



MEDICAL EXECUTIVE COMMITTEE

Essentials Handbook

Richard A. Sheff, MD

Robert J. Marder, MD

MEDICAL EXECUTIVE COMMITTEE

Essentials Handbook

Richard A. Sheff, MD

Robert J. Marder, MD

HCP_{ro}

Medical Executive Committee Essentials Handbook is published by HCPro, Inc.

Copyright © 2012 HCPro, Inc.

All rights reserved. Printed in the United States of America. 5 4 3 2 1

ISBN: 978-1-60146-947-2

No part of this publication may be reproduced, in any form or by any means, without prior written consent of HCPro, Inc., or the Copyright Clearance Center (978-750-8400). Please notify us immediately if you have received an unauthorized copy.

HCPro, Inc., provides information resources for the healthcare industry.

HCPro, Inc., is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks.

Richard A. Sheff, MD, Author

Robert J. Marder, MD, Author

Katrina Gravel, Editorial Assistant

Elizabeth Jones, Editor

Erin Callahan, Associate Editorial Director

Mike Mirabello, Graphic Artist

Matt Sharpe, Production Supervisor

Shane Katz, Art Director

Jean St. Pierre, Senior Director of Operations

Advice given is general. Readers should consult professional counsel for specific legal, ethical, or clinical questions.

Arrangements can be made for quantity discounts. For more information, contact:

HCPro, Inc.

75 Sylvan Street, Suite A-101

Danvers, MA 01923

Telephone: 800-650-6787 or 781-639-1872

Fax: 800-639-8511

Email: customerservice@hcpro.com

Visit HCPro online at: www.hcpro.com and www.hcmarketplace.com

Contents

Figure List	vii
About the Authors	ix
Chapter 1: Roles and Responsibilities of the Medical Staff, Management, and Board.....	1
Quality and Safety	1
Board Responsibilities	4
Medical Staff Responsibilities	8
Management Responsibilities	9
Understanding Influence.....	10
Chapter 2: The Power of the Pyramid: How to Achieve Great Physician Performance	13
Appoint Excellent Physicians.....	15
Set, Communicate, and Achieve Buy-In to Expectations	16
Measure Performance Against Expectations	20
Provide Periodic Feedback.....	20

Manage Poor Performance	21
Layers of the Performance Pyramid	24
Chapter 3: The MEC's Role in Credentialing and Privileging	33
What Is Credentialing?	35
What Is Privileging?	36
Four Steps in the Credentialing and Privileging Process	37
Policy in Action.....	41
Essential Credentialing and Privileging Policies.....	42
Chapter 4: The MEC's Role in Peer Review, Quality, and Patient Safety.....	45
Assigning Roles and Responsibilities.....	46
Oversight of Ongoing and Focused Professional Practice Evaluations	49
Managing Loose vs. Managing Tight	50
Managing Systems Performance.....	51
Patient Safety Basics.....	54
Four Components of Patient Safety.....	56
Organizational Performance Improvement.....	57
Chapter 5: The MEC's Role in Managing Professional Conduct	59
Protecting a Culture of Safety	60
Legal and Regulatory Obligation to Address Conduct Issues	60

Create and Enforce Code of Conduct Policy62

Performance Pyramid to Address Conduct63

**Chapter 6: The MEC's Role in Strategic
Collaboration With the Hospital 67**

The Right Number68

The Right Type of Physician.....69

The Right Quality69

The Right Relationship to the Hospital..... 70

The Right Medical Staff Culture 71

The Right Structure and Processes 72

The Right Leadership 72

Chapter 7: Effective MEC Meetings..... 75

Developing the MEC Agenda..... 75

MEC Members' Role in Meeting Effectiveness 78

Figure List

Figure 1.1 Organizational chart.....	6
Figure 1.2 Three legged stool	7
Figure 1.3 Sphere of control, influence, interest	12
Figure 2.1 The bad apple theory vs. performance improvement.....	14
Figure 2.2 The physician performance pyramid	15
Figure 2.3 Comparison of The Joint Commission's General Physician Competencies with the Physician Performance Pyramid dimensions	19
Figure 2.4 ACPE/Greeley dimensions of physician performance	26
Figure 2.5 ACGME/The Joint Commission dimensions of physician performance.....	27

FIGURE LIST

Figure 3.1 The medical staff's major functions	33
Figure 4.1 What is practitioner performance?	47
Figure 4.2 Why do events happen?	55

About the Authors

Richard A. Sheff, MD

Richard A. Sheff, MD, is principal and chief medical officer with The Greeley Company, a division of HCPro, Inc., in Danvers, Mass. He brings more than 25 years of healthcare management and leadership experience to his work with physicians, hospitals, and healthcare systems across the country. With his distinctive combination of medical, healthcare, and management acumen, Dr. Sheff develops tailored solutions to the unique needs of physicians and hospitals. He consults, authors, and presents on a wide range of healthcare management and leadership issues, including governance, physician-hospital alignment, medical staff leadership development, emergency department call, peer review, hospital performance improvement, disruptive physician management, conflict resolution, physician employment and contracting, healthcare systems, service line management, hospitalist program optimization, patient safety and error reduction, credentialing, strategic

planning, regulatory compliance, and helping physicians rediscover the joy of medicine.

Robert J. Marder, MD

Robert J. Marder, MD, is an advisory consultant and director of medical staff services with The Greeley Company, a division of HCPro, Inc., in Danvers, Mass. He brings more than 25 years of healthcare leadership and management experience to his work with physicians, hospitals, and healthcare organizations across the country. Dr. Marder's many roles in senior hospital medical administration and operations management in academic and community hospital settings make him uniquely qualified to assist physicians and hospitals in developing solutions for complex medical staff and hospital performance issues. He consults, authors, and presents on a wide range of healthcare leadership issues, including effective and efficient peer review, physician performance measurement and improvement, hospital quality measurement systems and performance improvement, patient safety/error reduction, and utilization management.

Roles and Responsibilities of the Medical Staff, Management, and Board

Many times physicians find themselves in leadership positions without the training needed to understand and carry out the responsibilities of the position. All too often, the medical executive committee (MEC) is comprised of a group of physicians who, though willing to contribute to the committee's goals, lack the knowledge and skill necessary to do so most effectively. Leadership training is not part of most medical school curricula or residency training.

In this chapter, we will address the roles and responsibilities of the medical staff, management, and the board. Think about these roles within the context of “good fences make good neighbors.” A hospital cannot run effectively unless leaders understand and respect the roles each of these groups play.

Quality and Safety

The answer to the question, “Who is responsible for the quality and safety of care at the hospital?” can vary depending on who you

ask. Some might say that physicians hold this responsibility. Physicians care for patients, write the orders, determine courses of care, and are often the ones sued if anything goes wrong. Another person may answer that the entire medical staff is responsible for quality of care and still another might assert that the hospital management is responsible. The trouble is that if everyone is responsible, it is difficult to hold someone accountable. The buck has to stop somewhere.

At the hospital, the buck stops with the governing board. However, that doesn't mean physicians and hospital management are off the hook. Anyone who interacts with the patient or touches anything that ultimately touches the patient is responsible for his or her role in patient care. Every individual is responsible for his or her own actions. But, at the end of the day, ultimate responsibility for quality of care rests with the board.

The governing board's responsibility for quality of care is tied to the concept of corporate negligence. The theory behind corporate negligence is that if a person or organization violates an assigned duty and that violation results in injury or harm, the person or organization is liable for that harm. When corporate negligence cases were first brought to the courts, the subjects of such cases were typically railroad and steel companies. Hospitals were off limits because they were seen as charitable organizations and therefore could not be sued under the principle of charitable immunity. That all changed in 1965 in a legal case in Illinois known as *Darling vs. Charleston Memorial Hospital*. In that case, a young

man came to the emergency room with a broken leg. The physician who set the leg did not have a lot of experience doing so. The young man was eventually admitted to the hospital suffering from gangrene and ultimately lost his foot to an amputation. His family sued the physician and the hospital. One of the charges against the hospital was that it granted the physician privileges for a procedure for which he was not competent to perform. The court found in the patient's favor. This was the first time that corporate negligence was applied to hospitals.

There have since been many court decisions that make clear that the governing board is responsible for the quality of care in the hospital. Does this precedent mean that if a physician removes a patient's right foot instead of the left that the board is responsible? If a dangerous dose of medication is administered because the physician misplaced the decimal point, is the board responsible for the resulting harm? The answer to both these questions is "yes." With that said, the physician has a duty to perform his or her duties well. The medical staff has a duty to conduct credentialing, privileging, and peer review. But all these responsibilities roll up to the governing board, which begs the question, "What does the board know about quality and safety of medical care?" The most common answer is not a lot. That's a problem and that's where the organized medical staff comes into play.

Quality standards adopted by the American College of Surgeons in the early 1900s established that hospitals must have an organized

medical staff with healthcare expertise and that is responsible for quality of medical care. Since the inception of the organized medical staff, governing boards have delegated responsibilities for monitoring and improving the quality of care to the medical staff and to management. This delegation of responsibilities complicates matters as many medical staffs and management struggle to determine who was responsible for what.

Board Responsibilities

Distilled down to the basics, the board's primary responsibilities are to preserve and enhance the financial assets of the organization and to achieve high-quality care for patients. The board is challenged to balance "dollars" and quality—not one at the expense of the other. Many times physicians assert, "Quality trumps cost." Management then pushes back and says, "No money, no mission." The truth is that they're both right. At a time when the cost for care often exceeds the reimbursement for that care, the organization must balance quality of patient care with the cost-effectiveness of care.

Boards also establish the organization's mission, vision, values, and the strategic plan. The board also adopts financial targets and quality targets. Developing a budget and financial targets is the easier task of the two. While generally accepted accounting principles are well established, the board has few guidelines to follow when developing quality targets. The board also has the

authority to grant medical staff membership and privileges. The medical staff makes recommendations concerning membership and privileges to the board, but it is the governing board that makes the final decision.

Boards are the ultimate conflict-resolving entity in the organization. When a conflict percolates up to the board, it owns the discussion and ultimate decision whether the issue is related to peer review, a turf battle, or physician-hospital conflict that can't be resolved. Keep in mind that the board carries out many of its responsibilities by delegating tasks and ensuring accountability. For example, the board delegates to management the responsibility to achieve financial targets and holding management accountable through periodic reviews of financial reports. Similarly, the board delegates responsibility for physician performance to the medical staff and holds the medical staff accountable for carrying out those responsibilities.

The board is also responsible for compliance legal and regulatory requirements and for ensuring patient, worker, and visitor safety.

That's a lot of responsibility, which is why it is important to acknowledge the difference between management and governance. Governance is a 30,000-foot view of responsibility. As noted earlier, boards are the ultimate conflict-resolving entity. They must rely on others within the organization. For example, the board must recruit and hire an effective CEO, set clear performance expectations for him or her to meet, and continually measure his

or her performance and provide feedback. The board must also ensure that the CEO has adequate resources to fulfill his or her responsibilities.

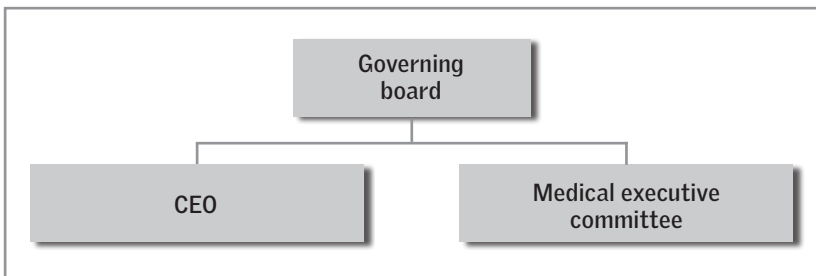
Organizational chart

To understand the MEC's role, you must first understand the relationship among other groups on the organizational chart (see Figure 1.1). The governing board hires the CEO, who hires the vice presidents, who then hire the directors, etc. The board delegates these hiring decisions to the CEO, who then delegates to the management team. The board holds the management team accountable by holding the CEO accountable.

By drilling down on the organizational chart a bit more, it becomes clear that the MEC makes recommendations to the governing board regarding credentialing and privileging decisions. The general medical staff reserves the power to amend bylaws and elect officers. The medical staff can also report/recommend directly to

Figure 1.1

ORGANIZATIONAL CHART



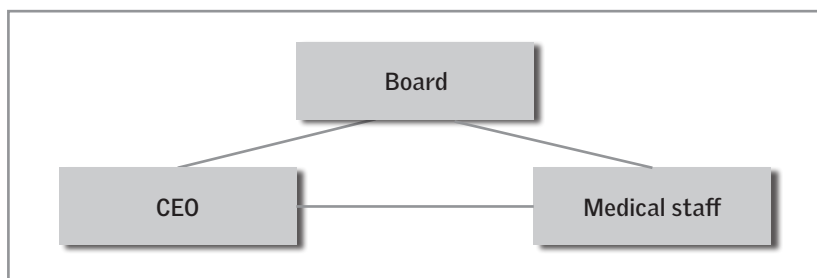
the board if it determines the need to override the MEC, but such events should be few and far between.

The organizational chart described here is the most common at hospitals today. However, there is another organizational chart that's alive and kicking. This "three-legged stool" approach arises when the medical staff throws up a red flag and says, "We are not subservient to the board. We should be an equal partner, an equal voice to management to the board and in some cases stand over and against the board and management." In some ways, the three-legged stool model is an advocacy model (see Figure 1.2).

When the medical staff is advocating for patient care quality, it is carrying out its board-delegated responsibility for quality of care for which it is held accountable. But when the medical staff is advocating for physicians, it is following the three-legged stool model. In this case, the medical staff wants to be seen and engaged as a partner with management and the board to accomplish physician success, hospital success, and good-quality patient care.

Figure 1.2

THREE LEGGED STOOL



The three-legged stool approach is a way of ensuring that the organization is not overvaluing one of those at the expense of any others.

The take-home message is that the organization is structured to hold physicians accountable to the board in a hierarchical relationship and, at the same time, to encourage physicians to partner with the board and hospital to achieve shared objectives. Keep these two organizational charts in mind and understand that both models are often at play.

Medical Staff Responsibilities

The board delegates to the medical staff the responsibility for monitoring and improving the quality of care that is primarily dependent on the performance of individuals granted privileges. For example, a patient comes to the emergency room complaining of abdominal pain. The surgeon diagnoses cholecystitis, performs good preop stabilization, takes the patient to the operating room, demonstrates strong technique, provides good postop care, and achieves a great clinical outcome. The medical staff owns the surgeon's actions that resulted in the good clinical outcome. However, the clinical outcome is also dependent on the competence of nurses, lab techs, etc. The medical staff does not "own" these other parts of the process.

To monitor and improve quality of care, the medical staff has organized itself into a self-governed structure. The model of self-governance presents challenges as healthcare becomes more and more complicated. Balancing costs, physician-hospital competition, financial dependence/referral relationships, and patient safety challenges make self-governance difficult. Again, the medical staff is assigned responsibility for the quality of care delivered by the medical staff, which means that physicians are mutually accountable to each other.

Management Responsibilities

Management is also responsible for meeting board-approved quality and financial performance targets and for ensuring compliance with regulatory requirements. Management must also ensure that the organization has adequate staff and facilities to meet these targets.

Management also provides resources to the board and the medical staff to help these groups fulfill their responsibilities. For example, the medical staff services department aids the medical staff by providing credentialing and regulatory expertise, and the quality management department partners with the medical staff to ensure effective peer review.

Physician executives or medical directors, vice presidents of medical affairs (VPMA), or chief medical officers (CMO) may also guide the medical staff. These physician executives fall under the CEO on the organizational chart. They are hired by, are compensated by, and are accountable to the CEO. The physician executives are not directly accountable to the medical staff, and the medical staff is not directly accountable to them. However, they are often a resource for and have influence on the medical staff.

Understanding Influence

What happens if a medical staff doesn't fulfill its responsibilities? Often, the CEO, VPMA, or CMO get pulled into the space between the board and the MEC to intervene. However, doing so usurps the role of the medical staff. Medical staffs must remember that if it fails to self-govern, to hold one another mutually accountable through effective quality, patient safety, peer review, and credentialing policies, the power will be taken out of its hands. The board has the authority to make that decision.

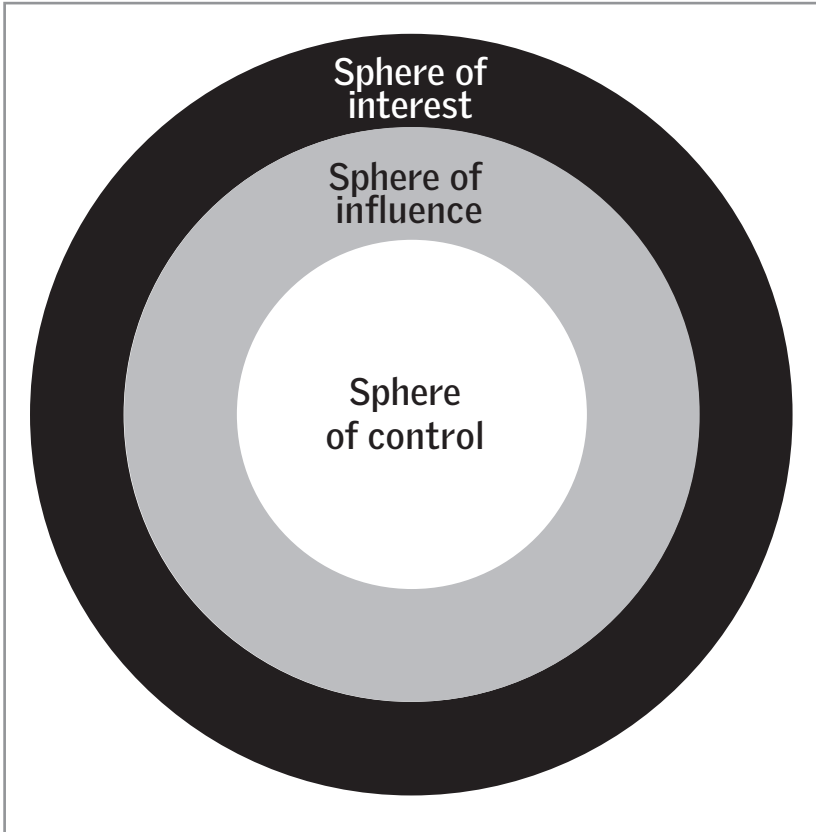
We return again to the idea of good fences making good neighbors. The medical staff owns physician performance issues. Physicians care about everything that happens to the patient—from admitting the patient, to treating the patient, to delivering meals. All these things fall within the physician's sphere of influence. Unfortunately, not all these things fall within the physician's sphere of control.

But things that fall into the medical staff's sphere of influence are critical to hospital operations. The medical staff can influence important decisions, such as staffing and strategic planning. In line with Joint Commission standards, the department chair has input into staffing within his or her department. The medical staff can also have an influence over the hospital's strategic planning, which is owned by the board. Further, the physician can influence the other practitioner's actions. For example, the physician can educate the nurse about the patient's condition and share the treatment plan with the nurse. The physician can also make clear that he or she is worried about the patient's condition and encourage the nurse to call should the patient's condition change overnight. Doing so expands the physician's sphere of influence.

As illustrated in Figure 1.3, the medical staff has a sphere of control, a sphere of influence, and a sphere of interest. As you can see, the sphere of control is much smaller than the sphere of influence and sphere of interest. The organized medical staff has an interest in everything that goes on at the hospital. The medical staff is interested in patient care, the hospital's reputation and financial standing, the physician plant, and the competence of all staff. But, again, the medical staff's sphere of control is limited to those tasks delegated to them by the board—the quality of care primarily dependent upon performance of individuals granted privileges.

Figure 1.3

SPHERE OF CONTROL, INFLUENCE, INTEREST



When keeping in mind these three spheres, it's important to recognize that the better the medical staff addresses the issues within its sphere of control, the better it can address things that fall within the spheres of influence and interest and expand the medical staff's ability to help the hospital and fellow physicians achieve mutual goals.

MEDICAL EXECUTIVE COMMITTEE

Essentials Handbook

Richard A. Sheff, MD • Robert J. Marder, MD

The **Medical Executive Committee Essentials Handbook** breaks down the medical executive committee role to facilitate understanding of the role's responsibilities and provide strategies for being an exemplary committee member. Oftentimes physicians end up in a leadership position without really knowing what the job entails and what they are meant to accomplish. This handbook can be used as a comprehensive guide for physician leaders throughout their appointment, providing them with the necessary skills and knowledge they may not have received as part of their medical school training and residency. Plus, to make staff training easy, this handbook includes a customizable PowerPoint® presentation highlighting key takeaways covered in the handbook.

Benefits of Medical Executive Committee Essentials Handbook:

- Compare and contrast the roles and responsibilities of the medical staff, management, and board
- Describe the dimensions of physician performance
- Explain the role of MEC as oversight for the credentialing and privileging committee
- Explain the role of MEC as oversight for the peer review, quality, and patient safety committees
- Describe the MEC's role in overseeing disruptive physician behavior, according to the law and Joint Commission standards
- Identify the seven factors of successful medical staff development planning
- Derive strategies to streamline MEC meetings

To complete your Medical Staff Leadership Training Handbook series:

Department Chair Essentials Handbook

Richard A. Sheff, MD & Robert J. Marder, MD

Credentials Committee Essentials Handbook

Richard A. Sheff, MD & Robert J. Marder, MD

Peer Review & Quality Committee Essentials Handbook

Richard A. Sheff, MD & Robert J. Marder, MD

©2012 HCPro, Inc. HCPro is not affiliated in any way with The Joint Commission, which owns the JCAHO and Joint Commission trademarks.

MSLMECE

HCPro

75 Sylvan Street | Suite A-101
Danvers, MA 01923
www.hcmarketplace.com

ISBN: 978-1-60146-947-2

