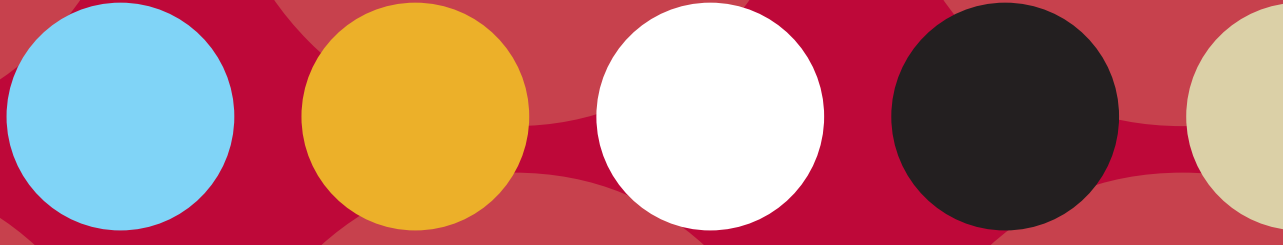
the Greeley Guide *to* New Medical Staff Models

SOLUTIONS FOR CHANGING PHYSICIAN-HOSPITAL RELATIONS



Richard A. Sheff, MD, CMSL | William K. Cors, MD, MMM, FACPE, CMSL

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Greeley Medical Staff Institute

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About the Authors

Richard A. Sheff, MD, CMSL

Richard A. Sheff, MD, CMSL, is the chairman and executive director of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. He brings more than 25 years of healthcare management and leadership experience to his work with physicians, hospitals, and healthcare systems nationwide.

Sheff has consulted, authored, and lectured on a wide range of healthcare management and leadership topics, including governance, hospital and medical staff performance improvement, management of low-quality and disruptive physicians, ED call, patient safety and error reduction, credentialing, medical staff effectiveness and redesign, medical staff leadership development, strategic planning, and regulatory compliance.

Prior to joining The Greeley Company, Sheff held positions including vice president of medical affairs, independent practice association president, physician-hospital organization medical director, president of a corporation that owned and operated physician practices, and group practice medical director. He has taught at Tufts University School of Medicine in Boston and served as chair of the Massachusetts Academy of Family Practice Research Committee. He has also achieved recognition as a certified medicl staff leader (CMSL).

Sheff is a graduate of the University of Pennsylvania School of Medicine in Philadelphia and of the residency program in family medicine at Brown University in Providence, RI. He was an undergraduate at Cornell University in Ithaca, NY, and a recipient of the Keasbey Scholarship for the study of politics and philosophy at Oxford University in England.

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William K. Cors, MD, MMM, FACPE, CMSL, serves as the vice president of medical staff services at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. This position involves overall operational responsibility for the national medical staff consulting practice.

Cors' background includes 15 years of clinical practice and more than 12 years of executive hospital/health system management experience. He also has extensive experience as a healthcare consultant. Cors has been involved 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; quality of care and patient safety improvement; 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 received his bachelor's degree from the College of the Holy Cross, his medical degree from New Jersey College of Medicine, and his Masters of Medical Management (MMM) degree from Tulane University. He is a Fellow of the American College of Physician Executives (FACPE) and is board certified in neurology and medical management. In addition, he has achieved recognition as a certified medical staff leader (CMSL). Cors holds an academic appointment in the Department of Neurosciences at Robert Wood Johnson Medical School, New Jersey. He was elected to the Board of Directors of the American College of Physician Executives (ACPE) in April 2007.

Introduction

"The old medical staff model is dead. What's the new model?"

This question, posed by CEOs and medical staff leaders alike, is the one we set out to answer when we started this book. *The Greeley Guide to New Medical Staff Models: Solutions for Changing Physician-Hospital Relations* is based on The Greeley Company's more than four decades of experience working with hospitals and medical staffs. We work with hundreds of hospitals, medical staffs, and other physician organizations each year in every state and every community across America. We experience firsthand the challenges confronting hospitals and physicians. We also have the privilege of witnessing examples of outstanding leadership from physicians, hospital managers, and board members.

How to Use This Book

In Chapter 1, we address the question of whether we need a new medical staff model. We identify the key challenges facing hospitals and medical staffs today, and turn each challenge into a goal medical staffs must achieve if healthcare is going to meet the needs of physicians, hospitals, our communities, and our country.

Chapter 2 examines the history of the medical staff, from the self-governed medical staff championed by the early founders of the American College of Surgeons to the broken social contract experienced by many physicians and hospitals today.

Chapter 3 provides a comprehensive review of the new medical staff models popping up across the country. (Readers may be surprised to find we've identified at least 18 medical staff models through our consulting and research!) As we analyze the strengths and weaknesses of each model, you'll readily recognize that we are not moving into a one-size-fits-all medical staff model. Instead, almost all medical staffs will be forced to integrate multiple models into a coherent approach to aligning physicians and hospitals.

In Chapter 4, we connect the dots by identifying which medical staff models can help your hospital and medical staff achieve key goals. The CD-ROM that accompanies this book includes a spreadsheet that, at a glance, helps physician and hospital leaders determine which goals are most important to them and select the best models to help them achieve those goals.

Chapter 5 looks at the evolving challenge of medical staff development planning. No longer is it just a matter of determining physician-to-population ratios. Instead, key strategic issues must be addressed if hospitals are going to achieve truly effective medical staffs that drive physician and hospital success while providing high quality patient care.

Chapter 6 examines one of the core challenges facing physicians and hospitals today: physician apathy. We ask whether the medical staff is even relevant to physicians today. Not surprisingly, this question can only be answered in the context of the generational differences that are playing out in medical staffs. We conclude by recognizing that, if the trend of physician apathy is to be reversed, investing in training medical staff leadership is the key.

Finally, in Chapter 7 we put it all together into a practical, 10-step process to achieve better physician-hospital relationships with the goal of achieving physician success, hospital success, and quality care for your community.

On the CD-ROM that accompanies this book, we've provided a white paper from The Greeley Company entitled *How Can Physicians and Hospitals Both Succeed When They Compete and Collaborate at the Same Time?* This white paper creates the most constructive frame for exploring new medical staff models throughout the book.

Buckminster Fuller—inventor, architect, engineer, mathematician, poet, cosmologist, and transcendentalist—once said that it is the obligation of each of us to help make the universe work. We hope you will use the information in this book to help make healthcare work for your physicians, your hospital, and your community.

Note: At the time this book goes to print, The Joint Commission has released its revised standards and elements of performance (EP) for 2009, which will take effect on January 1, 2009. Although no new standards have been added, some requirements have been split or consolidated, and standards have been renumbered. All references in this book to Joint Commission standards and EPs are according to the *Comprehensive Accreditation Manual for Hospitals,* 2009 Edition. To access The Joint Commission's history tracking tool, a crosswalk of the 2008 and 2009 standards and elements of performance, visit *http://www.jointcommission.org/Standards/SII/sii_hap.htm.*

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CHAPTER 1

Do We Need a New Medical Staff Model?

About a year ago, a hospital CEO came up to one of the authors of this book and announced, "The old medical staff model is dead. What's the new model?" Although this was an interesting comment and question, it didn't seem earth shattering. In fact, for the past 15 years, we have heard others predict the death of the organized medical staff as we know it. Yet the self-governed organized medical staff has persisted.

A few weeks later, another CEO reiterated the comment. A month later, it happened again. Now the comment was more than just intriguing. It raised some questions: Is the organized medical staff truly dead, and we just didn't know it? If so, what's the new model? What if the new model is not a single model but multiple models? These questions formed the impetus for writing a book on new medical staff models.

The place to start this discussion is with a vision of what you—meaning your hospital and physicians—are trying to accomplish for healthcare in your community. It can best be summarized in three simultaneous goals:

- Achieve physician success
- Achieve hospital success
- Provide great care to your community

If these three goals are met, we'd all consider it a home run. Let's call this the "vision" of a truly effective medical staff. The new medical staff model should make this vision a reality. Let's now discuss the challenges that make it difficult to achieve the vision of physician success, hospital success, and great patient care.

Today's Medical Staff Challenges

Hospitals and medical staffs face critical challenges. Reimbursement is not keeping up with rising costs. Physicians and hospitals increasingly compete with each other. The old social contract that linked medical staff membership to emergency department (ED) call responsibilities is unraveling. Regulatory requirements are becoming more stringent and invasive. In the face of all these challenges, physician apathy is growing.

Following are the areas we find that are the most pressing and important challenges facing hospitals today related to their medical staffs:

- Medical staff structure and governance
- Physician performance and accountability

- Hospital-medical staff collaboration
- Medical staff culture

In the following sections, we identify the specific challenges in these areas and reframe each challenge as a goal we are seeking to achieve through a better medical staff model. Please note that these and additional medical staff challenges are discussed in depth in *The Medical Staff Leader's Practical Guide,* Sixth Edition, published by HCPro, Inc., which includes practical strategies and tips for medical staff leaders to use when addressing each challenge. Here we are using these challenges as a framework to evaluate new medical staff models.

Medical Staff Structure and Governance

Challenge	Goal
Physician apathy and poor meeting attendance	✓ Physician engagement and active participation
Poor medical staff communication	✓ Good medical staff communication
Unprepared, ineffective medical staff leaders	✓ Well-prepared, effective medical staff leaders
Conflict over member rights and responsibilities	✓ Good balance between physician advocacy and mutual accountability

Physician apathy and poor meeting attendance

One of the most common complaints we hear in medical staffs across the country is that doctors don't come to meetings anymore. Physicians are also reluctant to serve in medical staff leadership positions. In a more effective medical staff, physicians would be engaged and participate actively in meetings (including asynchronous online meetings). Physicians would also be willing to serve as leaders.

Poor medical staff communication

Physicians struggle to keep up with the clinical information that bombards them, such as lab results, patient and family phone calls, and calls from hospital units and consultants. They tend not to read communications from the hospital or medical staff. They also feel so pressed for time that they tend to communicate about inpatients through the medical record, rather than speaking with other providers directly. An effective medical staff would be one in which physicians communicate well with one another about clinical issues and with their leaders about medical staff issues.

Unprepared, ineffective medical staff leaders

In many hospitals, a practicing physician with little interest in medical staff leadership could be appointed president of a medical staff at the blink of an eye. This happens for two reasons: high leadership turnover and inadequate investment in medical staff leadership development and succession planning. Effective medical staffs retain leaders longer and invest in leadership development and succession planning.

Conflict over member rights and responsibilities

Medical staffs often focus on protecting member rights—and for good reason. The medical staff doesn't want to negatively affect a fellow physician's ability to practice successfully and earn a good living. At the same time, with rights come responsibilities. Medical staffs today are less effective at holding physicians accountable for fulfilling their responsibilities. In fact, most medical staffs have not taken the time to adequately set and communicate comprehensive performance expectations and achieve physician buy-in. In addition, many are not holding members accountable for fulfilling these responsibilities. An effective medical staff strikes the right balance between advocating for physician rights (including the right to practice unencumbered and to earn a living) and holding physicians accountable.

Physician Performance and Accountability

Challenge	Goal
Inappropriate variation in physician performance	✓ Consistently excellent physician performance
Disruptive physician behavior	✓ Physician accountability for behavior
Poor physician compliance with medical staff and hospital policies	✓ Physician buy-in and compliance with medical staff and hospital policies
Unnecessary, lengthy, or costly fair hearings	✓ Physician performance issues addressed collegially and without resorting to legal processes
Excessive utilization and costs	✓ Physician buy-in and compliance with efforts to control utilization and costs

Inappropriate variation in physician performance

Physician performance data makes it clear that performance varies. Some of this variation is appropriate based on the needs of different patient populations and physician practice styles. But much of this variation does not add value. In fact, recent data shows that physicians do not practice evidence-based medicine much of the time. An effective medical staff is one that drives out non-value-added variation while preserving the types of variation that add value. Striking this balance well produces consistently excellent physician performance.

Disruptive physician behavior

Unfortunately, there are few (if any) medical staffs that haven't been faced with the effects of disruptive physician behavior. Though usually confined to a small number of physicians, it's a big problem for hospital staff and medical staff leaders. (Please see *A Practical Guide to Preventing and Solving Disruptive Physician Behavior,* published by HCPro, Inc., as well as HCPro's training DVD, *Dealing with Disruptive Physicians: How to End Problem Physician Behavior Now,* for an in-depth discussion of this problem and effective strategies for addressing it.) An effective medical staff establishes clear parameters of professional conduct and holds physicians accountable for meeting them.

Poor physician compliance with medical staff and hospital policies

A surprising number of physicians think medical staff and hospital policies don't apply to them and therefore fail to complete medical records on time, show up on time to the operating room, or adhere to the physician conduct policy. An effective medical staff communicates to physicians the importance

of following policies (especially those that affect patient care and hospital operations) and ensures compliance with these policies.

Unnecessary, lengthy, and costly fair hearings

Many medical staffs go through a fair hearing to address a physician performance issue. One fair hearing typically costs upward of $50,000, and particularly difficult ones can run $500,000 or more. They tend to polarize a medical staff and require large amounts of physicians' and hospital staffs' time. Many of these fair hearings could be avoided if the self-governed medical staff implements a fair and collegial process for addressing physician performance concerns. Medical staff models built on physician employment or physician contracting raise opportunities to address physician performance issues in a more business-like manner. In both models, many performance issues can be dealt with through the human resources process or the contract management process and never become medical staff issues. The effect of such changes are discussed in Chapter 3.

Excessive utilization and costs

Hospital costs are driven in large part by physician practice patterns, giving rise to utilization management programs, including case management. Most of these programs focus on changing physician practice patterns. Physicians historically have not welcomed hospital efforts to change how they practice medicine. Yet today's financial challenges require hospitals and their medical staffs to practice more cost effectively. Physicians on an effective medical staff understand the need to be cost effective and modify their practice patterns over time to achieve this goal.

Hospital-Medical Staff Collaboration

Challenge	Goal
Strained physician-hospital relations	✓ Trusting, collaborative physician-hospital relations
Rising costs for ED coverage and Emergency Medical Treatment and Active Labor Act (EMTALA) compliance risks	✓ Physician participation in ED coverage and EMTALA compliance
Aggressive physician-hospital competition	✓ Physician-hospital collaboration
Little physician participation in medical error reduction and patient safety initiatives	✓ Physicians drive medical error reduction and patient safety initiatives
Little physician participation in efforts to improve hospital performance on publicly reported data and pay-for-performance measures	✓ Physicians drive improvements in hospital performance on publicly reported data and pay-for-performance measures
Little physician support for hospital accreditation efforts	✓ Physicians support and participate in hospital accreditation efforts

Strained physician-hospital relations

In many medical communities, relations between physicians and hospitals are characterized by a lack of trust and poor communication. This sad state of affairs usually is the result of past actions. For example, physicians may resent that hospital leaders were unresponsive to their concerns about recruiting a physician's competitor into town. The hospital may resent physicians moving the most profitable business lines into physician-owned entities and "cherry-picking" payers in the process. Hospitals and the communities they serve cannot afford poor physician-hospital relations. They need physicians and hospitals to support each others' success and achieve high-quality medical care.

Rising costs for ED coverage and EMTALA compliance risks

Across the country, physicians are refusing to provide ED call unless the hospital pays them. (For an in-depth discussion of best practices regarding ED call and EMTALA, consult *Emergency Department On-Call Strategies: From Team Management to Compensation Plans,* published by HCPro, Inc.) Hospitals are paying millions of dollars each year to physicians for ED call coverage services that they previously provided for free. Hospitals that pay for call are finding that their physicians are increasingly unhappy about call—and some physicians refuse to provide ED call coverage at any price. In addition to the rapidly rising expense of paying for ED call, these tensions have created EMTALA compliance risks for many hospitals. ED call is one of the biggest challenges driving the consideration of alternative medical staff models. An effective medical staff will ensure adequate physician participation in ED coverage and eliminate problems with EMTALA compliance.

Aggressive physician-hospital competition

As physicians' net incomes have decreased due to rising costs, resource-based relative value scales (RBRVS), managed care, and other forces, they have actively sought alternative sources of revenue. The most common target has been services historically provided by hospitals. As a result, provider-owned ambulatory surgery centers (ASC), imaging centers, endoscopy suites, and specialty hospitals are popping up across the country. These facilities generally extract the most lucrative services out of the hospital. At the same time, these provider-owned entities take few, if any, no-pay and Medicaid patients. Hospitals are fighting back by directly competing with physicians or by creating joint ventures. An effective medical staff will achieve collaboration with physicians to support the success of physicians and the hospital.

Little physician participation in medical error reduction and patient safety initiatives

The patient safety movement is putting pressure on hospitals to reduce medical errors and improve patient safety. All too often, physicians perceive that these efforts make their practices less efficient, or the efforts just do not make sense to them. In an effective medical staff, physicians will support or, better yet, drive patient safety improvements.

Little physician participation in efforts to improve hospital performance on publicly reported data and pay-for-performance measures

Transparency is the new buzzword. Medicare is not only measuring and publishing hospital results on core measures, but patient satisfaction as well. Pay-for-performance is poised to become one of the primary methods for compensating physicians and hospitals. An effective medical staff drives improvements to hospital performance on publicly reported data and pay-for-performance measures.

Little physician support for hospital accreditation efforts

Hospitals must meet Centers for Medicare & Medicaid Services (CMS), Joint Commission, and Department of Public Health requirements to keep their doors open. Physicians most often see efforts to comply with complex and demanding regulations as irrelevant to, and often a distraction from, the real business of patient care. In an effective medical staff, physicians understand what it takes to meet accreditation requirements. The best approach to achieve this type of physician support is to focus on providing good patient care and running a great hospital. Regulatory compliance should be a natural by product of these efforts.

Medical Staff Culture

Challenge	Goal
Physicians overvalue collegiality to the neglect of excellence in physician performance	✓ Physicians achieve high levels of collegiality and excellent performance
Physicians focus on their practices and home life and commit little energy and time to the hospital	✓ Physicians maintain a balance between their practices, home life, and the hospital
Physicians demand autonomy in clinical practice and resist accountability to the medical staff	✓ Physicians maintain a balance between appropriate autonomy in clinical practice and mutual accountability to their peers
Physicians feel that the hospital does not appreciate what they do for patients and the hospital, causing them to resist performance improvement efforts	✓ Physicians feel appreciated and embrace continuous performance improvement efforts
Physicians cling to old ways of doing things and resist change	✓ Physicians achieve a balance between maintaining ways of doing things that work and embracing change
Physicians compete with each other for patients and revenue	✓ Physicians balance healthy competition with mutual respect

Medical staff culture requires a bit of an explanation before we can describe each challenge and its corresponding goal. An organization's culture is the sum of the values, attitudes, and behaviors that characterize the way people in the organization act. Culture drives behavior and behavior drives results. To achieve an effective medical staff, physician leaders must proactively mold and lead the medical staff culture so that it simultaneously promotes physician success, hospital success, and quality patient care. Recent literature

addressing organizational culture has recognized that truly effective cultures must simultaneously embrace and balance interdependent opposites, sometimes called polarities.[1] The primary polarities that must be optimized to achieve an effective medical staff include:

- Collegiality and excellence
- Freedom and commitment
- Appropriate independence and mutual accountability
- Appreciation and continuous performance improvement
- Stability and change
- Competition and respect

These polarities are discussed in greater depth in Chapter 5. For the current focus of addressing medical staff challenges, it is enough to recognize that historically medical staffs have tended to overvalue one pole and neglect the other. The goal in each case is to strike a balance between the two poles that allows the medical staff to achieve high levels of performance.

Physicians overvalue collegiality to the neglect of excellent physician performance

Physicians who work together and play together treat each other as valued colleagues, trust each other, and enjoy each other's company. Collegiality is based on unconditional respect, and excellence is based on conditional respect. A high-performing medical staff balances collegiality and excellence at the same time.

Physicians focus on their practice and home life and commit little energy and time to the hospital

Physicians need the freedom to choose how to spend their time, including how much focus to place on their practices and home lives. At the same time, if a medical staff is to be effective and relevant to important hospital issues, physicians must participate in medical staff and hospital meetings. If they consistently choose their practices and home lives over involvement in the medical staff and hospital, the hospital will seek other avenues for getting the medical staff's work accomplished. In fact, the evolution of new medical staff models has been driven by hospitals seeking such avenues. Whatever model(s) you choose, your medical staff must balance physicians' freedom to choose how to spend their time with their commitment to the hospital.

Physicians demand autonomy in clinical practice and resist accountability to the medical staff

Physicians need to feel that they can practice autonomously and independently. However, as noted earlier, unbridled autonomy produces excessive and non-value-added variations in physician practice patterns. For hospitals to succeed in a competitive environment that pushes them to simultaneously achieve high quality and lower costs, they need all physicians to ensure that their practice patterns help optimize the hospital's performance. This can only happen if physicians are held accountable for their performance. Hence, an effective medical staff is one in which physician autonomy is balanced by accountability to the medical staff.

Physicians feel that the hospital does not appreciate what they do for patients and the hospital, causing them to resist performance improvement efforts

Physicians often feel unappreciated by their medical staff and hospital for the hard work and excellent care they already provide. This perceived lack of appreciation causes physicians to resist improvement efforts. An effective medical staff achieves a healthy balance between appreciation and performance improvement.

Physicians cling to old ways of doing things and resist change

Medicine is an inherently conservative profession. Physicians are responsible for patients' lives, so they don't want to jump onto the latest fad until it's been proven effective. This natural tendency is exacerbated if physicians perceive that others are forcing change on them. Yet the healthcare industry is demanding that physicians and hospitals change at an accelerating pace. An effective medical staff will help physicians and the hospital succeed by respecting what has worked in the past and embracing change that is needed for the future.

Physicians compete with each other for patients and revenue

Physicians have competed for patients since the early days of medicine. Physician-to-physician competition can be healthy, encouraging physicians to strive for better outcomes and to provide better service. Unfortunately, in many medical staffs, physician-to-physician competition turns negative. In an effective medical staff, physician-to-physician competition can thrive, but only in an environment of mutual respect that is based on performance outcomes data, service, and other quality parameters.

These are the challenges facing medical staffs today and for the foreseeable future. These challenges are driving hospitals to experiment with new medical staff models. To understand the context of these new models, we must first examine the history of the medical staff that has shaped the issues medical staffs and hospitals now face.

ENDNOTES

1. Please see the book *Polarity Management,* by Barry Johnson (Human Resource Development Press) for further discussion of the powerful phenomenon of polarities and how to manage them.

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