The Reality of the Hospital:

Compliance Officers &

Chief Medical Officers in Harm's Way.

(*Hansel & Gretel* or is it *Alice Through the Looking Glass* .)

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Everything I needed to know about the hospital, I learned after I left neurosurgery.

Have you hugged your CMO lately?

A Basic Concept

Where you stand

(on an issue)

Depends on Where you sit

(your professional & personal experiences & your value system)

So, Where Have I Sat? 1

- Private practice, board - certified neurosurgeon, Tampa, FL: 1974 -2000.
- MBA along the way. FACHE.
- Medical staff leadership. CEO successfully lobbied against my advancement. “Trouble maker.” (I ask questions.)
- **HOSPITAL** medical staff bylaws project: Horty Springer hired by hospital to rewrite them favoring the hospital. I joined AMA. **Horty Springer critic**.
- Various healthcare advisory boards. Board of a public hospital.

So, Where Have I Sat? 2

- Accepted to multiple law schools 1999.
- Recommended by HSPH professor to get MPH.
- Harvard School of Public Health: MPH Policy & Management. May 2000 – June 2001.
- Kosova: Taught neurosurgery, WHO project, evaluation of State hospital. September 2001.
- Independent consultant to The Hunter Group (hospital turnaround company): October 2001 – March 2002.

So, Where Have I Sat? 3

- Chief Medical Officer – community teaching hospital north Colorado September 2002 – May 2005. Became a **Horty Springer Groupie**.
- Certified in Health Care Compliance – ~June 2005
- International Peace Keeping: Pisa, Italy: July 2005.
- Chief Medical Officer – County teaching hospital, Southern California. January – August 2006. Became a **Horty Springer Acolyte**.
- Executive Negotiation Workshop: Bargaining for Advantages. The Wharton School. October 2006.

So, Where Do I Sit?

Since January 2007

- Outpatient indigent neurosurgery patients.
- Examine refugees who have been tortured & are seeking asylum.
- Plaintiff & defense medical–legal work.
- Certified by the Florida Supreme Court as a Civil Circuit Mediator.
- Qualified Arbitrator.
- Mediators Beyond Borders.

Access to & Quality of Care in the Hospital

- One of my soap boxes. A passion.
  - I became a disruptive physician re consistently poor ER care to neurologically compromised patients.
- Peer Review & Compliance are the cornerstones of both.
- There is much work to be done.
- *No Good Deed Goes Unpunished* Clair Booth Luce

Issues in all shapes & sizes 1

- The man in the white coat.
- The frightened patient.
- Kill the messenger.
- The concerned nurses.

Issues in all shapes & sizes 2

- The liver transplant surgeon: WSJ & personal conversation.
- David Ciesla, MD: 'You don't see a bullet!': SPT
- Maria-Carmen Wilson, MD: A failure to inform USF of financial arrangements with Eli Lilly & Astra Zenica. SPT & John Curran, MD.

But a common theme: Human Nature

- The “negative:” Egos, Hubris, Avarice, Control, Fear.
- The “positive:” Courage, Gentleness, Assertiveness.
- Anything in excess is usually a problem - dlm.

So, who are the most important persons working in the hospital? 1

Consider the problems if they don’t show up for work:

Nurses

&

Those who clean the floors.

So, who are the most important persons working in the hospital? 2

Consider their compensation:

The CEO

So, who are the most important persons working in the hospital? 3

Consider those most patient focused:

Nurses & Physicians

So, who are the most important persons working in the hospital? 4

Consider if they fail at their job:

The Compliance Officer

&

The Chief Medical Officer

The Chief Compliance Officer & the Chief Medical Officer – a partnership

- Allow the hospital to effectively & efficiently carry out its mission. – by law & by regulation.
- All hospital mission statements contain the word “QUALITY.” (CMO)
- Most hospital mission statements allude to the utilization of scarce resources. (CMO & CO)
- Much money involved: a fertile soil for conflict, fraud & abuse. (CMO & CO)

Conflict in the Hospital: Agency Theory – who is the customer?

A pervasive dynamic tension between doing *what is right* & *maximizing the bottom line.*

Individual & group values for both issues.

What are the Important Issues in Life, Personally & Professionally?

- Relationships
- Incentives
- Politics
- Values
- Integrity
- Leadership (as it relates to the culture of an organization)

Needed Skills for Success in Life: Personal & Professional

- **Technical/Knowledge** (What you had to study or be trained to do.)
- **Adaptive** (to change; to the flow)
- **Negotiation**: the ability to understand the interests of others and to frame issues; game theory & strategy; there's always an audience.
- **Political**: The ability to manage others - up, down & laterally (your pesky values interfere).

Relationships

It is easy to be a good _____, but effective relationships are difficult.

- Intrapersonal: The one with yourself is the most important & often the most difficult.
- Interpersonal
- Group
- Organizational
- Societal: State & interstate (government, international)

Incentives

- **One will only do what they perceive to be in their best interest.**
- **Appropriate** vs. **Perverse**.
- **Moral Hazard**: no adverse consequences to an individual for their actions.
- Always **unintended consequences**. What you don't know you don't know.

Politics

That which determines who gets what, when, where & how. I forgot the source.

It's All Politics Kathleen Kelley Reardon, Doubleday 2005

Values: Those things that matter.

Who is sitting across the table from you?

Societal/Government's role

- **Libertarian**: limited role of government
- **Rawlesian Liberal**: those most fortunate set a floor for the most unfortunate.
- **Utilitarian**: a cost-benefit analysis.
- **Conservative**: a selective discarding of the old.
- **Post-modern**: an unabashed discarding of the old; situational ('That was then; this is now.')

BUT

There is ***THE RIGHT THING TO DO!!***

Integrity

Of these (personal attributes), integrity is the most important for a president. As former senator Alan Simpson said in introducing Gerald Ford at Harvard a year ago: "If you have integrity, nothing else matters. If you don't have integrity, nothing else matters."
Eyewitness to Power; the Essence of Leadership David Gergen, Simon & Schuster 2000, page 346.

Leadership Sets The Culture

Culture: what members of the organization do when the boss isn't around.

- Culture always trumps mission & strategy.
- If one is unable to live within the culture of an organization & is unable to change that culture so that it does become tolerable, that person must leave the organization.
- Medical Staff vs Administration & Board.
  - Independent vs Employed Medical Staff

The Hospital & Its Medical Staff 1

- Always a dynamic tension between administration & the medical staff.
  - Quality of Care vs Bottom Line
- Always a dynamic tension between & among members of the medical staff
  - Primary Care vs Specialists
  - Turf issues among Specialists

The Hospital & Its Medical Staff 2

It is the responsibility of the Chief Medical Officer & the Compliance Officer to work together to monitor & to manage (?) those conflicts.

It's been my experience that…

(including talking with others)

- A CEO is often conflict averse & risk averse.
- A CEO's primary concern is often self-preservation.
- The patient is often not central to the CEO; a bottom line or self-serving agenda is often contrary to what is best for the patient.
- A CEO will often protect physicians who are high admitters from quality investigations.

It's been their experience that…

- "Sometimes the intolerable becomes tolerable." A CEO.
- "Healthcare is a shark pit." Executive Negotiation Workshop: Bargaining for Advantages. The Wharton School. October 27, 2006.
- Covering her ears, "Don't tell me about this!!" HR director.

BUT

- Non-physician hospital CEOs have their own set of devils, especially the medical staff.
  - A poor CEO –Medical Staff relationship will break a CEO.
  - There is no guarantee of success with a good CEO-Medical Staff relationship.
- *My job is to build relationships*: David Callender, MD, Associate vice-chancellor & CEO UCLA, Hospital System. ~February, 2006

So, just what is Peer Review? 1

Why is it necessary?

- "Hospitals (& doctors - dlm) can't be trusted to do the right thing." Nancy Kane (Chair, Policy & Management, HSPH) to Congress 200? –disputed.
- Bad things happen.
- Medicine is an art, not a science.
- Standard of care vs Evidence Based vs Best Practice vs "it's the way I do it."

So, just what is Peer Review? 2

- Need to monitor trends. Metrics important.
- Need to evaluate individual events.
- Protection of those trying to do the right thing. **Can't prevent economic** (decrease in referrals, reactive law suits) **& social retaliation**.
- Abuses: Conflicts of interest.
- Physician pushback creates a negotiation challenge & a legal morass.

So, just what is Peer Review? 3

- Mandated by Medicare Conditions of Participation.
- *Patrick* (Caused Sen. Ron Wyden, (D) Oregon, to sponsor HCQIA 1986.)
- Healthcare Quality Improvement Act of 1986.
- Most, if not all, major adverse hospital events are issues of process rather than an individual "bad apple." - dlm (**The Board must accept responsibility for those events.**)
- Individual "bad apples" are process issues.

So, just what is Peer Review? 4

- Phase 1: collegial (1:1; no attorneys.)
- Phase 2: adversarial (Hearings; attorneys.)
- Bylaws definition of the **ENTIRE** process: must be followed & **DOCUMENTED**. This is a responsibility of both the CMO & the CO.
- Legal input mandatory.
- Need for confidentiality (vs transparency).

Peer Review Issues

- Employed vs. Independent Medical Staffs
- Disruptive Physicians
- Citizenship & Economic Credentialing
- Sentinel Events (Joint Commission)
- Amendment 7 (Florida)
- Relation to need for healthcare change, particularly with attention to cost.

Employed vs. Independent Medical Staffs – with apologies to Al Capone.

It's easier to control a medical staff culture with a smile, bylaws & a contract than with a smile & bylaws.

How is a medical staff governed? 1

- **Independent**: medical staff bylaws.
- **Employed**: medical staff bylaws & individual physician employment contracts.
- **Bylaws**: a "contract" between the Board & the medical staff; the Board delegates (but retains oversight responsibility for) the development, implementation & monitoring of actions pertinent to quality & appropriate issues of patient safety to the medical staff through the medical staff bylaws.

How is a medical staff governed? 2

- Internal economic & political favors & retaliation.
- This brutal retaliation rolls right downhill upon the Chief Medical Officer & the Compliance Officer. – The CO & CMO get no favors.
- **ARE YOU SUPPORTED BY THE MEDICAL STAFF LEADERSHIP (& THE CEO & THE BOARD)?**

How is a medical staff governed? 3

The best model: that which joins the physician & the hospital administration at the value system & at the wallet. – dlm

Employed medical staff with a compensation system based on a bundled payment to the hospital.

Disruptive Physicians

Impossible to control without a zero-tolerance culture of the Board **&** medical staff leadership. Quality & citizenship issues.

Citizenship & Economic Credentialing

Examples:

(1)Standardized treatment protocols for high volume, high cost DRGs.

(2) Disruptive behavior

"Never to be tolerated."

dlm ~1994

"Important concepts whose times have come."

dlm 2005.

Sentinel Events 1

The Joint Commission

A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase, "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. Such events are called "sentinel" because they signal the need for immediate investigation and response.

Sentinel Events 2

The Joint Commission

The terms “sentinel event” and “medical error” are not synonymous; not all sentinel events occur because of an error and not all errors result in sentinel events.

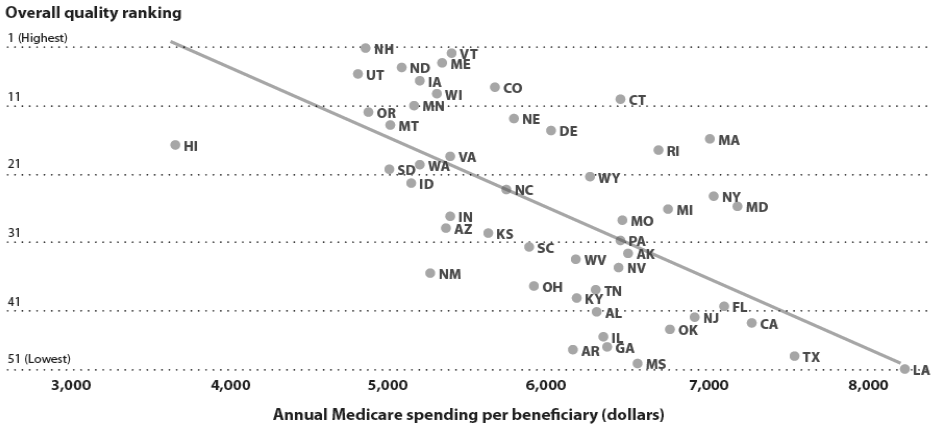
Sentinel Events 3

- >60% involve communication failure.
- Ideally, reviewed by non-involved physicians.
- Physician pushback.
- Are they even investigated?
- What is implemented as a result of the investigation?

Amendment 7 (Florida)

- Transparency of hospital & medical staff physician quality & safety information.
- Much pushback from hospitals.
- "Healthcare in Florida is the worst in the United States." (Quality, Attention to the Indigent, Fraud & Abuse by Providers, Medical Liability. Nancy Kane (Chair, Policy & Management, HSPH) to dlm 2000 – not disputed.

Relationship Between Quality of Care and Medicare Spending:
As Expressed by Overall Quality Ranking, 2000–2001



Data: Medicare administrative claims data and Medicare Quality Improvement Organization program data. Adapted and republished with permission of *Health Affairs* from Baicker and Chandra, "Medicare Spending, The Physician Workforce, and Beneficiaries' Quality of Care" (Web Exclusive), 2004.

Source: McCarthy and Leatherman, Performance Snapshots, 2006. www.cmwf.org/snapshots

Peer Review Issues & Healthcare Change.

Not discussed except in the negative: i.e. the need for liability reform to favor physicians & defensive medicine.

How much productivity is lost – the opportunity cost of failed compliance & failed peer review.

National Practitioner Data Bank.

Horty Springer Medical Staff Leader Handbook

- Mandated by HCQIA of 1986.
- Began operation September 1, 1990.
- Contains information concerning malpractice payments, adverse licensure actions & adverse actions pertaining to clinical privileges.
- To be used by hospitals & certain other health care entities "solely with respect to activities in the furtherance of the quality of health care."

As in All Critical Problems: What we have here is a….

A failure to communicate.

A crisis of leadership.

To ensure appropriate regulatory compliance & quality of care 1

The Board must honor its responsibility to achievement of mission by proper resource utilization by insisting on an integrated approach using the CEO, the CO & the CMO.

To ensure appropriate regulatory compliance & quality of care 2

The Board must insist the compliance officer & the chief medical officer (just as the CEO)

- be hired & fired by the Board.
- have direct reporting responsibility to the Board.
- be independent of the CEO.

So, what if you can't have that reporting relationship?

- If you are not willing to be a sycophant for the CEO, you must have a coach or mentor &/or an independent confidant.
- Understand the culture & politics of your organization.
- Work with your CEO or to whomever you report – they must be apprised of every issue of importance. That apprisal must be documented.
- Work with the Chief Medical Officer.

If all else fails

If one is unable to live within the culture of an organization & is unable to change that culture so that it becomes tolerable, that person must leave the organization.

What was advertised

Peer Review

- Why get involved? **Because it is meaningful to you.**
- What risks should a compliance program worry about? **Conflicts of interest: between & among stakeholders. Retaliation flowing downhill upon you.**
- How to get involved without having your head taken off. **Be very political; know how to negotiate & deal with difficult persons.**

QUESTIONS

COMMENTS