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Maintaining a Unified Medical Staff in a Multi-Hospital System

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As health care mergers proliferate and hospital systems expand and grow into regional and national systems, they are constantly confronting the question of how to manage the hospital governance and medical staff functions across the system in the most efficient and effective manner. One way of accomplishing this is through the unification of the governing bodies and medical staffs of multiple separately certified hospitals in a single system.[1]

The Centers for Medicare & Medicaid Services (CMS) has acknowledged the benefits of a unified medical staff, including that it facilitates the efficient, system-wide implementation of evidence-based best practices designed to improve patient safety and combat avoidable complications such as hospital-acquired infections.[2] CMS also recognizes benefits such as the improvement of hospital peer review, shared credentialing and privileging, more efficient sharing of knowledge and innovations among medical staff members, and better coordination to support emergency preparedness, community health planning, and accountable care organization participation.[3]

However, CMS has also acknowledged considerable industry concern regarding the loss of medical staff local autonomy, and the potential negatives associated with remote governance of a large and diffuse medical staff.[4] CMS has responded to these concerns by imposing procedural requirements designed to ensure that physicians on *each* hospital's medical staff have a meaningful voice in the decision to move to a unified medical staff, and that medical staff governance continues to be robust at the individual hospital level. The key is striking the right balance between centralized decision-making and continued, active surveillance and intervention at the local level.

Procedural Requirements

A system that wishes to have a unified medical staff across separately licensed and certified hospitals must secure the approval of the unified governing body as well as each separate medical staff that will be coming together to form the unified staff.[5] Therefore, a governing body's vote to unify the medical staff must be conditioned on the *acceptance* of the unified medical staff model by each of the participating hospitals.[6] The governing body must also ensure that the medical staff bylaws of each of the participating hospitals has appropriate procedures for voting and *opting out* by each hospital's individual medical staff. Each hospital's medical staff members must also receive specific notice of the right of that hospital's medical staff to opt out of the unified medical staff by majority vote at the time medical staff appointment is initially granted and each time it is renewed.[7]

The health system must be able to demonstrate that the medical staff members of each hospital voted by majority, *in accordance with its medical staff bylaws* to accept an integrated medical staff.[8] The decision must be by a "majority" of "the medical staff members who hold privileges to practice at that hospital."[9] This does not mean that the hospital must obtain a "majority" of *every* individual who had been granted medical staff membership and clinical privileges to secure a favorable opt-in vote. In fact, CMS has limited voting rights to medical staff members who have "privileges to practice on-site at that hospital"—thereby excluding telemedicine providers and/or offsite consultants of any kind.[10] CMS has also stated that medical staffs have the flexibility of determining which categories of privileged medical staff members can vote, so long as those decisions do not unduly restrict the right of the medical staff to opt in or out of a unified medical staff structure.[11] Once a hospital's medical staff has opted in to the unified structure, that hospital's medical staff members must be given the opportunity to review that decision (and potentially vote to opt out) at a minimum of once every two years.[12] If, at any time, a hospital's medical staff votes to opt out of a health system's unified medical staff, the health system must permit that hospital to maintain its own, separate medical staff.

Governance Structure and Medical Staff Bylaws

The medical staff governance structure, as reflected in a new, unified set of medical staff bylaws, is a critically important element for maintaining a successful unified medical staff. The bylaws define every element of the structure and functioning of the new medical staff, and should reflect a structure in which, despite the centralized decision-making, specific attention has been given to addressing the unique needs of each hospital—which may vary considerably from one another.

Combining multiple hospital medical staffs into a unified medical staff will inevitably cause a culture clash to a greater or lesser degree. It is therefore prudent to start the planning process many months in advance of initiating the voting process, and to include key representatives from each of the hospitals and their medical staffs on the planning committee. Ideally, the planning committee will include members of the unified governing body, hospital management (at the level of the CEO and/or CMO), influential medical staff members

(officers and key department and committee leaders), and support personnel from the respective medical staff offices. Each key medical staff function should be reviewed from an operational, legal, and accreditation perspective, and then an implementation proposal should be developed in the form of bylaws amendments. In the sections below, some of the key considerations that will inform that process will be discussed.

Medical Executive Committee

The medical executive committee (MEC) "plays a vital role in the relationship between the medical staff and the governing body."[13] It is the primary oversight body for the professional activities of the medical staff, accountable to the governing body for the safety and quality of medical care. It is also the "representative voice" of the medical staff to the governing body on issues pertaining to clinical services, and the governing body's point of access to the medical staff. The MEC's role is even more vital in the setting of a unified medical staff, where the governing body's remoteness from individual medical staff members is even greater than usual.

In structuring the MEC for a unified medical staff, the challenge is to include appropriate representation from each of the hospitals, without creating a body that is so large as to be unwieldy. MECs typically have an elected president, and additional elected officers, who "represent" the medical staff.[14] In a multi-campus medical staff, consideration should be given to including an elected representative from each campus in the slate of officers, and/or including *ex officio* representatives from each of the campuses such as each hospital's chief medical officer. This may help alleviate concerns about lack of responsiveness of the MEC to the individual campus concerns.

MECs also typically include the departmental (or service line) leaders. A unified medical staff may have a department structure that crosses all campuses, and therefore it may seem logical to simply include the chair from each unified department. However, in some cases, that could end up being a highly insular group. For instance, if a four-campus system has one teaching hospital and three community hospitals, the tendency might be to assign the teaching hospital chairs to be the chairs across all four campuses. In such a case the MEC would then have a highly concentrated cohort that is representative of the teaching institution to the perceived exclusion of the community hospitals. Consideration should therefore be given as to how to meaningfully include the "outer hospital" departmental leaders in the MEC decision-making.

In a very large system, the unified medical staff may wish to set up "regional executive committees" that are delegated some degree of local authority, but which report up to the central MEC (and then ultimately to a unified governing body or to regional governing bodies, depending on the structure that has been set up at that level). In designing such a system, there would need to be a careful balance struck to ensure that the central authority of the unified medical staff is not undermined.

Departmental Structure

One of the key challenges for a unified medical staff is how to maintain a departmental (and/or service line) leadership structure that effectively fulfills its professional oversight function across multiple campuses. Department chairs are typically responsible for administrative oversight, clinical coordination, and continuing surveillance of the quality and safety of the professional services provided, through credentialing, privileging, peer review, and corrective action. In teaching hospitals, department chairs frequently serve as academic chairs as well, thus having oversight responsibility for the training and supervision of residents, fellows, and medical students in addition to the medical staff. Performing such extensive responsibilities effectively over multiple campuses would be a monumental undertaking for a single individual. Therefore, when a unified medical staff is created, attention should be given to developing a departmental leadership structure that is centralized but also has a meaningful local presence. One approach is to create deputy directors or associate chairs for each local campus to work in close coordination with the overall director. However, care should also be exercised to ensure that the ultimate leader and their technical subordinates work closely and collaboratively together and coordinate their activities in order to avoid too much decentralization and/or working at cross purposes.

Centralized Credentialing

One of the great benefits of a unified medical staff is the ability to conduct centralized credentialing and to have one set of decision-makers (credentials committee, MEC, and governing body) make decisions on medical staff membership and clinical privileges across multiple campuses in the same health system. This facilitates sharing of credentialing and peer review information (including National Practitioner Data Bank (NPDB) reports) among multiple hospitals in a single system.[15] Health systems frequently struggle with whether and to what extent they should be sharing adverse credentialing/privileging information between related hospitals. While there is often a great desire to share adverse information and "act in tandem" in order to minimize risk exposure across the system, peer review privilege laws, other confidentiality restrictions, and associated liability exposures, can get in the way. When the credentialing/privileging function is centralized, that issue is substantially reduced because the information can be more readily shared and evaluated by the responsible committees (subject to multi-state privilege issues, discussed below).

There are some potential pitfalls that can arise with centralized credentialing. First, hospitals must keep in mind that CMS requires that the granting of privileges be done on

a campus-specific basis, based on consideration of the specific facilities and resources available at that campus to support the desired privileges.[16] Independent of that, a unified medical staff should consider whether there may be circumstances under which a practitioner may be granted requested privileges at one facility and denied at another based on the medical staff's evaluation of the practitioner's clinical capabilities. For instance, a particular practitioner may have excellent clinical outcomes at the suburban community hospital but a poor safety record at an inner city teaching hospital. In such an instance, the medical staff may need to delve more deeply than usual into the practitioner's clinical background to understand the differences in practice settings, and consider whether there may be good clinical reasons to grant privileges at one institution and deny privileges at the other. There may also be instances in which "turf" issues preclude an otherwise capable practitioner who is successful at one location from being granted privileges at another. The medical staff will need to carefully examine the reasons given for any unfavorable credentialing recommendations and ensure that they are being made for appropriate, clinically supportable reasons, and not based on anticompetitive or merely political reasons. Hospitals also need to consider the impact of an adverse NPDB report—whether it involves a single hospital or multiple hospitals across the system.

A departmental leadership team that works effectively in tandem and works through the areas of potential conflict between campuses to come up with a rational and defensible set of credentialing recommendations will make for a much smoother downstream review process than one which is in conflict, passive, or otherwise dysfunctional.

Peer Review, Disciplinary, and Corrective Action

A unified medical staff can create and implement a unified approach to peer review, disciplinary, and corrective action, with uniform procedures applicable across all campuses, shared information, and consistent standards—all of which should increase the efficacy and minimize the legal risk exposures associated with physician discipline. On the other hand, there are certain aspects of peer review and discipline that cannot be handled as effectively from a distance. Often the most effective form of peer review is hands-on evaluation and direct, collegial intervention by a respected departmental leader. The Joint Commission's Focused Professional Practice Evaluation (FPPE) requirements for evaluation of "privilege-specific competence" presume a highly personalized review using such techniques as simulation, proctoring, and "discussion with other individuals involved in the care of each patient (for example, consulting physicians, assistants at surgery, nursing or administrative personnel.)"[17] Likewise, many bylaws provisions require a period of collegial intervention by the department director prior to any more formalized peer review being initiated.

A unified medical staff model would ideally combine the best aspects of centralized peer review and local intervention. However, this would require careful coordination of efforts, to ensure that the approach across the entire medical staff, and health care system, remains consistent and supportable.

The formal corrective action, hearing, and appeal process can be unified as to approach, and can also take advantage of the larger physician base to secure peer review experts and hearing panel members from other campuses across the system, in order to reduce local bias and help control the cost of formal privileging action. This does require legal analysis on a state-specific basis as to whether there are licensure or peer review privilege laws precluding the use of peer reviewers or hearing panel members from other states.

System-Wide Patient Safety/Clinical Protocols

One of the great potential benefits of a unified medical staff is the ability to gather and analyze data on a system-wide basis so as to generate evidence-based clinical protocols for hospitals throughout the system, and the ability to implement system-wide quality and safety metrics (through the Quality Assessment/Performance Improvement (QAPI) program or otherwise) that will enhance the medical staff's ability to monitor quality and intervene proactively and appropriately when practitioners fall short of the quality goals. However, in implementing the system, a unified medical staff may not assume that the same precise metrics and goals will apply to all campuses. CMS cautions that clinical protocols and order sets should not be slavishly adopted by the medical staff for implementation across all campuses but must be tailored to each unique clinical setting in which they are to be applied.[18] To address this, the medical staff could create a system whereby any new protocol or order set proposed by a central medical staff committee would be reviewed and tailored as necessary by each local campus, subject to the ultimate approval of the centralized MEC and governing body.

Likewise, the unified medical staff must tailor the QAPI plans to account for the unique characteristics and resources of each of the member hospitals. CMS surveyors will be seeking assurance that each hospital-specific QAPI is: (1) defined, implemented, and maintained on an ongoing basis, (2) addresses hospital-specific priorities for improved quality of care and patient safety, and that all improvements are evaluated, (3) establishes clear, hospital-specific safety expectations, (4) allocates resources appropriate to the specific hospital's QAPI, and (5) determines annually the number of distinct improvements conducted in that hospital.[19]

Multi-Jurisdictional Issues

A unified medical staff that crosses state lines must also be designed to meet the requirements of a multitude of state laws. This may be accomplished through a single set of requirements and procedures that comply with *all* states' requirements, or alternatively, it may be necessary to create state-specific policies and bylaws provisions for specific sections where the requirements cannot be reconciled across all of the states involved. For instance, some states limit medical staff membership to physicians only, whereas others permit or even require a wide range of allied health providers to be members of the medical staff. Likewise, state scope of practice laws for allied health professionals may vary considerably, and a health system's unified medical staff must ensure that it does not inadvertently run afoul of those restrictions through broad, system-wide medical staff policies.[20]

Attention must also be given to the state peer review privilege and immunity provisions of each of the different states involved. Often those laws are written based on a presumption that all of the relevant activity will occur within a single state, and therefore they do not necessarily extend their protections to peer review activities that may cross state lines. Some specific issues that may arise include, for instance, the following:

- Whether peer review immunity extends only to physicians licensed in the particular state where the peer review is being conducted;
- Whether peer review is considered valid if performed by a physician from a different state;
- Whether the out-of-state peer reviewer is considered to be practicing medicine without a license in the jurisdiction where peer review is being conducted.

These are all important issues that will need to be analyzed on a state-specific basis and may impact the design of the peer review system.

Conclusion

The unification of a health system's medical staff across multiple hospitals offers many opportunities for coordination and consolidation of medical staff functions, as well as a number of initial hurdles and ongoing challenges in maintaining an effective medical governance system. This paper has highlighted the key issues that health systems will need to address as they move forward to consider and implement a unified medical staff.

1 *See* 42 C.F.R. § § 482.12 and 482.22. A health system that has multiple separately licensed/certified hospitals may maintain one unified governing body with multiple medical staffs, but it may not maintain one unified medical staff reporting up to multiple governing bodies. Thus, unifying the governing body is a necessary interim step to unifying the medical staff.
2 Final Rule, Medicare and Medicaid Programs; Part II- Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction, 79 Fed. Reg. 27106, 27115 (May 12, 2014) (2014 Final Rule).
3 *Id.*
4 2014 Final Rule, 79 Fed. Reg. at 27115 - 27116.
5 CMS State Operations Manual Appendix A, Survey Protocol, Regulations and Interpretive Guidelines for Hospitals (SOM), p. 190, 42 C.F.R. § 482.22(b)(4); *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf.
6 SOM, at 191, 42 C.F.R. § 482.22(b)(4).
7 SOM, at 196, 42 C.F.R. § 482.22(b)(4)(ii).
8 42 C.F.R. § 482.22(b)(4)(i).
9 42 C.F.R. § 482.22(b)(4)(i).
10 SOM, at 193, 42 C.F.R. § 482.22(b)(4)(i).
11 *Id.*
12 SOM, at 194, 42 C.F.R. § 482.22 (b)(4)(i).
13 The Joint Commission Hospital Accreditation Standards (2016 HAS), Introduction to MS.01.01.01, MS-6 (2016).
14 CMS requires that the responsibility for organization and conduct of the medical staff be assigned to a designated physician, and this typically is the President of the Medical Staff. *See* 42 C.F.R. § 482.22(b)(3).
15 With centralized decision-making, a health system can register its Credentialing Verification Office (CVO) as a single entity on behalf of all the hospitals in the system. NPDB Guidebook at D-15 (Centralized Credentialing) (2015). Absent that, the CVO must be registered as an authorized agent for each individual hospital in the system, and is not permitted to share NPDB reports between and among the various hospitals. NPDB Guidebook at D-17 (Querying Through an Authorized Agent) (2015); *available at* https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp.
16 SOM, at 190, 42 C.F.R. § 482.22(b)(4).
17 2016 HAS, Introduction to Standard MS.08.01.01 (Focused Professional Practice Evaluation), at MS-38 (2016).
18 SOM, at 200, 42 C.F.R. § 482(b)(4)(iii).
19 SOM, at 200, 42 C.F.R. §§ 482.21(e) and 482.22(b)(4)(iii).
20 SOM, at 201, § 482.22(b)(4)(iii).