System Focus

June 2017

Unification of Medical Staffs in Health Systems: The Time Is Now

By Todd Sagin, M.D., J.D., President and Medical Director, Sagin Healthcare Consulting

The changing healthcare delivery system in the United States has revealed many inadequacies in the anachronistic, 20th-century construct referred to as the "organized medical staff." The organized medical staff has been especially problematic because of its lack of suitability for multi-hospital health systems. Where such systems are striving to reduce variation, develop standardization, heighten efficiency, advance reliability, and promote transformation, the presence of multiple medical staffs can be a significant obstacle.

In addition, their existence creates potential legal liabilities. For example, when various medical staffs within a health system adopt divergent policies, privileging criteria, bylaws, and other documents that health system can be accused of maintaining conflicting standards of care. When these same medical staffs reach different decisions about a practitioner's credentials or medical staff status that an inattentive board lets stand, the potential for health system liability is high.

Maintaining multiple medical staffs is often a drain on the time and talent of physician leadership. Furthermore, the financial resources needed to staff and support multiple medical staffs can be substantial, as can be the organizational strain of enduring multiple accreditation reviews. Not least important, unnecessary work is required of the health system board to review and approve redundant medical staff applications and privileging requests. This burden can lead the board to undertake this work in a cursory fashion, potentially exposing the health system to future claims of corporate negligence. Alternatively, where the board does this duplicate work with the requisite diligence, it diverts time from other important board business.

Considering Obstacles and Seeking Buy-In to Unification

In spring 2014, CMS changed Medicare's Conditions of Participation to allow multi-hospital health systems to utilize a single consolidated medical staff model. A growing number of systems are now exploring a range of options from partial unification through the creation of combined medical staff committees, to complete merger with one medical executive committee. Merged medical staffs are typically more user-friendly for physicians and reduce burdens on doctors' time. It is also easier to coordinate their activities with those undertaken by an expanding cohort of physician executives and medical directors (e.g., CMOs, service line medical directors, leaders of employed physician groups, etc.). A unified medical staff is strengthened by its ability to deploy the best physician leaders from a bigger pool of potential candidates from multiple hospitals.

While the reasons to unify medical staffs are compelling, there are also challenges and potential downsides to creating a single organized medical staff. Unification may be impractical if large distances geographically separate a system's hospitals. Much of the current experience with consolidated medical staffs has been where a system's hospitals are aggregated in a single urban area or region. Where systems cross state lines, local regulations must be consulted to ensure there are no state regulatory obstacles to medical staff merger.

Another obstacle may occur where a particular hospital in a system has a unique culture, which it does not wish to see attenuated. If one hospital in a system has created an exemplary culture of excellence among its practitioners or has adopted highly effective medical staff practices, it would be foolish to undermine these

attributes with a thoughtless approach to medical staff merger. There are also unique challenges in merging academic and non-academic institutions, or unifying a large medical staff with a small staff from a critical access hospital.

In some institutions, local physicians may feel threatened if they perceive a merger of medical staffs will result in a dilution of their input and influence with management or the board. Sometimes opposition to medical staff unification can come from local hospital administrators, who may believe it will be harder to manage physician affairs on their campus if multiple medical staffs are consolidated.

Most of these obstacles can be overcome, but no effort to unify health system medical staffs should begin until there is clear board support for the endeavor. It is also critically important to achieve the buy-in of key physician stakeholders to any effort to unify medical staffs. In most hospitals this is not a difficult task since there is widespread indifference to medical staff affairs among doctors. Nevertheless, even if only a very small group voices opposition to unification, physicians can be quick to circle the wagons around the status quo. This makes it imperative that the board communicate its wish to see some type of staff unification occur and that it clearly explains why the change will strengthen the system to everyone's benefit.

The unification of medical staffs is a natural accompaniment to the increasing integration of care delivery systems and has great potential to strengthen organizations in an era of value-based reimbursement and population health. In recent years, many health systems have gone about thoughtfully reorganizing board structures across their multiple hospitals. Today every health system should have the option of medical staff mergers on its radarscope.

The Governance Institute thanks Todd Sagin, M.D., J.D., President and Medical Director of Sagin Healthcare Consulting, and Governance Institute Advisor, for contributing this article. He has worked with numerous health systems to merge medical staffs, rewrite medical staff governing documents, and simplify and strengthen medical staff structures and processes. He can be reached at tsagin@saginhealthcare.com.

■■■