The Leadership Institute Roundtable

Millennium Group

Updating the Organized Medical Staff
For Evolving Health Systems

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What is the current status of the "Organized Medical Staff"?

The ‘Organized’ Hospital Medical Staff

Designed long ago for a different era in medical care delivery where:

- Most physicians were in private practice
- Doctors needed hospitals and an unspoken ‘contract’ existed between the two – a ‘quid pro quo’
- Regulatory demands were minimal
- Quality and patient safety were assumed
- Interdisciplinary care was not the norm/integrated care was uncommon

The ‘Organized Medical Staff’ has been an ossified entity for more than fifty years, but is slowly evolving to fit into a changed health care world.

What does medical staff change and evolution look like?

More professionalization of roles

- More continuity; Provision of training and skill development
- Qualifications for positions (including availability to do the job adequately)

Updating problematic bylaws/policies/rules & regulations

Streamlining run-away bureaucracy

- Fewer committees; Fewer categories
- Downsizing or eliminating departments/divisions/sections
- Returning to the hospital responsibilities not essentially medical staff duties
- Downsizing policies, eliminating rules and regulations

"How many times have I told you not to play doctor?"

Is Unification of Medical Staffs Allowed?

2014 Updated CMS Medicare Conditions of Participation:

Allowed hospitals operating under a health system board to unify medical staff if:

- Permitted under state law
- Each constituent hospital's medical staff decides voluntarily to merge into a unified medical staff entity & 4 conditions met:
  1. The medical staff of each hospital must have voted by majority in accordance with its bylaws to join, or to opt out of, the unified staff;
  2. The unified staff must have bylaws, rules, and requirements describing its processes for self-governance, credentialing, peer review and due process and which have an opt-out mechanism;
  3. The unified medical staff must be established in a manner that takes into account each hospital's unique circumstances with respect to any significant differences in patient populations and hospital service;
  4. The unified medical staff must operate in a way that gives due consideration to the needs and concerns of all members of the medical staff, regardless of their practice or location, to ensure that local issues applicable to particular hospital are duly considered and addressed.

Why Combine Medical Staffs across Hospitals?

Greater “user-friendliness” for physicians

- One application, one reappointment to track, communications from one source, fewer meetings

Efficiency

- Consolidation of medical staff offices and staff
- Effective use of physician leadership bench strength
- Fewer meetings

Why Combine Medical Staffs across Hospitals?

- Fewer silos and less fragmentation of medical staff work
- Less work for health system board
- Reduced potential for liability
- Fewer accreditation reviews
- Ability to reduce unwanted variance in policies and procedures, rules and regulations, clinical practices and operational activities
- Minimize medical staff “politics” and ‘last angry man’ scenario
- Opportunity to rationalize and restructure physician leadership across all aspects of the integrated delivery system

Downsides to Medical Staff Consolidation

- Less focus on local hospital campus issues
- Fewer physicians engaged in the development of leadership skills
- Short-term political costs
- Creates a need to ramp up efforts at effective communication

Additional Factors for Consideration

- Geographic distances between hospitals
- Multi-state distribution of hospitals
- Historic medical staff cultures
- Number of hospitals within the health system
- Length of time hospitals have been part of health system
- Historic levels of trust between medical staffs and health system leadership

Additional Factors for Consideration

- Diversity across health system hospitals & complexity of medical staffs:
  - Academic institutions
  - Large vs. small community hospitals
  - Critical access hospitals
- Tensions between employed and private staff physicians
- Controversy over on-call coverage

Complete Unification or Intermediate Steps?

- Upside/downsides to “partial” unification
- What does “partial” unification look like?
- Who should consider “partial” unification?

An Urgent Need for a Coordinated Framework for Physician Leadership

Traditional Physician Leaders:
Medical staff officers, department and committee chairs
Physician leaders in academic affairs

Expanding Roles for Physician Leaders:
Physician executives (CEOs, CMOs, VPMAs, Chief Clinical Officer, CQO, CIO, Chief Integration Officer, Chief Transformation Officer, etc.)
Medical directors of service lines, centers of excellence
Physician leaders of employed and contracted group practices
More physicians serving on hospital governing boards
Physician leaders of ACOs and CINs
Physician leaders on the ‘front lines’ in PCMHs, perioperative surgical homes, PACE programs, etc.

Credentialing Challenges Posed By "New" and "Young" Physicians

"When I was a boy of 14, my father was so ignorant I could hardly stand to have the old man around. But when I got to be 21, I was astonished at how much the old man had learned in seven years."

Mark Twain

"Doctor, have you any advice to offer a young man who would love to be a physician but whose crowded schedule simply doesn't permit time for medical school?"

Are concerns about newly trained physicians age bias or real?

- “Restrictions on residency training hours are producing doctors with inadequate experience.”
- “Today’s residents spend so much time on the computer they don’t learn ‘hands-on’ medicine.”
- “A newly minted surgeon knows how to do robotic surgery but can’t convert it to an open procedure when there’s a complication.”
- “Today’s young doctors never show up at medical staff activities, never volunteer to serve, are more interested in work outside medicine than in being ***real*** professionals.”

Attitude of Some Young Physicians Toward 'Old' Physicians

"Bad news, Dad—you're brain-dead!"

How should hospitals assure newly graduated residents have adequate skills to perform in ‘the real world’?

Some Characteristics of Millennials

- Tech adept/tech reliant
- Like coaching, direction, feedback
- Want to work but do not want work to be their life
- Driven NOT by money but by meaningful work and expect to “fly up” the corporate ladder sooner rather than later in their career
- Prone to change jobs once every few years in search of greater intellectual or creative challenge
- Team oriented and value collaboration & sharing of ideas

Some Characteristics of Millennials

- More comfortable and thrive in multicultural, diverse environments
- Prefer democratic, non-hierarchical workplace and may feel stifled by traditional, rigid workplace practices
- May not prefer:
  - Mon- Friday
  - Bias toward seniority/titles
  - Exclusion of junior employees from decision-making
  - Micromanagement
- Millennials tend to see themselves as customers, even in their employment relationships

Henry Ford Health System's Recruitment and Engagement Strategies for Generation Y

(See Frontiers of Health Services Management, 29:1)

- Gen-ERG-Y: a team created by the HFHS Diversity Council for employees born after 1980. Charge is to leverage multigenerational differences & commonalities for purpose of attracting & retaining talent. Gen-ERG-Y holds meetings, workshops, & events that focus on effective communication among the generations, collaborative work styles, career life cycle, and more.
- Generational Diversity Class: to help manage tension between the generations.
- HFHS Administrative Fellowship: an opportunity to provide intensive career development and coaching to millennial employees.
- HFHS Leadership Academy & HFHS University

A Growing Number of Physicians Are Working Into Their 7th, 8th, and 9th Decades

Dr. DeBakey practiced

into his mid-nineties

Why Are ‘Late-Career’ Physicians A Concern?

- Demographic changes in the physician workforce

An Aging Physician Population

AMA estimate of number of active physicians in 2020 by age:

- > 65 years of age: 189,000 (18%)
- > 55 years of age: 409,500 (39%)

Why Are ‘Late-Career’ Physicians A Concern?

- Demographic changes in the physician workforce
- A high percentage of doctors plan poorly for retirement and find it necessary to work longer than they would like
- A high percentage of late career physicians work part time and are thereby becoming ‘low volume’ practitioners
- Evidence links quality of care and patient safety concerns to late career practitioners
- Colleagues often reluctant to challenge the quality of a long-standing member of their medical community, either because they don’t want to tarnish that individual’s reputation at the end of his career or because such persons may be influential and often are in positions of seniority.

How Do High-Risk Fields Address Aging?

- Commercial Airline Pilots
  - FAA mandated medical exams
  - Mandatory retirement at 65
- FBI Agents
  - Mandatory retirement is age 57
- Doctors
  - Mandatory CME
  - One third of physicians do not have a Primary Care Doctor

The Long Decline:

- Research suggests an inverse relationship between age and quality of performance.
- Over half the studies investigating age related performance of doctors find a very gradual decrease in clinical skill as one gets further from residency, with the decline accelerating after age 60.
- Additionally, state medical licensing board data show an increase in complaints and disciplinary actions for older physicians.
- Based on demographic and prevalence data, currently some 8,000 practicing doctors are cognitively impaired.

Annals Internal Medicine
15 Feb 2005/Vol. 142 Issue 4 p 260

Systematic Review: The Relationship between Clinical Experience and Quality of Health Care

Background: Physicians with more experience are generally believed to have accumulated knowledge and skills during years in practice and therefore to deliver high-quality care. However, evidence suggests that there is an inverse relationship between the number of years that a physician has been in practice and the quality of care that the physician provides.

The Canadian Experience: Quebec

2001-2010: 1,618 physicians were contacted 2-3 months in advance of an onsite visit to review their practice.

As a result of the review they were classified as follows:

- Level 0: No action, Received satisfactory evaluation
- Level 1: Recommendations
- Level 2: Recommendations and control visit follow-up
- Level 3: Refresher course or retraining or limitation mandatory (this action frequently resulted the option of retirement)
- Level 4: Cancellation of Licensure

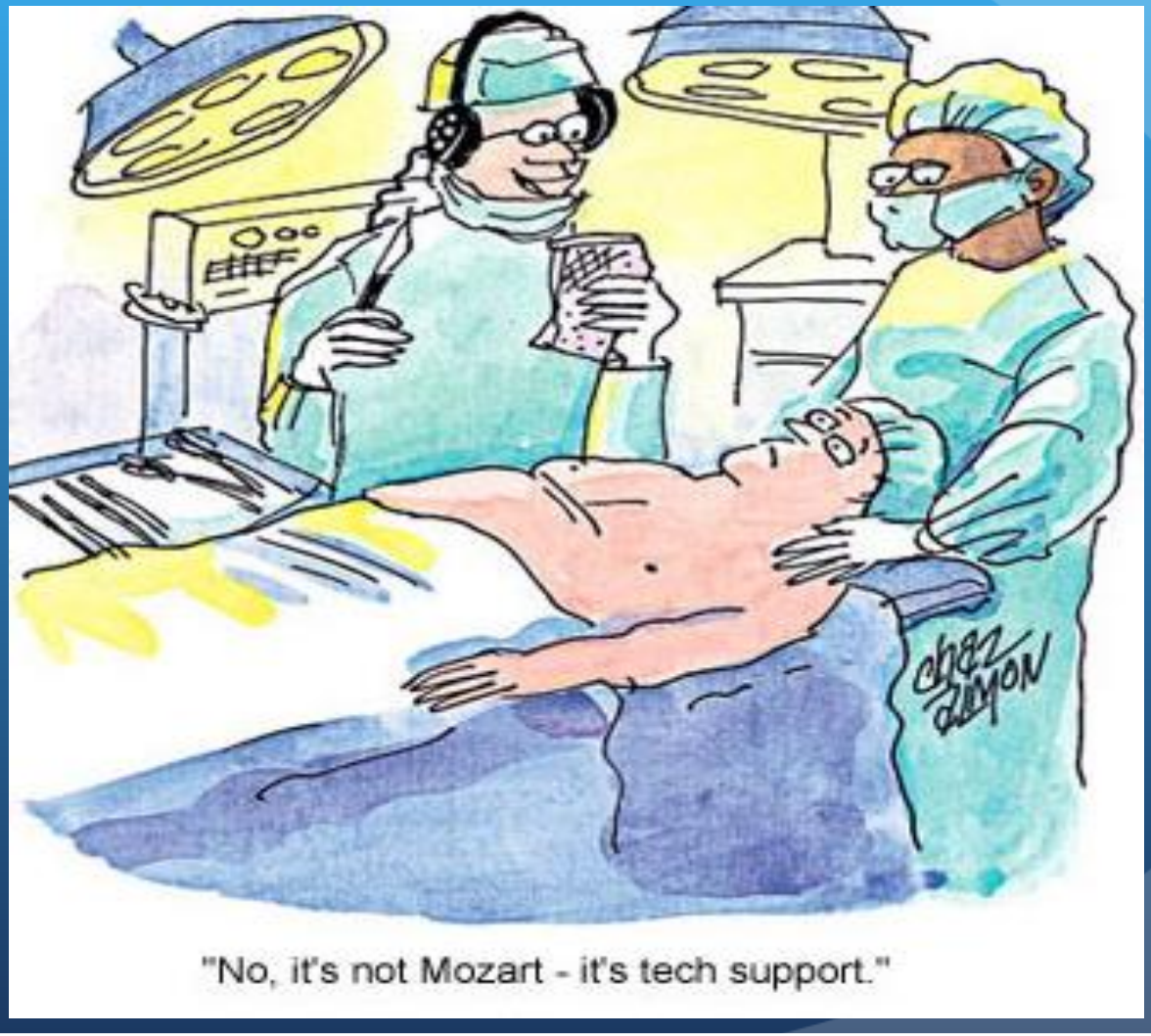
Physicians over age 70 had 3x higher rate of cancellation (31%) compared to the group less than 70 years of age (10%).

Age group 65-69 showed only a slightly higher rate of cancellation than those younger (13%) but they had nearly double the rate of Level 3 recommendations than those younger than age 65 (18% v. 10%)

The Canadian Experience: Ontario

- 22% of physician over 75 years of age had gross deficiencies in their practice
- 16% in the 50-74 age group had deficiencies
- 9% of physicians under age 49 had deficiencies
- (Journal of Medical Regulation, Vol. 99, No. 1: 10-18. 2013)

There is evidence to suggest that older physicians are less adaptable to rapid change in medicine and technology.



Physician's Self Assessment

Meta analysis of physician self-assessment studies:

"A number of studies found the worst accuracy in self-assessment among physicians who were the least skilled and those who were the most confident. These results are consistent with those found in other professions."

Meta analysis conclusion:

"… the preponderance of evidence suggests that physicians have a limited ability to accurately self-assess. The processes currently used to undertake professional development and evaluate competence may need to focus more on external assessment.

- Davis, et. al. JAMA 2006: 296(9)

Traditional Approaches to Competency Assessment of Older Practitioners

- Almost none for outpatient practitioners
- Medical staff peer review for those holding medical staff privileges
- Focused assessments after poor care discovered: ordered by medical staff or a licensing body
- No proactive competency assessments unless attempting to return to practice and reactivate a license. Most people are surprised to learn that medicine is not regulated to protect the public from aging practitioners. This is unlike other industries (e.g. pilots) or practice in some other countries (e.g. mandatory retirement ages for surgeons).

What do ‘Aging’ Credentials Policies Typically Include?

- A target age for implementation – most typical choice is age seventy. Some policies have a mandatory retirement age.
- Reappointment criteria that include a cognitive screen and a ‘fitness for work’ physical exam
- Some policies provide for annual assessments after a certain age – both health assessments and FPPE
- Reiterate the MEC’s authority to request functional assessments and health evaluations
- Some employed physician groups (especially hospital owned) have adopted such policies under their personnel requirements

Legal Concerns Regarding Interventions with Older Practitioners

- Federal Age Discrimination in Employment Act (ADEA) – applies to companies with more than 20 employees and applies to those over 40.
- State laws anti-discrimination laws may apply. For example, the Pennsylvania Human Relations Act prohibits employment practices that discriminate on the basis of age. The law protects independent contractors, employees, and job applicants who are 40 years of age or older. Applies to companies with more than 4 employees
- Americans with Disabilities Act (ADA) may apply.

Consider Practice Accommodations for Late Career Practitioners

- Decreasing hours and/or caseloads
- Allocation of more time with patients (e.g. scheduling adjustments)
- Accommodations based on findings (e.g. amplified stethoscope)
- Ongoing education with respect to electronic health records documentation
- Ongoing education to maintain fund of knowledge and awareness of current standards of care/competencies
- Decrease or limitation in scope of practice