

The Organized Medical Staff—Moving from Autonomy to Accountability

Change before you have to. If the external environment changes before you do, you will be out of business.

—*Jack Welch, former CEO of General Electric*

During times of stability, organizational structures can remain stable and serve their constituents well. But in times of rapid transformation, traditional structures lose their relevance. They must evolve or be replaced with new models that can adapt quickly to arising complexities and uncertainties.

The organized medical staff is one of those traditional structures: It has a proud and rich legacy but now must change or become obsolete.

THE TRADITIONAL MEDICAL STAFF MODEL

The organized medical staff has been at the center of professional life for physicians and surgeons for decades. It provides a professional, political, and social forum for physicians to discuss clinical issues, define professional perspectives, address professional concerns, and form a network for communicating with each other and with external parties.

Medical staffs and other professional organizations offer many potential benefits to their members. Inevitably, however, they can also pose some problems and challenges.

Beginnings of the Organized Medical Staff

The organized medical staff originated with a set of principles developed by the American College of Surgeons (ACS) in 1919 known as the “Minimum Standard Document.” It was the result of six years of work by Ernest Amory Codman, MD, and the ACS’s Committee on Standardization. The effort represented an early attempt to address the lax record keeping and significant systemic variation that led to poor clinical outcomes.

The original standard defined the medical staff as a “group of doctors who practice in the hospital inclusive of all groups.” Its membership was to “be restricted to physicians and surgeons appropriately trained and licensed” who are “competent in their respective fields and worthy in character and professional ethics.” The standard required that the medical staff “initiate and with the approval of the governing board of the hospital, adopt rules, regulations, and policies governing the professional work at the hospital,” including the following (ACS 2006):

- ◆ Regular monthly meetings
- ◆ A regular analysis of the clinical care provided
- ◆ Accurate and complete records for all patients
- ◆ The availability of competently supervised diagnostic and therapeutic facilities

The ACS’s organized medical staff model was so successful that when the organization helped found the Joint Commission on Accreditation of Hospitals (now The Joint Commission) in 1951, the document became an integral part of The Joint Commission’s original hospital standards.

The federal government later confirmed the importance of the organized medical staff in 1965, when the US Department of Health and Human Services’ Health Care Financing Administration (HCFA; now the Centers for Medicare & Medicaid Services) became significantly involved in the financing of healthcare through the creation of Medicare and Medicaid. HCFA mandated that the original concept of the organized medical staff be fulfilled for the healthcare entity to receive payment from the federal government for healthcare services rendered. That list has evolved to become the CMS Conditions of Participation (CMS 2009).

Benefits of Professional Organizations

A college of peers promotes a sense of professional identity, belonging, and security through its actions to advocate for members and protect the future viability of the profession. It confirms the unique beliefs that form the basis of any highly developed professional culture.

The traditional medical staff has the expertise to govern itself and conduct peer review, credentialing and privileging, and quality oversight functions. The typical structure of a hospital-based organized medical staff—which usually consists of a rotating body of voluntary leaders; a democratic, town-hall approach to meetings and communications; and a cadre of informal leaders with political influence and clout—has provided physicians with a professional guild–like culture that, among other attributes, allows them to share information with each other in a safe, confidential, and protected environment.

Problems Related to Professional Organizations

Any group characterized by a strong professional and cultural identity is vulnerable to issues of professional isolation—even within specialties and subspecialties—and various ingrained tendencies that limit its members’ ability or willingness to change and adapt, even when their livelihoods depend on it.

Seeing Issues Through a Predetermined Lens

An important part of any professional social contract is the “give” and the “get” of individuals entering a profession (Kornacki and Silversin 2013). To become physicians, students must agree to make personal sacrifices, including restrictions to personal freedom and time, family support, and potential income for an extended period of time. In exchange, society has promised them an above-average social standing and income and the right to make autonomous decisions that have potentially life-altering consequences.

This social contract is not unlike those of other elite professions that require years of preparation, training, and professional development, such as military command or judicial, religious, and corporate authority. The challenge with social contracts is that external economic, scientific, and political forces and changes often render the original culture unimportant or even irrelevant over time.

The military and other high-risk professions have transformed their cultures from revering autonomy to embracing crew resource management, structured

communication protocols, and interdependence. On the other hand, the organized medical staff in general struggles to accept evidence-based practices while its members are individually and uniquely accountable to themselves, their patients, and their state licensing boards.

Perpetuating a Culture of Protectionism

The purpose of any professional organization is to advocate for its members' interests. This goal can be positive when its members hold unique perspectives that need to be understood by the outside world. But it can be limiting when the same perspectives thwart an understanding of and appreciation for other points of view. Executives and managers, board members, patients, community leaders, vendors, regulators, and payers—in addition to physicians—all have a unique stake in healthcare outcomes.

The challenge associated with this tendency is that physicians as a whole continue to hold a protectionist stance and still consider the hospital to be the “physician’s workshop.” Although physicians are beginning to accept the shift to a balanced care delivery approach, some defend the physician’s assumed right to apply his skills independent of the needs and demands of others. Medical staffs today are often split between those who understand the need for interdependence and those who do not, creating a difficult and acrimonious environment in which to adapt to seismic external change.

Resisting Changes Seen as Undermining the Profession

Physicians generally have difficulty supporting change that is clearly necessary but that, to them, represents a threat to their professional identity. For example, a physician might understand that a significant portion of her work (e.g., normal deliveries, routine primary care, low-risk surgery and procedures) can be performed safely and competently by qualified nonphysicians, such as advanced practice professionals (APPs). Yet she continues to block initiatives that support APPs in these roles, fearing a loss of control.

A balance is needed between supporting physician interests and transforming care delivery to provide the highest quality at the lowest cost. Achieving this balance requires physicians to assume leadership roles and organizations to adopt techniques such as Crucial Conversations (VitalSmarts 2014; discussed in detail in Chapter 8) to effectively and safely navigate the future healthcare landscape.

Joseph S. Bujak, MD, FACP, principal of Bujak and Associates, paints an explicit picture of how the traditional medical staff does not meet today's challenges in a meaningful or responsive way.

The Future of the Organized Medical Staff

As more and more physicians move into employment relationships with healthcare organizations, and as essential healthcare services move away from the hospital, the traditional organized medical staff structure becomes increasingly irrelevant. If we agree that the sole purpose of the organized medical staff is to assess and improve the quality of care provided through peer review, credentialing, and privileging—activities that are intended to support continuous quality improvement—the organized medical staff is losing its ability to manage the hospital–physician relationship. A new perspective is required that is not based solely on economics and that transcends the traditional hospitalized patient in addressing the mandate to provide continuity of care.

Specifically, with the trend toward outpatient care delivery, many physicians will no longer work in the hospital, resulting in a lack of access to recredentialing and privileging by the organized medical staff. In turn, those physicians who oversee their peers will no longer be able to directly observe the competencies of those peers being evaluated and must defer to indirect evidence to support what becomes an unmanageable responsibility. Furthermore, because medical staffs are often composed of competing practices, peer review may be outsourced in deference to the internal politics and potential conflicts of interest that can dominate physician relationships.

Governance of employed physicians is provided by the employing organization, so as the percentage of physicians engaged as employees grows, independent physicians fear becoming isolated from their peers and denied access to patients. For this reason, the organized medical staff structure now tends to speak primarily for the independent physicians.

Older physicians tend to be more traditional, autonomous, digitally impaired, and intrinsically motivated to work long hours than are younger physicians. Because most younger physicians are employed and credentialing and privileging are managed by the employing entity, younger physicians often do not attend medical staff meetings and functions because those events are usually scheduled before or after working hours—on their

(continued)

own time. Given these factors, solving clinical problems is a significant challenge, especially when the only vehicle with which to drive integration is the traditional medical staff framework.

The need to orchestrate care in the new world of value-based reimbursement demands sacrificing self-interest for the collective interest. Under the healthcare reform mandate for the provision of coordinated care, the provider community is now responsible for the quality, cost, service satisfaction, and appropriateness of the care offered. One movement toward achieving these goals is to reduce variation and consistently apply evidence-based interventions. Problematic to this trend, however, is the traditional medical staff organization's primary commitment to preserving individual physician autonomy. Coordinating care across professions and specialties conflicts with the departmentalization of the organized medical staff structure, which excludes nonphysicians from participating in that care. As a result, the economically integrated provider community—not the traditional medical staff—will manage quality and cost.

Balanced accountability in the value-based reimbursement model requires a degree of integration not possible in the traditional medical staff organization, making that practice structure an inadequate one for managing relationships in the evolving provider community.

A NEW MEDICAL STAFF MODEL

In the new paradigm of value-based health services delivery, neither board trustees nor senior executives can be considered veterans of the system; thus, neither group can effectively lead the medical staff. The edicts that often emanate from hospital administrators serve only to create conflict, which can undermine trust and lead to organizational divisiveness.

Value-based reimbursement requires a redesigned medical staff, including its leadership model, organizational structure, and operational processes as well as the medical staff–management relationship. In this section, we outline what this redesigned medical staff should look like.

Redesigned Leadership

Physicians need to lead physicians, just as administrative leaders need to lead managers. Not even the chief medical officer (CMO) or vice president of medical affairs (VPMA)—as members of the C-suite—can lead staff physicians where they do not wish to go.

Succession Planning

Rotating voluntary leadership, as democratic as it seems, is no longer a relevant approach to preparing, supporting, and retaining qualified physician leaders. A stable, accountable physician leadership group is required, which is best developed through leadership succession planning. Think of succession planning as being just as essential for medical staffs as it is for any other group of professionals.

Some forward-thinking medical staffs have replaced the traditional nominating committee—the body of physicians on a hospital medical staff that is charged with vetting and recommending medical staff leaders to the organization's governing board and medical executive committee (MEC)—with a leadership succession planning committee. This committee develops criteria for leadership positions, helps identify potential leaders, prepares them for leadership roles, supports them during their term of office or role, and retains them in some leadership capacity following their term. The executive management team may participate as advisers, especially in cases where an individual with senior management potential wishes to grow into a medical director, VPMA, or CMO role.

A Deeper Dive

The medical executive committee (MEC) was developed by the The Joint Commission in the 1980s as organized medical staffs grew larger and more complex. Traditionally, the medical staff was self-governing and held itself accountable through a town hall approach with monthly general staff meetings where initiatives were generated and approved by super-majority consensus. This proved unwieldy in the modern era, and so the MEC, a smaller body made up of medical staff officers and department chairs, was a logical compromise and transitioned the medical staff culture from a democracy to a representative republic.

The leadership criteria that the succession planning committee creates may include the following:

- ◆ A specified number of years of qualifying service as a practicing clinician
- ◆ The ability to work harmoniously with clinicians, staff, and management
- ◆ A willingness to support medical staff–recommended quality, safety, and service initiatives
- ◆ Service on medical staff or hospital committees
- ◆ Service as a medical staff or hospital committee chair
- ◆ Service as a department or clinical service chair or as a medical director (for medical staff officers)
- ◆ Formal leadership training

Leadership Training

High-performing organizations often require physician leadership training prior to or concurrent with leadership service. For example, Baylor Scott & White Health in Dallas, Texas, offers a one-day, boot camp–style training seminar hosted by system CEO Joel T. Allison, FACHE, and system senior vice president and CMO Irving Prengler, MD. All physicians who wish to serve in leadership roles are required to complete the training. Other organizations, such as Allina Healthcare in Minneapolis, Minnesota, offer a five-day, 35-hour leadership program for every physician leader in their system. See the sidebar starting on this page for examples of a one-day and five-day program curriculum.

Sample Curricula for Physician Leadership Programs

One-Day Program

1. Orientation to leadership, and how to run a meeting (1.5 hours)
2. Roles and responsibilities, and orientation to the system (1.5 hours)
3. Introduction to performance management (1 hour)
4. Introduction to credentialing and privileging (2 hours)
5. Introduction to peer review (1 hour)
6. How to deal with performance management challenges and behavioral issues (1 hour)

Five-Day Program

Day 1: Medical Staff Structure and Purpose

1. Introduction to the system and program overview (1 hour)
2. Current healthcare challenges (1 hour)
3. Roles and responsibilities (3 hours)
4. Conflict resolution and negotiation (2 hours)

Day 2: Credentialing and Culture

1. Performance management and accountability (2.5 hours)
2. Credentialing and privileging (3 hours)
3. Privileging case study (1.5 hours)

Day 3: Peer Review and Performance

1. Ensuring an effective peer review process (3.5 hours)
2. How to manage poor performance and behavioral issues (1.5 hours)
3. Case studies in ongoing professional practice evaluation and focused professional practice evaluation (2 hours)

Day 4: Legal and Financial Obligations

1. Healthcare law for physician leaders (1.5 hours)
2. Common legal mistakes that healthcare leaders make (1.5 hours)
3. How to manage an investigation, a fair hearing, and an appellate review (2 hours)
4. Healthcare finance and case study (2 hours)

Day 5: Performance Improvement, Patient Safety, and Leadership Skills

1. Medical staff's role in performance improvement and patient safety (2.5 hours)
2. Transitioning from an effective clinician to an effective leader (3 hours)
3. Advanced leadership skills and conclusion (1.5 hours)

Note: In addition to this broad-based education, many organizations offer more focused training to new physician leaders or committee members assuming first-time roles. Topics may include orientation for new MEC members, credentials committee members, peer review committee members, and department chairs and medical directors.

Unfortunately, many physicians assume titled positions with little, if any, orientation, training, or foreknowledge of what the role expects of them, with undesirable results. Instead, job descriptions (many of which are seldom read and only partially described in the medical staff bylaws) should be included as an integral part of this training, to be discussed with each prospective committee member or leader prior to the assumption of her term of office.

Once physicians are trained, it is important to provide ongoing coaching as they make the transition from solving analytical problems for individuals in a rapid and decisive manner to managing people and systems in interdisciplinary team-based settings. Every good manager understands the length of time it takes to master enterprise oversight skills; without real-time mentoring and support, many

physicians do not become effective partners with management, despite their best intentions.

Many managers consider leadership training to be just another cost to contend with. A better way to think of it is as an investment with a calculable return on investment (ROI). Exhibit 1.1 shows how the benefits of leadership training can be calculated.

Exhibit 1.1: Hospital Metrics of Leadership Effectiveness

Average length of stay (ALOS): Some chief financial officers in large organizations have quoted a figure as high as \$4 million in cash flow differential for ALOS that can be reduced by 0.1 day.

Case-mix index (CMI): Like ALOS, a tenth of a point increase in CMI can have a profound impact on Medicare reimbursement and operating revenue.

Cost per adjusted discharge: Organizations that have installed effective cost accounting software demonstrate up to a 1,000 percent, or tenfold, variation in the way different physicians manage the same patient condition over time. Physician leadership that does not address resource outliers may inadvertently cost patients their lives and certainly costs the organization millions of dollars annually.

Core Measures: By 2016, value-based purchasing (VBP) will have a 2 percent impact on Medicare reimbursement. Even greater will be the impact of third-party payers that monitor the US Department of Health and Human Services' Hospital Compare website (medicare.gov/hospitalcompare/search.html) and create tiered and narrow networks—through both private and public insurance exchanges—to direct patients by offering significant financial inducements (e.g., low or no deductibles, copayments, and coinsurances) to those organizations that achieve high-quality, low-cost care delivery.

Patient safety: Many unsafe behaviors have become deeply imbedded in physicians' psyches during their medical training; these behaviors need to be eliminated and replaced with effective approaches that require continual reinforcement by physician leaders and champions. Standardizing safety behaviors and communication protocols can save tens of thousands of lives per year, whereas inadvertent adverse outcomes from safety breaches may cost human lives and cost an organization its reimbursement, quality measures, community reputation, and market share.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS): Customer satisfaction and loyalty has a three-pronged impact on healthcare organizations because it not only represents a 30 percent share of VBP but also is a significant indicator of medical liability costs and is the single greatest driver of market share in any industry.

Opportunity cost of lost referrals: It is surprising that many executive leaders never ask individual physicians about the out-migration of referrals; if they did, they would have the opportunity to learn directly how to mitigate the problem. This factor can have a

significant impact on operating revenues. Good leaders have ongoing relationships with key physicians and engage in dialogue about the perceived sources of both in- and out-migration.

Elimination of waste in operating systems: A good physician leader works tirelessly to reduce waste and inefficiency, as these conditions are both the bane of physician colleagues who struggle with declining efficiencies and the source of potentially significant reductions in operating costs that can enable a healthier margin.

Standardization to evidence-based practices: Good physician leaders work with physicians to continually optimize quality outcomes by standardizing high-risk, problem-prone clinical situations, such as general intensive care; ventilator management; postsurgical deep venous thrombosis prophylaxis; and the care of patients with congestive heart failure, community-acquired pneumonia, and acute myocardial infarction. Adopting evidence-based medicine not only reduces the cost per adjusted discharge but also, with appropriate horizontal and vertical integration, decreases the rate of avoidable readmissions, which will be subject to a Medicare penalty of 3 percent by 2016.

Elimination of disruptive behavior: A small number of physicians in each organization cost the institution millions of dollars annually in legal fees, lost referrals, staff turnover, medical liability, and community perception. Ineffective physician leadership may promote appeasement and enablement, which undermine morale, compromise quality and financial performance, and may even cost patients their lives.

Diagnosis of and intervention on impairments: In 2003, the American Medical Association estimated that more than 45,000 impaired physicians were practicing in the United States (Ross 2003). Their often preventable and treatable conditions may cause these physicians to commit unanticipated medical errors or cause adverse events because of their failures to communicate or their inability to process complex information quickly or efficaciously.

Physician Leader Compensation

Until recently, physician leaders were volunteers and did not receive compensation for performing their leadership roles. Physician leadership is now shifting to compensated, titled positions, and with that shift comes a set of new realities:

- ◆ Leadership now requires more preparation and commitment than in the traditional medical staff structure. Providing this service for the organization can take a physician out of a busy medical practice at significant opportunity cost.
- ◆ Leaders are increasingly being held to performance expectations and may be accountable for achieving measurable strategic goals and objectives.
- ◆ Many strategic goals and objectives have a calculable ROI. Meeting, and often exceeding, standard ROI metrics (see Exhibit 1.1) is now deemed essential to organizational success.

- ◆ Fewer qualified individuals are interested in pursuing leadership roles with real accountability than in the past, when these roles were often symbolic and ceremonial.

Effective compensation models base rates on benchmarking data, such as those provided by the Medical Group Management Association through its annual compensation survey. The floor can be set at the 10th percentile, with incentives that can bring compensation up to the 90th percentile. Categories of incentives include productivity measures, compliance with quality and safety initiatives, patient satisfaction and loyalty measures, cost-effectiveness measures, and corporate citizenship activities (e.g., attendance at meetings, completion of medical records, willingness to serve on committees).

Recruiting Physician Leaders

The level of accountability for physician leaders is clearly increasing, leading to fewer candidates for these roles. To offset this decrease, the medical staff can limit the number of leadership positions and enhance the effectiveness of those that remain.

Taking such a course might require a number of changes in the leadership structure:

- ◆ *More flexible terms of office.* Increased flexibility enables (qualified and supported) leaders to serve longer, staggered terms. Key committee chair positions (e.g., credentials, peer review) do not turn over at the same time as the MEC, thus ensuring greater leadership continuity.
- ◆ *Aggregate leadership roles.* Combining roles decreases the number of leaders significantly. For example, a medical director could replace the traditional medical department chairs of multiple specialties and subspecialties.
- ◆ *No nominations for leadership positions accepted from the floor.* All potential nominees must undergo a vetting process by the leadership succession planning committee to ensure that (1) only qualified nominees reach the floor of medical staff meetings for a vote and (2) individuals seeking office have a clear understanding of the leadership roles, responsibilities, and performance expectations.
- ◆ *Dual accountability.* Leaders such as medical directors and service line directors are generally accountable to both the MEC and senior management.
- ◆ *Dual clinical/operational focus.* Leadership roles can focus on both the clinical quality of care and the operational and financial performance of clinical services. This approach is often part of a dyad/triad model, in which each service

is overseen by a physician, an administrative or nursing leader, and an executive leader (e.g., COO, CMO) who manage the service together. Dyad/triad structures are discussed in more depth later in the book.

As reimbursement shifts from pay-for-volume to pay-for-value, effective physician leaders are essential for creating a sense of urgency for change among the medical staff. In addition to being necessary for survival in a value-based environment, this new model of leadership is a contemporary and professional approach that ensures a solid partnership with management. Together, physicians and executive leaders can implement important improvements to clinical and operational processes in a responsive and timely way.

Redesigned Structures

Once the organization has effective physician leaders in place, the next step is to reorganize the medical staff structure so that it is dynamic, responsive, agile, and able to partner with management to effect rapid change. Here we introduce the various types of committees; they are discussed in greater depth later in the book.

Medical Executive Committee

Originally, the MEC was made up of medical staff officers (president, vice president, secretary-treasurer, past president); department chairs; and ex-officio members of senior management, including the CEO, CMO or VPMA, and chief nursing officer (CNO), to manage large and unwieldy credentialing, privileging, peer review, and governance bodies. The same individuals who led their departments and served on the credentials and peer review committees oversaw the medical staff as a whole. Department chairs often sought seats on the MEC to protect departmental interests (or their own), and myriad conflicts of interest arose that threatened to damage the integrity of leadership decisions. Some MECs were managed and controlled not by the physician leadership at all but by the CEO, who used medical staff meetings to share management initiatives—without having gained physicians' input or support.

A contemporary approach is to create a small MEC made up of key physician leaders and physicians from both the hospital- and ambulatory-based segments. These individuals should have a desire to serve in a statesperson role representing the best interests of *all* members of the medical staff. This structure appropriately reflects the fact that the majority of physicians no longer practice in the hospital.

Many MECs now also include podiatrists; optometrists; chiropractors; allied health practitioners; and APPs, such as nurse practitioners, physician assistants, certified registered nurse anesthetists, and certified nurse midwives. These professionals represent the views and perspectives of the growing number of nonphysician clinicians on the medical staff. The shift in MEC membership is in line with a proposed change to the CMS Conditions of Participation that expands the definition

A Deeper Dive

Structure of the Traditional Organized Medical Staff

The traditional medical staff structure was founded on the ideals of autonomy, independence, and self-accountability. It was designed to protect the relationship between a single physician and his patient—not to adapt to rapid change in complex systems.

The following attributes of the medical staff organizational structure were built into the original model so that the organized medical staff could maintain control of its profession and professional identity and ensure that change was difficult to effect:

- ◆ Informal leaders were afforded the ability to drive the medical staff agenda and control formal, titled leaders.
- ◆ General medical staff meetings were organized as town-hall gatherings. The expectation was that consensus would be achieved through super-majority voting, thus essentially protecting the status quo.
- ◆ Leadership was voluntary and rotated frequently to ensure that no individual gained leadership tenure or skills that would potentially undermine the influence of the majority.
- ◆ The leadership of departments, committees, and the MEC overlapped to ensure that one structure did not hold another accountable or modify the other's recommendations.
- ◆ A complex set of economic and political relationships was forged through referral channels that were protected at all costs.
- ◆ A strong value of professional identity was instilled to promote protectionism.

The paradox in this structure is that when professionals are motivated by fear and resist accountability and transparency, they lose the opportunity to grow and the ability to reach their potential, undermining—albeit inadvertently—themselves and their organizations.

of *physician* to include podiatrists and, for rural health clinics and federally qualified health centers, optometrists and chiropractors (*Federal Register* 2013).

Some large systems have developed a super-MEC structure to focus on system-wide medical staff issues, such as

- ◆ strategic planning of and communicating about systemwide medical staff goals and objectives,
- ◆ strategic medical staff development, with recommendations made to the system board,
- ◆ arbitration of politically or economically charged issues that cannot be fairly or adequately resolved at a member organization, and
- ◆ preventive management or arbitration of potential corrective or legal action.

Credentials Committee

Ensuring that every privileged member of the medical staff is qualified to exercise every requested privilege and conducts herself at a high professional level requires a rigorous approach to governance. Physician leaders on the credentials committee must be trained in the technical, legal, regulatory, and accreditation aspects of credentialing and privileging and be accountable to the MEC for the quality and integrity of their recommendations. Some healthcare systems have created system-level credentialing committees—or *super-committees*, as HCA's HealthONE in Denver, Colorado, calls them—made up of the member hospitals' credentials committee chairs and their CMOs or VPMAs. The super-committee helps the hospital credentials committees fulfill their responsibilities by

- ◆ creating appropriate policies and procedures for the development of credentialing and privileging structures and processes to address contemporary credentialing and privileging challenges;
- ◆ developing and approving credentialing and privileging eligibility criteria;
- ◆ overseeing member hospital credentials committees to ensure that they are performing peer review in a transparent, fair, and judicious way;
- ◆ serving as a resource for difficult credentialing, privileging, and evaluation issues; and
- ◆ auditing or arbitrating complex or divisive credentialing and privileging activities, including those that lead to potential corrective action or civil litigation.

The credentialing and privileging functions are discussed in detail in chapters 3 and 4.

Peer Review Committee

Until recently, most peer review was conducted by a department chair, a departmental committee, or an aggregate committee of medicine or surgery. This approach resulted in numerous conflicts of interest; failures to address quality issues in a substantive or meaningful way, as in the use of the peer review process as a means of rewarding or punishing colleagues because of their political and economic relationships; and other untoward practices. Some peer review committees performed their function well; however, the widespread variation in approaches and intentions among peer review committees often clouded the transparency and marred the integrity of the entire process.

Medical staffs are moving toward a centralized, multidisciplinary model of peer review. Physicians who are motivated by the desire to improve quality are trained and compensated to conduct peer review using a transparent approach with a standardized scoring format and methodology. Improvement opportunities for individual physicians that arise from this process not only support the individual physician being reviewed but also bring to light nursing and systemic issues that can be addressed in tandem.

As with credentials committees, some larger systems are creating a super-peer review committee made up of the peer review committee chairs and the VPMA or CMO of member organizations. An extensive discussion of medical staff peer review is provided in Chapter 7.

Clinical Departments

A service line approach to departmentalization is emerging in medical staffs in response to the problems that come with isolated clinical departments, entrenched interests, and resistance to change. A service line may consist of one or more clinical specialties, and its purpose is to oversee and improve clinical care, operations, and the financial performance of that unit.

Well-conceived service lines offer the following benefits and should be considered part of the organization's overall strategy and portfolio:

- ◆ Targeted clinical services provided by interdisciplinary teams
- ◆ Branding and marketing that are responsive to the external environment and demand
- ◆ A focus on service to both internal and external customers
- ◆ Coordination with other service lines and other internal and external organizations
- ◆ Strong alignment between quality and safety goals and operational efficiency and financial performance

Service line leadership usually follows the dyad or triad model, with a physician leader, an administrative nursing manager, and an executive leader who work together in all phases of leadership and oversight.

A major cultural difference between the traditional clinical department and a service line is accountability. Many service line-oriented medical staffs have developed a balanced scorecard or dashboard reporting system for the MEC and management. As discussed in Chapter 5, the metrics or targets displayed on the dashboard should be negotiated with full participation of the medical staff and flow naturally from the organizational and medical staff strategic plan.

In a service line, reporting relationships may not be linear, as multiple services and departments may be involved in any given service line. For instance, a vascular surgery service line might include vascular surgery, general surgery, radiology, cardiology, podiatry, primary care, home health care, endocrinology, and a patient-centered medical home. Some physicians may not be psychologically or professionally prepared to transition from autonomous to collaborative decision making, which is essential to achieving a functional service line culture. Both managers and physicians must be realistic when creating service lines. Including individuals who are not compatible with a culture of collaboration may ultimately squander the time and resources spent to build them.

The Integrated Medical Staff Structure

The most successful medical staffs in the United States are fully integrated and aligned with the organizational structure to fulfill a shared mission, vision, and strategy. Integration does not require that the physicians be employed by the hospital, but it does require each member of the medical staff to be aligned with the organization's strategic goals and objectives. Agreements are a key component to building an aligned medical staff. (See Chapter 11 for a detailed description of the integration and alignment process.)

Each physician should have an individual agreement with the organization. A professional agreement can be structured in one of several forms, including employment, co-management, professional services, joint venture, enterprise partnership, and exclusive arrangement. It outlines both the medical staff bylaws and contractual performance expectations, metrics, and targets for the physician and the healthcare organization on the basis of a compensation plan with incentives that is mutually beneficial.

The emergence of these agreements has altered the culture of the traditional medical staff and the relationship between physicians and managers because both are now legally, economically, and clinically interdependent: They rely on each other for achieving goals for mutual benefit. In a conjoined relationship with the organization, the MEC becomes a strategic body, spending little time on areas of self-interest and a

great deal of time on organizational strategy; medical staff-wide goals and objectives; physicians' impact on quality, safety, loyalty, operations, and financial performance; and the relationships among the medical staff, management, and board.

Redesigned Processes

Transformed structures need to function in transformed ways. Thus, the work processes used by the medical staff need to transform as well.

Conflicts, and Conflicts of Interest

One key element of transformation is addressing potential conflicts and conflicts of interest to reduce the impact of self-interest on decision making.

Every physician has economic and political relationships with other physicians and managers. A good first step in transforming medical staff processes is to acknowledge that conflicts and conflicts of interest can arise in almost every interaction of a medical staff.

Some medical staffs have created a conflict resolution process that calls on an ad hoc committee to review potential conflicts as they emerge. This approach brings to light the sources of conflict and permits an even-handed method for reaching resolutions. Numerous medical staffs have adopted processes that encourage physicians to voluntarily disclose potential conflicts to the MEC or another decision-making body that can appropriately manage them. Others have developed system-level approaches to deal with commonly occurring conflict situations.

Meetings

The opportunity cost of taking busy physicians out of their practices to attend meetings is significant. According to Merritt Hawkins (2010), physicians generate, on average, \$1.5 million in revenues for a healthcare organization per year; some specialties generate almost \$1.5 million more. Assuming the average physician works 40 hours per week for 52 weeks per year, for a total of 2,080 hours per year, his work yields approximately \$721.15 per hour in revenue ($\$1,500,000 \div 2,080 = \721.15). It follows that a single one-hour meeting with 15 physicians could cost an organization more than \$10,000 in lost revenues.

The following guidelines are helpful in reducing the impact of meetings with physicians:

1. Only meet when face-to-face discussion or debate is necessary. Most routine medical staff work can be accomplished online, off-site, or in some expedited manner.

2. Eliminate redundant discussion by diversifying the membership of various committees.
3. Eliminate routine discussions and reports that do not drive change and that no one is interested in. Create a consent agenda, which reflects material that everyone agrees requires no formal discussion or debate.
4. Have a clear vision of what you would like the medical staff or individual departments or service lines to accomplish, and focus their work on essential strategic goals and objectives. Strategy should drive execution, not vice versa.
5. Support off-site participation in meetings by offering GoToMeeting, Skype, or other means of teleconferencing.
6. Do not keep participants in a one-hour meeting—or do not hold the meeting at all—if you have nothing relevant to discuss.
7. Team building is an important exercise; do not relegate it to business meetings.
8. Not everything is equally important; focus on the vital few actions that will drive change and results.
9. Leverage administrative staff to support physician meeting functions, and only tap physicians' input when it is required.
10. Communication is the life blood of any organization, but it does not have to occur in time-consuming meetings.
11. Spend more time developing relationships and less time conducting meetings. (This essential guideline is addressed more fully in Chapter 11.)

Value for the Work Done

Because the medical staff is an organization's most expensive resource, driving physician value is crucial to fulfilling the Patient Protection and Affordable Care Act (PPACA) mandates. Fortunately, in a pay-for-value world, where $\text{Value} = \text{Outcome} \div \text{Cost}$, high quality, high reliability, and service excellence can be quantified by measuring loyalty, market share, and net revenue per adjusted discharge—the most accurate predictor of financial performance (Kaufman 2013). For example, one organization resisted addressing a physician's behavioral issues because he generated \$3 million in gross revenues per year. Finally, the leadership assessed his net value to the organization by calculating his opportunity cost and was startled to find that the organization was losing more than \$5 million in seepage (out-referrals) annually as a result of the physician's poor behavior and low clinical quality.

Obviously, financial metrics should not be the sole driver of leadership. But placing all of the assets and liabilities of a defined challenge in perspective is a worthwhile exercise to prioritize and support organizational changes and initiatives. The following table illustrates this approach.

Projected revenues	Projected costs
Gross/net revenues per adjusted discharge	Direct variable costs associated with clinical services
Increase in market share/referrals	Cost per adjusted discharge
Increase in ancillary revenue	Leadership time (direct and opportunity costs)
Staff retention savings	Legal costs
Quality/safety/service metrics (positive findings)	Decrease in market share/referrals and related revenues
Quality/safety/service metrics (negative findings)	Turnover costs

Assessing the cost of supporting a peer review program is another example of determining value for the work. As shown in Chapter 7, an effective peer review program that focuses on performance improvement and not merely quality

Example of an Effective Peer Review Program

One medical staff experienced a number of quality events in the intensive care unit (ICU) that resulted in several risk-management and medical liability situations. These events led to a loss of reputation and market share in the community. Medical staff leadership conducted common cause analyses for each event in its peer review process and found that a lack of training and inadequate skill levels were major contributing factors.

The medical staff recommended to the hospital's board of directors that the organization convert the ICU to a step-down unit. It also suggested that the organization require physicians to demonstrate a higher level of training and competence to be eligible to apply for privileges in this unit. The recommendations were accepted and operationalized.

Following implementation, patient turnover was higher, length of stay was lower, and the cost per adjusted discharge decreased while quality, safety, and service metrics improved significantly. These improvements increased the organization's operating revenues and lowered its operating costs.

With the elimination of the ICU, the medical staff agreed to refer all patients requiring critical care services to a regional tertiary care center, which later approached the organization to be included in its network. The move enhanced the local organization's reputation and market share.

This turnaround occurred because an effective peer review program focused on individual, nursing, and systemic improvement and not on placing blame. It demonstrated an ROI that both the medical staff and management could point to with pride.

assurance (the identification of negative outliers) identifies measurable improvements for individual practitioners, clinical services, the entire medical staff, nursing, and the system as a whole. Many of these improvements can be reported on a spreadsheet and quantified easily. See the sidebar on page 20 for an example of how one medical staff improved quality and revived its reputation through the effective use of its peer review program.

Redesigned Medical Staff–Management Relationship

The preceding sections have made clear that physicians, managers, and board members need to work together in new ways to optimize quality, reduce costs, and address conflicts and conflicts of interest in an open and transparent manner. Organizations are beginning to modify their operational structures to support a close and trusting working relationship by placing physicians on the governing board, the senior management team, operating boards, and other hospital-based teams.

Physicians on the Governing Board

Many of today's physicians understand that, like executive and community leaders, they must set aside self-interest if they wish to govern effectively. Good governance includes bringing technical expertise and perspective to the board without the burden of conflicted interests or constituency bias.

Not every physician can play this role, but physicians' unique professional perspectives on quality, safety, and service must be represented directly in the boardroom. The key to selecting physicians for the governing board is that they have a strong character and the ability to insulate themselves from the sometimes intense social and economic pressures of their peers. The expectation is that they represent the organization with undivided loyalty.

Physicians on the Senior Management Team

It has long been common for a VPMA or CMO to be part of the senior management team, but presidents of the medical staff and chiefs of staff have not typically been involved. This exclusion is a missed opportunity to develop a channel of communication to the medical staff, which offers a pipeline for seeking physicians' input and gaining their buy-in on essential management and organizational initiatives.

Physicians on Operating Boards

Operating boards blend governance and operational oversight to approve clinical, safety, service, operational, and financial goals and objectives; convert those goals

and objectives to metrics with targets; and hold the operating unit accountable for results. In addition to seating a majority of clinical providers, as mandated by the PPACA (which states that at least 75 percent of an accountable care organization's governing board be controlled by individuals who provide patient care within the structure), operating boards typically include key operational managers; a representative from a strategic corporate sponsor or business partner; legal counsel; a patient advocate; and a few community leaders, who usually lack specific healthcare experience but who offer important community and enterprise perspectives.

Physicians on Committees

The role of the physician serving on a traditional hospital committee is one that many organizations are rethinking. Too often, these committees spend endless hours reviewing subcommittee reports rather than actively discussing, debating, and crafting solutions that produce measurable outcomes. Wise executives redesign these committees to include a committee chair who has excellent project management skills to promote a responsive, adaptive, and focused committee.

One contemporary committee that features robust representation of physicians is the physician–nursing council, an interdisciplinary body made up of physician and nursing leaders that addresses all matters related to the physician–nursing operational relationship in the areas of culture, process, communication, and performance management. Another is the APP interdisciplinary committee.

SUMMARY

The PPACA's mandate that US healthcare providers deliver world-class quality, ensure patient safety, and offer excellent service at a significantly lower cost than in the past requires a medical staff that is far more agile, responsive, and adaptive. Medical staff structures and processes must be transformed, with highly trained and skilled physician leaders at their helm, to develop the kinds of partnerships with management and the board that will enable an organization to respond to demands for continual improvement and change under increasingly tight time constraints.

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