Moving to a Unified Medical Staff Structure

A Toolbook for Healthcare Boards and Executives

THE GOVERNANCE INSTITUTE

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1245 Q Street, Lincoln, NE 68508
(877) 712-8778

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About the Authors

Douglas A. Koekkoek, M.D., FACP, SFHM, is Chief Medical Officer of Physician Enterprises for Providence St. Joseph Health. Dr. Koekkoek received his medical degree from Oregon Health Sciences University, completed his residency in internal medicine and was Chief Resident at Providence Portland Medical Center. Dr. Koekkoek has served in a variety of leadership roles, including Hospital Medical Staff President, Chair of hospital and regional quality councils, regional CMO, and Chief Executive of a regional medical group. While CMO of the Oregon region, he was responsible for redesigning the governance and medical staff structures into a regional board, regional MEC, and regional quality council. His current role has multi-state accountabilities within Providence St. Joseph Health, including oversight and guidance to strategic alignment, quality, safety, physician leadership development, and care delivery models.

Steven D. Freer, M.D., FACP, is the regional Chief Medical Officer for Providence Health & Services, Oregon. Dr. Freer is a graduate of University of Rochester School of Medicine and Dentistry, and he completed his medical internship and residency at the Beth Israel Hospital in Boston. He serves as Isidor Brill Chair, in the Department of Medicine at Providence St. Vincent Medical Center, and is the recipient of numerous awards in physician education. Dr. Freer is a charter member of the Society for Hospital Medicine and is a fellow of the American College of Physicians. Dr. Freer has led the professional staff, residents, and medical students with Providence for more than 17 years.

Michelle Graham is the Executive Director for Providence Health & Services, Oregon Region, in the division of Quality Management and Medical Staff Services. Michelle began her career in nursing at Veterans' Administration Medical Center in Vancouver, Washington. A member of Providence for more than 40 years, Michelle has served in leadership roles for the statewide division and in the Department of Nursing. She leads a team of more than 150 caregivers dedicated to ongoing quality improvement and professional staff credentialing and privileging.

The Governance Institute

The Governance Institute provides trusted, independent information, tools, and resources to board members, healthcare executives, and physician leaders in support of their efforts to lead and govern their organizations.

The Governance Institute is a membership organization serving not-for-profit hospital and health system boards of directors, executives, and physician leadership. Membership services are provided through research and publications, conferences, and advisory services. In addition to its membership services, The Governance Institute conducts research studies, tracks healthcare industry trends, and showcases governance practices of leading healthcare boards across the country.

Table of Contents

Introduction

Healthcare organizations across the United States, driven by mounting economic pressures, continue to consolidate into networks of hospitals and facilities, such as health systems, integrated delivery networks, and physician groups. These networks allow the newly merged organizations to standardize care processes and ensure improved patient safety and quality, capture the financial advantages of managing procurement and supply chain at scale, reduce administrative and management structures, and most importantly, better coordinate high-value care into regionalized centers of excellence.

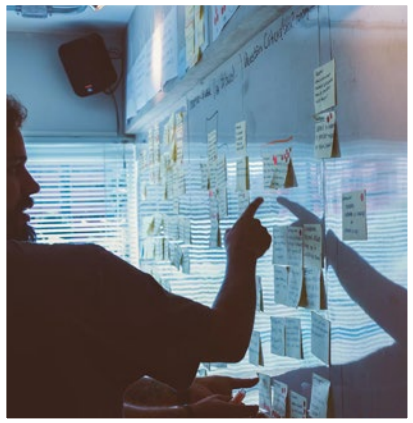
One central question in this shifting landscape is how to organize and govern the independent professional staff within these newly affiliated or merged institutions, while focusing on improved patient care. What are the benefits, barriers, and processes required to effectively bring multiple independent and employed medical staffs together into a unified structure?

This toolbook looks at how integrating medical staffs can improve patient care, provides two possible models for creating a single medical staff structure, and offers tips for successfully completing this process. It also highlights lessons learned from Providence in Oregon's experience during and after the move to a unified medical staff structure.

Why Medical Staff Structures Are Changing

During the past two decades, hospitals and provider groups have merged to function as both local and regional health systems. This trend has included non-profit, for-profit, faith-based, and secular organizations, as hospitals and health systems across the United States begin to work more collaboratively.

Proponents say these consolidations will result in enhanced coordination and referral of clinical care into quaternary care centers, allow for shared clinical expertise across campuses, and increase quality expectations established as new "system" standards. This has required new organizational structures that support input from local medical staff and medical executive committees, while coordinating the decision making and execution across these local campuses.



The Centers for Medicare and Medicaid Services (CMS) establishes rules and requirements for governance and oversight of participating healthcare entities, and it's worth reviewing the conditions that allow such a unified structure. CMS develops Conditions of Participation (CoPs) that healthcare organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are "the foundation for improving quality and protecting the health and safety of beneficiaries."[1] These include:

- COP 482.12 Governing Body: The governing body of the healthcare system has the option to act as the governing body of each separately certified hospital, unless doing so would conflict with state law.
- COP 482.22 Medical Staff: A hospital system may have a unified and integrated medical staff for multiple, separately certified hospitals. It is not necessary for each separately certified hospital within the system to have its own distinct medical staff organization and structure, including hospital-specific medical staff bylaws, rules and requirements, hospital-specific medical staff leadership, hospital-specific credentialing and peer review, etc.

1 CMS, "Conditions for Coverage (CfCs) & Conditions of Participations (CoPs)" (available at www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs).

Many organizations are moving to unified medical staffs because there is a correlation between this structure and better patient care. Some of the advantages of a unified medical executive committee (MEC) include:

- Providing a foundation for safe, high-quality patient care
- Providing consistency in accreditation and policy updates
- Coordinating with the organization's integrated structure (e.g., medical staff, medical groups, programs and services) to create a continuum of care
- Ensuring uniform, standardized credentialing and privileging processes
- Reducing variation in evaluating drugs and protocols for safety and efficacy
- Sharing sentinel event action plans and a common set of safety and quality priorities
- Establishing a mechanism to share and quickly adopt best practices and safety initiatives
- Improving collaborative quality oversight and peer review
- Supporting leadership development and institutional memory

Opponents of a regional MEC model worry that it would reduce local autonomy, diminish a hospital's local culture, place too much power/emphasis on larger entities within the regional system, and bring additional layers of bureaucracy. These concerns can be mitigated and examples of how to address them are included in this toolbook.

How Integrating Medical Staffs Improves Quality, Safety, and Cost

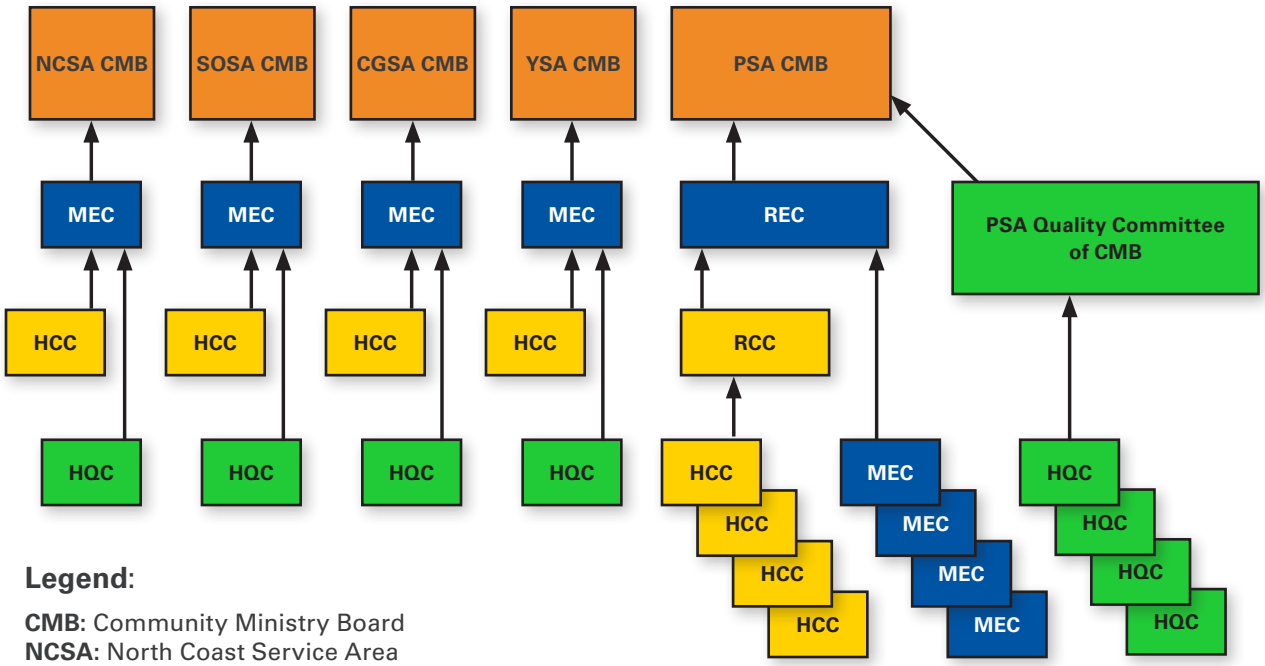
Providence Health & Services in Oregon (PHSOR) moved to a revised model of one statewide entity—a "super structure"—that relies heavily on the expertise, input, and recommendations of local medical executive committees within Providence's eight hospitals in Oregon. This new model promotes joint decision making across all hospitals to move quality, efficiency, and regulatory changes forward quickly on a regional level while supporting meaningful local input.

PHSOR went through a two-year process, completed in 2012, of converting the medical staff structure within eight hospitals into a single governance structure. At the same time, PHSOR as a delivery system also was moving to a single governance structure, consolidating five governing boards into one. A key learning was that, while there are significant advantages to a regional MEC, the local physician leadership and local medical executive committees can and should continue to play an important role. After more than seven years of experience adapting and improving, PHSOR has created a successful regional MEC system.

About Providence Health & Services in Oregon

Providence Health & Services in Oregon is part of the larger Providence St. Joseph Health system, which includes seven states throughout the western U.S. and is the third-largest not-for-profit healthcare system in the country. Providence St. Joseph Health has 51 hospitals, 25,000 physicians, and 119,000 employees. In Oregon, Providence Health & Services is the largest private employer in the state, with eight hospitals, 4,000 physicians, and 21,000 employees.

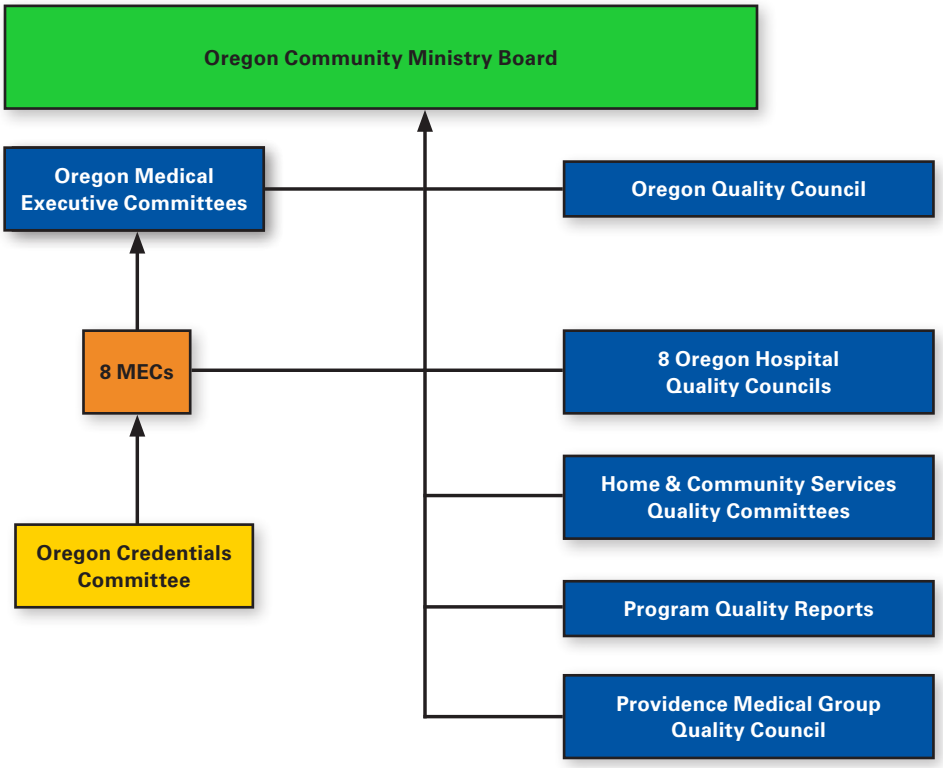
Exhibit 1: Combined Oregon Region Structure (Prior to 2011)



Legend:

CMB: Community Ministry Board
NCSA: North Coast Service Area
SOSA: Southern Oregon Service Area
CGSA: Columbia Gorge Service Area
YSA: Yamhill Service Area
PSA: Portland Service Area
MEC: Medical Executive Committee
REC: Regional Executive Committee
HCC: Hospital Credentials Committee
RCC: Regional Credentials Committee
HQC: Hospital Quality Council
PSA Quality Committee of CMB: Portland Service Area of Community Ministry Board

Exhibit 2: Current Oregon Region Structure (2020)



Although the average healthcare consumer may be aware of health system consolidations and mergers, most are unaware of how medical staffs are structured. Patients and consumers rightly want three things from their healthcare: improvements in quality, safety, and cost. A regional medical staff structure can help accomplish all of these goals. To better understand how, let's look at each of these areas:

- **Quality**: A larger, more cohesive medical staff structure means patients receive the collective expertise of medical staff members across a wide range of knowledge, perspectives, and experience. In this structure, there are more experts to design clinical improvement plans, and there is a greater ability to share best practices. For example, Providence St. Vincent Medical Center in Portland, Oregon, delivers about one out of every seven babies born in Oregon—more than any other hospital in the state. The OB-GYN team there developed new systems for reducing maternal hemorrhage. This important work then was brought to the regional MEC, where it was adopted as a clinical standard and shared with other Providence hospitals in Oregon.
- **Safety**: Just as the standardization of clinical protocols significantly improves patient safety, so does standardization within and among the medical executive committees. A unified regional MEC ensures the coordination and oversight of consistent and thoughtful decision making, with plenty of input from the local MECs. The regional MEC can efficiently share best practices among all local leadership teams, coordinate systems for tracking quality performance measures, and share lessons learned from sentinel events. Examples from Providence in Oregon include reductions in the number of surgical order sets used throughout the region from more than 100 to fewer than 20, as well as in the number of general and specialty-specific privileges from 250 to fewer than 75. Less unnecessary variation translates into better, safer, and more reliable patient care. This approach of standardization also applies to credentialing and privileges; evaluation of clinical protocols and formulary decisions; accreditation and policy updates; and clinical peer review, physician coaching, and discipline.
- **Cost**: An integrated organization has more leverage to contract for lower prices on medications, durable medical equipment, medical devices, and surgical equipment, all of which enhances the organization's ability to control costs. When medical staffs collaborate, rather than function in silos at their own hospitals, they can efficiently standardize and improve clinical work flows.

Key Questions to Ask When Considering Moving to a Unified Medical Staff Structure

1. How does restructuring affect engagement and perceptions in loss of autonomy?
2. Do changes create improved alignment in matters related to governance?
3. Does a unified structure provide for improved consistency and equity?
4. How does a new model promote recruitment of new professional staff members?
5. Is there more efficiency to be gained with ongoing restructuring?

Creating a Single Medical Staff Structure

What Is the Right Approach for Medical Staff Leadership?

Unifying smaller clinical systems into a larger combined entity requires a great deal of leadership, thought, planning, discussion, and organization. The same is true for creating a cohesive medical staff governance structure across multiple hospitals and/or medical campuses.

In many organizations, there are several independent operating groups—elected medical staff leaders, multiple MECs and hospitals, and governing boards—none of which are likely to come together organically as a cohesive body to make strategic and coordinated decisions. Collegial collaboration and professionalism as an organizing strategy are insufficient. Instead, the process requires a deliberate decision to unify the separate medical staff governance structures into a new entity.

Two Potential Medical Staff Models

The two most common models to achieve a consolidation of medical staffs are:

1. Dissolving all separate medical staffs and creating a single new medical staff structure
2. Maintaining separate individual medical staff structures but uniting them into a regional "super structure"

Here's a closer look at each of these two models, with the advantages and disadvantages of each approach.

Model 1: Single Medical Staff Structure

While consolidation into a single medical staff and MEC may seem like an easier, more functional solution, it has several disadvantages.

The single medical staff is more challenging to achieve, as it relies on voting from various previously independent medical staff members—many of whom may take a dim view of the change. They may feel that a single medical staff structure dilutes the local culture, reduces local autonomy and authority, and confuses brand identity that is key to successful marketing.

In addition, the single medical staff model tends to shift departmental leadership and peer review functions to the larger campuses. While this can provide smaller hospital medical staffs with a deeper "bench" for important committee functions, it can result in a lack of local leadership to manage physician disciplinary processes and champion quality and operational improvement initiatives. In short, smaller hospitals and medical staff teams may feel under-represented as they get absorbed into a larger entity.

Model 2: Separate Local Entity + Regional "Super Structure"

As mentioned, this regional "super structure" is the approach Providence in Oregon has taken, creating an overarching single decision-making body, under which each independent medical staff functions. At PHSOR, blending the strengths of both a regional and local medical staff structure into one super structure, with important roles for both local and regional decision making, has proved an effective strategy. Below is an overview of how the local and regional entities work together.

> Including local MECs, in conjunction with the regional committee, is critical for building the confidence and trust required for a successful super structure.

The local MECs are expected to:

- Lead quality initiatives and operational improvements unique to the individual facility and service area
- Recruit and mentor physicians with leadership potential
- Participate in physician peer review, performance improvement, and disciplinary matters

A regional MEC is expected to:

- Support leadership formation
- Establish standards for practice and collegial interactions
- Oversee physician credentialing and privileging
- Elicit support, guidance, and advice in addressing physician issues of concern
- Change bylaws, policies, and procedures
- Create physician practice improvement plans
- Provide recommendations for appointments, reappointments, and privileges prior to a governing board's approval

Including local MECs, in conjunction with the regional committee, is critical for building the confidence and trust required for a successful super structure. This point can't be overstated. Without that foundation of mutual trust, attempts to create a regional super structure will fail.

If multiple local committees are connected through a regional medical executive committee, it helps ensure equity and prevents favoritism toward any particular local entity. It also helps address conflict, biases, and indecision in the single medical staff structure by leveraging the regional committee for a final collective recommendation to the governing board.

Each hospital maintains its own local MEC with appropriate membership of its choosing. The single credentialing committee then forwards decisions to the regional MEC for approval. This eliminates the need for individual hospital credential committees, reduces duplication of efforts, and streamlines the process. Additionally, medical executives with experience in credentialing and peer review serve as consultants and mentors as new leaders join the process.

Case Study: Overcoming Opposition to a Regional Super Structure

Providence in Oregon underwent a lengthy process to develop a regional MEC, while still maintaining local MECs at each of its eight Oregon hospitals. Here's a look at the process, challenges, and results of the medical staff governance change through the lens of both a large hospital and a small hospital, both expressing concerns about how a regional super structure would work and how it likely would affect the local culture.

Providence St. Vincent Medical Center (Large Hospital)

Providence St. Vincent Medical Center—with 523 beds, 1,786 medical staff members, and 3,292 employees—is the largest Providence hospital in Oregon.

Initially, there was substantial resistance from the hospital's medical staff leadership. As the largest and most economically successful hospital in PHSOR, there was vocal skepticism that any compromise in autonomy would be offset by other advantages in administrative services, standardized processes, and collaborative efficiencies. It required a good deal of persuasion and patience to win over influential members of the hospital's medical community. The value of these medical staff "thought leaders" cannot be overstated. It required time, patience, transparency of purpose, a thorough explanation of details surrounding such a change, and an honest dialogue around the pros and cons. There were several presentations to the hospital's MEC and department chairs, and an off-site leadership retreat was dedicated to a candid discussion about what the new model would look like.

Articulating the "give" and the "get" was a critical step. Also key was keeping the focus primarily on the benefit to the patients, and secondarily, on the value and advantages to the professional staff, rather than on the business or financial rationale.

Providence Hood River Memorial Hospital (Small Hospital)

Conversely, Providence Hood River Memorial Hospital—with 25 beds, 73 medical staff members, and 540 employees—is the smallest Providence hospital in Oregon. In a word, Providence Hood River was…reluctant. The small hospital was worried about losing its character and independence, it didn't want to get swallowed up into a larger system, and the independent medical staff didn't want a big system telling it what to do.

Charlie Chambers, M.D., Providence Hood River's then-President of the hospital's professional staff, admits he was "quite skeptical about the process at first." He was part of a similar process in a large Midwestern health system where the local MEC felt "steamrolled." In short, it was not a good experience. "However, Providence followed up on our concerns at the local level, and it did embrace that medical environments are unique in different communities," he said. "The Hood River providers are very vested in their community and are vocal in their opinions. I do believe that we were listened to on our issues and concerns."

Since joining a regional MEC, Providence Hood River continues to advocate successfully for the needs of this small community whose nearest tertiary medical care is an hour's drive. The larger regional committee, in partnership with the local MEC, helps ensure that the Hood River community has adequate access to regional resources for healthcare, while ensuring the safety standards of patient care delivery are consistently met.

The Process: How to Morph from Many to One

Nothing about changing medical staff structures is as easy as it seems on paper. This process requires multiple conversations with time for everyone to digest and understand all the intended and unintended consequences. Tips for successfully completing this include:

- Start with the "why." Taking a page from the change acceleration process, describe the shared need to merge medical staffs across geography and institutions.
- Ensure that everyone leading and participating in the process understands the importance of three key factors: time, input, and listening.
- Don't rush the process; doing so will significantly reduce the success of your governance reorganization. Take the necessary time to solicit—and use—input from providers and other stakeholders. Listen to what stakeholders have to say; it should be much more than just an obligation. It is the foundation of building consensus and trust.

Change is difficult. But if all stakeholders have a chance to speak up, the odds of success increase dramatically.

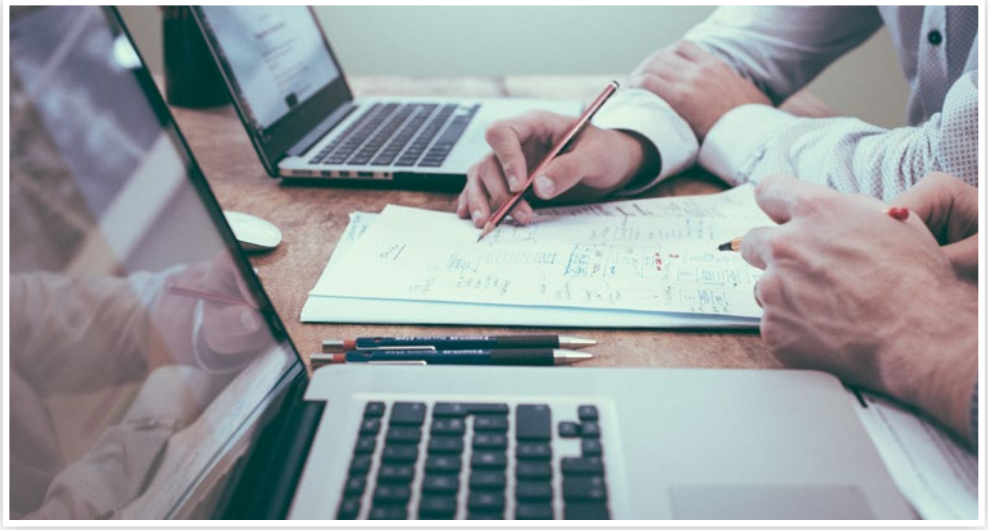
Where to Start?

At first (and second and third) glance, combining different MECs and boards into one single structure may seem too complex to take on. There is so much history, so many layers, so many expectations, and so much to do to make a change this significant. Expect this process to take one to three years, depending on the size and complexity of your organization.

But like any large project, it's important to break things down into manageable tasks. Based on learnings in Oregon, here (in chronological order) are several general steps to begin the journey toward a regional MEC:

- ***Step 1:*** *Stakeholders*: Identify major stakeholders, including those who will be the naysayers. It's critical to involve stakeholders, especially skeptics, at every major step along this journey for their expertise, perspective, and affirmation.
- ***Step 2:*** *Communication*: Work with stakeholders; listen to their concerns, questions, and ideas; update them often along the way; admit that some answers may be unknown, yet input is critical from each stakeholder; and use stakeholders' input whenever possible. Develop an internal communication plan to make sure you reach all important groups. An organization is more likely to achieve its goals by using consistent messaging when communicating the need (and why) for change.

- ***Step 3:*** *High-level plan*: This is not the acorn stage; this is the forest stage. It's important to clearly articulate the purpose, framing it in a way that will resonate with everyone involved, especially those who may feel they have something to lose. Create a big-picture plan of goals, objectives, and high-level strategies. Identify major tasks that should be addressed. Expect this plan to change along the way, but it's an important roadmap to get the work started. Goals, specific actions, and target dates for completion will develop as the virtual plan becomes real activity.
- ***Step 4:*** *Additional resources*: In the current healthcare environment, human resources and expertise are precious and valuable as project work ensues. Clinically focused change management experts can help tremendously in reaching deliverables.
- ***Step 5:*** *Work groups:* Identify a set of work groups based on major tasks and recruit and/or assign stakeholders to each work group. It is critical to engage skeptics. Establish regular small work group meetings, elicit written reports, use a timeline tool, and have all work groups report out in large meetings.



Key Learnings in Oregon

After several years of working with this regional medical staff governance structure, here are a few final words about what Providence in Oregon has learned along the way.

Important governance decisions must be made:

- Physician leadership is necessary to drive the process, including lots of time on the road and many conversations.
- Decide on a "senate" or "house of representatives" model for membership on the regional MEC.
- Be prepared to address the issue of variation in dues and stipends between facilities.
- Expect some compromises to manage privilege criteria variation (e.g., obstetric care, endoscopy, anesthesia, etc.).

What's working well:

- Physician discipline and corrective actions
- Less need for external peer review, due to shared local and regional ownership of peer review
- A single pharmacy and therapeutics committee to address shortages, substitutions, and drug protocols
- Savings in administrative resources by regionalizing the credentialing process
- Less complex paths for adjusting bylaws and polices, and for meeting new CMS and Joint Commission standards across eight facilities
- Uniform infection prevention protocols

What still needs work:

- *Scope of service in small hospitals*: CMS requires a definition of the scope of services provided in each accredited hospital. Examples include consolidating clinical services for managing populations of patients (e.g., heart disease, neurological, and orthopedic conditions). Integrating referral centers and methods to transfer patients within Providence in Oregon is important to patients for continuity of care and patient safety as clinical conditions change.
- *Credentialing redundancy*: It's important for the regional committee to hear and understand the details and rationale about credentialing and privileging matters at a local hospital. Having robust, thorough, and transparent discussions around credentialing enhances the decision-making process and leads to better understanding and results.
- *Adequate small hospital representation*: Smaller hospitals inevitably struggle to meet the governance requirements with a small professional staff. The demands of leadership and other representation fall disproportionately on relatively few individuals. The work itself can make it difficult to balance clinical demands. It's important that these local leaders have consistent, strong representation and do not feel marginalized or irrelevant.

Conclusion: Final Words of Advice

Healthcare is a dynamic and ever-changing field. The trend toward consolidations among similar organizations will continue as the industry works to better serve consumers and patients through value-driven healthcare. It's a leadership responsibility to create innovative, effective strategies to provide the best healthcare, to the most patients and in the most cost-effective manner possible. A regional medical staff structure that creates efficient operational governance while ensuring sufficient local autonomy is an important component of achieving those goals.

The single most important factor in this successful model is transparency. At Providence in Oregon, the CEO team and physician leadership convene annually for a retreat, where issues, challenges, a vision for the future, and ways to further refine this unique and integrated model are openly discussed. During the decade since this work began at Providence in Oregon, the perspective and attitude of medical staff leadership at eight distinct hospitals continues to evolve toward greater acceptance and support.

As local and regional leadership teams become more familiar with its members and work collaboratively to solve difficult issues, there is growing trust and confidence in each other and a deeper sense of collective purpose. The institutional memory of the leadership group also is extremely valuable to preserve. Shared experiences produce a body of wisdom that would be difficult to achieve at individual smaller settings where the frequency of a particular situation is too low for such expertise to develop.

It's the experience at Providence in Oregon that this change toward an integrated model needn't be feared or avoided; instead, it can be embraced and addressed forthrightly, thoughtfully, and respectfully with all involved parties. The result will be greater quality, safety, and value for the patients who entrust us with their care.

To Dos for Beginning the Move to a Unified Medical Staff Structure

- Consider how moving to a unified medical staff structure could improve aspects of patient care (e.g., quality, safety, and cost) at your organization.
- Think through the best approach for creating a cohesive medical staff governance structure across your hospitals and/or medical campuses.
- Decide which medical staff model is right for your organization: 1) dissolving all separate medical staffs and creating a single new medical staff structure or 2) maintaining separate individual medical staff structures but uniting them into a regional "super structure."
- If you choose to create a regional super structure, make sure the roles and responsibilities of the local MECs and regional MEC are established up front and are clear to everyone involved.
- Create a big-picture plan of goals, objectives, and high-level strategies.
- Develop an internal communication plan. Make sure you reach all important groups and expect there to be resistance to change. Prepare to put in the time and effort needed to thoroughly explain what the new model will look like and how it will benefit patients and staff. Be thoughtful in how you receive and implement input from stakeholders.
- Identify work groups that will help accomplish tasks related to this transition.
- Ensure leaders meet regularly to discuss any issues, challenges, or changes that need to be made.