

# **The Medical Staff Leader's Survival Guide**

**William K. Cors, MD, MMM, FACPE**

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**+HCPro**  
a division of BLR

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# About the Author

## William K. Cors, MD, MMM, FACPE



William K. Cors, MD, MMM, FACPE, is an experienced physician executive with a background that includes 15 years of clinical practice and more than 18 years of executive hospital/health system management experience and experience as a healthcare consultant. He currently serves as the chief medical quality officer for Pocono Health System in Pennsylvania. Formerly, he was the vice president of medical staff services for The Greeley Company, Inc., in Danvers, Massachusetts.

Cors has extensive experience in all facets of medical staff affairs, operations, and development. His primary areas of expertise include strategic alignment of medical staff and hospital leadership and governance; credentialing, privileging and peer review; clinical resource management; improvement of quality of care and patient safety; public accountability preparedness; and management of medical staff conflicts, change, and disruptive behavior. In addition, he has wide experience in medical staff documents and regulatory accreditation.

Cors holds an AB degree from the College of the Holy Cross, an MD from New Jersey College of Medicine, and a master's in medical management from Tulane University. He is a fellow of the American College of Physician Executives. Cors is board certified in both neurology and medical management. He holds an academic appointment in the Department of Neurosciences at Robert Wood Johnson Medical School in New Jersey. Cors served on the board of directors of the American College of Physician Executives from April 2007 to March 2010.

In addition to working with medical staffs, hospitals, and boards across the country, he has also authored or coauthored numerous publications. These include the following series that ran in HCPro's *Medical Staff Briefing* newsletter: a 12-part series on improving physician-hospital relations (2006–2007), a nine-part series on strategic medical staff development (2008–2009), a seven-part series on leadership challenges (2009), a 12-part series on new medical staff models (2009–2010), a 10-part series on leading change initiatives (2012), and a 10-part series on leadership (2013–2014). In addition, he was the lead author of *The Medical Staff Leader's Practical Guide*, Sixth Edition (2007), *The Greeley Guide to New Medical Staff Models* (2008), and *The Greeley Guide to Physician Employment and Contracting* (2010), as well as a contributing author to *An Integrated Approach to Marketing Orthopedic and Neuroscience Service Lines* (2013).



# Introduction

You have just been appointed or elected to a medical staff leadership position. This most likely occurred because you are a clinician respected by many of your peers. Like many medical staff leaders across the country, you have probably arrived at this point ill prepared and trained to carry out the demands of your position. Your experience is not unique. The skills required for this type of leadership were just not part of the standard medical school curriculum or postgraduate training education. The logical question is, “Well, now what?”

This is certainly a time of extraordinary change in healthcare. Many healthcare organizations recognize the value and the absolute necessity of having physician leaders at the table. Precisely at a time that such leadership is in demand, constraints on physician time and finances have increasingly kept them from stepping forward. For whatever reason(s) you have chosen to step forward, this book is dedicated to helping you and other courageous and committed physicians as you assume your role and responsibilities.

Because contemporary healthcare continues to be characterized by exponential and unprecedented change, this successor to *The Medical Staff Leader's Practical Guide*, Sixth Edition, has been extensively rewritten and brought up to date to offer medical staff leaders practical strategies to handle the very real challenges faced today and to be faced tomorrow. Indeed, because of the urgency in getting medical staff leaders up to speed rapidly, the book has been reengineered to serve as the medical staff leader's survival guide.

## 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. One is that 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 and 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.

## How This Book Is Organized

*The Medical Staff Leader's Survival 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 enumerated and outlined. 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 the medical staff leader can rapidly identify the area of interest and quickly access the content. The online access to forms, policies, and other documents offers a practical set of tools that the leader can deploy.

## ***The Medical Staff Leader's Survival Guide: Putting It All Together***

*The Medical Staff Leader's Survival Guide* is dedicated to helping medical staff leaders achieve their vision of becoming a truly effective medical staff. Hopefully, it will assist new leaders to become good leaders and good leaders to become great leaders. In writing this book, the clear intention is to offer practical information, useful resources, and identification of 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.

—WKC

# Chapter 1

## Where to Begin: Principles of Governance

You have just been appointed or elected to a medical staff leadership position. Perhaps it is as a medical staff officer, maybe as chief/president of the medical staff. Or perhaps it is 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 function, such as the credentials committee or the peer review committee. You might have a moment (or many moments) when you ask, “Now what?” Many physicians arrive at their leadership positions ill prepared to carry out the responsibilities of the position. 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.

Many physicians possess considerable natural leadership skills, talents, and abilities. It is a mistake, however, to leave it at that, because the medical staff leadership skill set is not one taught in medical school or residency. Yet organizations are increasingly looking to physician leaders to help guide their organizations through the significant upheavals and challenges facing the healthcare system today and for the foreseeable future. Physician leaders must be offered formal and structured opportunities to participate in a phased leadership training and development program. This ensures that over time those leaders will learn the necessary skills, knowledge, techniques, and approaches that best enable them to lead effectively.

So, the logical question is “Where do we begin?” A good place to start is to answer the question “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. They are the:

- ❖ Governing board
- ❖ Hospital administration
- ❖ Organized medical staff

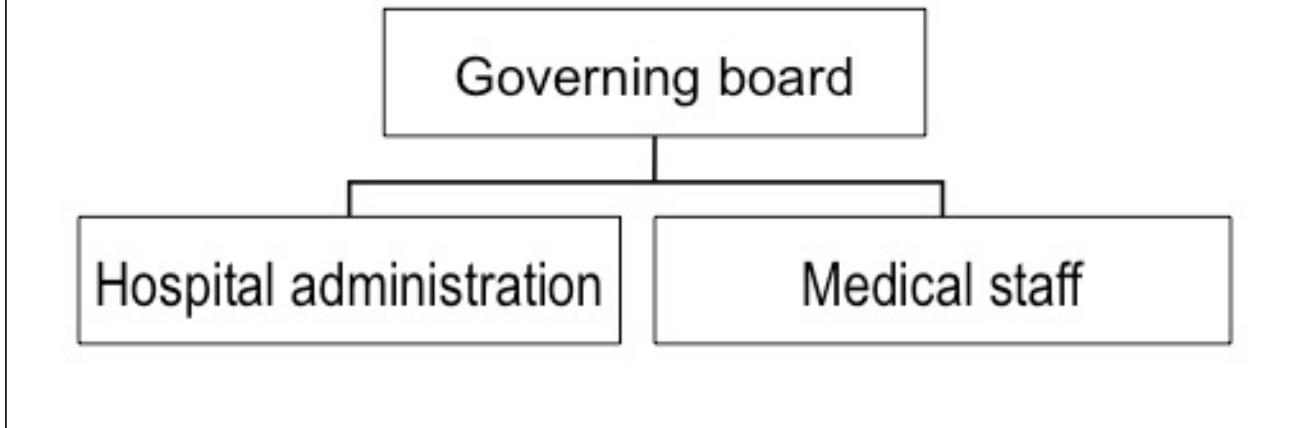
The governing board is the highest level of governance and the highest-level fiduciaries in the organization. A fiduciary has the duty created by his or her undertaking to act primarily for another's benefit in matters connected with such undertaking. Although the term "fiduciary" often refers to financial stewardship, it also includes accountability for the quality and safety of care delivered by the organization. Although boards are increasingly becoming more knowledgeable about quality and safety, they nevertheless delegate the "management" of these functions to administration and the medical staff. This is appropriate because boards "govern" and do 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 them.

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 administration's responsibility to manage the hospital's operations and finances. This 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. A key role in ensuring quality and safety is to establish appropriate staffing models, recruit people with the correct skill sets, and maintain the infrastructure required to effectively, safely, and responsibly run 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: often not a lot. So, the board assigns responsibility for monitoring and improving the quality of care to the medical staff. Specifically, 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 granted clinical privileges. This accountability to the board is the primary reason for the existence of the organized medical staff.

So the first structure we end up with looks like Figure 1.1.

Figure 1.1 | Sample Model: Hospital Organization



## How Does the Medical Staff Carry Out Its Accountability to the Board?

The medical staff exists because it is accountable to the governing board for the quality of care that is dependent primarily on the practitioners who are granted privileges. Now that we understand why the medical staff exists, we can address how the medical staff carries out this accountability. To help answer this, a good starting point is to examine what is required.

The Centers for Medicare & Medicaid Services (CMS) has established *Conditions of Participation* (*CoP*), which are the absolute minimum set of requirements that all hospitals must meet to participate in federal payment programs. The *CoP* require that there be an “organized” medical staff that operates under bylaws approved by the governing body and is responsible for quality of care. There is no guidance as to how the medical staff should organize itself, leaving that to each organization. Interestingly, there is no requirement for a medical executive committee (MEC) even though, as we shall see shortly, virtually every hospital has one. The only requirement set forth in the *CoP* is for a utilization management committee, which can either be an actual medical staff committee defined in the bylaws or a hospital committee with appropriate physician representation.

In addition to CMS, there are other organizations that have their own minimum standards for accreditation. These organizations must submit their standards to CMS to ensure that they meet or exceed the *CoP*. If they do, these accrediting agencies receive “deeming authority” and are allowed to accredit hospitals on behalf of the CMS. There are several key players in this arena, including The Joint Commission (TJC), the Healthcare Facilities Accreditation Program (HFAP), DetNorske Veritas (DNV) Healthcare, Inc., and Center for Improvement in Healthcare Quality (CIHQ). The latter two tend to closely mimic the CMS *CoP*. According to many medical staff leaders, TJC standards have become too prescriptive, requiring things far in excess of the CMS *CoP* or sometimes in seeming

conflict with them. There will be more on this in Chapter 27. One example of this concern is the Joint Commission standard MS.01.01.01, which has 36 elements of performance concerning medical staff governance and requirements for items to be included in medical staff bylaws. This standard also requires a self-governed medical staff (MS.01.01.01) and additionally a MEC (MS.02.01.01). So, if you are a TJC-accredited hospital, a MEC is required.

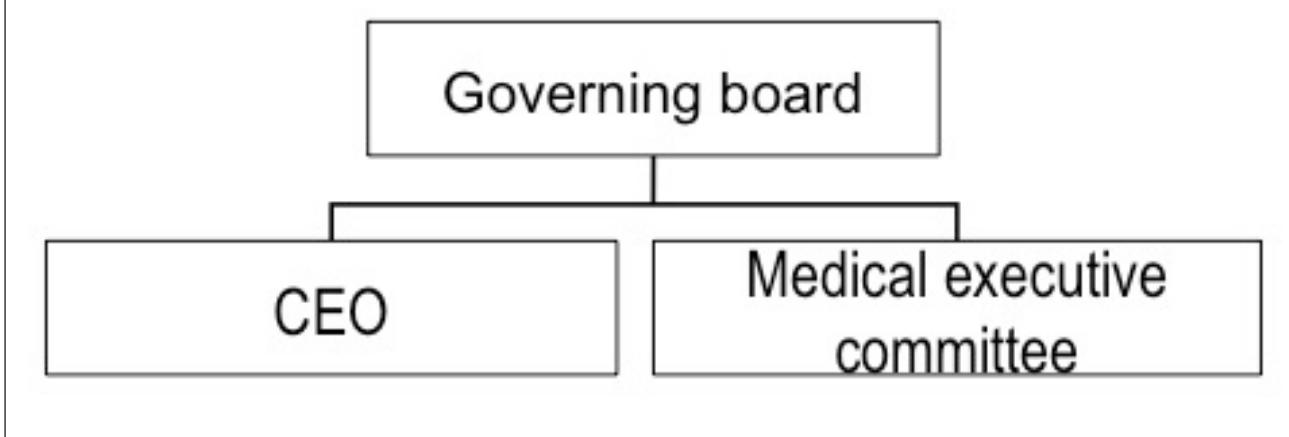
The simple truism, however, is that virtually every hospital has some form of MEC or medical board. The reason is that a truly effective medical staff needs to do at least three things:

1. Provide medical staff governance for a well-organized medical staff
2. Make recommendations to the board for approval or denial of credentialing and privileging of practitioners
3. Monitor the quality of care provided by these practitioners granted privileges

When properly organized, a MEC is a very efficient way of carrying out these responsibilities. In this scenario, the entire medical staff does not report to the board but rather organizes a MEC that can function as the medical staff's recommending body, which is the last to rule on matters before they are brought to the governing body for final decision.

So the structure we end up with now looks like Figure 1.2.

Figure 1.2 | Sample Model: Hospital Organization



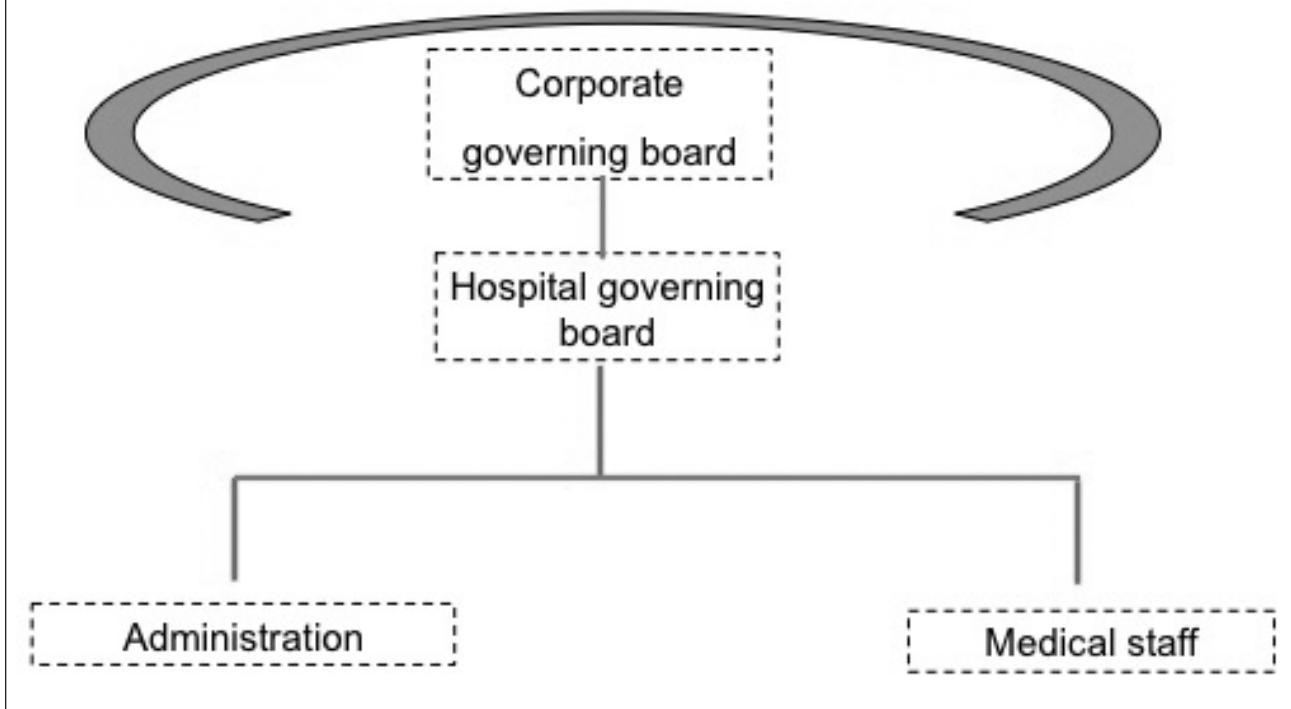
## What If Your Hospital Is Part of a Larger Health System?

Increasingly, stand-alone independent hospitals may find themselves involved in a merger and acquisition activity with a larger health system. In many cases, a health system will have a central board that holds certain “reserved powers,” particularly concerning performance on financial and quality metrics. There may continue to be a local site board that is authorized to approve the credentialing and privileging recommendations made by the MEC for that site.

There are any number of permutations possible, including whether the boards and/or medical staffs will be merged as well or continue to function at a “local” level. All of this, of course, is dependent on how your merged organization structure fits in to the CMS *CoP*, which sets requirements for hospitals and their governing boards. This is something that needs to be made clear to you as you assume your leadership position.

In general, the structure may now look more like that in Figure 1.3.

Figure 1.3 | Sample Model: Hospital Organization



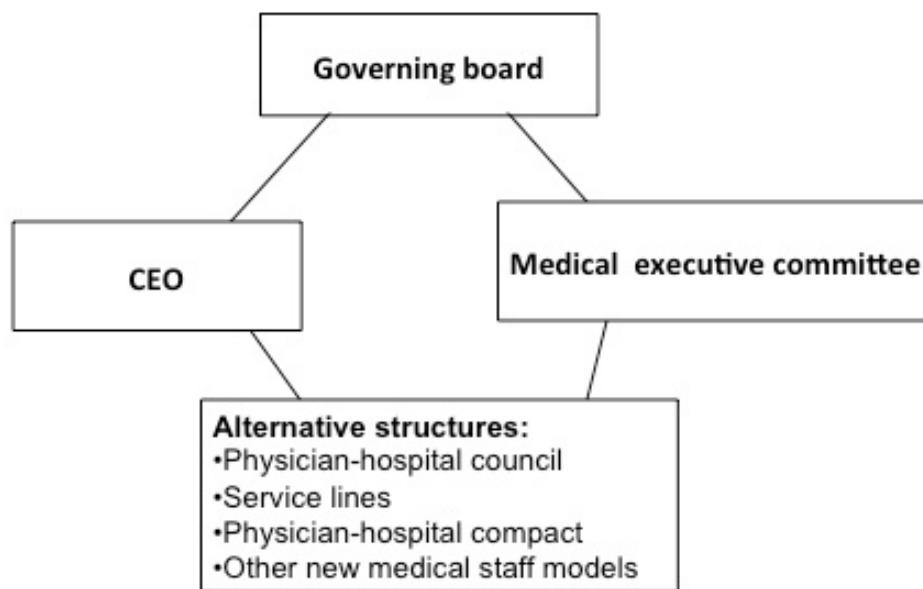
## What About Other Things of Interest to the Medical Staff?

The medical staff has the responsibility to the board for delegated responsibilities, including credentialing, privileging, and peer review. But the medical staff is interested in many other things, including hospital operations (staffing, cleanliness, timeliness and availability of services, competency of staff, patient satisfaction, reports on public measures of quality and safety, etc.) and the hospital's board-directed strategic development and initiatives (including a well-thought-out medical staff development plan). Interest in these other areas often leads many medical staffs to use its MEC as an advocacy board. Although this may work in some cases, it is really dependent on the organization, its culture, and the membership composition of the MEC. For the MEC to effectively function as an advocacy body requires a high degree of collaboration with the hospital and the appropriate voices on the MEC to address strategic initiatives.

Consider the case of a hospital whose main strategic initiative over the next three years is the development of a world-class certified cancer center, but no one from an oncology-related specialty sits on the MEC. If this is the case, consider one of the alternatives that many medical staffs and hospitals are looking to conduct this other "business." This might include the establishment of clinical service lines, development of a physician-hospital compact, establishment of physician-hospital councils specific to operations, or strategic planning and creation of a medical staff development plan. These newer models will be examined throughout subsequent chapters, as many organizations struggle with new and better ways of conducting the important business of the organization.

So now we may have a structure that looks like Figure 1.4.

Figure 1.4 | Sample Model: Hospital Organization



## How to Influence Things You Do Not Control

The first principle in cultivating influence is to understand that everyone, individually or organizationally, has a sphere of “control.” That is, an area over which the fundamental responsibility for designing and carrying out a task or exhibiting a set of behaviors rests with that individual or that stakeholder group. What is the sphere of control of the organized medical staff? First and foremost, it is its board-designated responsibility for monitoring and improving the quality of care that is primarily dependent upon the performance of individuals granted privileges. Because of this, practitioners on your medical staff are accountable to each other for the quality of care they provide. This is a given. This is the “sphere of control” of the medical staff, namely how credentialing, privileging, and peer review are conducted in the organization. Some medical staffs carry out their sphere of control in an extraordinary manner, utilizing best practices, consistency of process, and thoughtful recommendations to the board. Other medical staffs struggle with one or all of these responsibilities and do a rather poor job of that over which they have control.

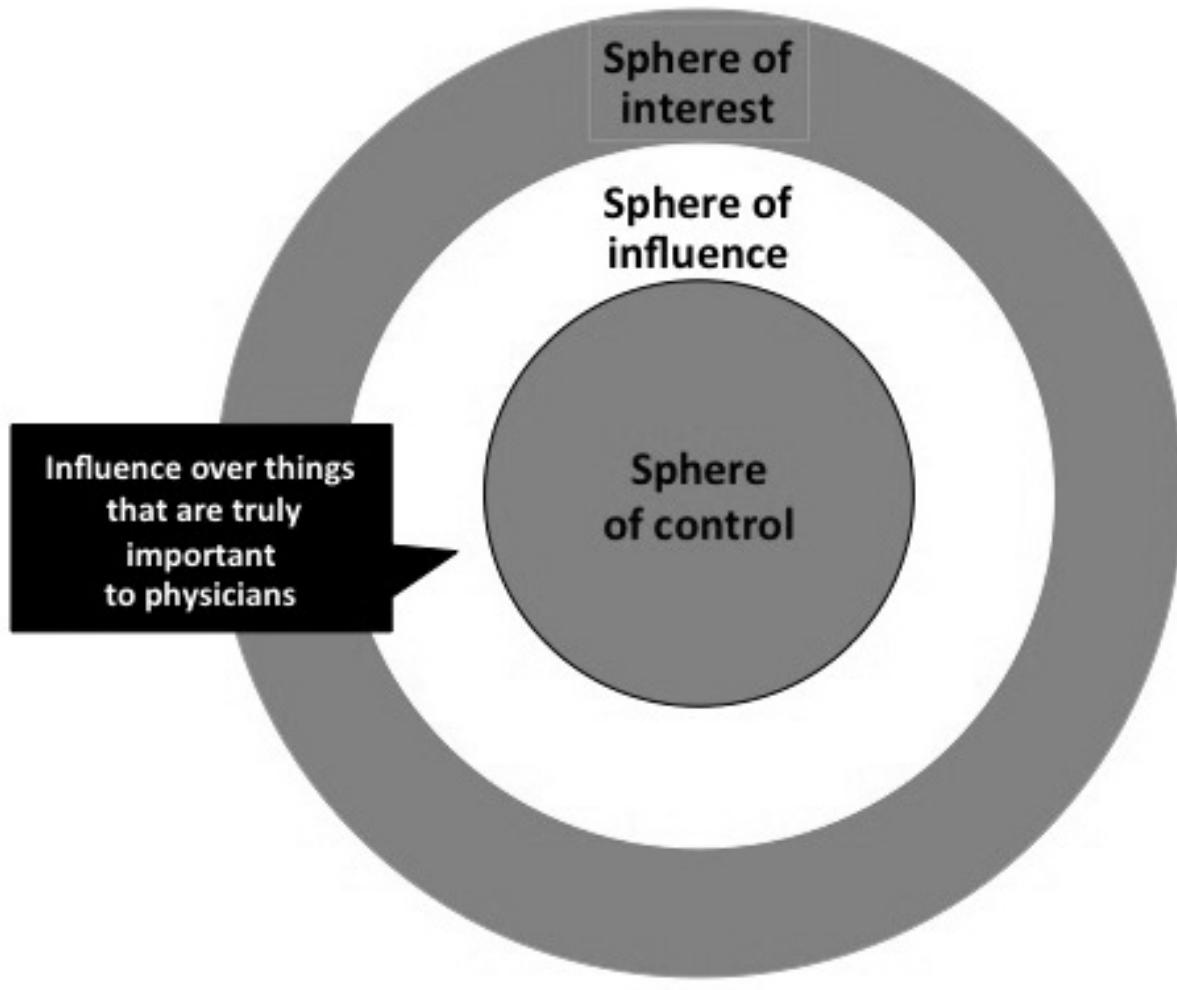
The second principle underlying cultivating influence is that as individuals or stakeholder groups in an organization, we are “interested” in far more than we actually control. This sphere of interest is large and far exceeds the size of our sphere of control. For example, medical staffs are interested in many things in the hospital. Is it clean? Is the staffing adequate? Is the perioperative staff adequately trained? Are laboratory and imaging studies available, accurate, and timely? Is there sound financial stewardship to ensure an adequate budget for capital and plant investments? Although the physician medical staff controls none of this, they most certainly are concerned with this sphere of interest. How are they able to influence this?

The third and unifying principle of cultivating influence is that people who do a great job handling their sphere of control are far more likely to be able to “influence” their sphere of interest. For example, the hospital board is much more likely to listen to the medical staff that does an outstanding job monitoring and improving the quality of care than the one that does a sloppy and haphazard job. Additionally, the high-functioning medical staff in their sphere of control is far more likely to have a collaborative working relationship with both the hospital administration and the board. In turn, they will solicit opinions from the medical staff and take under serious advisement input from the medical staff. This medical staff is truly able to “influence” a much broader area of the organization over which it has no direct control. Contrast this with the medical staff whose fundamental processes for determining medical staff competency are haphazard, unevenly applied, and often contradictory. This board will most likely have serious reservations about input from the medical staff on any strategically important challenge/idea. Consequently, this medical staff will struggle greatly with trying to influence its “sphere of interest.”

The point of this leadership lesson is graphically illustrated in Figure 1.5 of the spheres of control-influence-interest and can be simply stated as follows:

*To expand your influence, you must begin by doing what is in your sphere of control. Do what is in your sphere of control well, and your influence will expand. Don't do what is in your sphere of control well, and your influence will shrink. It is as simple and as difficult as that!*

Figure 1.5 | Spheres of Interest, Influence, and Control



# The Medical Staff Leader's Survival Guide

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Physicians who accept or are assigned leadership positions are often left on their own to develop leadership skills and educate themselves about their responsibilities as medical staff leaders. Just because a physician is a great clinician does not mean he or she is a great leader.

The challenges of being a successful medical staff leader are twofold: You must be well-versed in your role and responsibilities (i.e., peer review, credentialing, medical staff bylaws), and you must inspire other medical staff members to follow the rules while simultaneously delivering excellent patient care. 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.

This book aims to teach physicians how to become great medical staff leaders and how to motivate other medical staff members on topics such as:

- AHP credentialing and supervision
- Reappointment challenges
- Physician-hospital competition
- Liability risks
- Medical staff disharmony and distrust

Author **William K. Cors, MD, MMM, FACPE**, is an experienced physician executive with a background that includes 15 years of clinical practice and more than 18 years of experience in executive hospital/health system management and healthcare consulting. He currently serves as the chief medical quality officer for Pocono Health System in Pennsylvania. Formerly, he was the vice president of medical staff services for The Greeley Company, Inc., in Danvers, Massachusetts. Cors has extensive experience in all facets of medical staff affairs, operations, and development.



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