Driving Excellence: Leadership Orientation for Medical Staff Leaders

Leadership in Action: Oversight, Accountability & Performance Excellence

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“Our healthcare system needs the input of many skilled physicians – physician leaders across every state and specialty – who are working together with this incredible purpose and urgency.”

- Bobby Mukkamala, MD - 2025 AMA Annual Meeting

Continuing Medical Education Information

There was no commercial support for this activity.

The planners and faculty of this activity have no relevant financial relationships to disclose.

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of CME Consultants and Hardenbergh Group. CME Consultants is accredited by the ACCME to provide continuing medical education for physicians.

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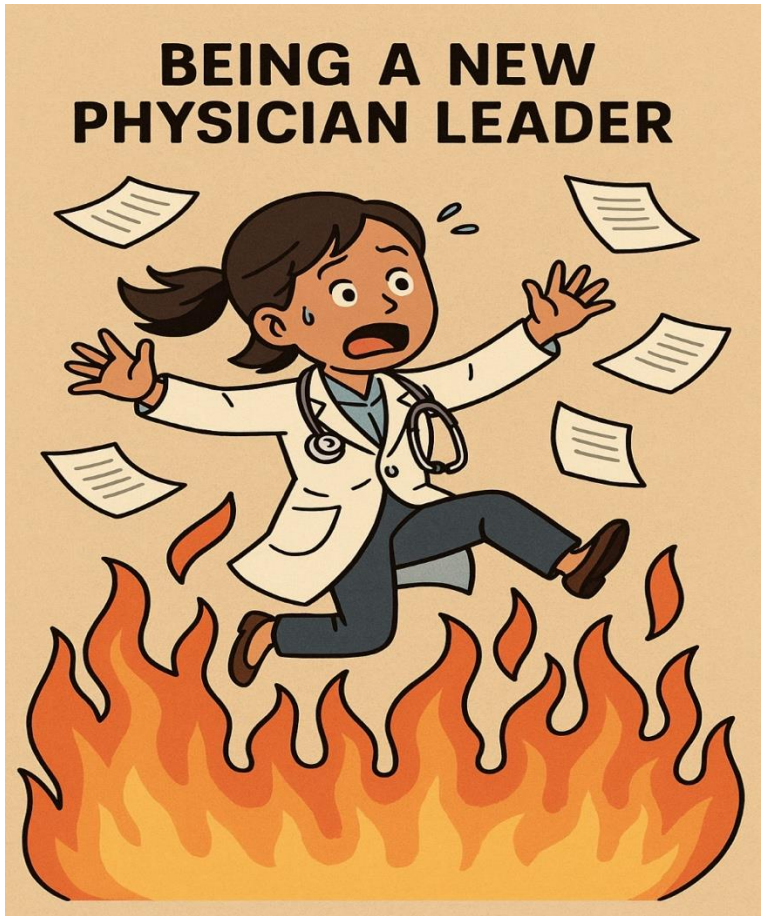
Welcome to your new leadership role!



Sound Familiar…?

I inherited this mess of being out of compliance with two documentation standards at the last Joint Commission survey.

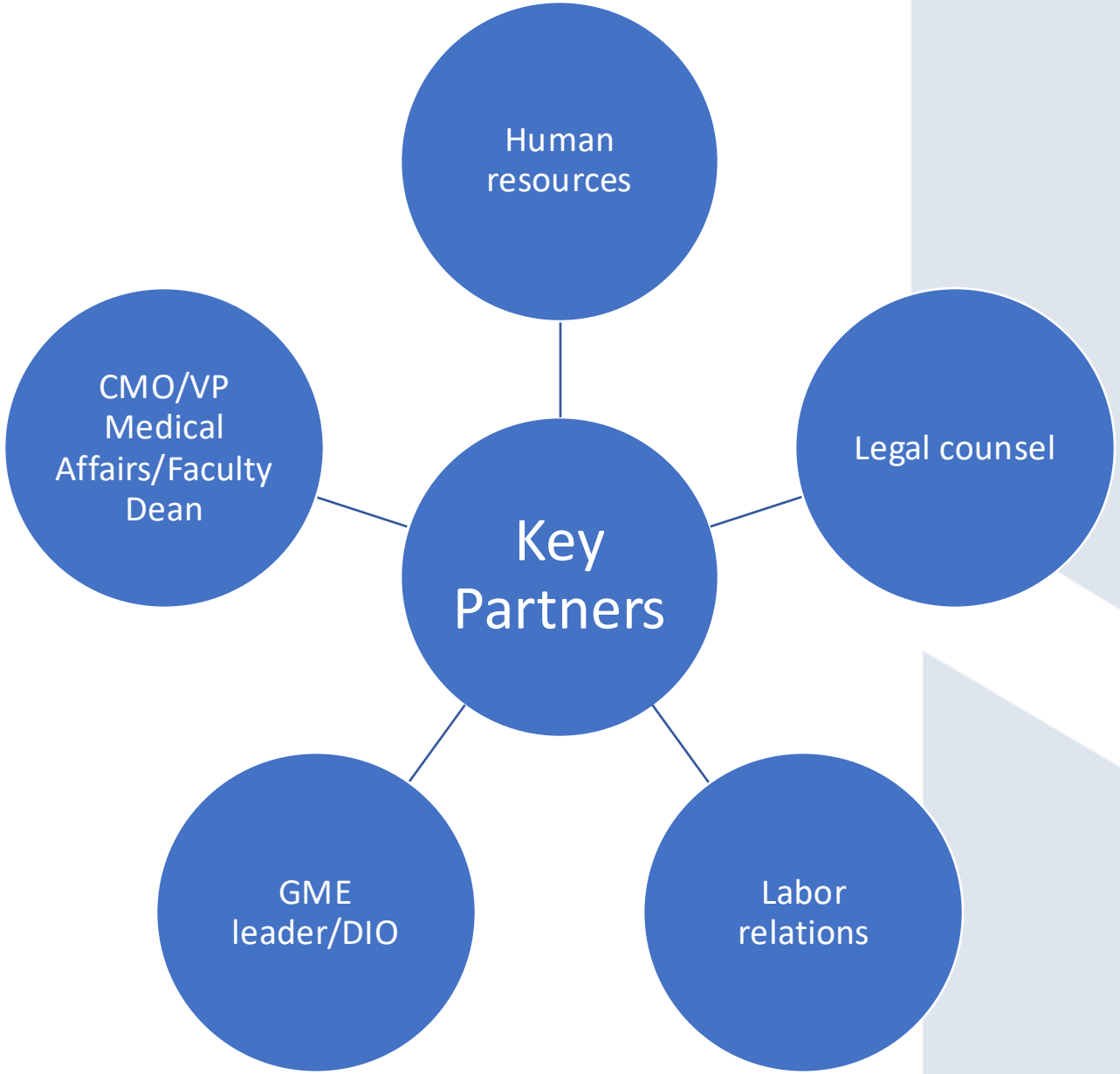
We need to hire 10 new ED docs in 3 months because we just had a mass exodus.

Nurse pulled me aside and is worried the doctor has memory issues.

A PA just yelled at the resident and nurse in the OR. There are dozens of complaints like this.

Agenda – The Essentials

1. Building a foundation: Key people, Bylaws, Hospital & Department Policies
2. Budget Planning/Forecasting
3. Recruitment & Credentialing
4. Onboarding & Initial FPPE
5. OPPE & Quality Metrics
6. Addressing Performance Concerns – Peer Review


Human resources
CMO/VP Medical Affairs/Faculty Dean
Key Partners
Legal counsel
GME leader/DIO
Labor relations

Governing Documents

Medical Staff Bylaws

- ➢Qualifications for Membership & Clinical Privileges
- Responsibilities of Members & other practitioners granted privileges
- Medical Staff Categories & qualifications (e.g., Active, Associate, etc.)
- Medical Staff Committees & Elected Officers
- Disciplinary Actions & Due Process Rights

Medical Staff Rules & Regulations

- ➢Medical Record Documentation
- Call Coverage & Emergency Response times
- Admission & Discharge guidelines
- Patient Safety Protocols

Policies

Medical Staff Policies

- Peer Review, FPPE, OPPE
- Practitioner Wellness
- Temporary & Disaster Privileging
- Credentialing

Hospital Policies

- EMTALA
- Informed Consent
- Disclosure of Unanticipated Outcomes
- Restraints & Seclusion

Department Standard Operating Procedures

Department Specific Clinical or Administrative Guidelines that set forth Department specific expectations – **Examples:**

- Interdisciplinary Rounding Requirements
- Post-Op PACU Monitoring Guidelines
- Fetal Monitoring Interpretation & Documentation
- Sepsis Protocol
- Turnaround times for STAT vs Routine Imaging
- Discharge planning for Behavioral Health Patients
- **Case Selection for Peer Review and FPPE**
- Participation Expectations – Department Meetings and CME events

Legal Tips for Physician Leaders

Read (and re-read) the Governing Documents	When in doubt, ask for help! These provide you with legal protection
Follow Established Policy – Even when Inconvenient	Skipping steps or making exceptions can expose you and the hospital to liability
Document According to Policy	Accurate, timely documentation protects patients and supports defensible decisions
Apply Standards Consistently	Unequal enforcement of rules can lead to allegations of bias

Budgets & Forecasting

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Case Scenario

It is the end of the year and just after Thanksgiving:

- Two PCPs with busy practices have announced their retirement in 3 months
- Another physician will be taking 6 months of family leave
- Your CEO has asked your group to do sessional work at a practice 10 miles away

Forecasting

- Know your current landscape
- What is the current state of supply, demand and compensation in your area?
- Project expansion for services (18-24 months)
- Any anticipated clinician changes– leaves of absence, retirements, changes in clinical effort
- Get to know the levers you can pull and the cost If you need more clinical help

Recruitment

Case Scenario – “The Deceptionist”

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Case Scenario – “The Deceptionist”

A candidate applying for a general internist position presented a CV that reflected sufficient training and education for the position – appearing very qualified for the position. The applicant was well spoken and interviewed well. The Division Chief extended an offer of employment.

As a part of the routine credentialing process, a Federal State Medical Board (FSMB) report was run which showed that this applicant held greater than 40 state licenses during their career – typically seen with those who do locum tenens work or telehealth. No locums work was listed on CV. He listed **7** state licenses on his CV but only listed training and work history in **3** states.

Additionally, a general google search was conducted, and throughout the US there were inconsistencies in the specialty in which he was listing as specializing in. Some reflecting Dermatology others showing specializing in Internal Medicine. As the provider had a very unique name, and photo was matched on many of the websites, it was confirmed to be the same provider.

In closer scrutiny by the credentialing team, his CV listed research all in Dermatology.

Case Scenario – "The Deceptionist" - Outcome

Credentialing discovery found that he blocked the use of the AMA profile (which is used to verify training) without a specialized release that required notification to the physician when someone queried the AMA. An email was received from a fake AMA email address with a forged AMA training certificate, confirmed by the AMA to be falsified.

Opportunities –

- Improved screening of the CV during recruitment would have led to questions related to his research that was listed
- Improved screening of CV should have led to ask probing questions related to what type of work he was doing in the 4 states he did not list training/work history for.
- A simple google search by the Department would have raised flags about being listed in numerous states across the US with different specialties

Result –

The department withdrew the offer of employment and lost 4 months of time filling the position as they had to start all over again…

Impact of Ineffective Recruitment

Wasted time and financial resources on candidates who are not a good fit

Prolonged vacancies that disrupt patient care and burden existing staff

Offer retractions or disputes, increasing the risk of reputational and legal complications

Early performance concerns requiring peer review or remediation soon after onboarding

Trends in Recruitment in Academic Medicine

- Intense competition for top talent
- Limited budget and resources
- Shortage of specialized experts
- Geographical constraints
- Time consuming recruitment process

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6 Faculty Recruitment Challenges in Health Care Education (eimpartnerships.com)

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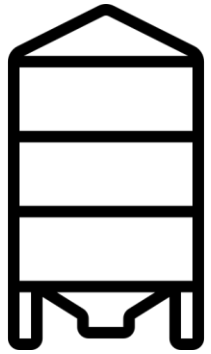
Challenges



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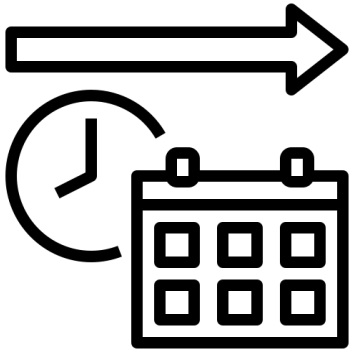
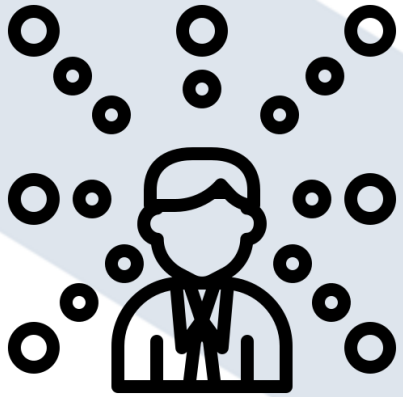


reactionary

financial
and operational
cost



system
awareness

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Pre-Screen Candidates *prior* to Interview

PRE-SCREENING CHECKLIST

- ○ **CV Scrutiny**
  - ✓ Evaluate Education/Training to ensure it aligns w/position requirements
  - ✓ Identify if the positions they held previously will make them a fit for the specific setting in which they are interviewing for (e.g., volume, complexity, etc.)
- ○ **Google**
  - ✓ Do a quick google search using some key words for example:
    - Applicant Name, MD, investigation
    - Applicant Name, MD, lawsuit
    - Applicant Name, MD, (prior city/state where they worked)
- ○ **At any point in which the Department feels comfortable doing so, you have the *option* to request that the applicant Self-Query the NPDB and provide you with a copy. This is often where the red flags that raise the most concerns can be identified. The NPDB reflects:**
  - ✓ Settled Malpractice Claims
  - ✓ Any State Medical Board Actions (from all States)
  - ✓ Any Formal Disciplinary Action taken by Hospitals who appropriately reported
  - ✓ Self-Query Link: https://www.npdb.hrsa.gov/pract/selfQueryBasics.jsp

Ask Probing Questions! Identify Red Flags Early

Are you Board Certified or Board Eligible in the area in which you are seeking privileges?

Have you ever been subject to any disciplinary action, sanction, restriction or reprimand by any organization, licensing board or other agency?

Are there any current, prior or pending investigations and/or disciplinary actions from ANY organization (e.g., civil, healthcare-related)? If so, please explain the circumstances.

Have you ever been named in a malpractice action? If so, how many? Have you had payment made on your behalf for any of the cases?

Legal Tips for Physician Leaders

Consult with HR	Educate yourself & others on what questions can be asked during an interview
Consult with Legal	There may be specific state laws to be aware of (e.g., criminal background considerations)
Apply Standards Consistently	Unequal enforcement of rules can lead to allegations of bias

Credentialing & Privileging

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Due Diligence Over Convenience

Credentialing is not just a regulatory requirement — it is your first line of defense in protecting patients, supporting your team, and minimizing risk. A thorough and well-documented process ensures that only qualified, competent, and professional practitioners are granted privileges.

- **Missed Red Flags:** Incomplete verifications or skipped reviews may fail to identify past clinical concerns, disciplinary actions, or behavioral issues.
- **Early Peer Review Cases:** Rushing the process often results in performance or conduct issues surfacing shortly after onboarding.
- **Disruption to Patient Care:** Hiring or privileging an unqualified practitioner places patients and the care team at risk.
- **Regulatory Non-Compliance:** Failing to follow proper credentialing procedures may violate Joint Commission, CMS, or State Department of Health requirements

Credentialing vs Privileging

Credentialing is the evaluation and verification of a clinician's background, education, training, licensure, certifications, employment, etc., to ensure Practitioners meet the minimum threshold criteria set forth in the Medical Staff Bylaws for Membership and/or Clinical Privileges.

There is a distinction between Membership on the Medical Staff and being granted Clinical Privileges.

Practitioners can be granted Membership w/o Clinical Privileges, and some Practitioners are granted Clinical Privileges but are not members of the Medical Staff (thus not entitled to certain rights).

Delineating Privileges

DOPs

- Delineation of Privileges (DOPs) set forth the patient care, treatment or services offered by the Department/Division, the criteria/qualifications for the privileges, and which sites the privileges are offered at. If granted Clinical Privileges, FPPE and OPPE is mandatory.

Core Privileges

- Clinical activities within a specialty or subspecialty that any practitioner who has completed the minimum level of training would be competent to perform (e.g., residency training)
- While the Core includes a list of privileges, each practitioner has the ability to 'opt out' or not select all procedures included in the core

Non-Core Privileges

- Requires an additional level of education, training & experience (fellowship, CME, specific competency, etc.). Not offered to all practitioners within the department. Sometimes referred to as a cluster if multiple privileges are covered under this non-core item.

Criteria

- Include education, training, and competency criteria for both initial and reappointments
- Set forth age-based criteria
- Outline what the initial FPPE criteria is (e.g., x procedures under direct observation, x retrospective chart reviews, etc.)
- Are site specific based on what equipment, resources, etc. are available at that site.

Temporary Privileges

The Joint Commission (TJC) allows the granting of temporary privileges under two circumstances:

- Pendency of an Application – When an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the MEC and the Board of Trustees.
- To fulfill an important patient care, treatment and service need (prior to full credentialing).

Providers on temporary privileges can not be enrolled in plans and cannot bill.

TJC will look to see if you are following your process and if you have sufficient justification to grant temporary privileges.

Temporary Privileges can put the organization at risk and are frowned upon by TJC. We encourage you to only request these if there is a significant need to do so (because it is before the credentialing process has been initiated and/or completed). Overuse of this may result in a Requirement for Improvement from TJC.

Red Flags – What You Can't Afford To Miss

Failure to Disclose Critical Information
→ Raises concerns about integrity, transparency, and possible concealment of past issues

Negative Evaluations or References
→ Indicates potential deficiencies in one or more of the six core competencies (clinical skill, professionalism, communication, etc.)

Adverse Actions by Other Organizations
→ Prior disciplinary actions, privilege restrictions, or terminations may signal patterns of concern

Criminal History or Pending Legal Issues
→ May reflect risk to patient safety, regulatory compliance, or institutional reputation

Malpractice History Trends or High-Payout Settlements
→ Patterns of claims or unusually high payouts may suggest issues with clinical judgment, documentation, or communication

Best Practice Credentialing Tips

In depth disclosure questions – some often overlooked questions:

- Failure to complete training program, remediation, academic advisement
- Found liable for or any pending *civil* cases reasonably related to their qualifications, competence, duties as a medical professional, or any offense involving allegations of fraud, violence or moral turpitude.
- Any *pending* law enforcement or federal agency investigations (such as the OIG for fraud) – will not be on a criminal background check

Clinical Evaluations vs. Peer References

- *In addition to* peer references, obtain a clinical evaluation. More candid than a peer references provided by the applicant.
- Program Director for new graduates (or within 5 years of training)
- *Current* Supervisor (Chair, Medical Director, etc.)
- Incorporate six general competencies
- Option to contact you directly by phone (often not comfortable putting something in writing).

Best Practice Credentialing Tips

In-depth Google Searches:

- Use key words (investigation, lawsuit, allegations, malpractice, etc.)
- Give some weight to patient reviews if there is a pattern or trend
- Pay attention to state licenses held but no listing of practice or training in that state on CV or application

Other:

- Ensure affiliation letters state no quality or performance concerns (common term “in good standing”). Letters that only provide dates should not be accepted. Example of Red Flag “*No current or pending investigations/actions”.* Prior?
- Failure to disclose
- Continuous Query

Onboarding & Initial Focused Professional Practice Evaluations (FPPE)

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Setting New Practitioners Up for Success

- Understand their background and skills and create a plan to support them in your organization
- Consider any issues or events disclosed in the application and plan for support
- Share any unique aspects about the patient populations, organization or capabilities of your department at the outset
- Share your expectations

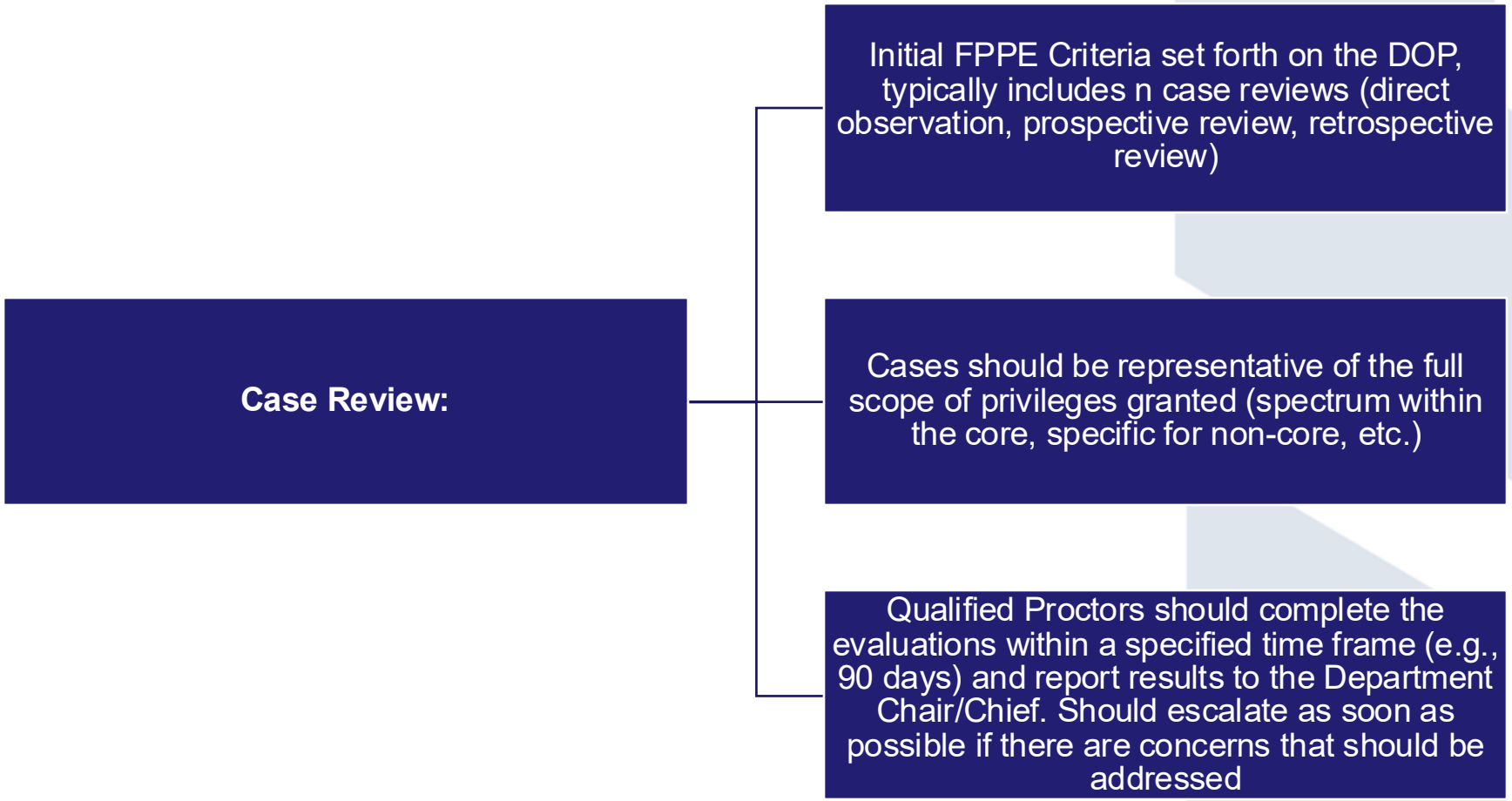
Orientation/Onboarding

- Year long process with focus on first 90 days
- Combination of organization + site/department orientation
- Have a check list with major areas to cover
  - Policies/procedures
  - Benefits
  - Practice resources
  - Performance evaluations
- Periodic check-ins, mentor/buddy system

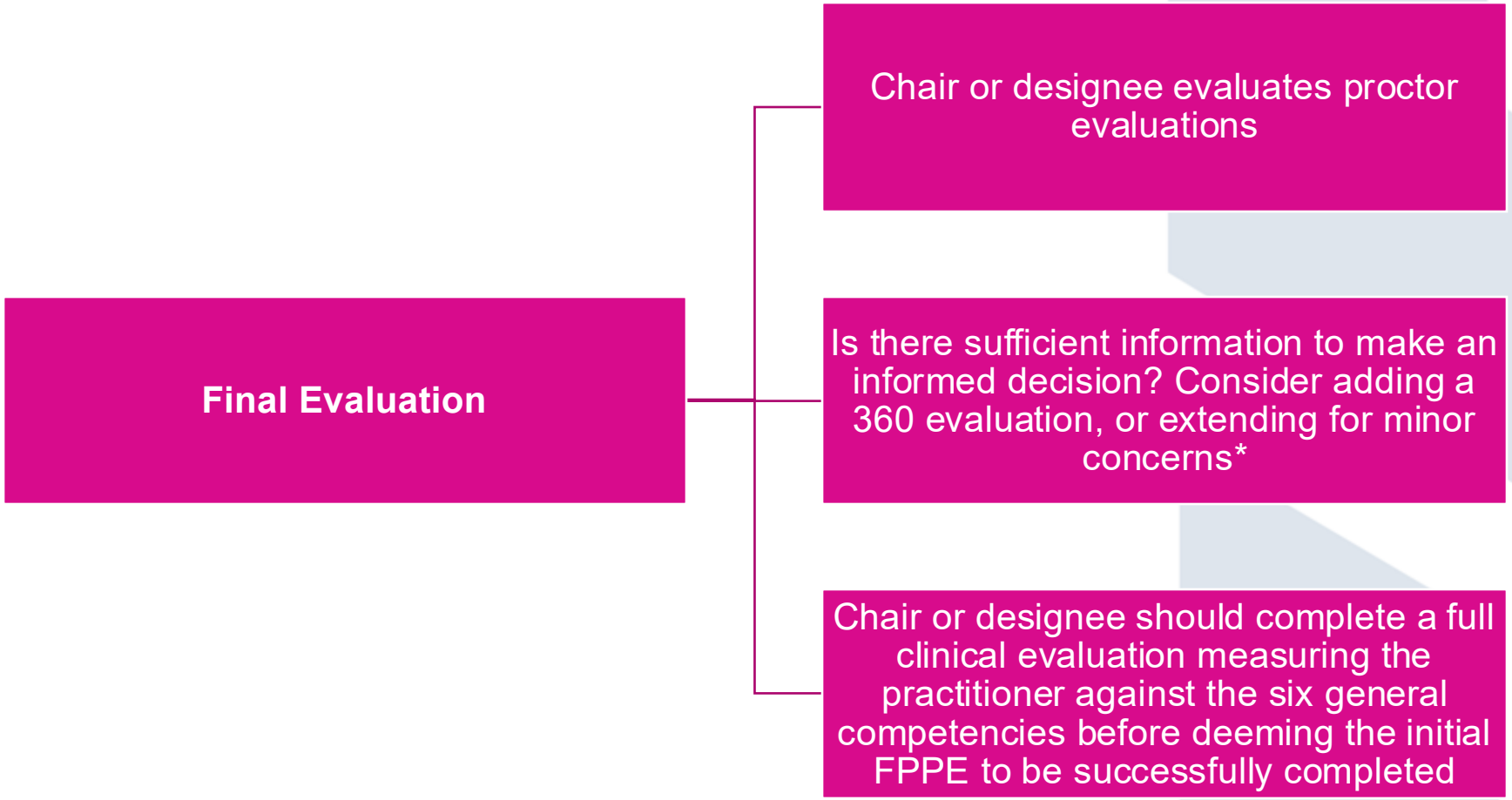
Starting Strong: Initial FPPE as a Safety Net

Confirm	Confirm clinical competence through real-time evaluation over the first 4–6 months
Assess	Assess overall fit within the department and organizational culture
Identify	Identify early concerns related to clinical skills, professionalism, or communication
Provide	Provide a structured opportunity for feedback, mentorship, and course correction
Protect	Protect patient safety by ensuring only qualified practitioners continue in their roles
Support	Support fair and defensible decision-making regarding continued privileges

Two-Step Process: Case Review & Final Evaluation



Two-Step Process: Case Review & Final Evaluation



Closing an Initial FPPE

Recommend having the ability to extend one time for *minor* concerns	Set clear expectations to be met within a brief period of time Can also extend a portion of the FPPE for low-volume procedures
If successfully completed:	Ensure all documentation is complete and filed in the appropriate area (e.g., credentialing file, peer review file, etc.) Notify the Credentials Committee to close the loop
If there are concerns that arise at any time during the initial FPPE:	Immediate escalation may be warranted Can modify the FPPE and customize to the individual May consider deeming the initial FPPE as unsuccessfully completed
Unsuccessful Initial FPPE	Notify the practitioner that the Initial FPPE was not successfully completed Address concerns through the peer review process

Ongoing Professional Practice Evaluations (OPPE)

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OPPE: A Continuous Look at Practitioner Performance

OPPE is a structured, ongoing evaluation of a practitioner's performance using both qualitative and quantitative data to identify potential trends and concerns that may affect patient safety or quality of care.

- OPPEs must be conducted at least annually to meet The Joint Commission standards but most departments are likely monitoring performance dashboards on a more frequent basis
- OPPE data should incorporate not just specialty specific quality indicators, but should also include rule-based indicators, such as patient complaints & grievances, policy or code of conduct violations, medical record or automatic suspensions (failure to maintain current credentials), etc.
- Volume data – OPPE reports should include volume data. If there is insufficient volume to measure quality then further discussions are needed to determine if clinical privileges are still needed, and if so, how to document current competency to justify continuing to grant them

Low/No Volume Practitioners

If a Practitioner has insufficient internal quality data to conduct an assessment due to having very low or no clinical volume at the time of OPPE, or at Reappointment, Department Chairs have several options to address:

Have a discussion with the practitioner to determine whether they should withdraw their clinical privileges due to non-use;

Encourage the Practitioner to change status to Membership only, with no clinical privileges;

Allow the provider to submit volume data from another organization to justify the continued grant of clinical privileges. Medical Staff Services should obtain a Clinical Evaluation from the Chair or Medical Director at that facility during reappointment (or at OPPE if requested);

Option to require that they complete an intended practice plan to outline how they plan to increase their volume/integrate into the Medical Staff moving forward.

Professional Enhancement – Addressing Performance Concerns Through Peer Review

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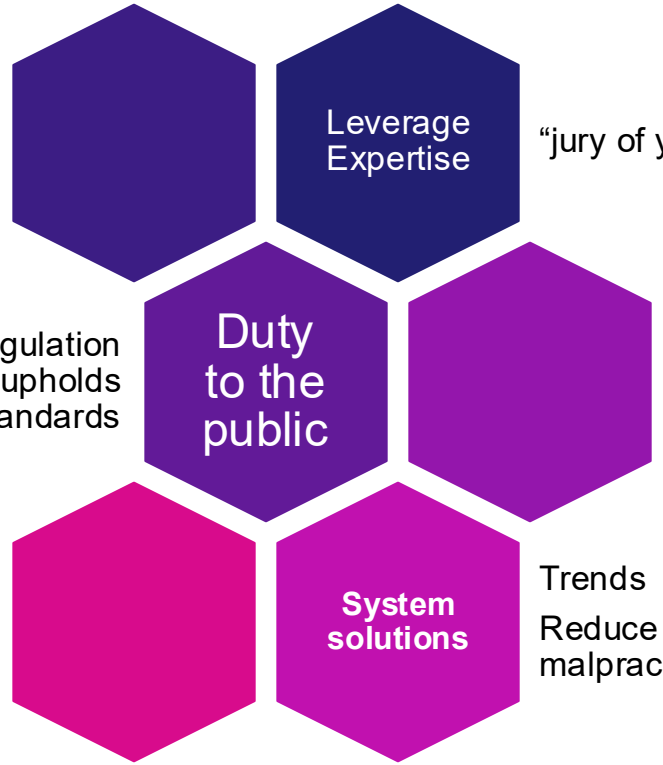
Importance of Peer Review



"jury of your peers"

Self regulation and upholds standards

Trends

Reduce malpractice risk

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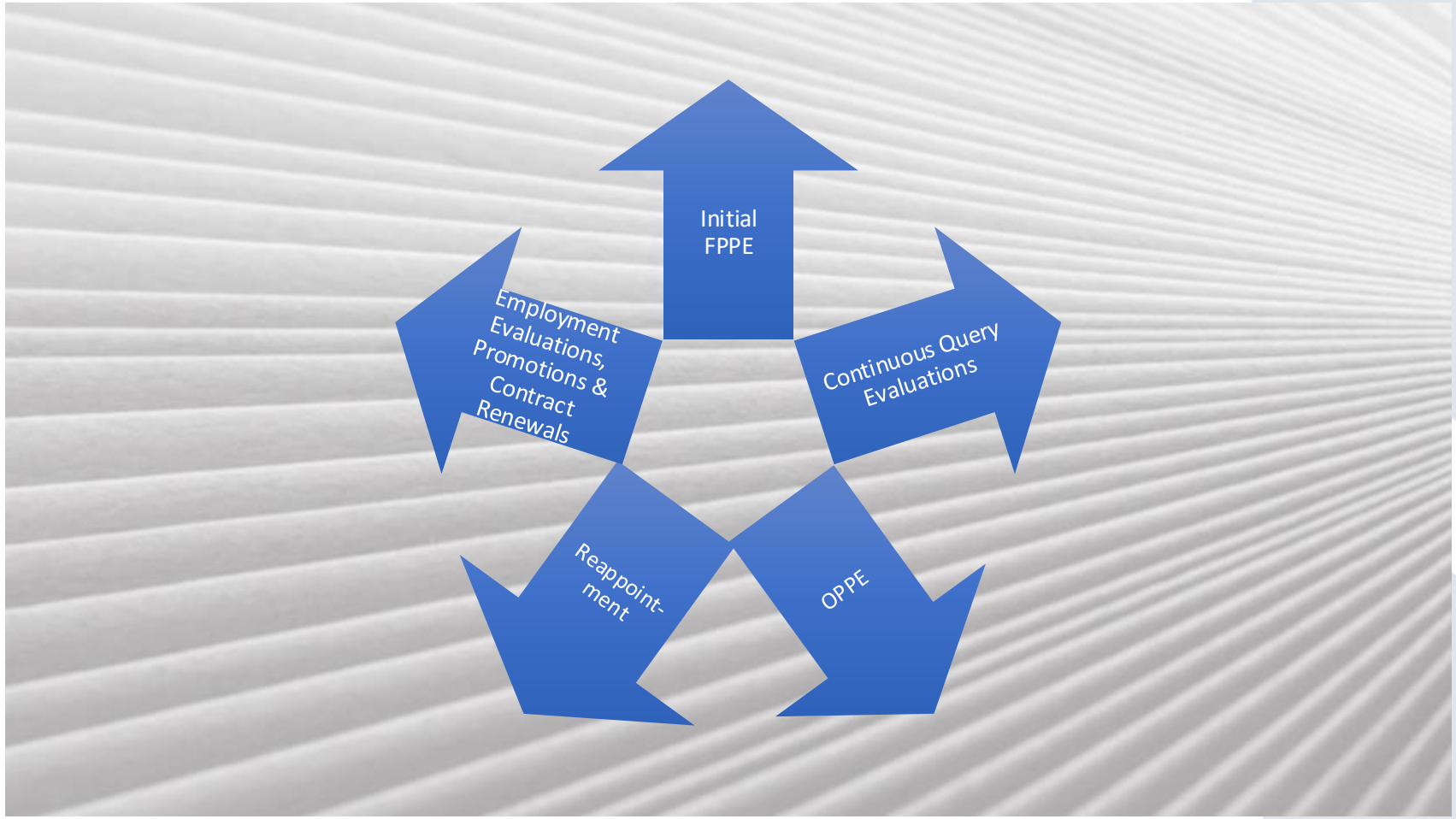
Utilization of Peer Review Data



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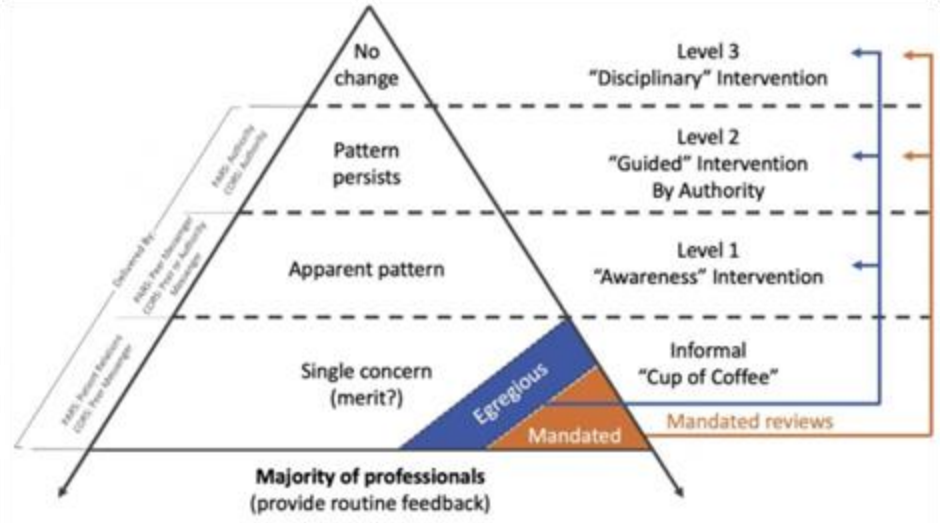
Collegial Intervention

What is Collegial Intervention?

A discussion between a Medical Staff member and one or more Medical Staff Leaders, the CMO, and/or the CEO, along with a follow-up letter that summarizes the discussion and expectations regarding the practitioner's future practice and/or conduct in the Hospital.



(The pyramid illustrates a tiered intervention approach that supports pursuit of professional accountability. Adapted from: *A complimentary approach to promoting professionalism: Identifying, measuring, and addressing unprofessional behaviors*)

In some cases, collegial and/or educational efforts may be appropriate before escalating to more significant actions. These cases include but are not limited to:

- When the Practitioner does not have a prior history of unprofessional conduct or performance issues
- When there are no significant deviations to the standard of care or standards of professional conduct

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If there is a pattern or trend, issues that rise above the level of collegial intervention, or issues that need immediate action – Escalate!

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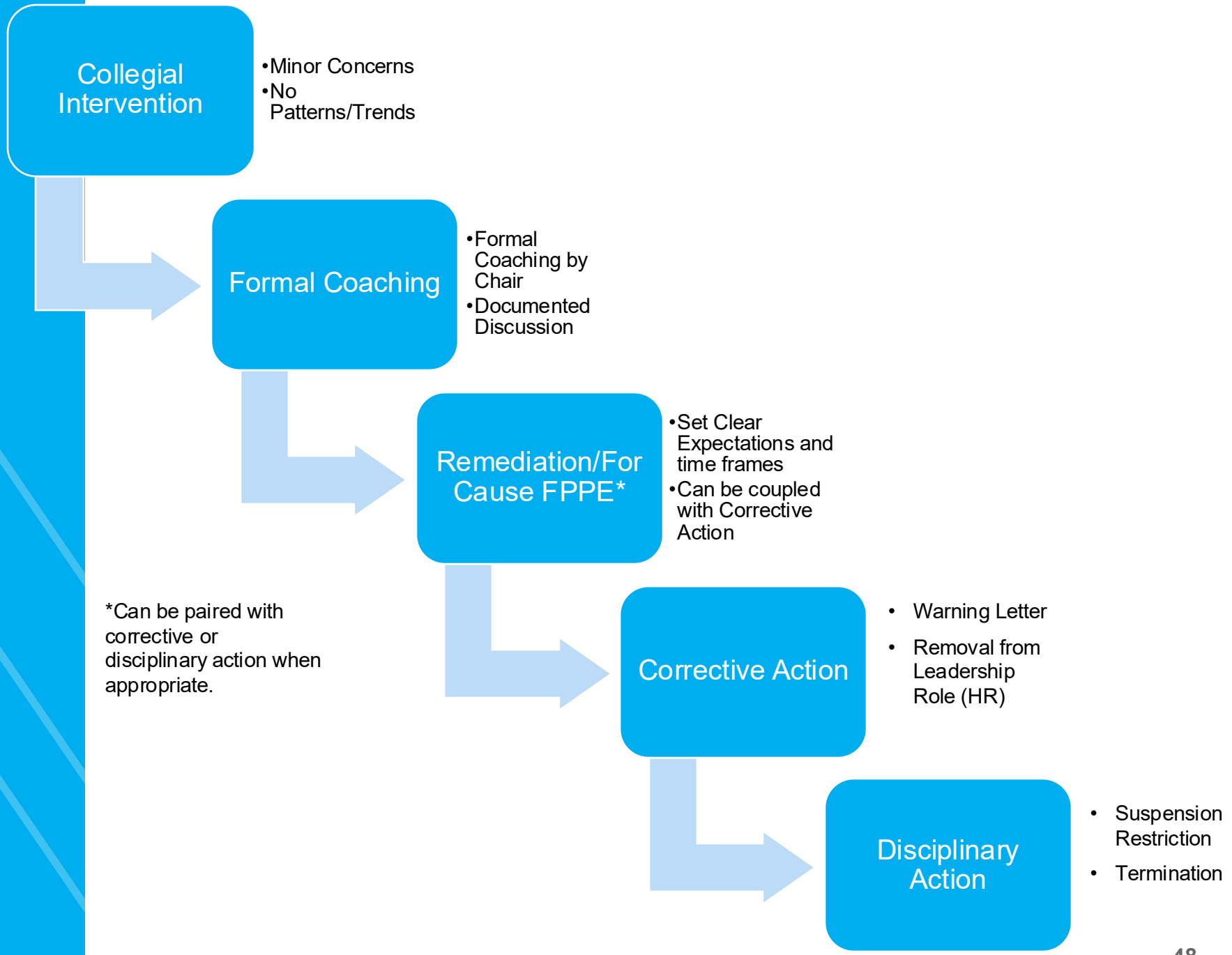
Progressive Approach



Department Peer Review Committee

Department Infrastructures may vary	Purpose: review provider competency/performance globally and for a subset of cases (complications, outliers, etc.,)
	Closed session with a small number departmental case reviewers
	Involved practitioner should attend for the purposes to better ascertain the details of the case under review
	Standard of Care (SOC) determination made
	Recommendations or plan of correction (POC) determined and agreed upon by case reviewers and referred to Chair (use medical affairs tools to address such as FPPE, counseling letter, warning letter)
	For system issues departmental QPS leadership should work with system leadership to improve process or system issue

Legal Tips for Physician Leaders

Document & Protect	Ensure thorough documentation (defensible) that is maintained in a confidential peer review file.
Decision Making	Take action that is best for patient safety, *then* determine if the action is reportable.
Follow Bylaws & Policies	For legal to appropriately defend you and your decision making – dot your I's and Cross your T's
Apply Standards Consistently	Unequal enforcement of rules, or failure to address similar actions in the same manner, can lead to allegations of bias or discrimination

Questions?