Wondering what to do with your medical staff dues?

Does your medical staff charge a reasonable amount for dues? Should the active staff be required to pay dues? Is your medical staff putting the money collected from dues to its best possible use?

MSPs and medical staff leaders may be curious as to how their practices regarding dues compare to other medical staffs. Charging too much may discourage a physician from joining your medical staff, whereas charging too little may mean that your medical staff doesn’t have enough funds to provide some of the niceties that physicians enjoy, which can also be a turnoff for potential medical staff member.

Thus, to maintain a competitive recruiting edge, it is important for medical staffs to charge an amount that physicians believe is reasonable but still allows for an appropriately funded budget.

There is no prescribed formula for how much to charge or how the dues should be put to use. Each medical staff must determine that on its own. However, it is helpful to know what other medical staffs are doing. MSB spoke with three medical staffs to find out how they manage dues.

How much should medical staffs charge?

St. Clair Hospital in Pittsburgh charges $125 per year for medical staff dues, according to Kathleen Tafel, manager of medical affairs and professional credentialing. Flagler Hospital in St. Augustine, FL, charges a comparable $200 per year for consulting staff and $125 for locum tenens staff, says Terry Wilson, CPMSM, CPCS, director of medical staff services. Good Samaritan Hospital in Los Angeles charges more—$350 per year, says Guenther Baerje, BSIT, CPMSM, HACP, director of medical staff management.

The amount that hospitals charge is not the result of a complicated formula. Rather, hospitals should survey their local competitors to see how much they are charging and then charge a comparable fee, says Wilson.

The amount that medical staffs charge for dues may be tied to supply and demand. “If you want the business, you charge less. If you are overwhelmed with practitioners, you may not need the business as much and charge a bit more,” Wilson says.

Which categories should the medical staff charge?

At St. Clair, the active, affiliate, courtesy, and assistant coverage surgeon categories are required to pay dues. Medical staff members in the emeritus category do not...
Medical staff dues

have to pay dues, and neither do hospitalists. According to Tafel, hospitalists are considered employees of the hospital and are not granted all of the benefits of medical staff membership, such as the ability to vote. Thus, they are not required to pay medical staff dues.

At Flagler Hospital, medical staff members in the consulting category and locum tenens physicians are required to pay dues, but physicians in the active category are not. Active staff members aren’t required to pay dues because they regularly admit patients to the hospital and participate in medical staff activities. In other words, they pay their dues through their actions, but some choose to pay monetary dues, also.

Locum tenens are required to pay dues at Flagler, even if they only plan on working there two days out of the year. “We continue to carry them, meaning we recredential and reappoint them,” says Wilson. “Whether it is one day, one week, or one month out of the year, they still have to pay dues if they want to be a locum tenens physician here.”

The courtesy staff members, who don’t participate as fully as active staff members, are required to pay dues because the medical staff must exert the same amount of effort credentialing and appointing them as it does for active staff members.

“The hospital would like something in return for all the work we do to get someone on board and continuously monitor the quality of their work and their current credentials,” says Wilson.

At Good Samaritan, all categories must pay medical staff dues, including AHPs, but the emeritus/honorary categories are exempt.

How should the medical staff spend the dues it collects from physicians?

Each medical staff must decide for itself how it wants to spend its dues. At St. Clair Hospital, medical staff dues go toward:

➤ A subscription to an electronic journal for physicians
➤ Medical staff leader stipends
➤ Donations to the hospital’s foundation when a physician has lost a loved one
➤ Medical staff social events
➤ Donations to the Pennsylvania Medical Society
➤ Educational events
➤ Niceties, such as a gavel for the medical staff president

St. Clair’s medical staff splits the cost of the journal subscription and medical staff leader stipends with administration.

Flagler’s medical staff is unique in that its dues go toward political donations. The president of the medical staff is highly involved in state politics and donates the
money collected from dues to politicians who support causes that affect physicians.

Initially, Flagler allowed only those who paid their dues to vote on which political cause the money would go toward. However, the physicians who were required to pay dues (locum tenens physicians and physicians in the consulting category) rarely voted, which stymied the medical staff’s ability to decide which cause to support. Now, the medical executive committee (MEC) decides where the money goes.

If the medical staff dues pay for political donations, how does Flagler’s medical staff pay for education and incidentals? Through its $500 application fee.

Good Samaritan is similar to St. Clair in that its medical staff dues have multiple purposes. At Good Samaritan, medical staff dues pay for:
- Medical staff officers’ stipends (the medical staff and hospital split the cost of stipends)
- Educational events for medical staff officers and department chairs
- Educational events for MSPs
- Charity donations

Baerje says it is common for medical staffs to spend the money they collect via dues on a yearly medical staff social event or to pay attorney’s fees should an issue arise that requires legal action.

**Should medical staffs collect dues at reappointment or on a specific date?**

On one hand, collecting medical staff dues at reappointment may be the best solution for smaller medical staffs that are tapped for resources. By making medical staff dues part of the regular reappointment process, MSPs at Flagler are spared the task of billing hundreds of physicians all at once. “If you charge dues on the same day every year, you are probably going to spend six months collecting those dues from a half dozen of your doctors,” says Wilson.

On the other hand, larger medical staffs with additional resources in the medical staff office may wish to bill physicians on the same date every year to avoid an extra step during the reappointment process. St. Clair Hospital bills physicians yearly between January 1 and 15.

Deciding whether to bill at reappointment or on an annual basis is largely up to each medical staff’s culture and resources.

**How should the medical staff manage physicians who don’t pay dues?**

Because Flagler’s method for collecting dues is tied to the reappointment process, if a physician fails to pay his or her dues, he or she is not reappointed because the application is considered incomplete. To get back on the medical staff, physicians on the consulting staff must pay the hospital’s $500 application fee on top of their $400 medical staff dues ($200 per year multiplied by the two-year reappointment period) for a total of $900. Locum tenens physicians would have to pay the $500 application fee on top of their $250 in medical staff dues ($125 per year multiplied by two years) for a total of $750.

Although collecting dues at reappointment is one method of ensuring payment, St. Clair uses another method: It penalizes physicians who don’t pay their dues after a certain date. At St. Clair, if physicians don’t pay their bills by March 31, their fees double, says Tafel. If a physician still fails to pay the bill, a medical staff officer approaches the physician and encourages him or her to settle the debt. If the physician still neglects to pay, the matter is brought before the MEC, which decides whether it is necessary to take action.

St. Clair requires medical staff members to attend 50% of their general medical staff and department or section meetings per year. If they fail to meet that requirement, they are charged a fee of $125 on top of the $125 for medical staff dues. If a physician fails to attend meetings and fails to pay dues by March 31, the fee inflates to $500 ($125 medical staff dues plus $125 fee multiplied by two years).

“I billed 500 physicians this year, and I only have three outstanding. That’s pretty good,” says Tafel.

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Medical staff dues

According to Baerje, it’s common for medical staffs to charge late fees. Good Samaritan’s policy regarding delinquent payments is as follows:

Practitioners who fail to pay their dues within 15 days after the date the second notice was mailed will be automatically suspended. Such suspension shall apply to the medical staff member’s right to admit, treat, or provide services to any patients in the hospital. The suspension shall remain in effect until the dues are paid.

Practitioners who are suspended for failure to pay dues will, in addition to suspension, automatically be assessed the following fines for each day the dues remain unpaid:

Medical staff dues survey

Thanks to the 233 respondents to our recent survey on MedicalStaffLeader.com. The majority (92%) require medical staff members to pay dues. The staff categories that must pay dues vary among respondents, but most medical staffs do not charge emeritus members. Dues are most often used to fund education and/or social events. Most medical staffs (79%) take action if a physician neglects to pay dues.

What categories of staff must pay dues?
➤ Fines for days 1–9: $25 per day
➤ Fines for days 10–30: $10 per day

Dues and applicable fines shall be payable no later than 90 days after the date of suspension.

A lack of payment after 90 days shall be deemed a voluntary resignation of medical staff membership and privileges. Thereafter, reinstatement to the medical staff shall require payment of the dues, accumulated fines, and an application with processing fee, per the appointment procedures for applicants.

Charging the appropriate amount and managing dues effectively can help keep your medical staff on the competitive edge of recruitment and ensure that it has enough funds to cover the activities it finds most important.

If your medical staff imposes dues, what are they used for?

- **Education**: 163
- **Social events**: 120
- **Fundraising**: 44
- **Other**: 178

If a member does not pay dues, does the medical staff take action?

- Yes: 79%
- No: 21%

If you currently do not impose dues, do you plan on doing so in the near future?

- Yes: 59%
- No: 41%
**Have limited resources?**

**Tips for critical access hospitals struggling to comply with MS.08.01.01 and MS.08.01.03**

According to the September issue of *Joint Commission Perspectives*, 27% of critical access hospitals (CAH) struggle to comply with MS.08.01.01 and MS.08.01.03, which pertain to peer review. Although 27% doesn’t seem like a high number, it’s safe to say that because of their limited resources, including an insufficient number of physicians, most critical access hospitals don’t consider peer review easy.

Although lack of resources contributes to the struggles CAHs have with regard to peer review, the biggest culprit may be medical staffs overinterpreting the focused professional practice evaluation (FPPE) and ongoing professional practice evaluation (OPPE) standards.

MS.08.01.01 states that the medical staff must define the circumstances requiring monitoring and evaluation of practitioners’ professional performance (in other words, FPPE). MS.08.01.03 states that OPPE information is factored into the decision to maintain, revise, or revoke an existing privilege prior to or at the time of renewal.

“Hospitals overfocus on operationalizing the standards,” says *Jonathan H. Burroughs, MD, MBA, FACPE, CMSL*, senior consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. "They think that it involves complex performance feedback reports and using all the dimensions of performance, and they develop a defeatist attitude."

Rather than letting FPPE and OPPE get the best of your hospital, consider these tips to get your peer review program moving in the right direction.

**Use data you already collect**

Create an OPPE process based on information your organization already collects, says *Barbara LeTourneau, MD, MBA, FACPE, FACEP*, senior consultant at The Greeley Company. For example, the medical records department likely has some data on record completion and history and physicals done within 24 hours; the OR often tracks late starts; and the quality department collects core measure data. Most hospitals also do routine case review on unexpected deaths, myocardial infarction (MI) during surgery, or unexpected transfers to the ICU.

**Start small with OPPE**

Medical staffs often stumble over the use of the six general competencies (patient care, medical knowledge, practice-based learning and improvement, interpersonal communication skills, professionalism, and systems-based practice). They often feel that they must measure multiple indicators within each competency to meet the OPPE standard, but that is not the case. OPPE simply requires a multidimensional performance assessment, which can be done manually if your facility hasn’t yet implemented electronic medical records, says Burroughs.

Start by measuring something about technical performance, interpersonal skills, and compliance with medical staff rules to get you started. As long as the data provide the medical staff with meaningful information regarding each practitioner’s performance, you’re on the right track.

Burroughs suggests measuring the following indicators for OPPE:

- Unexpected complications (patient care)
- Unexpected deaths (patient care)
- Validated incident reports or patient satisfaction surveys (interpersonal communication skills)
- Medical staff meeting attendance (professionalism)

**Gather meaningful information**

Collecting meaningful data can be a challenge for some medical staffs. Wasting time collecting data that
don’t provide valuable information about physician performance can make an already tight belt seem tighter, says Gaye Bear, CPMSM, professional staff coordinator at Columbia Memorial Hospital, a CAH in Astoria, OR.

Before redesigning its peer review program, Columbia reviewed every transfer and patient death. Because the facility is a CAH and does not have the resources of a full-service hospital, it is unable to provide care to some patients; thus, many of them are transferred to other facilities.

“Rather than screening those services for transfers that were appropriate, every single transfer got reviewed,” says Bear. “The only time we are looking at a death or a transfer now is if it falls out of the screening process.”

The following are examples of indicators that the medical staff collected prior to redesigning its peer review program that did not result in many (if any) cases falling out of the screening process:

➤ Emergency medicine
  – Patient undergoing MRI
  – Incident report involving physician
  – Patient seen twice in the ED within a 48-hour period who was not instructed to return to the ED

➤ Medicine department
  – Unplanned admission from outpatient surgery
  – Neurological deficit present on discharge that was not present on admission
  – MI occurring after admission to hospital

Since redesigning its FPPE and OPPE processes with the help of The Greeley Company, Columbia now has a set of indicators that are much more telling of physician competence and help identify system issues. Such indicators include:

➤ Possible permanent or serious infant injury (e.g., skull fracture, paralysis, neonatal hyperbilirubinemia)

➤ Intraoperative or immediately postoperative death (within 24 hours) in an American Society of Anesthesiologists Class I patient

➤ Patient death or serious physical injury associated with the use of a device in which the device is used or functions other than as intended or is difficult to use as intended

➤ Patient death or serious physical injury associated with hypoglycemia, the onset of which occurs while the patient is being cared for as an inpatient or in the ED

“We also implemented a screening mechanism for those cases that must be reviewed [death, transfer], and that eliminated a lot of work for the physicians,” says Bear.

Don’t overinterpret FPPE

When complying with MS.08.01.01, it’s important to remember that there are two kinds of FPPE. One is to verify that those who are new to the medical staff or are requesting new privileges are competent to practice at your facility. The other is to address potential competency issues when the performance of an existing member of the medical staff is flagged during the OPPE process.

For both kinds of FPPE, medical staffs simply need to answer one question: Is the practitioner competent and safe to exercise the privileges of concern? According to Burroughs, this is a yes-or-no question that can usually be answered quickly. “Sometimes it takes a single proctored case or case review to determine that.”

If a physician applies to your staff with 20 years of experience, glowing references, and impressive performance data and the physician performs well on his or her first tough case at your facility, you may have answered the question. “You’re done. You don’t have to review an arbitrary number of cases,” says Burroughs.

Tip: Some Joint Commission (formerly JCAHO) surveyors may have their own ideas as to what constitutes good FPPE or OPPE. If a surveyor attempts to dictate that your medical staff should be reviewing a specific number of cases, point out that none of the standards describe specific processes, says Burroughs.

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Don’t be afraid to fall back on chart review

If your facility cannot obtain a proctor, it’s okay to employ concurrent or retrospective chart review, says Burroughs.

According to Bear, Columbia Memorial Hospital’s FPPE process relies on chart review. “Because of our limited number of physicians, we don’t do any mentoring, and we don’t have a process for observation.”

The only time your organization may need to have a concurrent proctor is for surgeons fresh out of residency, says Burroughs. Most residents have never performed surgery independently, so having another physician scrub in for one or two cases may be in the hospital’s best interest.

Recommend privileges and FPPE simultaneously

Rather than the department chair recommending that the medical executive committee (MEC) grant privileges to a physician applicant, waiting for the MEC’s response, and then recommending an FPPE program for that new physician, LeTourneau recommends that the department chair make both recommendations at once.

“Sometimes I see medical staffs give someone privileges, and then they have to go back and figure out the FPPE for them. It is much better to do it at the same time,” says LeTourneau. This process saves time for medical staff members, who are already pulled in multiple directions.

Develop an FPPE framework for each specialty

FPPE must be individualized for each practitioner, but medical staffs should take time upfront to develop a standard for each specialty. This standard then can be adapted to meet each practitioner’s needs.

“If you start at the beginning and say, ‘Here is the evaluation we will do for most pathologists as they come out of residency, these are the things we will look at, and this is the general time frame,’ it will save you a lot of time in the long run,” says LeTourneau.

For example, the review process for orthopedic surgeons may include concurrent proctoring and retrospective chart review of three cases. If the physician’s background is a bit uncertain, the medical staff may up the ante to five cases. “You will be able to look at each applicant and say, ‘Is this person appropriate for what we usually do, or do we need to do something additional for this person?’” says LeTourneau.

Complying with FPPE and OPPE doesn’t have to be the bane of your medical staff’s existence. As a CAH, your medical staff can choose to simplify FPPE and OPPE. Remember, the goal is to meet the standard—there is no requirement to go above and beyond.
10 interview tips to bring your career to the next level

Interviewing for a job is no one’s cup of tea. Most of us are insomniacs the night before an interview because we worry about what could go wrong. However, you don’t have to lose a night’s sleep when a new job opportunity presents itself. These 10 interview tips will help you fine-tune your interview skills and give you the confidence to get that dream job.

1. Know what you have to offer

“The biggest mistake people make is going into an interview not knowing their own accomplishments,” says Deborah Walker, CCMC, president of Alpha Advantage in Portland, OR. An interview is a time to market yourself, but you can’t do a good job of that unless you have a firm understanding of what skills you could bring to your potential new employer.

Walker suggests that job seekers write down their accomplishments, keeping in mind that an accomplishment has three parts: challenge, action, and result. For example, if you were able to balance the medical staff’s budget when unexpected expenses arose, write it down.

These mini success stories will give you the ammunition you need to answer situational questions. Employers tend to ask situational questions to gauge how potential employees have reacted or would react given certain circumstances. For example, your interviewer may say to you, “Tell me about a time that you improved a process.” That would be a perfect time to share your story about the peer review data collection system that you streamlined.

You may have heard in the past that you should frame every weakness as a strength. However, this may not be the best advice. If your interviewer says, “Tell me about your weaknesses,” it’s okay to share one or two minor weaknesses, as long as you explain how you overcame them, says Walker. For example, you may say that you have always had a fear of speaking in public, but after taking a public speaking course and practicing with friends, you felt much more comfortable giving presentations to the medical executive committee of the hospital you worked at previously.

Keep in mind that any strength taken to the extreme can be considered a weakness, says Carole Martin, founder of InterviewCoach.com in San Diego and interview expert for Monster.com. For example, if you tell your potential employer that you are a perfectionist, he or she may envision you wasting time on unimportant details. However, if you state that you have high attention to detail, the employer is likely to interpret that to mean you notice details that others overlook.

Tip: If you’re stuck coming up with a list of accomplishments, strengths, and weaknesses, read your old performance reviews, Martin says. If others have shared positive comments on your reviews, adapt them for your interview.

2. Do some digging

Take some time to research the organization you are applying to prior to your interview. Learn whether the hospital is public or private, whether it has multiple campuses, and how many physicians it has on staff. “If someone has taken the time to investigate the organization, I feel they have an interest in possible employment here,” says Nancy Lian, CPCS, CPMSM, senior director of medical staff services at Cambridge (MA) Health Alliance.

3. Leave negativity at the door

You may be leaving your current job because you’re bored and burned out, but your interviewer doesn’t need to know that. “You should not in any way bring past problems with you,” says Martin. “The reason [interviewers] ask you why you are leaving your job is because they want to know if you are a problem.”

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Turn every negative feeling toward your old job into an opportunity to showcase your positive attributes. For example, if you did not get along with your boss, simply state, “I learned a lot working with my previous manager.” If your previous employer used an antiquated technology system, state, “I am looking forward to learning how to use the latest technology systems.”

6. Demonstrate the four Cs

When interviewing candidates, Lian looks for someone who embodies the four Cs:
- Communication skills
- Calmness
- Confidence
- Collaboration

Communication skills and the ability to remain calm when the job gets overwhelming are key attributes for any MSP, says Lian. Some candidates may not exude confidence during the interview because they don’t know exactly what the job might entail. However, have confidence in your basic skills. “I can train people, but they have to be confident in their current skills and their ability to take on new responsibility,” she says.

Finally, Lian looks for someone who can collaborate well with others. If your current position keeps you isolated, think of one or two circumstances in which you collaborated with a team and highlight them during your interview.

7. Listen

“I think that listening is a really important part of the interview, and it is the part that people neglect. They are focusing on their answers rather than listening to the question,” says Martin.

To show your interviewer that you are listening, make direct eye contact, says Lian. “I want people to look me in the eye because I want to know that they are listening. I also expect that when they are dealing with professional people, they are able to be direct and forthright.”

8. Ask the right questions

Strong listening skills will enable you to ask the right questions during an interview. Come prepared with a
question or two based on your research of the company, but base the rest of your questions on issues that arise during the interview, says Martin. For example, if your interviewer mentions several times that training other MSPs is part of the job, you may ask how many new MSPs the organization brings on every year and what percentage of your time would be spent on training.

Stay away from questions about salary, time off, and benefits, says Lian. Those types of questions convey that you are interested only in how you will benefit from the position rather than how the organization will benefit from having you on board.

Before leaving your interview, Martin and Walker suggest asking the interviewer, “Do you have any doubts that I can do this job?” or, “What concerns do you have that would prevent you from offering me the position?” This is your opportunity to discuss any misconceptions that your interviewer may have about you. For example, if your interviewer states that he or she is concerned about your lack of management experience, point out that although you don’t have formal management experience, you did manage a small team during a high-profile project.

“Come back with something in that area that shows you have done similar things. If it is something you don’t have experience with, maybe it isn’t a good fit for you,” says Martin.

**9. Send a follow-up note**

Send a brief follow-up note to your interviewer expressing your continued interest in the position, summarizing what you would bring to the job, and thanking the interviewer for his or her time. You may also wish to call the interviewer several days after the interview to follow up. However, at that point, the ball is in the interviewer’s court, and you should leave it there.

“One of the mistakes people make is hounding. They keep calling, and it starts to feel like stalking,” says Walker.

**10. Self-critique**

Take a few moments when the interview is over to sit in a quiet place and reflect on what went well, whether you still want the job, and what you should work on for future interviews. “Critique your performance and how you feel about working with the folks you just interviewed with. I believe in trusting your gut,” says Martin.
Medical staff leader orientation is worth the effort

by Barbara LeTourneau, MD, MBA, FACPE, FACEP, senior consultant with The Greeley Company, a division of HCPro, Inc., in Marblehead, MA

Medical staff leaders have important roles and responsibilities. When a leader steps into a new role, he or she should be fully oriented to prevent delays in fulfilling the responsibilities of the position. Any medical staff leadership orientation must have two parts. The first part is a general orientation to the structures and processes of the medical staff and hospital. The second part is specific to the responsibilities of the particular role.

Part 1: General orientation for all medical staff leaders

An MSP or medical staff leader can prepare and conduct the general orientation. This orientation should include:

- Review of the medical staff structure, including committees, key processes, and functions
- Review of how the hospital is organized and who holds key roles
- Summary of the hospital’s strategic plan
- Brief review of the hospital’s finances pertinent to the role of the leader
- Contact information of the vice president of medical affairs, medical director, administrative assistant, and others with whom the leader will frequently interact

Part 2: Role-specific orientation

This orientation should start with the job description. A physician experienced in the role should champion the orientation. The role-specific orientation that you provide will depend on whether the leaders are elected or appointed. Orientation for elected leaders should include the following:

- Review of current medical staff goals and specific problem areas
- A list of the committees of which the individual will be a member, minutes from the past few meetings, and committee charters, if available
- Expectations regarding office hours, meeting attendance, and responsiveness
- Lists of suggested reading and coursework pertinent to the leader’s role

Orientation for appointed leaders should include the following:

- A list of the medical staff leaders with whom the medical director must collaborate
- Expectations of how the medical director interacts with the elected leaders
- Meetings that the medical director is expected to attend or chair, minutes from the past few meetings, and a committee charter
- The role of the medical director in achieving quality plans and targets and resolving employment issues
- Regulatory requirements for which the medical director is responsible
- The budget of the specific area of responsibility

A successful orientation program gives a new leader a better understanding of the expectations and responsibilities of the role. It is well worth the time and effort to allow leaders to increase their effectiveness early in their new positions.

Questions? Comments? Ideas?

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