necessary skills, knowledge, techniques, and approaches that will best enable them to lead effectively. Ideally, such training occurs prior to assuming a critical leadership role. In reality, however, that often is not the case. So the logical question is "Where do we begin?" A good place to start is to answer the questions "Why does the medical staff exist in the first place?" and "What are its responsibilities and accountabilities in the hospital or the health system?"

Why Does the Medical Staff Exist?

To answer this question, it is necessary to understand there are three structural components found in U.S. hospitals and health systems:

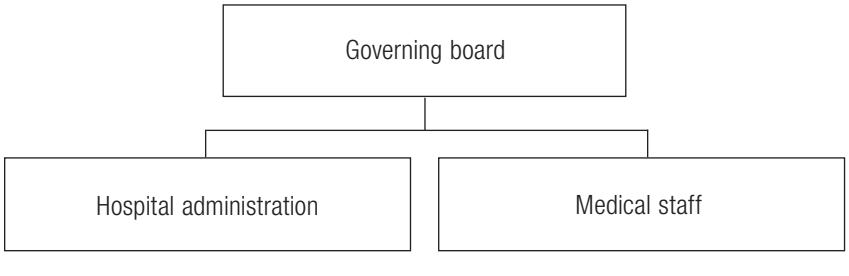
- Governing board
- Hospital administration
- Organized medical staff

The governing board is the highest level of governance and the highest-level fiduciary in the organization. A fiduciary has the duty created by his or her undertaking to act primarily for another's benefit in matters connected with such undertaking. Although the term "fiduciary" often refers to financial stewardship, it also includes accountability for the quality and safety of care delivered by the organization. Boards are increasingly becoming more knowledgeable about quality and safety, but they nevertheless delegate the "management" of these functions to administration and the medical staff. This is appropriate because boards should govern and should not manage. For example, the board needs to understand and approve the medical staff processes for delegated responsibilities, including credentialing, privileging, and peer review, but it is up to the medical staff to design, implement, and follow the processes.

To ensure appropriate administration for the operational and financial management of the hospital, the board hires a CEO and delegates responsibilities to the CEO to manage the organization. The CEO is charged with creating an administrative structure and process to oversee the management of the hospital's operations and finances. This structure generally includes a management team of vice presidents, directors, managers, and line staff, with the degree of complexity varying from one organization to the next. Key elements of ensuring quality and safety are establishing appropriate staffing models, recruiting people with the correct skill sets, and maintaining the infrastructure required to effectively, safely, and responsibly run the organization. Because there is no one-size-fits-all solution, it is important for the medical staff leader to understand upfront how the organization's administration is structured and who is responsible for what. As soon as possible, the medical staff leader should meet with the CEO or designee to discuss these basic facets of the organization.

The board is also responsible for the quality of medical care at the healthcare organization, but what does the board know about the quality of medical care? The answer is increasingly that boards understand more but, in reality, still often not a lot about quality, although that can vary greatly from one organization to the next. So, the board assigns responsibility for monitoring and improving the quality of care to the medical staff. In a general sense, this includes input, review, and recommendation on matters including clinical pathways, policies concerning safety and quality, and clinical care protocols for standardized care. Specifically, it means that the board delegates to the medical staff the responsibility for monitoring and improving the quality of care that depends primarily on the performance of individuals with clinical privileges. This specific accountability to the board is the primary reason for the existence of the organized medical staff. This first structure is illustrated in Figure 1.1.

Figure 1.1 Sample Hospital Organizational Model



5 How to Get Great Physicians and Leaders

You miss a meeting and learn afterward that, in absentia, you were named the new chairperson of that committee. Or you excuse yourself for a moment from the annual medical staff meeting to take a call and return to learn that you have been nominated to be a medical staff officer. In the days when the medical staff functioned more as a club and everyone was expected to take their "turn in the barrel," these stories were common. But chance leadership is no longer acceptable, as the responsibilities and accountabilities of the medical staff have increased. A more tightly managed approach is required.

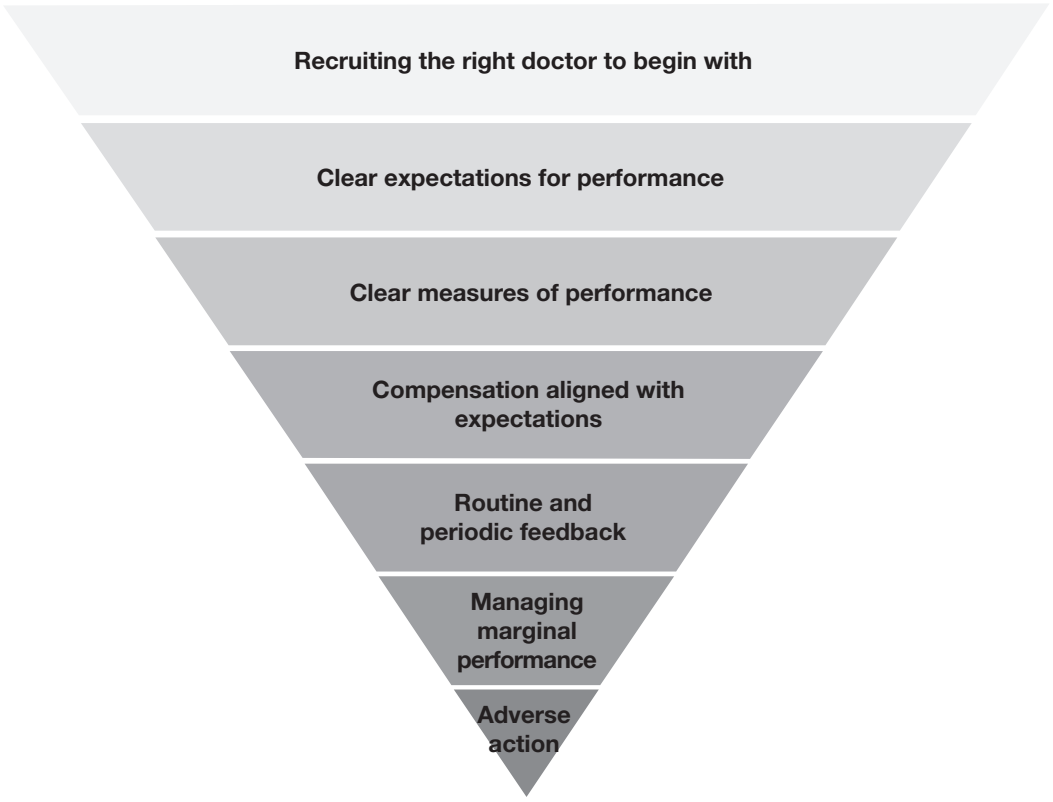
This chapter begins with an overarching physician performance management model that can be applied to multiple situations, including hiring a physician for your practice, appointing someone to your medical staff, and recruiting and retaining great physician leaders. This will be followed by a step-by-step application of the model as it applies to medical staff leadership positions.

A Physician Performance Management Model

A powerful tool for managing physician performance is the physician performance pyramid that was developed by the late Howard Kirz, MD, at the Group Health Cooperative of Puget Sound. Kirz for many years participated in teaching the "Managing Physician Performance in Organizations" course at the American College of Physician Executives (ACPE), now the American Association for Physician Leadership (AAPL). Simply put, his inverted pyramid model (see Figure 5.1) has seven layers, with the premise being that if more time is spent on fundamentals, then less time will be spent on managing poor performance and taking corrective actions.

Although designed as a performance system for employed physicians in a large multispecialty medical group, this model can easily be flipped and adapted for use with a contemporary medical staff as well (see Figure 5.2). This approach was pioneered by The Greeley Company. The pyramid layers are as follows.

Figure 5.1 Managing Physician Performance: The Inverted Pyramid Model of Howard Kirz, MD



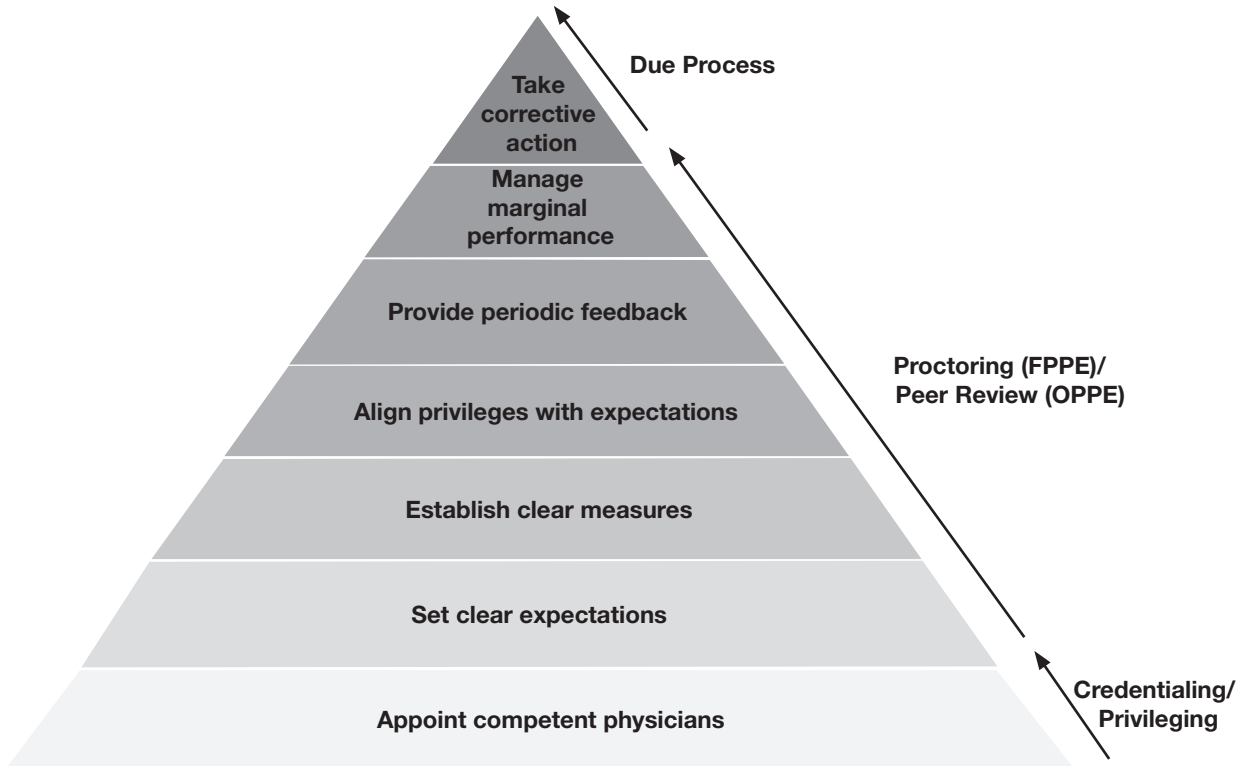
Level 1: Recruit the right doctor/Appoint competent physicians

Kirz's model involved hiring physicians for a multispecialty medical group. Applied to a medical staff, the equivalent would be to appoint the most competent and excellent physicians through the credentialing and privileging process. His premise suggests that spending additional time here is worthwhile because it will likely prevent many headaches later. For a medical staff, this level involves having a rigorous but efficient credentialing and privileging process that aims to determine appointment and reappointment of competent practitioners.

Level 2: Set clear expectations for performance

Kirz's model addressed expectations for being employed by the multispecialty group. For a medical staff, this involves explicitly stating what the expectations are for anyone who has been credentialed or privileged at your organization. These expectations need to be stated clearly and repeated whenever possible. The peer review process, as will be seen in Chapter 14, begins with setting clear expectations for performance and also includes measurement of, alignment of, and feedback related to that performance as outlined in levels 3–5.

Figure 5.2 Managing Physician Performance: Adapted For a Contemporary Medical Staff



Level 3: Establish clear measures of performance

Kirz's model also addressed metrics used to measure physician performance in the group. The medical staff also needs to measure actual performance against expectations. Examples will be offered in Chapters 14 and 15.

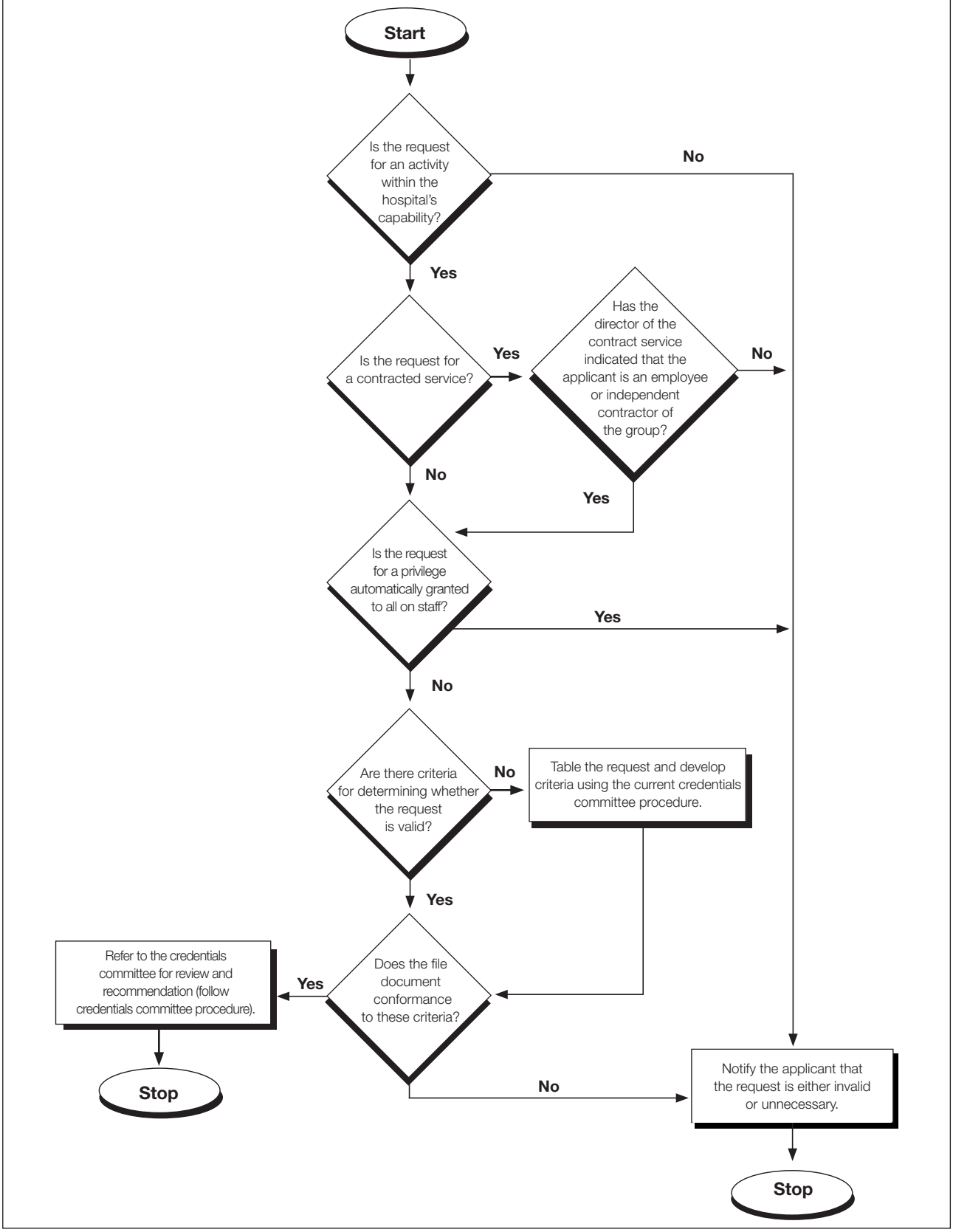
Level 4: Compensation/privileges aligned with expectations

Kirz's model addresses how an employer structures an agreement with the employee to tie compensation to performance. For the medical staff, alignment with maintenance of medical staff membership and privileges can be linked to overall performance metrics, as will be seen in Chapters 14 and 15.

Level 5: Routine and periodic feedback

The employed physician in Dr. Kirz's group received a physician performance feedback report on a regular basis. Many medical staffs are adopting ongoing professional practice evaluation (OPPE) reports and providing them both to clinical service/department chiefs and to the individual practitioner.

Figure 8.3 Decision-Making Process for Developing Scope-of-Practice Criteria



14 Peer Review (OPPE)

Peer review is the evaluation of a physician's professional performance by other physicians. Ideally, it identifies opportunities to improve the quality of patient care and offers ways for physicians to achieve these improvements. Traditionally, peer review meant review of a case, often because of some adverse outcome, but this is a very narrow encapsulation. A more contemporary definition of peer review is the ongoing evaluation of an individual physician's performance for all relevant performance dimensions using all appropriate and relevant sources of practitioner performance data that are available.

Some accreditation organizations use the terms focused professional practice evaluation (FPPE) and ongoing professional practice evaluation (OPPE) to describe elements of peer review from their perspective. If you have a robust and effective peer review process as outlined in this chapter, then you will meet and/or exceed these standards. Although many feel that a lot of this is new, truth be told, it is not.

Like proctoring, peer review can be as simple or as complex a process as the organization makes it. But it is a process, and, like any other process, it should be clearly delineated in a policy that is objective and applied equally to all. If emotions can run high concerning the proctoring of a physician's privileges, then the ongoing evaluation of competency through a peer review process can go positively nuclear if not handled effectively. A lot depends on the culture of your medical staff and the history of peer review in your organization. Many physicians have a tainted view that peer review is nothing more than an ill-conceived attempt to limit autonomy and question individual judgment. This may stem from experiences in medical school or residency, or it may reflect a punitive process in a different hospital. Given the emotions and the baggage that accompany this subject, it is critically important to have a very clear structure and process delineated in policy and an action process that is evidence-based, applied equally, and led by credible leaders of the medical staff. This chapter will outline a series of steps for creating a peer review policy that reflects current trends and best practices. For those desirous of more in-depth knowledge on this topic, the reader is referred to sources such as *Effective Peer Review,* available from HCPro.

Step 1: Define What Peer Review Is (and What It's Not)

Peer review most certainly is about the technical quality of care offered. That said, there are also more dimensions of physician performance than just technical quality of care. As will be seen in subsequent steps, there are competency frameworks that can be adopted and used by the medical staff to better delineate expectations and performance metrics on a multitude of performance indicators. Your policy could begin with the following definition of peer review:

Peer review *is the evaluation of all dimensions of current competency of individual physicians using all appropriate and relevant sources of performance data available.*

Your policy could also include the purpose and the goals of the peer review process. This is an opportunity to use language to change the scenario from looking to hang people out to dry to a culture that is based on performance improvement and helping everyone be the best they can be. Representative language could include the following:

- *The purpose of the peer review process is to ensure that the hospital, through these activities of the medical staff, assesses the performance and competency of individuals granted privileges through an ongoing process of professional practice evaluation and uses the results of such assessments to improve care and, when necessary, to perform focused performance evaluations.*
- *A goal of the program is to create a culture with a positive approach to peer review by recognizing practitioner excellence as well as identifying improvement opportunities.*
- *Another goal of the program is to ensure that the processes for peer review are clearly defined, fair, accurate, consistent, efficient, defensible, timely, and useful.*

It is also important to state clearly what peer review is not. The most frequent confusion occurs with the following two processes:

- **Mortality & Morbidity (M&M) Conferences.** The M&M session should be solely for education. It can be a collegial open discussion of clinical cases without the burden of making final determinations of care that will be recorded in some file somewhere. Trying to do peer review through the M&M process will invariably fall short because fairness and consistency can be difficult to achieve.
- **Root cause analysis (RCA).** An RCA is a systems-level analysis that is required after a sentinel event or a significant near miss. It is a multidisciplinary effort to identify the root cause factors that led to a variation in performance. It is possible that potential physician practice concerns may be raised by the RCA. If so, they should be referred to the medical staff–identified peer review process and not adjudicated by the RCA.

22 Alignment With Hospital Leaders and Nursing

For a hospital and its medical staff to be truly successful in today's challenging environment, each must take a proactive and win-win approach to improving physician–hospital relations. The truly successful organization is characterized by better solutions to achieving high-quality patient care while simultaneously ensuring the success of both physicians and the hospital.

The reality in many organizations, however, is quite different. What often exists is unmanaged conflict, poor communication skills, a lack of trust, and an absence of respect. It is no secret that with all the stress caused by the changes in contemporary healthcare, conflict is currently a growth industry in hospitals. There are multiple sources of conflict between physicians and hospitals today, such as the following:

- A history of past perceived injuries and injustices
- Poor or ineffective communication
- Physicians relying less on the hospital for success now that more care can be delivered in the ambulatory outpatient setting due to advances in technology, medications, and less invasive medical procedures
- Increasing competition for a shrinking revenue pool
- A simple lack of time and commitment to seek mutual answers to the problems faced by both physicians and hospitals

Add to that the fact physicians and hospital management often come at the same challenges from entirely different approaches. Both approaches are legitimate, and each party needs to understand the other if they are to be successful. These are just some basic cultural differences, and the first step is to acknowledge and understand those differences so that they can be overcome.

The first part of this chapter will introduce a series of practical tips to improve physician–hospital relations with a number of best practices incorporated where appropriate. While the emphasis is on hospital leadership in general, all of these steps can be applied to nursing as well. Figure 22.1 addresses some cultural differences between physicians and hospital leadership. The following section outlines six practical strategies for improving physician–hospital leadership relations. The goal is a more collaborative and proactive approach to mutual challenges and concerns.

Figure 22.1 Sources of Cultural Conflict Between Physicians and Hospital Leadership

Physician	Hospital leadership
Autonomy	Teamwork
Uniqueness	Consistency
Treats individual patients	Manages population
Quality trumps cost	No margin, no mission
Solves acute problems	Manages chronic problems
Works with individuals	Works with systems
Makes decisions	Manages processes
Prescribes and expects compliance	Leads, influences, and collaborates
Short-term focus	Short-, medium-, and long-term focuses
Being the expert	Being one expert of many
Relatively well-defined problems	Ill-defined, messy problems

Step 1: Acknowledge What Has Changed

It has become increasingly clear that the previous unwritten social contract between physicians and hospitals is broken. Under that contract, a hospital would provide the human and technical resources for the care of patients. It would grant the clinical privileges to physicians to use these resources for the diagnosis and treatment of patients. In turn, physicians would provide services to the hospital, which included participating in activities of departments and committees, providing emergency department coverage, and ensuring the quality of care rendered by the physicians or other individuals granted privileges. The granting of privileges was like conferring tenure to ensure a lifetime of professional security and success.

Today's landscape is littered with the acrimonious debris of this failed social contract. Department and committee meetings are unattended. Disputes about emergency coverage are an epidemic. In many cases, the peer review process to ensure the quality of care rendered by individuals granted privileges has become ineffective. Physicians are embittered, frustrated, and angry and are working harder and longer for decreasing satisfaction and shrinking revenue. Physicians and hospitals simultaneously try to compete and collaborate with each other. Economic agendas dominate conversations. Clinical outcomes are dragged into the public spotlight by external groups who publish the results of performance. Physicians are employed by hospitals in record numbers, and still problems persist, even though many hospitals felt that employing physicians would promote increased alignment with organization objectives.

Clearly, a new approach is required. The first step is to acknowledge that the change has occurred. It is necessary to accept that a fundamental shift in the relationship has and will continue to occur. Physicians are simultaneously the customers, partners, suppliers, and competitors of hospitals. Hospitals must accept the death of the old social contract. In order to make progress in this new environment, the change must first be recognized, discussed, and understood; only then can progression occur. It is hard to discuss the new when the death of the old has not been acknowledged.

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A well-trained medical staff leader is vital to the culture of a hospital's medical staff and can save a hospital from the expense of lawsuits affiliated with negligent credentialing/peer review. ***The Medical Staff Leader's Practical Guide: Survival Tips for Navigating Your Leadership Role*** offers you an affordable, time-saving solution to medical staff leadership training.

You'll find expanded chapters on peer review/OPPE/FPPE, advanced practice professionals, and physician employment, new chapters on the medical staff executive committee as well as service lines and other medical staff models, and so much more in this informative resource. Inspire your staff to follow the rules while continuing to deliver excellent patient care!

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Simplify Compliance, with its three pillars of thought leadership, expertise, and application, provides critical insight, analysis, tools, and training to healthcare organizations nationwide. It empowers healthcare professionals with solution-focused information and intelligence to help their facilities and systems achieve compliance, financial performance, leadership, and organizational excellence. In addition, Simplify Compliance nurtures and provides access to productive C-suite relationships and engaged professional networks, deploys subject matter expertise deep into key functional areas, and enhances the utility of proprietary decision-support knowledge.

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