Medical Executive Committee Institute

Essential Training for All Medical Staff Leaders

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Coping with today's challenges and preparing for tomorrow's: Healthcare trends impacting physicians and hospitals

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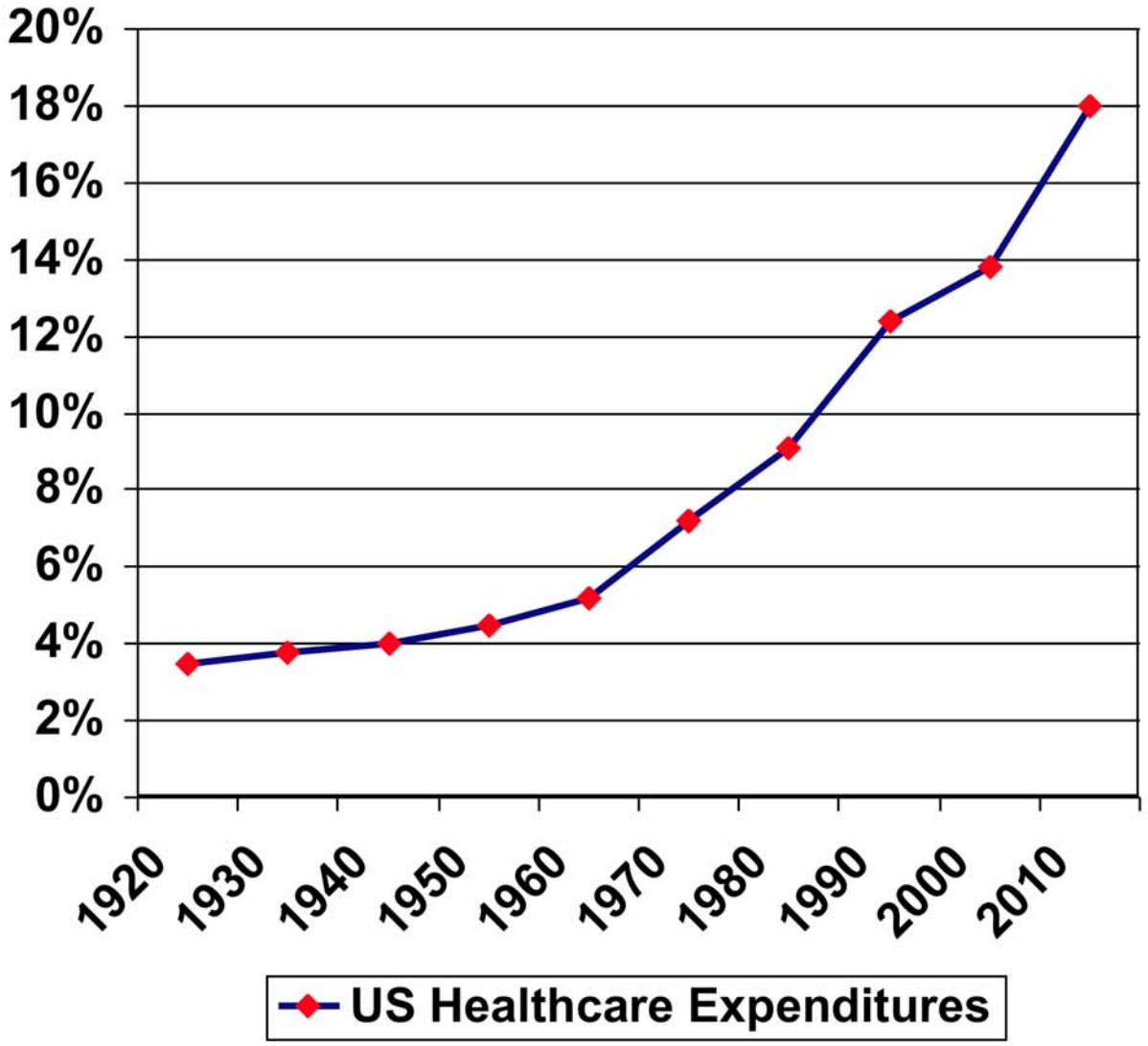
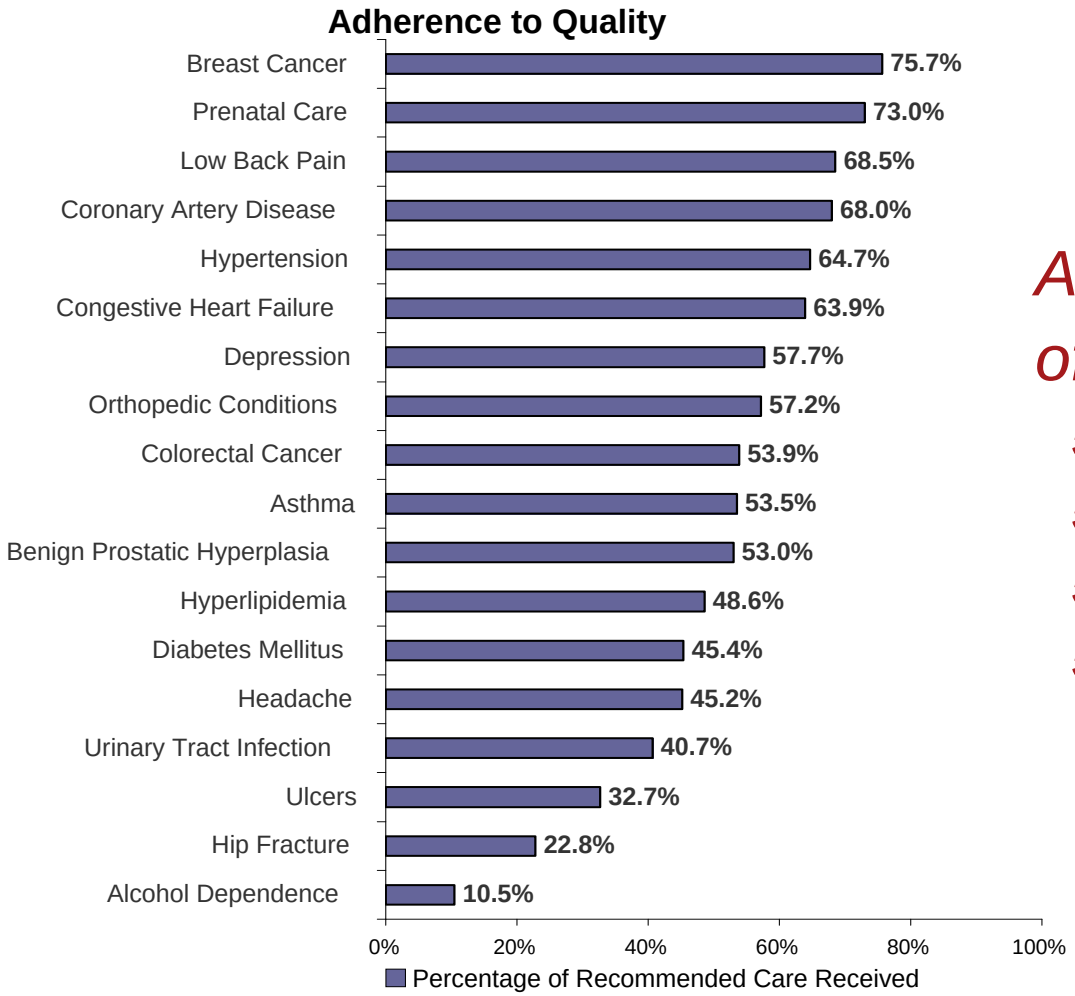
U.S. Healthcare Expenditures % of GDP



Quality shortfalls: Getting it right 50% of the time



Adults receive about half of recommended care

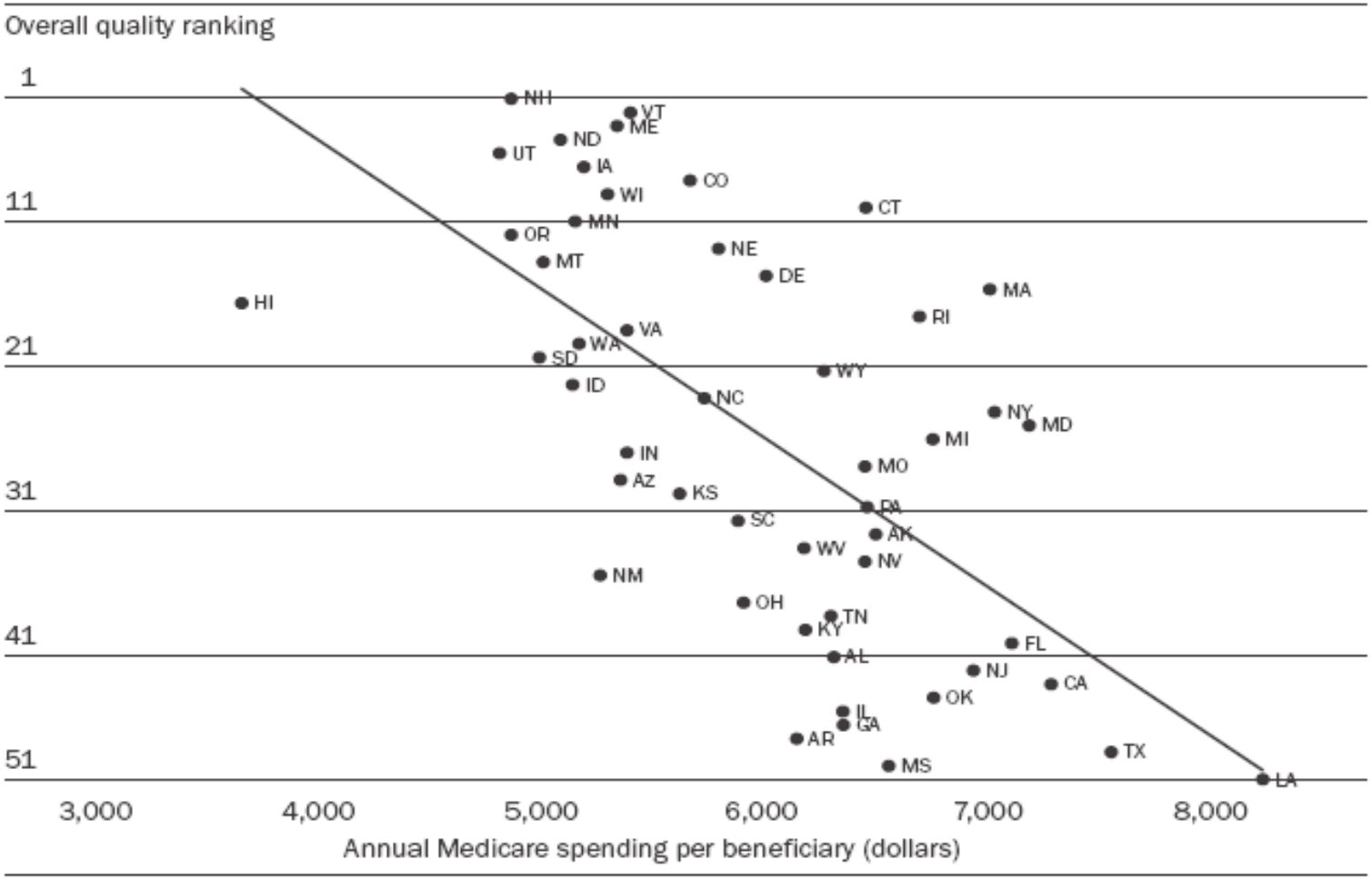
- *54.9% = Overall care*
- *54.9% = Preventive care*
- *53.5% = Acute care*
- *56.1% = Chronic care*

Source: McGlynn EA, et al., "The Quality of Health Care Delivered to Adults in the United States," New England Journal of Medicine, Vol. 348, No. 26, June 26, 2003, pp. 2635-2645

Medicare quality and efficiency by state

EXHIBIT 1

Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000–2001



SOURCES: Medicare claims data; and S.F. Jencks et al., "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1998–1999 to 2000–2001," *Journal of the American Medical Association* 289, no. 3 (2003): 305–312.

NOTE: For quality ranking, smaller values equal higher quality.

America wants to know …

- What value are we getting for all the money we are spending?
- How can we spend our money better to achieve higher value?
- How can we reduce the cost of healthcare while preserving or increasing value?

Drivers of healthcare change

- Payers
- Technology
- Consumer behavior
- Public accountability for quality
- Provider behavior
- Government (healthcare reform)

Rethinking the Medical Staff

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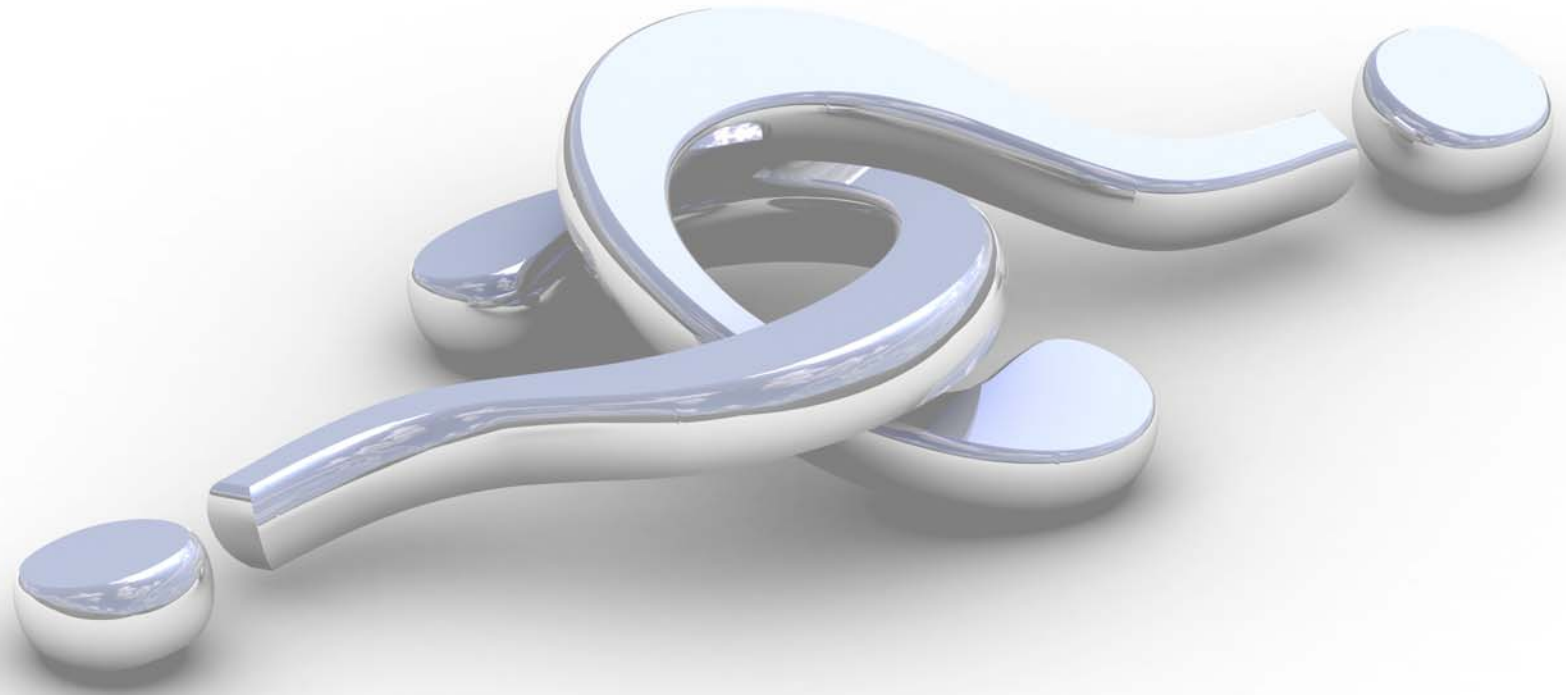


Which is more important, physician success or hospital success?

Guiding principle #1

For healthcare to work, we must find a way to achieve physician success, hospital success, and good quality patient care at the same time

Guiding principle #2

Our most difficult and important healthcare challenges are unsolvable problems

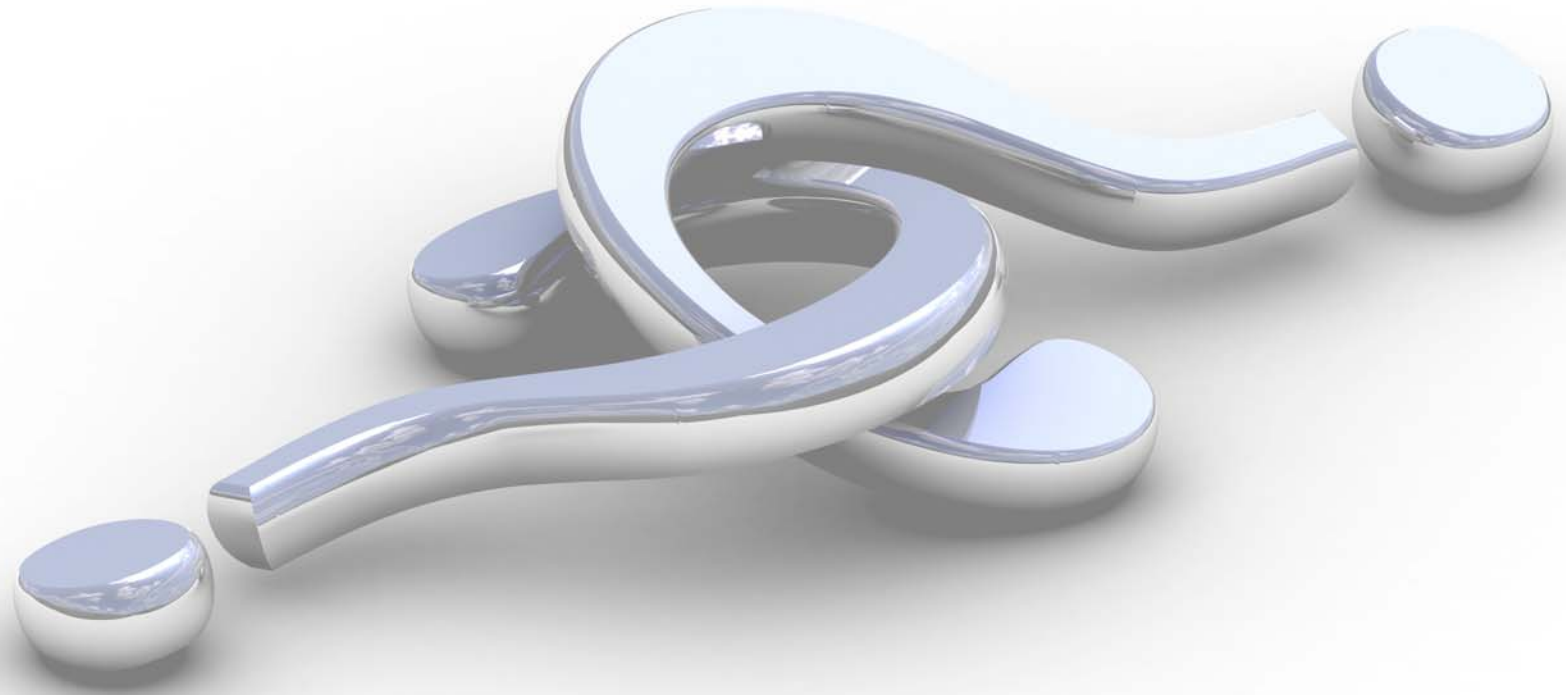
Guiding principle #3

You can’t solve a problem at the same level of thinking that caused it in the first place.

—Albert Einstein

Corollary

- Physicians and hospital leaders must find a new and better way to manage the unsolvable problems we face

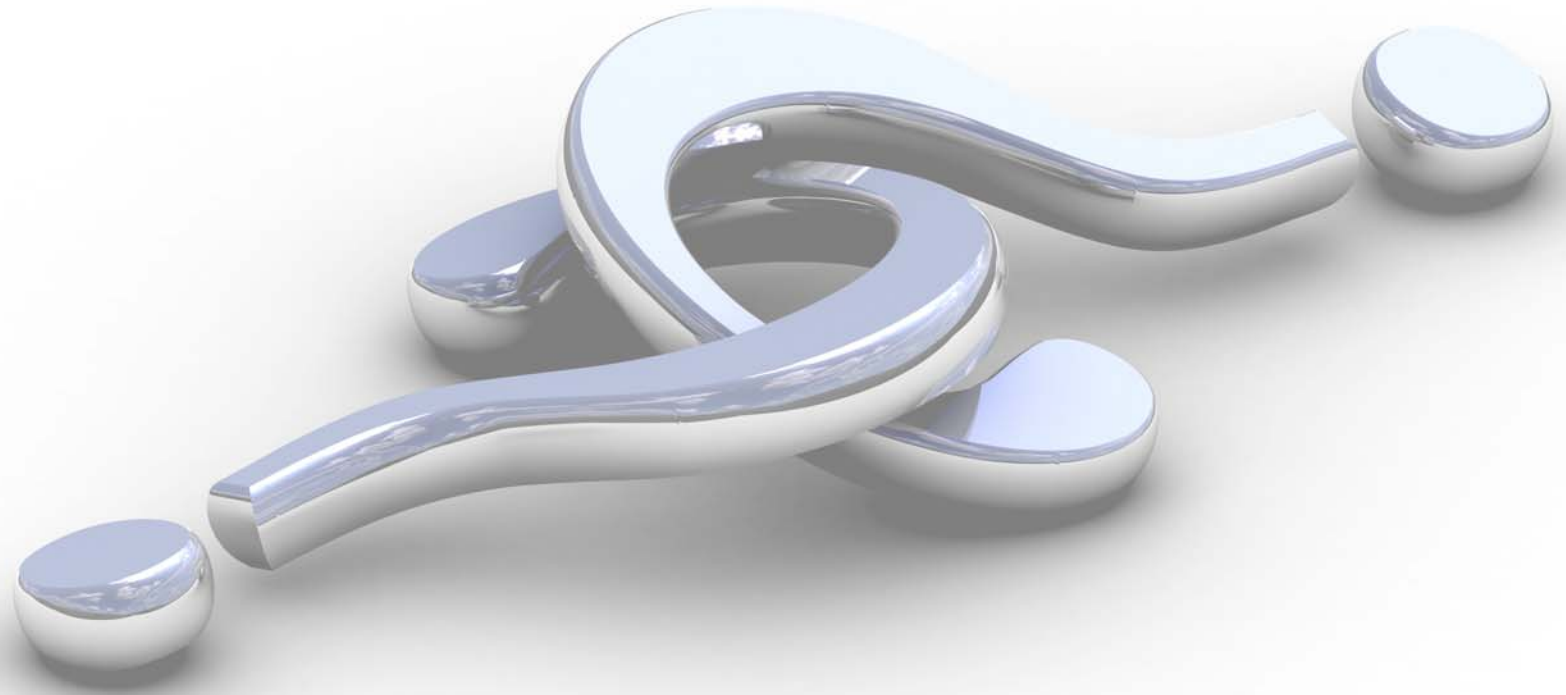


Who is responsible for the quality and safety of care at your healthcare organization?

Answer:

The board

However,
each individual is responsible for his or her own actions.



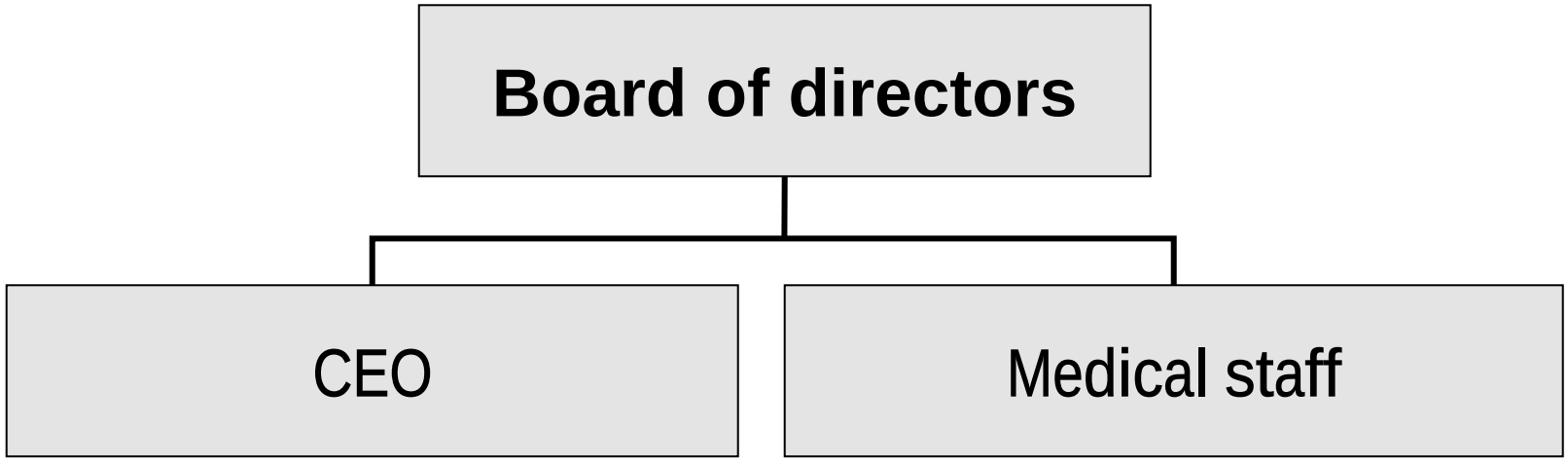
What does the board know about the quality of medical care?

Answer:

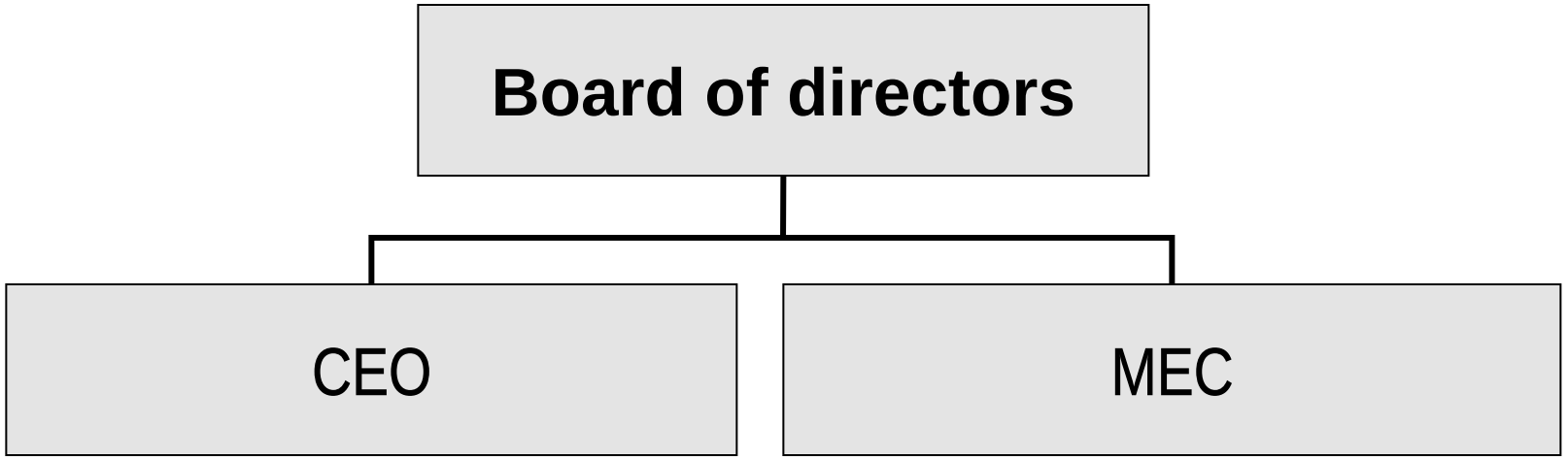
Not a lot.

So, the board assigns responsibility for monitoring and improving the quality of care to the medical staff and management.

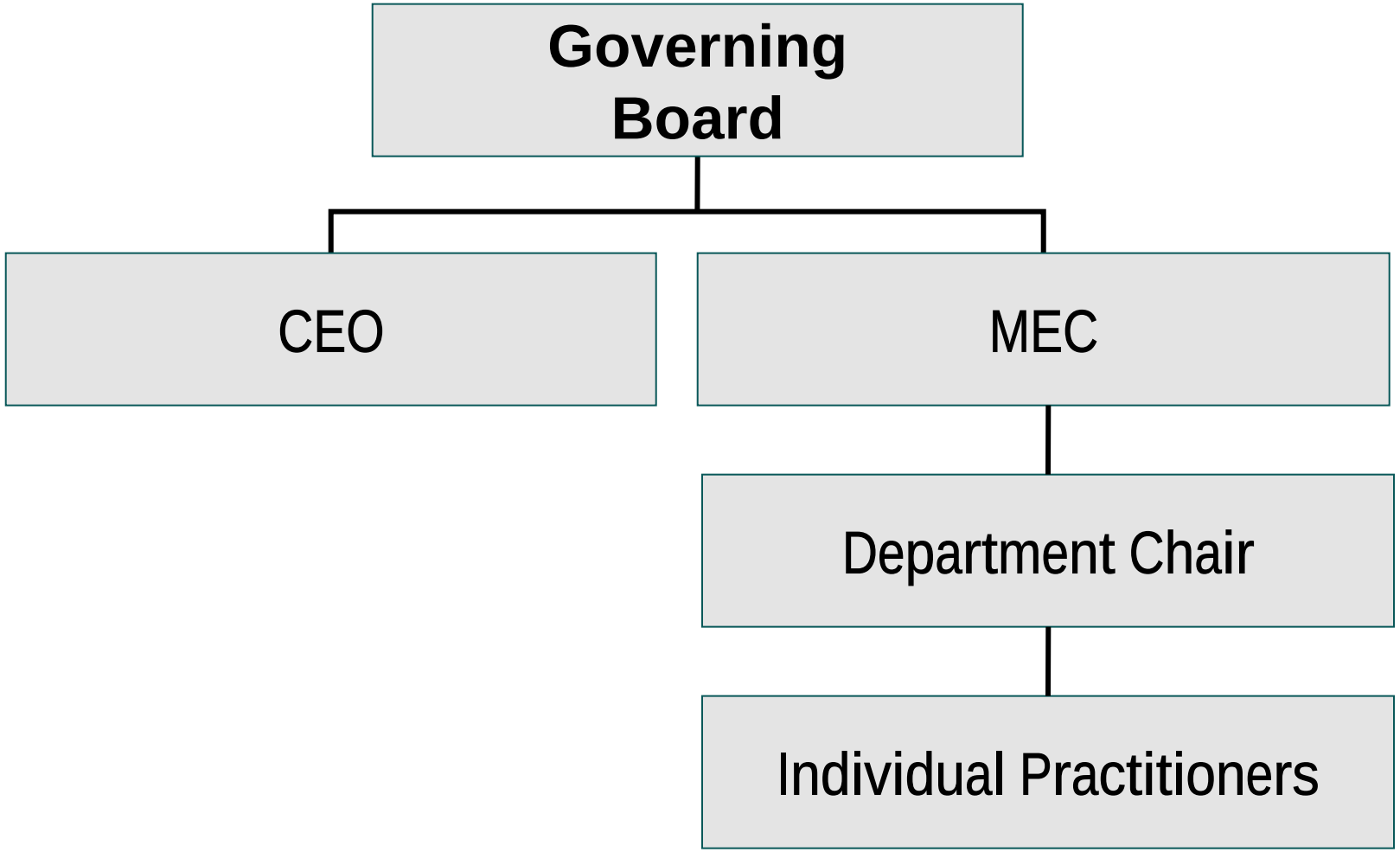
Board, administration, and medical staff relationships



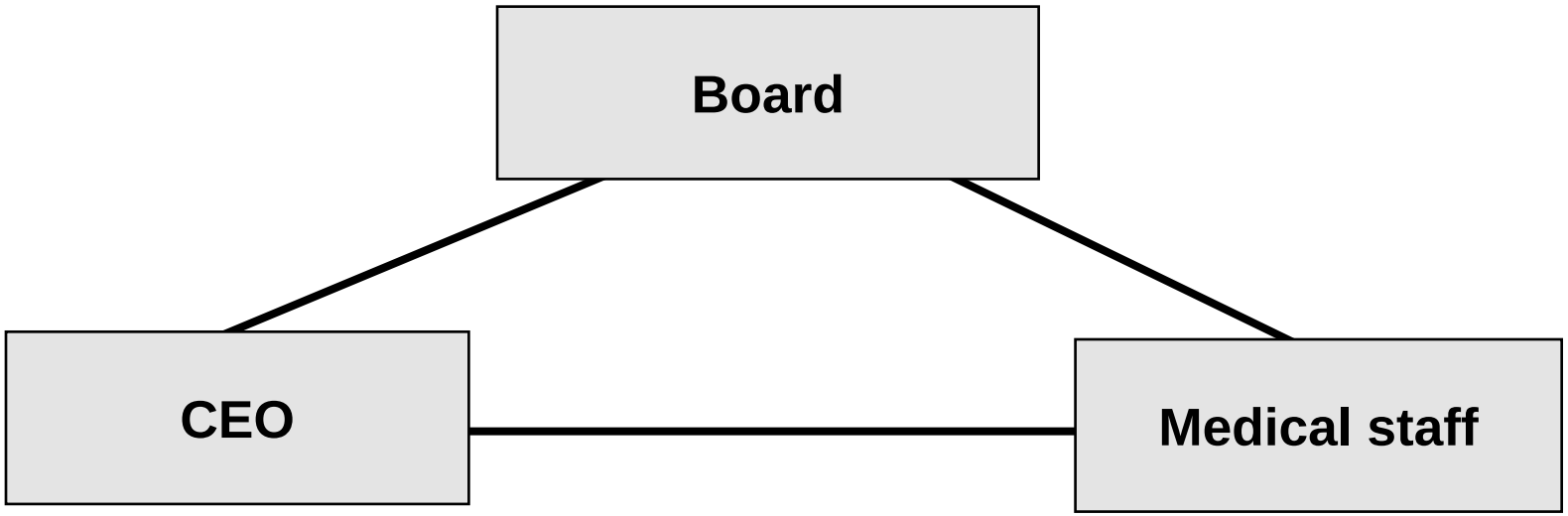
Board, administration, and medical staff relationships



Where do department chairs and individual physicians fit on the organizational chart?



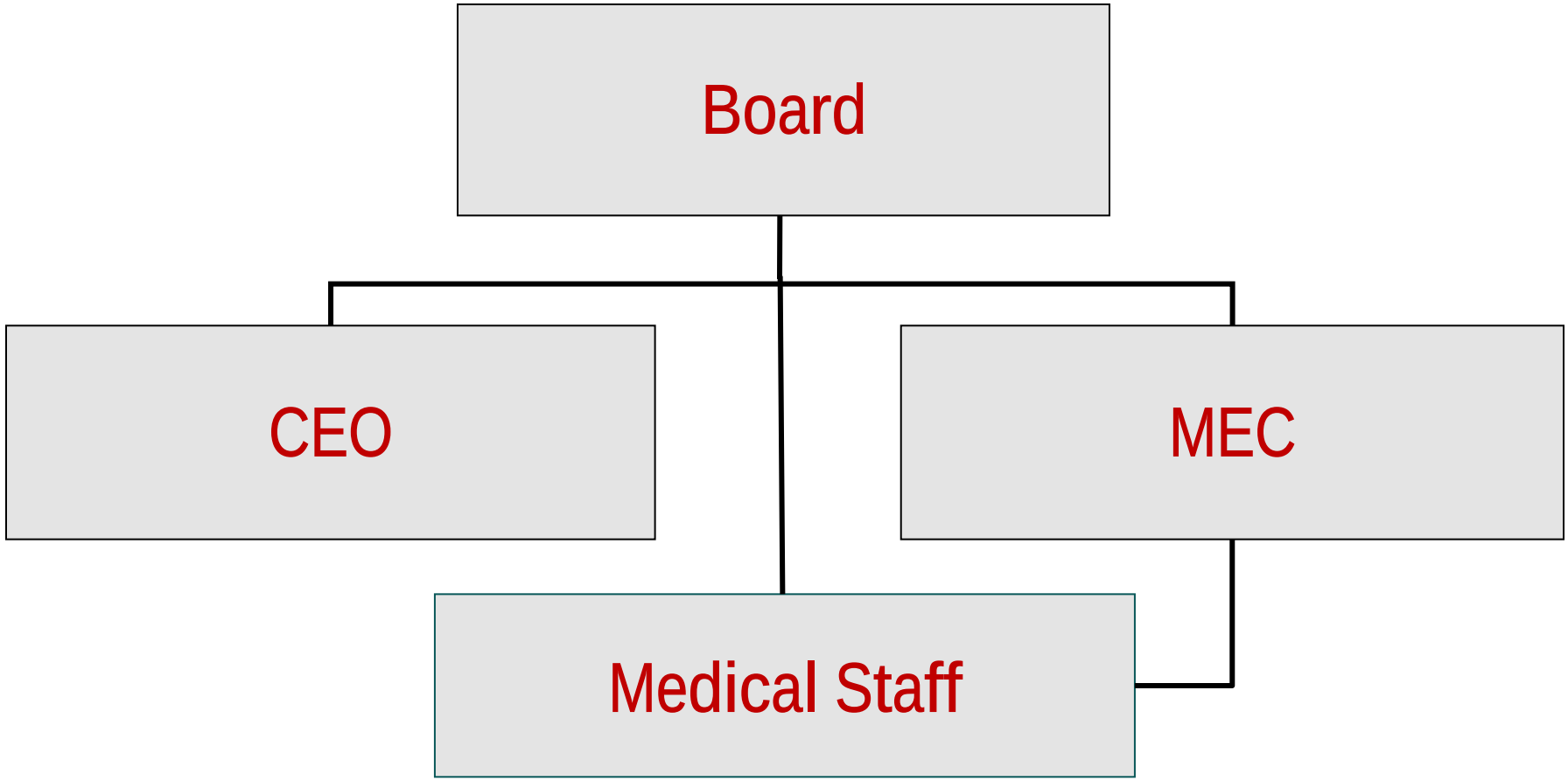
Board, administration, and medical staff relationships



Guiding principle #4

Physicians are accountable to the hospital and partner with the hospital at the same time

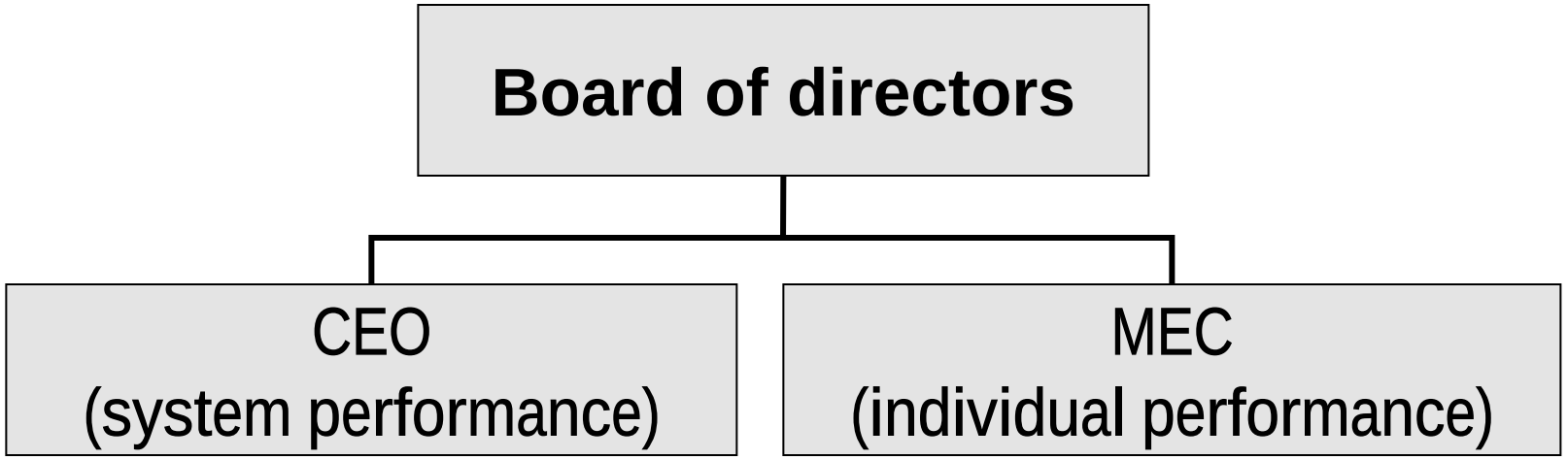
MS.01.01.01 revises the hospital organizational chart



MS.01.01.01 requires

- Governing board, medical staff, and management collaboration
- Medical staff self-governance and accountability to the board
- Medical Staff CoPs must be in the bylaws, including the "basic steps" of those elements, while "associated details" can be in other documents
- Medical staff may recommend directly to the board
- Conflict resolution process between MEC and the medical staff

Board, administration, and medical staff relationships



The medical staff is assigned responsibility for monitoring and improving the quality of care, which depends primarily upon **the performance of individuals granted privileges**

The medical staff democratically organizes through a self-governed structure to carry out these tasks.

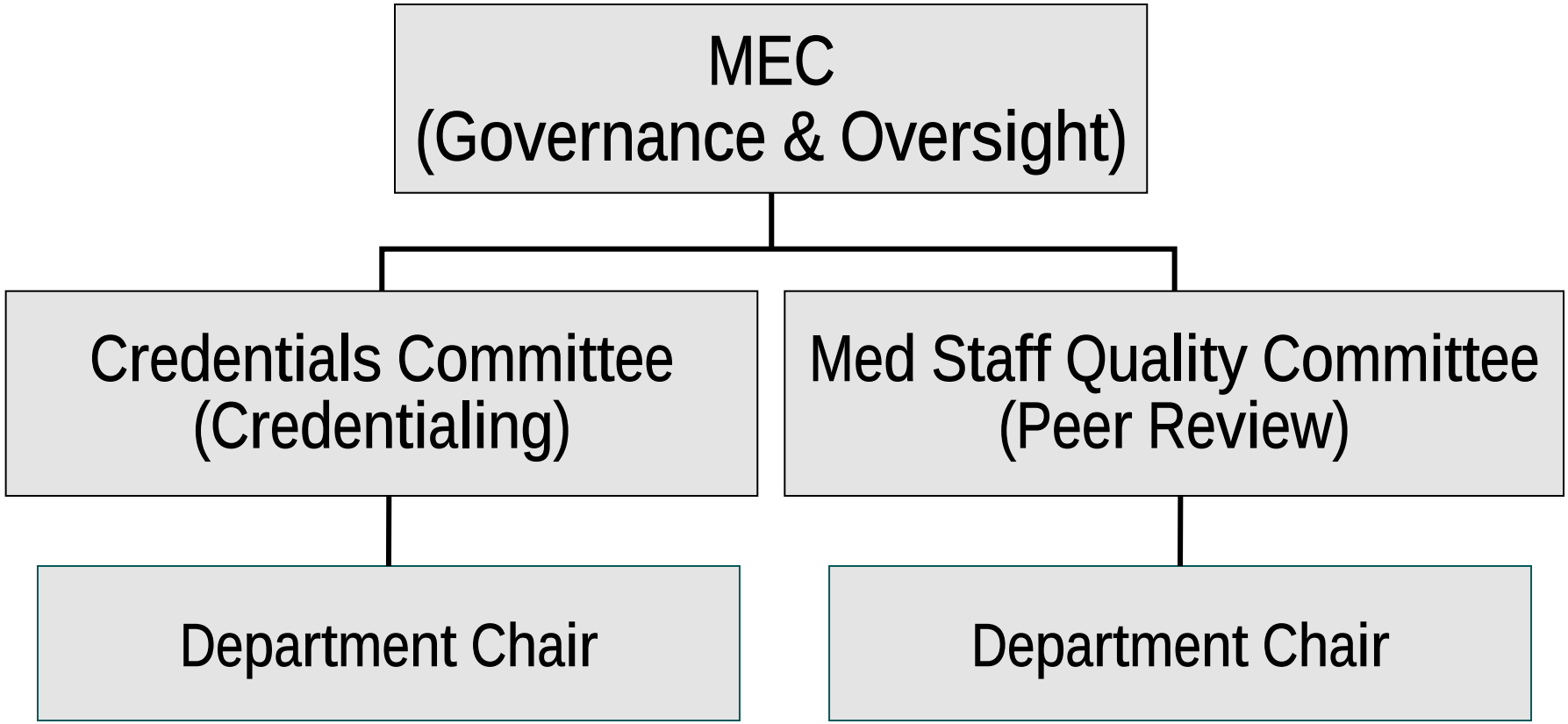
Physicians are mutually accountable to each other for the quality of care they provide.

What is the chief of staff's role?

The responsibility for the organization and conduct of the medical staff must be assigned only to an individual doctor of medicine or osteopathy or, when permitted by state law of the state in which the hospital is located, a doctor of dental surgery or dental medicine.

CMS CoPs 482.22(b)(3)

The medical staff's major functions



Roles of the department chair

- Recommend criteria for privileges for all specialties assigned to the department
- Review credentials files and recommend action on all initial appointments and reappointments for practitioners assigned to the department
- Review and recommend action on all requests for privileges from practitioners assigned to the department

Roles of the department chair

- Participate in peer review (i.e., measurement) consistent with the medical staff's peer review process
- Oversee and improve (i.e., manage) the quality of care and professional conduct of individuals granted privileges and assigned to that department

Roles of the department chair

- Review and, when appropriate, take action on any reports referred to the chair from other medical staff and hospital committees
- Perform any relevant activities assigned by MEC or management (e.g., develop new policies, investigate new technology, evaluate a department specific matter, etc.)

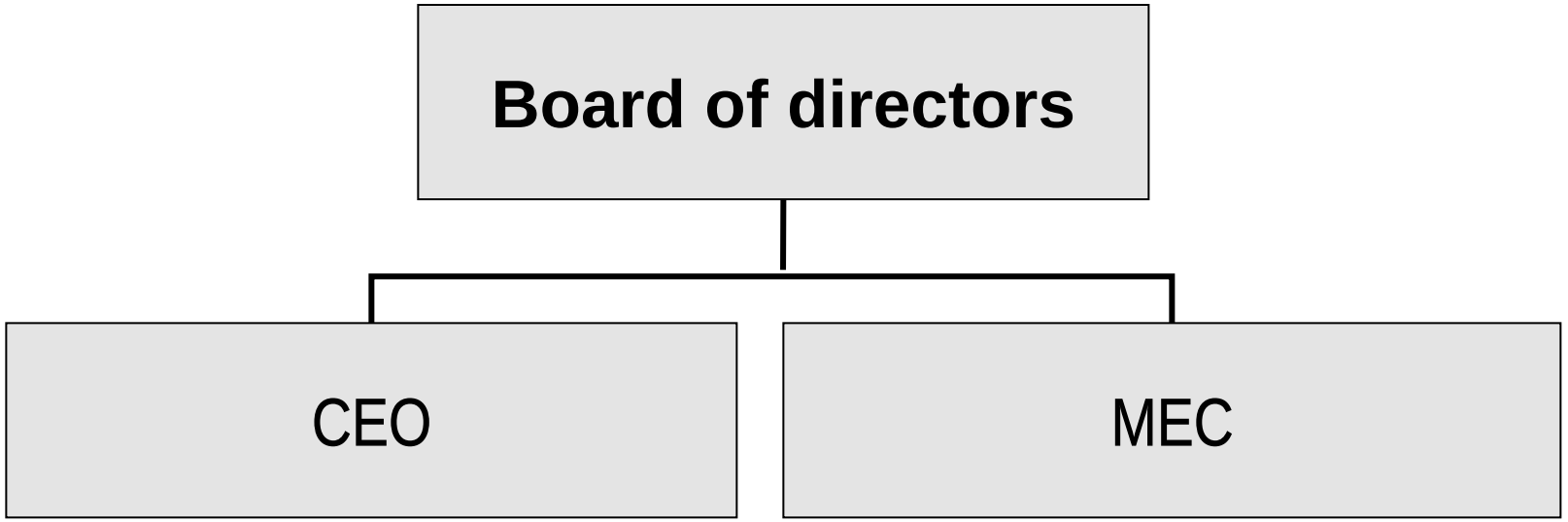
Roles of the department chair

- Represent the interests and needs of the department to other departments and members of the management team
- Orient new members to the department
- Work collaboratively with nursing, management, and medical staff leadership on all matters pertaining to the department and patients cared for by members of the department

What is management's role?

- Meet board-approved targets
- Ensure adequate staffing and facilities
- Provide resources to support the board in fulfilling its responsibilities
- Supply resources to support the medical staff in fulfilling its responsibilities

Where do the VPMA/CMO and medical directors fall on the organization chart?



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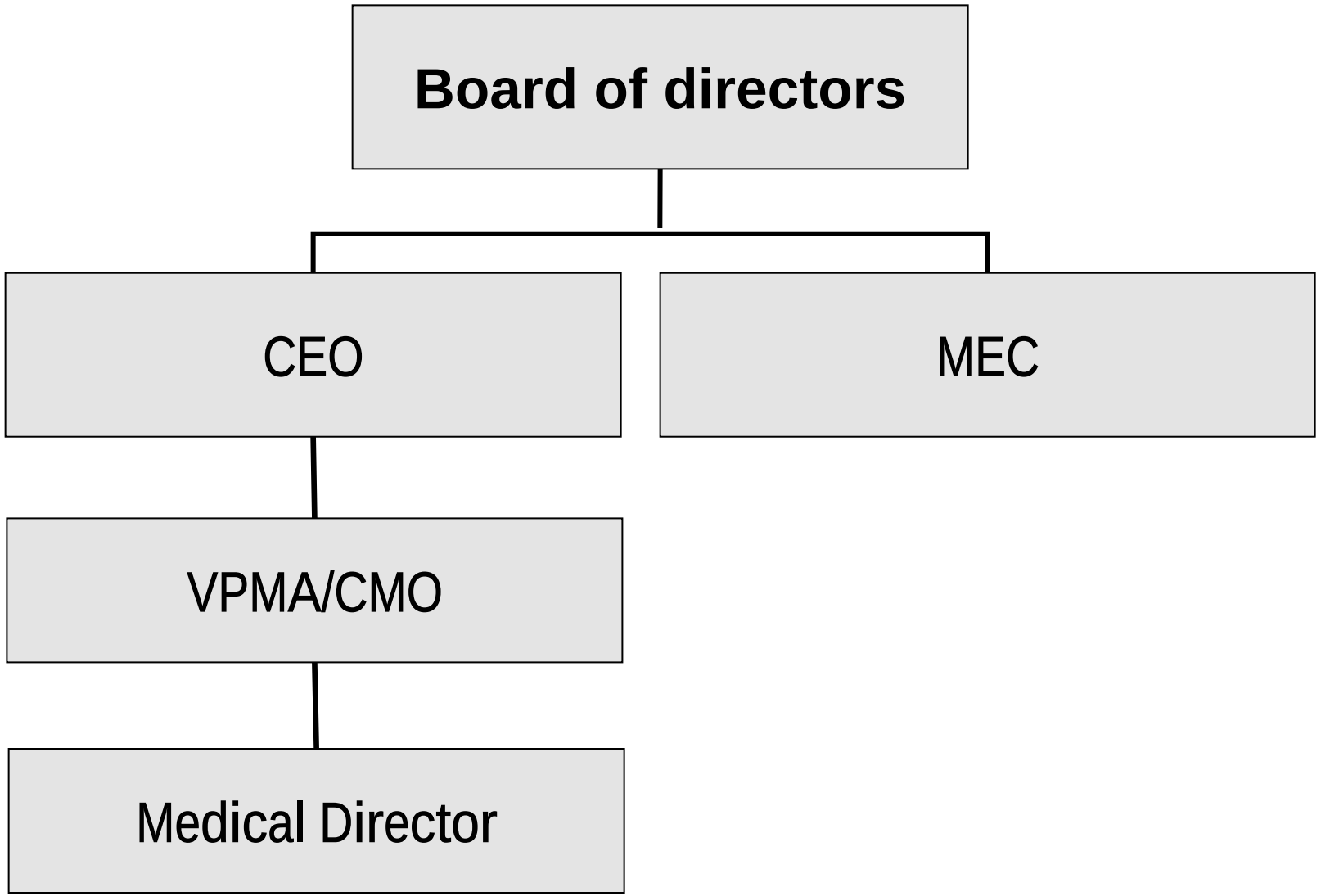

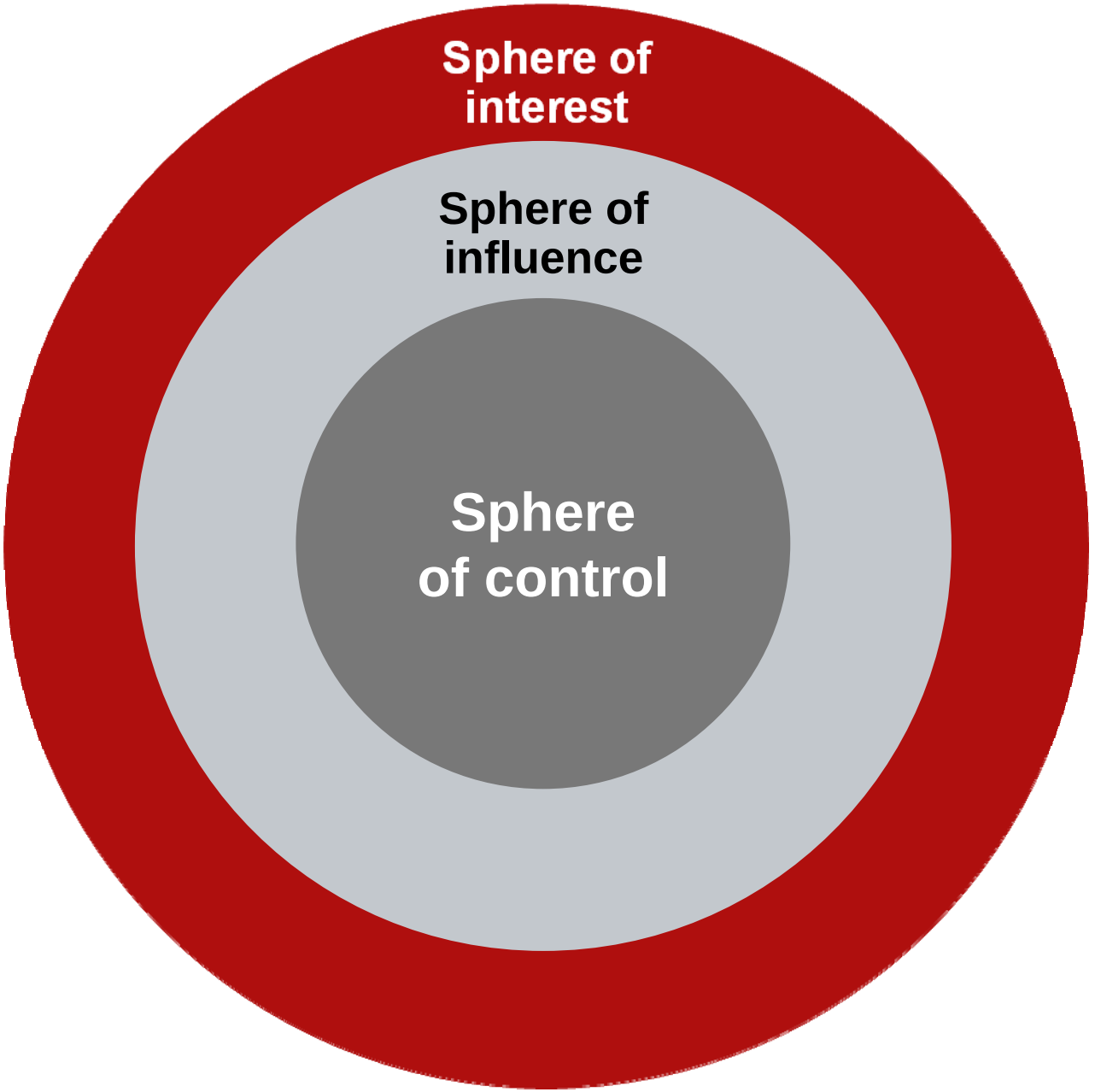
Sphere of interest
Sphere of influence
Sphere of control

The most common CEO question today

The old medical staff model is dead.

What's the new model?

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How did we get here?

- Ernest Codman, MD and the American College of Surgeons (1913)
- Minimum Standards for Hospitals (1919)
- Joint Commission on the Accreditation of Hospitals (1951)
- Medicare and the Conditions of Participation (COPs) (1965)

The original model: Medical staff as club

- Collegial culture
- Democratically organized
- Rotating leadership
- Focus on who's in and who's out
- Advocacy for members

Erosion of the "club"

Unraveling the social fabric of the medical staff

- Audits (1970s)
- DRGs (1983)
- EMTALA (1986)
- Stampede to outpatient care (1990's & 2000's)
- Hospital-physician competition (1990's & 2000's)
- The splintering of medical staff "self interest"
- Gen X and Gen Y physicians aren't joiners
- Withdrawal from the public sphere

Why the Rapid Erosion and Change?

Models of healthcare:

- Pre-industrial
- Industrial
- Post-industrial

Pre-Industrial Model:

- Stimulated by the Flexner Report (1910)
- Cottage industry with proprietary crafts people
- Quality defined by the individual crafts person
- The healthcare organization (workshop) and patients derived secondary benefit

Industrial Model:

- Utilizing the principles of industrial process control to standardize processes, outcomes and costs
- Integrated delivery systems
- Managed care to manage costs
- Employment and contracted relationships

Post-Industrial Model (the "new economy"):

- Immediate access to information
- Compression of time
- Global competition
- Chronic disease management and "wellness"
- Consumer movement to control their own healthcare

Post-Industrial Model (the “new economy”):

- Pro-sumption
- Disintermediation
- Deconstruction

Is the old model up to today's challenges?

- Patient safety
- Cost containment
- ED call
- Performance on public data
- Pay for performance
- Physician accountability
- Physician competency
- Physician behavior
- Physician-hospital competition
- Physician-hospital collaboration

Now what?

In other words …

- The driver of new medical staff models is the imperative to achieve physician success, hospital success, and good care to our community all at the same time while addressing today's medical staff challenges

Candidates for the new model: Self-governance

- Persistent self-governed medical staff with broad membership
- Self-governed medical staff with fewer, more committed physicians
- Self-governed medical staff reporting to CEO as board agent
- Intended practice plan
- Invitation only

Candidates for the new model: Management

- Physician executives and managers
- Service line management
- Contracts
- Physician-nurse dyads

Candidates for the new model: Economic integration

- Physician employment
- Joint ventures
- Medical services organization (MSO)
- Gain sharing
- Service line co-management company
- Physician equity
- Physician-hospital organization (PHO)
- Global pricing
- Accountable care organization

Candidates for the new model: Collaborative leadership and others...

- Physician councils
- Physician-hospital compact
- Large group practice relationship(s)
- Allied health practitioners
- Academic medical center
- Others?

Managing unsolvable problems becomes the key to navigating today's new medical staff models

- Manage loose and manage tight
- Hierarchy and partnership
- Physician success and hospital success and good patient care

Moving from a competent physician to a competent leader

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Traditional attributes

- Clinical respect
- Ability to effect change
- Overview from “above”
- Has the “ear” of senior management
- Sets the agenda
- Creates the tone/culture

Traditional pitfalls

- Autocratic rule
- Conflict of interest
- Quality assurance = “political insurance”
- We vs. they
- Temporary rotating position
- *“Après Moi Le Deluge”*
- Profile Club syndrome

What if:	Instead of:
Due process	Autocratic rule
Accountability	Conflict of interest
Steady performance improvement	Quality assurance
Collaboration	We vs. they
Commitment	Temporary rotating position
Confront and manage	*Après Moi*
Participatory	Profile club

Challenges

- Lack of knowledge/preparation
- Medical education/practice isolation
- Orientation toward acuity
- Captain of the ship
- Aversion to conflict/confrontation
- Immersion syndrome

Development of medical staff leaders ("succession planning")

- Selection/training
- Orientation
- Experience
- Ongoing education
- Mentoring

Leadership compensation

- Job descriptions, with expectations
- Anticipated time commitment
- Will someone volunteer to do this job? If not, how much do we pay?
- Who pays?

Conflict of interest

- Duty:
  To act in good faith with undivided loyalty, without malice or ill will

Culture clash (Physicians and management)

- Physicians value autonomy
  - Managers value teamwork

- Physicians acquire and value technical skills
  - Managers use skills when necessary

Culture clash (cont.)

- Physicians respect individual differences
  - Managers respect systemic uniformity
- Physicians respect individual variation
  - Managers respect necessary variation and attempt to reduce unnecessary variation

Culture clash (cont.)

- Physicians improve the health of individuals
  - Managers improve the health of a defined population
- Physicians consider cost a secondary issue
  - Managers consider cost a primary issue

Culture clash (cont.)

- Physicians like to solve acute problems
  - Managers need to manage chronic problems
- Physicians work with individuals
  - Managers work with systems

How to Run a Meeting So Physicians Will Come (and thank you!)

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Many long-established committees are little more than memorials to dead problems.

Antony Jay,
Corporation Man and
Management and Machiavelli

Cost of the meeting can be put on the top of the agenda

- For a typical roomful of doctors (nine), plus staff members, the meeting costs about $9,000 per hour …

- Are you getting your money's worth?

The old way to run a meeting

- Started late
- Lacked preparation
- Raised controversial topics
- Discussion monopolized by few
- Ceremonial dog and pony shows/ grandstanding/axe grinding
- Profile Club syndrome

Basic rules

- Plan your agenda
- Set up your room
- Start on time
- Limit nonproductive discussion
- Move the agenda
- Assign items for further development
- End on time

Plan your agenda

- If you don’t have a good reason for meeting, don’t have the meeting!

Plan your agenda (cont.)

- Premeeting with assistant, advisors
- Premeeting with key stakeholders
- Create a consent agenda

Plan your agenda (cont.)

- Put important items first
  - No need to follow traditional format
- Allot a specific amount of time for each agenda item
- Prepare materials needed for decision-making

Set up your room

- Arrive at least 10 minutes in advance
- Set up the tables and chairs for the most effective meeting configuration
- Arrange for any appropriate AV equipment:
  - Whiteboards
  - Flip charts
  - LCD projector

Start on time

- People will always arrive late unless you establish that you start on time every time
- Requires bylaws that define “quorum” as “those present”
- People will be late only the first time

Establish your leadership

- Table position
- Body language
- Tone of voice

Limit nonproductive discussion

- Aim of the meeting is to make decisions, not emotional expression, endless processing, or social gathering
- Solicit active input from all participants and limit the vocal minority
- Establish a bias toward action

Move the agenda

- Stay on task
- Use skillful interruption
- If discussion is not progressing toward a decision, terminate it, and assign one or two interested members to research and bring back recommendation (beer-and-pizza method)

Consensus vs. majority rule

Question: What do you call a medical staff vote of 99 to one?

Answer: A tie

Consensus vs. majority rule (cont.)

+3	We must do this
+2	We should do this
+1	I support this
0	I'm neutral
-1	I don't support this but won't oppose it
-2	We should not do this
-3	We must not do this

End on time

Key role of the chair

"To be a servant of the group rather than its master … to assist the group towards the best decision in the most efficient manner possible: to interpret and clarify, move the discussion forward, and bring it to a resolution that everyone understands and accepts as being the will of the meeting, even if individuals do not necessarily agree … "

—Antony Jay

Meetings management

- Task vs. people:
  - Leader and facilitator
- Meet only when interpersonal, face-to-face processing of information is necessary to add value and advance goals/culture.

Conflict Resolution, Negotiation, and Mediation for Medical Staff Leaders

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...And the problem is:

For every complex problem, there is a solution that is simple, direct, and wrong.

—H.L. Mencken

“The opposite of a deeply held truth is not a lie, but another deeply held truth.”

—Neils Bohr, physicist

What are the rules of the game?

- Position-based negotiation
- Power-based negotiation
- Interest-based negotiation
- Principle-based negotiation

Position-based negotiation

- It's about fighting for your position:
  - Begin by staking out a position
  - Incremental "giving up" of positions
  - Creates resentment and a sense of "losing something" at every step
- Key strategy: Give up as little as possible
- Goal: Get as much as you can for yourself

Power-based negotiation

- It’s a game to play
- Every “move” is a gambit
- Key strategy: Gain leverage over the other
- Goal: Win

Gambits

- Bracketing
- The “flinch”
- Withholding information
- Tricking the other person into disclosures
- “I’ll share this if you’ll share something in return”
- Signaling through changes in position
- “Are we done?”

Interest-based negotiation

- Moves beyond positions to interests
- Key strategy: “Enlarge the pie”
- Goal: Shared problem solving and mutual understanding

Interest-based negotiation

- People: Separate people from the problem
- Interests: Focus on interests, not positions
- Options: Generate a variety of possibilities before deciding what to do
- Criteria: Insist that the result be based on some objective standard

Principle-based negotiation

- Search for shared values
- Used to split differences once the pie is as big as it can be
- Key strategy: Identify, clarify, and optimize shared values
- Goal: Maximize fairness for all parties

What if you can't get to "yes"?

- Know your BATNA!
  - Best alternative to a negotiated agreement

To be understood …

Seek first to understand.

—Stephen Covey

and Saint Francis of Assisi

The source of power and influence

"Never expect anyone to engage in behavior that serves your values until you have given that person adequate reason to do so."

—Charles Dwyer

Effective Medical Staff or Obsolete Medical Staff?

How can physicians hold each other accountable?

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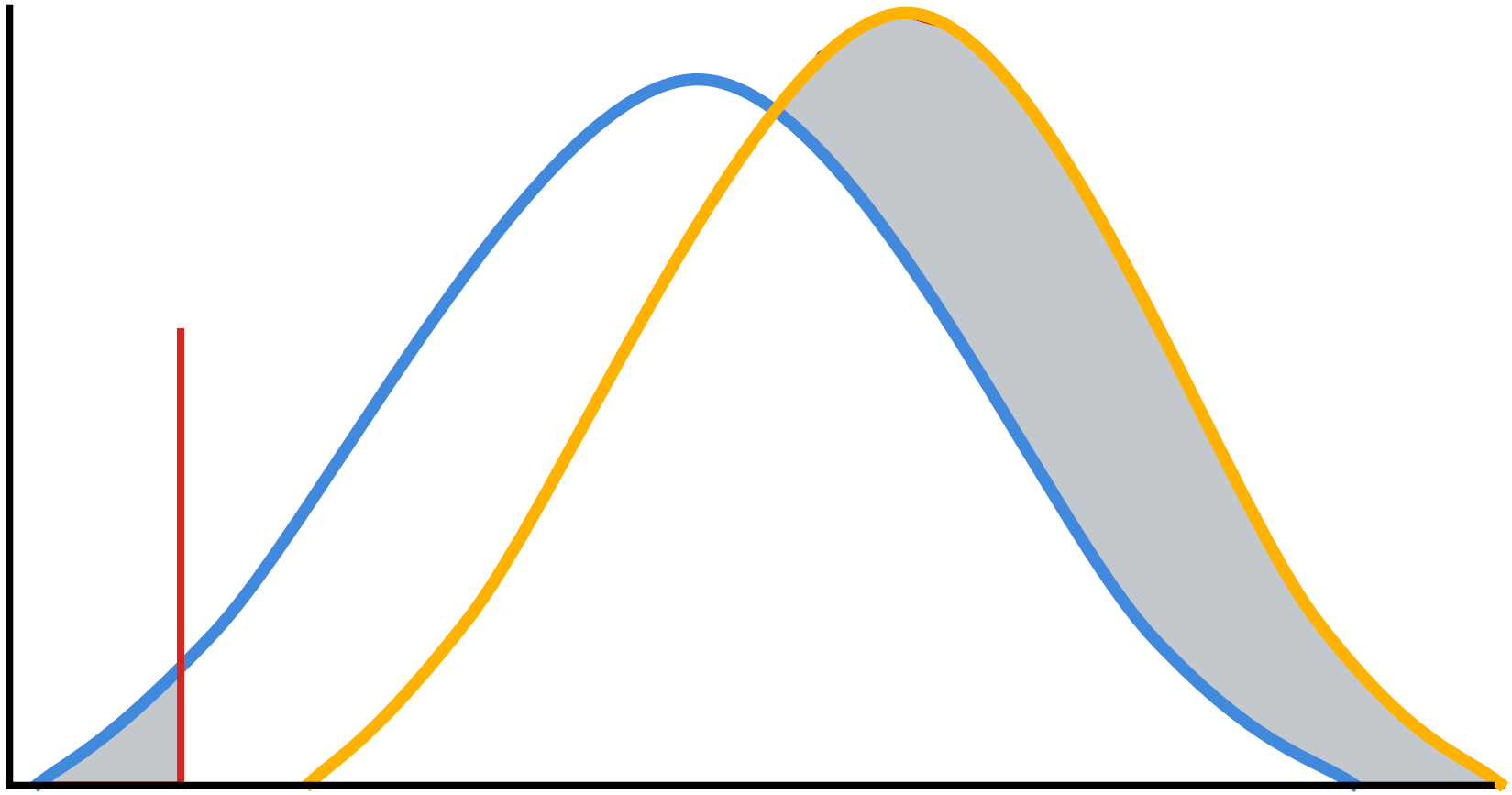
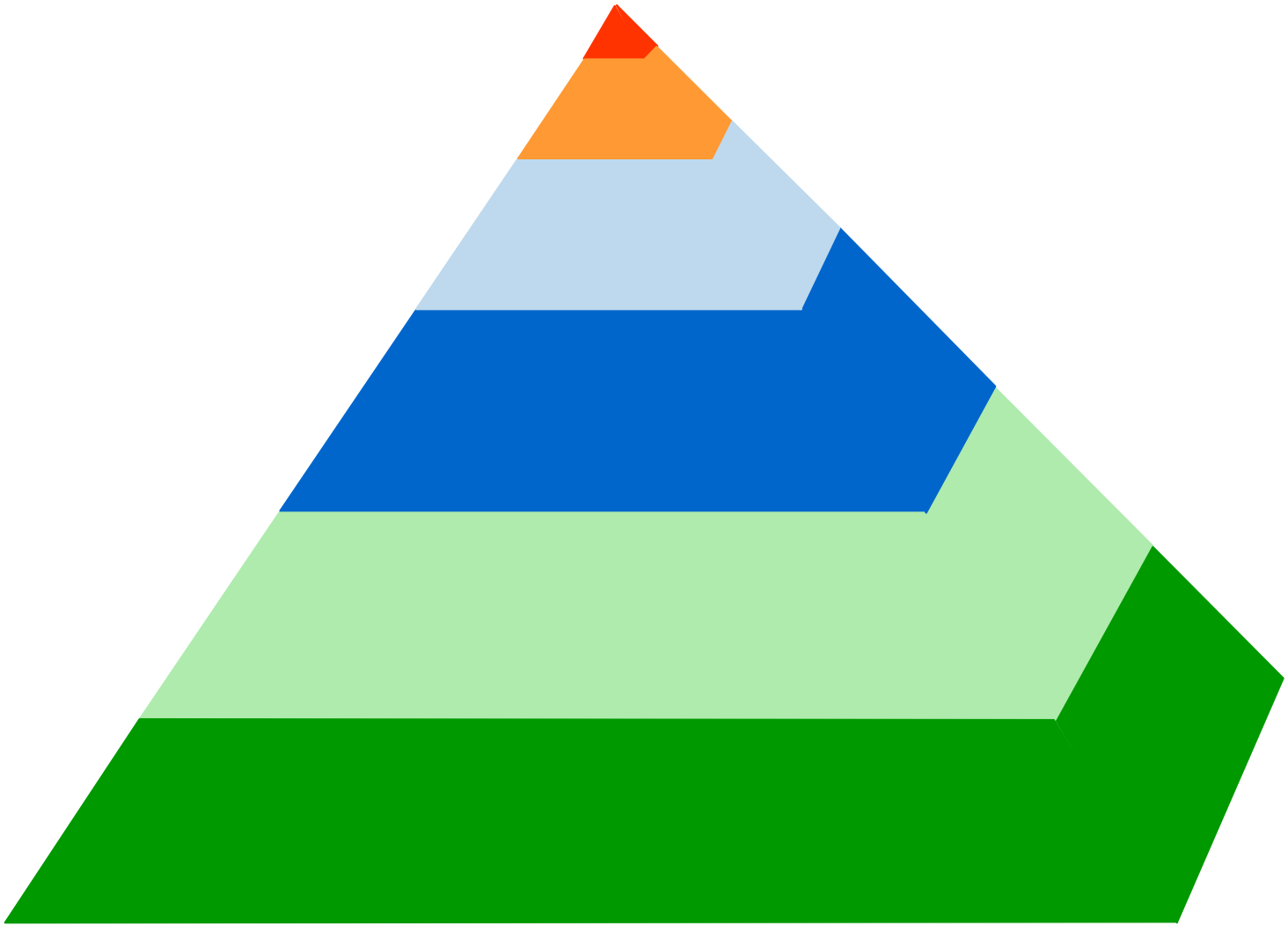
The bad-apple theory versus performance improvement



The Power of the Pyramid

Achieving great physician performance



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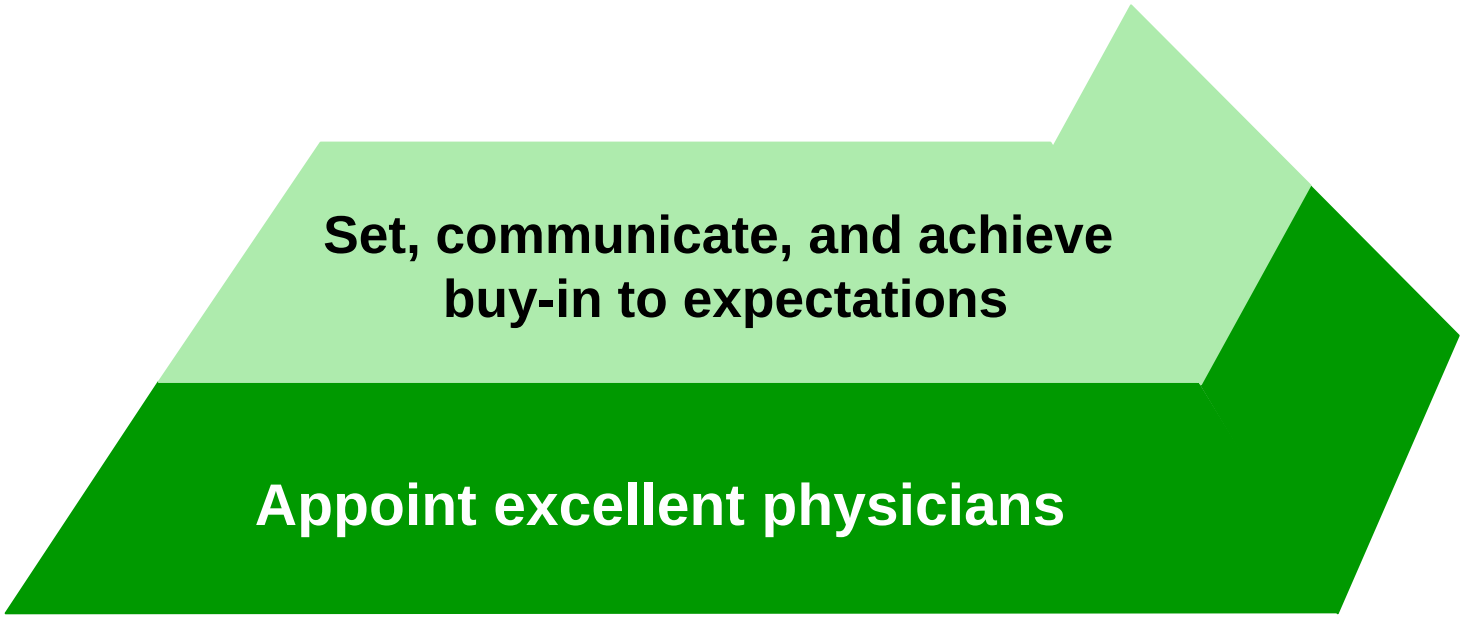

Dimensions of physician performance (ACPE/Greeley)

- Technical quality of care
- Quality of service
- Patient safety/patient rights
- Resource utilization
- Peer and coworker relationships
- Citizenship

Dimensions of physician performance (ACGME/The Joint Commission)

- Patient care
- Medical/clinical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

Comparison of the Joint Commission's General Physician Competencies with the Physician Performance Pyramid dimensions

JOINT COMISSION PYRAMID	Patient Care	Medical Knowledge	Practice Based Learning	Interpersonal/ Communication Skills	Professionalism	Systems Based Practice
Technical Quality	X	X	X			
Service Quality	X			X		X
Patient Safety/ Rights	X		X		X	X
Resource Use	X	X	X			X
Relationships				X	X	
Citizenship					X	X

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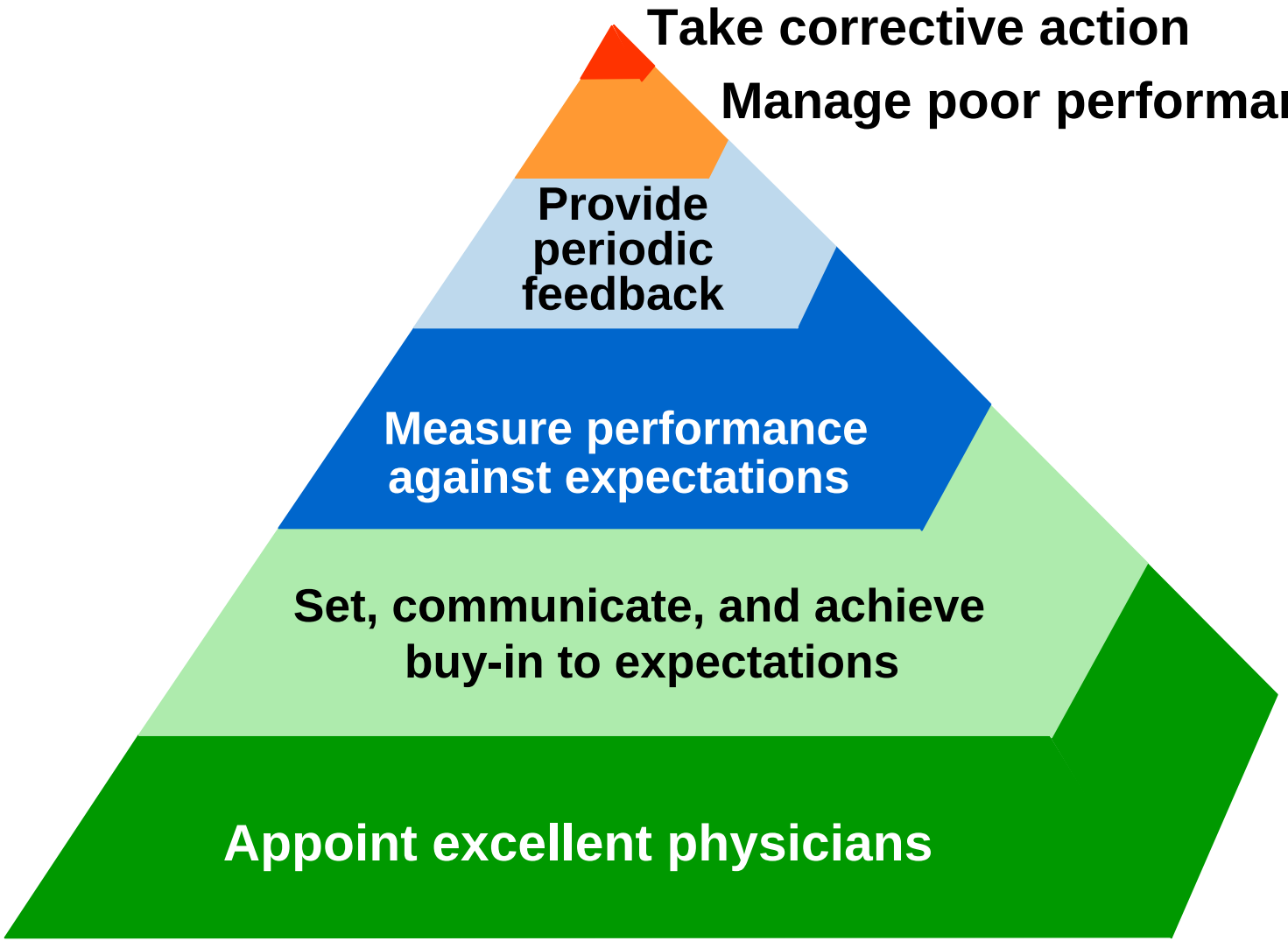

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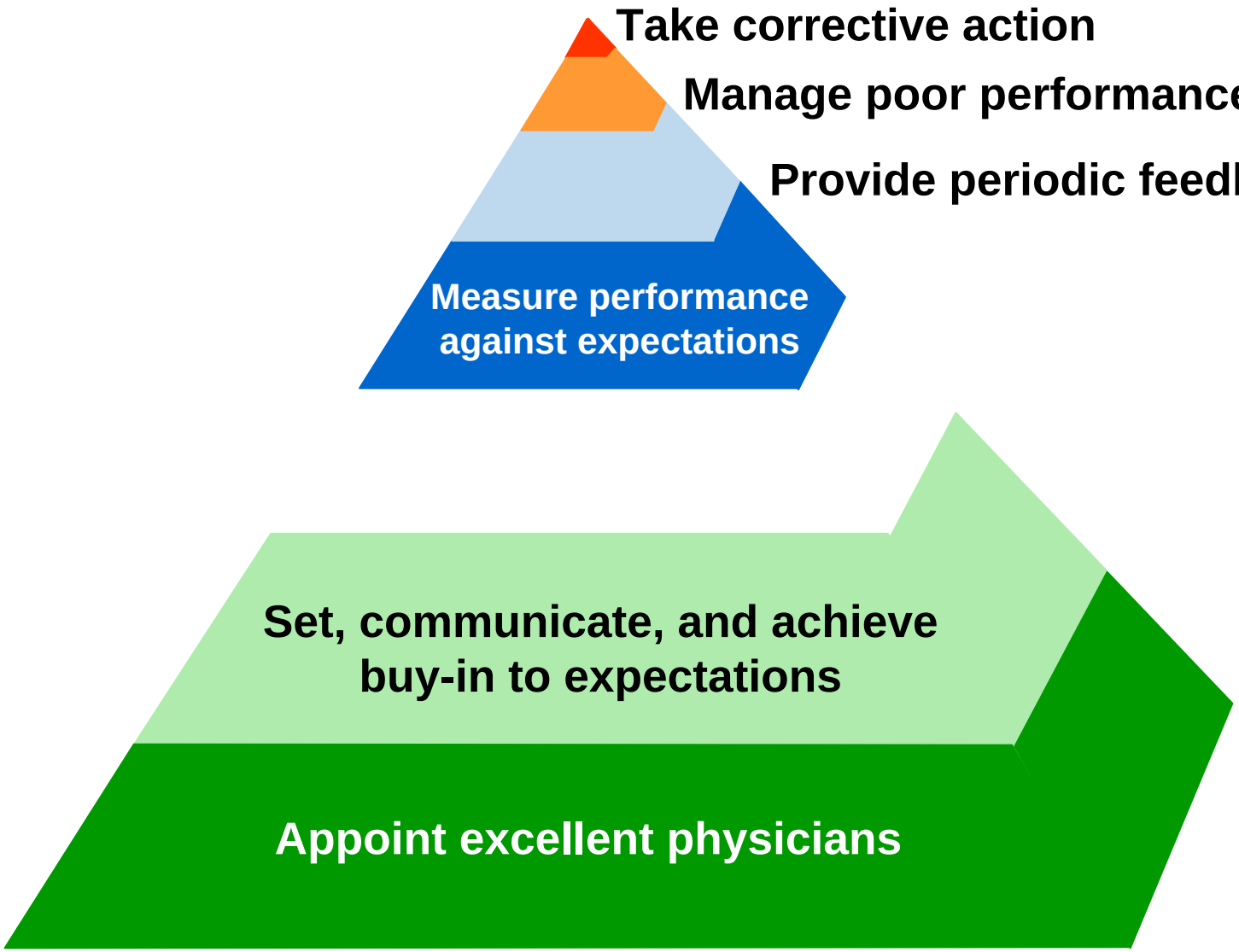

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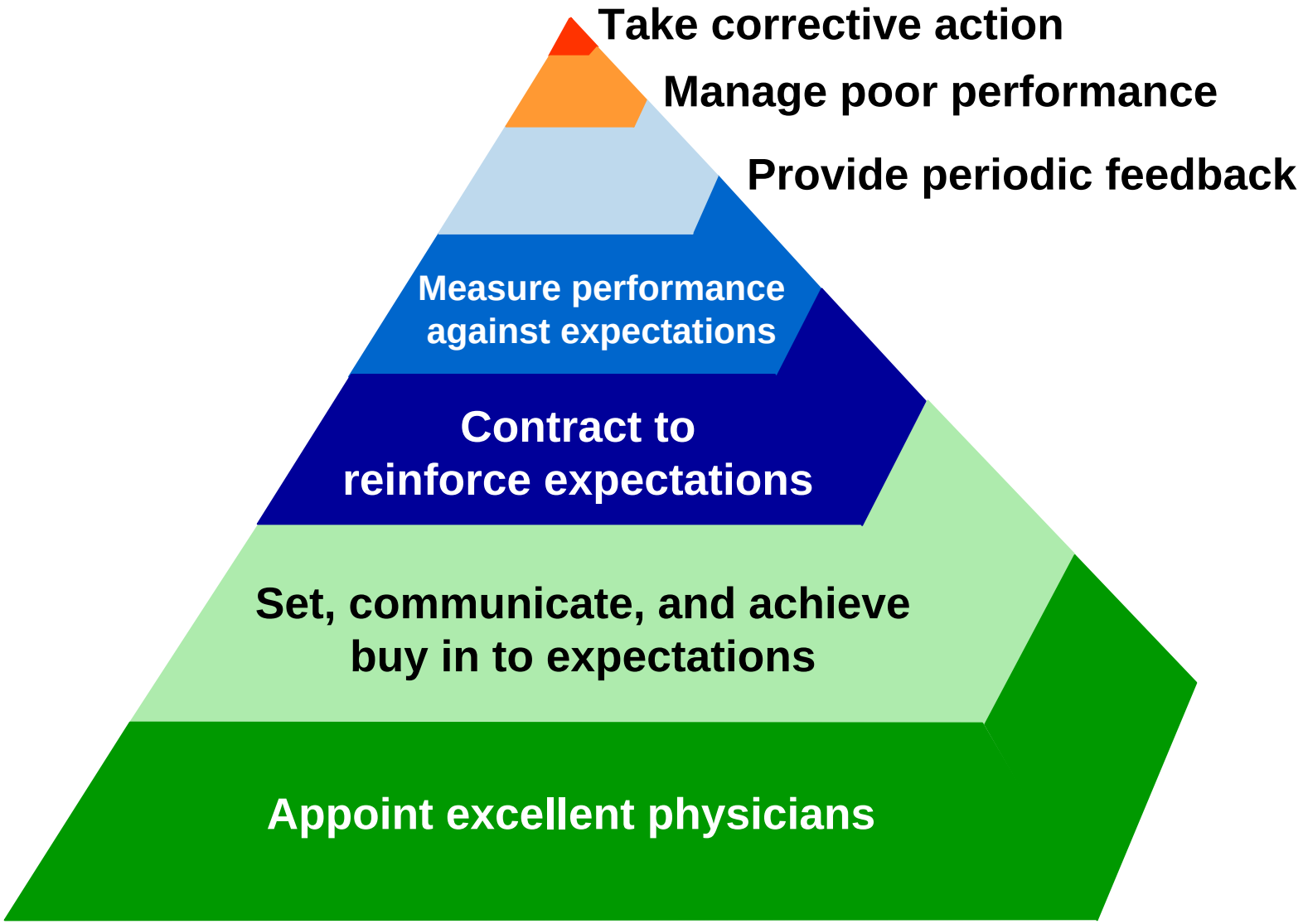

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