The dos and don’ts of conducting fair hearings

Hospital labs have a sterile environment in which to determine whether a patient has sickle cell anemia, and the outcome is typically straightforward. However, medical staffs do not have such a sterile environment to determine physician competence, and the outcome is often not crystal clear.

Generally, every member of your medical staff has the right to a fair hearing if they are accused of unprofessional behavior or technical incompetence, but ensuring a truly fair process can be difficult. MSB has highlighted some key dos and don’ts to help make your fair hearing process just that—fair.

Don’ts

When preparing a hearing panel, avoid the following:

➤ Don’t appoint direct competitors. “You can’t have a physician’s arch nemesis sitting on the hearing committee, because he or she stands to gain from the physician’s termination or will be less than objective,” says Michael Callahan, an attorney at Katten Muchin Rosenman in Chicago. However, sometimes the committee responsible for appointing panel members may not know where to draw the line, he adds. For example, he recalls being involved in the summary suspension of an orthopedic surgeon. The hearing panel was not only devoid of other orthopedic surgeons, but also general surgeons, “even though, technically, they don’t compete,” he says. The physician in question claimed the hearing was not fair, because none of the panel members were surgeons and did not understand his arguments.

When deciding who is a direct competitor, it is important to identify the issue at hand, says Callahan. If Dr. X is undergoing a hearing for disruptive behavior, panel members don’t have to be in the same specialty. “Anyone can understand [behavior issues],” he says. However, if Dr. X is undergoing a hearing for clinical or technical problems, the hospital should appoint at least a few panel members who practice in the same or similar specialty but are not direct competitors. If necessary, the hospital may need to bring in noncompeting physicians from other hospitals.

Also, if the patient populations of Dr. X and a panel member do not overlap, they technically are not direct competitors, Callahan says.

➤ Don’t appoint people who had direct involvement in the events leading up to the hearing. The person who blew the whistle on Dr. X cannot participate on the panel, says Callahan, and you must also exclude any members of a committee who met to discuss Dr. X’s poor performance. However, Callahan adds, individuals who have heard at the watercooler that Dr. X might undergo disciplinary action do not need to be excluded. “Knowledge of the situation is not enough to kick someone off of the hearing committee,” he says.
Fair hearings  < continued from p. 1

Annemarie Martin-Boyan, an attorney at Temple University Health System in Philadelphia, says that bylaws should be clear as to what level of involvement prohibits someone from serving on the hearing panel. “A lot of hospitals take the position that if you voted on the matter before or were directly involved in making a recommendation, that would preclude you from the panel,” she says.

➤ Don’t allow physicians access to other physicians’ records. When Dr. X is preparing a defense, the hospital should allow him or her access to all incident reports, meeting minutes, or other records that were used when making the decision to take corrective action against Dr. X, says Callahan. He adds that Dr. X may also want access to other physicians’ files to find information regarding disciplinary actions against them; if successful, he or she could make a case that the hospital is singling him or her out. “I can see the argument, but we don’t give access to peer review files of other physicians,” he says.

Boyan says that in seeking other practitioners’ files, Dr. X may be trying to divert attention away from the issue at hand. “As a rule of thumb, you want to limit the scope of the questions that go before the panel. You don’t want [the hearing] to become a trial of the institution or of all the medical staff members in a particular department.”

➤ Don’t make it impossible for the hearing panel to overturn the medical executive committee’s (MEC) decision. If the MEC recommends discipline for Dr. X, and Dr. X appeals, the hearing panel has the authority to recommend a different course of action to the MEC, Boyan says. For example, if the MEC suggested that the board suspend Dr. X, the hearing panel, on a second analysis, may recommend proctoring, professional development, and/or continuing medical education (CME) for a specific period of time.

The example can also be flipped around: if the MEC recommended proctoring, but the hearing panel determined proctoring was not sufficient discipline, the panel could recommend suspension. “You want the panel members to know that they have a say as to how [cases] ultimately go to the board,” Boyan says.

If the hearing committee gives complete deference to the MEC, “it raises the issue as to whether this is really going to be a fair proceeding,” Callahan adds.

➤ Don’t assume hearings are the only way to address physician behavior and/or competence problems. Callahan and Boyan say that hospitals should consider a hearing only as a last resort. “Hearings are expensive, time-consuming, and may lead to litigation,” says Callahan. As soon as a hospital begins looking into a physician’s performance, it should inform and consult with that physician, adds Boyan.

Callahan says hospitals have several options to help physicians get back on track, including:

− Monitoring
− Proctoring
− Counseling
− CME

Boyan says The Joint Commission’s ongoing professional practice evaluation requirements should help
hospitals identify negative trends in physicians’ performance far before disciplinary action is needed. “It works out better for everyone if the physician gets the help that he or she needs before a hearing is required,” she says, adding that taking proactive measures to help physicians may benefit the hospital if circumstances ultimately lead to a hearing. “If you are doing all of these things, and the individual fails to change [his or her] behavior or demonstrate improvement, you have shown as an organization that you have tried, and I think that makes the hearing easier,” says Boyan.

Dos

Strive for the following when preparing a panel:

➤ Do avoid biases on either end of the spectrum. Hospitals should avoid appointing panel members who have a grudge against or who are good friends with Dr. X, Callahan says. In addition, hospitals should also avoid appointing members that have a referral agreement or contractual relationship with the hospital or the physician. For example, if a hospital appoints a medical director who has an exclusive contract with the hospital, Dr. X can object, claiming that the medical director would vote in the best interest of the hospital. Callahan says that hospitals should avoid creating even the appearance of bias so as to not give Dr. X additional grounds to claim the hearing was unfair.

Boyan adds that hospitals need to remind physicians of their obligation to disclose any conflicts they foresee with panel members.

➤ Do appoint panel members who have good standing within the hospital. The hearing panel receives more information than any other committee regarding the claims brought against Dr. X. Fair hearings aggregate all documents and data illustrating Dr. X’s performance and involve testimonies from witnesses and experts. For that reason, the hospital takes the hearing panel’s recommendations seriously.

“With that in mind, you obviously want people who are highly regarded within the institution, professional, thoughtful, and fair,” says Callahan. “If, for example, you appoint courtesy staff members who hardly ever show up at the hospital, you are watering down the potential impact the panel’s recommendation is going to have.”

Although it may be difficult for hospitals to find medical staff members who are willing and able to serve on a hearing panel, Boyan says that hospitals should avoid overusing those individuals. The hearing process is not only time-consuming, but judging peers can also be emotionally taxing on panel members. “It is a lot of work, and they don’t get compensated for it,” she says.

➤ Do allow the opportunity to raise objections. Even if you have tried to be objective when choosing a hearing panel, you might not know that Dr. X and a panel member were partners 10 years ago and had a bitter falling-out, says Callahan. “That is why you give physicians an opportunity to object.”

If Dr. X objects to the appointment of a panel member, he or she needs to provide the committee responsible for appointing panel members with adequate justification. The committee chair will decide whether the objection is valid and determine whether the committee should remove the individual in question from the panel.

“As a general rule, [the committee would] abide by the physician’s request, but sometimes you will see physicians objecting for no reason,” Callahan says. He explains that Dr. X may object to a panel member he or she knows has no tolerance for deviations in performance, but notes that, “of course, that kind of objection would be denied.”

Hospitals that offer physicians an opportunity to object to panel members are protecting themselves in the long run, Callahan says. If Dr. X was given the opportunity to object, he cannot try to overturn the hospital’s decision to terminate his or her privileges by claiming the panel was biased.

➤ Do assure panel members of the protection your hospital will provide them. Finding individuals who are willing to sit on a hearing panel is difficult, so you want to protect them from the potential threat
Fair hearings  < continued from p. 3

of litigation, says Callahan. To help panel members feel safe throughout the hearing process, Callahan says the hospital should remind panel members that its insurance policy will cover and defend them from any claims associated with their recommendations. “The hospital needs to be able to say, ‘If that physician sues you, we will provide a defense for you,’ ” he says.

Boyan adds that insurance coverage varies depending on the relationship the physician has with the hospital. If the medical staff members serving on the hearing panel are employees of the hospital, they are likely to be automatically insured by the hospital’s policy.

“It gets tricky when you have volunteer medical staff. You would have to provide them some assurance of coverage if they asked for it,” she says, adding that hospitals should ask their insurance companies whether coverage for volunteer activities is available in the event Dr. X files suit.

➤ Do provide physicians with adequate notice.

Surprisingly, some hospitals take corrective action against physicians without providing those physicians with adequate reason, says Callahan. In such a scenario, the case could be thrown out of court because Dr. X did not have an opportunity to adequately defend himself or herself. Hospitals should always notify physicians as to why a corrective action is being taken against them.

“If I am a physician and you are going to take away or reduce my privileges, I want to know exactly what I did wrong and the data used to support that decision,” Callahan says.

Providing physicians with adequate notice can also help the hospital avoid a hearing altogether. Callahan says that if Dr. X receives enough evidence illustrating his or her performance problems, he or she may choose to forgo a hearing and instead choose to resign from the medical staff.

“There comes a point where the physician might say, ‘What’s the point of having a hearing—there is no way I can win,’ ” he adds.

➤ Do follow your bylaws and policies to the letter. If a hospital fails to follow its bylaws, it invites the panel to question the hospital’s motives against Dr. X, says Callahan. “The court might say, ‘Maybe there is something to this physician’s claim that he is being railroaded,’ and decide that there is no substantive basis for the charges.” He adds that most hospital bylaws are structured to ensure that the process is fair—but by not following their bylaws, hospitals undermine this careful structure.

Boyan adds that following your bylaws is only half the battle. “You have to make sure your bylaws are good, and that you are refining them as you learn.”

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Competency of the month

Measuring practice-based learning and improvement

Editor’s note: In the May MSB, we discussed how one hospital is measuring physicians’ ability to meet the ACGME/Joint Commission’s medical knowledge competency. This month, we explore how another hospital is measuring practice-based learning and improvement.

The Accreditation Council for Graduate Medical Education (ACGME)/Joint Commission’s six core competencies are:

1. Patient care
2. Medical knowledge
3. Practice-based learning and improvement
4. Interpersonal communication skills
5. Professionalism
6. Systems-based practice

According to the ACGME, the practice-based learning and improvement competency requires that physicians “demonstrate the ability to investigate and evaluate their care of patients, appraise and assimilate scientific evidence, and continuously improve patient care based on constant self-evaluation and lifelong learning.”

The past two articles in this series highlighted that hospitals typically have the necessary data to meet The Joint Commission’s (formerly JCAHO) patient care and medical knowledge competencies; they simply need to present it differently than they have in the past. However, the odds may be stacked against hospitals looking to measure their physicians’ ability to meet the practice-based learning and improvement competency.

Consider that physicians may not be receptive to this type of analysis. Robert Marder, MD, vice president of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, says although residents are open to constructive criticism as they learn, “practicing physicians don’t necessarily see themselves in that light. Do you spend most of your day trying to do your job?” In addition, because most of the data that hospitals have on physician performance are based on independent case reviews, which generally are only of negative events, hospitals may not possess the data systems required to gauge improvement.

“A nonevent is harder to measure than a negative one,” says Marder. “If you don’t have much data in the first place, you can’t tell whether or not physicians have improved.”

Building the foundation

Despite the odds, Southeastern Regional Medical Center (SRMC) in Lumberton, NC, started building the foundation for a successful program to measure practice-based learning and improvement about four years ago. Caroline Glus, director of quality management at SRMC, explains that the first step was to identify competency measures that physicians considered important and relevant and were supported by the hospital’s existing data systems.

So far, SRMC has identified a handful of measures that meet these criteria, including:

- Cardiac readmissions
- Angiotensin-converting inhibitors
- Left ventricular failure assessments
- Pneumonia antibiotic selection
- Unapproved abbreviations
- Legibility of handwriting
- Complete documentation

“We have a fairly robust information system, so we looked at our existing data and which data could be attributed to a single practitioner,” says Glus, whose quality management team aggregates data from SRMC’s disparate systems on a quarterly basis into what Glus calls a “practitioner performance feedback report tool.”

> continued on p. 6
SRMC had been sending out physician feedback reports every six months long before The Joint Commission began requiring hospitals to do so. It continued to maintain that pace when its new physician feedback process began. SRMC piloted the new feedback process for one year (the equivalent of two reports) to let its more than 120 physicians get used to working with the new data. “We promised we wouldn’t use those two reports,” says Glus.

To help physicians understand the nuances of the new reports, SRMC arranged for a consultant to do a presentation, as well as several question and answer sessions.

**Taking a page from the residency handbook**

Hospitals don’t have to reinvent the wheel when it comes to measuring physicians’ ability to meet the Accreditation Council for Graduate Medical Education (ACGME)/The Joint Commission’s (formerly JCAHO) six core competencies. Many residency programs have been measuring competencies for years and have developed some useful tools. Although not all tools developed in residency programs can successfully measure practicing physicians’ performance, they often serve as a foundation for tools that can.

The pediatric residency program at the University of Florida College of Medicine in Gainesville, has developed an interesting way to tackle the practice-based learning and improvement and systems-based learning and improvement competencies.

**Practice-based learning and improvement**

First-year residents complete online modules developed by the Tufts Health Care Institute in Boston. Students learn:

- What quality means to various stakeholders
- How structure, process, and outcomes interrelate
- Processes, tools, and techniques for quality improvement

Students take a test prior to taking the online course, complete self-assessments throughout the program, and undergo a summative evaluation once they complete the program. The course and its related series of tests helps measure residents’ ability to meet the practice-based learning and improvement competency.

**Systems-based learning and improvement**

Second-year students apply what they learn online in a clinical setting by selecting and piloting an improvement project. Maureen Novak, MD, program director and vice chair of pediatrics, says in the six years the program has evolved, residents have improved immunization registries, reduced language barriers between physicians and patients, and increased patient advocacy efforts. “Several have developed algorithms that have been used to create evidence-based order sets for the institution,” she says.

Not only do residents work to improve quality within the hospital, they also extend their efforts into the community. Thanks to the residents’ improvement programs, more children in the local community are wearing helmets when engaging in various outdoor activities; they’re also receiving topical fluoride treatments at the pediatrician’s office.

Third-year students typically put the finishing touches on their project or hand down the project to second-year students. “The fluoride project is a good example—it is in its fourth year and it needs a champion to continue it,” Novak says.

Engaging in improvement projects gives residents hands-on experience in system-based learning and improvement and teaches them ways to improve their own practices.

**Cause and effect**

Since the program began, Novak says that residents’ projects have not only changed hospital processes for the better, but they have gotten faculty more involved. “Board certification is going to require this type of thing in the future, so this is a good way of getting people used to it now,” says Novak.

In the future, Novak would like to survey graduates to see if the university’s practice-based learning and improvement/system-based learning and improvement program has helped them in their practices.
“We also sent out a guide that describes the measures, where the data come from, and how we set the targets,” says Glus, adding that the hospital is focusing its efforts on general medical and surgical providers. Specialty and mid-level practitioners will be assessed according to these measures in the future.

**Making feedback reports valuable**

Glus explains that the physician feedback report is designed to engage physicians in the improvement process. “We don’t just generate a report that becomes wallpaper,” she says.

Physicians are scored based on how closely they meet a target established by the hospital. For example, the target for the legibility measure might be zero phone calls from the pharmacist to clarify a prescription order. If a physician meets that target, his or her score would be colored green, which represents good or excellent performance. If the physician received one phone call from a pharmacist to clarify a prescription order, his or her score might be colored yellow, indicating average performance. If the physician received five phone calls, his or her score would be colored red, meaning the physician has fallen outside of the acceptable target range.

If a physician receives a red score for the same measure two reports in a row, the quality management team attempts to identify any pieces of data that might have thrown off the physician’s score. For example, Glus says, “a mortality in a patient population you wouldn’t normally expect, but in this particular case … was very much expected,” might account for a lower score. If data cannot explain what Glus calls a “double red,” then the physician must meet with the chair of his or her department to discuss specific improvement strategies.

One solution was for SRMC to measure percent excellence scores, which measure a physician’s improvement over time, says Marder.

“If you have 85% green [scores] on your report, that would be considered excellent,” he explains. “If you have 70%–80% green scores, that is considered acceptable. If you have less than 75% green scores, that means some follow-up is required to determine a pattern.”

But SRMC decided instead to measure the reduction in double reds over time. “One concern I see with using [percent excellence scores] is that we are constantly changing our targets to keep up with national standards,” Glus says. Because SRMC’s targets are always changing, it may appear that a physician’s score remains average, but in fact, he or she may have improved compared to the previous year.

“When you look at double reds, even though those thresholds are changing, if someone is really lagging behind, we could still see it,” Glus says, and adds that hospitals should not be overly concerned about addressing each of the six competencies in their physician feedback reports when they are just starting out. “Reporting data and taking action is far more important initially than making sure there are measures in each of the prescribed categories,” she says.

**Attribution causes challenges**

Making sure that the practice-based learning and improvement measures SRMC chooses can be attributed to a single physician is a constant challenge, says Glus. “This is a particular problem when you have a high volume of hospitalists who share responsibilities for patients. No matter what measures you have developed, if you can’t attribute it, you might as well throw the report away.”

The Centers for Medicare & Medicaid Services (CMS) will soon start collecting data to roll out a value-based purchasing program. Glus expects CMS to attribute mortality, readmissions, and other measures to the attending physician, regardless of which physician(s) admitted or cared for the patient. Although there isn’t much SRMC can do, Glus and her team are encouraging hospitalists who work in groups to share performance improvement data with each other and collaborate to find solutions.

“You should not only be aware of your own performance, but you should feel as though you can discuss that information with the colleagues you share patients with,” she says.
Ensuring adequate FTEs for an efficient MSO

Overtime is all in a day’s work for most MSPs. For some, “lunch break” is a foreign term, and leaving at 5 p.m. is only a dream. Some MSB readers claim to eat, breathe, and sleep their medical staff office (MSO) responsibilities, and why wouldn’t they? Lives depend on accurate credentialing and privileging.

Unfortunately, MSOs are understaffed, and this can lead to potentially devastating consequences for the hospital, says Kathy Matzka, CPMSM, CPCS, a medical staff consultant in Lebanon, IL. For example, if a MSP is rushing to credential or privilege a practitioner and overlooks a critical step, he or she may indirectly cause patient harm. “Hospitals don’t realize that the MSP is a firewall between poor providers and patients,” says Matzka.

Inadequate staffing in the MSO can also hurt a hospital’s accreditation status. Matzka explains that the accreditation standards hospitals are now required to follow are complex and require mountains of documentation—and compiling the documentation is increasingly falling to the MSP. “If there are not enough people to do that work, people end up juggling. When it comes time for reappointment, nothing else gets done because they have to meet that reappointment deadline,” she says.

At the very least, an understaffed MSO can cause MSPs to feel burned out. “Type A personalities tend to gravitate toward this field. Because we understand the importance of our jobs, we put in more than the 40-hour week,” Matzka says. Although MSPs’ dedication is an asset for the hospital, their tendency to overextend themselves can lead to burnout, which will hurt any hospital’s employee satisfaction scores.

But the stakes are getting higher. Matzka explains that medical malpractice caps in nearly every state have prompted plaintiff’s attorneys to point their fingers at hospital MSOs for negligent credentialing. “As a result, I think we are going to see more and more hospitals faced with negligent credentialing claims, and it will force them to take a look at how they are staffing [the MSO],” she says.

Understanding the MSP’s role

Matzka says many MSOs are understaffed because hospitals do not fully understand the role of the MSP. In many hospitals, the responsibilities of the MSO fall on a handful of people—sometimes only one.

Christina Giles, CPMSM, MS, president of Medical Staff Solutions in Nashua, NH, has come up with a tool to help hospital administrators and medical staff leaders better understand the role of MSPs. The tool can also be used to help MSPs and medical staff leaders understand how to better allot time.

During the course of several weeks, MSPs keep track of their responsibilities and how much time each task takes (see “Sample MSP task analysis tool” on p. 9). “When [MSPs] start filling out the tool, they are often surprised to find how much time all of the little tasks actually take,” says Giles. Once an MSP fills out the tool, medical staff leaders should review it and work with the MSP to make reasonable adjustments. For example, MSPs and medical staff leaders may agree to eliminate certain functions or adopt an electronic processing system.

However, if the tool uncovers that the only MSP in the MSO is working 80 hours per week, “no one is going to agree that is okay. The ultimate idea is to have fully objective documentation that all of the tasks being performed take 80 hours, and then you either cut down on the tasks or hire another individual,” Giles says.

Spelling out MSPs’ responsibilities can serve as an eye-opener to medical staff leaders and hospital administrators. “Most medical staff leaders and hospital administrators may sign the time cards, but they probably don’t understand how much work is not getting done,” says Matzka.

She explains that although medical staff leaders generally do not have the authority to hire and fire employees in the MSO, they can approach HR in person or in writing to recommend hiring additional staff members if they believe the MSO is understaffed.

> continued on p. 10
Sample MSP task analysis tool

Note: All times provided in this tool are rough estimations. MSPs should calculate their own times for each task for the most accurate results.

To determine the number of hours per year each FTE in your medical staff office (MSO) works, subtract vacation, holiday, and sick hours from 2,080 (40 hours per week multiplied by 52 weeks a year). If you factor in two weeks of vacation time, the number should be around 1,872. (If you factor in four weeks of vacation time, the number should be close to 1,808.) Once you have listed all of the tasks performed in the MSO (we’ve provided a small sample) and evaluated the amount of time each task takes, divide the total number of hours by 1,872. This number should give you an estimation of how many FTEs are required to carry out all of the tasks.

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<th>Task</th>
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<tr>
<td>Initial appointments:</td>
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<td>Medical staff: 8 hours</td>
<td>8 hours x 20 apps./year = 160 hours</td>
<td>160 hours + 100 hours = 260 hours</td>
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<tr>
<td>AHPs: 5 hours</td>
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<tr>
<td>Reappointments:</td>
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<td>Medical staff: 6 hours</td>
<td>6 hours x 100 med staff reapps./year = 600 hours</td>
<td>600 hours + 300 hours = 900 hours</td>
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<tr>
<td>AHPs: 4 hours</td>
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<td>Temporary privilege requests:</td>
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</tr>
<tr>
<td>Pending application: 2 hours</td>
<td>2 hours x 15 pending apps./year = 30 hours</td>
<td>30 hours + 40 hours + 20 hours = 90 hours</td>
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<td>Locum tenens: 4 hours</td>
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<td>One-time only: 4 hours</td>
<td>4 hours x 5 one-time only apps./year = 20 hours</td>
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<td>Change in privilege request or change in staff member status:</td>
<td>2 hours x 15 priv. req./year = 30 hours</td>
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<tr>
<td>Reference questionnaire responses:</td>
<td>.25 hours x 15 resp./week = 3.75 hours</td>
<td>3.75 hours/week x 52 weeks = 195 hours</td>
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<tr>
<td>Phone calls: 2–5 minutes</td>
<td>.03 - .083 x 35 phone calls/week = 1.5 to 2.9 hours</td>
<td>1.5 to 2.9 hours/week x 52 weeks = 78 to 150.8 hours</td>
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<tr>
<td>E-mails received/answered: 2–5 minutes</td>
<td>.03 - .083 x 35 e-mails/week = 1.5 to 2.9 hours</td>
<td>1.5 to 2.9 hours/week x 52 weeks = 78 to 150.8 hours</td>
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<tr>
<td>Walk-ins: 5 minutes</td>
<td>.083 x 25 walk-ins/week = 2.075</td>
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<tr>
<td>Meeting management: 8.5 hours (prepare, attend, minutes, follow-up)</td>
<td>8.5 hours x 11 meetings/month = 93.5 hours</td>
<td>93.5 hours x 12 months = 1,122 hours</td>
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Source: Christina Giles, CPMSM, MS, president of Medical Staff Solutions, Nashua, NH.
Advocating for MSPs

It is important for the hospital’s HR department to understand the role of the MSP, as it has the ultimate authority to provide the MSO with additional full-time equivalents (FTE).

One of the major reasons most hospitals’ HR departments don’t fully understand the role of the MSP is because MSPs are often given inappropriate job classifications. Matzka explains that many hospitals’ HR departments group employees into categories, such as administration, management, and clerical support.

“In many cases, only one, two, or three people work in the [MSO], and HR doesn’t want to make a new job category for those few people, so they lump them into another category,” she says.

Even though some MSPs run the MSO, they may not fall into a management category because they do not have the authority to hire and fire other employees. In that case, the hospital may put them into a clerical category. “If an MSP is still in a clerk’s position as far as their job classification, their job is still considered entry level. In general, people who have lower job classifications are a lower priority when hospitals are determining how much staffing is required,” says Matzka, adding that if HR changes an MSP’s title to, for example, medical staff coordinator or director of medical staff services, that does not necessarily mean that HR has moved him or her into a higher job classification.

Collaborating with HR

HR may benefit from seeing a tool similar to the one Giles created, as it would highlight MSPs’ responsibilities that don’t fit into a clerical job classification. However, Giles adds that medical staff leaders and MSPs should not simply take the tool to HR and say, “We need more FTEs.” Instead, medical staff leaders and MSPs should present their recommendations to make the situation better and work with HR for a solution.

Advice from the CEO

John Gorman, CEO of Memorial Hospital in Fremont, OH, has worked with dozens of MSPs during the course of his career, and he has been working with Memorial Hospital’s medical staff director for the past 16 years. For him, having a healthy relationship with MSPs is a must. He offers the following advice to help medical staff leaders create relationships with MSPs that are professionally rewarding and productive:

- **Create team spirit.** “If the medical staff and hospital CEO aren’t getting along, [the MSP] is in an awkward position to determine ‘Where is my loyalty?’ ” says Gorman. The secret is to create an environment where MSPs don’t feel loyalty to one party or the other, because all parties are working as a team.

- **Interact often.** When Gorman became CEO of Memorial Hospital 16 years ago, one of the first things he did was relocate the physicians’ lounge, medical records, the medical staff office, and other physician hot spots on the same floor. Doing so created a greater opportunity for him to interact with the medical staff and MSPs.

  ➤ **Maintain professionalism.** Both parties need to maintain professionalism at all times. This will help create trust in the relationship through the years.

  ➤ **Reward MSPs.** In response to a job well done, Gorman has rewarded Memorial Hospital’s medical staff director with professional growth opportunities. For example, the director oversees individual physician practices, is responsible for marketing, keeps tabs on the hospital’s real estate, and recruits physicians. “This is clearly a step beyond what is typical for her position,” Gorman says.

  ➤ **Encourage work-life balance.** Although Gorman has provided Memorial Hospital’s medical staff director with professional growth opportunities, he keeps a close eye on whether those responsibilities unbalance her work-life scales. “You have to keep life in balance—that is my style, and I think it is more necessary today than ever.”
Kathy Roberts, HR manager at Bay Regional Medical Center (BRMC) in Bay City, MI, says that medical staff leaders can and should approach HR about obtaining additional FTEs. Although staffing is not an issue at BRMC, if it were, the hospital would conduct a job audit and a time study. “We look at the current job description, talk to employees in the area, and have them complete a time study to determine how much time is being spent on any particular function they are responsible for. That helps to determine if we are comparing apples to apples,” Roberts says. If needed, BRMC would compare its audit data against other hospitals in the McLaren Health Care Corporation, of which it is a member. Roberts explains, “we look at that comparison first to see if we are on target in terms of their numbers of FTEs and the responsibilities they have in their [MSOs].”

Another option, says Roberts, is to hire an outside consultant to assess the MSO’s productivity and determine whether the problem is understaffing or inefficient processes. She says that just because a process is computerized does not mean it takes less time, so she suggests that MSOs analyze their processes and procedures to ensure that they are as efficient as possible.

Matzka adds, “HR should be solicited for support. That is their job: to support the departments of the hospital and get them the staffing that they need.”

Delegating responsibility

“If HR finds that additional FTEs in the MSO are unwarranted, or if the hospital’s budget will not allow for a staff increase, our CEO and [chief medical officer] ensure that MSPs receive the overtime necessary to complete all of their tasks,” says Mary Brooks, CPCS, medical staff coordinator at San Jacinto Methodist Hospital in Baytown, TX. “A lot of the other departments are not allowed to work overtime,” she adds.

However, the drawback is potential burnout. “The extra money is nice, but the time away from your family isn’t,” Brooks says. To help keep overtime to a minimum, the MSO can possibly delegate certain noncredentialing, nonprivileging tasks to administrative assistants in other departments.

Brooks explains that the MSO at San Jacinto Methodist Hospital is only responsible for credentialing committee meeting minutes. Administrative assistants from other departments are responsible for taking minutes at department and other committee meetings, medical staff quarterly meetings, and board meetings.

“The MSO could oversee all of that, but we are so busy making sure our doctors are not going to be a liability to the hospital that we don’t have time to do minutes for these other meetings,” she says. “Either you spend your entire life in the office, or you have to delegate.”

Strategic development and planning

Step 4a: The right relationship

As noted at the start of this series, the “Seven Rs” of medical staff development and planning are:

Step 1: Right number of physicians
Step 2: Right type of physicians
Step 3: Right quality of physicians
Step 4: Right relationship to hospital
   a. Organized medical staff
   b. Alignment by specialty
   c. Recruitment and retention
   d. Competition and collaboration
Step 5: Right culture
Step 6: Right medical staff structure and process
Step 7: Right leadership

> continued on p. 12
When hospitals and physicians establish the right relationship with each other, both parties win. However, the right relationship will mean something different to each hospital.

Regardless of differences, though, the key here is for the hospital to recognize that all groups should be treated fairly.

The right relationship will be explored in four sections. This section deals with organized medical staff strategies. Organized medical staff strategies fall into several categories:

➤ **Medical staff leadership development.** Best-practice hospitals have made significant investments in educating and training present and future medical staff leaders. Leadership development and training should be formal, curriculum-driven, and ongoing.

Designation as a certified medical staff leader also adds a degree of recognition and prestige to physicians completing such coursework. Additional information on certification can be found at [www.greeley.com/msleaderscertification](http://www.greeley.com/msleaderscertification).

➤ **Medical staff effectiveness.** Strong medical staff leadership ensures medical staff effectiveness in key areas such as:

  - Structure and processes, including bylaws, credentialing, privileging, peer review, and policies
  - Medical staff culture
  - Medical staff-hospital collaboration
  - Communication

➤ **Physician-hospital compact.** A compact between the medical staff and hospital defines the give and get between the two parties. The compact guides both parties in their interactions, deliberations, and decisions.

➤ **Activities to build social capital.** The theory here is that people who play together argue less. To this end, best-practice organizations offer the medical staff multiple opportunities for social interaction with events such as regularly scheduled medical staff/hospital board retreats, structured access meetings between the medical staff and CEO, nonfundraising social events, and board representation on key medical staff committees.

➤ **Communication links.** The days of being able to simply deliver a message at a medical staff department or committee meeting are over. In today’s challenging healthcare environment, hospitals need to communicate with their medical staffs often and through various media.

Effective communication methods include a combination of memos, blast faxes, e-mails, dedicated medical staff Web sites, chat rooms, blogs, and whatever else works at your organization.

➤ **Quality and pay-for-performance positioning.** Federal, state, and local regulators, as well as the general public, are demanding that hospitals adopt transparent practices.

To keep pace with these demands, the organized medical staff and the hospital need to consider how they can work together to create measures of quality, particularly those concerning pay-for-performance initiatives.

Next month, we will continue to explore the fourth of the “Seven Rs,” the right relationship involving alignment strategies by specialty. Until next time, stay well and be the best you can be.
How to get the most from your June 2008 Medical Staff Briefing

Measuring practice-based learning and improvement
Southeastern Regional Medical Center in Lumberton, NC, is building the foundation for a successful program to measure physicians’ ability to meet the Accreditation Council for Graduate Medical Education/The Joint Commission’s practice-based learning and improvement competency. Learn more on p. 5.

Make sure your MSO has appropriate staffing
Not having enough staff in the medical staff office (MSO) can lead to inaccurate credentialing and privileging. MSB investigates why so many MSOs are understaffed and how you can ensure you have the staffing you need on p. 8.

Task analysis tool
Medical staff leaders may be surprised to hear that initial appointments for medical staff members can take up to eight hours each! Christina Giles, CPMSM, MS, shares her analysis tool for evaluating how much time and effort MSPs put into their required tasks on p. 9.

The right relationship: Organized medical staff
William K. Cors, MD, MMM, FACPE, discusses how hospitals and the organized medical staff can create a relationship that allows both parties to win in his series on the “Seven Rs” of medical staff strategic development and planning. Find out more on p. 11.
2008/2009 Calendar of Events

JUNE
The Ritz Carlton, Amelia Island, FL
9-10 Medical Executive Committee Institute: The essential training program for medical staff leaders
9-10 Peer Review for Today: Practical solutions to make peer review effective, efficient and fair
11 ED Call: Effective solutions for hospitals and physicians
12-13 Quality, Cost and Accountability: The medical staff’s responsibilities in a changing healthcare world

OCTOBER
The Ritz Carlton, New Orleans, LA
1 Evidence Based Practice in Nursing: Culture-building solutions to support your practice environment
1 ED Revenue Cycle Management: Tools to ensure revenue integrity in EDs and clinics
2-3 HCPro’s Workshop on the ANCC Magnet Recognition Program®
2-3 Observation Status Symposium: Strategies for compliance, quality and revenue integrity for all stakeholders
The Art Institute of Chicago, Chicago, IL
15 HealthLeaders Marketing Awards
The Drake, Chicago, IL
16-17 5th Annual Top Leadership Teams in Healthcare Conference

JANUARY 2009
Hyatt Grand Champions, Palm Springs, CA
15-16 Medical Executive Committee Institute: The essential training program for medical staff leaders
16 Physician Competency: Using data to evaluate performance
17 Proctoring and Focused Professional Practice Evaluation
17-18 Leading Physicians through Change: Critical skills for challenging times
18-19 Peer Review for Today: Practical solutions to make peer review effective, efficient and fair
18-19 Advanced Credentialing & Privileging Retreat: Tackling today’s toughest credentialing challenges

MARCH 2009
Renaissance Glendale Hotel & Spa, Phoenix, AZ
18 Evidence Based Practice in Nursing: Culture-building solutions to support your practice environment
19-20 Collecting, Analyzing and Presenting Quality Data: Tips and techniques for getting your data under control
19-20 HCPro’s Workshop on the ANCC Magnet Recognition Program®
19-20 Observation Status Symposium: Strategies for compliance, quality and revenue integrity for all stakeholders

SEPTEMBER
Omni Parker House, Boston, MA
4-5 Collecting, Analyzing, Presenting Quality Data: Tips and techniques for getting your data under control
5 Environment of Care for 2009: Strategies for Joint Commission compliance
The Hyatt, Chicago, IL
24 Shared Governance
25-26 Nursing Leadership Summit
25-26 3rd Annual Residency Program Management Workshop
25-26 Developing and Maximizing your Hospitalist Program: A symposium by Hospitalist Management Advisor
27 Nursing Peer Review: Tools and techniques to promote nursing accountability

NOVEMBER
The Ritz Carlton, Naples, FL
12 ED Call: Effective solutions for hospitals and physicians
13-14 Medical Executive Committee Institute: The essential training program for medical staff leaders
13-14 Peer Review for Today: Practical solutions to make peer review effective, efficient and fair
15 Proctoring and Focused Professional Practice Evaluation
15-16 Leading Physicians through Change: Critical skills for challenging times
16 Breakthrough to Patient Safety’s Next Generation: Moving beyond compliance to high reliability
16 Core Privileging Essentials: Advanced course in criteria-based design and implementation
17-18 Advanced Credentialing & Privileging Retreat: Tackling today’s toughest credentialing challenges
17-18 Quality, Cost and Accountability: The medical staff’s responsibilities in a changing healthcare world

MAY 2009
Caesars Palace, Las Vegas, NV
13 Core Privileging Essentials: Advanced course in criteria-based design and implementation
14-15 3rd Annual Hospital Safety Symposium
14-15 12th Annual Credentialing Resource Center Symposium
14-15 3rd Annual Association for Healthcare Accreditation Professionals Conference
14-15 Association of Clinical Documentation Improvement Specialists Annual Conference
16 Physician Competency: Using data to evaluate performance

To register or for more information visit www.greeley.com/seminars or call 800/801-6661.

* Dates and locations subject to change. MT09022