JCAHO unveils 2007 credentialing and privileging standards
New emphasis on practitioner performance data

The JCAHO released its 2007 pre-publication standards in late May, including a completely revamped credentialing and privileging section that focuses hospitals’ attention on practitioner competence in six categories codeveloped by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties.

*Note:* For more information about the six general competencies, see “How to use data to evaluate practicing physicians in the JCAHO’s six general competencies,” on p. 7.

The JCAHO’s emphasis on the six competencies—plus its introduction of the expectation that hospitals will evaluate practitioners’ competency on an ongoing basis, rather than merely at reappointment or prior to granting new privileges—means that the JCAHO is seeking to push hospitals into adopting a more data-driven process for credentialing and privileging, says Kurt Patton, MS, former executive director of the hospital accreditation program at the JCAHO, now principal of Glen-dale, AZ–based Patton Healthcare Consulting, LLC.

“The reprivileging process at many hospitals is a sort of paperwork ex-

### Identify and evaluate potential leaders using survey tools

In response to industrywide challenges (e.g., evaluating emerging technologies, filling an increasing demand for services, and adapting to increased accountability) and those specific to its own organization, Catholic Healthcare Partners (CHP), a 30-hospital chain based in Cincinnati, developed tools for identifying and training potential leaders via its Leadership Academy.

With hospitals in five states, 35,000 associates, and 8,000 affiliated phys-
icians, CHP recognized six years ago that it needed to enhance its hospitals’ cooperation and efficiency through strong leadership, says Jon Abeles, CHP’s senior vice president for talent management and diversity.

In cooperation with the Center for Creative Leadership, a nonprofit educational institution based in Greensboro, NC, CHP identified the top 470 potential candidates from across the system,
very much a data-driven, clinical evaluation,” Patton says. “The Joint Commission has been searching for years for a way to make this a more credible review process. This is the culmination of that effort.”

Although the elements of performance (EP) in the 2007 Medical Staff Standards do not appear to indicate that hospitals will be required to collect specific data to comply, hospitals will be required to implement policies that could eventually incorporate performance data into the privileging process.

For example, **MS.4.15 EP 1** states that hospitals must establish criteria that determine a practitioner’s ability to provide patient care, including:
- current licensure/certification
- relevant training
- physical ability to perform privileges
- data from professional practice review, if available
- peer/faculty recommendation

In the meantime, many hospitals will have considerable difficulty adjusting their existing data collection systems to measure practitioner performance in the six general competencies, experts say.

**Susan T. Goodwin, MS, RN, CHE, CPHQ, FNAHQ**, chair of the JCAHO’s Professional and Technical Advisory Committee, says the committee anticipated hospital data collection problems and sought greater lead time before full implementation.

“Our largest issue [with the 2007 standards] had to do with the technology available for collecting data and having data available for an individual practitioner on an ongoing basis,” Goodwin says. “We felt that information systems aren’t there yet to do that.”

**Data collection downfalls**

Hospitals already report and receive vast amounts of data (e.g., voluntary reporting of core measures to the Centers for Medicare & Medicaid Services and the JCAHO).

However, processing all of these data in a way that is useful for performance monitoring can be challenging due to differences in data sources and issues of data quality, among others.

“There’s a whole realm of problems with data collection,” says **Marla Smith, MHSA**, a consultant with The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. Smith specializes in practitioner data collection.

Problems that hospitals currently face in their data collection include the following:
- Data collected using medical billing codes may be attributed to the wrong physician (e.g., the admitting physician rather than the physician who wrote the discharge orders)
- Many of the available data (e.g., core measures) are not physician-specific (e.g., smoking cessation counseling upon discharge for heart failure is handled by nursing staff)
- Many of the most valuable data (e.g., hand-written orders) must be manually typed, introducing room for human error

Given these common pitfalls, experts say the industry may require several more years before the privileging process can align fully with the JCAHO’s vision. “This certainly adds a lot more structure to the process for reviewing an application,” Patton says. “It adds a high degree of rigor to the review process, and that’s going to take some getting used to, I think, in the hospital industry.”

**John Rosing, MHA, FACHE**, a consultant with The Greeley Company, says the standards will likely evolve during the next several years to require more specific use of data in the privileging process.

“It will evolve into something that requires greater depth and specificity in data collection, even though the standard as it’s written is pretty benign,” he says. “Often when a standard like this comes out, there’s a couple of years of learning curve as the surveyors themselves sort out what they think this should look like.”
creating a pool of possible candidates to enroll in a two-year leadership program.

**Evaluation of potential leaders**

After selecting the initial group—which included regional directors, facility CEOs, physician leaders, and chief nursing officers, among others—CHP used a series of instruments to identify the most promising and capable candidates for the Leadership Academy.

“We do leadership surveys throughout our system to look at people not only for their leadership competence, but for their capability for the future,” Abeles says.

A talent identification instrument surveys potential leaders and their supervisors, and compares the assessments for discrepancies. For example, a supervisor may not always see the potential leader’s full capabilities. “It’s a good chance to have a conversation about what might be unseen,” Abeles says.

The survey asks whether the potential leader has had experience with developmental challenges, including the following:

- leading teams
- developing new service lines
- project management
- turnarounds
- developing and implementing strategy
- navigating workplace demands

The survey then seeks the potential leader’s level of exposure to and knowledge of various functional roles, including the following:

- customer service
- information technology
- quality
- finance
- community relations

Finally, the talent identification instrument asks potential leaders and their supervisors to evaluate the potential leader’s competence in the following key categories identified by CHP as crucial to its organizational mission and values:

1. **Passion about the organization’s core mission**—Understands the uniqueness of the organization as a faith-based healthcare provider and has a teachable point of view

2. **Servant leadership**—Leads with purpose and demonstrates strong commitment to the organization and its success

3. **Complex mental processes**—Is skilled at analyzing problems and making clear decisions

4. **Bias for action**—Makes tough decisions and marshals resources to get things done

5. **Development of others**—Effectively delegates responsibility, involves others in decision-making, and coaches and encourages employees in their careers

Once the evaluation surveys are completed, CHP charts the potential leaders’ information to determine which individuals are the most adept and best suited for leadership development and enrollment in the Leadership Academy.

“Using these instruments and performance assessments, we were able to identify where people fell on the grid,” Abeles says. “We had people who were emerging, people who were on performance watch, people who were solid performers, and then we had people who were strong performers with high potential. We looked at the strongest leaders with high potential for the Leadership Academy.”

**Evaluation after the Academy**

CHP tracks the performance of the new leaders
Potential leaders  

after graduation from the Leadership Academy using the Center for Creative Leadership’s 360-degree survey instrument “Reflections” to gauge their improvements in various categories.

Note: The 360-degree instrument surveys the leader’s supervisors, peers, and subordinates—a complete circle (360 degrees) of those connected to the leader in the organization.

“We look at their progress year over year in those categories and then [create] a development plan, which is required as part of the talent management initiative,” Abeles says. From there, CHP decides how to best leverage its new talent throughout the organization.

Resources:
Catholic Healthcare Partners (www.healthpartners.org)
Center for Creative Leadership (www.ccl.org)

The Catholic Healthcare Partners Leadership Academy

The two-year Leadership Academy at Cincinnati-based Catholic Healthcare Partners (CHP), developed in conjunction with the Center for Creative Leadership (CCL), is a series of intensive retreats involving “action learning” sessions during which trainees tackle difficult—and real—business challenges faced by the organization.

In action learning, trainees break up into three or four teams to look at some of the complex issues that the system faces. The groups are expected to use their creativity and innovation, bringing their knowledge to bear on outstanding organizational problems.

After several months of working in teams, the leadership trainees attend a week-long intensive learning seminar at the CCL in Greensboro, NC, to participate in simulations and attend workshops. After a second round of action learning, the teams report their solutions during a systemwide leadership conference.

The second year of the Academy includes more action learning, mentoring in specific areas by executives, a second retreat for the CCL Leadership Development Program, and finally, the Governance Academy and Retreat, at which the trainees meet with the board of trustees and formally graduate from the Academy.

“We’re into the third cohort of this program,” says Jon Abeles, senior vice president for talent management and diversity at CHP. “We’ve found that a number of [leaders] have been promoted and have gained significant responsibility in the workplace.” Other leaders have moved on to high-responsibility roles at other Catholic health systems—which Abeles considers a mark of the program’s success.

Abeles says Academy graduates now comprise a unique network of leaders across the system. “They are leveraging their strengths in a much different way than we’ve ever done before with leadership. It’s an opportunity to share tacit knowledge, to connect with people you don’t report to.”
Improving physician satisfaction: Communication is key

The pressures building on physicians due to the changing nature of healthcare (e.g., rising overheads, rising expectations and accountability, rising malpractice insurance premiums, etc.) have the potential to create a dissatisfied and counterproductive atmosphere in medical staffs. Fortunately, using data collected from physician surveys, hospitals have the opportunity to model best practices for improving physician satisfaction and hospital-physician relationships.

“Hospitals across the country are currently undergoing a revolution in how we conceptualize, how we view, and how we manage our physician relationships,” says Paul Alexander Clark, senior knowledge manager at Press Ganey Associates (www.pressganey.com), a leading independent vendor of satisfaction measurement and improvement services.

As healthcare enters an era of measurement, transparency, and accountability for improvement, the same trend is now emerging in hospital relationships with physicians. Hospitals can apply the same techniques that they use for service quality measurement to assess their needs for building and maintaining loyal medical staffs. Data from Press Ganey’s surveys of nearly 30,000 physicians provide strong evidence to show that the key to improving physician satisfaction is communication, says Kay Clark-Cox, MBA, principal consultant for physician satisfaction services at Press Ganey.

Physician pressures
To improve their relationships with physicians, hospital and medical staff leaders must first understand the nature of physician dissatisfaction. Physician stressors include multiple losses and overloads, Clark-Cox says, such as the following:

1. Physician losses:
   - Reduced income from reimbursement
   - Loss of autonomy
   - Loss of status
   - Professional isolation
   - Loss of support staff
   - Loss of personal time

2. Physician overloads:
   - Rising overheads
   - Regulatory interference and excessive documentation requirements
   - Excessive workloads
   - Rising expectations and accountability
   - Rising malpractice insurance premiums

“The result that we all see is less time for the physician to communicate with hospital staff and peers,” Clark-Cox says. “They are more detached and less involved: overworked, overwhelmed, and underappreciated.”

Surveying the medical staff
Using the results of a medical staff survey to...
Physician satisfaction

formulate and implement action planning addresses two paramount issues for physicians—the need to base decisions on scientific evidence and the need to communicate their perspectives on operational and clinical concerns on a consistent basis.

Physicians think that face-to-face communication with medical staff leaders and the administration is critical, says Rick Sheff, MD, executive director and chair of The Greeley Company, a division of HCPro, Inc.

Press Ganey survey data show that physician dissatisfaction is most likely to arise from physicians’ sense that they do not have adequate communication with hospital administration and other leaders (e.g., the medical executive committee).

A representative sample of responses to Press Ganey survey questions about physician-hospital communications includes the following comments:

- “Share all information, not just the administration’s side of the story.”
- “Meet with physicians who are not in leadership positions.”
- “Administration should seek out physicians for face-to-face contact. I feel I don’t know the administration. I therefore feel like an outsider, even though I’ve practiced at this hospital for 27 years.”
- “As a medical staff leader and member of the medical executive committee, I’m satisfied with my communication with the administration.”
- “The medical executive committee needs to share its meeting information with the other physicians on the staff.”

Improved communications can help to reduce physician dissatisfaction and provide administrators and medical staff leaders with crucial information to resolve conflicts and meet staff-related challenges, says Sheff.

“If you ask administrators, many of them will say, ‘We try very hard to communicate—we understand it’s important.’ And they are very frustrated,” Sheff says. “So you have administrators being frustrated, and physicians being frustrated, and the result is [that] nobody is happy with the current circumstance.”

Improving communications—best practices

The usual methods for communicating with physicians (e.g., staff meetings, e-mails, letters, newsletters, etc.) are not effective in reaching them, Sheff says. Not only do physicians not have time for staff meetings or reading impersonal letters, but these communications also only travel one way. Physicians want to be heard.

Administrators and medical staff leaders should meet with physicians weekly, Sheff says. Set aside two hours for meeting with physicians—one hour with medical staff leaders and one hour with a different set of representatives from various specialties and demographics within the hospital. These are often difficult discussions, perhaps involving heated exchanges, but the sharing of information is an essential benefit.

Administrators and physicians should be “ruthlessly honest” about the real challenges facing the hospital and the medical staff, Sheff says.

“Everything is on the table—it’s not spin-doctor time,” Sheff says. “Trust flowers from structured access. That’s what physicians want. It is such a rare commodity in healthcare today to have trust between physicians and the hospital. And structured access, and good, honest communication on a regular basis [are] critical to achieving that level of trust and healing from the injuries of the past.”

Another effective means to improve hospital-physician communications is providing meals for physicians in the staff lounge. Physicians can congregate to make informal dialogue and build trust.

Note: Providing free meals to the medical staff does not violate the Stark law if the invitation is open to everyone on the staff and is not tied to patient volume.

The key to improving physician satisfaction is communication, which builds trust and loyalty.
How to use data to evaluate practicing physicians in the JCAHO’s six general competencies

Expectations that hospitals use standardized indicators to measure practitioners’ competency and performance have increased as payers move toward pay for performance and consumers demand higher-quality care. Experts now anticipate that those expectations of data-driven measurement will eventually become requirements from the hospital industry’s leading accrediting agency.

The JCAHO’s 2007 Medical Staff Standards emphasize ongoing measurement of practitioner competency in six general categories:

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

The six general competencies, originally developed by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties for measuring resident competency, provide a new framework for hospitals to evaluate practicing physicians, says Robert Marder, MD, vice president of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

“The question is, how well does this framework translate to practicing physicians? It’s one thing to say, ‘This is what you need to become a physician, or certified as a physician,’” Marder says. “How well does it relate to current competency? I think it’s an interesting question.”

Despite the drawbacks associated with data collection that many hospitals currently face (e.g., difficulty attributing outcomes to the proper physician), hospitals should consider the following options for measuring physician competency in the six categories:

Patient care
The introduction to the credentialing and privileging section of the JCAHO’s 2007 Medical Staff Standards states that physicians are expected to provide compassionate, appropriate, and effective patient care for the promotion of health, prevention of illness, treatment of disease, and at the end of life.

The expectation to measure both compassionate care and appropriate and effective care in each of the areas described above is problematic because it combines technical quality with the “soft” quality of compassion, Marder says.

“From a [human resources] standpoint, you would never lump together your interpersonal skills with your technical knowledge,” he says. “Part of the issue here is, when you try to measure these categories, some of them [require the measurement of] multiple things. That’s going to be a challenge for hospitals.”

Marder suggests breaking the three qualities (compassionate, appropriate, and effective) and the areas of care (promotion of health, prevention of illness, treatment of disease, and care at the end of life) into a three-by-four matrix to determine how to measure each element.
For the qualities of care, Marder says the following types of measures can be used:

- **Effective** = Outcomes (e.g., mortality rates)
- **Appropriate** = Processes (i.e., core measures, such as angiotensin converting enzyme inhibitors on discharge for heart failure)
- **Compassionate** = Communication with patients and families (e.g., informed consent)

**Marla Smith, MHSA**, a consultant for The Greeley Company, says facilities can use checklists of physician behaviors to measure compassionate care, such as whether the physician shakes the patient’s hand and explains the patient’s diagnosis or treatment options in a clear and understandable manner.

**Medical/clinical knowledge**

The JCAHO states that practitioners must “demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and apply that knowledge to patient care and educating others.”

“It’s fine in training to measure medical knowledge because you have a test,” Marder says. “Is the measure of medical knowledge that [a physician has] maintained board certification? That may be all you need.”

Marder suggests the maintenance and documentation of continuing medical education may also serve to measure competency in this category.

**Practice-based learning and improvement**

The JCAHO seeks evidence that practitioners are able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

“This is going to be tough to measure,” Marder says, unless hospitals define practice-based learning as the...
implementation of core measures (e.g., participation in preprocedure timeouts). However, hospitals should only use core measures that are physician relevant.

**Interpersonal and communication skills**
The JCAHO expects practitioners to demonstrate skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams.

Marder suggests that incident reports of staff or patient complaints regarding physician interpersonal and communication skills could be used to document noncompliance. Another way to measure these skills involves surveys of staff and patients (see the sample patient satisfaction surveys on p. 10–11).

**Professionalism**
Practitioners are expected to demonstrate behaviors that reflect commitment to continuous professional development, ethics, and sensitivity to diversity, as well as responsible attitudes toward patients, the medical profession, and society.

One way to measure competency in this category could be to document incidents of disruptive behavior or other examples of noncompliance with professional or ethical codes, Marder says.

**Systems-based practice**
The JCAHO seeks evidence that practitioners demonstrate an understanding of the contexts and systems in which healthcare is provided and are able to apply this knowledge to improving healthcare.

Examples of systems-based practice include patient advocacy and coordination of care between levels of care and among teams. Marder says competency could be measured based on utilization management data (e.g., correct use of resources such as blood transfusions, cooperation with patient safety practices, etc.).

Other measurements could include compliance with:
- the Situation-Background-Assessment-Recommendation technique for communication between members of the healthcare team about a patient’s condition
- preprocedure timeouts
- order read-back requirements

This expectation requires physicians to understand that they operate in a system with rules that take into account care beyond the physician-patient relationship. “Sometimes the system has to override how you would like to operate,” Marder says.

Editor’s note: For more information about the JCAHO’s six general competencies and Ongoing Professional Practice Evaluation, listen to Dr. Marder’s live audio-conference on August 29. To sign up, call HCPro’s Customer Service Department at 800/650-6787, or visit www.hcmarketplace.com.
**Sample patient satisfaction survey—Format 1**

To be completed by the recent patient of *(name of physician)*

**Instructions:**
For each statement below, please indicate the extent of your agreement or disagreement by placing a check in the appropriate box.

1. How would you rate the daily visits made by your hospital physician (time spent, quality of visit)?
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

2. How would you rate your physician's ability to communicate with you (listening, giving clear explanations)?
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

3. How would you rate your physician's ability to communicate with your family (listening, giving clear explanations)?
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

4. How would you rate the way that you were treated by the physician (kindness, respect, dignity)?
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

5. How would you rate the overall medical care that you received from the physician?
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

6. Was a physician assistant or nurse practitioner involved in your care?

7. If yes, can you identify him/her?

Please provide any additional comments you may have regarding your stay as a whole or any individual physician who treated you.

---

**FOR OFFICE USE ONLY**

Patient's admission date:

Patient was admitted from:
- [ ] Doctor's office
- [ ] Emergency room
- [ ] Direct from home
- [ ] Nursing facility
- [ ] Other

Discharged to:

Primary care physician:
Physician name: _________________________________
Office phone: _________________________________
E-mail: _________________________________

Source: Northeast Inpatient Medical Services, St. Joseph Hospital, Bangor, ME.
## Sample patient satisfaction survey—Format 2

To be completed by the recent patient of (name of physician)

### Instructions:
For each statement below, please indicate the extent of your agreement or disagreement by placing a check in the appropriate box.

1. **Were you satisfied with the quality of medical care delivered in the hospital?**
   - Not applicable
   - Very dissatisfied
   - Dissatisfied
   - Somewhat dissatisfied
   - Satisfied
   - Very satisfied

2. **Were you satisfied with the quality of medical care received from the physician who cared for you?**
   - Not applicable
   - Very dissatisfied
   - Dissatisfied
   - Somewhat dissatisfied
   - Satisfied
   - Very satisfied

3. **Did you feel that your medical care was coordinated well among the physicians caring for you?**
   - Not applicable
   - Very dissatisfied
   - Dissatisfied
   - Somewhat dissatisfied
   - Satisfied
   - Very satisfied

4. **Did the physician treat you with respect, kindness, and dignity?**
   - Not applicable
   - Very dissatisfied
   - Dissatisfied
   - Somewhat dissatisfied
   - Satisfied
   - Very satisfied

5. **Did your physician spend adequate time with you and your family explaining your condition?**
   - Not applicable
   - Very dissatisfied
   - Dissatisfied
   - Somewhat dissatisfied
   - Satisfied
   - Very satisfied

6. **Did your physician conduct him- or herself in a professional manner?**
   - Not applicable
   - Very dissatisfied
   - Dissatisfied
   - Somewhat dissatisfied
   - Satisfied
   - Very satisfied

7. **Were you seen by a physician each day?**
   - Yes
   - No

8. **Were you satisfied with your discharge plan?**
   - Not applicable
   - Very dissatisfied
   - Dissatisfied
   - Somewhat dissatisfied
   - Satisfied
   - Very satisfied

9. **Rate your overall satisfaction with the hospitalist who cared for you:**
   - Excellent
   - Very good
   - Good
   - Fair
   - Poor

Please provide any additional comments you may have regarding the physician who cared for you.

---

**FOR OFFICE USE ONLY**

Patient's admission date:

Patient was admitted from:  
- [ ] Doctor's office
- [ ] Emergency room
- [ ] Direct from home
- [ ] Nursing facility
- [ ] Other

Discharged to:

Primary care physician:  
Physician name:  
Office phone:  
E-mail:  

*Source: Northeast Inpatient Medical Services, St. Joseph Hospital, Bangor, ME.*
News briefs

CDC: Ambulatory care visits up 31% from 1994 to 2004

Americans made more than 1.1 billion visits to physician offices and hospital emergency and outpatient departments in 2004, up 31% since 1994, according to the latest data released by The Centers for Disease Control (CDC) on June 23 in its annual national hospital ambulatory medical care survey.

Although nearly half of those visits (48.1%) were to physician primary care offices, hospital emergency department visits represented 10% of all visits, increasing from 93.4 million visits in 1994 to 110.2 million visits in 2004, an 18% jump.

The 31% increase in ambulatory care visits from 1994 to 2004 was primarily due to a 19% increase in utilization per person and an increase in population (11%). Visit rates have shown an increasing trend since 1994 for persons aged 22–49, 50–64, and 65 and older.

IOM: Emergency care at breaking point

The nation’s emergency medical system as a whole is overburdened, underfunded, highly fragmented, and ill-prepared to handle surges from disasters, according to a series of reports released last week by the Institute of Medicine (IOM).

Key findings in the IOM’s reports include the following:

- **Many emergency departments (ED) and trauma centers are overcrowded**—ED visits grew by 26% between 1993 and 2003, whereas the number of hospital beds declined by 198,000
- **Emergency care is highly fragmented**—Emergency medical services (EMS) agencies do not coordinate effectively with EDs and trauma centers, resulting in poor patient flow
- **Critical specialists are often unavailable to provide emergency and trauma care**—Three quarters of hospitals report difficulty finding specialists to take ED and trauma calls
- **The emergency care system is ill-prepared to handle a major disaster**—There is little surge capacity for a major event, and EMS received only 4% of Department of Homeland Security first responder funding in 2002 and 2003.

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Medical Staff Briefing provides its readers with current information and advice on how to manage medical staff functions, from organizational structure to physician leadership to medical staff reengineering. In addition, it provides cutting-edge news and insights into developments in medical staff credentialing.
How to get the most from your
August 2006 Medical Staff Briefing

For you . . .

How to measure performance in the JCAHO’s six general competencies
The JCAHO’s 2007 Medical Staff Standards include expectations that hospitals will measure practitioners in six general competencies. Learn how to use data to measure current competency within this new framework on p. 7. Plus, learn how to use patient and staff surveys to measure “soft” skills on p. 8.

Sample patient satisfaction surveys
Use these sample patient satisfaction surveys to build your own tools for measuring physician competency in patient care, interpersonal and communication skills, and professionalism. See pp. 10–11.

For your physicians . . .

JCAHO unveils 2007 credentialing and privileging standards
The JCAHO released its 2007 prepublication standards May 26. Find out what challenges hospitals will face to comply with the completely revamped credentialing and privileging standards. See p. 1.

Tools for identifying and evaluating potential leaders
In response to industrywide challenges and those specific to its own organization, Catholic Healthcare Partners, a 30-hospital chain based in Cincinnati, developed tools for identifying and training potential leaders via its Leadership Academy. Medical staffs can learn how to adapt these tools for developing their own emerging leadership on p. 1.

Improving physician satisfaction: Communication is key
The pressures building on physicians due to the changing nature of healthcare have the potential to create a dissatisfied and counterproductive atmosphere in medical staffs. Read how to model best practices for improving physician satisfaction and hospital-physician relationships on p. 5.
October 4-5, 2006, The Sheraton Hotel, Boston, MA
- Achieving Continuous Survey Readiness: Solving chronic JCAHO and CMS compliance problems.

October 5, 2006, The Sheraton Hotel, Boston, MA
- Discharge Planning Summit: Decrease denials, maximize length of stay and increase efficiency.

October 5-6, 2006, The Sheraton Hotel, Boston, MA
- NEW! Effective Residency Program Management: Administrators’ Workshop: Solving management problems: Learn what tools your colleagues are using to carry out their responsibilities and gather practical tips for complying with ACGME standards.

October 6, 2006, The Sheraton Hotel, Boston, MA
- Case Management Institute: Managing by influence to maximize the effectiveness of case management programs.

October 12-13, 2006, The Drake Hotel, Chicago, IL
- Advanced Medical Staff Leadership Retreat: Where today’s leaders come to solve their toughest medical staff problems.
- Peer Review for Today: Practical solutions to make peer review effective, efficient and fair

October 13-14, 2006, The Drake Hotel, Chicago, IL
- Surgical Team Summit: Bringing together chiefs of surgery, chiefs of anesthesia, and surgical services leadership to tackle the toughest OR challenges.

November 2-3, 2006, The InterContinental Mark Hopkins, San Francisco, CA
- Magnet Resource Center Advanced Workshop: Learn from top healthcare professionals how to answer your most pressing Magnet questions.

November 3, 2006, The InterContinental Mark Hopkins, San Francisco, CA
- Rapid Response Team Retreat: Learn to implement a Rapid Response Team from an expert in the field.

November 8, 2006, The Westin Resort Hilton Head Island, Hilton Head, SC
- Core Privileging Essentials: Advanced course in criteria based design and implementation
- Physician Performance Profiles: A course in quality data and current competence

November 9-11, 2006, The Westin Resort Hilton Head Island, Hilton Head, SC
- Advanced Credentialing Retreat: Tackling today’s toughest credentialing challenges.
- Medical Executive Committee Institute: The essential training program for all medical staff leaders. Give your physician leaders the skills to assume their medical staff leadership responsibilities with confidence and effectiveness.