Centers for Medicare and Medicaid Services (CMS) Hospital Conditions of Participation (CoPs): What Medical Services Professionals Need to Know About the Final Rule

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CMS Hospital Conditions of Participation

What Medical Services Professionals Need to Know About the Final Rule

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Chair, American Medical Association Organized Medical Staff Section

Regulatory history

• First round of CoPs revisions proposed in 2011.
• AMA, AHA, and many other stakeholders commented on each iteration of the rule. AMA was primarily concerned with protecting and enhancing the role of the medical staff by advocating for provisions such as:
  • Medical staff representation on the governing body, and
  • A separate medical staff at each hospital.
• Final rule published May 2014, and effective as of July 11, 2014.
• Major changes for the medical staff and, more broadly, for the hospital governance structure.

What the final rule does:
Medical staff-governing body communication

• Eliminates a previously finalized requirement that the hospital governing body include a member of the medical staff.
• That requirement, which was included in a previous iteration of the rule, has now been modified to require that the governing body consult at least two times per year with the “individual assigned responsibility” for the medical staff.
What is the duty of the governing body to communicate with the medical staff?

- The governing body must “…consult directly with the individual assigned the responsibility for the organization and conduct of the hospital’s medical staff, or his or her designee.”
- “At a minimum, this direct consultation must occur periodically throughout the fiscal or calendar year [at least two times] and include discussion of matters related to the quality of medical care provided to patients of the hospital.”
- “For a multi-hospital system using a single governing body, the single multi-hospital system governing body must consult directly with the individual responsible for the organized medical staff (or his or her designee) of each hospital within its system…”

42 CFR 482.12(a)(10)

What does “consult directly” mean?

- “‘Direct consultation’ means that the governing body, or subcommittee thereof, meets with the medical staff leader(s) either face-to-face or via a telecommunications system permitting immediate, synchronous communication.”

79 CFR 27113

Define this “individual” and his/her role in the bylaws:

The President [Chief of Staff] elected by the Medical Staff pursuant to these Medical Staff Bylaws shall:

- Serve as the individual responsible for the organization and conduct of the Medical Staff, with whom the Governing Body shall directly consult on all matters related to the quality of medical care provided to patients at the Hospital and other matters of mutual concern at each Governing Body meeting and otherwise as frequently as deemed helpful by the Governing Body, the President/Chief of Staff, or the Medical Staff;
- Provide continual consultation directly to the Governing Board as he/she determines warranted by the scope and complexity of Hospital services and the specific patient populations served by a Hospital;
Define this “individual“ and his/her role in the bylaws (cont.):

- Work with the Governing Board to discuss and collaboratively resolve issues of patient safety and quality of care identified by the hospital’s quality assessment and performance improvement program or the medical staff, including at a minimum:
  - hospital-wide systemic deficiencies,
  - system-wide opportunities for quality improvement,
  - achievable goals for improved community health; and

- Serve on the [Physicians’ Council] [Physicians’ Advisory] [Medical Staff Leadership Panel] [any other standing or ad hoc Hospital committee or process not elected or established by the Medical Staff which purports to inform the Board or Hospital Administration on the quality of patient care and other medical staff issues].

Limited applicability of the new rule?

- Existing Joint Commission hospital accreditation standards require much greater communication and collaboration between the governing body and the medical staff than do the revised CoPs:
  - “The governing body works with the senior managers and leaders of the organized medical staff to annually evaluate the hospital’s performance in relation to its mission, vision, and goals.”
  - “The governing body provides the organized medical staff with the opportunity to participate in governance.”
  - “The governing body provides the organized medical staff with the opportunity to be represented at governing body meetings (through attendance and voice) by one or more of its members, as selected by the organized medical staff.” (LD.01.03.01, EPs 6, 8, and 9)

- The Joint Commission has not amended these leadership standards, meaning that hospitals accredited by The Joint Commission will continue to be held to these higher standards.

What the final rule does: Medical staff structure

- Permits a multi-hospital system to have a unified, system-wide medical staff, provided that each individual medical staff within the system has voted to accept the unified staff structure.

- Medical staffs incorporated into a unified staff structure retain the right to “opt out” of the unified staff and reestablish a separate, hospital-specific medical staff at a later date.
What is a “system”?

- “multiple separately [Medicare] certified hospitals”
  42 CFR 482.22(b)(4)
- Hospitals must first share a “system governing body” if they are to share a unified medical staff.
- More than half of all community hospitals are system hospitals. (AHA Fast Facts on U.S. Hospitals, January 2014)

Who can unify medical staffs, and how is this accomplished?

- If the hospital is part of a hospital system consisting of multiple separately certified hospitals and the system elects to have a unified and integrated medical staff for its member hospitals... each separately certified hospital must demonstrate:
  - That medical staff members of each separately certified hospital in the system (that is, all medical staff members who hold specific privileges to practice at the hospital) have voted by majority, in accordance with medical staff bylaws, either to accept a unified and integrated medical staff structure or to opt out of such a structure and to maintain a separate and distinct medical staff for their respective hospital...
  42 CFR 482.22(b)(4)

How does a vote for unification affect the existing bylaws?

- A vote for unification has no effect on the existing medical staff bylaws.
- Sample bylaws language:
  - If the Medical Staff votes to accept unification, these Medical Staff Bylaws will remain in effect as to the Members, until the Medical Staff Bylaws are amended or new Medical Staff Bylaws are adopted pursuant to the terms of these Bylaws.
  - A vote by the Medical Staff to accept a unified medical staff shall have no effect on the application of these Medical Staff Bylaws, which shall continue to govern this Medical Staff and be upheld by the Governing Body. Peer review and other activities of the Medical Staff and its Members shall continue to be governed by [name of state licensing the Hospital] law by which the Hospital is licensed.
Unresolved questions about unification

- If one medical staff votes against, is the medical staff “unified”?
- Can a 10-hospital system “unify” its medical staffs into 5 subgroups of 2 staffs each?
- Can a hospital be licensed if most members of its “unified” medical staff are not licensed in the state?
- Which peer review law applies?
- Implications for credentialing, privileging?

Potential benefits of unification

- Larger medical staff organization can form a stronger organization
- Avoid conflicts of interest, local politics
- Clinical standards developed across greater numbers of peers, patients
- Access to system-wide contracting, education opportunities

Potential benefits of unification (cont.)

- Eliminate discrepancies across system bylaws
- Reduce redundancy across hospitals /medical staffs
- Protection of better peer review protections under other state’s laws
- Consolidation of duties, obligations
Potential costs of unification

- Reduction of medical staff connection with or representation on the governing body
- Disenfranchisement of smaller medical staffs with smaller ratio of members
- Loss of community standards
- Loss of hospital-specific services
- Loss of influence over medical staff bylaws, rules and regulations, and policies

Potential costs of unification (cont.)

- No recognition of variances in staffing, equipment in support of medical practice between hospitals
- State law peer review protection may not apply
- System-wide obligations, such as ER call
- Imposition of system bylaws that may not be physician-friendly
- Subject to disunification vote at any time

Disunification of a unified medical staff

- The unified and integrated medical staff has bylaws, rules, and requirements that describe its processes for self-governance, appointment, credentialing, privileging, and oversight as well as its peer review policies and due process rights guarantees, and which include a process for the members of the medical staff of each separately certified hospital (that is, all medical staff members who hold specific privileges to practice at that hospital) to be advised of their rights to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their hospital.

42 CFR 482.22(b)(4)(i)
What happens after a vote for disunification?

- No clear guidance from CMS on this question. AMA recommends a return to the state of affairs before the original unification:
  - The Medical Staff shall disunify from any system-unified medical staff by vote to disunify by two-thirds of all Medical Staff Members with voting rights who hold clinical privileges to practice on-site at the hospital. The Medical Staff shall be the unique Medical Staff of the Hospital effective immediately, operating under the Medical Staff Bylaws in effect immediately prior to unification. Special election shall be called to elect officers, department chairs and other medical staff leadership immediately consistent with the Medical Staff Bylaws in effect immediately prior to unification.
  - Upon disunification, the Medical Staff Bylaws in effect the date of unification shall return to full force and effect.

What you can do now

- Educate yourself and your medical staff about the new rules and their implications for patients, individual physicians, and the medical staff as an organization.
- Update the medical staff bylaws to ensure that “the individual assigned the responsibility for the organization and conduct of the hospital’s medical staff” is the elected medical staff president/chief of staff.

What you can do now (cont.)

- Lead your medical staff through discussions about the costs and benefits of unification.
- Are your bylaws in compliance? Update your medical staff bylaws to address unification and disunification, even if there is no current indication that your hospital system intends to pursue this option.
Relevant resources from the AMA

- Medical staff unification/disunification discussion guide
- Sample medical staff bylaws language
- Job description for the “individual responsible for the organization and conduct of the medical staff”

- AMA Organized Medical Staff Section
  - Is your medical staff represented?
  - www.ama-assn.org/go/omss
PHYSICIAN’S GUIDE TO

MEDICAL STAFF ORGANIZATION BYLAWS

SIXTH EDITION

Full publication available at: ama-assn.org/go/bylaws

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sharing. However, system wide bylaws can create complications. All the same legal and accreditation requirements that must be met by the individual medical staff bylaws must be met by the system bylaws. System bylaws must also be agreed to by each medical staff. Further, once the common bylaws are adopted, each medical staff can amend its own iteration of the bylaws, so the work achieving one set of bylaws can be unwound. Where the only commonality among the medical staffs is the system ownership, a common set of medical staff bylaws may not be worthwhile.

1.6 Medical Staff Unification and Disunification

In May 2014 the Centers for Medicare and Medicaid Services (CMS) published a final rule revising the Conditions of Participation (CoPs) for hospitals. The final rule, which became effective July 11, 2014, makes two major changes to the hospital governance structure:

1. In the past, each hospital was required to have its own organized medical staff. Under the new regulations, a multi-hospital health system is now permitted to have a unified, system-wide medical staff, provided that each individual medical staff within the system has voted to accept the unified staff structure. Medical staffs incorporated into a unified staff structure retain the right to “opt out” of the unified staff and reestablish an independent staff at a later date.

2. The final rule also eliminates a previously finalized requirement that the hospital governing body include a member of the medical staff. That requirement, which was never fully implemented, was replaced with a requirement that the governing body simply "consult" at least two times per year with the individual assigned responsibility for the medical staff (presumably, but not necessarily, the medical staff president or chief of staff). That responsibility should be documented in bylaws. See Section 11.4, Duties of Medical Staff Officers.

Under the new regulations, CMS permits a multi-hospital system to maintain a single, unified medical staff, provided that the members of the medical staff of each individual hospital “have voted by majority, in accordance with medical staff bylaws, either to accept a unified and integrated medical staff structure or to opt out of such a structure and to maintain a separate and distinct medical staff for their respective hospital.” Per the CMS State Operations Manual, Appendix A, the new regulations limit voting on the issue of unification or disunification to members exercising clinical privileges at the

24 Title 42 §482.22(b)(4), emphasis added
hospital, thereby disqualifying those members with no privileges, or whose practice at the hospital is conducted under telemedicine privileges. Medical staff voting rights provisions that do not comform with these restrictions may be augmented with a provision directed at this special issue. See Section 3.23, Voting Rights.

The medical staff’s decision to accept a unified staff structure should not automatically invalidate the existing medical staff bylaws, even though this decision could be used as an excuse to replace the existing bylaws with system-level bylaws. Instead, the medical staff must amend or replace (i.e., amend by substitution) the existing bylaws according to the medical staff-driven process set forth in the existing bylaws. Included in the bylaws for the unified medical staff must be a process by which those medical staff members entitled to vote on disunification (specifically, those members who exercise privileges at the hospital other than telemedicine privileges) are notified of the right to vote on disunification, per Joint Commission Standard MS 01.01.01, Element of Performance 37. The unified medical staff must also develop policies and procedures geared toward maintaining the quality of care at all hospitals it serves, per Joint Commission Standard MS 01.01.05.

Because acceptance of unification is at least as significant a change for the medical staff organization as amending the medical staff bylaws, the threshold required to make this decision should be at least as high as the threshold required to amend the bylaws (typically, a 2/3 majority vote). Arguably, given the extraordinary nature of this decision and its potential to divide the medical staff, the threshold should be even higher. 25 For example, the medical staff may wish to consider requiring a 100% quorum for a vote to unify, meaning that 2/3 of all members with voting rights, not just 2/3 of those who actually cast votes, must affirmatively accept a unified staff structure—under this quorum requirement, an individual with voting rights who does not cast a vote is counted as a vote against unification. Fortunately, CMS’s requirement that the vote to unify be made “in accordance with medical staff bylaws” presents ample opportunity for the medical staff to ensure that unification/disunification occurs only after careful deliberation and only when such action is supported by a substantial portion of the medical staff’s membership. Note that in the case of disunification, the medical staff’s decision is not subject to hospital board approval, under the regulations.

25 Note that a super-majority for unification purposes cannot exceed the majority level set for medical staff bylaws amendments, as stated in the CMS State Operations Manual, Appendix A.
Regardless of whether a multi-hospital system decides to pursue a unified staff structure and regardless of whether the medical staff decides to accept a unified staff, every medical staff in a hospital that is part of a system must amend its bylaws to define the processes by which the medical staff votes on unification/disunification. Medical staffs whose hospitals are not yet parts of systems should consider including a process for votes on unification/disunification, so as to be better prepared should the hospital someday be acquired by or otherwise incorporated into a system with a unified medical staff.

See Appendix B, Medical Staff Unification/Disunification Discussion Guide, for a listing of potential costs and benefits of medical staff unification/disunification.

Sample Bylaw: Medical Staff Unification Process

The Medical Staff can be included in a unified medical staff of any health system in which the Hospital participates only after:

(a) Six months’ prior written notice to all Medical Staff Members describing the proposed unification, setting forth its risks, benefits, and effects to the Medical Staff and its members;

(b) The Medical Executive Committee concurs [based on favorable recommendations from two-thirds of all Departments reported to the Medical Executive Committee,] following review and study; and

(c) No less than two-thirds of all Medical Staff Members with voting rights who hold clinical privileges to practice on-site at the hospital cast votes in favor of unification. The Medical Executive Committee shall determine whether the Medical Staff votes:

   (i) at a special meeting called for that purpose, or

   (ii) via confidential mail or electronic balloting.

If all these requirements are not met, the Medical Staff shall remain separate from any System unified hospital and continues as the Medical Staff of the Hospital. If the Medical Staff votes to accept unification, these Medical Staff Bylaws will remain in effect as to the Members, until the Medical Staff Bylaws are amended or new Medical Staff Bylaws are adopted pursuant to the terms of these Bylaws.
Sample Bylaw: Medical Staff Disunification Process

The Medical Staff shall disunify from any system-unified medical staff by vote to disunify by two-thirds of all Medical Staff Members with voting rights who hold clinical privileges to practice on-site at the hospital. The Medical Staff shall be the unique Medical Staff of the Hospital effective immediately, operating under the Medical Staff Bylaws in effect immediately prior to unification. Special election shall be called immediately to elect officers, department chairs and other medical staff leadership consistent with the Medical Staff Bylaws in effect immediately prior to unification.

Sample Bylaw: Unification/Disunification Effect on Bylaws

(a) A vote by the Medical Staff to accept a unified medical staff shall have no effect on the application of these Medical Staff Bylaws, which shall continue to govern this Medical Staff and be upheld by the Governing Body. Peer review and other activities of the Medical Staff and its Members shall continue to be governed by [name of state licensing the Hospital] law by which the Hospital is licensed.

(b) Upon disunification, the Medical Staff Bylaws in effect the date of unification shall return to full force and effect.

1.7 New Bylaws?

Where the medical staff is a new entity—either a brand new organization for a new hospital or the product of a merger (see Section 19.7.1, Hospital Transactions) or unification (see Section 1.6, Medical Staff Unification and Disunification)—or the medical staff determines its bylaws are beyond repair, bylaws have to be built from the ground up. The newly merged or system hospital typically presents the medical staff with a template to be adopted. A template drafted to favor the hospital will cut back on individual physician rights, undermine medical staff leadership, and cut into medical staff organization rights. The medical staff, through a bylaws committee (see Section 13.2, Bylaws Committee) and with the assistance of medical staff counsel (see Section 1.11, Independent Medical Staff Counsel) should dissect any template to replace provisions that do not work for the medical staff.
See Appendix E, AMA Principles for Developing a Sustainable and Successful Hospitalist Program for more information.

### 3.23 Voting Rights

A clear statement of voting rights in the medical staff bylaws can ease daily operation of medical staff committees and departments. At a minimum, voting in medical staff committees, departments, general staff meetings, and elections should be limited to members of the organization. Thus, administrators and those with temporary privileges should not be allowed to vote. Some bylaws also provide that provisional members have no voting rights. Voting rights can be addressed in the appropriate staff category under rights and responsibilities.

Some medical staffs include other professions along with physicians. State law should be considered in assigning voting rights by profession or professional degree. For example, California regulations state that “Medical staff by-laws, rules and regulations shall not deny or restrict within the scope of their licensure, the voting right of staff members or assign staff members to any special class or category of staff membership, based upon whether such staff members hold an MD, DO, DPM, or DDS degree or clinical psychology license.”

47 States may or may not allow full voting rights for professionals working under a license that limits the scope of practice of that profession.

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<thead>
<tr>
<th>Sample Bylaw: Voting Rights</th>
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<tbody>
<tr>
<td>Only members of the medical staff may vote in departmental, sectional or general medical staff elections and at committee, department and medical staff meetings, unless otherwise specified in these bylaws.</td>
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<tr>
<th>Sample Bylaw: General Exceptions to Prerogatives</th>
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<td>Regardless of the category of membership in the medical staff, limited license members:</td>
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<tr>
<td>(a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the medical executive committee; and</td>
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47 California CCR §70703(b)
(b) shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 5.4.

*California Medical Association Model Medical Staff Bylaws §3.11*

Restrictions on voting on the issue of medical staff unification and disunification are imposed by Medicare Conditions of Participation, which limit voting on these questions to members exercising clinical privileges at the hospital, thereby disqualifying those members with no privileges, or whose practice at the hospital is conducted under telemedicine privileges. See Section 1.6, Medical Staff Unification and Disunification.

**Sample Bylaw: Voting on Disunification**

The Medical Staff can disunify from any system-unified medical staff by vote. To disunify, two-thirds of all Medical Staff Members with voting rights who hold clinical privileges to practice on-site at the hospital, other than telemedicine privileges, must vote in favor of disunification.

### 3.24 Payment of Dues and Use of Medical Staff Funds

Medical staffs, like other organizations, may require annual dues from their members. The obligation to pay annual dues should be stated in the medical staff bylaws. This source of financial resources can support medical staff organizational activities such as retaining independent counsel or consultants, or meeting other extraordinary costs. An account independent of other hospital health care entity accounts gives the medical staff control, privacy, and discretion of fund use. A distinct account also protects the medical staff fund from being inappropriately commingled with hospital funds and subject to liability, as in the case of hospital bankruptcy. Depositing medical staff funds into an account that does not bear interest could obviate any tax questions.

**Sample Bylaw: Dues**

Members shall pay annual dues in [an amount set by the medical executive committee the first meeting of the medical staff year] [the amount of $______]. Failure to pay dues in a timely manner shall be grounds for ineligibility for membership renewal or corrective action.

*Medical Association of Georgia Model Medical Staff Bylaws §III.G*
11.4 Duties of Medical Staff Officers

Duties of elected officials of the medical staff should be clearly delineated in the medical staff bylaws and should be designed to promote medical staff self-governance.

Sample Bylaw: Duties of Medical Staff Officers

Duties of the President
The president is the individual responsible for the organization and conduct of the Medical Staff, with whom the Governing Body shall directly consult on all matters related to the quality of medical care provided to patients at the Hospital and any other matters of mutual concern. The president:

- Chairs the medical executive committee;
- Presides at medical staff meetings;
- Appoints chairs and members of medical staff committees, and medical staff representatives to hospital committees, subject to medical executive committee ratification, unless otherwise stipulated in these bylaws;
- Represents the medical staff at board meetings and communicates with board members on behalf of the medical staff;
- Represents the medical staff, or designate a medical staff representative on any physician or medical staff council, task force, or panel organized by the hospital administration;
- Serves as medical staff spokesperson within and without the hospital;
- Communicates regularly with the medical staff and is responsive to individual members’ complaints, concerns and requests;
- Fulfills such other responsibilities assigned by the medical staff or medical executive committee, stipulated elsewhere in the bylaws or as usually pertain to the office of president.

Duties of the President-elect
The president-elect:

- Assumes the office of president following the conclusion of the term of his/her predecessor;
- Assumes the duties of the president when he/she is temporarily unavailable;
- Is a member of the medical executive committee and chairs the quality committee;
• Represents the medical staff to the board along with the president;
• Fulfills such other responsibilities assigned by the medical staff or medical executive committee, stipulated elsewhere in the bylaws or as usually pertain to the office of president-elect.

**Duties of the Secretary**

The secretary:

• Assures that minutes of medical staff meetings and executive committee meetings are thorough and accurate;
• Is a member of the medical executive committee and chairs the bylaws committee;
• Fulfills such other responsibilities assigned by the medical staff or medical executive committee, stipulated elsewhere in the bylaws or as usually pertain to the office of secretary.

**Duties of the Treasurer**

The treasurer:

• Oversees the medical staff accounts, disbursements and receipt of funds, and reports thereon to the medical executive committee and medical staff at each meeting;
• Is a member of the medical executive committee and chairs the finance committee;
• Signs and keeps the bank account(s) signature cards current;
• Fulfills such other responsibilities assigned by the medical staff or medical executive committee, stipulated elsewhere in the bylaws or as usually pertain to the office of treasurer.

**Duties of the Immediate Past President**

The immediate past president:

• Assumes the duties of the president when both the president and president-elect are unavailable;
• Is a member of the medical executive committee and chairs the credentials committee;
• Fulfills such other responsibilities assigned by the medical staff or medical executive committee, stipulated elsewhere in the bylaws or as usually pertain to the office of immediate past president.

*Massachusetts Medical Society Model Medical Staff Bylaws §VII.B.1*
Sample Bylaw: Individual Responsible for the Medical Staff

The President [Chief of Staff] elected by the Medical Staff pursuant to these Medical Staff Bylaws shall:

(1) Serve as the individual responsible for the organization and conduct of the Medical Staff, with whom the Governing Body shall directly consult on all matters related to the quality of medical care provided to patients at the Hospital and other matters of mutual concern at each Governing Body meeting and otherwise as frequently as deemed helpful by the Governing Body, the President/Chief of Staff, or the Medical Staff;

(2) Provide continual consultation directly to the Governing Board as he/she determines warranted by the scope and complexity of Hospital services and the specific patient populations served by a Hospital;

(3) Work with the Governing Board to discuss and collaboratively resolve issues of patient safety and quality of care identified by the hospital's quality assessment and performance improvement program or the medical staff, including at a minimum:
   (a) hospital-wide systemic deficiencies
   (b) system-wide opportunities for quality improvement
   (c) achievable goals for improved community health; and

(4) Serve on the [Physicians’ Council] [Physicians’ Advisory] [Medical Staff Leadership Panel] [any other standing or ad hoc Hospital committee or process not elected or established by the Medical Staff which purports to inform the Board or Hospital Administration on the quality of patient care and other medical staff issues].

11.5 Duties of Medical Staff Representatives

In addition to elected officers, a medical staff may structure its governance to include the election of individuals whose leadership role is limited to representing the organized medical staff to outside entities. This spreads out the duties of leadership among more members, which may help to alleviate the burden and time commitment for officers.
Appendix B: Medical Staff Unification/Disunification Discussion Guide

Under the revisions to the Medicare Conditions of Participation finalized in May 2014, a multi-hospital health system is now permitted to have a unified, system-wide medical staff, provided that each individual medical staff within the system has voted to accept the unified staff structure. Medical staffs incorporated into a unified staff structure retain the right to “opt out” of the unified staff and reestablish a separate, hospital-specific medical staff at a later date.

Under certain circumstances, medical staff unification may be an attractive option for medical staffs and their members. In other circumstances, however, unification may seriously impede the ability of medical staffs to ensure the quality and safety of care provided to patients across the system.

Before deciding whether to accept a unified, system-wide medical staff, the medical staff must carefully weigh the potential costs and benefits of this decision. The following checklists are presented as a starting point for medical staff discussions regarding unification and disunification. Because circumstances vary widely across hospitals and systems, these checklists may not comprehensively address the circumstances of every medical staff.

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<tr>
<th>Issues to consider before your medical staff votes to become part of a unified, system-wide medical staff:</th>
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<td><strong>Potential benefits of unification</strong></td>
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Issues to consider before your medical staff votes to opt out of a previously unified, system-wide medical staff:

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<td>□ Restoration to status quo before unification</td>
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<td>□ Loss of state peer review protections applicable to unified staff</td>
<td>□ Return to state peer review protections</td>
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<td>□ Access to broader clinical resources</td>
<td>□ More direct relationship with Governing Body</td>
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<td>□ Return to local politics</td>
<td>□ Greater medical staff self-governance</td>
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<tr>
<td>□ Bylaws will require amendment to reflect different medical staff structure</td>
<td>□ Bylaws may be restored to pre-unification bylaws</td>
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