



The Medical Staff's Guide to Employed Physicians

William K. Cors, MD, MMM, CPE, FAAPL

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HCPro
100 Winners Circle, Suite 300
Brentwood, TN 37027
Telephone: 800-650-6787 or 781-639-1872
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About the Author



William K. Cors, MD, MMM, CPE, FAAPL

William K. Cors, MD, MMM, CPE, FAAPL, is an experienced physician executive whose background includes 15 years of clinical practice, 20 years of executive hospital/health system management experience, and experience as a national healthcare consultant. He currently serves as chief medical officer for Pocono Health System in Pennsylvania. Formerly, he was the vice president of medical staff services for The Greeley Company in Danvers, Massachusetts.

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

Dr. Cors holds an AB degree from the College of the Holy Cross, an MD from Rutgers New Jersey Medical School, and a Masters of Medical Management (MMM) from Tulane University. He is a Fellow of the American Association of Physician Leaders (FAAPL), and is board certified in both neurology and medical management. From April 2007 to March 2010, Dr. Cors served on the Board of Directors of the American College of Physician Executives (now the American Association of Physician Leaders). He currently serves as a member of the American Association of Physician Leaders teaching faculty.

In addition to working with medical staffs, hospitals, and governing boards across the country, Dr. Cors has authored or co-authored numerous publications. Since 2007, he has written a monthly column in the HCPro periodical *Medical Staff Briefing* on a variety of subjects, with a particular emphasis on change management, physician employment, new medical staff models, and physician-hospital integration. He was the lead author for *The Medical Staff Leader's Practical Guide*, Sixth Edition (HCPro, 2007); *The Greeley Guide to New Medical Staff Models* (HCPro, 2008); and *The Greeley Guide to Physician Employment and Contracting* (HCPro, 2010). He was a contributing author of *An Integrated Approach to Marketing Orthopedic and Neuroscience Service Lines* (HealthLeaders Media, 2013). His most recent book is *The Medical Staff Leader's Survival Guide* (HCPro, 2014).

Introduction

Once upon a time, there was an unwritten social contract between physicians and hospitals that went something like this: Physicians would spend a lot of time in medical school, internship, and residency, and after that training, they would apply for privileges at the hospital as an independent private practitioner. In return for being granted those privileges, the physicians would serve on hospital committees to carry out the work of the medical staff. They would also participate in an on-call roster to provide emergency department coverage of their area of expertise. In return, the hospital would provide the staffing, services, and equipment that the physician required to practice his or her specialty at the hospital. Under this arrangement, the medical staff and the hospital had clearly defined roles and responsibilities. The medical staff would deal with “physician issues,” and the hospital would deal with everything else.

Somewhere along the line, a number of rapid and profound forces intervened and affected physicians, medical staffs, and hospitals. The unwritten social contract has been irrevocably broken. The relationship between physicians, medical staffs, and hospitals has been and continues to be radically altered. One of the most fundamental changes is the employment of physicians by hospitals and health systems, a trend that is accelerating and that blurs the lines of responsibility: Who has responsibility for “physician issues” when the physician is both a member of the medical staff and an employee of the hospital? The net result is that a new contract needs to be established. Many of today’s misunderstandings, conflicts, and frustrations stem from the fact that we are between contracts. The old one is dead. The new one is still being written. This book aims to be a step in the realization of the new order required for physicians, medical staffs, and hospitals to succeed in delivering high-quality clinical care.

How This Book Will Help

This book is designed as a guide for medical staff leaders, medical staff professionals, and anyone else in the organization who is dealing with the fundamental shift in the relationship between the medical staff and the hospital/health system as the latter increasingly becomes the major employer of physicians. This book acknowledges that, given all the changes that have occurred and are still occurring, a very different way of doing things is necessary. It offers a set of principles that will form the bedrock of the new structures, processes, and relationships that will be required for all parties—medical staff, physicians, and health systems—to succeed in providing quality patient care. It recognizes that the

current situation is a work in progress, with many variations and complexities from one organization to the next. It acknowledges that one size does not fit all and, because what might work in Health System ABC might be a disaster in Health System XYZ, it offers various solutions to challenges that many organizations share.

The last word has yet to be heard on many of these topics. This book is offered as a guide and aims to help leaders who struggle every day with some or all of the challenges outlined in this work. It lays out a framework and a toolkit that your organization can implement today to get you on a path of collaborating with all the necessary parties to ensure a smooth process when employing physicians.

How This Book Is Organized

The Medical Staff's Guide to Employed Physicians is organized into 15 chapters.

The first three chapters set the stage. Chapter 1 outlines the forces that affect contemporary physicians, medical staffs, and health systems, with an emphasis on how they affect you as a medical staff leader. Chapter 2 lays out the guiding principles that will serve as the bedrock upon which challenges will be addressed and solutions for implementation generated. One of the tools in this chapter is a set of Physician Performance Building Blocks, which both medical staffs and employers can use as a physician performance management system. Chapter 3 dissects the structure of a modern health system so that leaders develop a better understanding of how these behemoths actually work. The emphasis is on how recent changes actually affect you, the medical staff leaders.

Chapters 4 through 14 systematically examine the common challenges experienced by medical staffs and health systems at each step of the way—from recruiting through termination—as outlined in the Physician Performance Building Block system introduced in Chapter 2. Each chapter is designed to address a specific challenge. Although these challenges are tackled separately, remember that the book as a whole encourages an overarching, rather than a piecemeal, approach. These chapters require you to use the guiding principles (Chapter 2) and knowledge of your health system (Chapter 3) to design implementable solutions and best practices for your organization. To demonstrate how the principles can be used to generate solutions, Chapter 4 is explicitly written to follow the guiding principles from Chapter 2 in sequence. Although subsequent chapters use the same guiding principles, they will be less transparent and more seamlessly embedded into the issue at hand.

Chapter 15 uses the format of frequently asked questions (FAQ) to summarize key challenges covered plus answers to questions that did not logically fall into one of the preceding chapters, such as, “Can an employed physician serve as a medical staff officer?”

A Note About Terminology

The term “physician” is used throughout the book as a convenience. Although the audience for this book will include MSPs and others who address these challenges, this book is primarily addressed to

physician leaders charged with carrying out the responsibilities of the medical staff. Having said that, there is an equally large (if not larger) group of employed clinicians who are advanced practice professionals, such as physician assistants, advanced practice registered nurses, certified nurse midwives, certified registered nurse anesthetists, psychologists, and others. These practitioners play an increasingly large role in most health systems and are assuming greater responsibilities for the delivery of patient care across the continuum. Their contribution is great and needs to be acknowledged. The use of the term “physician” throughout this book is in no way meant to denigrate the contribution of these important practitioners.

Additionally, the term “health system” will be used throughout this book instead of the term “hospital.” Just as independent physicians are increasingly becoming employed, so too are many stand-alone hospitals becoming part of or forming their own health system. It will be more convenient to use a single naming convention to establish consistency.

The Medical Staff’s Guide to Employed Physicians: Putting It All Together

The Medical Staff’s Guide to Employed Physicians is dedicated to helping medical staff leaders understand and help implement solutions to the myriad challenges that arise in the new “social contract” between medical staff, employed physicians, and the health system employer. It is my sincere hope that the pain and frustration that these challenges generate on an almost daily basis can be effectively channeled into efficient and workable solutions for your organization. I hope that this book will help realize the goal of having a truly effective medical staff.

Chapter 1

Impacting Forces Driving Physician Employment

Prior to today, you have never spoken with the hospital CEO. She has just stormed out of your office. Quite frankly, you were surprised that she even knew where it was. The purpose of her visit was to berate you and the entire medical staff services department (MSSD) for your ineptitude and intransigence in delaying the recently recruited surgical star from receiving privileges. The CEO also had some choice words for the medical staff leaders, saying that they are “embedded in ossified processes that hold back the rapid growth and expansion of the health system.” Had you been allowed to speak, you might have described the concerns that you and your experienced credentials committee chair have identified with the applicant. These concerns include questions about the National Practitioner Data Bank (NPDB) report, with three rather hefty professional liability settlements over the past five years; the two professional references that expressed concerns about communication and interpersonal relationships; and the most recent hospital affiliation having answered affirmatively that privileges were resigned while under investigation but refusing to provide any further details. Ten years ago, this conversation would have taken place with a community physician who was looking to expedite credentialing for a new associate who needed privileges immediately so that the senior partner could leave on vacation the next day. Today, it is with the person who signs your paycheck. What to do?

While trying to figure out what to do about the CEO’s issue, a medical staff professional (MSP) comes into your office. She has a question about Dr. Jones, who is up for biannual reappointment. The MSSD has no information in the medical staff quality file, as Dr. Jones is employed by the health system and therefore the health system must have that information. The health system has nothing because it assumed that the MSSD tracked quality information because Dr. Jones is a member of the medical staff. As a medical staff leader, you are asked how to handle Dr. Jones’ reappointment.

Next, you get a question about Dr. Cuttins, who is employed by the health system as a general surgeon. The peer review committee is reviewing a third case of Dr. Cuttins’ involving surgical complications. The committee makes a recommendation that she attend a laparoscopic review course offered by the Society for Advanced Gastrointestinal and Endoscopic Surgery. Her response is that the course is a great idea but that she has already exhausted her annual continuing medical education (CME) benefit and

her employer (the health system) knows nothing about her clinical care concerns. As chair of the peer review committee, now what do you do?

Lastly, the MSSD receives a reference request from an out-of-state hospital regarding Dr. Smith, a health system–employed internist. Because you are president of the medical staff, the medical staff professional (MSP) calls you and asks you what to do: It turns out that Dr. Smith reportedly was “fired” a month ago and is no longer at your hospital, but the MSSD knew nothing about this. How should the reference request be handled?

What Is Going On Here?

Before becoming a medical staff leader, you probably had some ideas about how things might work and what you would try to accomplish as a leader. It is fair to say, though, that these are very different times than many imagined. The traditional assumptions about how medical staffs work—that is, how they make themselves accountable for the quality of care provided by individuals with privileges—have been flipped on their heads. If there was ever clarity about roles and responsibilities, those margins have been blurred, bent, or downright severed.

If you are struggling with challenges at the intersection of employed physicians and the organized medical staff, you are not alone. Many organizations are dealing with fundamental questions about such basic processes as credentialing, privileging, proctoring, peer review, managing poor performance, taking corrective action, and providing references for employed physicians. Some do it well, and others, not so well.

Before diving into specifics, medical staff leaders might find it useful to develop a better understanding of how we got here in the first place. Physician employment by health systems is an unabated and growing phenomenon across the country. It is not going away! The Medical Group Management Association reports that more than 50% of physicians are now employed by organizations affiliated with health systems, and in some specialties, such as cardiology, the number is closer to 75%. The recruiting firm Merritt Hawkins suggests that the industry will see 75% of the nation’s physicians employed by hospitals within five years.

But why is this? There are a number of compelling reasons and impacting forces for physicians, hospitals, and health systems to pursue the employment route.

Impacting Forces: Physicians

For many physicians, the bottom-line impacting forces are both financial and generational. Physicians, as well as their health systems, want to maximize revenue, secure leverage with payers, and expand market share, or at least mitigate losses and attain some degree of financial stability.

Many older physicians are seeking financial security and relief from administrative burdens as private practice reimbursements shrink and administrative requirements (e.g., IT, paperwork, quality metrics,

etc.) increase. Many private practices struggle with the trifecta of decreasing revenue, increasing expenses, and difficulty recruiting new physicians to the private practice model. Coupled with the specific increased burdens mandated by meaningful use for IT and practice management headaches in general, many physicians are seeking a way out. Increasingly, that exit strategy is to become employed by the health system.

This situation creates an interesting tension within the medical staff: The older physician will see his or her relationship with the organized medical staff as unchanged. And as we will see through the course of this work, some things do stay the same. However, now because the physician is employed, many aspects of physician performance against expectations will be handled through an employment agreement that may diverge significantly from the remedies called for in the due process sections of the medical staff bylaws.

Younger physicians, who tend to value work-life balance very highly, almost universally seek employment with a health system or a large physician-owned group. There is little to no interest in the private practice model of their predecessors. They are concerned with debt incurred from their training and with having a very predictable income stream and call schedule. At the same time, many younger physicians see organized medical staff activities as increasingly irrelevant to them. The challenge for medical staff leaders, then, is that physician apathy and disengagement will continue to grow, which raises concerns about the long-term sustainability of the traditional medical staff model.

Yet another major change to the medical staff is the increasing divide between physicians who practice primarily in the hospital and those who practice exclusively in the ambulatory setting. The challenge for medical staff leaders is to carry out its accountability to the governing board and thereby ensure quality care and competence by physicians credentialed and privileged through the medical staff process—even if they practice exclusively in the ambulatory system. And what happens when those physicians are increasingly employees of the health system itself? How does that affect the medical staff's ability to carry out its functions? This book will attempt to offer solutions to this and other fundamental questions in this rapidly changing context.

In the past, a physician would apply for medical staff membership and privileges through processes that often existed in isolation from other health system functions. Today, however, the medical staff must establish working relationships and communication with multiple health system departments, such as human resources, physician practice management, recruiting, and managed care payer relations. To account for these changes, the basic understandings, working relationships, and accountabilities of the medical staff with other health system stakeholder groups need to be revisited and revised.

Impacting Forces: Hospitals

Like the forces impacting physicians, the forces impacting hospitals also include the need to maximize revenue, secure leverage with payers, expand market share, mitigate losses, and attain some degree of financial stability. Most hospitals acknowledge that some form of clinical integration with physicians is

the key to survival. Integration efforts can run the gamut, from providing a nice medical staff lounge for community physicians all the way up to and including full employment. Such integration drives efforts to control costs and utilization; secure market share and negotiating clout with payers; provide mandated on-call services; and be able to respond to demands for increased accountability and transparency in a fee-for-value world.

The challenge for medical staff leaders is that, in the quest to employ new physicians, the hospital will want to bring physicians on board as soon as possible, so they can begin seeing patients, making referrals, and generating revenue for the health system. In turn, the pressure to get someone credentialed and privileged expeditiously might be intense. The opening scenario in this chapter is not at all unusual. How your organization deals with it is extremely important, as this trend shows no sign of abating and will most likely increase in both the short and long term.

Impacting Forces: Health Systems

Just as the merger and acquisition of private physician practices rages on, so, too, are many stand-alone hospitals consolidating into health systems. In fact, this activity is so prevalent that it is the new norm (and the reason that this book refers to “health systems” as opposed to “hospitals”). There appears to be no letup in merger and acquisition activity since the passage of the Patient Care and Affordable Care Act of 2010. According to a 2012 HealthLeaders Media Intelligence Report, nearly 80% of healthcare leaders said that they would have merger and acquisition deals underway or would be exploring such deals over the following 12–18 months.

Although the reasons are many, one driver appears to be the belief that “larger is stronger” in handling decreased revenues—that is, that expanding market share and having greater clout with payers are of benefit in the current climate. A second is that larger systems offer better access to capital. A third is the belief that significant economies of scale can be achieved.

Regardless of whether the last point is true, it means that the credentialing/privileging function often moves from the local medical staff to a central corporate entity or is outsourced entirely to a credentials verification organization.

Impacting Forces: Medical Staff

The “old” medical staff was characterized by a collegial culture that was democratically organized, very loosely managed, with rotating, elected leadership focused on advocacy for medical staff members. Today, there are increasing pressures on medical staffs, not only for physician competency determination but also for a host of additional challenges, including patient safety, regulatory oversight, accreditation compliance, physician-health system collaboration/competition, and cost containment. As described earlier, physicians are withdrawing from this medical staff space just when health systems require more engaged and knowledgeable physician leaders. It is not clear where this situation

will lead, but many of the opportunities to work together at the interface of the medical staff and the employed physician may be useful in approaching other physician–health system challenges.

Because of these new challenges and requirements, the medical staff may find it increasingly difficult to carry out its responsibilities and accountabilities, especially with so many physicians withdrawing from the inpatient setting. The medical staff may see employed physicians as being able to help fulfill their accountabilities, since the health system employer can offer administrative time to employed physicians to carry out medical staff work.

One More Observation

Finally, both medical staff leaders and MSPs should appreciate that no one in their hospital or health system truly understands the physician competency determination process (i.e., credentialing/privileging/proctoring/peer review) the way you do. This includes new applicants to your staff, the majority of credentialed/privileged physicians, hospital administration, and probably the CEO! Very often others will view the process as bureaucratic, inefficient, overly rigorous, and an impediment to the speedy onboarding of new physicians, who are sorely needed to generate revenue and market share for the health system in an increasingly competitive landscape.

This book will demonstrate that, time and again, this fundamental lack of knowledge can cause all kinds of derailments, frustrations, and misunderstandings. Part of your job as a medical staff leader is to educate other stakeholders, including physicians, hospital management, and the governing board about the regulatory and accreditation requirements embedded in the CMS *Conditions of Participation* (*CoP*) and other accreditation bodies' requirements for determining physician competency. You live it day in and day out. They don't. Help others understand what you do and, reciprocally, for you to understand what they do. Remember the adage attributed to St. Francis and paraphrased by Stephen Covey: "To be understood, seek first to understand."

The Medical Staff's Guide to Employed Physicians

William K. Cors, MD, MMM, CPE, FAAPL

Bring medical staff and hospital employment processes together

The rate of employed physicians in the United States is on the rise and shows no sign of slowing. Employed physicians are subject to medical staff processes as well as human resources/employment processes. This can lead to employed physicians slipping through the cracks or experiencing double jeopardy. In ***The Medical Staff's Guide to Employed Physicians***, author William K. Cors, MD, MMM, CPE, FAAPL, guides medical staff professionals and medical staff leaders through revising their typical processes, such as credentialing, privileging, proctoring, peer review, management of poor performance, and corrective action, to ensure smooth onboarding and retention of employed physicians. With this book, you'll be able to reduce redundancies created by having multiple onboarding processes for employed physicians and ensure all involved departments are kept up-to-date on a physician's performance, disciplinary actions, and privileges during his or her tenure with the hospital.

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100 Winners Circle, Suite 300

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