Medical staff leaders need to understand the nuances of PSQIA because of the effect it’s likely to have on participating healthcare providers’ quality improvement processes—and the effect it may have on medical staff peer review processes.

What is PSQIA?

Under PSQIA, healthcare providers, including pharmacies, nursing homes, and hospitals, can confidentially report patient safety data, known as “patient safety work product,” to a PSO.

In addition to aggregating patient safety work product, PSOs can provide consulting services to healthcare providers looking to implement quality improvement initiatives specific to the data they provide to PSOs. (See “Patient Safety and Quality Improvement Act: Protecting patients and physicians” in the May MSB.)

Under PSQIA, patient safety work product cannot be used in civil, criminal, or administrative proceedings. This should encourage healthcare providers to more openly report and analyze patient safety events and near misses, according to HHS.

This doesn’t mean patient charts and adverse incidents will be considered confidential—patients can still sue—and PSOs won’t replace the need for healthcare providers to report to other federal or state agencies, says William Munier, MD, MBA, director of the Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality (AHRQ), a division of HHS.

“The whole thrust is away from a regulatory punitive system. Once an entity becomes listed as a PSO, it is up to that entity to operate appropriately.”

—William Munier, MD, MBA

Medical staff leaders are one step closer to reaping the legal protections provided by the Patient Safety and Quality Improvement Act of 2005 (PSQIA). On November 21, 2008, the U.S. Department of Health and Human Services (HHS) issued a final rule for patient safety organizations (PSO), which are defined as entities that collect and analyze patient safety data to identify negative trends and improve the quality of healthcare. That final rule, which became effective January 19, outlines:

- Requirements entities must meet to qualify as a PSO
- The processes HHS will use to list and delist PSOs
- Confidentiality protections for patient safety information collected by providers to report to PSOs
- Exceptions to confidentiality protections
- Procedures to impose civil monetary penalties for PSOs that inappropriately disclose patient safety work product

HHS releases final rule for patient safety organizations under PSQIA

Healthcare providers are one step closer to reaping the legal protections provided by the Patient Safety and Quality Improvement Act of 2005 (PSQIA). On November 21, 2008, the U.S. Department of Health and Human Services (HHS) issued a final rule for patient safety organizations (PSO), which are defined as entities that collect and analyze patient safety data to identify negative trends and improve the quality of healthcare. That final rule, which became effective January 19, outlines:

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Rather, a healthcare provider can now submit data to a PSO regarding, for example, a wrong-site surgery. The PSO can then engage the physicians, nurses, anesthesiologists, and others involved in a candid but confidential conversation and analysis of why the incident occurred.

In the past, many physicians have been reluctant to engage in such discussions for fear that what they said would be used against them during a medical staff hearing or litigation. PSQIA provides federal protections that keep any discussion and analysis confidential.

What are the highlights of the final rule?

HHS published a proposed rules notice February 12, 2008, and accepted comments through April 14. HHS made several significant changes to the final rule (Federal Register: November 21, 2008) based on comments it received during the comment period, says Munier. Some of these changes regard:

➤ Security requirements. In the proposed rule, PSQIA did not allow a PSO that is a component of a larger parent organization to share information technology (IT) systems or certain employees. “This requirement was felt to be onerous. In today’s world of IT, there are plenty of ways to protect information within a single system, so we relaxed that rule,” Munier says.

➤ Reporting systems. The proposed rule required healthcare providers to use a separate software system to report identifiable patient safety data to the state than they would use to report nonidentifiable data to a PSO. The final rule provides greater flexibility and allows healthcare providers to determine the flow of information. This meets other reporting requirements and maintains PSO protections through the use of a single system.

➤ Delisting of PSOs. PSOs are required to apply for relisting every three years, and the proposed rule offered a step-down process for PSOs that failed to reapply, Munier says. The final rule automatically delists any PSOs that don’t reapply within the three-year time frame.

Who can apply for PSO status?

Any for-profit, nonprofit, public, or private entity whose primary activity involves patient safety and quality improvement can apply for PSO status, as long as it is not considered an excluded entity. Entities excluded by the final rule include:

➤ Insurance companies and their subsidiaries
➤ Entities that accredit or license healthcare providers
➤ Entities that oversee or enforce statutory or regulatory requirements governing the delivery of healthcare services

However, subsidiaries or components of these entities, with the exception of insurance companies, can apply for PSO status. “For instance, The Joint Commission is an excluded entity, but a component of The Joint
Commission could apply,” says Munier. Subsidiaries or components of excluded entities must disclose their parent organization to the healthcare providers they serve.

As of publication, AHRQ has listed 30 PSOs on its Web site, www.pso.ahrq.gov/listing/psoolist.htm.

**How can entities apply for PSO status?**

Eligible entities interested in applying for PSO status can download and fill out the application at www.pso.ahrq.gov/listing/listprocess.htm.

“The application itself was not very demanding,” says William Hyman, a PSO representative with ACCE Healthcare Technology Foundation in Bellevue, WA. The application contains a list of questions regarding the existence of various policies and procedures, Hyman says. To meet the requirements of the application, the foundation needed to review its current policies and procedures and create new ones as necessary.

For example, the PSO application requires applicants to have policies and procedures regarding computer security, “which, in my interpretation, was routine computer security that we practice anyway,” Hyman says. The foundation needed to put those processes in writing as required by the application.

The foundation has not added additional staff members or technology resources to support its PSO status, but this may change as more healthcare providers begin reporting.

The ACCE Healthcare Technology Foundation has been working to improve the design and use of medical devices since 2002, so it already met many of the PSO requirements. “If you were a startup and didn’t have these things in place, you might find it daunting,” Hyman says.

**How will PSOs interact with each other?**

Although each PSO is a separate entity, AHRQ has developed common definitions and reporting formats all PSOs may use, allowing them to collect and analyze comparable data. At the end of the first three-year listing period, all PSOs must use these common definitions and reporting formats or provide a reasonable explanation of why they don’t. For example, a specialty PSO may develop different forms specific to its niche.

PSQIA allows PSOs to freely exchange de-identified data with each other, Munier says. Or, if a PSO enters a contractual relationship with another PSO for assistance in carrying out patient safety activities, the initiating PSO can share identifiable data, although the HIPAA privacy rule may apply. AHRQ hopes the ease of exchanging data will encourage PSOs to collaborate.

PSQIA calls for the establishment of a network of patient safety databases to track regional and nationwide trends via the aggregation of de-identified data. AHRQ will publish the national and regional statistics developed from the data collected through this network in its annual *National Healthcare Quality Report*.

**How will PSOs interact with providers?**

“The PSO and the provider have a completely open relationship,” says Munier. This relationship is based on a mutual desire to improve quality of care and learn from past mistakes.

PSQIA requires that PSOs have contracts to review patient safety work product with at least two healthcare providers during every 24-month period following the date of initial listing, but the conditions of those contracts are entirely up to those parties.

“We don’t even see those contracts, let alone oversee them,” Munier says.

However, unless the requirements of the HIPAA privacy rule apply, a provider does not need a contract to report a patient safety incident, says Stephanie Unger, JD, business development manager at the Institute for Safe Medication Practices (ISMP) in Horsham, PA. Any

> continued on p. 4
Because the data that providers collect and submit to PSOs are de-identified, providers do not need to receive authorization from patients before submitting those data. PSOs will be required to notify providers of any inappropriate use or disclosure of patient safety work product.

Why participate?
Healthcare providers that wish to participate in PSQIA will:
➤ Be able to report patient safety data and conduct root-cause analysis in a protected, confidential environment
➤ Receive counseling and assistance when implementing effective quality improvement programs from the PSOs they choose to work with
➤ Become part of a nationwide effort to identify and thwart negative trends

It will take time to iron out the kinks and for PSOs to collect enough data to make significant findings. Until then, participants should focus on the learning experience.

“They are, in theory, going to get useful patient safety data back from participating in this that they could not have generated or understood by themselves,” says Hyman.

Who oversees PSOs?
The final rule gives AHRQ the authority to periodically check in on PSOs to ensure that they are complying with PSQIA regulations. Since PSQIA is a voluntary program not supported by federal funds, “HHS adopted a light touch from a regulatory standpoint,” Munier says. “The whole thrust is away from a regulatory punitive system. Once an entity becomes listed as a PSO, it is up to that entity to operate appropriately.”

Although AHRQ is responsible for ensuring that PSOs remain compliant with the requirements of PSQIA, the Office for Civil Rights will investigate and enforce breaches of confidentiality and issue civil monetary penalties, if needed.

What about HIPAA?
“The Patient Safety Act is clear that it is not intended to interfere with the implementation of any provision of the [Health Insurance Portability and Accountability Act of 1996 (HIPAA)] privacy rule,” according to the November 21, 2008, Federal Register. Additionally, the final rule states that a healthcare provider cannot be required to pay civil monetary penalties under both HIPAA and PSQIA for a single violation.

Upcoming event
Save the date!
Send your team to the 12th Annual Credentialing Resource Center Symposium May 14–15 in Las Vegas to learn cutting-edge best practices and network with peers. Register by March 13 and save $100!

For more information, call 800/801-6661 or visit www.greeley.com/seminars.
It’s no secret that hospitals tend to work in silos, but lack of communication between the medical staff services department (MSSD) and the recruiting department can put patient safety at risk if the hospital recruits a licensed independent practitioner (LIP) with a smoking gun in his or her past.

“By the time the application gets to the credentialing specialist, they are finding all kinds of problems that should have and could have been identified during the recruitment process,” says William K. Cors, MD, MMM, FACPE, CMSL, vice president of medical staff services at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

Consider following the tips below to ensure that your organization:

➤ Saves time and money by interviewing only LIPs who meet your hospital’s credentialing criteria
➤ Identifies red flags early on in the recruitment process
➤ Reduces the risk of physician applicants demanding a fair hearing to dispute denied applications
➤ Improves patient safety by allowing only the most qualified LIPs to practice

Understand how both departments work

When Catherine Cabrini became a physician recruiter at Verde Valley Hospital in Cottonwood, AZ, she sat down with medical staff services coordinator Debby Castro to create a map of the hospital’s recruiting and credentialing processes. This allowed them to see where their responsibilities overlapped and identify gaps in the recruiting and credentialing processes.

“I wanted to see what [the MSSD’s] needs were, how they operate, and what their timeline for credentialing is,” says Cabrini.

Once the current recruitment and credentialing processes are mapped out, the MSP and physician recruiter should work together to eliminate redundancy, create realistic timelines, and decide which department will tackle each responsibility, such as background checks and who calls the physician if he or she neglects to return a form included in the application. Cabrini and Castro continue to work closely to tweak such processes as necessary.

When Maggie Lewis, a physician recruiter, sat down with Sheree Yazzie, an MSP at Flagstaff (AZ) Medical Center, to map out the hospital’s recruiting and credentialing processes, they were each surprised to find the other was conducting background checks, a time-consuming and costly duplication of resources.

Now, Lewis confirms each physician candidate’s license online and asks all candidates to fill out a universal background form. She shares this information with Yazzie, who performs primary source verification during the credentialing process.

Consider adjusting department structure

Castro and Cabrini report to Verde Valley’s vice president of medical affairs (VPMA). This reporting structure has brought the recruiting and credentialing processes closer together. The VPMA coordinates efforts from both departments and sees that they keep each other in the loop.

“Both sides are encouraged to work together if you have to report to the same person,” says Cabrini.

Lewis and Yazzie also report to the same person: Flagstaff Medical Center’s chief medical officer. Although the two do not necessarily attend the same meetings, Lewis says it is helpful for both departments to get support from a physician leader who is also on the credentialing committee.

“He understands both sides of the recruitment process,” Lewis says.

Castro notes that doesn’t matter who individuals in the recruiting department and MSSD report to, as long
as they communicate with each other. “However, when you start putting people under different organizational umbrellas, you run the risk of a lack of communication,” she says.

Get MSPs involved from square one

Regardless of whether your hospital has the credentialing and recruiting departments reporting to the same executive, Cors suggests that MSPs and recruiting specialists work together from the moment the hospital determines the need for an additional practitioner.

MSPs and recruiting specialists should simultaneously review a potential candidate’s curriculum vitae. Recruiters and credentialing specialists scan these documents for different information, Cors says, and a credentialing specialist may spot red flags that the physician recruiter would not, and vice versa.

By identifying red flags early on, the recruiting and credentialing departments can halt the process before a physician candidate even fills out an application. Not only does this spare the hospital the expense and time associated with recruiting the wrong physician, but it also eliminates the risk of that physician demanding a fair hearing should his or her application get denied.

“There shouldn’t be any surprises when you extend an application to a physician,” says Cors. “The credentialing specialist has a sixth sense about applications. A best practice is to have them involved from the start.”

Maintain communication

Maintaining clear and frequent communication will help staff members in both departments do their jobs better. Yazzie says about 80% of her communication with Lewis are via e-mail, which is convenient and creates a paperless trail. Having this easily searchable trail makes tracking communication easy.

Lewis says part of her job as a physician recruiter is to be a resource for the MSSD. She checks in periodically with Yazzie to see whether she has all the pieces necessary to process a physician’s application. If pieces are missing, Lewis picks up the phone and calls the physician. “I have a different relationship with the physicians since I’ve been working with them for a longer period of time,” she says, adding that physician applicants sometimes need that extra push.

“It cuts down a lot of the delay of getting a physician on board,” Yazzie says. For example, since Flagstaff Medical Center began integrating its recruiting and credentialing functions, the MSSD has reduced the time it takes to process a physician application from 90 days to about 45 days, and it is able to grant temporary privileges within 48 hours of receiving a completed credentials file, she says.

Include MSPs in physician recruitment meetings

After Cabrini and Castro met to map out recruiting and credentialing processes, they determined Castro should be included in the medical staff’s physician recruitment committee meeting. As a permanent member of that committee, Castro no longer receives applications out of the blue.

“I know the candidates who are being considered, and I am much more involved in the process,” she says, adding that she appreciates being able to voice her opinions—especially if she’s had a past experience with a particular physician candidate.

Recruiting a physician costs thousands of dollars and countless hours, says Cors. Physician recruiters run ads in medical journals, talk to physicians over the phone, and fly physicians and their families to their facility for interviews and tours, and MSPs spend hours gathering data on each physician who applies. “You are investing too much money to find out you’ve recruited someone you don’t want practicing at your facility,” Cors says.

By creating an integrated recruiting and credentialing process (see “Algorithm for processing physician applications” on p. 7), your organization can reap myriad benefits.
Algorithm for processing physician applications

1. Recruitment office identifies candidates
2. Recruitment office receives CV
3. Recruitment office and MSSD review CV
4. Recruitment office conducts a mini-background check
5. Red flags? (yes, stop)
6. MSSD runs NPDB report, shares findings with recruitment office
7. Red flags? (no, go to step 8)
8. Does LIP have acceptable explanation? (no, stop)
9. Does the interview go well? (no, stop)
10. Recruitment office invites the candidate to the facility for interviews and a tour, includes MSP
11. MSSD extends an application to physician applicant
12. MSSD conducts background check and begins credentialing process
13. Recruitment office and MSSD welcome physician on board
14. Stop

Source: HCPro, Inc., Marblehead, MA.
**Legal lessons**  
**Physicians think twice over ‘loser pays’ rule**

A physician at the receiving end of a negative credentialing or peer review decision may want to think twice about responding with a lawsuit aimed at the hospital or peers. That physician may be surprised to learn that:

- 42, U.S.C. 11113 of the Health Care Quality Improvement Act of 1986 (HCQIA) states that defendants may recover attorneys’ fees from a physician who files a frivolous or bad-faith claim (see sidebar at right)
- Some medical staffs are adopting no-sue clauses into their bylaws and medical staff applications
- Some medical staffs, following the HCQIA, are adopting clauses in their bylaws and/or medical staff applications that require a physician to reimburse the hospital or other members of the medical staff if he or she loses a peer review or credentialing case

On one hand, hospitals and medical staffs appreciate the additional protections afforded to them by the HCQIA and no-sue clauses. “If I am a medical staff leader, knowing full well I might have to deal with [litigation], I would want some kind of protection,” says Joseph Cooper, MD, a consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

On the other hand, physicians find these provisions onerous and unfair. “If you are the one who is being kicked off [the medical staff] or getting your privileges restricted, you may think it is going overboard,” says Michael Callahan, Esq., an attorney at Chicago-based Katten Muchin Rosenman, LLP.

Where can you find common ground? The answer varies from hospital to hospital. What is ideal for physicians is problematic for the hospital, and vice versa. The following tips may help hospitals and physicians work together to more effectively manage these sticky situations.

**Read the bylaws.** Ironically, physicians are voting provisions that work against them into the medical staff bylaws, including those that protect medical staff members from getting sued as a result of a peer review or credentialing dispute and/or require physicians who bring a peer review or credentialing case to court to reimburse medical staff members for attorneys’ fees if they lose.

Why? Because physicians fail to read the bylaws before they vote, says Michael Cassidy, Esq., an attorney at Tucker Arensberg in Pittsburgh, who represents physicians.

“If, indeed, medical staff members read the bylaws and found [a no-sue] clause in there, I think most of them would say that’s not fair,” says Cooper. Since medical staff members must vote bylaws into action, they can prevent no-sue clauses from being adopted and work with medical staff leaders for a more reasonable alternative.

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**Health Care Quality Improvement Act**

**Title 42:** The Public Health and Welfare  
**Chapter 117:** Encouraging good-faith professional review activities  
**Subchapter I:** Promotion of professional review activities  
**Section 11113:** Payment of reasonable attorneys’ fees and costs in defense of suit

_In any suit brought against a defendant, to the extent that a defendant has met the standards set forth under section 11112(a) of this title and the defendant substantially prevails, the court shall, at the conclusion of the action, award to a substantially prevailing party defending against any such claim the cost of the suit attributable to such claim, including a reasonable attorney’s fee, if the claim, or the claimant’s conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief._

Physicians may also be voting for these provisions, which are generally written by hospital counsel, because they have no other options.

“The vast majority of the time, individual physicians never ask for an outside opinion. They just vote on what is suggested to them,” says Cassidy. “I don’t think it ought to be the responsibility of an individual physician [to seek an outside review]. Officers should do that as a matter of course.”

➤ Weigh your options. Although some physicians may consider a no-sue clause over the top, they may feel differently about a clause requiring plaintiff doctors to reimburse defendant hospitals, seeing it as a more reasonable means of protecting members of the medical staff from monetary damages. “I think most medical staffs would go along with that,” says Cooper.

If a physician loses a credentialing or peer review case, he or she will be reported to the National Practitioner Data Bank, Cooper says. “That is like wearing a scarlet letter on my chest for the rest of my life, so I am going to do everything possible to prevent that from happening, even if it means I may have to pay $20,000 in lawyers’ fees,” he says.

➤ Check state and federal laws. Medical staffs and hospitals may not need to include a provision in their bylaws stating that physicians must reimburse attorneys’ fees because such a provision already exists in the HCQIA, Cassidy says.

Note: The HCQIA does not shut the door on physicians who have legitimate cases against members of the medical staff or the hospital. The statute is discretionary, meaning that a physician needs to reimburse attorneys’ fees only if the case he or she files is frivolous or in bad faith (generally, the courts decide whether a case is filed frivolously or in bad faith). This provision applies only to court cases, not medical staff proceedings, Cassidy adds.

Some state statutes allow the prevailing party to seek recovery of legal fees, Callahan says. In addition, courts commonly rule that the plaintiff doctor must reimburse the defendant hospital regardless of whether the medical staff includes such a provision in its bylaws.

In addition, some states consider medical staff bylaws a contract between the physician and the medical staff. If your state is one of them, physicians on your

Sample bylaws language: Ensure legal protections

It’s not every day that a physician wants to sue members of the medical staff, or even the hospital, but it happens, and when it does, you’ll need an action plan. The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, offers the following sample bylaws language to help keep your medical staff out of court.

**Protections for releasing peer review and credentialing information**

[The physician] authorizes the hospital medical staff and administrative representatives to release any and all credentialing and peer review information to other hospitals, medical associations, licensing boards, appropriate government bodies, and other healthcare entities or to engage in any valid discussion relating to the past and present evaluation of the applicant’s training, experience, character, conduct, judgment, or other matters relevant to the determination of the applicant’s overall qualifications.

[The physician] acknowledges and consents to agree to an absolute and unconditional release of liability and waiver of any and all claims, lawsuits, or challenges against any medical staff or hospital representative regarding the release of any requested information and, further, that all such representatives shall have the full benefit of this release and absolute waiver, as well as any legal protections afforded under the law.

**Reimbursement of attorneys’ fees**

If an individual institutes legal action and does not prevail, he or she shall reimburse the hospital and any member of the medical staff named in the action for all costs incurred in defending such legal action, including reasonable attorneys’ fees.
medical staff may already have limited legal options; the court will most likely see the contract as binding, says Callahan. “It is a factor that any physician must take into consideration and talk to his or her counsel about when they decide to pursue any type of litigation,” he says.

➤ Balance the scales. Medical staff bylaws can provide protections to physicians that go over and above—but do not contradict—what is provided in the HCQIA.

For example, the medical staff bylaws could make the “loser pays” rule reciprocal so that medical staff members or a hospital involved in a peer review or credentialing decision would have to reimburse the physician (the plaintiff) for his or her attorneys’ fees if the plaintiff prevails.

“The federal law doesn’t say that doctors can’t [get reimbursed],” Cassidy explains. “It just says that hospitals can.”

➤ Get comfortable with compromise. Unfortunately, not everyone is going to walk away happy when it comes to Section 42, U.S.C. 11113 of the HCQIA and various bylaws amendments regarding reimbursement of attorneys’ fees and the physician’s right to sue.

“Ideal for the hospital means it is the only party that can collect attorneys’ fees. Ideal for physicians means they are the only ones that can collect attorneys’ fees. If your idea of ideal is neutral, that means either winning party can collect attorneys’ fees,” says Cassidy.

There is no right or a wrong—what your organization decides depends on its culture, Cooper says. “It comes down to what will the medical staff tolerate and what won’t they tolerate,” he says.

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Appreciating medical staff members

Creative ideas for celebrating Doctors’ Day

March 30 is just around the corner, so it’s time to start planning your Doctors’ Day festivities. MSB sought ideas from MSPs around the country to help your organization show medical staff members appreciation in ways that will have them talking for weeks.

➤ Doctor Oscars. Doctor Oscars have created a lot of buzz in recent years. The first step is to brainstorm category ideas, says Danette Minehart, medical staff coordinator at Uniontown (PA) Hospital. Last year, Uniontown Hospital gave awards in such categories as:

- Most like Doogie Howser from the ‘80s TV show
- Most like Marcus Welby, MD, from the namesake 70s TV show
- Most contagious laugh
- Best sense of humor
- Best bedside manner
- Most fashion sense
- Dr. McDreamy and Dr. McSteamy, inspired by Grey’s Anatomy (slightly controversial, but a big hit)

Uniontown Hospital presented winners with a stainless steel mug emblazoned with an “Oscar winner” logo, as well as a certificate to hang on the wall.

Divine Savior Healthcare, Inc., in Portage, WI, also adopted Doctor Oscars and added categories such as “Most likely to win on Survivor,” “Most likely to win on Dancing with the Stars,” and “Best documentation and legibility,” says Linda Preuss, CPCS, CPMSM, medical staff coordinator.

Divine Savior’s CEO emceed the event, playing music clips appropriate to each category as physicians mounted the stage to accept their awards. Award presenters were asked to wear their Sunday best.

“This was an inexpensive event and was talked about for weeks afterward,” says Preuss. “One of our physicians even called her mother that night to tell her about it. I would recommend that every hospital do this at least once.”

➤ Baby pictures. In addition to Doctor Oscars, Minehart coordinates a game of “Guess Who” using baby pictures she secretly solicits from physicians’ families. She posts them on a large poster board, and as physicians and other employees enjoy the Oscars celebration, they try to guess who each bonnet-clad tot grew up to be. Whoever matches the most pictures wins a prize.

Terry Wilson, BS, CPMSM, CPC, director of medical staff services at Flagler Hospital in St. Augustine, FL, has coordinated similar contests, such as “The eyes have it,” for which she blew up pictures of physicians’ eyes for employees to identify. She has also coordinated a “match the physician to their pet” photo competition.

➤ Written recognition. St. Mary’s Health Center in Jefferson City, MO, asks staff members to recognize a physician they appreciate in writing. It distributes recognition forms throughout the system and receives hundreds of responses from staff members, patients, and other physicians. Responses are posted outside the medical staff lounge and recipients receive a letter containing those responses and an acknowledgment from the president of the health center, says Angie Tuttle, medical staff coordinator.

Silverton (OR) Hospital salutes its medical staff in the local newspaper, and features medical staff members in its own newsletters. “Sometimes we will feature the president or the medical staff members, or sometimes we’ll focus on the PCPs,” says Jan Buller, manager of medical staff services.

➤ Gifts that keep giving. Coming up with creative gift ideas every year can be difficult, so try expanding your definition of the word “gift.” Last year, Silverton Hospital donated money normally spent on physicians’ gifts to a local food bank, which not only fed needy families, but also complemented physicians’ innate desire to work for the greater good.

➤ Buffet. Don’t forget the free catered buffet! Doctors’ Day wouldn’t be complete without an indulgent breakfast and lunch for all medical staff members.

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Leadership changes: Sailing the seven Cs

Introduction to the new C-suite

by William K. Cors, MD, MMM, FACPE, CMSL, vice president of medical staff services at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA

Healthcare organizations have traditionally relied on a core group of C-suite executives to make smart business decisions and lead them through changes. These C-suites often include a:
- Chief executive officer
- Chief financial officer
- Chief operating officer
- Chief medical officer
- Chief nursing officer

Given today’s tumultuous healthcare environment, in which the traditional medical staff structure is challenged by increased physician-hospital competition, we’re right to ask ourselves whether these traditional positions are capable of leading hospitals down the road to success. For decades, joining a medical staff was an essential step for most physicians—physicians needed the hospital to practice, and the hospital needed the physicians to bring in business. But today, physicians are engaging in business arrangements that do not always benefit hospitals, and hospital leaders are struggling to find ways to keep physicians engaged.

In addition to these traditional C-suite roles—or perhaps instead of them—consider a new definition of C-suite that includes a:
- Chief communications officer
- Chief culture officer
- Chief competition officer

Regardless of the titles your origination uses, the point is to determine whether a new set of leadership and management competencies are required. These competencies, which I will be addressing during the next several months using a step-by-step approach, include:
- Step 1: Embracing change
- Step 2: Achieving collaboration
- Step 3: Improving communication
  a. Develop communication channels
  b. Put tools in your toolbox
- Step 4: Managing competition
- Step 5: Resolving conflict
- Step 6: Influencing culture
- Step 7: Cultivating influence

Individuals will need to obtain education and training in this new set of competencies before assuming leadership in today’s healthcare industry. This applies to leaders at every level of the organization—the medical staff, management, and the board.

Individuals considering a leadership position at a hospital may wish to consider becoming a certified medical staff leader. More information about this certification, which is offered by the Greeley Medical Staff Institute, can be found at www.greeley.com/msleadercertification.

Having the right attitude can also see contemporary healthcare leaders through tough times. Whether your organization is fielding resistance from physicians because it has signed an exclusive contract for cardiac surgery services provider or whether it’s ironing out the nuances of employing physicians, remember these time-tested tenets:
- Change is inevitable—get used to it
- You must spend money to make money
- You can’t make everyone happy all of the time
- An ounce of prevention is worth a pound of cure.
Q&A with IPC’s Adam Singer, MD

Hospitalist programs must take new direction to stay viable

Editor’s note: HLA spoke with Adam Singer, MD, CEO of IPC The Hospitalist Company and Modern Healthcare’s 2008 Physician Entrepreneur of the Year.

What do you perceive to be some of the major challenges the hospitalist industry faces?

The staffing model the hospitalist industry has most frequently adopted cannot support hospitalist medicine for long. Many hospitalist groups are creating staffing models in which the doctors only work half-time, essentially. They are scheduling doctors for seven days on and seven days off, and they are working shifts measured in hours. Where else would you see doctors work like that?

In certain respects, I don’t think the seven days on/seven days off schedule is in the best interest of patients. It constrains your ability to be a true hospitalist because a hospitalist, by definition, must engage with the hospital to drive the delivery system, which is difficult when you are only at the hospital every other week. But because of the work force shortage, doctors can dictate that they are only going to work a certain number of days per month. Doctors are being paid more than $200,000 per year to work, in effect, part-time, and that is not financially viable.

If you pay doctors more money than they generate, you are under water. Would any business do well paying out more money than it takes in? Hospitalist programs need to encourage doctors to see enough patients to pay for themselves and stop relying on hospital subsidies.

What are your suggestions for hospitalist programs struggling to become financially viable?

If hospitalist programs can reorganize their staffing models, they can prevent a lot of problems coming their way. Doctors who work Monday through Friday and share a call loop with their partners are going to make just as much, if not more, than the average hospitalist and not be dependent on hospital subsidies to stay afloat.

This type of scheduling reduces the number of physicians a program needs to hire to provide adequate, quality coverage. If a program schedules doctors for seven days on and seven days off—which is only 14 days per month on average—it needs 10 doctors to fill five shifts. But you may only be able to recruit seven, so three shifts are left empty. If you schedule doctors Monday through Friday and convince them to share call, you can fill five shifts with five doctors. And they will make more money because they will see more patients.

The hospital is happy because doctors are available every day, and the referring community PCPs are happy because they can develop a referral relationship with the program.

“For some practices, the crisis has already arrived, and for many others, it will soon be at their doorstep.”

—Adam Singer, MD

Questions or comments?
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Do you find that hospitalist programs struggle to develop referral relationships with PCPs in the community?

Let’s say I’m a hospitalist and my referral source is Dr. X. He and I get along, and I take good care of his patients. But I only work every other week. Will Dr. X bother referring patients to the practice? Probably not. When he has a patient who needs to be hospitalized, he doesn’t want to check his calendar to see whether I happen to be around that week.

Is the seven day on/seven day off shift appropriate for hospitalists whose main focus is emergency care?

Yes, the shift model works great for ED doctors because they are doing episodic care. No one is referring to them—patients show up in the ED, and the episode of care is soon over.

Does IPC The Hospitalist Company get pushback from doctors who don’t want to work Monday through Friday?

No. Our doctors typically make 20% more than the average U.S. hospitalist. The funny thing is that hospitalists in our company receive no subsidies from hospitals, yet they make more money than those who receive subsidies. What’s really interesting is that many doctors who work seven on/seven off for other hospitalist programs moonlight for us with all the free time they have. What does that tell you? Show me data that say if a doctor works seven days, he or she needs seven days to recover.

Some believe hospitalist programs serve a less lucrative payer mix. Are there any data to the contrary?

I don’t know whether there are public data, but at IPC, we have more than 2 million patient encounters per year in more than 300 facilities, so we have a substantial database of our own. At IPC, less than 10% of our encounters are uninsured. In our view, that figure is well within the realm of what we should give back to the communities we serve. Groups that talk about less lucrative payer mixes are those that have contracts to manage all unassigned ED patients, and those are generally the patients who don’t have health insurance. If you only cover the ED, 20%–30% of your business may be uninsured.
When you start marketing to the physicians who refer the other 75% of patients that didn’t come through the ED and who are generally insured, the percentage of uninsured business drops, and giving back to the community by caring for the uninsured becomes very manageable.

How can hospitalist programs start to market to referring physicians?

Each of our practices hires a business development manager who lives and works in his or her community. This person meets the PCPs in the community, visits the urgent care clinics, and develops a marketing plan to build relationships with those physicians. Many practices don’t have the resources or bother to develop that kind of local marketing capability.

Are hospitalist programs suffering from the current economic crisis?

For some practices, the crisis has already arrived, and for many others, it will soon be at their doorstep. Hospitals are coming under incredible financial pressure from the decline in elective admissions created by the slowing economy and by the lack of available credit. I think each hospital CEO who is supporting a hospitalist program will look at that budget closely and ask a lot of questions. According to Society of Hospital Medicine’s 2007–2008 Biannual Survey, more than 50% of all hospitalist revenues come from hospital subsidies. That’s a lot of money.

I also think as hospitalist programs slow down, they will see contract renegotiations become tense. If you’ve been working 14 days per month, it is difficult to switch to a Monday through Friday schedule. A lot of doctors will resist working nights and weekends, and that will make staffing programs even more difficult than it is today.

In light of the economic crisis, should programs offer more or less money to doctors during the recruitment process?

If you offer physicians a base salary that’s too high, your physicians won’t be as motivated as you would like them to be. That’s human nature.

I understand the challenge: If you don’t pay up, maybe you can’t hire a certain doctor, but if you do, your program will implode. It is a catch-22, but if you can’t staff your program, then you don’t have a program.

How else should hospitalist programs motivate their physicians?

IPC pays a base salary between 50% and 60% of a physician’s income—about $160,000, which is way under the national average for a hospitalist. That person can earn 40%–60% more in incentive compensation; our doctors ultimately earn 20% more than the national average because they are motivated to see more patients and get involved in hospital business. Whenever you use money to motivate, it should be mainly in the form of incentive compensation and not in the form of base pay.

Loyalty doesn’t come from money either. You get loyal employees when they believe they can achieve their personal and professional goals by following your organization’s values.

How would you suggest hospitalist programs become transparent in a way that will help them improve care and be useful to the community?

Hospitalist programs need to be clinically and financially transparent. They need information systems to capture their performance data to compare to the hospital’s. The hospitalist group and the hospital need to develop a joint operating committee that meets every month so everyone can see how everyone else is performing.

To maintain financial transparency, IPC provides a monthly financial statement to physicians so they can gauge their performance, and we share financial performance with our client hospitals so they know how we are doing.
Benefits and disadvantages of bonus types

Most hospital medicine programs provide some sort of bonus plan for their physicians. Whereas a signing bonus is a tool to attract recruits, a formal bonus plan is intended to motivate specific physician behavior and reward physicians for performing well. If constructed properly, a bonus plan could enhance retention too.

See the chart below for pros and cons of productivity- and quality-based bonuses.

<table>
<thead>
<tr>
<th>Bonus Type Description</th>
<th>Pros</th>
<th>Cons</th>
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<tbody>
<tr>
<td>Bonus is based on group work performance</td>
<td>It may create healthy peer pressure for hospitalists to improve performance</td>
<td>Hospitalists have different degrees of performance success, and performance evaluation may be subjective</td>
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<tr>
<td>Bonus is based on gross collections</td>
<td>It is an accurate way to distribute payment</td>
<td>Hospitalists have little control over the payer mix and collections process</td>
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<tr>
<td>Bonus is based on the amount of dollars billed, regardless of collections</td>
<td>It eliminates complications of billing and collections</td>
<td>It may lead to upcoding or longer length of stay</td>
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<td>Bonus is based on a fixed flat fee per patient admission</td>
<td>The per-admission bonus might be an incentive for physicians to accept admissions</td>
<td>Hospitalists might take on more patients than they are reasonably able to care for</td>
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<tr>
<td>Bonus is based on the number of times a physician has a billable encounter with a patient</td>
<td>It is an easy and straightforward approach to measure productivity</td>
<td>This type of bonus might penalize those physicians who see patients with complicated medical histories since all encounters are treated equally</td>
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<tr>
<td>Bonus is based on wRVUs on a weighted scale</td>
<td>wRVU bonuses are the most accurate measure of actual work performed</td>
<td>No real downside</td>
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<tr>
<td>Bonus is based on patient satisfaction, as noted in a survey</td>
<td>Hospitals’ patient satisfaction data are now being publicly reported and, thus, it is an important metric to administer</td>
<td>Patient satisfaction is subjective and not an accurate measure of quality; patients often see many physicians during their stay, thus making it difficult to pinpoint their satisfaction</td>
</tr>
<tr>
<td>Bonus is based on referring physician satisfaction, as noted in a survey</td>
<td>It reminds hospitalists that the referring doctors are their customers too</td>
<td>Referring physician satisfaction is subjective and not an accurate measure of quality</td>
</tr>
<tr>
<td>Bonus is based on core measures protocols, including pay-for-performance initiatives</td>
<td>This type of bonus aligns incentives for the hospitalists and the hospital regarding core measures performance</td>
<td>Often, core measures performance relies on nurses and other staff members rather than hospitalists</td>
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<tr>
<td>Bonus is based on low readmission rates of patients</td>
<td>It could help keep hospitalists from discharging patients too quickly</td>
<td>It could be somewhat meaningless unless the readmit rate is grossly high</td>
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<tr>
<td>Bonus is based on participation in hospital committees, timely medical records, and good behavior</td>
<td>It rewards hospitalists who are involved in optional hospital activities, who complete their medical records quickly, and who treat staff members well</td>
<td>It can be overly subjective on the physician behavior part</td>
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Source: Practical Guide to Hospitalist Recruitment and Retention, by Kirk Mathews, CEO, principal, and founder of Inpatient Management, Inc., St. Louis, with a foreword by John Nelson, MD, FACP. Published by HCPro, Inc.