Rethinking The Role of The Medical Staff In The New Quality Era

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Perceived Barriers to Practice as a Medical Staff

- We don’t have staff and resources to do QI
- If we set up orders and there’s a bad outcome, won’t the staff get sued?
- Can we decredential someone who won’t use the orders?
- We mostly practice in the office; how can the staff help with that?
- How do we get physicians to do this? Can we pay them?
- Isn’t this illegal or antitrust or something?
Definitions (or neologisms)?

- **Accountable health care organization**: one which has explicitly focused on its clinical culture as supportive of appropriate quality for which such an organization is willing to be evaluated compared and held responsible.
More Definitions

- **Quality**: Whether the patient has received the right treatment, procedure or care for his clinical condition; whether he was actively engaged in the care; where opportunities for process improvement were available they were pursued.
And Again…

- **Clinical Culture**: the extent to which technical quality is assured and supported or neglected and undermined.
The Hospital Accountability Mandate

- Crossing the Quality Chasm
- Leapfrog
- Commercial Report Cards
- Government Report Cards
- Data to Consumers: Healthgrades.com, DoctorQuality.com, US News and World Report, Hospital Mortality Rates…
Legal Recognition of The Medical Staff Role

- Medicare Conditions of Participation:
- JCAHO: “deemed status”
- State licensure rules
- HCQIA
“Every system is perfectly designed to achieve the results it gets.”

Donald Berwick, M.D.
How the Medical Staff Plays Today

- Self-governed, autonomized and excluded from real power
- Individualized credentialing
- Barely true review for privileges: only for serial maimers
- Avoidance of NPDB reports: “there but for the grace of God go I”
- Difficult to get a quorum at Medical Staff meetings
What absorbs the Medical Staff today?

- Economic credentialing
- EMTALA on call obligations
- Using NPPs
- Cross departmental privileges (i.e., clinical turf)
- Board, Administration, and Medical Staff communication failures
Questions

- Are these the highest and best uses of the Medical Staff?
- Do any of these activities have a meaningful impact on the most important things patients expect when they come into a hospital?
  - Cure me: outcomes
  - Heal me: patient satisfaction
  - Don’t hurt me: mortality rate, ADE’s, mishaps
A Better Role for the Medical Staff

- Become the primary driver of quality of care in the hospital, and the community
- Take aim at major issues such as mortality rates, patient safety, nurse staffing, and professional quality of life
- Accept accountability as a medical staff for the results of the hospital as a care system
Then a miracle happens...?

Current Medical Staff Role: Marginalized

Future Medical Staff Role: Driving Quality
Current Medical Staff Role: Marginalized

• Take a leadership stance
• Learn and use quality methods
• Practice the science of medicine as a team

Future Medical Staff Role: Driving Quality

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Principles for physician leadership

- Involve physicians at the earliest stages of initiatives that will affect them
- Identify the real leaders: not always the one with the crown and scepter
- Build trust: Do what you say, say what you do consistently over time
- Communicate openly, frequently, candidly
- Be willing to be held accountable for participation
Principles for physician leadership (2)

- Pay attention to process, not structure
- Do something real and meaningful: take a risk
- Don’t let one loud negative voice stop you
- Work across boundaries: you need administrators, and they need you
- Start by defining reality, using data, on a small scale, about something important
Where will you find the time and resources for these Medical Staff activities?

- Contract out pieces of corrective action including fair hearings
- Use the Stark regulation to get help from the hospital (make compliance clinically relevant)
- **Standardize and simplify your clinical work**
- The hospital can help with this work; if you need to pay physicians you can
- What do you do with the medical staff dues money?
A Continuum of Involvement – Imperative Physicians Are There

- Quality of the physicians rendering services in the setting: selection; recruitment; ongoing monitoring; privileging
- Team approaches to care delivery – Highest and best use
- Medical management systems (utilization review; clinical integration initiatives; CPGs)
- Patient safety: CPOE; NQF measures
More Imperatives

- Infrastructure: IT system design and implementation; documentation systems; EMR
- Establishment of financial incentives for physicians
- Quality Improvement initiatives generally: HSMR; P4P
Important – They don’t need to control but they’d better be there

- Payor contract negotiations regarding P4P or whether the money supports what EBM says should be done
- Risk management
- Strategic planning – what business are we in?
- Budgeting – who gets the money for what capital and operations?
- Manpower planning – which clinicians to do what?
Useful – They Can Really Help

- Other aspects of payor negotiations
- Financial, administrative reporting design and applications
- Marketing where physicians or quality are the subjects
- Customer satisfaction data
- Other data reports and external reporting generally especially on quality
Not a priority

- Marketing
- Human resources
- Materials management
- Claims payment
- Financial management
Attributes of Leaders

- Practiced in the trenches
- With standing among physician peers
- Demonstrated integrity
- Willing to give up personal or specialty goals for the greater good
- Good communicator who can act as a conduit
- Willingness to learn skills and renew for others

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Challenges to Make It Real

- **Being accountable**: showing up consistently; positive response to criticism; willingness to collaborate; avoiding paranoia and separateness
- **Followership**: Trusting leaders and representatives
- **Accepting inevitability of change**
- **Respect for diversity of opinion and multi-disciplinary accountability**
- **Volunteerism is limited**

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Removing The Barriers

- Resources and staff support are there and you don’t need much from the physicians except time.
- You can pay for this work if you have to.
- You can decredential the physicians who don’t want to offer the brand of care you do with these processes in place.
- These approaches lower malpractice risk. Hospital will get sued. Medical staff could. Carry insurance.

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Summary

- Hospitals are under enormous pressure to produce better results
- The Medical Staff organization is a part of the “system” producing the current results
- We can’t expect better results without changing the system, including the Medical Staff
- Medical Staff organizations can’t do this alone: cooperation with Boards and Administrators will be essential to success
- Other constituencies (e.g., nurses) can be major allies in this
Will this quality work change your medical staff culture?
Resources