Unifying the Medical Staff: A Critical Look at New CMS Conditions of Participation

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Healthcare institutions in the United States have been undergoing a frenzy of consolidation in response to a new, emerging business model.

The rationales for the merger of hospitals into larger health delivery systems range from the hope of greater leverage with payers to enhanced facilitation of integrated care. CMS has slowly been adapting its Medicare Conditions of Participation (COPs) to recognize this sea change as America's hospitals organize into complex health systems. In May 2012, CMS modified its COPs to allow health systems comprised of multiple hospitals to operate under a single system governing board. Until that time, the government required that each hospital with a Medicare provider agreement and unique CMS Certification Number (CCN) have its own governing body. While some multi-hospital systems prefer to have local boards for each of their hospitals, many have found it more efficient and effective to operate under a single board. Paradoxically, the modifications made to COPs in 2012 did *not* allow multiple hospitals within a system to share one unified medical staff.

This proscription was lifted in May of this year when CMS made its latest modifications to the COPs. According to CMS, it acted to reform regulations the center found "…unnecessary, obsolete, or excessively burdensome…." The new final rule on COPs explicitly allow a multi-hospital system to utilize a unified, integrated medical staff structure rather than having a separate medical staff at each component hospital.

Traditional Medical Staff Structure

To understand the importance of this change in CMS rules it is helpful to understand the evolution of the hospital medical staff. The traditional medical staff model is a product of the last century and took on its most common attributes almost 50 years ago. There is increasing recognition that it is poorly adapted for today's rapidly evolving healthcare environment. The historic "voluntary" medical staff is clearly in decline as doctors increasingly choose to divorce their work from the hospital or to become employed by it. The most obvious manifestation of the growing irrelevance of the organized medical staff is the poor participation of physicians in these anachronistic entities. Many hospitals struggle to find leaders to perform medical staff duties and the attendance at many medical staff meetings is dismal.

Nevertheless, the maintenance of hospital medical staffs is still required by both the federal COPs and most state regulations. For this reason, it is important to find ways to enhance the effectiveness and efficiency of these entities. In recent years, an impressive number of medical staffs have undertaken thoughtful efforts to redesign their structures and processes, recapture physician interest, and become meaningful contributors to improved patient safety and higher-quality care. For medical staffs that are part of multi-hospital health systems, one design option finally available is to streamline functions across two or more hospitals through medical staff unification.

Potential Advantages for Multi-Hospital Systems

What are the potential advantages of creating a single medical staff within a multi-hospital system? Many combined staffs will choose to create system-wide working committees to replace duplicative committees at multiple institutions. In theory, unified medical staff committees will have more qualified leaders and members since the best talent can be reaped from across multiple medical staffs. This may yield better quality results in challenging areas of medical staff work such as peer review and collegial performance improvement.

There are also potential gains in efficiency as duplicative bureaucracy is swept away. For example, in a three-hospital system that historically maintained three pharmacy and therapeutics committees, the work can be done by one. Fewer committees means less time physicians need to spend away from clinical work or other valuable administrative tasks. These changes could also result in cost savings if the elimination of redundant and duplicative work results in a need for fewer support staff. Where a single standardized protocol is sought throughout a health system, the work product of a committee won't have to journey from institution to institution to multiple groups for review, reconciliation of differences, and ultimate approval. This will result in health systems that can respond more rapidly to the growing demands for improvement.

Physicians who work in multiple hospitals that have a unified medical staff will no longer have to apply and reapply at each facility, saving them from the work and aggravation connected with this biannual credentialing requirement. Board time will likewise be saved since it will not have to review and approve as many duplicative credentials applications.

Along with a gain in efficiency, unification also creates greater consistency. Instead of three medical staffs taking three disparate approaches to a similar problem, a single best tactic can be deployed at all three hospitals. This in turn means less work for the health system board that no longer has to reconcile the varying inputs of three different medical staffs. Where problematic physicians exercise privileges at multiple institutions within a system, burdensome tasks like fair hearings do not have to be repeated at each hospital.

Unified medical staffs also present reduced liability for their health systems because it is less likely physician leaders will take contradictory actions on contentious matters. For example, if one medical staff suspends a doctor and another does not, it may appear that only one hospital in the system is adequately protecting patients. Similarly, if a system board allows its individual medical staffs to maintain different privileging criteria from one another, that system is painting a target on itself for aggressive plaintiff attorneys. In malpractice actions, these lawyers inevitably ask how a system board can allow higher minimal competency standards at one of its institutions than at another. On the other hand, a unified medical staff with one set of privileging criteria will not create these kinds of contradictions.

Other advantages claimed by some systems that have consolidated medical staffs include greater flexibility in cross-coverage

of employed clinical practices across hospitals and enhanced ability to coordinate specialty call coverage for emergency departments.

Addressing Potential Challenges

There are, of course, also challenges and potential downsides to creating a single medical staff organization. Unification may be impractical if large distances geographically separate a system's hospitals. Local physicians at any one hospital may feel like a merger of medical staffs dilutes their input. It is also possible that local needs will not receive adequate attention on the agendas of combined medical staffs. Those opposed to the new CMS COPs argue that medical staff unification will hurt quality since local medical staffs will no longer exist to safeguard appropriate performance.

In issuing its latest rule on COPs, CMS implicitly recognized some of these concerns when it articulated specific conditions for the unification of health system medical staffs. CMS has enumerated the following four requirements that must be met under a unified medical staff model:

1. The medical staff of each hospital must have voted by majority in accordance with its bylaws to join, or to opt out of, the unified medical staff.
2. The unified medical staff must have bylaws, rules, and requirements describing its processes for self-governance, credentialing, peer review, and due process, which shall include advising each medical staff of its rights under number 1 above.
3. The unified medical 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 services.
4. The unified medical 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 localized issues applicable to particular hospitals are duly considered and addressed.

While some health systems will find the rationales for medical staff unification compelling, there are many practical challenges to making it happen. First, such consolidation must be permissible under state law. Many state regulations pertaining to hospitals and their medical staffs were written decades ago when large multi-hospital systems were not common. Next, there is the challenge of determining where unified approaches to medical staff work add value, and where the continuation of local approaches is more prudent. If a particular hospital has created a strong culture of excellence among its physicians or exemplifies state-of-the-art medical staff practices, it would be foolish to undermine these attributes through a thoughtless approach to unification. For example, if one medical staff within a system has an excellent track record of highly effective peer review, this activity can be preserved locally even within a unified medical staff structure.

The politics of unification can be tricky terrain. Some questions for boards to consider include:

- Should all medical staffs have equal representation in a unified organization or should leadership opportunities be proportional to staff size and complexity?
- How do you keep a combined medical executive committee from becoming overly large?
- Should medical staff clinical departments become single system-wide departments, or preserved at each hospital?
- How much of the peer review process should be centralized, and how much should be kept at a local level?

Opinions will certainly differ over which approach delivers a better product and acceptable solutions will have to be negotiated. New bylaws will have to be drafted for a combined medical staff, as will many of the medical staff traditional rules, regulations, and policies. The medical staff services support staff across multiple hospitals will usually need restructuring to best serve a new unified entity.

The move to unified medical staffs is slowly gaining momentum and we will continue to see health systems taking advantage of CMS' new flexibility. Regardless of whether your hospital stands alone, is in a system, or is considering a merger, governing boards should encourage dialogue among physicians, management, and directors to explore whether now is the time to create stronger, more effective medical staff organizations.

The Governance Institute thanks Todd Sagin, M.D., J.D., for contributing this article. *He is a healthcare consultant who has worked with hundreds of hospital medical staffs to strengthen their operations, consider redesign options, and write new bylaws. He can be reached at tsagin@saginhealthcare.com.*