

Medical Staff Briefing

A TRAINING RESOURCE FOR MEDICAL STAFF LEADERS AND PROFESSIONALS

Does your governing board understand medical staff issues? Help boards perform better under the watchful eye of regulators

Do your hospital governing board members understand why peer review is such a contentious issue among physicians? Can they map out the credentialing process? Have they read the medical staff bylaws? For many hospitals, the answer to these questions is “no,” says **Napoleon Knight, MD, CPE, CMSL**, vice president of medical affairs and chief medical officer at Carle Foundation Hospital in Urbana, IL.

“Most board members don’t understand how the medical staff functions in terms of who is responsible for what, who reports to who, and how matters affecting the medical staff are handled,” Knight says.

Hospital administration is ultimately responsible for providing governing board members with the resources

and education they need to carry out their duties, but not all hospitals provide adequate training.

The need for knowledgeable board members is growing, according to *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors*, a white paper issued by the Office of Inspector General (OIG) and the American Health Lawyers Association. The report states the following:

Important new policy issues are arising with respect to how quality of care affects matters of reimbursement and payment, efficiency, cost controls, collaboration between organizational providers and individual and group practitioners. These new issues are so critical to the operation of healthcare organizations that they require attention and oversight, as a matter of fiduciary obligation, by the governing board.

“Most board members don’t understand how the medical staff functions in terms of who is responsible for what, who reports to whom, and how matters affecting the medical staff are handled.”

—**Napoleon Knight, MD, CPE, CMSL**

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Thus, physician leaders must be more involved in educating the governing board on issues that affect quality of care, “which is just about everything,” says **Michael Callahan, Esq.**, of Katten Muchin Rosenman, LLP, in Chicago. “Those boards that are not going down the path of monitoring quality, adopting evidence-based standards, and proper credentialing are being held responsible for bad outcomes.” (For more information about the governing board’s responsibilities, see “Governing boards 101” on p. 3.)

To help boards meet these heightened expectations, physician leaders should work with hospital administration

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Governing board

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to ensure that board members are educated on the medical staff's four primary functions: credentialing, privileging, bylaws, and peer review. The following are some tips to get you started:

► Solicit feedback from existing board members.

If you want to know how you can improve the board's knowledge of medical staff issues, Knight suggests asking existing members the following questions:

- What do you wish you knew when you first came on board?
- What would you like to know more about now that you have some experience on the board?
- What would help you better perform your duties in the future?

As chief medical officer, Knight presents regularly to the governing board, and many of his presentations are based on questions that board members ask him. "For example, at one of our board meetings, one of the members asked, 'How is it that a radiologist in Australia is reviewing x-rays taken at our hospital?' That led me

to create a 30-minute PowerPoint presentation about teleradiology," he says.

► **Roll out the welcome mat.** Have you ever joined a committee and, during your first meeting, felt so lost that you wondered, "Am I in the right room?" Don't let that happen to your board members. Knight recommends presenting them with a welcome packet that contains the following items:

- A summary of the governing board's responsibilities and the medical staff's/hospital's expectations of its members
- Minutes from one or two past meetings to provide new members with a sense of how meetings are conducted and which issues are discussed during meetings
- A list of acronyms and medical lingo and definitions
- An invitation to attend an educational session for new board members provided by an external consulting or education firm (if the hospital does not have in place its own formalized education program for board members)

To help guide newcomers into their role, ask an experienced board member to serve as a mentor. "The new member can call the mentor and say, 'I really don't understand this. Can we talk about it so I understand what is going on at the meeting?'" says Knight. "The new member can get practical knowledge and ramp up to speed pretty quickly."

► **Set time aside at each meeting for education.** "One of the best practices that I have seen is that at some point, either before, during, or after the board meeting, there is a focused education session," says **William K. Cors, MD, MMM, FACPE, CMSL**, vice president of medical staff services at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

Plan these education sessions ahead of time, since they will require you to pull resources from across the hospital. For example, the chief financial officer may present on healthcare finance, an MSP may explain the ins and outs

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of the application process, or the hospital's legal counsel may speak about risk management.

When developing a curriculum, Cors and Knight suggest introducing board members to the following medical staff topics:

- Credentialing
- Privileging
- Peer review
- Physician performance measurement systems
- How your organization defines quality
- Medical staff bylaws

Hospital administration will most likely organize educational events focused on hospital operations, corporate bylaws, finance, transparency and public accountability, and healthcare reform. At any given time, your board most likely consists of green and veteran members, so don't worry if some of the board members have heard presentations about peer review three times. "It takes several repetitions for something to really sink in," says Cors.

► **Speak the same language.** Since most board members are laypeople from the community, such as

bankers and business owners, assume that they don't know what "NPDB" or "CMS" stand for, says Knight. It's important to include a list of acronyms and jargon to newcomers to help them get acquainted with health-care terminology.

However, don't assume that the board member is going to scan the list every time he or she hears a new word or acronym—spell out terms in your presentations to accommodate for the learning curve. "Whenever I create a presentation, I'll give it to a layperson and ask, 'Can you read this and tell me if there is anything that doesn't make sense?'" Knight says.

► **Require the president of the medical staff and other physician leaders to sit on the governing board.** No regulatory agency dictates the composition of the governing board. The medical staff president/chief of staff often sits on the governing board by virtue of his or her leadership position, but this is not always the case. Some hospitals may worry that having the president of the medical staff/chief of staff sit on the board represents a conflict of interest.

"They have to understand that by having the president of the medical staff serve as an ex officio member of the board, they are likely to get a representative whose interests are solely aligned with the medical staff and not the hospital," says Callahan.

However, having medical staff representation on the board is critical to the board's understanding of medical staff issues. "Best practice is to have the president of the medical staff, at a minimum, sit on the governing board to represent the medical staff," says Cors. "Also, have physician representation on the board to capture clinical expertise."

► **Invite board member to attend credentials committee meetings.** By inviting a board member to sit in on credentials committee or medical executive committee (MEC) meetings without a vote, you allow them to witness how medical staff business is conducted.

"Let's say you have a thorny credentialing issue that gets to the board. You have a member who has sat

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Governing boards 101

The hospital governing board is ultimately responsible for the hospital's performance. It performs two functions. First, it ensures the quality of care provided by the individuals who have been granted privileges at the hospital. To fulfill that responsibility, the board oversees the quality of the credentialing, privileging, and peer review processes.

Second, the board hires a CEO, who forms an administrative team that is capable of making smart strategic and financial decisions.

Boards are typically comprised of laypeople from the community, such as bankers and business owners. Physicians who are on the hospital's medical staff may also sit on the board, but rather than representing the medical staff, they serve as community members with medical expertise.

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

Governing board

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through the whole process and can attest to the fact that it was a thorough process," says Cors.

Callahan adds that not every member of the board can have expertise in each of the medical staffs' primary functions. "Delegating learning to certain people by having them sit on various medical staff committees gives them a way to gain insight into certain areas, and they can bring what they learned back to the full board," he says.

Board member education required in New Jersey

New Jersey is the only state that requires hospital governing board members to receive education regarding their duties and responsibilities. According to 40 NJR 3553 (a), any governing board member appointed after April 30, 2007, must receive seven hours of training within six months of appointment. The governing board member must participate in an educational program that has been approved by state agencies and includes a review of financial, organizational, legal, regulatory, and ethical issues.

As of July 30, 2009, the Health Research and Education Trust of New Jersey offers two courses: "Understanding and Interpreting Financial Reports" and "The Mission and the Margin," which describes the board's responsibilities and how to achieve them. Check out the New Jersey Hospital Association's Web site (www.njha.com) for other great topics to present to your own board members.

► **Host a retreat for the MEC, administration, and governing board.** By inviting the MEC, administration, and governing board to a retreat, each group can educate the others on their functions and responsibilities. It also helps members of all three groups to build social capital, which is essential to having a positive working relationship.

"Medical staffs have this idea that the board is some mysterious body that sits in a room and rubber stamps things that the CEO wants," says Cors. By allowing the board members to introduce themselves to the MEC and hospital administration, that tension is reduced. "When you can put a face to a name, it takes some of the mystery out," he says.

Cors recommends that the retreat not focus on fundraising for the hospital. "Sometimes, the only time these bodies come together is on the golf course for a fundraiser. To build social capital, you want to get people together for non-fundraising activities."

As the OIG places more accountability on governing boards for hospital performance, they must be involved in more than just strategic planning and finances. By educating board members about medical staff functions, physician leaders are ensuring that their boards will successfully fulfill their responsibilities. ■

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The new marketing frontier: Recruit physicians by engaging in social media Web sites

As a medical staff leader or MSP, if you had to sum up your duties in three sentences, could you do it? Could you also make it sound appealing enough to convince a stranger to move 1,000 miles to take over your position?

Most MSPs and medical staff leaders have not been formally trained to create and disseminate attention-grabbing messages to recruit physicians. However, many are being asked by hospital administrators to do just that.

“A number of the MSPs throughout the country also do recruiting. In fact, a large number of them are getting certified as recruiters, largely due to cutbacks at hospitals,” says **Richard Baker, CPMSM, CPCS**, director of medical staff services at Gulf Coast Medical Center in Panama City, FL. Although medical staff leaders are already somewhat involved in recruiting, hospital cutbacks are forcing them to hone their marketing skills as well.

MSPs and medical staff leaders with newfound recruiting responsibilities should first familiarize themselves with social networking sites, such as Facebook (www.facebook.com), Twitter (www.twitter.com), and LinkedIn (www.linkedin.com), because physicians are increasingly turning to these sites to help them find new career opportunities.

If you’ve never heard of these social media sites, here’s a quick rundown. Twitter allows users to send 140-character updates (i.e., “tweets”) in real time. Facebook allows users to create personal profiles filled with photos, messages, and links. LinkedIn is a professional networking site for people who want to keep in touch with industry peers or move up the career ladder. All three sites are free, although LinkedIn charges a fee for some of its premium features.

Create the right message

Writing tweets is a far cry from writing lengthy advertisements for specialty or association journals. So how do you boil down your messages and make them appealing

to physicians using social networking media? Get started with the following tips:

➤ **Know your audience.** If you are untrained in recruiting and marketing practices, you may fall into the trap of describing career opportunities for physicians in a way that appeals to you, and not necessarily the physician. “Usually, people write about what they like about the community or what they think is great about the hospital,” says **Shannon Penney**, director of recruiting at Delta Physician Placement in Dallas. But to appeal to physicians through marketing, you should put yourself in the physicians’ shoes.

To do that, you must consider that different age groups look for different perks. For example, physicians who are fresh out of training place great emphasis on work-life balance, so your marketing should describe how many days per week they are expected to work (for an employed position) or how many nights they are expected to be on call (for independent physicians), says **Allan Cacanindin**, director of interactive marketing at Cejka Search in St. Louis.

Mid-career physicians are also seeking work-life balance and expanding their practices, so be sure to mention the referral base, facilities, and equipment that will be available to them, Cacanindin suggests.

Pre-retirees may not be as interested in growing their practices as much as their younger counterparts, so market your community as a great place for them to spend their golden years. You may also want to highlight leadership opportunities for these veteran physicians.

➤ **Elicit an emotional response.** Any physician who is looking for a new career opportunity is dissatisfied with something, says Penney. They may not be making enough money, feel trapped by a bureaucratic hospital administration, or want to exchange the buzz of the city for the slower pace of a rural community. Highlight facts about your community and organization that

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Social media

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speak to the physicians' pain points. (See the sidebar on p. 7 for sample language.)

"The facts that you want to represent are the facts that support the emotional appeal—not just that you're a 230-bed hospital," says Penney.

► **Play up location.** Physicians oftentimes look for certain things when considering a career move: location and compensation. "You can offer all the money in the world, but if you're in a bad location, you're not going to get physicians to bite," says Cacanindin.

If you're in a rural community, Cacanindin suggests highlighting nearby features, such as mountains, a lake, or even the nearest city if it is less than a one-hour drive away. Describe the proximity of these features in time, rather than mileage, which can seem high. For example, write "Less than a one-hour drive from pristine beaches" rather than "Fifty-five miles from pristine beaches." You may also want to include pictures of points of interest on your hospital's social media pages.

If you're not in a metropolitan location, Penney suggests using vague terms such as "Southeast" or "Northwest" to get physicians to bite. "We don't say Texas unless it is Dallas or Houston, and we don't say Georgia unless it is Atlanta," he says. Why do this? To appeal to a greater pool of candidates. "The job of any advertisement is to get as many responses as possible, and someone might look at Albany, GA, and automatically say 'I've never heard of it—no way.' They've just ruled that out, but they know nothing else about the opportunity," Penney says.

Reveal the location of the hospital after the physician has called to inquire about the opportunity and you've described all of the benefits of the hospital and community. "We hear from physicians all the time, 'I'm really glad you talked me into going there. I would never have expected what I saw and I was pleasantly surprised,'" says Penney.

► **Accentuate the positive.** When writing a marketing piece, remember that a family physician in rural Iowa performs the same clinical functions as a family physician

in downtown Los Angeles. Focus your social media marketing less on the clinical responsibilities and more on the unique benefits your specific organization provides.

"What looks different is their commute to work, their pay structure, administrative duties, and their lives outside the clinic," says Penney.

► **Be up front.** Although it's smart to play up positive attributes and delay disclosing your location if it's not in a metropolitan area, be careful not to embellish position descriptions or hide information from potential candidates.

"Giving physicians all of the information they need will give you a better-qualified candidate because that candidate is making a more informed decision," says Cacanindin.

Being honest with physician candidates will not only help with your recruitment efforts, it will also help with retention. "If you tell candidates up front what is involved, you increase retention because they know what to expect," Cacanindin says. "No one wants to be blindsided."

► **Ask current physicians what they like about working at your facility.** Need to recruit a gastroenterologist to the community but not sure what to highlight in your marketing piece? Ask gastroenterologists who currently practice at your facility what attracted them. "A marketer needs to get it from the horse's mouth," says Cacanindin.

► **Remember that less is more.** When writing marketing pieces, skip the long, cumbersome paragraphs. Boil down essential information into a bulleted list instead. "Make it five or six bullets that encapsulate what the physician should expect when they walk in the door on day one," says Cacanindin.

Penney adds that you defeat the purpose of a bulleted list if each bullet point contains five sentences. "Less is more," he says.

Avoid online recruiting pitfalls

Now that you've developed concise, catchy marketing messages, it's time to deliver those messages to your

audience. Hospitals often make three major mistakes when marketing career opportunities to physicians through social media Web sites.

First, they only use one channel to deliver their message. To reach the maximum number of potential candidates, hospitals should use several modes of communication, including direct print mail, e-mail, ads in association or specialty journals, and social networking sites. (See p. 8 for an in-depth discussion on how hospitals can use social networking Web sites as recruiting and retention tools.)

Physicians can be found on all three major social networking sites, so it's a good idea to have a presence on each of them. Cacanindin suggests starting internally by telling current physicians about the opportunity and asking them to spread the word through their own social networks. "Then I'd post it on a Facebook page specific to my organization and a LinkedIn group I belong to through an association or society," he says. "Follow up with e-mail and Twitter."

The second mistake that thwarts hospitals' recruiting efforts is sending marketing to a too-narrow audience. Market to the masses and let the candidates decide

whether they are interested in following up with you, says Penney. Social networking sites allow you to link your account to others' accounts, creating a network. When creating a network, don't discriminate too much. Since social networking is free, you have nothing to lose if your message gets in front of a few physicians who don't match the qualifications you're looking for.

The third mistake that in-house recruiters often make is failing to consider how much effort it takes to launch and maintain a social networking campaign. "A lot of organizations are shifting their marketing toward interactive media, and as they do, they realize they don't understand the full impact. It creates more work for them. You need to figure out how you can best support that," Cacanindin says.

Since MSPs and medical staff leaders who have been handed down recruiting responsibilities are already pressed for time, they may wish to delegate certain tasks to others within the hospital who have a strong working knowledge of the Internet.

By following these tips for writing great marketing copy and avoiding these common pitfalls, MSPs and medical staff leaders will be well on their way to using social media Web sites as effective recruiting and retention tools. ■

Speak to your audience's pain points

When marketing career opportunities to physicians, speak to their pain points—the reasons that they are looking for a career move in the first place. **Shannon Penney**, director of recruiting at Delta Physician Placement in Dallas, and **Allan Cacanindin**, director of interactive marketing at Cejka Search in St. Louis, suggest addressing pain points with specific marketing language. Try the examples below.

Physicians' pain point	Marketing language
My current position doesn't allow me enough time to spend with my family.	"Four-day work week with limited call."
I want to participate in recreational activities but find it difficult to do in my current community.	"Half-hour drive to mountains/beaches/city."
I'm buried under student loans.	"Student loan assistance guaranteed."
I don't see many opportunities to become a leader at my current facility.	"Leadership education and training program available to medical staff members with potential."
I'm trapped in a house that can't be sold during a sluggish economy.	"Mortgage assistance program available" or "Relocation assistance guaranteed."

Use social networking Web sites as physician recruiting and retention tools: Tips for getting started

Physicians are increasingly using social networking Web sites, such as LinkedIn, Twitter, and Facebook, to find opportunities to advance their careers. As a result, hospitals need to jump on the social networking bandwagon if they want to recruit competitively. **MSB** spoke with **Jeremy Rodriguez**, senior recruiting consultant at Delta Physician Placement in Dallas, to find out how hospitals can get started using social networking Web sites as recruiting and retention tools.

MSB: Is it difficult to start using social networking sites if you've never used one before?

JR: They are easy to use once the sites are up and running. What better way to enhance employee relations than to have the CEO sit with someone in HR for 30 minutes to get the process started? The nice thing is that once you get going, you can delegate someone to put information about the hospital up on the sites, and you don't have to worry about it too much.

MSB: Should recruiters create accounts on Facebook, Twitter, or LinkedIn as individuals who represent the hospital or a global account for the institution?

JR: It is important to reflect on your brand and values through your organization's page. It is better to unify your social networking efforts by creating one account per Web site, and that account should be for the hospital. It would get confusing if you had the HR department on Facebook, the CEO Tweeting, and the recruiter on LinkedIn, all presenting themselves as individuals. Create one account per site and give multiple people access to it.

MSB: What tone should hospitals take as they present themselves on social networking Web sites?

JR: The great thing about social networking sites is that it is not nearly as formal as your official Web site. You can put pictures of staff birthday parties on the hospital's Facebook page, but you wouldn't necessarily want them on your Web site.

MSB: What's the benefit of putting pictures of staff and events on the hospital's social networking sites?

JR: Every family likes to take group pictures to remember a special occasion and to share with others. Exposure on the company's social networking page is something the healthcare organization and staff members can be proud of.

MSB: How can social networking sites help hospitals achieve community appeal?

JR: Hospitals need to be a part of the community. The hospitals that are successful with social networking are the ones that have patients following them online. They are tweeting ER wait times every morning and afternoon. They offer their followers updates on what's going on at the hospital. Compare those hospitals to the ones that don't share any information, and you tell me which one is more appealing.

Many physicians will have the newspapers from the towns that they are moving to sent to their homes. Doing so helps them feel like they are already a part of the community, even though they may be three states away. Social networking sites provide that same feeling. A physician who is thinking of joining your hospital can subscribe to your tweets to get the most recent news.

MSB: How can social networking Web sites help hospitals retain the physicians they recruit?

JR: Hospitals need to make physicians feel like part of the community, rather than a walking dollar sign. One neat thing you can do is conduct a brief introductory interview with a new physician and post it on YouTube. Then, link to the video on your Facebook or LinkedIn page or tweet the link to your followers. It's a great way to get a new physician's face and name out to the community and make the physician feel like part of the family.

MSB: What are some of the dangers of using social networking sites, and how can hospitals avoid them?

JR: Exposure can be perceived in several ways. At the end of the day, it's a chance for the organizations to show its transparency. You will always have negative opinions, but as long as you are doing your job, the positives will far outweigh the negatives.

MSP perspective

Reciprocal audits offer low-cost learning for MSPs

Ask any MSP, and he or she will tell you that having the funds available to attend conferences and purchase educational materials, such as books and newsletter subscriptions, is essential to having a well-functioning medical staff services department (MSSD). However, those funds are often the first to go when hospitals launch cost-saving initiatives.

One innovative way to provide all the MSPs in your MSSD with the education they need at low to no cost is through reciprocal audits. During a reciprocal audit, MSPs from Hospital A visit the MSSD at Hospital B and spend the day reviewing credentialing and peer review files, processes, and policies. During that time, they look for inefficiencies, share best practices, and discuss common problems and possible solutions. In return, MSPs from Hospital B do the same for the MSPs at Hospital A at a later date.

“We all have limited budgets for education and travel, so it is really helpful to do what we can for each other,” says **Marna Sorensen, CPMSM**, director of medical staff services at Portneuf Regional Medical Center in Pocatello, ID. Sorensen and **Michelle Zachary, CPCS**, credentialing specialist at Portneuf, have been conducting reciprocal audits with **Chris Hinton, CPCS**, medical staff coordinator at St. Luke’s Magic Valley Medical Center in Twin Falls, ID, since 2008. They share their tips and strategies for making reciprocal audits work at your facility.

Get buy-in from leaders

Prior to implementing reciprocal audits at your facility, get buy-in from medical staff leaders. Leaders may be concerned about competition and confidentiality, so draft a formal agreement, which includes a pledge to confidentiality, for both hospitals to sign. Present it to medical staff leaders with an outline detailing how reciprocal audits will be scheduled and performed and what will be done with the information garnered from them.

Find the right partner

When planning a reciprocal audit, be careful to contact MSPs working in hospitals that are not in direct competition with your hospital, says Sorensen. Portneuf and St. Luke are 1.5 hours apart, so their patient and physician populations do not overlap. However, don’t reach out to MSPs in hospitals that are too far away. Your day may be less productive if you are burdened with a three-hour drive each way.

Chat over the phone with the MSPs at the other hospital to introduce yourself and propose your idea. You need to make sure you will get along with that person or group and that everyone understands exactly how the audit will work.

Keep in mind that you will be reviewing another organization’s confidential information, such as physician peer review and credentialing files. Before one party sets foot on the other’s doorstep, review state laws, the Health Insurance Accountability and Portability Act of 1996, and the Patient Safety and Quality Improvement Act.

“Ideally, the two organizations would create an organized healthcare arrangement so that all parties are permitted to examine federally protected information,” says **Jonathan H. Burroughs, MD, MBA, FACPE, FACEP, CMSL**, senior consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

Schedule in advance

MSPs should plan reciprocal audits well in advance because it is the equivalent of taking a day off from work. Sorensen, Zachary, and Hinton explain that they use their paid time off to conduct audits. “It’s no different than if I take a vacation or I’m ill,” says Hinton.

Portneuf and St. Luke conduct reciprocal audits every six months, generally on a Friday. This allows Sorensen, Zachary, and Hinton to get the majority of their

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Reciprocal audits

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everyday tasks accomplished Monday through Thursday so they can concentrate on the audit on Friday. In addition, scheduling on a Friday allows all three MSPs to have fun at end of the day and go out to dinner.

Although it's important to schedule audits well in advance, be flexible, says Hinton. "There have been times when we have an audit scheduled and then something got put on my plate and I couldn't do it. We work with one another to make sure it is the best day for all of us."

In addition to taking paid time off to conduct audits, Sorensen, Zachary, and Hinton use their personal funds to pay for mileage and meals. "We haven't asked for reimbursement for gas because it is an enjoyable day for us," says Sorensen.

"People expect to be paid for everything, but there is a pride that comes with being an MSP and going out of your way to help someone else. It takes sacrifice," says Hinton.

However, it is reasonable for MSPs to ask for mileage and meal reimbursement. Compared to the airfare, tuition, and hotel expenses associated with sending MSPs to conferences, leaders will likely jump at the chance to chip in for gas and a sandwich. As a compromise, consider brown bagging a lunch to reduce expenses.

Have the right tools

Having the right tools can make auditing another MSSD a breeze. Sorensen, Zachary, and Hinton use a practitioner file audit form (see p. 11). Use a blank audit form for each file you review during the audit, says Sorensen. You can even use it to conduct your own internal audits.

In addition to using the audit form, take notes during audits. "The last time I went to St. Luke's, I categorized everything by reappointment, appointment, and continuing education, and put my notes under each category," says Sorensen.

Zachary notes that she, Sorensen, and Hinton focus on compliance with The Joint Commission (formerly

JCAHO) and Centers for Medicare & Medicaid Services standards during audits.

"If I am reviewing a new applicant, I look at what processes the hospital followed to ensure compliance with Joint Commission standard MS.06.01.05," Zachary says. "Were all the elements met? Was the National Practitioner Data Bank queried? Were peer references obtained? Was there adequate evidence of current competencies for granting clinical privileges requested?"

Just as a writer passes his or her work to an editor to check for mistakes, it's important for MSPs to have a fresh set of eyes review their work. "I am a one-person office, and it is difficult to be my own proofer. Without having someone to review my files and look at my processes, I could look at the same file 10 times and not catch what Marna catches," says Hinton.

Apply lessons to your own MSSD

Once you return to your office with the practitioner file audit forms and many pages of notes, it's time to act. For example, reciprocal audits changed the way that Portneuf handles physician references, says Zachary. Hinton shared with her and Sorensen a forevermore reference form that the relevant department chair fills out immediately after a physician leaves the facility.

Whether an MSP at another facility requests a reference four months or four years down the road, he or she receives an evaluation that the chair completed at the time the physician left. Forevermore references help the MSSD from passing on information that is pulled from a department chair's distant memory, which may not always be accurate.

"That changed the way I do references drastically," says Zachary. "It saves our clinical service chiefs an enormous amount of time."

Hinton also adopted Portneuf's practice of sitting down with department chairs prior to a credentialing meeting to review credentials files. This allows the chairs

time to ask questions without taking up valuable meeting time. "It's much better than the chairs reviewing the files on their own," says Hinton.

Network, network, network

If reciprocal audits aren't in your future because of scheduling constraints or lack of support from leadership,

start small by establishing a mutual mentoring relationship with another MSP in your state who works at a hospital that does not compete with yours. Let that MSP know that he or she is free to call or e-mail you with questions any time, as long as the favor is returned.

"Networking is one of the most important tools we have," says Hinton. "Use it." ■

Practitioner file audit form: Compliance with regulations and standards

Below is a form used by MSPs when conducting reciprocal audits. Visit www.credentialingresourcecenter.com/blog to view the complete form.

Practitioner: _____ Auditor: _____ Date: _____

N=New appointment R=Reappointment		Yes	No	N/A	Follow-up action items
General criteria	Standard				
Preapplication	Present, completed, signed				
Application signatures N&R	The credentialing process is based on recommendations by the medical staff and approved by the board (signatures of applicant, clinical service chief, credentials committee, medical executive committee, board)				
Application N&R	Application complete and signed				
Application N&R	Consent signed				
Application identification N	The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents (copy of license or passport)				
Practice plan N	Practice plan in file prior to approval				
Preferred contact protocol N	Contact protocol completed				
Application identification N	Identification verified in person (form signed indicating a current picture hospital ID or valid photo ID were viewed)				
Application foreign grads N	Current Education Commission for Foreign Medical Graduates certificate for graduates from a foreign medical school; current visa if not U.S. citizen				
Application Medicare attestation N	Current Medicare attestation signed, sent to health information management and copy in office				
Application military N	Copy of DD214 if military experience				

Source: Marna Sorensen, CPMSM, director of medical staff services and Michelle Zachary, CPCS, credentialing specialist, Portneuf Regional Medical Center, Pocatello, ID; Chris Hinton, CPCS, medical staff coordinator, St. Luke's Magic Valley Medical Center, Twin Falls, ID.

Choosing the right medical staff model

Clinical service lines: Clear as mud



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

Hospitals and health systems are increasingly interested in designing and implementing clinical specialty service lines. Clinical service lines are designed to cut across organizational and disciplinary boundaries to organize patient care around one of the following:

- Specific diseases, such as cancer or cardiovascular disease
- Populations, such as mothers and infants or the elderly
- Procedures, such as orthopedics or endovascular surgery

Clinical service lines are based on the product line management model developed in manufacturing industries. In this model, all of the disciplines needed to develop, manufacture, and sell a product are brought together to promote better working relationships and greater efficiency.

In their 1993 book, *Collaborative Management in Health Care: Implementing the Integrative Organization*, Charns and Tewksbury define clinical service lines as a family of organizational arrangements based on output rather than input.

Based on this definition, clinical service lines are coherent organizational structures that can achieve the common purpose of producing a comprehensive set of clinical services.

Hospitals that implement clinical service lines are often able to:

- Improve strategic planning and decision-making
- Improve organizational accountability
- Reduce costs

- Improve utilization and coordination of clinical resources
- Achieve higher patient satisfaction and clinical outcomes
- Increase market share in their service area

For many organizations, the disadvantages of clinical service lines include:

- Difficulty implementing change
- Differing stakeholder expectations
- Difficulty defining the authority and responsibility of service line managers, particularly the physician medical director

With regard to this last point, it is important to recognize that in most organizations, clinical service lines coexist with the self-governed medical staff. They are often overseen by an administrative manager and a physician manager (i.e., the medical director).

Although these two individuals are at the helm of the service line, the medical staff may be organized into traditional departments or sections that are distinct from the managerial service line structure. This arrangement makes it unclear whether the organized medical staff, through its relevant departments and sections, is responsible for ensuring physician performance or whether the medical director owns that responsibility. In next month's column, I will discuss how to address this sticky problem.

Until next time, be the best that you can be. ■



Check out www.credentialingresourcecenter.com/blog, an online venue dedicated to MSPs. You'll find great credentialing and privileging information, as well as opportunities to take polls, interact with your peers, and read the latest news!

hospitalist leadership

A SUPPLEMENT TO
MEDICAL STAFF BRIEFING

Advisor

Tips to help program managers climb the leadership ladder

Be your own mentor

The hospitalist movement has changed the dynamics of leadership. Traditionally, physicians who had more than 20 years of clinical experience and were nearing retirement were chosen as leaders, sometimes regardless of their capacity to do the job well. Today, thanks to the under-40 crowd that is leading the hospitalist movement, those in the upper ranks are starting to realize that emotional maturity, interest in taking on a leadership position, and personality traits weigh more than clinical experience.

“The average age of a hospitalist is 37, and the average age of a hospitalist leader is 41,” says **Russell Holman, MD, FHM**, chief operating officer (COO) at Cogent Healthcare in Brentwood, TN, and past president of the Society of Hospital Medicine (SHM), citing the *SHM 2007–2008 Biannual Survey*. “No one can be afforded that extensive period of clinical practice. As a hospitalist, you are often leading people who are older and have more clinical experience than you do.”

Because hospital medicine and the physicians who practice it are relatively young, the path they take toward

leadership is distinct from that of their counterparts in longer-established specialties, such as cardiology or neurology. As a hospitalist program manager looking to take the next step, these tips will help you climb the leadership ladder and keep you from falling off.

Don't take a victim's mentality

Although it may be tempting to take the perspective of Rodney Dangerfield and say, “I can't get no respect around here,” anyone looking to move up the leadership ladder will undermine their own authority if they do.

“Do not commiserate or take a victim's stand-

point. That will only beget negative attitudes and a sense of entitlement,” says Holman. He says many hospitalists feel that within a few months of joining a medical staff, they should be considered equal to the other physicians at the facility. “That is simply not the way it works.”

It takes time to develop a reputation as someone who is clinically competent and poised for leadership. In the meantime, keep your frustrations private. Also work with your hospitalist team to help them adopt a similar mind-set.

“Some of the things that make you an outstanding clinician make you a terrible leader.”

—David Edwards, MD

Help out others to garner respect

One way to gain respect from peers and leaders is to develop social capital. Developing social capital requires hospitalist program leaders to work with other departments to meet specific goals, says Holman. For example, if the ED has throughput issues or trouble finding physicians to accept unassigned patients, hospitalist program managers can work with the ED to overcome those challenges.

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Want to move up the leadership ladder but not sure who is going to take your place? Here are some tips to help program managers spot future leaders.

p. 4 Taking in the homeless
Read our Q&A session with one hospitalist program leader who discusses how to care for homeless inpatients.

HCPPro

Leadership

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“You want to build a reputation of service, accomplishment, teamwork, and selflessness, even if it means that the hospitalist program is going to be a bit busier,” says Holman. “Build political capital so that when there comes a time you need help, you can cash it in.”

In addition, establish relationships with informal leaders within the hospital. Informal leaders are those who do not have a formal title but are well respected and have the ability to influence decisions. These are the people who mentor others, speak up at meetings, and share

their opinions while keeping an open mind. By finding ways to help these individuals achieve the goals of their pet projects, you build your personal social capital, as well as that of the entire hospitalist group.

Develop your own critical skills

“Some of the things that make you an outstanding clinician make you a terrible leader,” says **David Edwards, MD**, CMO at Banner Gateway Medical Center in Gilbert, AZ. For example, strong clinicians often take an “If you want something done right, you have to do it yourself” attitude, whereas strong leaders delegate responsibilities and trust others to carry them out.

Regardless of the level of your position, leaders or those striving to become leaders must develop some basic skills. Edwards suggests brushing up on:

- Running a meeting
- Managing conflict
- Communication
- Negotiation

Also, hospitalist program leaders should continue to develop their clinical skills. “You don’t have to have the most brilliant clinical mind, but if you are a poor clinician, your peers won’t respect you,” says Edwards.

Advanced degrees, such as a master’s in medical management, a master’s in public health, or a master’s in business administration, may also help you develop leadership skills, but they are no substitute for experience, say Holman and Edwards.

“If you are lacking experience but want to ascend to higher levels of management, such as vice president of medical affairs or CMO, then an advanced management degree will sometimes open doors for you,” says Holman. “But when you weigh it all out, experience trumps degree.”

Learn to respect others’ skills

Hospitalist program managers and medical directors are often paired with nonphysician business leaders to effectively

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run a program. Together they serve in a dual leadership role. The hospitalist leader or medical director may focus more on issues related to clinical activity, mentorship, and performance improvement initiatives, whereas the business leader focuses on financials, establishing service agreements, and day-to-day operational issues.

“There is a division of responsibility that is highly complementary that calls on both skill sets,” says Holman. “You need to have appreciation, awareness, and respect for the skills that the other individual brings.”

Like any relationship, the one between a hospitalist leader and a business leader needs work. If you are in the position of working with a business leader, take time to establish the following:

- How will you communicate with each other (e.g., via phone, e-mail, or text)?

- When are you both available to communicate?
- How will you make joint decisions?

Advancing your career is an exciting experience if you have the right tools in your belt, and a daunting experience if you don't. But the rewards that being in a leadership position has to offer are plentiful. “There is always great stuff to learn, whether it is quality, finance, interpersonal skills, regulatory issues—you are never bored,” says Edwards.

Becoming a leader isn't in the cards for many hospitalists, and that is a decision that individuals need to make for themselves.

These tips, which are applicable across all hospital settings, will help get you started up the leadership ladder so you can reap those rewards. ■

Succession planning tips for program managers

Want to move up the leadership ladder but need someone to take your place? The following are two essential tips to help you find and keep future leaders.

Identify future leaders

If you are a hospitalist program leader seeking to recruit new leaders, the first step is to identify those who are not only interested in taking on additional responsibilities but also capable of doing so.

Some physicians understand hospital politics and are capable of making smart decisions that address the business side and the clinical side of running a hospitalist program. However, they may simply not have the interest. Other hospitalists may be interested but lack the capacity to become leaders.

It may take months or years to identify the right people and put them on the path toward leadership, so have patience.

Some key signs to look for in a potential leader include:

- Active participation in meetings
- Having the respect of others
- Ability to manage conflicts effectively
- A balanced sense of confidence and humility

Don't throw new recruits into the deep end

If you're a hospitalist leader mentoring others, don't throw them into the deep end, says **David Edwards, MD**, chief medical officer at Banner Gateway Medical Center in Gilbert, AZ. They need time to decide whether they like their new responsibilities and want to pursue them. “To be thrown into a situation and not have it work well for you is tough, and it can really sour someone from ever trying it again,” Edwards says.

For example, don't throw a hospitalist headfirst into a project improvement process that would affect operations throughout the entire hospital. Rather, walk him or her through a department- or unit-based process improvement project, explaining each step along the way. As you do, take mental notes regarding the person's ability to handle the additional responsibilities, his or her attitude throughout the process, and how quickly he or she absorbs the new information.

There is no perfect age or number of years of experience that will determine whether a hospitalist is ready to move into a leadership position. “I would argue that it is probably your maturity as a person,” says Edwards.

Q&A

What hospitalists need to know about treating and discharging homeless patients

When homeless patients are admitted to the hospital, it presents hospitalist programs with not only an opportunity to help those in need but a challenge as well. For example, homeless patients are admitted to the hospital more frequently and with more severe conditions than patients who have a stable residence. They also stay in the hospital longer and are less likely to follow discharge instructions, according to the article, *A SAFE DC: A Conceptual Framework for Care of the Homeless Patient* in the July/August 2009 *Journal of Hospital Medicine*.

To find out what hospitalists and program managers must know when treating homeless patients, **HLA** spoke with **Jennifer Best, MD, FACP**, assistant professor of medicine and hospitalist in the Consultative and Hospital Medicine Program at Harborview Medical Center in Seattle and author of the review.

HLA: What processes should hospitalist programs tweak when admitting homeless patients?

JB: You need to identify homeless patients early. A hospitalist's management plan might be dictated by the patient's lack of residence. The admissions department usually takes down an address, but the patient might offer the address of a shelter or a friend's residence. Hospitalists should be asking questions, such as "How long have you been at this residence?" and "How long do you expect to stay there?"

Also remember that some people become homeless during their hospital stay as a result of the medical bills they incur. Although someone might come in with an address, they might leave without one.

HLA: What processes should hospitalist programs tweak when discharging homeless patients?

JB: Hospitalists often end up transferring discharge summaries [directly from] doctor to doctor. But in many cases, homeless patients use multiple facilities, so giving

them that information directly so they have it on their person is really important.

Provide patient discharge instructions in ways that account for varying degrees of health literacy. Verbally review all instructions, but be sure to also consider audio-, video-, or picture-based instructions.

Because many homeless patients may not have reliable contact information, you may not be able to get in touch with a patient to follow up on test results, so explore innovative ways to deliver messages. It could be something such as setting up a private voice mail system or a free e-mail address that the patient can access through the local library. Consider contacting a patient's case manager.

HLA: Does it cost more to treat homeless patients than those who have a stable residence?

JB: It can be more expensive because homeless patients don't often have insurance; therefore, they access the ED as their first line of care. Homeless patients present with between eight to nine medical problems on average, and they present with more severe stages of disease. It's not the early hypertensive patient, it is the patient who has been hypertensive for years and is now experiencing renal and heart failure.

HLA: Does treating a large number of homeless patients affect the program's profitability?

JB: Not all homeless patients are uninsured, although many are, so necessary medical services are often provided under the umbrella of charity care. Providing this care is one of the missions of my institution. One way to offset this uncompensated care is to have a blended program model where you balance charity care with consultative care. Many of our consultative patients are insured.

It is important for hospitals in a given city or region to consider how the burden of uncompensated care can be fairly divided, so no one institution is unduly challenged in this difficult economic climate. ■