THE MEDICAL EXECUTIVE COMMITTEE MANUAL

William F. Mills, MD, MMM, CPE, FACPE, FAAFP

Mary J. Hoppa, MD, MBA

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HCPro

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Hoppa is one of The Greeley Company's leading national speakers and is the author or coauthor of the following HCPro/Greeley books: *The Medical Executive Committee Handbook*, Third Edition (2007); *The Top 40 Medical Staff Policies and Procedures*, Fourth Edition (2010); *The Medical Staff Leaders' Practical Guide*, Sixth Edition (2007); and *Engage and Align the Medical Staff and Hospital Management* (2010). Hoppa is a family physician with 15 years of post-residency practice experience, including chief medical officer at Methodist Hospital in Merrillville, Ind. Her previous positions include physician advisor, medical director of an employed physician group, medical director of various insurance plans, and member of the Iowa Board of Medical Examiners.

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Introduction

The Centers for Medicare & Medicaid Services' (CMS) *Conditions of Participation (CoP)* requires that a hospital has an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital. Most medical staffs choose to fulfill this requirement by creating a medical executive committee (MEC) that serves as the leadership body of the self-governing medical staff. Although CMS does not require a MEC, other regulatory agencies do. The duties of the MEC, as delegated by the medical staff, include:

- Serve as the final decision-making body of the medical staff in accordance with the medical staff bylaws and provide oversight for all medical staff functions
- Coordinate the implementation of policies adopted by the governing board
- Submit recommendations to the board concerning all matters relating to appointment, reappointment, staff category, clinical service/department assignments, clinical privileges, and corrective action
- Report to the board and to the staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the medical staff in organizational performance improvement activities
- Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff members including collegial and educational efforts and investigations, when warranted
- Make recommendations to the board on medical administrative and hospital management matters
- Keep the medical staff up to date concerning the licensure and accreditation status of the hospital

- Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs
- Review and act on reports from medical staff committees, clinical services/departments, and other assigned activity groups
- Formulate and recommend to the board medical staff rules, policies, and procedures
- Request evaluations of practitioners privileged through the medical staff process when there is question about an applicant or member's ability to perform privileges requested or currently granted
- Make recommendations concerning the structure of the medical staff, the mechanism by which medical staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures
- Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the hospital by entities outside the hospital
- Oversee the portion of the corporate compliance plan that pertains to the medical staff
- Hold medical staff leaders, committees, and clinical services/departments accountable for fulfilling their duties and responsibilities
- Make recommendations to the medical staff for changes or amendments to the medical staff bylaws

Additionally, the MEC is empowered to act for the organized medical staff between meetings of the organized medical staff.

How This Book Will Help

This book will serve as a guide and reference manual on how the MEC can discharge its duties in an effective and efficient manner. Not only will there be an academic and regulatory focus, but real-life examples of common issues and how to address them will be provided. Methods for providing leadership that is fair, honest, and consistent will be shared.

Additionally, skills for managing practitioner performance, dealing with disruptive practitioners (those who undermine the culture of safety and quality), running efficient and effective meetings, and honing communication and influence will be presented. An understanding of the material in this book, a synthesis of the best efforts of countless individuals, will speed you on your way to creating, improving, and sustaining a relevant medical staff and MEC.

How This Book Is Organized

This book is organized into 21 chapters, beginning with the roles and interactions of and between the MEC, management, and board. The next section will describe how to achieve great practitioner performance. From there, the direction will move to specific responsibilities of the MEC and how best to accomplish them. The final section of the book will address leadership skills and how to make the MEC meeting an effective tool for change and improvement and not just a regulatory requirement. Although the book is structured to be read from cover to cover, each chapter will stand alone as a ready reference for a quick refresher or a resource to answer a specific issue.

Throughout this book, references will be made to standards from The Joint Commission (TJC), as this hospital accreditation organization currently accredits over 4,000 hospitals, more than HFAP and DNV combined. HFAP (Healthcare Facilities Accreditation Program) was originally created in 1945 to conduct an objective review of services provided by osteopathic hospitals. DNV Healthcare, Inc., a wholly owned subsidiary of Det Norske Veritas, a global organization, was approved in 2008 by CMS to accredit hospitals. This authority, referred to as deeming authority, is granted by CMS to accrediting organizations that determine, on CMS' behalf, whether a hospital evaluated by the accrediting organization is in compliance with Medicare regulations. Thus, if an organization is accredited by an organization with deeming authority, that organization does not need to be routinely surveyed by CMS for compliance with the *CoP*. Both TJC and HFAP have had deeming authority for much longer than DNV.

Since generally there is more familiarity with TJC, its standards will be used as examples throughout this book. Many of these standards have similar counterparts in other accrediting organizations. The format for the citations will be: chapter abbreviation followed by the standard number. For example, MS.03.01.01 would be the Medical Staff chapter, standard 03.01.01. The use of TJC standards as examples is not an endorsement of accreditation by TJC nor is it intended to suggest that accreditation by HFAP or DNV is not equally valuable. Each hospital will need to decide whether accreditation by an organization other than CMS is something it wishes to pursue, and if so, which accrediting organization best fits the needs and culture of the individual institution.

Another note before we get started: There is a deliberate use of the word "practitioner" throughout this book. This is to remind you that the medical staff is responsible for monitoring the quality of all those privileged through the medical staff process, not just physicians. The word "physician" is used to reference medical staff leaders and functions that are performed predominantly by physicians.

The Journey Begins

There is no magic recipe for the development of the perfect MEC, but by the end of this book, you will be well on your way to creating a highly effective and efficient committee that will help prepare your organization to succeed in the ever-changing healthcare arena. The skills you will learn are significantly different from the skills you learned that made you an effective, clinically competent healthcare provider. Imagine the benefits you will bring to your organization when you harness the power of the pyramid and transition your MEC from a regulatory requirement into a dynamic, living, learning committee truly invested and excited to be part of the new healthcare system.

So fasten your seatbelts, and prepare to go wherever the journey takes you.

DOWNLOAD YOUR MATERIALS NOW

Sample tools and documents for this book are available online at the website listed below. As with the sample tools featured in the book, these should be used as a guide only. Always adhere to your organization's bylaws, policies and procedures, and rules and regulations, as well as state, federal, and accreditor's rules and regulations when taking ideas from these sample forms.

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1 Roles and Responsibilities of the Medical Staff, Management, and Board

Medical staff leadership is a role that most physicians are not prepared to assume. The usual path to serving in such a role generally comes from either: a clinically competent physician that is respected for his or her diagnostic or patient management skills is elected by the medical staff, or it was that physician's "turn" to take the position (also described as the physician may not have been present at the meeting when he or she was elected). There is a path less traveled where physicians seek out leadership training so that they can be effective medical staff leaders. Hopefully this is why you are reading this book.

The medical staff leadership skill set is not one that is traditionally taught in medical school, residency, or fellowship programs, but it is a skill set that is becoming increasingly necessary in this era of health-care reform. Management and the board are looking to physicians to help create this "new world," and therefore the development of physician leadership skills greatly improves physician credibility with management and the board. Although the focus of this book is not to develop competent physician leaders, most of the chapters will include tips and tools to improve these skills.

This chapter will address the roles and responsibilities of the medical staff, hospital management, and the board. Although all of these groups have similar objectives, a basic understanding of and respect for the differences is crucial to creating and maintaining an effective and efficiently functioning hospital. The context of "good fences make good neighbors"—a mid-17th century proverb made popular by the 1914 poem "Mending Wall" by Robert Frost—is a useful way to think about how these relationships should continue to evolve. As in most proverbs, the meaning of this one is somewhat ambiguous. Are boundaries necessary to prevent anarchy? Does having personal or group boundaries allow awareness and respect for the boundaries of others? Does the annual wall mending mentioned by Frost really speak to the required social interaction of good neighbors? Enough philosophy; it is time to move on, learn where the boundaries are, and how to respect the roles and responsibilities of the three main groups charged with creating and maintaining the complex systems required to run a hospital.

Rather than beginning with a laundry list of the roles and responsibilities of the three groups, let's begin with one responsibility that *surely* must belong to all of the groups.

Quality and Safety

Who is responsible for the quality and safety of care at the hospital? Is it the physicians? After all, they are the people who care for the patients, write the orders, determine courses of care, and get sued if anything goes wrong. Maybe it is the entire medical staff? Maybe it is hospital management since systems, structures, and processes are put in place by them? Or maybe it is everybody. That must be it, since all healthcare workers strive to increase quality and safety. But there is a problem here: if everybody is responsible, then who is accountable? Put another way, if everybody owns it, then most likely nobody owns it. So where does the buck stop? Who is ultimately responsible?

It stops with the governing board.

The governing board's responsibility for quality of care is tied to the concept of corporate negligence. The theory of corporate negligence is that if a person or organization violates an assigned duty and that violation results in injury or harm, the person or organization is liable for that harm. The initial cases of corporate negligence were brought against large companies such as railroad and steel companies. Since hospitals were "charitable organizations" they were thought to be exempt from suit based upon the doctrine of charitable immunity. This doctrine provided immunity from civil liability relating to negligent tort claims. This immunity was granted to charitable or nonprofit organizations. The legal doctrine of charitable immunity holds that a charitable organization is not liable under tort law. The elements of a negligent tort claim are:

- A duty exists
- There is a breach of that duty
- The breach of that duty is the actual cause and the proximate cause of the harm

So hospitals thought they were safe, protected by charitable immunity, until 1965 when a case in Illinois known as *Darling vs. Charleston Memorial Hospital*[1] went to trial. Dorrence Darling II broke his right leg while playing in a college football game. He was taken to the emergency room of Charleston Community Memorial Hospital where the physician treated him by applying traction and placing the leg in a plaster cast. Soon after the cast dried, Dorrence began experiencing pain in his toes, which became

swollen and discolored and later cold and insensitive. On several occasions thereafter, the physician made slight modifications to the cast including notching it around the toes and then splitting the sides with a saw, cutting Dorrence's leg in the process. The nurses failed to follow hospital procedures to monitor his toes for changes in color, temperature, and movement; to check circulation every 10–20 minutes; and to report any changes to medical staff. Dorrence was transferred to another hospital where he was treated by a physician who found that his leg contained dead tissue likely resulting from an overly tight-fitting cast, which interfered with blood circulation in the leg. After several unsuccessful operations to the leg, a below-the-knee amputation was performed. At trial, the Darlings argued that it was the duty of the hospital staff to ensure that all policies and procedures were followed. The physician settled, but the hospital went to trial assuming that it would be protected by the doctrine of charitable immunity. The jury returned a verdict in favor of the Darlings that was affirmed by the appellate court. This was the first time that corporate negligence was applied to hospitals.

Since then, there have been many court decisions that make it clear that the governing board is responsible for the quality of care in the hospital.

The fact that the board is ultimately responsible does not mean that the medical staff and administration are absolved from responsibility. In fact, everyone who interacts with a patient, or who is involved in a process that touches a patient, is responsible for his or her role in patient care. Everyone is responsible for his or her own actions and, hopefully, is part of a culture that holds each other accountable. As in the Toyota Production System, everyone can and should "stop the line" if a quality or safety issue is identified. Physicians have a duty to perform too. The medical staff has a duty to conduct credentialing, privileging, and peer review well.

But just what does the board really know about the quality and safety of medical care? The answer to that question, as you probably already know, is "not a lot." This is where the medical staff comes in.

Since the inception of the organized medical staff in the early 1900s, the governing board has delegated responsibilities for monitoring and improving the quality of care to the medical staff and to management. This does complicate the issue as now the medical staff and board have to determine who is responsible for what.

Board Responsibilities

It should now be clear that the governing board has ultimate responsibility for quality and safety at the hospital, but there are other fiduciary responsibilities that belong to the board. Certainly one of these is preserving and enhancing the financial assets of the organization to facilitate high-quality care for

patients. Managing the polarity: "Quality trumps cost" (physicians) versus "No money, no mission" (administration) is a critical issue for hospitals. (For more on the topic of polarity management, see Chapter 19.) The challenge is that both of these statements are true. To paraphrase a quote from the Nobel Prize–winning physicist Neils Bohr, "The opposite of a correct statement is a false statement. But the opposite of a profound truth may well be another profound truth." So the board has a dilemma and must find a way to balance cost-effectiveness with the quality of patient care. Achieving the "Triple Aim" of the Institute for Healthcare Improvement (improving the health of the defined population; enhancing the patient care experience; and reducing, or at least controlling, the per capita cost of care) is becoming increasingly important for all sectors of healthcare.

Additionally, the board has other duties and requirements that specifically relate to the medical staff which include:

- Determine, in accordance with state law, which categories of practitioners are eligible candidates for appointment to the medical staff
- Appoint members of the medical staff after considering the recommendations of the existing members of the medical staff
- Ensure that the medical staff has bylaws
- Approve medical staff bylaws and other medical staff rules and regulations
- Ensure that the criteria for medical staff selection are based on individual character, competence, training, experience, and judgment
- Ensure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship, or membership in a specialty body or society
- Ensure that, when telemedicine services are furnished to the hospital's patients, certain regulations are followed[2]

A description of the other requirements and duties of the governing board are beyond the scope of this book but include:

- Appoint a CEO who is responsible for managing the hospital

- Ensure that an annual operating budget is prepared according to generally accepted accounting principles, including capital expenditures
- Ensure that the services performed under a contract are provided in a safe and effective manner
- Ensure compliance with regulations concerning the provision of emergency services
- Establish the organization's mission, vision, and values
- Establish the organization's strategic plan and direction
- Ensure regulatory and legal compliance
- Ensure safety of patients, employees, healthcare providers, and visitors

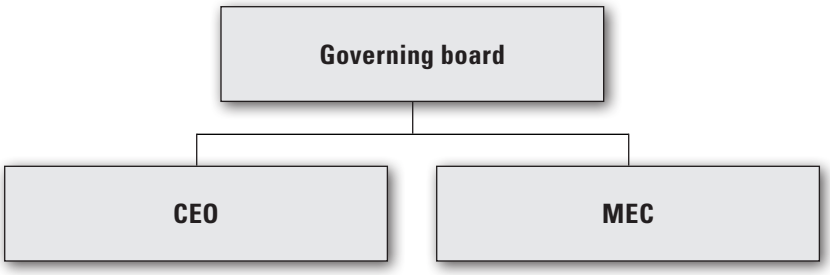
Conflict resolution is ultimately the responsibility of the board when resolution cannot be obtained at a lower level. These conflicts include, but are not limited to: peer review, turf battles, physician–hospital conflict, and medical executive committee (MEC)–medical staff conflict. Lest you think that the board has more work than it can handle, remember many of its responsibilities are delegated to the medical staff and management. The board is responsible for holding accountable those to whom it delegates the responsibilities. Also the board is charged with governance, not management. An understanding of the differences between governance and management is important for not only the board, but the medical staff.

Governance is often described as the 30,000-ft. view—meaning a broad understanding of the issues, not exquisite knowledge of all the details. A board needs to have a "nose in, fingers out" approach so that disasters, such as the Enron scandal, will not occur, while at the same time, it allows management to manage. The board must rely on others within the organization. As mentioned above, the board is responsible for recruiting, hiring, setting clear performance expectations, measuring/reviewing performance, and providing feedback to the CEO. The CEO, in turn, is responsible for those same responsibilities for the senior management team.

Organizational Chart

An understanding of the relationship among groups on the organizational chart is necessary to have a good understanding of the MEC's role (see Figure 1.1). The governing board hires the CEO, who hires the senior management team (vice-presidents), who then hire the directors and managers, etc. The board

1.1 **Hospital Organizational Model**



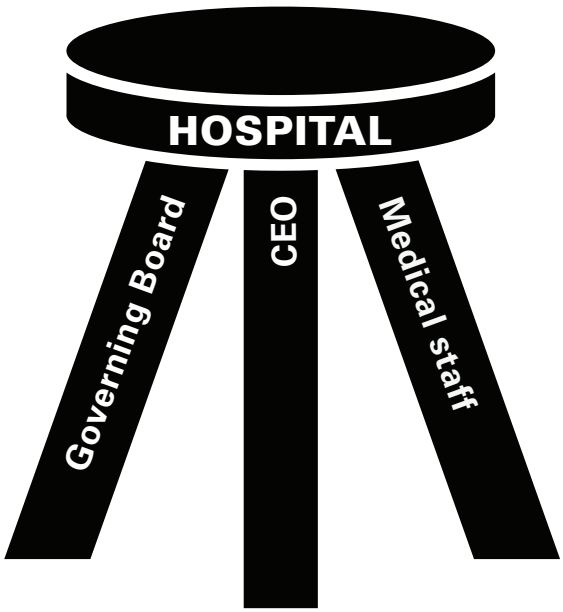
delegates the hiring decisions to the CEO, who delegates them to the management team. The board holds the management team accountable by holding the CEO accountable.

A look at the right side of the organizational chart shows the MEC reporting directly to the board. This is most clearly demonstrated in the credentialing and privileging process where the MEC makes recommendations to the board for final action. The general medical staff retains the power to amend bylaws and elect officers. The medical staff can also report or recommend directly to the governing board if there is a need to override the MEC. This is an occurrence that should be rare, but it should be known that this option is available. Although this organizational chart is the most common one in hospitals across the country, another version is alive and well.

This chart is a three-legged stool model, which is an advocacy model (see Figure 1.2). This occurs when the medical staff says, "We are not subservient to the board. We should be an equal partner, a voice equal to management and the board and, in some cases, stand over and against the board and management."

The medical staff must advocate for quality patient care as this is a responsibility delegated to it by the board. The board holds the medical staff accountable for this responsibility. There are often times when the medical staff/MEC is advocating for physicians. This is the third leg of the stool. The medical staff wants to be seen and engaged as a partner with management and the board to maximize the potential for quality patient care, physician success, and hospital success. The three-legged stool approach is a way to ensure that the organization is not overvaluing one "leg" at the expense of the others.

1.2 **Three-Legged Stool Organizational Model**



The take-home message is that the organization is structured to hold physicians accountable to the board in a hierarchical relationship and, at the same time, to encourage physicians to partner with the board and hospital to achieve shared objectives. This somewhat complicated relationship needs to be kept in mind to be able to fully appreciate the structure of the organization.

Medical Staff Responsibilities

As mentioned previously, the board delegates to the medical staff the responsibility for monitoring and improving the quality of care, which is primarily dependent on the performance of practitioners' granted privileges. For example, a patient comes to the emergency department complaining of abdominal pain. The surgeon diagnoses cholecystitis, performs good preoperative stabilization, takes the patient to the operating room, demonstrates strong technique, provides good postoperative care, and achieves a great clinical outcome. The medical staff owns the surgeon's actions that resulted in the good clinical outcome. The medical staff would also own a poor clinical outcome if the surgeon did not perform well on any of these steps.

As mentioned in the introduction of this book, one of the Centers for Medicare & Medicaid Services' *Conditions of Participation* for hospitals is that a hospital has an organized medical staff that operates

under bylaws approved by the governing body, and the medical staff is responsible for the quality of medical care provided to patients by the hospital. This "self-governing" medical staff model presents multiple challenges, especially as healthcare becomes more complicated. Physicians are accountable to the hospital, partner with the hospital, compete with the hospital, serve as part of the hospital's workforce, and are key customers of the hospital—all at the same time. Talk about conflicting interests! Now add in the medical staff's delegated responsibility for ensuring the quality of care and you have created a system that has a high likelihood of becoming dysfunctional. Without physicians holding each other mutually accountable for quality, the system will have limited success. This will be more fully developed in Chapters 12–14.

The "mission" or "functions" of the medical staff consists of the following five components:

- Quality assessment and improvement
- Credentialing and privileging
- Governance
- Administration
- Communication

These functions will be recurring themes throughout the remainder of this book. For now, a brief overview should suffice. **Quality assessment and improvement** is a primary function of the medical staff as delegated by the board. This function goes back to the early 20th century when the American College of Surgeons began surveying hospitals to assess the quality of care. As for **credentialing and privileging**, although it is the board that grants membership and privileges to practitioners, it is the medical staff that recommends the criteria and evaluations upon which the board acts. The **governance** of the medical staff is outlined in the medical staff bylaws (see Chapter 9). The bylaws can be considered the constitution of the medical staff. **Administration** refers to the method or methods the medical staff chooses to discharge their duties. Delegation of work to committees and departments and the establishment of policies and procedures provide for improved efficiencies. **Communication** is often not thought of as a medical staff function but, indeed, it is a critical one. Communication between and among caregivers, management, and the board is necessary in the provision of safe and high-quality care and in the development and execution of strategic initiatives (see Chapter 19).

Management Responsibilities

Management also has responsibilities for the quality of care delivered within the hospital. While the medical staff is responsible for the quality of care delivered by those privileged, management is responsible for the systems of care including hospital employees such as nurses, technicians, etc. Management is also responsible for financial performance, regulatory compliance, appropriate staffing, and facilities.

Management provides the necessary resources to the board and medical staff to fulfill their responsibilities. For example, the medical staff services department provides credentialing and privileging support and expertise, and the quality management staff provides assistance with data collection and the peer review process.

Some of the other responsibilities of management include:

- Recommend and provide input on long-term strategic plans
- Establish and carry out short-term plans
- Make management decisions for day-to-day operations
- Develop and recommend budget
- Prepare requests for capital purchases
- Purchase and maintain inventory
- Develop fee schedules
- Develop and implement policies on billing, credit, and collection
- Approve hiring and firing of staff
- Establish staff responsibilities, job descriptions, and assignments
- Recommend and administer personnel policies
- Approve staff salaries
- Evaluate staff performance

- Prepare reports for the board
- Receive reports and maintain relationships with the medical staff
- Establish and implement quality plans
- Establish and implement corporate compliance plans
- Guide community relations
- Coordinate business functions
- Manage patient records

Physician executives such as medical directors, vice presidents of medical affairs (VPMA), or chief medical officers (CMO) serve as a resource to the medical staff. In the organizational chart, the physician executives are hired, compensated, and accountable to the CEO. Some physician executives are also members of the medical staff with clinical privileges and are accountable to the organized medical staff in reference to the quality of care provided to patients. This dual "reporting" structure is difficult to maintain unless a clear separation of the responsibilities is delineated.

Although the physician executive can have many roles and responsibilities as a member of the senior management team, his or her main role as related to the medical staff is serving as a resource. This role may include medical staff leadership development, mentoring and educating physician leaders, providing assistance in healthcare law and regulatory requirements, and serving as a liaison between the medical staff and senior management. The physician executive must be cognizant of the line that exists between serving as a resource and actually doing the work of the medical staff.

As the physician executive has no direct (line authority) reporting relationship with the medical staff, the "power" comes in the form of influence. Influence can be a more potent form of power than a direct reporting structure described by the organizational chart.

Understanding Influence

Influence can be defined as the capacity or power of persons or things to be a compelling force on or produce effects on the actions, behavior, opinions, etc., of others.[3] It is beyond the scope of this book to provide an in-depth discussion on power and influence, but the book *The Shifting Sources of Power and*

Influence by Charles Dwyer[4] can provide you with a deeper understanding of this topic. Dwyer's basic concept is that you should never expect anyone to engage in behavior that serves your values until you have given that person *adequate reason* to do so. Adequate reason is the secret to influence. Additional information on influence will be presented in Chapter 19. The remainder of this chapter will provide a framework for considering the sphere of interest, influence, and control.

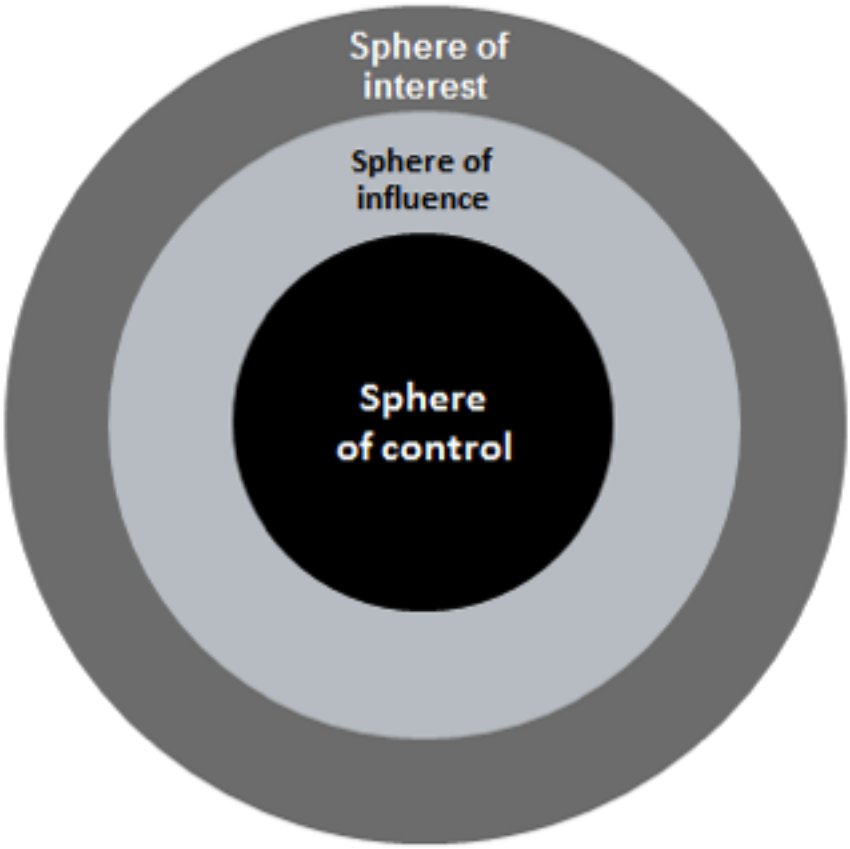
We now return to the concept of good fences making good neighbors. Physicians care about everything that happens to the patient: from admitting the patient, to treating the patient, to delivering meals. Although the medical staff owns physician performance issues, it certainly does not own all of these other things. These areas do fall within the physician's sphere of interest and influence, but certainly not within the physician's sphere of control.

The fact that physicians do not control many of the critical elements of effective, efficient hospital operations does not mean these are outside of physicians' spheres of interest. The medical staff can influence important decisions such as staffing (owned by management) and strategic planning (owned by the board). Physicians can influence other practitioners' actions. The physician can educate the nurse about the patient's condition and share the treatment plan with the nurse. The physician can also make it clear that he or she is worried about the patient's condition and encourage the nurse to call should the patient's condition change overnight. By doing this, the physician's sphere of influence is expanded.

Figure 1.3 illustrates the physician's sphere of control, influence, and interest. The sphere of control is the smallest of the three. The organized medical staff has an interest in everything that goes on at the hospital. The medical staff is interested in patient care, the hospital's reputation and financial standing, the physical plant, and the competence of all staff. But as stated previously, the medical staff's sphere of control is limited to the tasks delegated to them by the board—the quality of care is primarily dependent upon the performance of individuals granted privileges.

When keeping in mind these three spheres, it's important to recognize that the better the medical staff addresses issues within its sphere of control, the better it can expand its sphere of influence to encompass most of its sphere of interest. As the sphere of influence expands, the medical staff becomes better able to help the hospital and fellow physicians achieve their mutual goals. The most effective MECs are those that have been able to increase their sphere of influence with all of the stakeholders involved with the hospital. One way to increase influence is by achieving great physician performance. This will be explored in the next chapter.

1.3 **Spheres of Interest, Influence, and Control**



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THE MEDICAL EXECUTIVE COMMITTEE MANUAL

William F. Mills, MD, MMM, CPE, FACPE, FAAFP • Mary J. Hoppa, MD, MBA

Don't waste another minute of medical executive committee members' time and skills

Physician leaders are pressed for time. Give them the knowledge and tools to confidently and effectively carry out their MEC responsibilities and comply with accreditors' standards. This book will help MEC members understand their role in important medical staff functions, such as credentialing and privileging; practitioner competency and peer review; physician contracts and alignment; and quality and patient safety. This book also helps MEC members understand their relationship to the medical staff, other committees, administrators, and the governing board.

This book will serve as a guide and reference manual for how the MEC can effectively and efficiently carry out its duties, including:

- Methods for providing leadership that is fair, honest, and consistent
- Maximizing members' leadership skills and minimizing time spent in meetings
- The MEC's role in OPPE, FPPE, and peer review
- The MEC's role in physician contracting, physician-hospital alignment, and hospital strategies
- Communicating with the governing board and hospital administrators

About the authors

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