Combining Medical Staffs in a Multi-Hospital Setting

Webinar

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Presented by

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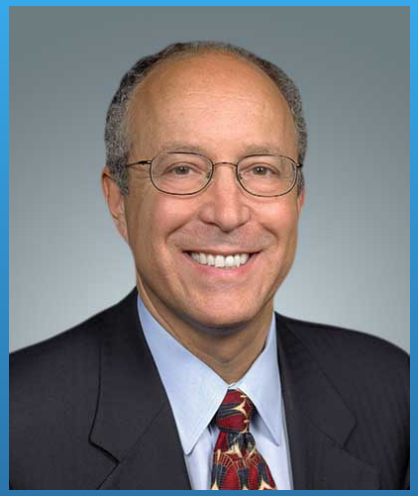
Today's Presenter



Todd Sagin, M.D., J.D., is President & National Medical Director of Sagin Healthcare Consulting, LLC and a Governance Institute advisor. He is a Physician Executive recognized across the nation for his work with hospital boards, medical staffs, and physician organizations.

Dr. Sagin is a popular educator, consultant, mediator, and advisor to healthcare organizations. He is frequently asked to assist hospitals and physicians develop strong working relationships, as healthcare becomes a more integrated enterprise. Over the past decade, he has helped develop effective hospital employed physician group practices, redesign medical staffs and facilitate their unification when part of multi-hospital health systems, and clarify and rationalize physician leadership roles as they proliferate in today's health care world.

Learning Objectives

After viewing this Webinar, participants will be able to:

- Discuss the pros and cons of consolidating medical staffs in a multi-hospital health system.
- Describe various design options for the consolidation of medical staffs in a multi-hospital health system.
- Describe implementation steps that should be taken to win buy-in for merging medical staffs, how to win board approval, what changes to medical staff bylaws are generally required, and best approaches to address the concerns of medical staff members.

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None of the presenters intend to discuss off-label uses of drugs, mechanical devices, biologics, or diagnostics not approved by the FDA for use in the United States.

What is the current status of the "Organized Medical Staff"?

The “Organized” Hospital Medical Staff

Designed long ago for a different era in medical care delivery where:

- Most physicians were in private practice
- Doctors needed hospitals and an unspoken contract existed between the two — a “quid pro quo"
- Regulatory demands were minimal
- Quality and patient safety were assumed
- Interdisciplinary care was not the norm; integrated care was uncommon

The “organized medical staff” has been an ossified entity for more than 50 years, but is slowly evolving to fit into a changed healthcare world.

What Does Medical Staff Change and Evolution Look Like?

More professionalization of roles

- More continuity
- Qualifications for positions (including availability to do the job adequately)
- Training and skill development

Streamlining run-away bureaucracy

- Fewer committees; fewer categories
- Downsizing or eliminating departments/divisions/sections
- Returning to the hospital responsibilities not essentially medical staff duties
- Downsizing policies, eliminating rules and regulations

Is Unification of Medical Staffs Allowed?

Old CMS Medicare Conditions of Participation:

- Required each hospital with a CMS Certification Number (CCN) to have its own "organized medical staff."
- 2012 updates allowed health systems for the first time to create a common governing board.

Is Unification of Medical Staffs Allowed?

2014 Updated CMS Medicare Conditions of Participation to allow hospitals operating under a health system board to unify medical staff if:

- Permitted under state law
- Each constituent hospital's medical staff decides voluntarily to merge into a unified medical staff entity & four conditions met:
  1. Each hospital's medical staff must have voted by majority in accordance with its bylaws to join, or to opt out of, the unified staff.
  2. The unified staff must have bylaws, rules, and requirements describing its processes for self-governance, credentialing, peer review, and due process, along with an opt-out mechanism.
  3. The unified staff must be established in a manner that takes into account each hospital's unique circumstances with respect to any significant differences in patient populations and hospital service.
  4. The unified staff must operate in a way that gives due consideration to the needs and concerns of all members of the medical staff, regardless of their practice or location, to ensure that local issues applicable to a particular hospital are duly considered and addressed.

Is Unification of Medical Staffs Allowed?

Positions of Accreditation Agencies: Either silent or they follow the CoPs

Joint Commission MS.01.01.05:

- Has four Elements of Performance which follow the four criteria listed in the CoPs

Why Combine Medical Staffs across Hospitals?

Greater "user-friendliness" for physicians

- One application, one reappointment to track, communications from one source, fewer meetings

Efficiency

- Consolidation of medical staff offices and staff
- Effective use of physician leadership bench strength
- Fewer meetings

Why Combine Medical Staffs across Hospitals?

- Fewer silos and less fragmentation of medical staff work
- Less work for health system board
- Reduced potential for liability
- Fewer accreditation reviews
- Ability to reduce unwanted variance in policies and procedures, rules and regulations, clinical practices and operational activities
- Minimize medical staff "politics"
- Opportunity to rationalize and restructure physician leadership across all aspects of the integrated delivery system

Downsides to Medical Staff Consolidation

- Less focus on local hospital campus issues
- Fewer physicians engaged in the development of leadership skills
- Short-term political costs
- Creates a need to ramp up efforts at effective communication

Additional Factors for Consideration

- Geographic distances between hospitals
- Multi-state distribution of hospitals
- Historic medical staff cultures
- Number of hospitals within the health system
- Length of time hospitals have been part of health system
- Historic levels of trust between medical staffs and health system leadership

Additional Factors for Consideration

- Diversity across health system hospitals & complexity of medical staffs:
  - Academic institutions
  - Large vs. small community hospitals
  - Critical access hospitals
- Tensions between employed and private staff physicians
- Controversy over on-call coverage

Complete Unification or Intermediate Steps?

- Upside/downsides to “partial” unification
- What does “partial” unification look like?
- Who should consider “partial” unification?

The Unification Game Plan

Achieve stakeholder buy-in to change: board, management, and physicians

Create a governance task force

Consider all design options

- MEC composition
- Departmentalized or non-departmentalized
- Local campus bodies
- Approach to privileging
- Standing committees

Achieve stakeholder buy-in to final plan

Implementation Challenges

- Beware legal counsel with a ‘risk management’ bias
- Beware C-suite timidity that manifests as soon as any opposition appears on the horizon
- Get medical staff documents right
  - Bylaws
  - Rules, regs, policies — local or system documents
- Consider a “bridging” plan — making the transition from fragmented to unified

Tales from the Field: Four Unification Stories

Health System 1 — California

- Two general hospitals and one specialty hospital merge staffs
- Addressing hospital "ownership" concerns
- Balancing campus equity issues

Health System 2 — Pennsylvania

- Seven hospitals ranging from urban academic to small rural
- Addressing the physician leadership "big picture"
- Getting the infrastructure right
- Letting some players have time

Tales from the Field (cont.)

Health System 3 — South Carolina

- Four-hospital system moves to unify three staffs and breach historic cultural divide
- Watching out the "tail doesn't wag the dog"

Health System 4 — Virginia

- Five-hospital system moves to relabel partial unification as a true unified medical staff

Questions?

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