REPRINT APRIL 2013

hfm
healthcare financial management association hfma.org

John Byrnes

managing your medical directors

We recently finished another installment of Quality BootCamp.®

Nine hospitals sent teams, each composed of the hospital's chief medical officer (CMO), chief nursing officer, and quality director, to this five-day workshop focused on practical, "how-to" tactics of quality program implementation. Most of the hospitals represented were award-winning hospitals with remarkable achievements in quality and safety. By the end of the conference, it was clear that all of us had work to do to fine-tune the operations of our quality and safety programs. Four key areas where work was needed rose to the top and were common across all hospitals: organization of medical directors, quality department staffing and skill mix, C-suite leadership roles, and board effectiveness.

I've written about the role of medical directors on many occasions, particularly related to the ROI that can be realized when medical directors are strategically deployed on high-value projects. Even so, with medical director budgets exceeding $1 million per year in many of the nation's hospitals, the topic seems worth revisiting. Let's review the most important tactics for developing a well-organized, highly productive group of medical directors—directors who help create the value proposition (e.g., top-decile quality and lowest quartile in cost).

Job description. Each medical director should have a job description that clearly articulates the primary roles, responsibilities, and deliverables for the position. A well-written job description focuses the physician on the organization's priorities. For instance, primary responsibilities should include leading department-level quality and safety initiatives; ensuring that evidence-based medicine is practiced by all department members; focusing physicians on complication, mortality, and readmission (outcome) improvement; and leading electronic health record (EHR) design and adoption.

Annual project list and goals. Medical directors should be assigned an annual list of top-priority projects that tie directly to the organization's strategic priorities. Each project on the list should include quarterly milestones and annual deliverables with objective and measurable goals. For an orthopedic medical director, for instance, typical improvement projects include total hip and knee replacement. For each surgical procedure of this type, the medical director could have the following six goals:

- To embed all nationally endorsed treatment standards in order sets
- To ensure that order sets are utilized at least 95 percent of the time
- To ensure that all department members are practicing according to the current evidence base
- To reduce selected complications by 25 percent by year end
- To reduce length of stay to less than 3.5 days by year end
- To reduce readmission rates to less than 5 percent by year end

Annual performance review. The performance of medical directors should be reviewed annually by an upline supervisor, using the same formal review process that is used throughout the organization. Accountability for results should be enforced, with consequences for below-average performance. I also like to include a 360-degree

evaluation as well. Evaluations such as these provide much-needed insight into the more subjective strengths and weaknesses of the directors. To avoid stacking the results, upline supervisors should play an active role in selecting a broad range of reviewers, especially from peers, nursing directors, and nursing managers.

Reporting lines. I like matrix reporting relationships for most medical directors. This approach most commonly entails a reporting line to the CMO and to an operational vice president responsible for the medical director's service line/specialty. The reporting line to the CMO is important both for medical oversight and in teaching the medical director what it takes to be a physician executive. The reporting line to the vice president is important for operational learning and access to coaching from a seasoned hospital administrator.

Monthly status reports. Medical directors should be in the habit of providing monthly status reports to their upline supervisors. They should be directed to use a simple project management form to assess and report on the status of their projects every 30 days. This simple requirement will result in a litany of complaints, but as all good managers know, it is necessary for accountability and getting things done. After several months, the complaints will fade and a newfound appreciation will emerge as projects start to move forward at a reliable pace.

Monthly project review (coaching) sessions. The monthly status reports will provide the basis for monthly project review sessions between the medical director and his or her upline supervisor. These monthly touch-base sessions are a must—a non-negotiable. Not investing this time is one of the primary reasons for medical director failure. These sessions provide a multitude of benefits, including just-in-time training, coaching through barriers, and setting expectations. They give the medical director the opportunity to learn from more experienced and seasoned physician executives and operational leaders and are invaluable for a medical director's continued growth and learning. Such sessions are also invaluable to organizations, as they ensure forward momentum is maintained for organizations' priority projects.

Personal development plans. It is important that personal development plans be developed annually for each medical director. The most common elements of a personal development plan include training in quality and safety science, design and implementation of an EHR, and development of management and leadership skills. It is also critical to ensure that each medical director has access to and regularly reviews appropriate professional literature. Especially for new medical directors, help in establishing a professional network of colleagues and peers will improve their chances of success. I also like to encourage each director to publish one article per year in a peer-reviewed journal and present at least one regional or national conference related to major projects.

Basics that Aren't So Basic

Many of you may be thinking that this is all common sense—that these management tactics are already in place at most hospitals. Rest assured, more than likely, they are not—and a discussion with your CMO and service-line vice presidents may be very enlightening. Please consider sharing this article with your CMO or vice president of medical affairs and working with these leaders to ensure that all medical directors are contributing to the value proposition in your organization. If they are not, then they are just one more line item of overhead. ●

John Byrnes, MD, is chief medical officer, Sisters of Charity of Leavenworth Health System, Denver, and a member of HFMA's Western Michigan Chapter (john.byrnes@sclhs.net).