Pennsylvania Bar Institute

"Hot" Topics for Medical Staff Leaders and the Counsel Who Advise Them

Linda Haddad and Barbara Blackmond

Horty, Springer & Mattern

March 13, 2018

Medical Staff Implications of the Opioid Crisis

Physicians as Users

1. Preventing Diversion
2. Identifying Diversion

Physicians as Users

3. Reporting and Assessing

- Practitioner Health/Wellness Policy
- Credentialing Practitioners with Past Impairment Issues

Physicians as Prescribers

Prescription Drug Monitoring Program requirements

Hospital liability for employed physician's overprescribing opioids

Koon v. Walden (Mo. Ct. App. 2017)

Jury Verdict

Patient: $938,000

Wife: $804,000

(compensatory damages)

Punitive Damages: $15 million!

- No specific intent to injure
- Usually high amounts of opioids
- Without any monitoring system
- Conscious disregard for [the patient]'s safety and the safety of others….

Expert witness:

- Amount of opioids “colossal,” “astronomical”
- Should have been referred to a specialist

Lessons for Counsel

- Regulatory and licensure entities are scrutinizing physicians who are outliers
- Hospitals should do their own internal monitoring
- Develop policies

Medical Staff by Invitation Only

Invented by ACS 100 years ago.

"Open," but discriminatory.

FTC, DoJ and private litigation "opened" it further.

Exclusive contracts for hospital-based services.

(Didn't do anything wrong, but promise never to do it again.)

Adler v. Montefiore Hospital Association, 311 A.2d 634 (Pa. 1973)

"While [Adler] was qualified to provide good service… Montefiore determined that the best… could be achieved only by limiting the conduct of [cardiac caths in the lab] to the full-time laboratory director…."

Key Elements of Exclusive Contracts

Step 1:

Review all current contracts before beginning request for proposal process.

Step 2:

Determine how to best provide services.

Interview:

- Referring physicians
- Physicians currently providing services
- Others who use the services

Determine:

- How many physicians
- Necessary qualifications
- Hours of coverage
- Scope of professional and administrative services

Step 3:

Board Resolution.

Step 4:

Solicit Proposals.

Step 5:

Evaluate proposals and offer contract.

Once exclusive contract exists, do not accept applications from others.

Invented by ACS 100 years ago.

"Open," but discriminatory.

FTC, DoJ and private litigation "opened" it further.

Exclusive contracts for hospital-based services.

Selectivity, beyond individual qualifications.

Robinson v. Magovern,
521 F. Supp. 842 (W.D. Pa. 1981), *aff'd. without opinion,*
688 F.2d 824 (3d Cir. 1982)

"By rejecting the concept of an open staff and, instead, by building a high quality staff that takes an integrated approach to the delivery of medical services, Allegheny General has improved its ability to compete with the other regional referral hospitals in Western Pennsylvania."

Hay v. Scripps Memorial, 228 Cal. Rpt. 413 (Cal.Ct.App.1989)

Redding v. St. Francis Medical Center,
225 Cal. Rptr. 806 (Cal.Ct. App. 1989)

Invented by ACS 100 years ago.

"Open," but discriminatory.

FTC, DoJ and private litigation "opened" it further.

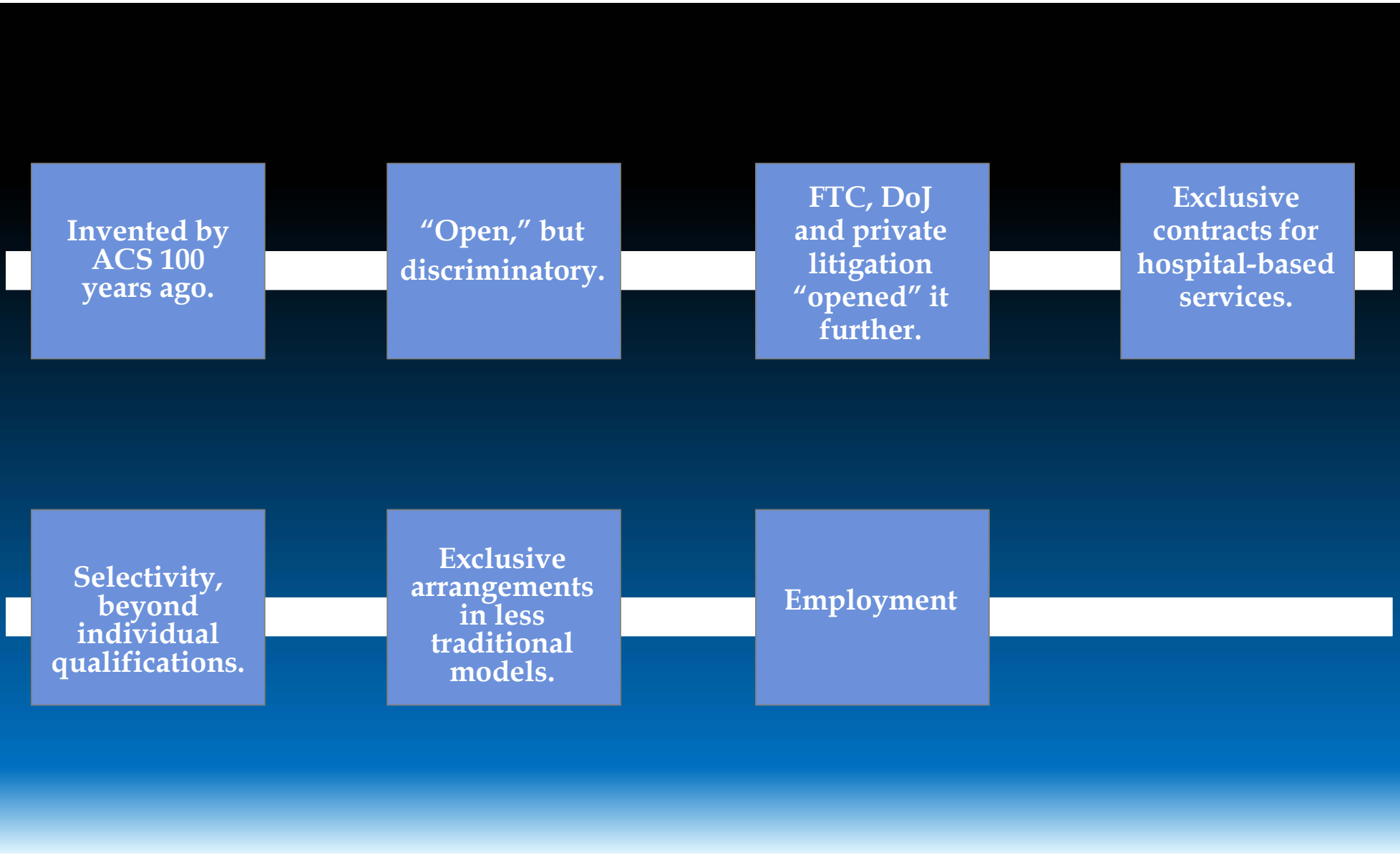
Exclusive contracts for hospital-based services.

Selectivity, beyond individual qualifications.

Exclusive arrangements in less traditional models.

Hospitalists, Intensivists

Benefits: imposition of service requirements, coverage, call, waiver of hearing rights.


Invented by ACS 100 years ago.
"Open," but discriminatory.
FTC, DoJ and private litigation "opened" it further.
Exclusive contracts for hospital-based services.
Selectivity, beyond individual qualifications.
Exclusive arrangements in less traditional models.
Employment

Taken a while to get this right:

- Too expensive
- Need to erase conflict between employment and still-required appointment, so may or may not include procedural rights
- Define what process, law applies
- Coterminous language

Invented by ACS 100 years ago.

"Open," but discriminatory.

FTC, DoJ and private litigation "opened" it further.

Exclusive contracts for hospital-based services.

Selectivity, beyond individual qualifications.

Exclusive arrangements in less traditional models.

Employment

Medical Staff by Invitation Only

Back to the future. What drives this?

a. Value-based payment
b. Care across the continuum
c. Disruptive innovation that attracted very consumer savvy competitors
d. Attractiveness of direct contracting (Boeing, Starbucks, Walmart, Loew's)

How is it done? and What does it look like?

Process:

Mission Credentialing: A Board Process

If you could design the very best Medical Staff, what would it look like?

1. It would be adequate to meet the needs of your community
   a. Community needs assessment
   b. Outcome: list of services required, ideal complement of providers (M.D.s and others)

MEDICAL STAFF DEVELOPMENT

BOARD RESOLUTION AND POLICY

WHEREAS, long-range planning is essential to all aspects of Park City Medical Center's operations and to its future growth and stability; and

WHEREAS, Park City Medical Center seeks to enjoy the benefits of a highly qualified medical staff as an integral and essential part of its commitment to provide quality health care services to this community and its service area; and

WHEREAS, Park City Medical Center desires to create an appropriate mix of primary and specialty care practitioners to effectively and efficiently care for patients in this community and its service area; and

WHEREAS, experience has demonstrated that in the normal course of events, there will be changes in the composition of Park City Medical Center's medical staff because of retirements, relocations, the influx of new practitioners, and a variety of other circumstances, some of which are advances in medicine and medical technology, and the evolving health needs of the community; and

WHEREAS, in order to be better able to project the needs of practitioners and patients and to be able to reasonably plan for the demand on existing facilities and services, the Governing Board deems it advisable to adopt specific criteria for development of its medical staff. The criteria outlined in this Policy will supplement those in the Medical Staff Bylaws in that they describe threshold qualifications necessary to be met to be eligible to receive a medical staff application. The Medical Staff Bylaws, this Policy and related documents apply to those who have received a medical staff application or are appointed to the medical staff.

THEREFORE, BE IT RESOLVED by the Governing Board of the Medical Center that the Medical Staff Development Plan and Policy are hereby adopted, effective April 7, 2009, and that the Board Committee on Medical Staff Development be charged with responsibility for ongoing development and oversight of the Medical Staff Development Plan.

2. Qualifications, education, training, experience, ability to work with others, etc.
3. Location and hours?
4. Relationships: exclusive to hospital/system? Independent? In satellite locations?
5. Expectations: telehealth skills, evening hours, etc.

How Is That Done?

A. MSDP

1. Board Task Force (minimal physician membership, careful about conflicts/ appearances)
2. Community Needs Assessment (include input from current practitioners) (Process)

How Is That Done?

B. Possible Outcomes:
   1. Define need (by number and qualifications) on specialty-by-specialty basis
   2. Employ everyone
   3. Exclusive/semi-exclusive contracts
   4. Mix of relationships (but expectations well-defined in contract)

How Is That Done?

C. Revisit every year or two…or more frequently if an issue arises.

What does this "designed" Medical Staff look like?

A. Still must meet CMS/accreditation/State regulations

B. More realistic and useful structure:

1. MEC is required, but composition could be smaller and designed as “leadership,” not “representational” committee
2. Medical Staff Bylaws are still required, but contract will define each practitioner’s responsibilities/status
3. Clinical Departments with Physician Chiefs (now archaic except in teaching facilities) converted to clinically integrated units that involve all members of a care team and include clinical and management leadership

C. **Strategic Leadership Committee – a construct to enable senior management and clinical leadership to meet regularly on strategic issues.**

D. Criteria and Expectations:

1. able to provide timely, year-round care to their patients;
2. committed to care for all Medical Center patients, regardless of their ability to pay;
3. committed to actively utilize the Medical Center's facilities, so as to permit the ongoing monitoring and evaluation of their practices; and
4. willing to make an active commitment to assist the Medical Center in continually overseeing and improving the Medical Center's facilities and services;

2.B.7 …must not have an ownership interest in, contract with, or be employed by an entity that would cause his or her interests to be in conflict with the Medical Center's commitment to the community or provide incentives for the practitioner to refer patients to other facilities for reasons unrelated to patient preference or medical needs.

2.B.8 …have a full-time, year-round practice in the Medical Center's service area. A full-time practice shall be defined to be a minimum of 10 months per year and a minimum of two days per week.

2.B.10 …must be willing to be a member of a care team, willing and able to work collaboratively to deliver system-based care, using the right level of caregivers, such as primary care physicians, specialists, certified nurse midwives, certified nurse anesthetists, advanced practice nurses, physician assistants, therapists, coaches, nutritionists.

2.B.11 …must be willing to devote four (4) hours per month to care design and oversight (such as protocol development, ongoing professional practice evaluation, focused professional practice evaluation).

2.B.12 …proficient in the use of relevant technology, such as EHRs, etc.

2.B.13 …must be willing to devote one week per year to develop new skills, retrain, refresh, etc.

2.B.14 …must be willing to abide by all quality of care measures adopted by the core or to seek advance approval to vary from such measures.

2.B.15 …must be willing to communicate with other caregivers, patients, and family by e-mail or other arrangements.

Unification of Medical Staffs Within a System

Medicare Conditions of Participation ("CoPs") revised in 2014 to allow a "unified"

(42 C.F.R. §482.22(b)(4))

Interpretive Guidelines

- CMS State Operations Manual
- The Medical Staff members of each separately certified hospital in the system voted by majority

COPs:

- Election of the unified Medical Staff option by the hospital's governing body
- Opt out

COPs:

- **A hospital that is part of a hospital system is expected to have Medical Staff bylaws, rules and requirements that address the regulatory regulations related to a unified Medical Staff**
- **Flexibility to determine the details of the voting process**

Pennsylvania Department of Health

- Hospitals must seek an exception
- No exceptions have been granted as of January 2018

Key points for DOH

- A DOH surveyor must be able to readily see that each hospital can demonstrate compliance with all DOH regulations and CoPs
- Any benefits of a system would need to be balanced with concern about "unique circumstances" (local interests)

Key points for DOH

- An exception request must clearly lay out how all system hospitals will meet all of the requirement
- Demonstration that each local Medical Staff has opted in by majority vote and has right to opt out

Practical Considerations

- Advantages: Stronger peer review, systems can aid quality, safety initiatives
- The larger the system (number of hospitals), the greater the disparity in size, teaching status, rural vs. urban, with less existing overlap, the harder it may be to obtain significant advantages or physician buy-in

Most other states' statutes, regulations silent – Illinois specifically allows unification.

Work-arounds?

- Uniform documents, different cover pages
- Meetings – separate minutes

UNDERSTANDING PHYSICIAN BURNOUT

- Why Burnout? New and Old Stressors
- Effects of Burnout
- Strategies to Minimize

HealthAffairsBlog

Physician Burnout Is A Public Health Crisis: A Message To Our Fellow Health Care CEOs

March 28, 2017

The Quadruple Aim recognizes that a healt[illegible] and resilient physician workforce is essential to achieving national health goals of [illegible]quality, more affordable care and better health for the populations we serve. Yet in a recent study of U.S. physicians, more than half reported experiencing at least one symptom of burnout—a substantial increase over previous years—

Why Burnout?

EMR

CPOE

Privacy/Security Risks

Stolen devices

Ransomware

OIG

MACRA

HCAHPS

Bundled payment/VBP

Yelp

O M G

Effects of Burnout

Increased

- Medical Errors
- Turnover
- Suicidal Ideation
- Impairment

Decreased

- Professionalism
- Patient Satisfaction
- Productivity
- Safety Culture

AMA | STEPSforward

PRACTICE SUPPORT | RESOURCE LIBRARY | CONTACT US | SHARE

HOME | MODULES | EVENTS | HOW IT WORKS

Improve patient satisfaction, quality outcomes and provider recruitment and retention.

Preventing Physician Burnout

Mark Linzer MD, FACP Hennepin County Medical Center

Laura Guzman-Corrales, MPH Hennepin County Medical Center

Sara Poplau Hennepin County Medical Center

AMA IN PARTNERSHIP WITH Hennepin County Medical Center | ACP | SGIM

CME CREDITS: 0.5

How will this module help me successfully eliminate burnout and adopt wellness approaches in my practice?

1. Seven key steps to help you prevent provider burnout
2. Ten-item survey designed to assist you in assessing burnout
3. Examples of successful burnout prevention programs in a variety of practice/organization settings

Share

Download module as PDF

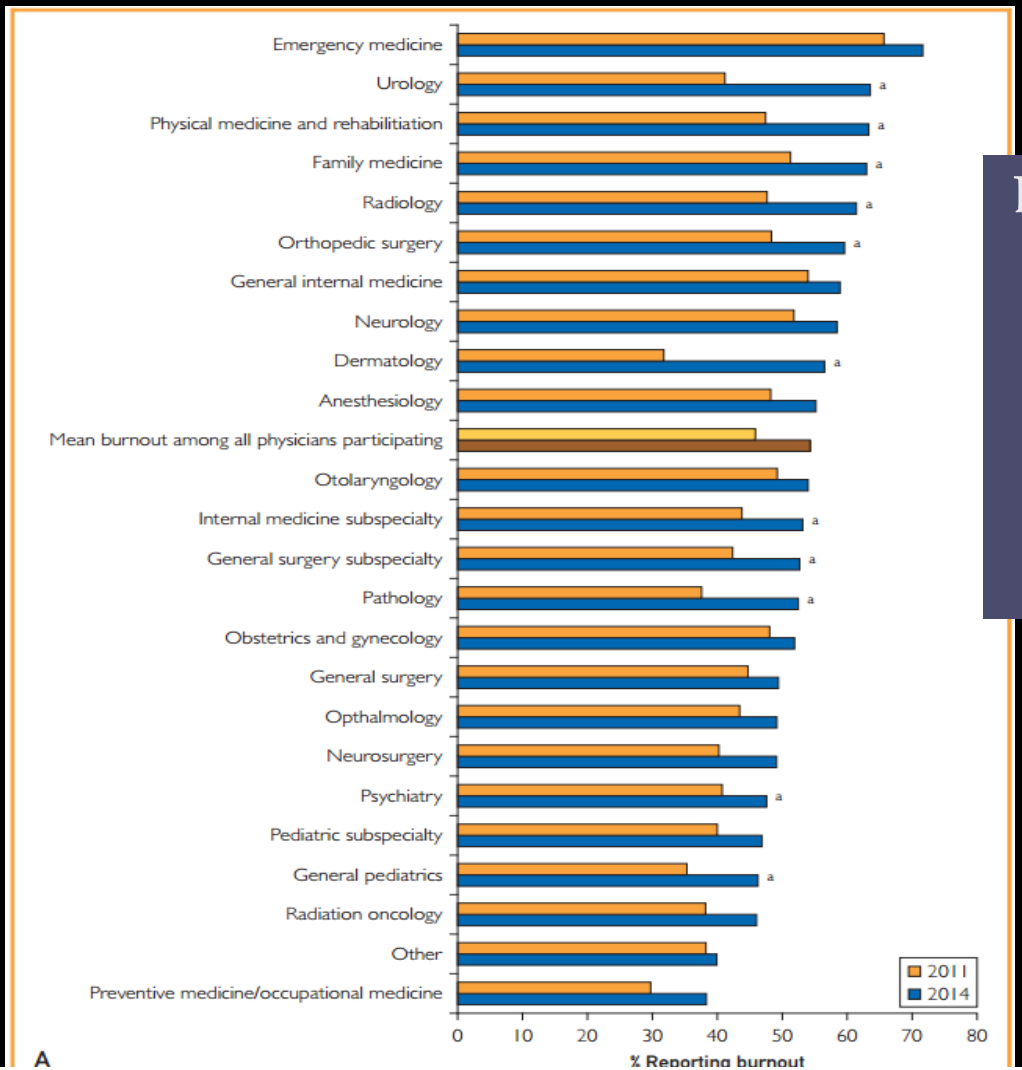
Download module PowerPoint

Online module | STEPS in practice | Downloadable tools | Implementation support

Counseling medical staff leaders:

- Identify signs and symptoms of stress and burnout
- Develop strategies and options for policies to proactively help colleagues avoid burnout
- Design leadership interventions to mitigate burnout
- Implement best practices for collegial steps, counseling and mentoring practitioners

Mean Physician Burnout Score Rises to 54.4%



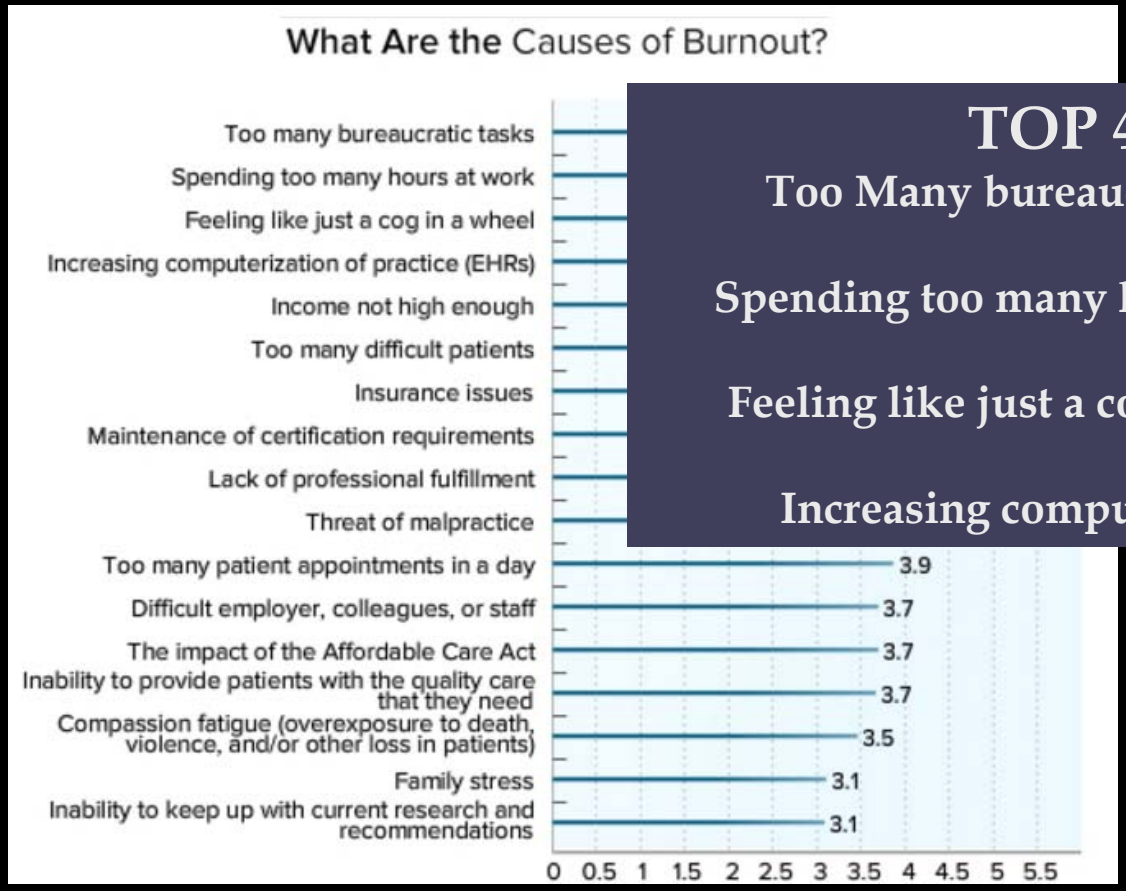
Depersonalization

Low Personal Accomplishment

Emotional Exhaustion

Shanafelt, T et al. Mayo Clin Proc. Dec. 2015;90(12):1600-1613

What Contributes to Burnout?



TOP 4

Too Many bureaucratic tasks

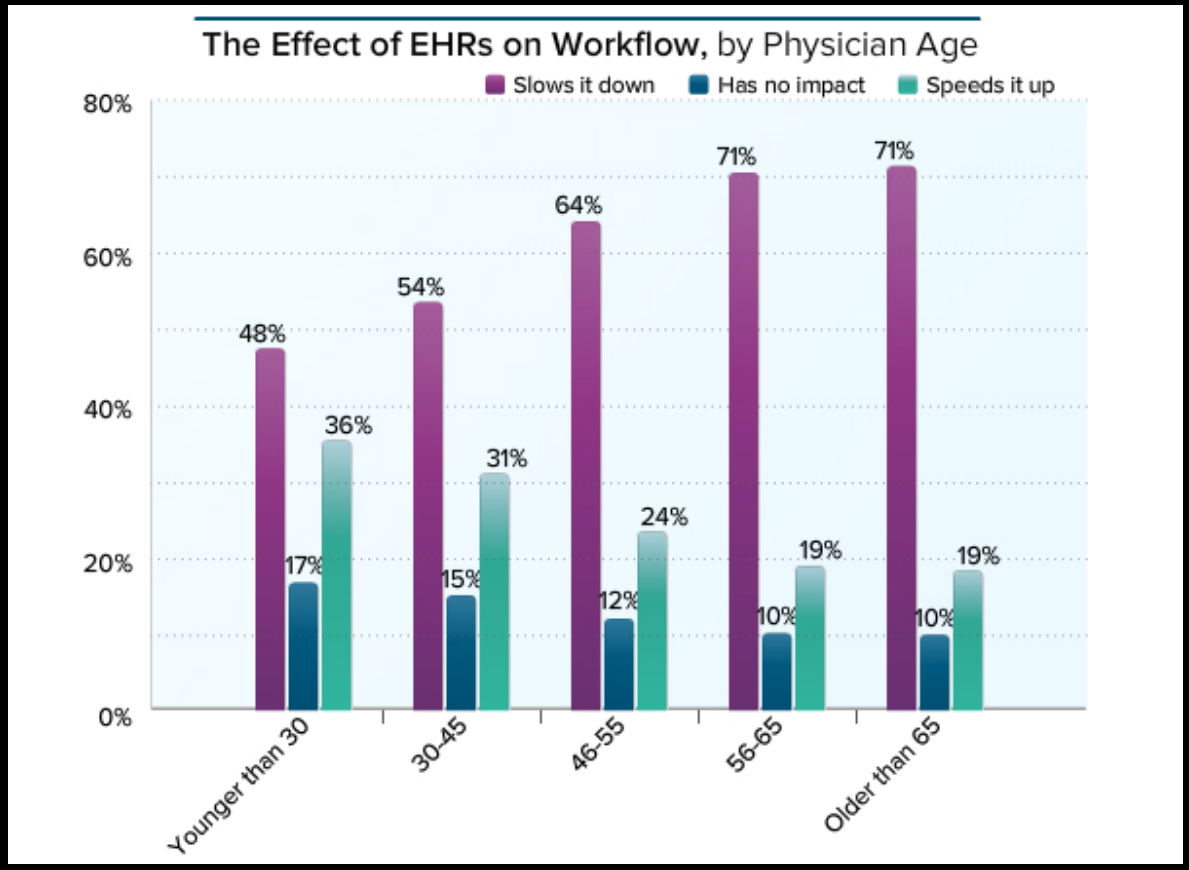
Spending too many hours at work

Feeling like just a cog in a wheel

Increasing computerization

Medscape Lifestyle Report 2017

EHRs have had a severe impact on workflow



Medscape EHR survey of 15,300 physicians across 25 specialties
August 2016

Use of CPOE was an independent factor associated with burnout.

Shanafelt, T. et al. Mayo Clinic Proceedings 2016: 91 (7) pp. 837-848

National Academy of Medicine Initiative

- nam.edu/ClinicianWellBeing

Investing in leadership is a key vaccination for burnout.

Strategies:

- Well-being committee
- Leadership development, succession planning, role in governance, management

Thank you.