Unification of Medical Staffs: Perceived Loss or Gain in Influence? A Case Study

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NAMSS Educational Conference & Exhibition
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Overview
- Medicare Conditions of Participation
- Joint Commission Standards
- Suggested Steps in Unification of Medical Staffs
- Key Elements of Unified Medical Staff Bylaws
- Case Study of Unification of Three Separate Provider Hospitals

Medicare Conditions of Participation
- Previously each Medicare provider hospital was required to have own medical staff
- Effective July 11, 2014, CMS amended regulations to allow for single or unified medical staff for hospitals that share governing board – Tag A-0348 Sec. 482.22(b)(4)
Key Elements of COP

- Must be an affirmative vote of each separate medical staff to unify
- Members of the unified medical staff must have right to vote to “opt-out” at least every two years and must be informed of this right
- Medical staff bylaws of each hospital in a system with shared governing board must include “opt-in” provisions
- Unified medical staff must:
  - Take into account hospital-specific issues
  - Ensure needs of medical staff at each hospital and localized issues are considered and addressed

Joint Commission MS.01.01.01

EP 37: When a multihospital system has a unified and integrated medical staff, the bylaws describe the process by which medical staff members at each separately accredited hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) are advised of their right 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 respective hospital.

Suggested Steps to Unification

1. GB verifies unification is permissible under state and local law.
2. GB passes resolution for unification subject to affirmative vote by medical staffs.
3. Meetings with MS leaders of separate hospitals to discuss.
4. Draft unified medical staff bylaws to comply with CMS requirements (and any other requirements) and address MS concerns.
5. Draft amendments to existing medical staff bylaws with opt-in and opt-out provisions.
**Suggested Steps to Unification**

6. Schedule “Town Hall” meetings for MSs on unification and unified medical staff bylaws.
7. Hold vote by each separate MS under that medical staff’s bylaws on unification.
8. Hold vote by each separate MS under that medical staff’s bylaws on adoption of unified medical staff bylaws.
9. Staff categories and privileges are granted on hospital-specific basis.
10. Revise notice of appointment letters to include notice of opt-out provisions.

**Some Key Elements/Issues for Unified Medical Staff Bylaws**

• Develop brand new bylaws or amend existing set of one of the hospitals
• Composition of unified medical executive committee (or super-MEC) and division of voting rights between hospitals/medical staffs
• Medical staff officers
• Medical staff committees
• Medical staff department/service line structure following unification
• Staff categories

**Case Study**

2014 Healthcare System consisting of three separately licensed hospitals combines into one Governing Body

Effective July 11, 2014, CMS 482.22 Final Rule allows for either a unique medical staff for each hospital or a unified and integrated medical staff shared by multiple hospitals within a hospital system.
January 2015 Physician Leadership Institute (PLI)

- The Division Medical Staff Services Director and Chief Medical Officer did a SWAT analysis with a group of about 30 Medical Staff Leaders across the division.
- The decision was made to begin vetting with the MECs the concept of “Unification” as the Medical Staff Leaders immediately recognized the positive impact this would have on credentialing and peer review across the system.

Concerns Voiced by MECs:

From January 2015 – March 2015 the following concerns were raised by the Medical Staff:

1. Governance
2. Representation
3. Disenfranchisement of the smaller medical staff
4. Dilution of influence
5. Loss of local governance
6. Perceived inequitable distribution of funding

2015 Decision to Continue

During this vetting period with the MECs, Task Force Models 1.0 and 2.0 were circulated amongst the eight facilities (one of the hospitals consists of six campuses).
Current State

Board Committees

- Credentialing & Performance
- Grant
- Patient Care Experience & Meta-Credentials
- Risk

Hospitals

- A
- B
- C

MHS Board of Governors

Committee Board

MODEL 1.0 (Jan 2015)

- Hospital A– 6 in 1
- 6 Votes
- 3 Votes
- 3 Votes

MODEL 2.0 (April 1, 2015)

- Hospital A– 6 in 1
- System Reps (privileges at multiple Campuses)
- 8 Votes
- 4 Votes
2016 Formation of Special Bylaws Committee

Beginning January 2016 all three MECs/MEBs agreed to the formation of a “Special Bylaws Committee” to develop a reporting structure and DRAFT Bylaws for consideration. Representatives from all eight facilities were selected to serve on this Committee.

The Committee met from Jan 2016 thru May 2016.

MODEL 3.0 (January 2016)

Unified Medical Staff Medical Board

Quorum: 14

All three (3) current officers would maintain a vote (Chief/Vice/Past) at the 6 in 1

Campus 1
Campus 2
Campus 3
Campus 4
Campus 5
Campus 6
Hospital A – 6 in 1

Chief
Vice Chief
Chief & Vice
Chief & Vice/Designee

18 Votes
3 Votes
3 Votes

26 members - 25 regularly vote - Chair votes in the event of a tie

MODEL 4.0 Final (May 2016)

Unified Medical Staff Medical Board

Quorum: 10

Chief and Vice Chief are voting members. Past COS only votes in the absence of Chief or Vice and does not count toward quorum.

12 Votes
2 Votes
2 Votes

18 members - 17 regularly vote – Chair votes in the event of a tie
Lessons Learned

1. Do not rush the Medical Staff.
2. Focus on education and role of the Medical Staff.
3. Make sure you listen to the concerns being voiced and make changes to address those concerns.
4. Address deficits or opportunities as they arise before proceeding. This builds trust which will be beneficial throughout the process.

Questions? Thank you!

This presentation is solely for general educational purposes. Neither the information on the slides nor the speakers’ statements during the presentation are intended as legal advice.

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UNIFICATION OF SEPARATE MEDICAL STAFFS:
Perceived Loss or Gain in Influence?
A Case Study

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Unification of Separate Medical Staffs:
Perceived Loss or Gain in Influence? A Case Study

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A. Background and General Considerations. On May 12, 2014, CMS published the amended Conditions of Participation for Hospitals allowing separately certified Medicare provider hospitals with a common or system governing body to have an integrated or unified medical staff. 79 Fed. Reg. 27105 – 27157 (May 12, 2014) (amending 42 CFR Sec. 482.22).

1. Under the 2012 proposed rules, a single or unified medical staff was not permitted for separately certified hospitals. Comments filed in support of the proposed rules argued that a unified medical staff would destroy medical staff self-governance. Those opposing the prohibition cited the benefits of efficiency and standardized evidence-based practices.

2. Some commonly cited benefits of a unified medical staff:
   a. Efficiency in the peer review processes.
   b. Facilitation in sharing information in credentialing and peer review between hospitals.
   c. Consistency and standardization of in credentialing criteria, peer review, and delivery/quality of care.
   d. Facilitation of the ability to transition to ACO and clinical integration arrangements.
   e. Consolidation and efficiency in carrying out medical staff functions.
   f. Larger medical staff organization is stronger.
   g. Access to system-wide contracting and education opportunities.
   h. Fewer conflicts of interests.

3. Some commonly cited limitations or detrimental aspects of unification:
   a. Limitation or dilution of influence of the smaller hospitals’ medical staffs.
   b. Reduction of representation on governing body.
   c. Loss of ability to customize the medical staff bylaws to the needs of the medical staff, hospital and community served.
   d. Need for changes in existing contractual relationships with practitioners or breach of existing arrangements.
   e. Less ability to address unique needs of separate medical staffs and patient populations that they serve and loss of community standards.
   f. Difficulty in accommodating exceptions in credentialing criteria and other requirements applicable to medical staff.
   g. Unified medical staff subject to disunification vote at least every two years.

B. CMS Conditions of Participation for Unified Medical Staff, Sec. 482.22(b)(4) Tag A-0348 (eff. July 11, 2014).

Key Elements:

- Unification requires the affirmative vote of separate medical staff to join under existing medical staff bylaws – cannot be unilaterally required by the governing board.
- Members of unified medical staff belonging to each separate certified hospital must have right as a medical staff to “opt-out” of unified medical staff at least every two years, and must be informed of this right.
- Medical staff bylaws of each hospital in system must include opt-in provisions, regardless of whether are currently considering unification.
- Unified medical staff must take into account hospital-specific issues.
- Unified medical staff must ensure that needs of medical staff at separately certified hospitals and localized issues are considered and addressed.

If a 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, after determining that such a decision is in accordance with all applicable State and local laws, each separately certified hospital must demonstrate that:

(i) The medical staff members of each separately certified hospital in the system (that is, all medical staff members who hold specific privileges to practice at that 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;

(ii) 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;

(iii) The unified and integrated medical staff is established in a manner that takes into account each member hospital’s unique circumstances and any significant differences in patient populations and services offered in each hospital; and

(iv) The unified and integrated medical staff establishes and implements policies and procedures to ensure that the needs and concerns expressed by members of the medical staff, at each of its separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated medical staff has mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed.
C. The Joint Commission, Hospital Accreditation Standards (2016).

Medical Staff Standard MS.01.01.01 EP 37 For hospitals that use Joint Commission accreditation for deemed status purposes: When a multihospital system has a unified and integrated medical staff, the bylaws describe the process by which medical staff members at each separately accredited hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) are advised of their right 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 respective hospital.

D. Suggested Steps in Unification of Medical Staffs. The unification of medical staffs under the Condition of Participation (CoP) requires a shared system governing body with separately certified hospitals. The following is a suggested sequence for moving to a unified medical staff:

1. Governing body verifies that unification is in accordance with state and local law. Check state hospital licensing law to verify use of unified or integrated medical staff for two or more separately licensed hospitals is permissible.

2. Resolution by governing body to unify medical staffs of separately certified hospitals, conditioned on affirmative vote by the separate medical staffs.

3. Meetings (and more meetings) with medical staff leaders of separately certified hospitals to address benefits of unification and concerns of the separate medical staffs.

3. Draft unified medical staff bylaws to comply with the CMS CoP and provide for unification, and address medical staffs’ concerns.

4. Present draft unified medical staff bylaws to appropriate separate medical staff bylaws committees (or may form an ad hoc joint committee of the separate medical staffs).

5. Draft amendments to existing medical staff bylaws of separate medical staffs within system to include opt-in and opt-out provisions – these would go to separate medical staff bylaws committees. Required of all separate medical staffs, even if not currently considering unification.

6. Schedule “Town Hall” meetings with separate medical staffs on unification and unified medical staff bylaws.

7. Hold vote by each separately certified hospital’s medical staff under that medical staff’s current medical staff bylaws to unify (or not) and to amend existing medical staff bylaws per Item #5.

8. Hold vote by each separately certified hospital’s medical staff under that medical staff’s current medical staff bylaws to adopt unified medical staff bylaws (strongly recommend combining (7) and (8) into one vote).
9. Staff category and clinical privileges are granted on hospital-specific basis under unified medical staff bylaws (see Interpretive Guidelines to CoP Sec. 482.22(b)(4)).

10. Revise notice of appointment and reappointment letters to include notice of opt-out provisions of members of unified medical staff (and additional mechanisms for notice if preferred).

E. Key Elements of Unified Medical Staff Bylaws. These are some of the more significant issues that will have to be addressed in drafting unified medical staff bylaws.

1. Brand New Unified Medical Staff Bylaws or Revising an Existing Set.

The first decision that will need to be made is whether to create a brand new set of medical staff bylaws for the unified medical staff or to take an existing set of medical staff bylaws from one of the medical staffs being unified and modify it. Making this decision will take into consideration how current the bylaws of the separate medical staffs are, the different sizes of the potentially combining medical staffs, which are in the best shape to amend, and how the use of an existing set will be perceived by the other medical staffs. Sometimes, just from a political standpoint, it may be advisable to create a new set (or what looks like a new set).

2. Composition of Medical Executive Committee (or “super – MEC”) and voting rights.

a. Is each separately certified hospital/medical staff going to be afforded equal representation on the MEC regardless of size or number of active staff members? Or will larger medical staffs be afforded greater representation?

b. Will there be any “at-large” members on the MEC?
   (1) If so, are they elected from the entire Unified Medical Staff?
   (2) Do they have to practice at all of the hospitals or certain ones?

c. Will department chairs still be represented on the MEC?

d. What are the MEC’s responsibilities, particularly as to CoP 482.22(b)(4)(iii)-(iv)?
   (1) Ensuring needs and concerns of separate medical staff members are given due consideration.
   (2) Ensuring mechanisms are in place to consider and address issues localized to the separately certified hospitals.

3. Medical Staff Officers.

a. How will the officers of the Unified Medical Staff be elected and what are their qualifications?

b. What are the duties of the Unified Medical Staff officers?

c. How are the Unified Medical Staff officers removed?

d. Will the original separate medical staffs retain their own officers in addition to having officers of Unified Medical Staff? If so, do they have to have the same officer structure (e.g., Chief of Staff, Chief of Staff-Elect) or can it vary by hospital?
4. **Medical Staff Committee and Department Structure.**

   a. Will the separate MECs be retained in any form?
   b. If so, what are its duties? Will the MECs report to the “super-MEC”?
   c. Will departments, sections or services be retained at the separately certified hospitals or will they be consolidated at the unified medical staff level?
   d. If retained at the hospital level, will they report to the separate MECs or to the super-MEC?
   e. Will all medical staff committees report to the separate MECs or to the super-MEC? Will any medical staff committees be specific to the separately certified hospitals?

5. **Staff Categories.**

   a. Will there be a single set of staff categories for the unified medical staff, regardless of hospital, or may a member hold a different staff category at different hospitals? Can a member only practice at one of the hospitals?
   b. What staff categories will there be?
      (1) What if the separate medical staffs had different categories?
      (2) Which ones stay and which are eliminated?
   c. What if the criteria for staff categories differed between hospitals – which criteria will be used?
   d. What happens to members in staff categories that are eliminated in the new unified medical staff?

6. **Contracted Practitioners.**

   Are any amendments needed to address contract practitioners at the different hospitals? Did the separate medical staff bylaws have differing provisions on contract practitioners that have to be reconciled?

7. **Voting Rights of Members.**

   a. If a member of the unified medical staff is in the active staff category at each of the hospitals, is the member allowed to vote at each of those hospitals? Or only once?
   b. Does it depend on the matter that is the subject of the vote?
      (1) Unified medical staff officers
      (2) Amendment to the Unified Medical Staff Bylaws
      (3) Medical staff officers at one of the separate hospitals

8. **Emergency Services Call Obligations.**

   a. Is a member of the active staff at all of the hospitals subject to serving on the emergency services call roster at each of the separately certified hospitals or a “primary hospital”?
   b. Can the members of the active staff agree to some other arrangement as long as there is adequate coverage for each of the hospitals?

a. Clinical privileges will be granted by hospital since all privileges are not offered at every hospital and every member will not necessarily practice at every hospital. See Interpretive Guidelines CoP Sec. 482.22(b)(4).

b. When merging differing sets of credentialing criteria of separate medical staffs, will the credentialing criteria rise to the higher level or go to the lower?

c. How will the credentialing process handle issues such as board certification if required by some of the unifying hospitals but not others?

d. Will the credentialing process include a mechanism to address hospital-specific needs or unique circumstances, or will this be addressed in some other manner or at some other level?


a. Any disciplinary or corrective action taken under the unified medical staff bylaws will be applicable at all of the hospitals and there will be one procedural due process mechanism applicable to all hospitals.

b. The unified medical staff bylaws will need to address who can impose summary and precautionary actions to encompass each of the hospitals.


a. Each member of the Unified Medical Staff must have the right to initiate a vote to opt-out of the unified structure and return to a separate medical staff. 42 CFR Sec. 482.22(b)(4)(i). The Interpretive Guidelines provide that the hospital may establish a minimum interval between these votes of not more than once every two years.

b. Interpretive Guidelines for Sec. 482.22(b)(4)(i) provide that hospitals may not use different criteria for opt-in/opt-out votes than are used for other amendments to the medical staff bylaws (e.g., what staff categories can vote, requiring a “super-majority”).

c. Opt-in/opt-out provisions must also be included in existing medical staff bylaws for all separately certified hospitals within the system.

d. Example of an opt-out provision in Unified Medical Staff Bylaws:

(1) The voting members of the active staff of a Hospital already included in the Unified Medical Staff may vote to opt-out of the Unified Medical Staff structure as provided below. Initiation of the voting process requires submission to the Medical Staff Office of a written petition signed by at least 10% of the active staff members of the Hospital requesting an opt-out vote. A copy of the petition shall be provided by the Medical Staff Office to the Unified MEC and the Board at least 20 days prior to submission to the active staff members of that Hospital for the opt-out vote. Any comments of the Unified MEC or the Board on the proposed opt-out vote shall be included with the written ballot.

(2) Voting shall be by mail ballot sent to all voting members of the active staff of the Hospital that has petitioned for the opt-out vote, by regular mail or electronic transmission. A decision to opt-out of the Unified Medical Staff requires an affirmative vote of at least 51% of the ballots returned within 30 days of mailing.
(3) If the result is an affirmative vote to opt-out, the opt-out shall be effective 60 days after the vote to allow sufficient transition time. Any provisions in these Bylaws specific for that Hospital shall be automatically deleted from these Bylaws on the effective date without the need for compliance with the procedures in Article ___ [bylaws' amendments].

(4) If there is an affirmative opt-out vote by all but one of the separately licensed Hospitals, these Unified Medical Staff Bylaws shall be automatically superseded by the medical staff bylaws for each of the separately licensed Hospitals that were in existence on the day each of the medical staffs voted to become a Unified Medical Staff.

(5) The results of a mail ballot on a petition to opt-out of the Unified Medical Staff pursuant to this Section are final for a period of two years. Unless otherwise approved by the Board, a vote to opt-out may not be held sooner than two years from the date such Hospital's active staff “opted in” to the Unified Medical Staff or two years after a previous vote under this Section.

12. Concerns of Separate Medical Staff/Hospital. There need to be “policies and procedures to ensure that the needs and concerns expressed by members of the medical staff, at each of its separately certified hospitals” are given due consideration, and “mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed.” The Interpretive Guidelines to CoP 482.22(b)(4)(iv) provide that the policies and procedures must cover: a process for members to raise their local concerns with medical staff leadership; how members are informed of the process; a process for referring the concerns or needs to the appropriate committee or group with the medical staff; and documentation of the outcome of the medical staff’s review of the concerns or needs.

Some possible mechanisms:

a. Medical staff committee with medical staff and administrative representation from each separately certified hospital, that addresses requests for variation in operational policies by the medical staff or hospitals due to different needs. Committee makes recommendations to the MEC and super - MEC.

b. Governing board subcommittee with representation from medical staff members at each separately certified hospital that receives referrals and makes a recommendation to the super – MEC or Governing Board.

c. Dispute resolution committee that can be invoked by super – MEC with representation from medical staff from each separately certified hospital and governing board that makes a recommendation to the super - MEC.

d. Subcommittee of super - MEC, similar to the dispute resolution committee above, that makes a recommendation to the super - MEC (may include a governing board representative)
e. Modifications of Rules and Regulations or protocols approved by super –
MEC to address local issues or unique circumstances, with performance
improvement monitoring to assess single standard of care being provided.

f. Different voting requirements on local issues or those addressing unique
circumstances.

F. Separately Certified Hospitals. Keep in mind that unification of the medical staffs does
not mean unification of other CoPs or the ability to comply at the system level, such as
using a single performance improvement plan for all the hospitals. Each separately
certified hospital must still demonstrate compliance with the CoPs.
Case Study: Medical Staff Unification

Scenario: In late 2013 our urban multi-hospital system consisting of three separately licensed hospitals, each with a separate Medicare provider number, for a total of eight physical facilities, made the choice to combine their governing bodies into a single system governing body effective January 1, 2014.

Hospital A had six separate campuses including a pediatric hospital. These six hospitals were previously separately licensed with separate Medicare provider numbers. In July 2002 these six hospitals were consolidated into one hospital and medical staff under one provider number. Hospital B was new hospital that was opened in 2009 and Hospital C was a surgical hospital with the ability to accommodate patients for short overnight stays.

The six campuses of Hospital A have 2963 providers granted clinical privileges through the Medical Staff and consist of the following:

- Two campuses located within a single facility are described as the 5th largest hospital in the USA. The facility includes an acute care adult hospital with a children’s hospital physically joined to it, for a total of 917 beds. The adult hospital is designated as a Level III Advanced Trauma Center and specializes in cardiac transplant and advanced cardiac procedures such as trans-aortic valve replacement (TAVR). The hospital is also well-known for its oncology service lines including active stem cell transplant programs for adults and children.
- The third campus specializes in solid organ transplant and psychiatric services consisting of 383 beds, and is the largest living donor kidney transplant program in the nation.
- The fourth hospital is a downtown, inner city hospital consisting of 354 beds. It is an anchor hospital in the downtown area and has just completed an addition of a new ICU tower in an effort to keep up with community healthcare needs.
- The fifth campus is a general community facility which does not offer women’s services, consisting of 179 beds
- The sixth campus was purchased in 2011 and used be a “heart hospital”; however, it now also offers orthopedic services and has a dedicated rehab facility for a total of 120 beds.

Hospital B was opened in 2009 with 80 beds and has quickly grown to a 140 bed hospital located in what is now considered a second medical center for our city. To accommodate continued growth, the hospital just broke ground to add another tower. Hospital B has 1463 providers granted clinical privileges through the Medical Staff. With the exception of Psychiatric, Transplant Services, Women’s Services, and Children’s Services, all of the above seven facilities offer similar service lines.
Hospital C is solely a surgical facility that provides short stays and consists of 28 beds. It has 469 providers granted clinical privileges through the Medical Staff. Credentialing and Medical Staff Peer Review are centralized for Hospital A; however, these services remain separate for Hospitals B and C. There is a sharing agreement in place between the hospitals which allows the sharing of peer review and credentialing information in accordance with state law.

**Sequence of Events:** When the Medicare Conditions of Participation were revised to allow a "unified and integrated" medical staff for hospitals that are part of a health system with a single governing body, the System Medical Staff Services Director reviewed the change in the COPs with System Administration, legal counsel, and Medical Staff Officers at all facilities. Since there was significant overlap in Medical Staff membership between the three hospitals, the Medical Staffs had been asking for a way to have membership and privileges processed at one time for all System hospitals and recognized this change in the COPs would allow for such action to take place.

After several months of vetting the pros and cons with the Medical Staff Officers, the decision was made to approach the Community Board (governing board) about unification of the Medical Staffs. After careful consideration and because six of the eight facilities were already under one hospital license the Community Board approved a resolution in November of 2014 allowing the three Medical Staffs to unify. In January 2015 a SWAT (Strengths, Weaknesses, Advantages, and Threats) Analysis was conducted with the Physician Leadership Institute (PLI). The PLA consisted of a group of Active Medical Staff selected by facility MECs and Administrators to receive quarterly education in the hopes of their serving as future medical staff officers and/or medical directors.

From January thru March of 2015, input was gathered from the three Medical Staffs through meetings with each of the eight facilities' Medical Executive Committees and ad-hoc meetings as requested. Mid-2015 a task force was developed consisting of Medical Staff officers from each facility.

Major concerns voiced by the Medical Staff at this phase of the project were:

1. Limited hospital-specific self-governance and ability to obtain exceptions for unique circumstances to the system-wide rules and requirements.
2. Limited representation of the medical staff at the Community Board level, especially if medical staff leaders view their role as representative of their specialty rather than the medical staff as a whole.
3. Disenfranchisement of the smaller medical staff.
4. Dilution of the influence of certain specialty areas and specialized clinical service lines.
5. Increased use of medical staff service lines by a unified medical staff resulting in loss of local medical staff.
6. Perceived inequitable distribution of funding.
While the Medical Staffs immediately recognized the positive impact unification would have on credentialing and peer review activities, the Medical Staffs and some hospital/facility administrators favored maintaining the current separate medical staffs. A number of the Medical Staff Leaders thought being separate would give them more decision-making capacity and input over the operations and funding of the hospitals. There were numerous discussions of the pros and cons, with the Medical Staff leadership finally deciding in November 2015 that unification would create a stronger model and give the Medical Staffs a unified voice to the Community Board.

In early 2016, a special Bylaws Committee was formed and the drafting of Unified Medical Staff Bylaws and Amendments to the three sets of existing Medical Staff Bylaws was kicked off. This Bylaws Committee consisted of Medical Staff membership representation from each of the eight facilities. Legal counsel worked with the System Medical Staff Services Director to prepare a first draft using the current Medical Staff Bylaws from the largest hospital (these bylaws were most recently revised and updated with TJC, CMS and State requirements). This process began before the Bylaws Committee was appointed and a first draft was prepared before the first meeting of the Bylaws Committee.

The Bylaws Committee met monthly beginning in January 2016 reviewing and amending the draft, and then approved a set of Unified Medical Staff Bylaws ("DRAFT Bylaws") in May 2016. The DRAFT Bylaws, the required amendments to existing Bylaws of each of the three hospitals, and an Executive Summary were then circulated to each facility’s Medical Executive Committee for input prior to being distributed to the Medical Staff for a 60-day vetting/comment period beginning July 1, 2016. A member of the Bylaws Committee presented at each MEC.

During this 60-day vetting/comment period, all input/questions will be gathered and responded to by the Bylaws Committee Chairman with assistance from the Medical Staff Services Director and legal counsel. The comments and responses will be shared as received online with the three Medical Staffs and will be included in the information when the DRAFT Bylaws are mailed for a vote on unification by the Active Medical Staff at each of the three separately licensed hospitals. The vote for unification and for adoption of the DRAFT Bylaws will be done on one ballot. (The vote will also include amendment of the existing bylaws to include the opt-in and opt-out provisions.) The voting will be in accordance with the procedures in the existing Medical Staff Bylaws for each hospital.

**Lessons Learned:** You cannot rush the Medical Staffs through this process. You must meet individually with officers, leaders, and your naysayers. You must always come prepared with solutions and options to choose from to help keep the Medical Staff focused on the topic. We found that the Medical Staffs, even those who initially requested this unification, were not fully informed about the Medical Staff’s role in the Hospital and required much education about their role. As with any process of amending bylaws, concerns about existing bylaws-provisions that have been in place for years and may have nothing to do with unification - were raised.
Specifically, we found the following:

1. A big concern from the outpatient surgical hospital that they would be overrun by the bigger acute care hospitals and lose their voice.
2. Opportunities still existed with the 6-in-1 hospital where specialties (such as pediatrics) felt they had not been given voice in decisions that affect patient care.
3. Some physician leaders with a negative mindset had some valuable points about loss of voice and differences in practice patterns across the city.

We were successfully able to address these to most everyone’s satisfaction with a new conflict resolution process that would allow applicable issues to be vetted in a fair and uniform process across the system. One of the positive discussions that we witnessed was the concern with possible differences in patient care across the city under one hospital system. The Medical Staff Leaders ultimately united in the position that any patient that walked into our hospitals should receive the same level of care from the same level of provider regardless of location.

Finally, we recognized the need for an annual orientation process for all Medical Staff committees focusing on the requirement that the self-governing organized Medical Staff provides oversight of the quality of care, treatment and services delivered by practitioners who are credentialed and privileged through the Medical Staff process by providing the following oversight of:

1. The ongoing evaluation of the competency of practitioners who are privileged.
2. Delineating the scope of privileges that will be granted to practitioners.
3. Providing leadership in performance improvement activities within the organizations.
4. Creating and maintaining a set of Bylaws that define the role of the organized Medical Staff.

The vote is currently scheduled for late September 2016 which will result in a total time frame of approximately 2 ½ years for this process.

Attachments:

- PowerPoint Presentation for Medical Board and Medical Executive Committees
- Educational Notice to Medical Staff
The medical staff leadership has proposed that the medical staffs of all three MHS Hospitals---the 6-in-1 (considered one hospital), Methodist Stone Oak Hospital (MSOH) and Methodist Ambulatory Surgical Hospital (MASH)---be coalesced into one unified medical staff. This proposal is the result of many meetings and many hours of work/input from your medical staff officers, and has been crafted to keep the advantages while eliminating any perceived disadvantages to the medical staff.

The attached informational document discusses the pros and cons of a unified medical staff and the regulatory issues surrounding unification. This is a somewhat complicated undertaking, hence the length of the document. It is important that you read the entire document for a more complete understanding of this issue.

Areas of particular interest include:

- Potential advantages and disadvantages of unification (pages 1-2).
- Accommodation of potential disadvantages (page 2).
- Bylaws changes are required to enable the option of unification, regardless of any intent to implement that option (page 3, highlighted).

Over the next several weeks, additional informational emails will be forthcoming and “town hall” meetings will be held to allow full discussion of this proposal. Following that period, bylaws changes will be circulated, and subsequently voted on, to determine whether or not the medical staff adopts the unification of the medical staffs.

Please contact your officers (Vice-Chief, Chief and Immediate Past Chief of Staff) if you have questions not answered by the attachment. As always, you may contact me as well.
Since January 2015 your Methodist Healthcare System Medical Staff Leaders have been researching and evaluating the option of a “unified and integrated” medical staff. With a unified medical staff the three currently separate Medical Staffs (MH 6 in1, MSOH, and MASH) would operate as one Medical Staff, while the three separately licensed hospitals would remain separately licensed. Included in this correspondence is a brief summary of their findings including the role of the Medical Staff as defined by The Joint Commission, the CMS regulation allowing for a unified medical staff and the potential benefits associated with a unified medical staff.

Role of the Medical Staff:

The Joint Commission notes that the self-governing organized medical staff provides oversight of the quality of care, treatment and services delivered by practitioners who are credentialed and privileged through the Medical Staff Process. The four primary functions of the organized medical staff are:

1. The ongoing evaluation of the competency of practitioners who are privileged.
2. Delineating the scope of privileges that will be granted to practitioners.
3. Providing leadership in performance improvement activities within the organization.
4. Creating and maintaining a set of Bylaws that define the role of the organized medical staff.

After careful consideration the following have been identified as potential advantages to the Medical Staff resulting from unification:

1. **Stronger Influence** – With one unified voice representing a now larger medical staff, the medical staff would have a stronger influence in board and management decisions.
2. **Consolidation of Credentialing and Privileging** – Currently there is significant redundancy required of the medical staff and its members: completing three separate and unique applications, with three separate and unique credentialing processes requiring committee approval at all three hospitals, all for many of the same practitioners. With the formation of a unified credentialing committee and process redundancy would be eliminated.
3. **Consolidation of Quality and Performance Improvement Activities** – Currently each of the three separate hospitals perform peer review separately. This has the potential for wide variations in acceptability of levels of clinical skill, professional conduct, and health. Unification provides us with an opportunity to implement standardized peer review policies and address peer review consistently across the system making it safer for patients seen within Methodist Healthcare System Hospitals, and more fair for the medical staff by providing consistency in standards, expectations and process.
4. **Consistency in Enforcement and Application of System Policies** - This would allow for one consistent set of Medical Staff Bylaws, Rules and Regulations, and Medical Staff Policies to follow. We believe our Medical Staff members who work at multiple hospitals within the system would benefit from these consistent rules, making compliance easier.
5. **Consolidation of Committee Functions** – Currently, multiple medical staff committees perform a single medical staff function (Utilization Review, Credentials, Pharmacy and Therapeutics etc…) at three separate hospitals. When those committees unify as part of a unified medical staff structure, those functions will be performed more efficiently with a mechanism to give and receive feedback from each hospital. This means fewer medical staff leaders will be necessary to staff those committees, although additional participation is always welcome.
Unified Medical Staff  
(June 18, 2015)

January Physician Leadership Institute  

The following items were identified as a weakness, opportunities and threats with our current structure:

• Meaningful real time data and using that data to affect decision making
• Focus on Centers of Excellence
• Development of robust system clinical service lines
• Communication opportunities amongst the medical staff and community
PLI- Continued

- Need for improved core work processes (more standardization, minimized variability)
- Inconsistent approach to identified silos. (the example was given of how clinical service lines are sometimes aligned with campus vs. system goals)
- Different messages at facility from system identified goals. Example was given of default alarms on anesthesia monitors; emergency room drug ordering varies between facilities.
- Lack of collaboration amongst the campuses
- Lack of consistent, coordinated communication about expectations across the campuses

Current State

- MHS Board of Governors
- Community Board
  - Credentialing & Peer Review
  - Quality
  - Patient Care Experience & Safety Committee
  - Bioethics
- MH 6-1
- MSOH
- MASH
Regulation Change

Effective July 11, 2014 CMS 482.22 Final Rule allows for either a unique medical staff for each hospital or for a unified and integrated medical staff shared by multiple hospitals within a hospital system.

Unified Medical Staff

• Creation of unified and integrated medical staff bylaws, rules, and requirements
  – appointment, credentialing, privileging, and oversight – as well as peer review policies and due process rights guarantees
• Creation of a Unified Medical Board for Self Governance
• Each hospital would continue to have their separate certification and be separately licensed.
• Not an 8-1 solution.
Policies and Procedures Req.

- Unified medical staff must take differences of separately certified hospitals into account in policies and procedures.

- Must take into account each hospital’s unique circumstances and any significant differences in patient populations and services offered in each hospital.
MODEL 1.0
Prior to initial Feedback

Unified Medical Staff Medical Board

Chief
MH
Chief
MCHST
Chief
METRO
Chief
MSTH
Chief
NEMH
Chief
MTEX

Chair

Chief
MSOH

Vice Chair

Chief
MASH

At Large

3 Votes

6 Votes

At Large

3 Votes

MEC LEVEL

MODEL 2.0 (April 1, 2015)

Unified Medical Staff Medical Board

Chief
MH
Chief
MCHST
Chief
METRO
Chief
MSTH
Chief
NEMH
Chief
MTEX
Chief
MSOH
Chief
MASH

Chair

At Large

4 Votes

At Large

At Large

At Large

May include pre-determined invitees for general session (e.g. vice-chief, prior chief, etc).
NEW Proposed: Sub Committee of the UMB would be triggered if decision made and one of the campuses/hospitals believes that it has unique circumstances and significant differences in its patient population or services offered that was not addressed.

Consist of Representative from (1) each separately certified hospital, (2) Vice Chair of UMB, Subject Matter Expert (when applicable) and (3) Community Board chair. If 6-1 Campus is triggering the committee then additional representative from 6-1 MH license would be appointed as well.

Purpose: (1) Determine if unique circumstances and any significant differences in patient populations and services offered in each hospital/campus exist, and if so, (2) provide UMB with recommendations to address differences.
THANK YOU
After careful consideration the following have been viewed as potential disadvantages to the Medical Staff resulting from unification:

1. Limited hospital-specific self-governance and ability to obtain exceptions for unique circumstances to the system-wide rules and requirements.
2. Limited representation of the medical staff at Board level, especially if medical staff leaders view their role as representative of their specialty rather than the medical staff.
3. Disenfranchisement of the smaller medical staff.
4. Dilution of the influence of certain specialty areas and specialized clinical service lines.
5. Increased use of medical staff service lines by a unified medical staff resulting in loss of local medical staff.
6. Perceived inequitable distribution of funding.

To accommodate these identified potential disadvantages and meet CMS regulatory requirement the Medical Staff Bylaws for a Unified Medical Staff will include the following:

1. Dispute resolution process.
2. Medical Board composition with representation from each campus.
3. Use of campus Medical Executive Committees reporting to Medical Board.
4. Unified Committee reporting system.
5. Opt Out voting provision to allow local medical staff to leave the Unified Medical Staff.

**CMS Unified Medical Staff Regulatory Requirements:**

In May 2014, CMS 482.22(b)(4) Final Rule allowed for either a unique medical staff for each hospital, or for a unified and integrated medical staff (unified medical staff) shared by multiple hospitals within a hospital system. In the case of MHS, the three separate hospitals within the hospital system are the 6-in-1, MSOH, and MASH.

The following four provisions must be in place if the hospital(s) and medical staffs utilize the unified medical staff model.

1. A provision allowing medical staff members holding privileges at each separately certified hospital in the system to opt in to a unified and integrated medical staff structure, or to opt out of such a structure (if a unified medical staff already exists), in order to regain a hospital-specific, separate, and distinct medical staff for their respective hospital.
2. Bylaws, rules, and regulations that describe its processes for self-governance, appointment, credentialing, privileging, and oversight – as well as its peer review policies and due process rights guarantees – 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 if a majority vote by the members mandates a separate and distinct medical staff for their hospital.
3. The unified and integrated medical staff is established in a manner that takes into account each hospital’s unique circumstances and any significant differences in patient populations and services offered in each hospital.
4. The unified and integrated medical staff gives due consideration to the needs and concerns of members of the medical
Other Regulatory Guidance:

- Governing body must document its decision to approve the formation of a unified medical staff, pending acceptance by the medical staff [CMS 482.22(b)(4) Interpretive Guidelines (IG)]. (The MHS Board of Governors has already taken this step.)

- Voting by separately certified hospital’s medical staff requires majority of medical staff members “who hold privileges to practice on-site at the hospital.”
  - Voting on whether to unify would be conducted under provisions in current medical staff bylaws [(i) IG] (to be completed by amendment) *References to (i) – (iv) are to CMS 482.22(b)(4)
  - Can vote on whether to accept unified medical staff before have required bylaws’ amendment addressing unified option [(i)IG]
  - Practitioners who hold telemedicine privileges are not to be included [(i)IG]

- Any hospital that is part of a hospital system is expected to have medical staff bylaws that address unified medical staff option in 482.22(b)(4), regardless of whether currently using a unified medical staff, or not. [(i)IG]

  Specific caveats include that the medical staff and governing body:
  - Have flexibility to determine details of voting process such as whether all categories of members holding privileges to practice on-site are afforded voting rights [(i)IG]
  - May not establish different criteria as to which categories of members have voting rights with respect to unified medical staff than are used for other amendments to medical staff, except that only members holding privileges to practice at a separate hospital may vote [(i)IG]
  - May not require filing of petition for opt out vote that must be signed by same number of voting members required to approve opt out [(i)IG]
  - May require “supermajority” vote for acceptance or opt out vote only if a supermajority is required for other amendments to bylaws [(i)IG]
  - May not permit delegation of opt out decision to medical executive committee [(i)IG]
  - May establish minimum interval between acceptance of unification and opt out votes as long as the interval does not unduly restrain rights of members of medical staff - intervals of more than two years might unduly restrain [(i)IG]

- Bylaws of the unified medical staff must identify each separately certified hospital covered by the bylaws, and include the process by which members of each hospital are advised of their right to vote to opt out of a unified medical staff. At a minimum, members should be so advised when first granted appointment and on reappointment. [(ii)IG]

- Bylaws of the unified medical staff may be in addition to or instead of hospital-specific bylaws, rules and requirements. [(ii)IG]

- A unified medical staff must consider differing circumstances of separately certified hospitals when developing policies and procedures, which could have implications for medical staff functions such as periodic review of credentials and privileges and ongoing peer review of the quality of medical care, standing orders/protocols, on-call requirements. [(iii) IG]

- A unified medical staff must establish and implement policies and procedures that address how it considers and addresses needs and concerns of members of medical staff regarding own separately certified hospitals’ needs – local concerns and how make them known. [(iv)IG]

- Clinical privileges will be granted on hospital-specific basis for each separately certified hospital. They are not automatically granted for each hospital under unified medical staff since services at each hospital will vary. [482.22(b)(4) IG]

- Chairman of Medical Board is not required to have clinical privileges at all hospitals covered by unified medical staff. [482.22(b)(1)-(3) IG]