• MODULE 4 •
COMMUNICATION

Pennsylvania
MEDICAL SOCIETY®

module 4

COMMUNICATION

module 1: Values, Trust, Conduct

module 2: Assessment of Current Medical Staff Structure and
Restructuring for the Future

module 3: Engaging Physicians and Enhancing Professional Satisfaction

module 4: Communication

module 5: Credentialing and Privileging

Pennsylvania
MEDICAL SOCIETY®

Introduction

In this module, we will look at how to build transparent communication between medical staff, administration and board of directors. We will also explore the need for improvements in communication between physicians and hospital staff, employed and independent physicians, and physicians and patients.

Medical Staff Communication

Formalized communication mechanisms to and from the medical staff members are important. In today's cost conscious environment, many facilities limit communication almost exclusively to email. Unfortunately, survey a large group of physicians about how often they read their email, and a significant number will respond "I don't have time for that." Many times office managers or other staff will review emails for the physicians in their practices and make sure the physicians see the important things. For hospital-employed physicians without any administrative support, getting to their email may not be high on their list of priorities, and so the communications sent to these physicians will only get spread by word of mouth. We will explore efficient, effective and low cost methods of communicating important information to physicians within the hospital setting.

Medical Staff Leadership vs. Hospital Administrators vs. Governing Body

Communication between these three bodies is often limited and formal. Documents are sent to the medical staff from the administration or board that announce changes that affect the medical staff but about which the medical staff has had no prior knowledge or input. Often these types of communications have very little information of value and provide no answers to questions. The frustration that arises from these communications can cause physicians to feel alienated and sometimes hostile toward the administration and/or the board of directors. While there are times when all the details leading to a decision cannot be put into writing, or decisions need to be made and implemented too quickly to allow for medical staff input, many times that is not the case. Sometimes, past issues prevent good communication now. Open discussion should always be encouraged to get past these issues that are no longer relevant.

We will look at ways of helping administrators and directors understand the importance of medical staff involvement in decisions or changes directly affecting patient care or medical practice. When physicians don't agree with decisions made by management, perhaps because they don't have all the facts, they need to have an open discussion with management. Allowing disputes to fester is like not treating a malignancy – in the end, it becomes incurable. Failure to communicate can escalate into a conflict that ends up in court.

Having the Difficult Conversations

There are many things that can happen to physicians, or be done by physicians, that can require a difficult conversation. Who is responsible for this? How should it be done? Can you ignore bad behavior, dangerous practices or sub-par clinical skills? The answer to that determines how much of a leader you truly are. No one wants to have the conversation, but someone must.

Gap Analysis

QUESTION	ANALYSIS	DESIRED OUTCOME	ACTION OR FOLLOW-UP
Is transparency in communication well defined and in place at your system?			
If yes, explain the process.			
If quality data results are published at your facility, how often?			
If quality data results are published, how much information is identified – full disclosure, blinded data, or something in between, as it relates to source identification?			
Where is the information published?			
Is publication of results consistent?			
Are results reviewed with practitioners by department chairs?			
Does the Medical Staff use quality data, and if so, to what extent? What is the expectation of the use of quality data? Are these expectations met? Is there meaningful value to the use of the data?			
Do physicians use clinical data results to improve themselves clinically? How do physicians receive/perceive their own data?			

Pennsylvania
MEDICAL SOCIETY®

COMMUNICATION

Gap Analysis

QUESTION	ANALYSIS	DESIRED OUTCOME	ACTION OR FOLLOW-UP
How does executive leadership respond to physician claims that their lower scores are a result of their patients being sicker than their peers?			
Is data used to reduce cost and improve quality?			
Is there comparative analysis to national trend results?			
Is there comparative analysis to hospital groups or practice groups - cross coverage resulting in errors - whose error is it?			
How can groups improve their overall results?			
Does the Medical Staff use cost data, and if so, is it compared against quality data to assess highest quality with lowest cost?			
Is there a difference between system-employed physicians and independent physicians as to how the data is valued and used by the physicians?			
Are there formal effective processes in place for ensuring communication within the health system between Medical Staff and administration?			
Can physicians schedule appointments to meet with the CEO?			

Module 4

Gap Analysis

QUESTION	ANALYSIS	DESIRED OUTCOME	ACTION OR FOLLOW-UP
How long does it take a physician to get an appointment with the CEO?			
Do you feel that physicians have timely access to the CMO, CEO and other administrators?			
If there are currently two or more hospitals within your system, is there collaboration between the organized Medical Staff of each?			
Is there rapid communication of important information between all hospitals?			
How is communication rapidly disseminated between hospitals within the system?			
Is there competition between the different hospitals and/or Medical Staffs?			
Is there collaboration between the different hospitals and/or Medical Staffs?			
Is there a single governance system of the Medical Staff for all hospitals, or does each have its own separate body?			
Has there been an assessment of what type(s) of communication methods physicians prefer?			

module 4

Gap Analysis

QUESTION	ANALYSIS	DESIRED OUTCOME	ACTION OR FOLLOW-UP
Is there a standard method of communication to members of the Medical Staff?			
Are multiple methods of communication routinely used?			
What methods of communication are currently used?			
Does your system measure readership (open rate) on emails to medical staff members? If so, is this data reported to the medical staff?			
Do you receive regular feedback from physicians that they were never informed about important events?			
Are there regular events where physicians are given information, and where members of the executive leadership team and/or governing body attend?			

Communication Across All Lines

Communication between medical staff, executive leadership and governing body is often limited to formal reports. While reports are beneficial, face-to-face is the still the best method of communicating.

- If not currently inviting members of the executive leadership and governing body to medical staff meeting or department meetings, consider doing this. Perhaps make it a regular standing agenda item, or once a quarter, or any other time period that seems reasonable. Involving these individuals helps to open lines of communication that might be currently missing or limited.

- Consider inviting department administrators on a rotating basis. Hear about their challenges while they hear about yours. Often in these types of meetings, solutions arise or people offer to help each other by sharing resources.

- If these solutions are not practical for any reason, consider having a regularly scheduled (monthly, quarterly, semi-annually) meeting with executive leaders, governing body members, department heads and medical staff members for conversations and networking. Make them informal and social, as a way to have them well attended.

If there are issues or concerns between physicians and various departments, do not let them fester. Schedule a meeting of all interested parties as soon as practicable. Open and honest discussions will clear the air and participants are more likely to find a solution that works for everyone. It is often stressed that physicians (the organized medical staff) are responsible for clinical decisions within the hospital, but at the end of the day, these decisions need to be implemented and paid for. Having direct communication with all involved will make for a smooth and successful implementation. The key is to make sure that the communication is well organized to be effective. There are still many people who do not or will not use email or other electronic communication methods. These individuals also need to receive the same

communication. This may mean that in addition to email, communication may need to be:

- Faxed (fax blasting)
- Mailed (interoffice or USPS)
- Website postings, including intranet
- Messages posted to EMR sign on screens
- Electronic bulletin boards
- Flyers
- Posters (physician lounge, nursing stations, other areas physicians frequent)
- Robo-calls
- Physician liaisons (meeting with physician groups, practices, etc., to share information)
- Facebook
- Twitter

Don't limit your communication methods or many people may miss the information. If your system employs physician liaisons, consider using these individuals as a two-way communication tool—they can share information with physicians face to face or over the phone, and can bring back concerns from the physicians to the appropriate people. Look for other innovative options within your system that can be used as communication opportunities.

When topics include changes that will impact the majority of any group, it is vitally important to begin early. As soon as you are able to share information, even the slightest amount, you should. Provide introductory information, project updates, expectations, requirements, and any other feedback that will keep everyone informed.

Intranets are readily available at most hospitals, and many have areas that are limited to employees and/or physicians. Consider having an area on your intranet that is open to physicians, administrators and governing body members only. This area can include news updates, meeting schedules, reports, statistics, and even various blogs, chat rooms and other forms of interactive communications. Consider having a Medical Staff President blog that is available for all medical staff members, where information can be shared, the President can give updates, ask for

assistance or solicit opinions. The uses of an intranet are vast and are a quick and easy way to meet the busy person's need to receive and give information.

Embracing Technology

The days of paper charts and white boards are over. The charts are electronic and the white boards might be LED screens at the nursing station, tablets that each physician carries, or even individual smartphones. There is so much information, and so much interconnectivity that not learning how to use the various tools available is simply not an option anymore. The hospital IT team is now an integral part of clinical care. They are the ones who connect all of this information together. They may have developed or implemented a system that notifies nursing staff of patient activity such as device alarms and monitors. They are responsible for the EMRs, hardware, software and connections. What physicians care about, though, is "does it work and is it user-friendly"? The learning curve on the tools available can vary individually. If you have physicians who are struggling with learning the EMR, or can't figure out how to retrieve lab reports on their smartphones, consider developing a mentoring program. Younger physicians, residents and medical students are usually much more tech savvy and are an excellent resource for physicians who may be struggling.

Work with your IT professionals to design and build various methods that can be easily implemented for communication to medical staff members. These are the people best able to tell you what options are available, or can be easily built to cover multiple methods of communications. Technology is constantly changing, and these are the people who will tell you what will work best for your current structure and budget. If your EMR system does not currently support message boards, or if you are not using this

technology if it is available, consider that this may be the ideal means of communicating with physicians. If you can get the attention of physicians as they are logging into the EMR system, you have a good chance of getting your messages out to the staff.

When implementing new systems, training is provided, but this is often not easily recalled once physicians begin actually to use the systems on a day-to-day basis and many might need help. Consider having a 15 minute "Tech Talk" at the end of each week's Grand Rounds, or other regularly held conference. Ask one of your tech-savvy physicians to provide helpful and practical information, demonstrate shortcuts, or simply be available to answer questions.

Many physicians who struggle daily with these issues feel that patient care is being compromised by the rapid implementation of new technology. Addressing the frustration will enhance patient care, and at the same time, improve physician satisfaction. Failing to get and keep physicians up to date and confident in their tech skills serves no one. If a physician simply is not able to successfully use an EMR, for example, or you have a group of physicians who are struggling and you start to see data that suggests that patient visits are taking longer, for example, consider providing medical scribes to do the data entry for the physicians. This will enable them to spend more time with more patients as well as reduce the frustration of trying to implement the EMR. Over time they will probably absorb and internalize it, and may even become competent at using it. The time and effort will be well worth it, regardless of which method or combination of methods you use.

Physician Involvement in Decision Making

While there will be times when decisions need to be made quickly, with little or no input from physicians, these should be rare. In general, for any decisions affecting patient care, physician input must be an integral part of the process. According to PA Code § 107.1 Principle—There shall be an organized medical staff which is accountable to the governing body and which has responsibility for the quality of all medical care provided to patients and for the ethical conduct and professional practice of its members.

Making decisions that impact patient care without including physician input is not a good idea for several reasons—optimal quality of patient care, physician satisfaction, appropriate expenditure of capital resources, to name a few. Any decisions that impact patient care and the practice of medicine within a health system must include physician input.

Quality Measurements, Goals and Improvement Projects

Every health system engages in the measurement of quality as it pertains to health care delivery. What elements are measured, how they are measured, where their evidence based medicine being supported, what are the goals and/or metrics, and how corrections or necessary changes are made, all require the input of clinical staff. There are many resources available online and from insurance carriers that already define quality measures and provide tools to track and analyze these. Physicians are best positioned to determine if these tools are all inclusive, or may be measuring elements that are not relevant to their particular health system. The algorithms are best built by or with physicians.

Physician input into quality improvement projects is vital. Many projects cross staffing lines—nurses, doctors, technologists, etc. Staff who are directly involved or impacted by these projects should be represented in identifying and designing the projects as well as receiving and reviewing reports of outcomes.

Patient Satisfaction Surveys

Obtaining physician input into the development of patient satisfaction surveys can be invaluable. Not only can physicians provide survey elements that are of value to physicians in gauging the care that they provide, but they also can help to provide the unique perspective of the physician.

Infrastructure Planning

The infrastructure of health systems directly impacts patient care. Decisions to renovate or build patient care areas should involve physicians. Physicians and executive staff must work together to build the best possible clinical settings while working within the budget. The design of emergency departments, operating suites, laboratories, acute care units (ICU, CCU, NICU, etc.), specialized care areas (chemotherapy units, dialysis units, etc.), patient floors, labor and delivery areas, mental health care areas and educational facilities should all have physician input. In addition, adequate medical equipment and supplies should be determined with physician input. Staffing models, team structures and patient-centered activities must all be included in this planning, and the input of the medical staff is vital to making the best possible decisions.

Workflow Improvement

Workflow improvements and designs that impact the care given to patients must include input from physicians, as well as other professionals directly involved in care. Standardized order sets, standardized patient care forms and evidence-based guidelines should all include input from medical staff members. Patient safety guidelines should be reviewed and approved by the medical staff as well. If medical teams are currently in place or being developed, physicians, as leaders of these teams, must be included in the design and implementation.

Planning and Expenditures

Consideration should be given to forming a standing committee of hospital executives, physicians and other clinical professionals, which would be charged with reviewing capital purchases, infrastructure design, standardized supplies, staffing needs and implementing new procedures and clinical care processes.

Aligning Physician and Administrator Concerns and Goals

The financial concerns of hospital CEOs are many, and increase all the time. There are increases in costs of supplies, equipment and staffing, for example. There are funding cuts, reimbursement issues, bad debt and decreasing patient volume. Competition from other health systems creates the need for improved services, marketing, and innovation. The need to reduce operating costs while increasing services offered can seem like an impossible task.

Physicians need to work together with the hospital executive staff to provide the highest quality care at the lowest possible cost. If the medical staff and the administrative staff cannot find a way to do this, no one succeeds, least of all the patients being served by the health system. Physicians need to do their best to provide the highest quality of care to their patients, while conserving and responsibly using hospital resources. Administrators need to do their best to provide the best possible tools their financial resources will allow. When there is clear and open communication between the hospital administration and the physician staff regarding the financial situation of the health system, each party is better able to uphold their part of the shared responsibility to the patient population they serve.

Having the Difficult Conversation

There are many things that can happen to physicians, or be done by physicians, that can require a difficult conversation. Who is responsible for this? How should it be done? How long do you ignore bad behavior, dangerous practices or sub-par clinical skills before someone addresses it? No one wants to have the conversation, but someone must.

Scenario 1

No one wants to sit down with Dr. Flowers and tell him that he needs to stop operating. He has been a respected member of the medical community for nearly 50 years. He did the first open heart surgery in this town, and has been looked up to his entire professional career. He has taught hundreds of residents and medical students, and saved countless lives. He is revered in the hospital and the community.

For the past six months or so, there have been more and more comments and complaints from the O.R. nursing staff, the anesthesiologists and the surgical residents. It began with concerns that perhaps he was losing his hearing because he did not always respond when spoken to in the O.R. Then, several of the anesthesiologists mentioned that they were not sure, but they thought that several times he came into the O.R. completely unaware of what procedure he was scheduled to perform. The head nurse in the O.R. said that he has been blaming the nursing staff for things that were clearly his fault, and now, the residents are refusing to go into the O.R. with him because they fear that they might end up getting sued, or worse, as a result of his mistakes. His hands are no longer as steady as they once were, he seems to have trouble tying knots, and his reaction time is much slower than it should be, especially if the patient starts bleeding or there are other serious complications during the procedure. If anyone questions him, or tries to help him, he becomes indignant and yells at them. No one

wants to work with him anymore, and they all agree that he needs to put down the scalpel. You must now deal with this issue.

Scenario 2

Dr. Winters has recently developed the habit of having his resident complete the procedure and close once he has done the "tricky part." That would be acceptable under normal circumstances, but Dr. Winters is not only leaving the O.R., he's leaving the hospital! Several staff members and employees have seen him hurrying out of the O.R. and out of the hospital. They have mentioned it to the O.R. Director several times. She has asked him three different times about it, and each time he denies it and asks if she is questioning his integrity. Today, she followed him to the parking garage to make sure for herself. She has now come to you to ask you to deal with this issue.

Scenario 3

Dr. Somers works two shifts a week in the E.D. He is employed by the hospital to cover weekend hours. Right before you are ready to leave at 5:30 on Friday evening, the administrative director of the E.D. comes into your office in a panic. He says that one of the nurses came to him saying that she thought that Dr. Somers smelled of alcohol. He went to speak to him, and confirmed that he does indeed smell of alcohol. He questioned him about it, Dr. Somers denied that he had been drinking before coming to work, but the director is afraid to let him start his shift. Dr. Somers has been told that he is not to see any patients until he hears back from the director, and the nursing staff has been notified not to assign any patients to Dr. Somers until told otherwise. The director has now come to you to ask you to deal with this issue.

Scenario 1—Scenario 3

What do you do first?

- Develop a plan

- Initiate an investigation

- Collect information and examples

- Meet with the physicians

- Work with the physicians to determine what steps need to be taken to meet the needs of all parties and protect patients

In any situation where there is imminent danger, obviously the first step will always be to remove the danger. The speed with which each step is taken is determined by the type of scenario and potential for patient harm. Developing a plan can take as long as two minutes or two days. Conducting an investigation may already be completed by the time you become aware of the situation, i.e., someone brings you evidence or has firsthand knowledge, or you may need to talk to people, look at records, etc., before being able to confirm and move on to correction. Meeting with the physician can happen immediately by walking to the E.D., or scheduling for Monday morning. Again, each of these things needs to be determined by the severity of the situation.

Now comes the really hard part—having that difficult conversation. This is one of the worst parts of any leader's job. Sometimes the situation is so egregious that it is easy for you to talk to the individual. Sometimes, it may be a "there but for the grace of God" situation, and you might even feel guilty having to have this conversation. Maybe, it is clear that you are dealing with a mental illness or addiction issue. Regardless, you must have the conversation, and if you are like most people, it never gets easier. What you need to remind yourself of is that this is simply another form of patient care. You, as a physician leader, are providing care and safety for the patients that this physician might otherwise harm.

Resources

There are resources available to help these physicians. The guide below is not all inclusive, nor should it be considered an endorsement of any program.

Comprehensive Assessment Program
Professionals at Risk Treatment Services
Elmhurst Memorial Healthcare
Glenn Siegel, MD
183 N. York Rd
Elmhurst, IL 60126
(610) 58-5110

LifeGuard
Re-entry, remediation, aging physician assessment
777 East Park Dr
Harrisburg, PA 17105-8820
(717) 909-2590
info@lifeguardprogram.com
www.lifeguardprogram.com

Multidisciplinary Assessment Program (MAP)
Rush Behavioral Health
Carl Main
Chicago, IL
(312) 942-4000

Physicians Health Programs
Foundation of the Pennsylvania Medical Society
Louis Verna
777 East Park Dr
Harrisburg, PA 17105-8820
(717) 558-7817

Pine Grove Professional Enhancement Program (PEP)
Alexis Polles, MD, or Mark Ely
2255 Broadway Dr
Hattiesburg, MS 39402
(800) 301-6693

Professionalism Program at Penn Medicine
Jody J. Foster, MD, MBA
Executive Clinical Director
3 Blockley Hall
423 Guardian Dr
Philadelphia, PA 19104
(215) 662-7677
www.pppmed@upenn.edu

Professional Renewal Center (PRC)
Kristen Judd or Betsy White Williams
1201 Wakarusa, Ste E-200
Lawrence, KS 66049
(877) 978-4771
www.prckansas.org

Sierra Tucson
Assessment and Diagnostic Program (ADP)
Christi Cessna or Keith Arnold
39580 S. Lago del Oro Parkway
Tucson, AZ 85739
(800) 842-4487
www.sierratucson.com

Talbott Recovery Campus (TRC)
Talbott Pathways Program
Lauren Smith or Nanci Stockwell
5448 Yorktown Dr
Atlanta, GA 30349
(800) 445-4232

Vanderbilt Comprehensive Assessment Program for Professionals
A.J. Reid Finlayson, MD, or Ron Neufeld
3rd Fl PHV
1601 23rd Ave, South
Nashville, TN 37212
(615) 322-4567

References/Resources/Readings

Alicia Gallegos. Calming a hospital culture clash. Amednews, April 29, 2013
www.amednews.com/article/20130429/
profession/130429951/4/?utm_source=nwltr&utm_
medium=heds-htm&utm_campaign=20130429

Nine Tips to Bring Order to Hospital Communications Chaos
www.amcomsoftware.com/pdf/WP-US-9-Tips-
Hospital-Communications-Chaos.pdf

Disruptive Physician Behavior
www.quantiamd.com/q-qcp/Disruptive_Physician_
Behavior.pdf

Toxic Docs Require Management Finesse
www.healthleadersmedia.com/page-1/PHY-295026/
Toxic-Docs-Require-Management-Finesse