

Medical Staff Development: Into Uncharted Territories

BY ALAN M. ZUCKERMAN

No issue facing community hospitals is as significant as the size, mix, and quality of physicians on the medical staff. Despite the importance of a strong and balanced group of physicians who ensure patient satisfaction and high-quality outcomes, most community hospitals infrequently and inconsistently use strategies to build better medical staffs. Often pursued haphazardly, medical staff development usually depends on individual physicians expanding their practices or new physicians seeking out practice opportunities in a particular community or hospital.

Although more hospitals are realizing the importance of building a strategically sound medical staff, their efforts are often hampered by long-standing traditions that physicians should recruit physicians and monitor medical staff performance. With a never-ending stream of pressing problems, most healthcare managers have not been compelled to fight the opposition and elevate medical staff development to a top priority.

Yet recent events are making it easier for hospitals to pursue medical staff development strategies. The growth of managed care and the new resource-based relative value scale are weakening physicians' organized resistance to hospitals' efforts to manage medical staff development. The fiscal uncertainty these changes cause may allow many community hospitals to take the lead in medical staff development for the first time and serve as a stabilizing force for medical practices in their community.

STRATEGIES FOR SUCCESS

To play a leading role in the healthcare delivery system in the next decade, community hospitals must actively pursue medical staff development, rather than leave it to chance.

In all but the smallest hospitals medical staff development should be a daily responsibility of a senior hospital executive. This executive should submit to the proper board committee a regularly updated medical staff development plan with rec-



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ommendations by specialty for the size of the current and future (five-year horizon) medical staff. The plan should specify action plans for attaining the desired staff complements by specialty, and it should have a monitoring and evaluation process to ensure progress toward medical staff development goals.

But development efforts should focus on more than the medical staff's size and specialty complement. Hospitals must also address three additional issues:

- Quality of medical staff
- Financial effects of practice patterns
- Physician-hospital relationships

Improving Medical Staff Quality Historically, hospital leaders have not been able to measure or directly affect the quality of the medical staff. However, with the emergence of the Health Care Financing Administration annual mortality statistics; the first quantitative, albeit crude, outcome-related quality measures; and the increasing availability of quantified patient satisfaction measures, evaluation of quality is entering a new and potentially fruitful era. Quality data should become more prevalent and more valid in the next few years, leading for the first time to provider competition on the basis of quantifiable data. Thus hospital leaders must move quality management to the top of the agenda for medical staff development by creating processes to ensure that their medical staffs provide the highest-quality care available in their market area.

Efforts to monitor and enhance medical staff quality will focus on structural, procedural, and outcome-oriented quality management measures. These include improving credentialing and recertification, developing more stringent privileging requirements, establishing clinical protocols, boosting continuing education requirements, and participating in quality management or improvement programs.

Reducing Practice Pattern Variations One significant cost-cutting opportunity for hospitals is the development of more economical practice pat-

terns. Most hospitals are now able to measure (although sometimes crudely) variations in practice patterns for physicians on their staffs and resulting financial implications for the hospital. Although measurement methods in this area are still underdeveloped, the current financial environment will generate increasing interest in standard protocols for patient management in certain diagnostic categories, practice pattern analysis as a management tool, and economic credentialing for medical staffs.

Improving Physician-Hospital Relationships In the next few years, the growth of managed care plans and other economic pressures will compel hospitals and physicians to seek new opportunities for cost control. Many of these opportunities will be realized only if physicians band together to achieve economies of scale and if physicians and hospitals break down historical barriers and cooperate to achieve new operating efficiencies.

Medical staff development plans can strengthen hospital-physician relationships by supporting the creation of stronger physician practice structures to help medical staff members cope with environmental pressures and position both hospitals and physician practices for continued growth. The plans can strengthen physician practices by fostering group practices, foundations, and management and marketing support that makes such practices more economical to operate and enables them to achieve strong patient and revenue bases. The plans can also be used to educate hospital and medical staff leaders about the common threats facing them and the opportunities to jointly address these challenges.

CASE STUDIES

The experiences of two Catholic hospitals, one in an inner city and the other in a growing suburban community, illustrate how organizations have responded to emerging medical staff development issues.

Inner-City Hospital The major problems facing the inner-city hospital were a lack of primary care physicians and some subspecialty physicians and dissatisfaction with quality of care on the part of some referring physicians. These problems had three significant effects on the hospital: The emergency department was overutilized for primary care; the hospital had an unbalanced caseload because of the deficiencies in many specialties; and the payer mix was not representative of the insurance mix of the community.

Through traditional techniques (e.g., analysis of physician-population ratios and interviews of

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area physicians and consumers), hospital planners studied the community's need for various specialists. Although a shortage of primary care specialists was found, it was much less severe than expected. The hospital's service area had many primary care physicians, but they either had ties to another hospital or were unaffiliated. In response to these findings, the hospital launched an ambitious plan to convince local primary care physicians to affiliate with the hospital. The plan also called for modest, targeted recruitment of new physicians. In the first 18 months of the plan's implementation, the number of primary care physicians on the active medical staff at the hospital doubled, most of them from the local community.

In addition, the hospital examined community needs in each subspecialty area and developed an overall strategy for program development. In many areas, particularly surgical services, recruitment of new physicians was necessary. Analyses were developed to show potential candidates what the projected volume and payer mix could be and how these practice demands might be achieved through referral sources and practice management strategies.

The hospital was able to recruit physicians in all the targeted specialties within 12 months. In each case, the hospital attracted one or more groups practicing at nearby hospitals and encouraged practice expansion. Not only did new volumes materialize for surgical specialists and the hospital, but some local patients who had previously been referred to these specialists were recaptured by the hospital as surgical inpatients or outpatients.

Another major issue the inner-city hospital addressed was quality problems in some subspecialties. These included high rates of complications following treatment, high readmission rates, and numerous negligence actions against the hospital and its medical staff. Customer service problems also existed, especially responsiveness to primary care physicians' requests for consultations and referrals. To address these quality problems, the hospital collected and presented relevant data on patient satisfaction, referral source satisfaction, and quality. Senior administrators met with the affected physicians individually and in groups to discuss the findings and develop alternatives for addressing the problems.

Most physicians reacted constructively to the issues the hospital raised. Plans were devised with qualitative and quantitative objectives (such as lowering the rate of complications following

surgery) and specific action steps (such as case review of all patients with complications). In one situation, dialogue proved useless and the hospital had to decide whether to suspend the physicians' privileges or dilute their effect by adding new, highly qualified specialists to the medical staff. Although the hospital chose the latter course, a more direct approach might be needed in the future.

The hospital also enhanced the effectiveness of its quality monitoring by using physician and hospital peer group data (when available) and applying the data to the most prevalent patient or procedure types rather than to the specialty or department. These quality review enhancements have improved decisions about physicians applying to the staff, credentialing, recredentialing, and privileging. In addition, the hospital established a preapplication process for initial screening of medical staff applicants and it began requiring that physicians become board-certified in their practice specialty within six years of completing residency training.

Four other quality improvement recommendations, which were more difficult to achieve, were delegated to a task force to determine methods for implementation:

- Granting specialty or subspecialty clinical privileges based on procedure volumes at or above minimum annual standards for clinical proficiency
- Restricting privileges based on the hospital's physical or technological capacity constraints
- Adopting nationally accepted, specialty-specific training and experience requirements
- Incorporating formal peer recommendations, both in initial admission review and in ongoing recredentialing

Suburban Hospital The suburban Catholic hospital faced a different set of problems because of its overall success and favorable community demographics. In a number of specialties, the hospital had more physicians than it could reasonably accommodate, with regulatory constraints leaving little prospect of obtaining greater diagnostic and treatment service capacity. The hospital also faced quality problems in some specialties because of inadequate and ineffective quality management processes.

Although the hospital was "full," its payer mix favorable, and its staffing patterns average for its case mix and size, it began to experience operating losses for the first time and was unsure about the cause. The hospital's approach to the quality issues was similar to that of the inner-city

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Catholic hospital, but certain aspects were unique.

Oversupply of physicians in general surgery and cardiology created competition for scarce hospital resources. Since it was impossible to accommodate some specialists' demands for access to hospital facilities and technologies, the hospital faced either the loss of specialists or increasingly divided practices. Rather than intervening directly to adjust physician supply to capacity constraints, the hospital decided to raise quality standards in the affected specialties and thus appeal to the best physicians in the area.

Using the general surgery and cardiology departments as pilots for its new quality measurement and management efforts, the hospital involved specialists in discussions about new, more stringent recredentialing and privileging standards and policies. Standards and procedures evolved out of these discussions on the quality issues of granting privileges based on volumes at or above minimum annual standards for proficiency, adopting nationally accepted requirements for training and experience, and including formal peer recommendations in the admission and recredentialing processes.

This approach made it clear to the affected physicians that the hospital was prepared to raise its healthcare delivery standards. Early evaluation of this effort indicates it is having the intended effects. Fewer but better surgeons are now working at the hospital.

After considerable analysis, hospital planners determined that the financial problems were the result of extreme practice pattern variations in many specialties. For certain categories of patients, diagnostic testing and length of stay varied widely. In response to this finding, the hospital is now sharing data on differences in diagnostic and treatment patterns and conducting several pilot projects to develop care maps to modify physician behavior and achieve more desirable financial performance.

BEYOND TRADITIONAL APPROACHES

As these case studies illustrate, medical staff development is moving beyond the traditional numbers game into uncharted territories. With competition for patients increasing and changes in reimbursement a certainty, medical staff development will become more complex and sophisticated in the next few years, moving from its historical emphasis on staff size and complement into strategies that ensure success for physicians and hospitals and high-quality care for patients. □