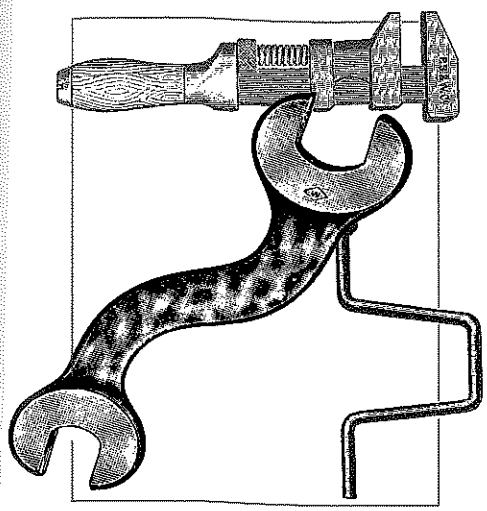
Re-Engineering the Medical Staff

Simplification is Key - Suzanne van Hall, Esq.



Medical staffs are finding they must make do with less — less administrative support from financially strapped hospitals, and less volunteer physician member time from physicians who are distracted by managed care and by managing their changing practices. All too often the medical staff tries to do what they have always done, only faster, and with less help. This just frustrates those who were already working hard. The better alternative? Re-engineer the medical staff with the goal of simplifying operations.

A critical look at the tasks undertaken by the medical staff often reveals that far too much time is spent doing unnecessary things. When asked, "Why do you do all this?" the answer is often, "because we are required to do it!" Yet scrutiny reveals that it is not required and that the task could be eliminated.

Just because something "has always been done that way" does not mean it still must. It is time to look at the medical staff structure and procedures with a new set of questions: *What is really required? What has great value for us? What can be jettisoned without affecting our operations?*

Twenty-five suggestions that will simplify life for the medical staff.

1 **Pre-application.** Some medical staffs use a pre-application process that requires sending a pre-application package to prospective new members and then sending a second packet only to those who pass the threshold pre-application tests. This doubles the medical staff office work and slows down the process. Alternative: require applicants to meet minimum standards and automatically stop processing those who do not. (As is discussed below, the bylaws should then specify that there are no hearing rights for those who do not meet the minimum standards.) The minimum standards should be objective. Examples of minimum standards include: requirements for licensure, malpractice insurance, board certification, and drug enforcement administration certificates (for physicians who prescribe).

2 **Department Review.** Many medical staffs still require full department review for each appointment and reappointment. This is increasingly burdensome and it delays processing since it is hard (impossible?) to get a quorum for department meeting and departments often skip meetings during the summer and winter holidays. Also, it creates some risk of antitrust liability whenever the "competitors in the department" make an adverse decision on less than a careful study of the applicant's qualifications. Alternative: review by the Department Chair. This means that a single person will look at the file. This person can be asked to study the file carefully and make a reasoned recommendation.

3 **Following up on Missing Information.** Too often the medical staff office sends out hundreds of letters requesting information that is missing from the appointment or reappointment application (or even to get the reappointment application submitted). Physicians have learned to expect 99 warnings before anything happens. There is no longer enough staff for this hand-holding, plus it never was effective since physicians who procrastinate wait for the last warning, whether it is

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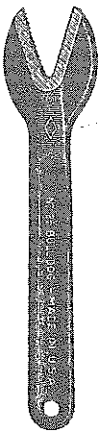
given in the first or the 99th letter. Alternative for initial applicants: give them one notice describing what is missing and a thirty day deadline to submit the information. If they miss the deadline, the application is deemed automatically withdrawn (with no hearing rights). Alternative for members who seek reappointment: give them one notice describing what is missing, a deadline for getting the information in, and a warning that their membership will be suspended if the information is not submitted by the deadline. If they miss the deadline, send a second letter explaining that their membership is suspended and further that it will expire when their appointment expires if the information is not submitted before the last deadline. Then, send the final letter informing members who missed the last deadline that their memberships have expired and they can practice at the hospital again only if they apply as a new applicant. One caveat: if an applicant tries diligently to supply the missing information but a third party refuses to cooperate (e.g., the third party refuses to provide the reference information), you should not penalize the applicant. Examples of diligent effort: writing letters, making calls, and signing releases that provide absolute immunity from liability for people who submit information.

4 Centralized Credentialing. Physicians are tiring of completing multiple applications asking them for the same information in different formats. They are tired of sitting on committees at several places to review the same physicians. Alternative: It is wise to use the standard credentialing form. California's organizations have developed the California Participating Physician appointment and reappointment forms with the goal of having one form that everyone can use. This form is adequate, especially with a minor supplementation to cover questions that have been missed. (Copies of the supplemental form and application form can also be obtained from the author or CHA.) Another time-saver is to share credentialing information with the other providers and entities in your area who are busy credentialing the same individuals. While care must be taken to design a system that will ensure that you do not lose the valuable legal protections for credentialing and the records, it is possible to jointly investigate applicants and share the information in order to eliminate duplicate processing.



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5 Reduce and Consolidate the Categories in Your Medical Staff. Some medical staffs still have multiple categories of medical staff: active, associate, provisional, courtesy, consulting, honorary, retired, and more. Alternative: cut to the minimum needed to reduce the strain of tracking. For example, ask the applicant: do you really need to force members to stay in an associate category for two or three years before advancing them to active (which allows them to serve as officers)? If they are able to win an election after one year, why not let them serve as officers? Also, do you really enforce and use the courtesy (somewhat inactive) versus active standards? And why distinguish between those who have retired and those who deserve an "honorary" status? Why not combine categories?

6 The Affiliate Category: Consider adding a new category for physicians who do not practice in the hospital, but who still need hospital membership in order to qualify for insurance panels. Insurance companies often continue to delegate (abdicate) their credentialing responsibilities to hospitals and simply require members of their panels to have hospital privileges. This makes no sense for physicians whose practices are strictly outpatient, but as a practical matter hospitals will want to establish relationships with these rich sources of referrals. Credentialing these applicants is difficult because they have no hospital

practice to review. Thus, there is no basis for awarding hospital privileges. Alternative: create an "affiliate" staff with members who are credentialed only for the basics (licensure, malpractice insurance, etc), and who are not granted any meaningful hospital privilege and therefore do not have to demonstrate current competence. Affiliate staff members may be granted only the extremely limited privileges of visiting their patients in the hospital and entering progress notes in the records.

7 **Locum Tenens Category.** Another problem is that some hospital based physicians who have exclusive contracts to provide certain services, such as radiology, pathology, anesthesiology and emergency services, will rely heavily upon locum tenens physicians to cover vacations and illnesses. They are unwilling to add the extra staff to the exclusive contract group and therefore refuse to process them for "membership," yet they may use the same physicians repeatedly. This leads to the Friday afternoon "rush" request for temporary privileges, which forces the medical staff office to scrounge around looking for someone to approve the temporary privileges. It also removes the physicians from the routine quality assurance process, creating the risk that undesirable patterns of behavior will go undetected. Alternative: Establish a "locum tenens" category for physicians who will be practicing at the hospital occasionally, but who will not be joining the group.

8 **House Physicians.** Some hospitals also have "house physicians" who may still be in training and who provide after hours and holiday coverage for inpatients. They may not be eligible for membership given their training status and sometimes have slipped by without being credentialed and having their work monitored. Alternative: create a category for the "house officers." They may require full credentialing review depending upon the level of independent judgment they are allowed to exercise in patient care. Note, however: this category is not designed for physicians who are in training at the hospital. The hospital's own interns, residents and fellows should not be added to the medical staff. Instead their credentialing, quality review, and hearing procedures should be governing by their training program and the medical staff should simply have an "Training Affiliation Agreement" with the program that spells out how interns, residents, and fellows will be assigned to the program and reviewed.

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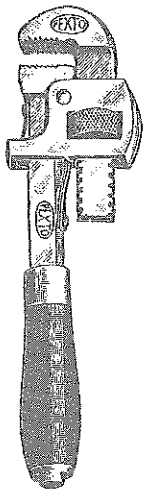

9 **Proctoring.** In some parts of the country, proctoring is a term used only in connection with training programs and never in the context of medical staff activities. In other parts of the country, proctoring has become a burden for medical staffs, which have required their members to review multiple cases for all new applicants. Proctoring is not required by licensing laws or accreditation standards. It is a self-inflicted burden. It should be manageable, especially since improved quality assurance systems have largely replaced the retrospective case review. Alternative: Minimize the proctoring burden. Three observed cases (or retrospectively reviewed for non-invasive specialties such as internal medicine or family practice) should be enough to know if there is cause for alarm. Otherwise rely on the quality assurance system to identify problem cases.

10 **Automatic Termination for Failing to Complete Proctoring.** If only three cases are needed to complete proctoring, there is no reason to continue the privileges of someone who cannot complete proctoring within the first year (or two at most). Alternative: Provide for automatic termination, with no hearing rights, for anyone who fails to complete the minimum

number of cases required to complete proctoring.

11 **Meeting Attendance Requirements.** Do you require physicians to attend meetings? Do you ever terminate or otherwise penalize physicians because they do not attend meetings? If not, then why are you bothering to take attendance? Alternative: If you are not enforcing your meeting attendance requirements, get rid of them and get rid of the attendance sheets. Keep records only when necessary for continuing medical education credit (a positive incentive for attending meetings).

12 **Quorum.** Ever stymied in transacting business because there was no quorum? If your answer is "often," you need a change. Alternative: Set realistically, low quorums for your committee, department and staff meetings. Another alternative: think about getting rid of the meeting. Some medical staffs persist in keeping committees that have outlived their usefulness, and the members express their opinion by refusing to attend. If getting a quorum is a persistent problem, consider disbanding the committee or department and assigning the functions to another committee or department. One more alternative: If your problem is that you lose your quorum during the course of a meeting, consider having bylaws that allow business to still be transacted after the quorum is lost so long as the action is approved by the number of votes that would have been necessary when there is a quorum.

13 **Departments.** Do you suffer from department overload: too many departments with too few members and too little active participation? Alternative: reduce your departments to the minimum needed to effectively conduct peer review. Generally it is unnecessary even in larger hospitals to have separate departments for anesthesia, pathology, emergency medicine, radiology, and family practice/internal medicine.

"If you are not enforcing your meeting attendance requirements, get rid of them and get rid of the attendance sheets. Keep records only when necessary for continuing medical education credit."

14 **Department Committees.** Once a department is the proper size, it may have too many members to actually do the work. Alternative: Larger departments should have smaller department committees, so the committee members may perform the quality improvement, utilization management, surgical case, blood usage, drug usage, and medical records reviews. The committee can meet as often as needed to complete its work, but it probably will need to meet most months given the heavy assignment of responsibilities. As noted above, the department chair, rather than the full department, may be given responsibility for appointment and reappointment reviews.

15 **Committees.** In an era of increasing specialization, we have sometimes split up the tasks so finely that the same case may be reviewed by seven different people for seven different reasons. Alternative: Instead of splitting case review, it is prudent to cross-train the reviewers so they can pick up a chart and review it once for the following aspects: medical records completion, medication and drug usage, blood usage (if there was or should have been a transfusion), surgical, tissue, death, quality, and utilization management. Well designed forms can help to remind reviewers of the various aspects to consider.

16 **Meetings.** Some committees meet every month because the bylaws require monthly meetings, even though the workload may not warrant monthly meetings. Alternative: Have the bylaws state the minimum frequency (e.g., require quarterly meetings), and then schedule more meetings if the workload dictates an extra meeting or two

17 **Automatic Action (No Hearing Rights).** Hearings are extremely time consuming to

organize and hold even if the issues at the hearing seem quite simple. But in some states, such as California, the courts will require hearings for even the most mundane issues unless the bylaws provide for automatic action, with no hearing rights. Alternative: The bylaws should specify when action will be taken automatically, with no hearing rights. Consider automatic action for the following situations:

a. Failure to meet the minimum standards, such as having a license, malpractice insurance, or DEA certificate.

b. Reassignment in medical staff category for failing to meet activity requirements (e.g., for demotion to courtesy staff when the member falls below the required activity level).

c. Termination from contract positions for physicians who are part of groups that have exclusive contracts.

d. Failure to complete the minimum number of proctoring cases.

e. Licensure revocation, suspension or expiration.

f. DEA certification revocation, suspension or expiration.

g. Failure to satisfy special appearance.

h. Failure to complete medical records.

i. Cancellation or nonrenewal of malpractice liability insurance.

j. Failure to pay dues.

18 **One Warning for Automatic Action.** As is noted above, some medical staffs require multiple warnings to be given before any action is taken and indeed have elaborate schemes for the timing and content of each notice. But there is insufficient staffing to send out all those letters. Alternative: Keep the procedure simple: all automatic actions should require only one warning, not multiple warnings. If the member or applicant does not comply, the action should then happen automatically, with the final letter simply confirming what has happened.

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19 **Enforce the Automatic Actions.** It is not helpful to suspend members for failing to complete records or meet other standards, but then to allow them to ignore the suspension and continue to admit and treat patients. Alternative: automatic actions should be enforced, consistently. Once the members understand the medical staff is consistent and tough, they will conform.

20 **Waiting Periods After Adverse Action.** After completing adverse action, the last thing most medical staffs want to do is to start over immediately with the same physician. Yet your bylaws may allow the physician to apply immediately for the same privileges he or she just lost or was denied. Alternative: the bylaws should establish a waiting period that must be fulfilled after adverse action, for both applicants and members.

21 **Routine Corrective Action.** Most quality improvement warnings and actions are not "formal corrective action," although they result in correspondence identifying concerns and opportunities for improvement and, sometimes, provide warnings, counseling, and requirements for ongoing review in the form of proctoring and monitoring. Burdening these actions with hearings is unnecessary and stifles productive peer review activities. Alternative: Provide for routine corrective action in the bylaws and specify that there are no hearing rights when there have been no restrictions of privileges.

22 **Expedited Initial Review.** Sometimes medical staff leaders (and medical staff directors) will investigate complaints that are submitted to decide whether there is a good reason to present

the case to the medical executive committee and ask for a formal investigation. But typical bylaws do not allow such an initial review and may leave the leaders without protections or waiting until the next executive committee meeting to get permission to look into the complaints. The delays may cause particular problems when there are serious allegations of misconduct, sexual harassment, or discrimination. Alternative: The bylaws should authorize the leadership to initially review complaints. An expedited review process should define who may delve into the facts, and make it clear the person is acting for a medical staff committee in order to invoke the full legal protections afforded medical staff committee activities.

23 **Hearings.** Hearings can be incredibly burdensome. Hearing details should be simplified as much as possible, consistent with meeting the stringent federal and state hearing requirements. But some medical staffs burden themselves needlessly when they have hearings. Alternative: make certain your hearing process has the following features:

a. Provide for forgiveness of technical, insignificant or non-prejudicial deviations from the bylaws.

b. Delegate authority to the chief of staff rather than the medical executive committee to arrange the hearing. The chief of staff can appoint the hearing committee members, approve the notice of charges and notice of hearing, schedule the hearing date, and appoint the hearing officer.

c. Require only three members on the committee rather than five.

d. Provide for pre-hearing exchanges from witness lists and documents, with real penalties for non-compliance (such as prohibitions on introducing documents that have not been shared with the other side prior to the hearing, with the exception of documents used to impeach a witness).

e. Allow members who miss a single session in a lengthy hearing to catch up by reading the transcript.

24 **Technical and Editorial Amendments to the Bylaw.** Having a vote from the full medical staff requires tremendous coordination, especially if the proposed change must be submitted earlier for review. The burdens seem especially unwarranted when the desired change is a minor technical or editorial amendment. Alternative: Allow the medical executive committee (with governing board approval) to make technical and editorial amendments.

25 **Moving Non-essential Items to the Rules.** Very few medical staff members take the time to read and understand the bylaws and proposed amendments. Yet they are routinely asked to vote on the changes. Alternative: Non-essential provisions should be moved from the bylaws to the rules. For example, all of the details describing how applications are received and processed, the categories of staff membership, the composition and duties of committees, the duties of departments can and should be moved from bylaws to the rules. Then, the medical staff should delegate responsibility to the medical executive committee to study those rules and approve changes rather than requiring a vote of the full medical staff.

The language needed to implement these changes can be found in the bylaws of the California Healthcare Association, CHA, at (916) 443.7401

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CME Post-Test

1. The RN-to-population ratio in California is exceeded only by that of New York.

T or F

2. Age is not a relevant concern when evaluating the nursing work force.

T or F

3. The pre-application process has been shown to consistently simplify hospital credentialing.

T or F

4. Proctoring is performed because it is required by licensing laws and the JCAHO.

T or F

5. From the list below, which items have been recommended for automatic action in order to avoid time delays:

a. Failure to meet minimum standards
b. Failure to complete medical records
c. Failure to pay dues
d. All of the above

6. When it is learned that a medical record will be evidence in a legal proceeding, all the necessary changes should be made promptly in order to avoid late entries.

T or F

7. The Electrostatic Detection Apparatus is used to determine if a record has been altered or destroyed by evaluating the indented impressions on consecutive pages.

T or F

8. Deleted computer files are not retrievable and therefore not discoverable.

T or F

9. In the study by Lave, et al, a statistically significant correlation between uncertainty and utilization was noted.

T or F

10.It has been clearly demonstrated that Internists are superior to specialists when performing a hospitalist role.

T or F

11. Academic medical centers have been slow to adapt to the hospitalist model because they already have housestaff in the hospital 24 hours per day.

T or F

12. The fact that medical costs are evenly distributed over a broad range of diagnoses supports the Focused Factory concept.

T or F

13. The article by Kaplan emphasizes the fact that externally imposed guidelines have universally been shown to improve outcomes while insulating physicians from malpractice claims.

T or F

14. The article by Krieger emphasizes the difficulty in comparing healthcare to other industries when it comes to the challenge of aligning goals and efforts to control costs.

T or F

15. Capitation cannot be used to compensate specialists because of the invasive procedures that many of them perform.

T or F

Name _____ License Number _____ State _____

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The Objectives of this self-study program are: (1) To review speciality capitation methodologies, (2) To study the hospitalist model for inpatient care, (3) To review the problems created by managed care cost control strategies, (4) To learn how diagnostic uncertainty affects utilization decisions at a teaching hospital, and (5) To review how healthcare as a business endeavor can learn from other industries.

This program (which includes the topics highlighted with an asterisk in the table of contents) has been reviewed and is acceptable for up to one Prescribed hour by the American Academy of Family Physicians. AAFP Prescribed credit is accepted by the AMA as equivalent to AMA PRA Category 1 credit for the AMA Physicians Recognition Award. When applying for AMA PRA, Prescribed hours earned must be reported as Prescribed hours, not as Category 1. Term of approval is for one year from beginning distribution date of 1/1/97, with option to request yearly renewal.