Resolve Practitioner Turf Conflicts

Medical Staff, AHP, and Off-Site Disputes

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In his role, Cox has systemwide strategic and operational responsibility for the six clinical institutes, physician alignment, performance improvement, and regulatory compliance. The six institutes cover a major portion of Hoag’s comprehensive mix of healthcare services, including orthopedics, women’s health, neurosciences, cancer, heart and vascular, and primary care.

Prior to Hoag, Cox served as chief medical officer and senior vice president of Premier, Inc., a national healthcare alliance with more than 2,000 nonprofit hospital/system members, a group purchasing organization with more than $30 billion in GPO purchasing contracts, and a 2006 Malcolm Baldrige Award winner. There, he developed and led a model for quality improvement initiatives in conjunction with the Institute of Healthcare Improvement.

Cox was a regional medical director for Intermountain Health Care, Inc., where he led operational and quality improvement for eight outpatient physician group practices. He served on the corporate board of trustees for two years. He has served on the clinical faculty for five medical schools and was previously involved in academics and research for 13 years, including serving as director for two residency programs. He has served on a number of boards and committees, including the American Hospital Association, the Health Technology Center, an Institute of Medicine subcommittee, and the JCAHO Journal on Quality.

Cox is a board-certified family physician, a fellow of the American Board of Family Practice, and a fellow of the American College of Physician Executives and holds a master’s degree in medical management from Tulane University. He has published and spoken nationally and internationally on various aspects of healthcare and healthcare management. He is author of Privileging for New Procedures and Technologies (HCPro, 2012) and is on the editorial board of the HCPro publications Medical Staff Briefing and Clinical Privilege White Papers.
Rosemary Dragon, CPMSM, CPCS, is currently a medical staff coordinator with St. Anthony Hospital in Lakewood, Colo., working primarily with the OrthoColorado Hospital medical staff. OrthoColorado Hospital opened in 2010 as a state-of-the-art surgical hospital on the St. Anthony Hospital campus. Dragon works closely with the medical staff leadership, hospital administration, and physician ownership in their combined effort to make OrthoColorado Hospital the premier choice for orthopedic surgery in the region. With an unrelenting focus on quality and process improvement, it has already gained a reputation for leading practices, high quality, and patient satisfaction.

Prior to working with OrthoColorado Hospital, Dragon was the lead credentials coordinator for the HealthONE credentials processing center (CPC), a division of HCA. She was instrumental in assisting the HealthONE hospitals and surgery centers with the transition to an HCA CPC and with the development of the HealthONE credentials support center.

Dragon’s career as an MSP began at Poudre Valley Hospital, following a career in retail management. She benefitted greatly from the mentorship and education in medical staff services best practices that she received at this Malcolm Baldrige Award–winning community hospital. In gratitude for the mentorship she received, Dragon is committed to assisting with the professional development of other MSPs. She acts as a professional mentor, provides one-on-one education for certification preparation, and is a contributor to HCPro’s Credentialing Resource Center Journal.

Dragon is a member of the National Association Medical Staff Services (NAMSS), the Colorado Association of Medical Staff Services (CAMSS), and the American Health Lawyers Association (AHLA). She volunteers professionally with the St. Anthony Hospital employee assistance committee and the Center for Personalized Education for Physicians (CPEP) hospital engagement committee.

In addition to her professional activities, Dragon volunteers with various charitable and faith-based organizations in her community. Her favorite hobbies include cooking, reading, writing, camping, and being entertained by her nieces and nephews.
Christine Hearst, CPMSM

Christine Hearst, CPMSM, has more than 25 years of experience in medical staff services. She is currently group director of medical staff services for Centura Healthcare in Lakewood, Colo. She is responsible for the oversight of four hospitals’ medical staff services departments. She previously worked as a consultant for The Hardenbergh Group, LLC, and as an independent consultant for four years in California.

Hearst is currently the treasurer of the Colorado Association of Medical Staff Services, a member of the National Association Medical Staff Services, a member (and past regional representative) of the California Association of Medical Staff Services, and a past member of the Desert Chapter of California Association of Medical Staff Services. Hearst is also a member of the American Health Lawyers Association (AHLA) and a volunteer for the Center for Personalized Education for Physicians (CPEP).

Hearst obtained her education in Connecticut and is currently pursuing certification with The Joint Commission as a Certified Joint Commission Professional.

When not working, Hearst enjoys hiking, making jewelry, archery, and volunteering with raptors (owls, falcons, etc.), as well as spending time with her family and her dogs.
DEDICATIONS

To my professional mentor and friend, Rosalie Randolph, CPMSM, CPCS. Thank you has never seemed sufficient for the wisdom and knowledge you gave me. The time we spent as a “Rosie” team will forever be with me.

—Rosemary Dragon

To my daughter, Jessica, for her encouragement, and for keeping me on task! And to all those medical staff professionals throughout the years that have in one way or another made a difference in my life, and I in theirs.

—Christine Hearst

To my wife and best friend, Patty, you inspire me daily. To our eight beautiful grandchildren whose healthcare future makes this work worthwhile.

—Jack Cox
INTRODUCTION

Only one thing is constant: change. For the next three to five years, we are entering into a significant period of transformational change in healthcare. With this change comes uncertainty, and with the uncertainty comes more conflict. Turf battles will heat up and become more frequent as providers attempt to adapt to a changing structural landscape (i.e., where services are provided) as well as a changing payment landscape (i.e., who pays for what). Changes will be needed in focus, and skill sets of MSPs will also change to adapt to the new needs of the organization. This book is intended to help you anticipate some of the changes taking place, develop and implement a process and policy for conflict resolution, and resolve conflicts, especially around turf issues that are bound to arise.

Historically, the main areas of contention with physicians have been around subspecialty training for specific procedures (more than one subspecialty claiming an area of expertise), changes in reimbursement with an evolution from the current pay-for-volume in a fee-for-service world to paying for value and population health in the new model, a move away from inpatient hospital procedures toward more ambulatory-based delivery centers (e.g., ambulatory surgical centers) that are freestanding and not on a hospital license, and, of course, the adoption of ever-evolving new technologies and procedures.

Today, additions to these challenges seem to be fueled in part by healthcare reform (and understanding its implications as it is implemented) as well as systemwide reaction to the cost of healthcare. These new challenges include:

- An increase in the number of people with some form of insurance coverage, thus increasing access for a number of individuals
- Predicted physician shortages, which exacerbate the access problem
- An increase in payment reforms, including risk-based contracts, payment for quality, and bundled payments
- Physician and hospital (healthcare system) alignment, including physician employment
- Changing roles for advanced practice professionals (e.g., physician assistants and nurse practitioners) and clinical assistants (e.g., clinical pharmacists, surgical technicians, etc.) along with changing legal status in many states¹
- Outside entrants into the healthcare market (retail stores and pharmacies)
Introduction

The effects of the reforms, exchanges, and increased access won't be known for some time. What is known is that all will cause disruption.

The changing role of the AHP alone has the potential to cause some significant rifts within your medical staff. National organizations like the AMA, the American Association of Nurse Practitioners, and other subspecialty organizations all have an opinion as to the role of their constituents. States wanting to deal with provider shortages and besieged by specialty lobbyists are changing laws to allow for expanded care capabilities for many allied health groups. Complimentary care is becoming more mainstream, and many hospitals have instituted complimentary or alternative care programs to expand treatment options for patients, often at the patients’ specific request. Some insurance companies and employers are paying for these expanded care options. All these changes further obscure the provider “field of view” for the hospital-based medical staff services department and the MSP.

With these observations in mind, in order to sidestep the political landmines but offer usable advice, the areas we won’t address in this book include:

• Making recommendations on policy
• Recommending whether the scopes of practice for these providers should be expanded
• Recommending what your facility should be doing from a policy perspective
• Recommending what your state should be doing
• Recommending what the federal government should be doing (plenty of advice from other sources for this one)

Our goal is to provide you with tools and approaches you need to identify and navigate through many of the turf battles your hospital or health system will face. We will approach this in a systematic way, including:

• Identifying some key components of the changing healthcare landscape and areas to watch
• Discussing the changing role of the advanced practice professional and the allied health professional
• Identifying the fundamentals of both the physician engagement (employment) model as well as the rise of the hospitalist movement
• Identifying the changing expectations of where care is delivered
• Identifying ways to avoid conflict and disputes before they happen

In addition, we will discuss a path to developing a good policy and process for dispute resolution and take you through the basic steps to use if/when you need
Introduction

to resolve a dispute. We will discuss the changing role of the MSP and how to use these valuable resources optimally. In addition, there are some posted tools and resources online for you to use.

Our hope is that you never have to use the dispute resolution tools we share. Experience has told us it is a matter of when, not if. Enjoy the book and the resources we have provided.

Reference

1. There are two distinct groups of allied health professionals. One group consists of practitioners who must be granted privileges through the medical staff process in accordance with The Joint Commission’s and Healthcare Facilities Accreditation Program’s standards, and can be called advanced practice professionals (APP). An APP is an individual other than a licensed physician who provides direct patient care services in the hospital under a defined degree of supervision by a physician medical staff member with clinical privileges. APPs are designated by the board to be credentialed and privileged through the medical staff and are granted clinical privileges as defined in the medical staff bylaws.

The second group of AHPs consists of individuals that the hospital does not need to privilege through the medical staff but who provide services that are consistent with a scope of care approved by the medical staff and the board. These AHPs can be called clinical assistants (CA). CAs are typically not credentialed and privileged through the medical staff services department. Rather, their services are approved by the hospital’s human resources department. CAs provide services only under the supervision of a member of the medical staff and provide only those services that are consistent with a written scope of practice or job description approved by the board.
Section 1

Process
CHAPTER 1

What Is All the Fuss About? New Environments That Lead to Disputes

It’s no news that the healthcare industry is evolving rapidly as it grapples with insurance reform, physician shortages, and challenges in caring for the underserved. New regulatory requirements/rules, healthcare reform, changing payment structures, and shrinking reimbursement add to the uncertainty, creating the ideal environment for disputes.

Nowhere are these concerns voiced louder than at the highest levels of healthcare leadership. In the 2013 Industry Survey: Strategic Imperatives for an Evolving Industry, conducted by HealthLeaders Media, one of the key questions asked of healthcare leaders regarding healthcare industry challenges was, “Which of the following does your organization consider to be a threat?” Physician shortage came in second place (76%), only behind reduced reimbursements (92%). Healthcare reform scored fourth at 40%.1 See Figure 1.1 for a full list of the results.

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Figure 1.1 | Greatest Threats

Q: Which of the following does your organization consider to be a threat?

<table>
<thead>
<tr>
<th>Threat</th>
<th>%</th>
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<tbody>
<tr>
<td>Reduced reimbursements</td>
<td>92%</td>
</tr>
<tr>
<td>Physician shortage</td>
<td>76%</td>
</tr>
<tr>
<td>Organized labor</td>
<td>56%</td>
</tr>
<tr>
<td>Healthcare reform</td>
<td>40%</td>
</tr>
<tr>
<td>Industry consolidation</td>
<td>33%</td>
</tr>
<tr>
<td>Rationalizing financial reporting to VBP objective</td>
<td>21%</td>
</tr>
<tr>
<td>Value-based purchasing</td>
<td>20%</td>
</tr>
<tr>
<td>Health insurance exchange</td>
<td>19%</td>
</tr>
<tr>
<td>Personalized medicine</td>
<td>8%</td>
</tr>
<tr>
<td>Health information exchange</td>
<td>5%</td>
</tr>
</tbody>
</table>

As with any significant cultural change, the parties involved will feel increasing pressure as their fundamental business model shifts (true for both hospitals and physicians) and as uncertainty increases. In the following sections, we describe some of the changes taking place. As you read through these sections, keep the following questions in mind, which will help you prepare your organization to deal with the disputes that will arise:

- How are these changes manifesting themselves in my organization?
- How might these changes manifest themselves in disputes, specifically turf issues?
- Do we have the structure in place to strategically anticipate the changes and to deal with the potential issues in advance?
- Do we have a structure in place to help educate our leadership and our practitioners about change?
- For each of the areas covered, have we begun to think through our potential impact and solutions?

**Healthcare Reform**

Although one could consider the nexus of healthcare reform to have hit when President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA) into law on March 23, 2010, the underpinnings of the current tsunamic changes in healthcare have a long history.

For at least the past 30 years, we have heard that the current spend in U.S. healthcare was unsustainable. The United States has the most expensive healthcare system in the world. In the United States, the share of health spending to GDP has remained at 17.7% percent between 2009 and 2011, which is about $25 trillion\(^2\). See Figure 1.2 to see how U.S. healthcare spending compares to other countries. This is on top of an estimated 50.2 million citizens not covered by insurance and an estimated 77 million reaching retirement age within the next few years. According to census projections, the population over 65 years old will increase by 60% from 2010 to 2025\(^3\). The per capita healthcare spending is projected to increase by 65% from 2009 to 2025 and account for about 25% of the GDP\(^2\). These issues, on top of the increased out-of-pocket expenditure, healthcare insurance premiums
to employers and consumers, and cost of delivering expected healthcare benefits to employees by employers, has gotten us to this place of no return. The true debate over healthcare reform seems to revolve around questions of:

- The right to healthcare
- Access to healthcare
- Fairness of distribution of healthcare resources (payment is shrinking in the fee-for-service model)
- Financial sustainability of a program
- The quality of care delivered and how to measure it
- Who pays (how much should the federal government pay)
- The cost of expanding healthcare to previously uncovered individuals

The PPACA law adds a burden of resource need because it provides coverage and benefits to a segment of the population previously uncovered. CMS estimates that an additional 34 million people will have access to healthcare insurance. The law includes provisions to be enacted over the next few years that:

- Provide subsidized insurance premiums for some groups
- Provide incentives for businesses to provide healthcare benefits (as well as penalties for not providing benefits)
- Establish penalties for individuals not having healthcare insurance
- Expand a parent’s ability to claim children up to age 26 under the parent’s healthcare benefits

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**Figure 1.2 | Total Expenditure on Health, % Gross Domestic Product**

<table>
<thead>
<tr>
<th>Country</th>
<th>Percentage of Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>10</td>
</tr>
<tr>
<td>Turkey</td>
<td>7</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>12</td>
</tr>
<tr>
<td>Canada</td>
<td>10</td>
</tr>
<tr>
<td>Australia</td>
<td>8</td>
</tr>
<tr>
<td>United States</td>
<td>14</td>
</tr>
</tbody>
</table>

• Prohibit denial of coverage and denial of claims based on preexisting conditions (thus opening the door to individuals with expensive healthcare conditions)
• Establish health insurance exchanges
• Prohibit insurers from establishing annual coverage caps

**Did You Know...**

With the passage of the Patient Protection and Affordable Care Act:\(^3\):
• The Association of American Medical Colleges (AAMC) projected this increase in universal coverage will increase use of all physicians by 4%
• The Bureau of Health Professions projected a 5.2% increase in physician use

According to census projections, the population will increase by 15.2% from 2010 to 2025:
• Those over 65 years old will increase by 60%
• Those younger than 18 years old will increase by 13%

### Payment Models

Payment models under healthcare reform are changing as well. There is movement away from the traditional fee-for-service model to a fee-for-value model. More commercial insurers are entering into at-risk contracts with hospitals and providers. Implementation of the value-based purchasing (VBP) program by the Centers for Medicare & Medicaid Services (CMS)—which started in fiscal year 2013—rewards hospitals for performing on certain value metrics (e.g., clinical quality processes and patient service). Based on their performance, hospitals could earn back a portion of the CMS withhold in funding (1% the first year but increasing annually thereafter) and, with top performance, earn back a bonus as well.

This changing reimbursement model will require a rethinking of physician alignment models and potential disruption of current revenue streams. Short-term disputes will likely arise under a shrinking fee-for-service environment and decreasing payment for the services provided. Hospitals will be challenged to move more of their lucrative inpatient business to an outpatient model (e.g., ambulatory surgery centers), and a significant amount of the inpatient business will be subject to tiered payment models (e.g., the movement to “observation status” for patients admitted, leading to a decreased reimbursement).

Changing payment models will also lead to changes in how hospitals align/contract with practitioners, leading to potential disputes among practitioners. For example:
• Hospitals will align with groups of physicians to develop care networks that can contract with payers. This will begin to split the traditional medical staff along the lines of the perceived “haves and the have-nots.” This is especially true for risk-based contracts negotiated for the system around value.

• The move to employed physicians and an increase in the hospitalist model of care. This has created a divide with the traditional practice physician, who considers the other models competitive (e.g., a primary care physician [PCP] who feels a loss of control for his patients who are admitted to the hospital and are taken care of by a hospitalist).

• Access to patients. As mentioned above, negotiated risk-based contracts may select a group of subspecialists to provide a service at the exclusion of another (e.g., contracting with only general surgeons to do thyroid surgery and leaving out the ENT physicians).

• Negotiated contracts that allow for advanced practice professionals to deliver care at the exclusion of physicians (e.g., allowing only payment for nurse anesthetists to deliver sedation for gastroenterology procedures at the exclusion of anesthesiologists).

Our nation may be in grave disagreement about how healthcare reform should be carried out, but there seems to be a consensus that healthcare reform is necessary. Under the fee-for-service model, there was minimal financial incentive to improve the quality of care provided within the walls of the hospital, outside of the threat of lawsuits. When we talk about pay for value, bundled payments, or other changes in the current reimbursement model, the focus has been to provide financial incentives to improve the quality and efficiency of healthcare, while decreasing the cost of that care.

In order for hospitals to achieve the maximum amount of reimbursement with any of these internal reforms, they must be able to ensure the quality of care provided by their physicians, and those physicians must comply with the methods determined by the hospital to achieve these goals. As your hospital or health system implements these changes, you will undoubtedly face frustration from physicians as they may perceive decreased independence in their practice. With the looming physician shortages and as physician job satisfaction drops, it becomes increasingly more important to address these concerns in order to retain the physicians you have and to provide an attractive workplace for the physicians you are recruiting.

As we take a closer look at each of these reimbursement models, we will discuss how they may be viewed by your medical staff, and the potential turf conflicts for which you may need to prepare. The changes needed to meet the requirements of these payment models has, and will continue to, impact physician job satisfaction.
As the physician shortage looms, many older physicians are considering retirement rather than working through the difficult growing pains of acclimating to these new requirements, whether they be the use of electronic health records, additional reporting requirements, or changes in documentation, coding, and billing. As you prepare to work through or prevent potential turf battles arising from these changes, it will be important for you to identify the benefits to the physician in each program implemented. Work to identify within your facility how compliance with these models can benefit the physician and improve their business, and provide the information necessary for them to improve the quality of their patient care. For example, a hospital’s move toward electronic medical records (EMR) ensures optimal CMS reimbursement, but it can also have benefits to the provider, including:

- Reduce the number of follow-up phone calls required from nursing staff on orders that are difficult to decipher
- Review the chart and input orders remotely from phone or tablet
- Provide patients with access to review their medical records online
- Extract patient data that was previously unavailable and use to identify trends that could help improve quality of care

**Fee for service**

In the departing fee-for-service model, the patient is assigned a specific diagnosis-related group (DRG) by the hospital, which largely determines the reimbursement the hospital receives. There are set costs associated with each individual DRG, and those are taken into consideration in the billing process. The hospital is concerned with the services rendered within its walls, but the nonemployed physicians involved in the care will bill separately. The reimbursement is based on the care provided during that patient stay, regardless of quality, readmission, or medical errors. While hospitals may have strived for quality care in the past, their reimbursement was not directly tied to quality. The incentives to improve quality were mixed when you consider the fact that hospitals received a larger amount of business, were able to bill more, and received no penalty for medical errors or readmission. Poor performance could be lucrative in the fee-for-service model.

**Pay for value**

As we shift from the fee-for-service model, we move toward a pay-for-value model. Although this is a fairly complex reimbursement system, the concept is simple. Basically, it means that hospitals and physicians will ultimately be paid for the quality and cost efficiency of their work product. In order for a hospital or health system to remain financially viable, it must improve the quality and efficiency of its care. The costs associated with poor-quality healthcare, hospital-acquired infections, hospital-acquired conditions, and poorly managed chronic diseases are some of the
biggest contributors to the incredibly high cost of healthcare in this nation. CMS and private insurers are continually focusing more on providing financial incentives to facilities and providers who are able to do a better job providing the same service. Starting in 2013, hospitals began to see their quality affect their bottom dollar in Medicare reimbursement. Hospitals will either receive incentives or be penalized based on the quality of care they provide, implementation of electronic health records, meaningful use, improved patient satisfaction, etc. Either hospitals will have to ensure top performance, which will be increasingly difficult as the rest of the nation is working to capture that additional reimbursement, or previous poor performers will have to demonstrate significant improvement. Figure 1.3 outlines the breakdown of what will be measured over time affecting reimbursement.

Some of these measures, while seemingly simple, have become the fuel for many battles in healthcare, such as:

- Who should determine what constitutes quality care?
- Who determines how to meet these performance expectations?
- Are some specialties better suited than others in providing specific types of care at a higher quality and lower cost?
- Should specific services move to the inpatient or outpatient setting?
- Should physician ownership impact the services offered in a hospital or clinic?

In addition to all this, and more importantly, the debate circles about what is best for the patient. On one hand, these measures have been designed with the goal of ensuring high-quality care, benchmarking against the facilities that provide the
best care. On the other hand, each facility or population is not the same. Providers often contend that what is good for one facility’s patients may be detrimental to a different facility’s population. A health system’s well-intentioned attempts to streamline policies affecting physicians across their facilities may prompt derision from physicians if those policies do not make sense at each facility or with each physician specialty.

Cost containment efforts can also have a big impact on patient satisfaction, because they perceive that quality of care is decreased. For example, CMS will only reimburse for a 2 day LOS on a standard total knee replacement. Some patients complain they must be getting poorer care because they now have a shorter length of stay for most procedures. While this may be the case if the procedure and hospital is poorly managed, it can be quite the opposite if managed well. Decreased patient satisfaction can also be a big practitioner dissatisifier, as practitioners develop long-term relationships with their patients.

**Bundled payments**

Although the term “bundled payments” has been around the healthcare sector for a long time, the current definition is unique from the versions we had experienced in the past. CMS introduced a pilot program for the new bundled payment system, requiring hospitals to submit a letter of intent if they were interested in joining the pilot program. In January 2013, CMS announced the healthcare organizations selected to participate in the Bundled Payments for Care Improvement Initiative and is rolling it out by payment model.

CMS stratified the system into four types of payment models, allowing facilities to determine the amount of risk they were willing to take. Figure 1.4 shows the features of each payment model. With each, the hospital identifies specific DRGs to include in the program. The procedures chosen have often been those with the greatest reimbursement, those with the greatest possibility of control, and those that CMS and private insurers lose the greatest amount of money on if managed poorly.

<table>
<thead>
<tr>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
<th>Model 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Episode</strong></td>
<td><strong>Selected DRGs, hospital plus post-acute period</strong></td>
<td><strong>Selected DRGs, post-acute period only</strong></td>
<td><strong>Selected DRGs, hospital plus readmissions</strong></td>
</tr>
<tr>
<td><strong>Services included in the bundle</strong></td>
<td><strong>All Part A services paid as part of the MS-DRG payment</strong></td>
<td><strong>All non-hospice Part A and B services during the initial inpatient stay, post-acute period and readmissions</strong></td>
<td><strong>All non-hospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions</strong></td>
</tr>
<tr>
<td><strong>Payment</strong></td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare and Medicaid Services.
Let’s take just one of these models to illustrate first how it works and then what effect it has on the physician. Say your hospital chooses to follow model 2. In addition to the usual costs of an episode of care, as you consider the new bundled payment model, you must consider the quality and cost of care provided in a skilled nursing facility, the cost of readmission for an infection, and the cost of a surgical revision if necessary. CMS sets a discounted target price based upon the historic fee-for-service payments. The facility is paid a set amount, becoming the payer—paying itself, the physician, and the nursing facility from the set reimbursement provided. If the patient is readmitted or requires additional surgery during a set period of time, the facility must absorb the full cost of that additional care. If the hospital is able to improve the cost-efficiency of care, it would be able to retain the saved money/share it with participating providers. As you can see, the hospital takes a great risk in choosing to adopt this payment model. It must be able to coordinate care well and ensure the quality of care along the continuum from admission to 30, 60, or 90 days after hospital discharge. One of the greatest variables that a hospital must consider when adopting this type of system is the quality and consistency of care provided by its physicians, as well as that physician’s utilization of hospital resources.

You must take physicians’ perspective into account before considering such a plan. As you imagine their response, you may hear accusations of cookbook medicine, a lack of physician independence, concern over your facility’s ability to act as a payer, and a threat to what they perceive as the quality of the care they provide. They must be able to see how this new program will benefit both their patients and themselves. How will you handle it if most of the physicians on staff at your facility are willing to follow the model but not a few key physicians? Will you design a closed medical staff or exclusive contracts for the specialties affected? Is there a better way to get the approval and compliance of the physicians on your medical staff? Will you provide financial incentive to the providers that participate?

Perhaps the greatest way to ensure buy-in from physicians is to acknowledge and value their expertise and the central role that they play in any of the care provided at your institution. This cannot be achieved with mere lip service to the physician; leadership must truly listen to the concerns and ideas of the medical staff and integrate those suggestions into the programs. Bring your medical staff in from the ground floor and ask them how to improve the quality of care while decreasing costs. Remember that while the administrators may speak with the occasional patient or smooth over complaints, the physician is the central point person for every patient. They know what works well and can tell you which systems help or hinder in the treatment of patients. Systems implemented with the best of intentions by hospital leadership may stifle a physician’s ability to care for patients in a high-quality, cost-effective manner if the valuable input of physicians is not considered with the
design. Obviously it would be impossible to have the full medical staff in at the ground floor, but use your MSP to identify which physicians may be the greatest stakeholders in the program. As those key physicians provide their input, consider electronically asking for the input of other members of the medical staff affected.

**Cookbook medicine, a growing turf battle**

In order to implement a system that will use evidence-based metrics to ensure the quality of care facilities would like their patients to receive while obtaining optimal reimbursement, many facilities have moved toward the use of clinical protocols. Set protocols are used by some of the nation’s leading institutions to ensure that evidence-based medicine is practiced, but they are sometimes seen by physicians as cookbook medicine, taking crucial judgment out of the physician’s hands for an individual patient and into the hands of researched recipes for medicine, assuming that every patient’s maladies follow disease processes the same and would benefit from the same treatment as the patient in the room next door. Turf battles arise over whether protocols should be implemented, who should design them if they are, whether they can be over-ridden for specific patients, and what should be done if practitioners refuse to use the established and approved protocols altogether.

Protocols help to ensure the consistency of care provided and can improve communication, reduce human errors, and save time. There is great incentive for facilities to implement protocols, first for the benefit of their patients, but also to remain financially viable to continue treating other patients.

As your facility develops protocols, the same tools for working through turf battles apply. Bring the key stakeholders to the table. This should include the greatest possible dissenters, the most influential providers of the related specialties, those who keep their fingers on the latest research, and those who create the benchmarks in your facility by providing the highest quality of patient care within their respective specialties. This can be achieved in a physical meeting, electronically, or by phone. The important thing is that each of these stakeholders has an active voice in the protocol development, with the ability to provide feedback and suggestions that are considered thoughtfully and seriously. If you are able to accomplish this, the result will be a well-researched and balanced protocol that will have a greater buy-in from your medical staff, ensuring compliance.

**Shrinking Physician Reimbursement**

As with hospitals, one of the primary challenges physicians face today is the constant threat of reduced reimbursement. What had once been a lucrative and fairly predictable field has become increasingly more difficult to navigate, particularly for physicians with independent practices.
The primary threat to physician reimbursement is the sustainable growth rate (SGR) formula from the Balanced Budget Act of 1997. SGR determines the rate of Medicare reimbursement for physicians based on a formula calculated using the following factors:

- The estimated percentage change in fees for physicians’ services
- The estimated percentage change in the average number of Medicare fee-for-service beneficiaries
- The estimated 10-year average annual percentage change in real GDP per capita
- The estimated percentage change in expenditures due to changes in law or regulations

The SGR has prompted reductions in reimbursement every year since 2002; however, from 2003 to 2013, Congress has taken various legislative actions to delay these reductions. The formula for SGR continues to use data comparing expenditures to the GDP, which has created a snowball effect for the SGR. Efforts are being made to find a permanent solution to the SGR, but until then it remains a constant threat to the viability of physician reimbursement. Even when a permanent solution has been found, the legitimate fears associated with SGR will continue to influence your medical staff’s view of anything they perceive as threatening their reimbursement for years to come.

Although Congress has continued to delay the cuts each year, the constant threat of cuts has prevented physicians from having the certainty needed to run an effective business. Even with the delayed cuts, physician reimbursement has not increased at the rate of inflation, making it impossible for many physicians to cover the operating costs of their practices. The threat and reality of shrinking reimbursement affects the physician’s response to each of the turf battles we are addressing. For example:

- Privileging disputes are exacerbated when the procedures in dispute are viewed as a potential safety net against the threat of physician reimbursement
- The expansion of allied health professional (AHP) scopes of practice can be perceived as a threat to the volume needed for physicians to remain financially viable
- Although this uncertainty has caused many physicians to move from owning their own practices to being employed by hospitals, those who continue their private practice have felt threatened by the competition created between their practices and hospital-owned clinics
Impact on physician satisfaction

Threats of reimbursement cuts and increased nonclinical responsibilities have led to increased physician dissatisfaction. In a survey of 13,575 physicians published by The Physicians Foundation, this increased dissatisfaction was evident in the following results:

- 63% of physicians over the age of 40 reported that they would retire today given the opportunity
- 57% of the physicians surveyed said that they would recommend medicine as a career to their children or young people
- 68% reported having negative feelings about the current state of the medical profession
- 82% of physicians agreed with the statement, “Physicians have little influence in the direction of healthcare and have little ability to affect change”
- 75% of physicians described their current practice at full capacity or as overextended and overworked
- 8.6% stated that time or cost constraints had compelled them to close their practice to Medicare patients and 26.7% to Medicaid patients

Physician Shortages

On top of the healthcare reform movement, we are facing a shortage of physicians to deliver care. Current estimates by a number of agencies indicate we are facing a looming physician shortage by the year 2025. Significant among these are predictions for PCPs in an environment demanding more PCP involvement for patient management. Figure 1.5 highlights factors that will contribute to the need for more PCPs. Some of the recent statistics include:

- The AMA Masterfile indicated there were 246,090 PCPs in direct patient care in 2010; after adjustments, there were 208,807 PCPs delivering office-based primary care in 2010.
- The total number of office visits to PCPs is projected to increase from 462 million in 2008 to 565 million in 2025.
- The United States will require 52,000 additional PCPs by 2025 (a 3% increase in the current workforce). Primary drivers for this increased need include:
  - 33,000 additional physicians needed for population growth
  - 10,000 additional physicians needed for population aging
  - 8,000 additional physicians to accommodate insurance expansion
- A decrease in medical school graduates seeking primary care:
  - The number of residents choosing a specialty fellowship increased from 50% in 1988 to 80% in 2006
If one considers all physician specialties, there is considerable disagreement as to how severe the shortage of physicians will be\(^\text{10}\). Most of these estimates are based on a traditional model of physician need and PCP interaction (a one-to-one patient-to-physician encounter and traditional PCP panel sizes). Various estimates of the magnitude of the impending shortage include:

- The American Association of Medical Colleges (2013) predicts that if physician supply and demand patterns remain constant, then the United States will experience a shortage of 91,500 full-time physicians by 2020
- The Federal Department of Health and Human Services (2006) projected a shortfall of 55,000 physicians by 2020:
  - The physician full-time equivalents (FTE) is projected to grow to 866,400 by 2020, but the demand will grow to 921,500 physician FTEs
  - Report projects the greatest shortages in non–primary care specialties
- The U.S. Council on Graduate Medical Education Report (2005) projected a net shortage of 85,000 physicians by 2020
- Merritt, Hawkins & Associates (2004) predicted a shortage of 90,000–200,000 physicians

It is easy to see how confusing this might make doing strategic planning for a hospital or health system concerned about what healthcare reform and the looming physician shortage might play into its economic future. It also helps explain the different physician alignment strategies (discussed in Chapter 5) on changing engagement models for physicians. Aside from the increased demand from the PPACA going into effect, the primary reasons given for the physician shortage include:

- Population growth in the United States in general.
- Aging of the population, as mentioned in the section above. Older adults require more healthcare services.
• Changing practice patterns (e.g., concierge practices in which a physician will cut their patient population from 1,500–2,500 patients to 700–500 patients and charge the patients an annual fee for the extra services provided, generally in the range of $1,000–$4,000 per patient per year; this in essence decreases the physician FTEs available for patient care and, in this case, puts 1,000–2,000 patients out looking for a new PCP).

• Changes in work schedules (lifestyle):
  - Changing demographics, increased number of female physicians (many of whom choose to work shorter hours in order to help raise a family)
  - Expectation of a decrease number of hours worked by physicians (especially by physicians in employment models, described in detail in Chapter 5)

• Increasing regulation and paperwork (along with electronic medical record use that for the most part makes physicians less efficient).

• Geographic misdistribution of physicians in the United States (fewer physicians choosing rural areas and some urban neighborhoods).

• Aging of the U.S. physician population\(^9\).
  - In 2008, 99,000 U.S. physicians were 65 years old or older

Of particular concerns to hospital and acute care facilities are the predicted shortages in hospital-centric physician specialties. The most notable hospital-centric physician shortages include:

• Anesthesia

• Cardiology
  - Shortage of general cardiologists projected to increase from 1,500 in 2008 to 16,000 in 2025

• Intensivist (critical care)

• Emergency medicine
  - Over the past 10 years, the need for emergency services has increased 32%, from 90.3 million people to 119.2 million people
  - Over the same period, the number of hospital emergency departments has dropped approximately 7%, from 4,109 to 3,833

• General surgery
  - There are 723 fewer general surgeons practicing today than in 1981; the number has remained static since 1994
  - The general surgeon-to-population ratio has decreased from 7.68 per 100,000 in 1981 to 5.69 per 100,000 in 2005\(^{10}\)

These shortages will make delivering care that produces revenue more costly, will increase challenges around emergency department physician call, and may lead to
increased disputes over turf that is considered profitable. It will also cause hospitals to reevaluate the use of physician extenders, especially physician assistants (PA) and nurse practitioners (NP).

Hospitals have begun the transition of providing significant amounts of care to the ambulatory setting. Procedures we never anticipated are now being delivered in outpatient or short-stay venues (e.g., laparoscopic cholecystectomies, hysterectomies, and total hip replacements). As hospitals enter into integrated delivery systems of care, which include ambulatory-centric physicians delivering care across the continuum, they will realize the physician specialty shortage for ambulatory-centric physicians as well. This shortage will complicate transitions of care from the hospital (potentially driving up lengths of stay), may increase readmissions because of the lack of physician follow-up, and may lead to more patients in the ED (especially for patients needing mental health services in an already overburdened system) and a general increase in healthcare cost. The most commonly cited specialty shortages include:

- Allergy and immunology
  - Allergic conditions affect up to 20% of the population
  - Noticed 34% decrease in residents choosing allergy and immunology training from 1990 to 1998
- Child psychiatry
- Dermatology
- Endocrinology
- Family physicians
- Gastroenterology
- Geriatric medicine
- Medical genetics

What is unclear is how innovation and changing care models might impact these predictions of physician shortages. Several models predict the increased use of PAs and NPs as a solution for not only primary care but also certain hospital-centric specialties, such as nurse anesthetists. Estimates of PAs from the 2010 National Provider Identifier file indicate that of the 70,383 in practice, 30,402 (43.2%) were in primary care. For NPs, of the 106,073 in practice, 55,625 (52.4%) were in primary care practice. Some states are changing the necessity of requiring physician oversight for the NPs, so they can practice on their own. Different models of primary care, such as primary care medical homes, use a variety of healthcare professionals (e.g., clinical pharmacists, case managers, social workers) to treat the patient. This may decrease the number of PCPs needed to deliver care to a specific number of patients. Other models may prove disruptive to the traditional model of
healthcare delivery, for example, retail delivery of some primary care services (think Walgreens pharmacy, CVS pharmacy, Wal-Mart) and care delivered via the Internet directly to a patient, such as telehealth (Teladoc [www.teladoc.com]). In addition, many employers are providing primary and complimentary care services on sight in a customized way to meet the employer’s needs (Crossover Health [crossoverhealth.com]). Yet, at the same time, the shortage may well lead to an increase in the use of emergency departments and urgent care clinics.

One thing that is clear, the looming physician shortages (both ambulatory and hospital centric) and changes from healthcare reform will have big impacts on medical staff structures and on physician privileging and credentialing for the next few years. The physician shortages will likely see various allied health professionals playing a larger role in delivering care, further stressing the medical staff structure and culture. Increasing numbers of midwives, NPs, PAs, and even clinical pharmacists, among others, will seek (and likely) receive more autonomy to practice at increased levels to offset some of the physician shortage. Turf battles will likely ensue as physicians in traditional practice seek to protect their shrinking revenue sources. Being prepared through clearly stated policies and procedures as well as having easy-to-follow processes in place will help, along with education to both physicians and your MSPs.

**Changing Membership Rules**

In what we call the “olden days,” only physicians (MDs/DOs) were granted the privilege to sit on medical executive committees and most hospital boards. The same group of practitioners (usually what was fondly called the “silver backs”) rotated mostly through the president/chief of staff, vice president/vice chief of staff, secretary, and treasurer roles. Often, these practitioners were not specifically trained for these roles; however, bylaws succession rules called for these rotations.

Times have certainly changed. Many medical staff have abandoned the secretary role, have leadership training requirements in place, and have longer-than-two-year commitments for the more important medical staff leadership roles. One of the recent significant changes is that as of 2012, CMS now allows podiatrists the right to be responsible for the organization and conduct of the medical staff. Previously CMS only permitted MDs, DOs and dentists (as permitted by state law) to hold the position of medical staff president or chief of staff. Podiatrists and dentists are allowed to assume these same leadership roles within hospitals as an MD/DO if the state permits and the facility’s medical staff bylaws are revised to reflect this change.
Podiatrists can be successful in medical staff affairs, particularly since they do not have the same referral patterns as other members of the surgical and medical departments. As more podiatrists serve as members of the active staff of their hospitals, particularly with the changes in state and federal laws, involvement in medical staff leadership will be more common.

One way to develop leadership skills before a podiatrist becomes president of the medical staff is to have your potential podiatrist leader become involved in various committees of the medical staff. Serving on the credentials committee, the medical quality review committee, and/or the performance improvement council can provide experience that should help provide a foundation for medical staff leadership. A foundation in these areas is most helpful, as the president of the medical staff reports directly to the board of directors on the issues of credentialing and quality of care. This will also allow your existing medical staff members to have some contact with this potential podiatrist leader in areas other than their granted clinical expertise and to see the podiatrist’s potential as a leader.

All that being said, how will this be accepted by the “old school” members of your medical staff, as well as the orthopedic members of your medical staff? There have been longstanding battles between podiatrists and orthopedic surgeons, mostly related to where the podiatrists’ expertise ends relative to the anatomy of the leg. Also, podiatrists are now playing an important role as part of the team in many wound care centers. Diabetic patients have specific needs for their feet. Hyperbaric oxygen therapy is often used for treatment, which is part of the treatment provided in wound care centers. This has become a niche for many podiatrists.

Encouraging podiatrists to serve in a leadership role could actually help ease tensions with orthopedic surgeons. Once physicians on the medical staff see a podiatrist participating in a credentials, quality/peer review, or medical executive committee efficiently and effectively, they will have more respect for the individual and the profession, along with their more active role as a clinician in the wound care centers. They may no longer see them as a threat, but perhaps as an ally.

Being the medical staff leader is more about being a leader, which has to do with running the medical staff efficiently. There is a team approach to determining patient safety concerns and clinical competence, as outlined in most bylaws, rules, and regulations, determined by respective medical staff committees, the medical executive committee, and ultimately the board. This team approach is not always necessarily best led by any one particular specialty, or major group, of any organization.
Changing Credentialing and Privileging Rules

CMS has also given facilities the ability to broaden the scope of their medical staff, as well as assume new leadership roles within hospitals, as provided by state law, and encourages physicians and hospitals to recruit nonphysician practitioners to assist them in overseeing and protecting the safety of patients within the hospital. This includes the everyday duties of caring for the patient, embracing an interdisciplinary approach to patient care as the best model. This will also free up the physician to focus on their patients’ more difficult health issues.

CMS issued a final rule encouraging hospitals to allow nonphysician practitioners to apply for medical staff membership and clinical privileges “in alignment with their professional education and training to the full extent allowed under State licensing and scope-of-practice laws.” This means hospitals can extend medical staff membership to PAs, advanced practice registered nurses, and any other category of practitioner deemed eligible by the individual organization. More and more hospitals and clinics are utilizing PAs and NPs to assist in these roles.

CMS feels that the greater the flexibility that hospitals, medical staffs, and individual physicians have to enlist the services of nonphysician practitioners to carry out the patient care duties for which they are trained and licensed, the better the quality of care will be for patients. However, CMS does state that physicians must be the leaders in patient care delivery.

This greatly changed the old medical staff structure, which mostly comprised MDs and DOs and usually a handful of podiatrists. There is now a large section of the bylaws, rules, and regulations dedicated to advanced practice professionals (APP). What does this mean for the traditional hospital medical staff structure? Are medical staff members accepting of the new roles of practitioners?

One method of integration of APPs into their roles and responsibilities is to form an Advanced Practice Professional Task Force. This group would be made up of a representative of each of your key APP providers/stakeholders. This committee would be tasked with assistance of the following, under the supervision and guidance of the medical staff committees and respective department chairs:

- Development of ongoing and focused competency assessment criteria for each provider (i.e., PA, NP, etc). Some facilities obtain this type of information already from those APPs that are part of a contract group. For example, anesthesia and emergency medicine are contract services. These services often have outside contractual assistance with ongoing competency assessment data, which can be provided to your facility.
• Review and revision, as needed, of privilege forms, based on current criteria. Most often, the appropriate department chair, and the credentials committee, is tasked with this burden, if not sometimes just the MSP. And, more often than not, the input is not solicited from the APP.

• Assistance with review of appointment and reappointment files. Just as the appropriate privileged practitioner should be responsible for reviewing like files, so should the APP be involved in appropriate review.

• Review and revision, as appropriate, to existing APP rules and regulations.

• Potential assistance with behavioral/clinical practice concerns relative to individual APP performance. When a case is presented to peer review, and it involves the APP as well as the physician, APP education and collaboration should also be completed, along with medical staff education. These should then become part of the practitioner’s ongoing competency assessment and peer review file, for review at the time of reappointment.

• Collaboration with key medical staff members as it pertains to a “team approach” for the care of the patient (i.e., the role of the APP versus the role of the physician). Some hospitals have team approach patient rounds that include physician, APP and ancillary and nursing staff.

• Attendance at credentials committee meetings when APP files are being reviewed for privileges.

Although the ultimate responsibility for the above will lie with the medical staff, MEC, and the board, the input from these practitioners is invaluable. This also gives more credence to this group of practitioners, which may result in more collegial collaboration, as well as an understanding of each other’s roles, both for the care of the patient and as part of a key member of the medical staff. (It will also help make the life of the MSP a little easier, who is tasked with making sure that there is monitoring of all of the above APP requirements.)

Webster’s online dictionary defines the AHP and the physician as follows:

Allied health professional: AHPs are healthcare professions distinct from nursing, medicine, and pharmacy. One estimate reported that AHPs make up 60% of the total health workforce. They work in healthcare teams to make the healthcare system function by providing a range of diagnostic, technical, therapeutic, and direct patient care and support services that are critical to the other health professionals they work with and the patients they serve.

Physician: A licensed professional (MD or DO) who has earned the degree of Doctor of Medicine or Doctor of Osteopathic Medicine and who treats illness and helps maintain wellness in the human mind and body.
These definitions alone denote that collaboration between these two groups of healthcare providers is essential and key to the best care for the patient.

**APP Reimbursement Rates**

As the scopes of practice for APPs expand, there has been a greater push to get equal reimbursement for APPs who provide a similar service to their physician counterparts. Currently, NPs receive 85% of the reimbursement available to a physician through Medicare for the same services. Various APP societies, most notably the American Association of Nurse Practitioners (AANP), argue that they should be offered the same amount if the quality and content of the care they provide matches a physician’s. Physicians argue that their higher reimbursement is appropriate because of the additional training and experience they have in treating more complex diseases and identifying illnesses that the AHP might be prone to miss because of their lack of additional training.

The AMA house of delegates passed recommendations in November 2013 for payment models supporting team-based healthcare, calling for:

- Physicians who lead team-based care in their practices to receive payments for healthcare services provided by the team and to establish payment disbursement mechanisms that foster physician-led team-based care

- Physicians to make decisions about payment disbursement in consideration of team member contributions, including factors such as volume and intensity of the care provided, the profession, training, and experience of each team member and the quality of care provided

- Payment systems for the physician-led team-based care to reflect the value provided by the team, with the savings accrued by this value shared by the team; to reflect the time, effort, intellectual capital provided by individual team members; to be adequate to attract team members with the appropriate skills and training to maximize the success of the team; and to be sufficient to sustain the team over the time frame that is needed

The AANP labeled the AMA’s recommendations anticompetitive and noted that it limits patient access to care. On the other hand, attempts by APPs to receive an equal share of reimbursement can be viewed by physicians as another threat of shrinking reimbursement. In a recent study done by the *New England Journal of Medicine*, when asked whether NPs should be paid equally for providing the same health services, 64% of NPs agreed, as opposed to less than 4% of physicians. These are just snapshots into the fuel heating up the dispute between physicians and AHPs over reimbursement. We will address the physician and APP turf conflict in greater detail in Chapter 4.
What Is All the Fuss About? New Environments That Lead to Disputes

References


Resolve turf conflicts among practitioners before they affect patient care.

Resolve turf battles with guidance from conflict resolution experts Jack Cox, MD, MMM, Rosemary Dragon, CPMSM, CPCS, and Christine Hearst, CPMSM. This guide incorporates the perspectives and advice of both the physician and the MSP, providing MSPs with the direction they need to deal with turf conflicts among practitioners, including the role the MSP needs to play in conflict resolution and physician leader education.

This book provides solutions for long-standing turf battles, such as privileging, as well as new issues including allied health professionals, ambulatory surgery centers, employment, and locum tenens.

Resolve Practitioner Turf Conflicts: Medical Staff, AHP, and Off-Site Disputes helps physicians and MSPs develop skills and identify resources for preventing and dealing with disputes. This book will help you:

- Identify changes in healthcare and your organization that could lead to a turf dispute
- Develop policies and procedures for dealing with conflict
- Review your privileging policies and requirements to make sure they are fair to providers
- Understand the expanding role of allied health professionals and advanced practice professionals and how this affects your medical staff