

Medical Staff Briefing

A TRAINING RESOURCE FOR MEDICAL STAFF LEADERS AND PROFESSIONALS

Section 1921 changes unite NPDB and HIPDB All licensed professionals now reportable

Since the Health Resources and Services Administration (HRSA), a division of the U.S. Department of Health and Human Services, issued changes to Section 1921 of the Social Security Act in January, the credentialing world has been in a flurry. The changes require state licensing agencies to report nonphysician and nondentist practitioners to the National Practitioner Data Bank (NPDB) for any adverse licensure actions.

The good news for MSPs and medical staff leaders is that these changes don't affect medical staff functions much, says **Mary Hoppa, MD, MBA, CMSL**, senior consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. "States, peer review organizations, and accreditation organizations have extra mandatory reporting requirements. It doesn't affect the medical staff in any way other than

it increases the robustness of information coming out of the data bank."

However, even though these changes don't directly affect the medical staff, it is still important for MSPs and medical staff leaders to understand the nuances of the changes because these individuals may help facilitate hospital reporting and querying processes. In particular, credentials committee members

"To the extent that a hospital wishes to make use of this new information, the daily work of medical staff services professionals could be affected."

—Mark Pincus

will need to consider red flags that the new reporting process raises for nonphysician practitioners who are credentialed and privileged through the medical staff.

Section 1921 highlights

The NPDB was created as a result of the Health Care Quality Improvement Act of 1986 in an effort to prevent problem physicians from sliding under the radar by jumping from state to state. It encourages hospitals, state licensing boards, and other healthcare entities to report adverse actions taken against physicians, including restrictions to licensure and/or clinical privileges, changes to professional society membership, and exclusions from Medicare and Medicaid. In 1987, the Medicare and Medicaid Patient and Program Protection Act created the Healthcare Integrity and Protection Data Bank (HIPDB), which collects information regarding adverse licensing actions taken against healthcare practitioners and entities. The changes to Section 1921 bring the two databases together.

According to the *Federal Register*, Vol. 75, No. 18, January 28, 2010, the following changes were kicked into gear as of March 1:

IN THIS ISSUE

p. 5 Deliver presentations without breaking a sweat
Does the thought of standing behind a podium make you nervous? These tips will give you the confidence to wow the crowd.

p. 8 Help aging docs taper their practices safely
As the current wave of baby boomers crests, medical staffs need to manage aging practitioners' practices to protect patient safety while maintaining collegial relationships.

p. 10 Sample aging practitioner policy
Adapt this sample policy to meet your facility's needs.

p. 12 Physician employment: Panacea or poison?
William K. Cors, MD, MMM, FACPE, CMSL, explores physician employment arrangements in this monthly column.

HCPro

Section 1921

< continued from p. 1

- State licensing agencies must report to the NPDB certain licensing actions taken against nonphysician practitioners, such as revocation, reprimand, censure, suspension, and probation. These practitioners include but are not limited to chiropractors, podiatrists, pharmacists, physician assistants, optometrists, professional and paraprofessional nurses, physical therapists, respiratory therapists, and social workers. This change means that hospitals now have access to information that previously resided only in the HIPDB. Previously, only federal and state government agencies and health plans had access to this information.
- According to the *Federal Register*, “Section 1921 expands state reporting of licensure actions taken against physicians and dentists to the NPDB.” State licensing agencies are now required to report healthcare practitioners for all types of actions taken against their licenses, not just those that are related to clinical competency.

- Healthcare accrediting agencies, state licensing authorities, and peer review organizations (PRO) must report negative actions or findings against healthcare entities (e.g., loss of accreditation status). Entities were previously not reportable. (See “Section 1921 Q&A” on p. 4 for more information about PROs.)
- Medical malpractice insurers must report payments made on behalf of physicians, dentists, and other licensed healthcare providers. “If an RN is named in an insurance settlement, that insurance provider has to report that RN to the NPDB,” says **Jodi Schirling**, director of medical and professional staff services at Nemours in Wilmington, DE.

Section 1921 requires state licensing agencies, peer review organizations, and private accreditation organizations to report their adverse actions. It does not require medical staffs to report, according to **Mark Pincus**, acting director of the Division of Data Banks at HRSA.

Hoppa notes that hospitals have never been precluded from reporting nonphysician and nondentist practitioners to the NPDB, but because it was never required, very few hospitals did.

So why make these changes? “Think about the gap between an anesthesiologist and a [certified registered nurse anesthetist]. Before these changes, both of them could commit the same error, both of them could have their privileges restricted, but only the anesthesiologist would be reported to the NPDB,” says Hoppa.

Frances Cullen, Esq., an Atlanta-based attorney who specializes in healthcare issues, says that these changes are a logical progression. “There has been an increase in the number of allied health professions, and there is so much transfer across the states, so it seems logical to increase NPDB reporting.”

Raising the red flag

One of the questions that querying hospitals might have with regard to the changes to Section 1921 is, “What do we do with all of this extra information?”

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With broader reporting, credentialing committees may be faced with more red flags than in the past. (Remember, nonphysician and nondentist practitioners are generally employees of the hospital but may be credentialed and privileged through the medical staff or an equivalent process through the hospital HR department. Therefore, although the hospital’s HR department will most likely be responsible for querying the NPDB regarding adverse actions taken against nonphysician practitioners, the credentials committee may be responsible for deciding what to do with that information.)

“It is going to take more diligence and time to ferret out if a red flag is truly something of concern,” Cullen says. The problem, she explains, is that many good nonphysician and nondentist practitioners’ records are ruined when red flags snowball. For example, an insurance company may report a medical malpractice settlement to the NPDB, prompting a case review by the state licensing

board, which may result in reportable disciplinary action. The individual’s professional organization may then review and take action on any or all of these reports. That’s three or four red flags stemming from a single incident.

Luckily, credentialing committees are adept at chasing red flags given their years of experience with NPDB reports. “A red flag means that you have to ask more questions and get more information and make your own decisions accordingly. That’s all it means,” says Hoppa.

Another concern is that the changes to Section 1921 do not require hospitals to query the NPDB for actions taken against nonphysician and nondentist practitioners every two years, as they must for physicians and dentists. “For example, if I’m hiring nurses or a respiratory therapist, I’m going to query the data bank one time when I hire them,” says Schirling.

Cullen adds that although it is not a requirement, medical staffs and credentialing committees should create a policy to routinely query the NPDB regarding nonphysician and nondentist practitioners to safeguard themselves.

If your hospital is accredited by The Joint Commission (formerly JCAHO), it must already query the NPDB for initial granting of privileges and whenever privileges are renewed. “It is rare that a practitioner’s NPDB status would change while working at the hospital without the hospital knowing, but it can happen, so regular querying is a must,” says Cullen.

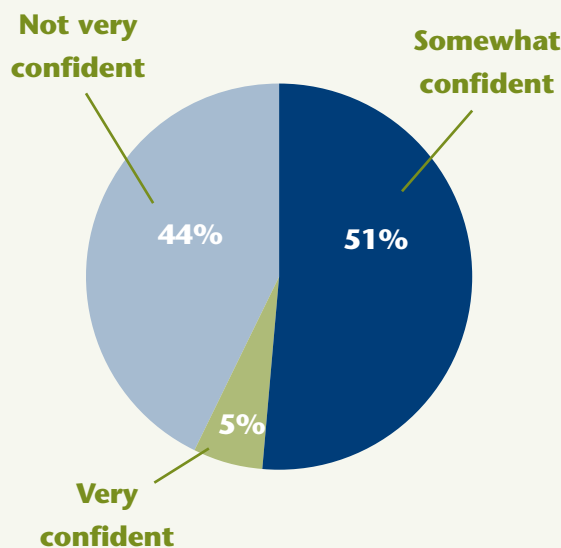
The bottom line

The changes to Section 1921 likely won’t drastically change the daily lives of MSPs or medical staff leaders. “Section 1921 makes adverse state licensure actions taken against nurses, podiatrists, chiropractors, and allied health professionals available to hospitals. To the extent that a hospital wishes to make use of this new information, the daily work of medical staff services professionals could be affected,” says Pincus.

> *continued on p. 4*

**Readers respond:
Few confident in NPDB**

A recent poll on *www.CredentialingResourceCenter.com* asked readers how confident they are that the National Practitioner Data Bank (NPDB) contains up-to-date information. The majority of the nearly 150 respondents reported that their faith in the system is low.



Section 1921

< continued from p. 3

Pincus adds that hospitals will have to decide for themselves which departments are responsible for querying the NPDB regarding non-physician practitioners.

For example, the medical staff may be responsible for querying the NPDB regarding only practitioners privileged by the medical staff, whereas HR might make queries regarding practitioners not privileged by the medical staff (e.g., nurses, acupuncturists, respiratory therapists).

“HRSA does not dictate or suggest how an organization structures itself to query. This is considered a business decision of the organization,” says Pincus.

If the hospital decides that HR is responsible for querying the NPDB for non-privileged practitioners, HR may ask the medical staff services department for guidance.

“I think we’ll see that most of this is going to be handled through the HR process. MSPs may need to educate HR on how to best implement a system for querying at the time of hire for other licensed healthcare practitioners,” says Schirling.

Most new regulation and policy changes create a flurry of questions and confusion when they are first issued, but remember that for this particular change, hospitals have always been able to find the relevant information about nonphysician and nondentist practitioners by querying state licensing boards, professional societies, and other

primary sources. Therefore, the information provided in the NPDB as a result of changes to Section 1921 of the Social Security Act is not new, but now more easily accessible to hospitals in a single location. ■

Section 1921 Q&A

Q Do the changes to Section 1921 of the Social Security Act affect the medical staff peer review process?

A The requirements for reporting by peer review organizations under Section 1921 are not expected to affect hospital reporting. Section 1921 requires the reporting of “any negative action or finding” by a peer review organization. For the purposes of Section 1921 reporting, the term “peer review organization” does not include the internal peer review committees of hospitals, professional societies, or other healthcare entities as defined in the current National Practitioner Data Bank regulations. To be subject to reporting requirements, the peer review organization must be a stand-alone organization separate from a hospital or other healthcare entity.

Source: Mark Pincus, acting director of the Division of Data Banks, Health Resources and Services Administration.

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Public speaking 101

Deliver presentations without breaking a sweat

Adopt crowd-pleasing podium skills

As a medical staff leader or MSP, at some point during your career, you will inevitably find yourself standing in front of a crowd delivering a presentation. You may be presenting to only five board members or a crowd of 400. Either way, you should have the right tools in your belt if you want to hold your audience's attention.

Whether you seldom stand at a podium or have delivered dozens of speeches and presentations, these tips will help you polish your preparation and speaking skills to ensure that you feel confident in front of a crowd:

► **Prepare detailed handouts.** Avoid including supplemental reading material, such as lengthy reports and white papers, in your slide presentation. Most likely, the print will be too small to read when projected on a screen. Rather, compile the supplemental material into a printed or electronic takeaway packet.

If you have the luxury of knowing the individuals in your audience, cater your handouts to their needs. "We have a [medical executive committee (MEC)] of about 35 people. We have some physicians who want the bare-bones presentation, and a few who want a one- or two-page summary. Others want all the details, and for them, I prepare a full report," says **Guenther Baerje, BSIT, CPMSM, HACF**, director of medical staff management at Good Samaritan Hospital in Los Angeles.



For more information about preparing presentations, Baerje suggests *slide:ology: The Art and Science of Creating Great Presentations*

by Nancy Duarte.

► **Get to know your audience.** If you are presenting in front of a crowd you are unfamiliar with (e.g., at a national seminar as opposed to a department meeting), take the time to get to know your audience. For example, let's say you are a medical staff leader presenting on the effect of recent Joint Commission changes to a crowd

of 200 MSPs. You understand how The Joint Commission's (formerly JCAHO) changes affect physicians and medical staff leaders, but you need to tailor your presentation to MSPs.

"MSPs are bent toward detail, compliance, and regulation. The medical staff leader is going to be thinking about conflicts of interest, politics, and how something will affect business in the future," says Baerje.

To better understand this audience, ask around to see whether any of your colleagues have presented in front of a similar crowd and can share their experiences. Also, chat with MSPs in your organization's medical staff services department about how Joint Commission standards factor into their daily work and what information they would want to learn more about.

When researching your audience's needs, ask yourself the following questions, suggests **Jeff Hornstein**, president of The Speaker's Choice, a communications consulting company in St. Charles, IL:

- What are my audience's positions, titles, functions, and tenure?
- What is the demographic makeup?
- What is the audience's knowledge level?
- In what method does the audience take in information? Do they prefer to listen rather than read? Do they require more illustrations or fewer slides altogether?
- What kind of political, informational, or logistical barriers might I face?

If you are presenting at a seminar and have access to the attendee list, you may want to send out an e-mail survey several weeks before the presentation.

"When you are surveying people ahead of time, one of the questions you want to ask is, 'What are the top two or three things you want to learn from this presentation?'" You might get several responses that make you

> *continued on p. 6*

Public speaking 101

< continued from p. 5

think, 'I wasn't going to cover that, but now I will,' " says Hornstein.

If surveying your audience weeks in advance is not an option, you may poll your audience during the presentation. For instance, using the Joint Commission example, you may say, "How many of you struggle to comply with LD.02.04.01?" and ask for a show of hands from the audience.

However, unless you are an experienced speaker, take caution when using this approach. "You need to be agile enough during the presentation to change course based on the response of the audience," Hornstein says.

► **Tailor your presentation.** Using the information you gather about your audience, design a presentation that speaks specifically to them.

"People make the mistake of thinking that one size fits all. They create one presentation and deliver it in the same way using the same content regardless of who is in the audience. That is a mistake," says Hornstein.

By knowing your audience members' knowledge level, you will avoid frustrating them. "I've given basic material to an advanced audience and watched them fall asleep," says **Jonathan H. Burroughs, MD, MBA, FACPE, CMSL**, senior consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. "I've also presented complex material to groups that were not ready to absorb it."

► **Be aware of your own bad habits.** According to Hornstein, not making eye contact with the audience, keeping your back to the crowd, and bartering for time with "ahh" and "umm" are three of the biggest mistakes that speakers make. These habits may damage your credibility with your audience, as it sends the message that you haven't adequately prepared. Record yourself practicing your presentation and play it back, preferably with a friend or colleague in the room to help you identify the habits you need to break. Then practice eliminating those habits.

"These skills need to be practiced when it doesn't matter—when you're having dinner with friends or any situation that is not high stakes. If you do that, the skills become habitual and will carry you through high-stakes situations," says Hornstein.

► **Bring a point home with a well-placed story.** Anecdotes can bring statistics to life, but don't tell a story just to tell a story, says Burroughs. "Every story should make a point," he says. For example, during a recent presentation, Burroughs illustrated the dangers of poor communication between physicians and nurses by relaying the true story of two preventable deaths at his former hospital and the emotional impact they had on the physicians and nurses involved. "You are trying to teach them the experience around the idea, and then they will remember the idea."

► **Come prepared with solutions.** Most presenters are not just trying to inform their audiences—they are trying to convince them to act in a certain way. For example, you may be trying to compel your MEC to adopt a policy or change a rule. "You have to prepare for potential objections and come up with two or three solutions," says Baerje, and back those solutions up with data.

For example, during a presentation to medical staff leaders, Baerje explained how difficult it was for the medical staff services department to get physicians to complete their medical records promptly. Leaders expressed that enforcing administrative suspensions on physicians who did not complete their medical records on time was also difficult. To help convince leadership to enforce administrative suspensions, "I found a way to display the data to illustrate the enormity of the problem and presented them with some options," Baerje says. "The result was a unanimous decision to adopt one of the suggested actions."

► **Manage your Q&A session.** The first step to ensuring a smooth Q&A session is to anticipate any questions the crowd might throw at you and incorporate those answers into your presentation. This will cut

down on the number of questions the audience is likely to ask.

If an audience member throws you a curveball, don't pretend you know the answer, says Hornstein. "Admit that you don't know the answer and promise to get back to that person with an answer within a certain time frame," he says. You may give the individual who asked the question your e-mail address and ask him or her to send you an e-mail with the question. Hornstein also suggests writing the question down to remind you to research the answer.

However, if you are presenting to the board of directors or the CEO, it is not appropriate to ask the questioner to send you an e-mail. "If I am communicating upward, that is my responsibility," Hornstein says.

He also suggests avoiding the phrase, "That's a good question." If you use it every time, then the audience will perceive it as a stall tactic, and if you use it intermittently, you may make some attendees think that their

questions aren't good. "We suggest not using it at all," Hornstein says.

➤ **Go easy on the jokes.** Hornstein recommends not breaking into a stand-up comedy routine in front of your audience. "A joke is only funny if it offends someone," he says. This is not to say that you should avoid all humor. Rather, humor is best when it is spontaneous and mildly self-deprecating (e.g., "I was startled when I saw that statistic, too—hence the coffee stain on my shirt.").

➤ **Be yourself.** When giving presentations, relax and be yourself. Don't change your personality in front of a crowd, but rather work these tips around your personality traits. "If you behave one way in the break room, another way in the board room, and another way in the ballroom, people will smell that from a mile away," Hornstein says. ■



For more information on public speaking skills, Burroughs suggests *I Can See You Naked* by Ron Hoff.

Create an attractive slide presentation

When preparing a slide presentation, content is king, but don't forget about visual appeal. The following tips will give your presentation a professional tone:

➤ **Slide presentations aren't scripts.** To keep your slides easy to follow, remember that their purpose is to serve as an outline. Only include four to five bullet points per slide and be sure to use at least 30-point font, says **Guenther Baerje, BSIT, CPMSM, HACP**, director of medical staff management at Good Samaritan Hospital in Los Angeles.

You are also more likely to grab your audience's attention by keeping the content of your slides succinct. "As humans, we can't read and listen to someone speak at the same time. They are two different thought processes," says Baerje.

➤ **Use graphics to your best advantage.** You may wish to include graphs and charts in your slide presentation to illustrate a trend or summarize important data. Baerje recommends looking at reputable publications, such as *The Wall Street Journal* or the *New England Journal of Medicine* to see how they design their charts and graphs. "You can get a feel for how you want your charts to look."

➤ **Avoid cartoons, clip art, and animated slide transitions.** Graphs and charts can support the information you provide in your presentation, but cartoons, clip art, and animated slide transitions can undermine it if used excessively, says Baerje. That's not to say that these visual elements are never appropriate, but you must choose them with care and use them sparingly. For example, you may wish to include a photo of people who work at your organization (with their permission) to give your presentation an emotional appeal. "Human pictures help because they give us an immediate connection, but cartoons look unprofessional, and slide transitions distract the audience."

➤ **Obey copyright law.** Keep in mind that most images on the Internet are copyrighted, even if the Web site hosting the images doesn't explicitly say so. You shouldn't copy and paste an image or content directly from a Web site that does not belong to you or your organization. Baerje suggests purchasing images and photos from online photo libraries, such as www.istockphoto.com or www.shutterstock.com, to ensure that you abide by copyright laws.

Help them out, don't boot them out

Medical staffs guide aging docs toward retirement to maintain collegiality and ensure patient safety

When you combine the heart-wrenching possibility of taking away a colleague's livelihood with the threat of getting involved in a discrimination lawsuit under the Americans with Disabilities or Age Discrimination in Employment Acts, it's no wonder that many medical staffs find it difficult to confront aging physicians about their ability to practice medicine. But as the current wave of baby boomers reaches its peak, it's clear that the problem isn't going to wash away.

Most physicians realize when it is time to hang up the stethoscope and start planning their retirement bash, but some physicians are determined to hang on to their privileges, says **Debra Williams, MD**, emergency center medical director at Gulf Emergency Specialists, which services Gulf Coast Medical Center in Panama City, FL. "Many physicians are not financially able to stop practicing. As physicians, we train and practice for so long that we don't have time to develop other skills that would allow us to have another type of income. It's a tough transition," Williams says.

It's even tougher for physicians who are forced to stop practicing medicine due to a physical or mental illness because they may not realize that their skills have deteriorated.

When developing policies and procedures for managing senior physicians, it is important for medical staff leaders to remember that a proactive approach will help preserve collegial relationships, reduce the likelihood that a physician will file an age discrimination lawsuit, and reduce risk to patients.

Picking up on docs who are slowing down

Medical staffs will likely find it easier to detect a procedure-based specialist's possible physical impairment than a general medicine physician's cognitive or mental decline, says Williams. "People who are doing procedures

are observed by colleagues, so it is easier to detect a decline in their ability to perform. It is much more difficult to determine whether a primary care physician made the right diagnosis or followed best practice," she says.

To keep track of both procedural- and cognitive-based physicians, the department chairs at Gulf Coast Medical Center have made a list of quality measures by which to gauge physician performance in their respective departments. In addition, physician performance is tracked against The Centers for Medicare & Medicaid Services' core measures, such as those for pneumonia, acute myocardial infarction, and venous thromboembolism. Gulf Coast also keeps a keen eye on length of stay as quality performance indicator. "It's not much different than what the insurance companies use to measure quality," says Williams.

Tracking physician performance according to these quality measures has allowed the medical staff at Gulf Coast to identify the performance trends of all physicians—not just the older ones.

"When it came time to say, 'Your complication rate is three times that of your colleagues,' we had some leverage," says Williams. "We have been able to use the quality data to start the discussion with aging practitioners."

Don't wait for problems to occur

They say you're never too old to learn something new, but you may not like what you learn. Medical staff leaders should delicately approach physicians who may not have realized that they need to slow down.

Dean White, DDS, MS, medical staff advisor at Texas Health Resources Harris Methodist HEB Hospital in Bedford, suggests that the medical staff start conversations with aging practitioners early, before any problems arise. To do this, the medical staff should devise a policy stating that whenever a physician reaches a certain

age, he or she must meet with the physician wellness committee.

If your hospital is accredited by The Joint Commission (formerly JCAHO), standard MS.11.01.01 requires hospitals to implement a process to identify and manage issues that affect the health and well-being of licensed independent practitioners that is separate from disciplinary processes. For some hospitals, this process includes implementing a physician wellness committee.

When it comes to addressing aging physicians, the wellness committee should strive to send the following message: “We are not implying that there is a problem with your performance, but we want to let you know that we are here to assist you as you age and your practice changes,” White says.

Best practice is to approach physicians before any problems arise, but if a physician on your staff is already causing concern, the department chair, a close colleague, a subcommittee of the credentials committee, or members of the physician wellness committee should sit down with the physician to encourage him or her to make practice changes.

“If the administrators sat down with the physician and said, ‘You need to alter your practice or retire,’ I don’t think that works well. But if the physician wellness committee or the credentials committee did it with the right people and the right resources, it would probably have a better outcome,” says White.

When it doubt, test it out

To gauge the physician’s possible loss of cognitive and physical function, the physician wellness committee might suggest that the physician undergo neuropsychological testing, or the physician may choose to pursue such testing independently. Testing is generally conducted by a neuropsychologist. “Neurologists are their primary referral source, but anyone can have the tests without a referral,” says White. However, some physicians may choose to undergo neuropsychological testing on their own without the medical staff’s knowledge,

> *continued on p. 10*

Five steps to managing aging practitioners

Jonathan H. Burroughs, MD, MBA, FACPE, CMSL, a senior consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, suggests that medical staff leaders take the following five steps to help aging practitioners transition into retirement safely and with dignity:

- Proactively draft a policy and a procedure that address aging practitioners. The airline industry has done this for years by requiring aging pilots to participate in simulation exercises every six months and creating a mandatory retirement age (65). Like pilots, physicians are responsible for people’s lives.
- Choose an age (e.g., 70) at which the medical staff will begin to more closely monitor a physician’s performance. Medical staffs may choose to decrease the reappointment period from two years to one year and require a more detailed evaluation of a practitioner’s ability to safely exercise his or her requested clinical privileges.
- Request a fitness-to-work evaluation. This evaluation is not a history and physical, but rather a vocational examination based on requested privileges. A practitioner who is familiar with the aging practitioner’s specialty should perform the fitness-to-work evaluation. The physician conducting the evaluation should be directly accountable to the medical executive and credentials committees. The hospital may need to pay for this evaluation.
- Create co-management privileges to enable physicians to make a dignified transition from independent privileges to refer-and-follow privileges. Refer-and-follow privileges are ambulatory-based privileges that allow physicians to refer patients to the hospital, order ancillary studies from an outpatient setting, and follow their patients in the hospital.
- Require physicians to accept refer-and-follow privileges at a predetermined age (e.g., 85), unless waived by the medical executive committee and governing board in extraordinary situations.

Retirement

< continued from p. 9

either before or after meeting with the physician wellness committee.

White says several types of neuropsychological tests are available, but the most common is the Halstead-Reitan Neuropsychologic Battery. It takes about six hours at a cost of \$1200 to \$1800. "These tests have been done for many years, and their standardization and validity have been proven," White says.

If a physician undergoes testing without the medical staff's knowledge, he or she is obligated to foot the bill. The physician may choose to share the test results with the medical staff, but in most cases, he or she would keep them private. "They get to use that information to make life decisions," says White. He adds that, on occasion, the medical staff may offer to pay for the testing if

it has concerns about a physician's performance but no concrete evidence. However, if the medical staff pays for the testing, it gets access to the results.

Some physicians may not need to resort to neuropsychological testing. Rather, a simple fitness-to-work evaluation may detect whether physical, cognitive, or psychological issues preclude a practitioner from safely exercising the requested/granted clinical privileges.

Offer alternative practice options

The meeting between the physician wellness committee and the aging physician may also be a good time for the committee to outline alternative practice options. Because the meeting is held before any problems arise, physicians have time to think about what they

Sample policy: Physical assessment of practitioners over the age of [n]

It is the policy of the medical staff that the [credentials committee/medical executive committee (MEC)] specifically consider, on an ongoing basis, the abilities, competencies, and health status (i.e., ability to perform) of each practitioner who has privileges in accordance with the medical staff bylaws and policies and procedures related to clinical privileging.

In conjunction with their biennial reappraisal/reappointment, at the age of [n], practitioners holding clinical privileges shall complete an examination that addresses both their physical and mental capacity for the privileges requested. The physical and mental exam will be conducted by a physician who is acceptable to the [credentials committee/MEC]. The outcome must be documented on the approved form and submitted by the date requested by the [credentials committee/MEC].

The physical examination is a fitness-to-work evaluation and must indicate that the physician has no physical or mental problem that may interfere with the safe and effective provision of care permitted under the privileges granted. Adverse findings that interfere with the safe and effective provision of care under the privileges requested are

processed in accordance with the applicable medical staff bylaws, including adherence to state or federally mandated reporting requirements.

In addition to the physician examination, a practitioner may be required to undergo a focused review of his or her clinical performance as part of the assessment of his or her capacity to perform requested privileges. Such focused review may be required in the absence of any previous performance concerns. The scope and duration of the focused review shall be determined by the MEC upon recommendation of the department chair and credentials committee.

The board must also receive a recommendation from the MEC stating that the practitioner has been found to be clinically competent and is recommended for the privileges requested.

At the age of [n], medical staff appointees shall automatically relinquish all clinical privileges [and will be reassigned to the appropriate medical staff category].

Source: The Top 40 Medical Staff Policies and Procedures: Solutions from the Greeley Medical Staff Institute, *Fourth Edition*, available at www.hcmarketplace.com.

may like to do in the future should certain skills deteriorate. For example, if neuropsychological testing or outcomes data suggest that an orthopedist is on the decline, the committee may suggest he or she no longer operate on spines, but rather focus on knee replacement surgeries. Other options are to allow the orthopedist to assist other surgeons or to require a proctor to be present for all cases.

“You are not telling anyone to retire—it’s an effort to educate the physician on strategies for safety as he alters his practice while transitioning to retirement,” says White.

Whoever approaches the aging physician—be it the physician wellness committee or a close colleague—should come prepared with options for the physician to consider so he or she doesn’t feel attacked. For example, when a diagnosis of spinal stenosis at the age of 55 brought White’s decades-long practice to an abrupt halt, the medical staff at Texas Health created the medical staff advisor position to keep him engaged in the field he had dedicated his life to and tap into his strong interpersonal skills and institutional knowledge.

Today, White’s part-time medical staff responsibilities include serving as an advisor to the chief of staff, overseeing the physician’s health committee, sitting in on quality and performance improvement meetings, and mentoring medical staff members. The hospital granted him honorary status on the medical staff, meaning that he cannot vote on medical staff matters but can voice his opinion.

“Most people, if they are 60 and know that they are going to retire at 66, can start figuring out what they are going to do with the rest of their lives, but when you abruptly have to stop, you don’t have time to ponder alternatives,” says White.

Williams says transitioning physicians to leadership positions certainly helps maintain collegial relationships, but it doesn’t replace the income that the physicians lose as a result of giving up their practices. In White’s case, Texas Health pays him commensurate with other physician administrators, but because he

works part-time, he does not receive benefits. Replacing income, in many cases, is something that the medical staff unfortunately cannot do much about.

The last resort

Ideally, after meeting with medical staff leaders and discussing various options, the physician relinquishes some or all of his or her privileges voluntarily. If he or she refuses, the hospital may be forced to summarily suspend the physician, which results in a report to the National Practitioner Data Bank (NPDB).

“When push comes to shove, we ask people to voluntarily relinquish privileges, because the last thing we want to do to them after 30 years of service is report them to the NPDB,” says Williams.

The good news is that many physicians respond well to performance data, and they can’t argue with policies. Medical staffs should develop a policy that every physician over the age of X needs to be recredentialed every year, rather than every two years, and must undergo a fitness-to-work evaluation.

“As broad as it may be, you need to have something that is standardized across the board. It lets people know that at some point in their career, they will be asked to document that they are still okay to practice,” says Williams. ■

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Choosing the right medical staff model

Physician employment: Panacea or poison?



by *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*

Many medical staff and hospital leaders believe that employment is a panacea for misaligned incentives that currently characterize physician-hospital relationships.

However, it is easy to overlook the downsides or enter into poorly constructed employment agreements that leave neither physicians nor the hospital satisfied. The bottom line is that physician employment can relieve some symptoms of misalignment if implemented correctly, but it is not a cure-all.

It is important to understand the factors that contribute to a physician's decision to become an employee of a hospital.

These factors include:

- **Physicians' desire to practice medicine rather than run a business.** Many physicians do not wish to be bothered with the management and financial hassles of running a practice. For many physicians, the hassle factor diminishes their joy of practicing medicine.
- **A volatile financial environment.** Employment arrangements offer physicians a sense of financial security. This is particularly important to many graduating physicians who are saddled with large student loan obligations.
- **Declining physician incomes.** Physician incomes have not kept pace with inflation thanks to increasing malpractice insurance fees and decreasing reimbursement. Some physicians prefer to reduce their overhead by becoming hospital employees.

Likewise, hospitals enter employment relationships with physicians for numerous reasons. These include:

- **The need to ensure an appropriate physician base for the community.** In primary care, as well as many medical and surgical specialties, hospitals are unable to recruit or retain physicians unless they offer employment.
- **Competition from physician-owned facilities.** Many hospitals are losing their most lucrative services to physician-owned entities and are looking to align physician and hospital interests through employment.
- **ED call coverage.** Many independent physicians resist participating in ED call rosters for unassigned patients. When the hospital cannot secure enough physicians to cover ED call, or when stipends for ED call rise beyond a certain level, it becomes more cost effective for the hospital to employ physicians to provide the needed coverage.

There are, however, disadvantages to physician employment. For example, many hospitals are not adept at physician billing. Considering that billing is the source of the physicians' and the hospital's income, hospitals need to brush up on these skills.

Another downside is that physicians have been trained to be independent. However, hospitals cannot expect physicians to relinquish their independence once they become employees. Finding the balance between autonomy and the responsibilities of employment will require collaboration and time.

When considering employing physicians, be careful of who you hire and what incentives you offer because you might get what you ask for. This will be discussed in next month's column.

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

hospitalist leadership

A SUPPLEMENT TO
MEDICAL STAFF BRIEFING

Advisor

Prevent hospitalist burnout

Five ways to promote a culture of work-life balance

Many hospitalists will tell you that one of the reasons they choose to practice hospital-based medicine is because it offers greater scheduling flexibility than office-based practice. But many will also tell you, often in the same breath, that they are exhausted. Going to bed earlier isn't the solution—hospitalists must create better work-life balance, and to do so, they need support from hospitalist program managers.

To find out how hospitalist program managers can create a culture that promotes work-life balance, **HLA** spoke with two field experts who offer the following tips.

Steer clear of the seven-on/seven-off schedule

Many hospitalist programs operate using a seven-day-on/seven-day-off schedule. This type of schedule is easy to coordinate, and hospitalists enjoy having seven consecutive days off. However, "Seven days multiplied by 12 hours is 84 hours in a row. If you are working too hard, you are going to end up crashing when you are off," says **Jonathan Lovins, MD, FHM**, hospitalist and assistant clinical professor of medicine at Duke University Health System in Durham, NC, and former director of hospital medicine at the Hospital of Central Connecticut.

The time hospitalists spend sleeping and staring blankly at the TV for the first day or two after completing the seven-day grind is time they can't spend pursuing other endeavors.

Monday-through-Friday schedules are also tricky because program managers end up relying too much on moonlighters to cover nights and weekends, and hospitalists can't easily swap shifts. "You are rounding most of the time, so if you have some-

"Just seeing patients and doing nothing else is a recipe for burnout."

—Jonathan Lovins, MD, FHM

one take your place for one or two days, patients can end up seeing three or four doctors during their stay, and they don't like that," Lovins says.

Consider experimenting with more creative schedules. For example, one hospitalist program that Lovins worked for scheduled hospitalists for seven days of 10-hour rounding shifts plus 10 less intense 10-hour admitting shifts scattered throughout the month. "For patient care continuity, hospitalists held on to their rounding shifts, but for the admitting shifts, you could swap with your colleagues because you didn't have to worry about loss of continuity," he says.

Another example is the hospitalist program at Duke, which schedules hospitalists for six days of rounding and two to three days of admitting, followed by several days off.

"Mature hospitalist programs go beyond seven-on/seven-off and do something more creative that allows for flexibility and autonomy," says Lovins.

Create a sick-call rotation

Another approach to solve the scheduling conundrum and prevent hospitalist exhaustion is to create a sick-call rotation, says **Sylvia Cheney McKean, MD, FACP**,

IN THIS ISSUE

- p. 3 Intensivist hospitalists on the rise**
This month's specialty series Q&A discusses the increasing number of intensivist hospitalists.

HCPPro



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> continued on p. 2

Work-life balance

< continued from p. 1

former director of the hospitalist service at Brigham and Women's Hospital in Boston. Sick-call rotation is a dedicated shift, and a hospitalist's duties during that shift depend on whether another hospitalist calls in sick.

Every hospitalist within a service is granted a certain number of vacation weeks, administrative time, weeks on service, and weeks in sick-call rotation. If a hospitalist calls in sick, the hospitalist who is scheduled next on the rotation fills in. The rotation also works well for extended absences, such as maternity leave. The rotation is commensurate with each hospitalist's full-time equivalent status. For example, a hospitalist who dedicates 50% of

his or her time to clinical work is on rotation half as much as a hospitalist who dedicates 100% of his or her time to clinical work.

McKean explains that the rotation doesn't come to a halt if no one calls in sick or takes maternity or paternity leave. Rather, the hospitalist scheduled next on the rotation devotes the time he or she would spend doing clinical work to program improvement efforts. "There is a quality improvement expectation—you do chart review and other things to improve care during that time," she says. "It is easier than if you were on service, and it allows people to take a deep breath so they don't burn out."

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Guide hospitalists into niches

"Just seeing patients and doing nothing else is a recipe for burnout," says Lovins. "The hospitalists who are the happiest have found ways to achieve some balance between clinical and nonclinical work because it exercises another part of your brain."

Hospitalist program managers can guide hospitalists toward niches depending on their talents and interests. Some niche activities include research, teaching residents and physician assistant students, participating in medical staff activities, spearheading quality improvement projects, developing information technology, streamlining hospital operations, and leading committees.

"That is the future for hospitalists maturing into leaders. We need hospitalists getting involved in leadership activities because the director can't do it all," Lovins says.

McKean says she previously thought that hospitalists would be more committed to a service if they worked a full-time clinical schedule, but she has learned over the years that is not the case. "They just burn out. It isn't just about punching a clock and being shift workers—you have to improve the system of care," she says.

Establish an awards program

If changing your program's schedule or creating a sick-call rotation will cause more problems than

solutions at this time, try starting an awards program. McKean suggests establishing a nomination process and setting targets in quality improvement, teaching, research, and clinical service. Your program can host formal awards ceremonies or acknowledge the winners in a newsletter or another form of hospitalwide communication.

“There are steps you can take that are inexpensive and that encourage people to want to succeed in your organization, and that is recognition,” McKean says.

Check in regularly

McKean suggests checking in with new hires monthly and tenured hospitalists yearly to discuss their work-life

balance. Set up a formal meeting or chat over lunch. “Ask them specifically how things are going and how you can be helpful. Look for feedback. It has to be bidirectional communication,” McKean says.

You can also discuss which nonclinical activities the hospitalist is interested in and suggest solutions if he or she is feeling burned out. For example, if the hospitalist moonlights during his or her time off, you may state that although you understand that the additional income is a plus, the individual’s health and well-being should come first.

These tips will create a program culture that promotes work-life balance, which in turn promotes loyalty, physician satisfaction, and safer patient care. ■

Specialty series: Q&A

Hospitalists fill gap as intensivist numbers fall

The future of critical care is now

As the number of intensivists dwindles and demand for their services rises, hospitalists are stepping in to care for critical patients.

“We are way beyond the discussion of whether hospitalists should be in the ICU—they are already there. In many cases, they are managing the patients as the attending physician, and depending on where they are, they do or don’t have the advantage of an intensivist co-manager or consult,” says **Michael Heisler, MD, MPH**, professor of medicine at Sanford School of Medicine at the University of South Dakota and author of “Hospitalists and Intensivists: Partners in Caring for the Critically Ill—The Time Has Come,” published in the January *Journal of Hospital Medicine*.

According to the *Society of Hospital Medicine 2007–2008 Biannual Survey*, 4% (mean) of hospitalist billable encounters were for critical care services. “The numbers have only increased since then,” says Heisler, adding that this trend has affected hospitalists in all types of hospitals, from small community settings to large academic medical centers.



An informal reader poll on www.HospitalistLeadership.com revealed that 38% of respondents have seen a dramatic increase in the number of critical care patients they treat, 25% reported a moderate increase, and 38% reported a slight increase. Results are accurate as of presstime.

HLA sat down with Heisler to wrangle some of the most pressing questions hospitalist program leaders have regarding this growing trend.

HLA: Why is the critical care crisis hitting now?

MH: The number of intensivists is decreasing at the same time that demand for critical care services is increasing. The demand is increasing because there are more patients—namely baby boomers—going into those years where they are more likely to need critical care services. Another factor that contributes to the crisis is that more and more hospitals want to become certified by The Leapfrog Group. One of Leapfrog’s targets, called the ICU Physician Staffing Standard, is designed

> *continued on p. 4*

Q&A

< continued from p. 3

to increase the intensivists in the ICU, so more hospitals are competing for fewer available intensivists.

HLA: What should hospitalist program managers do in the face of this shortage of critical care providers?

MH: Hospitalist leaders need to identify hospitalists in their groups who are particularly interested in and adept at critical care. To force all hospitalists to do critical care won't be the best use of their time and talent. On the same note, to limit the amount of time that a hospitalist who loves critical care can spend in the ICU isn't a good use of his or her time either. Build your schedule so that those who love critical care spend the majority of their time in that environment.

HLA: How can hospitalist and intensivist program managers enable their groups to work together effectively?

MH: Leaders should sit down and define policies describing when a hospitalist must consult an intensivist. Typically, the patients who intensivists are required to see within 24 hours of admission are those on ventilators and all acutely ill patients who are hemodynamically unstable. The rest are standard patients that the hospital can treat. The majority of hospitalists have training in the critical care setting, so they are comfortable managing the vast majority of patients who are admitted to the ICU.

Leaders also need to establish protocol so that no matter who is caring for a patient, we all agree to treat sepsis, for example, the same way.

They also need to create a coverage schedule that is fair and that provides scheduled time away from the ICU for both intensivists and hospitalists. This is one area where hospitalists in the ICU can be especially helpful to their intensivist colleagues.

The good news is that hospitalist and intensivist groups already work together quite well because they already collaborate in the ICU. You have to sit down with your colleagues and discuss how you want to work the schedule, define each group's role, establish when hospitalists

really need to consult intensivists, and figure out how to bill appropriately within the guidelines.

HLA: Is there any certification for hospitalists who wish to focus on critical care?

MH: No, but there should be. A certifying body or university should establish some kind of certification program for hospitalists that gives them additional recognized expertise in critical care. It should require certain standards and levels of competency and require hospitalists to spend a certain amount of time—I suggest 50% of all clinical time—in the ICU. That type of certification may increase the opportunity for hospitalists to provide care and bill at a higher level.

HLA: If hospitalists provide care in the ICU, will it divert revenue away from the general internal medicine hospitalist program?

MH: If hospitalists document the critical care services they provide and bill and code them correctly, the program's revenue is enhanced because insurance providers reimburse critical care codes at a higher rate. Program managers must take the time to be sure that their hospitalist team is doing all of those things correctly.

HLA: How should hospitalist and intensivist programs work together to ensure accurate billing?

MH: You can't have two attending physicians or two critical care consultants on the same case. You can have an infectious disease consultant and a critical care consultant, but those are different enough to allow you to bill third-party payers and Medicare/Medicaid for their services separately. Where you get into trouble is when a hospitalist and an intensivist are both listed as the attending or the consulting physician. Leaders of both groups need to decide who will be the admitting physician and who will serve as a consultant by policy in the ICU. You can do it either way. The intensivist can ask the hospitalist to consult on general medical management, or the hospitalist can be the admitting physician and ask the intensivist to be the consultant. The key point is that when you do this correctly, everyone—including the patient—benefits. ■