Historical Perspective on the Organized Medical Staff

Why was it necessary to create the hospital ‘voluntary, organized medical staff’?
The ‘Organized’ Hospital Medical Staff
Designed long ago for a different era in medical care delivery where:
- Most physicians were in private practice
- Doctors needed hospitals and an unspoken ‘contract’ existed
  between the two – a ‘quid pro quo’
- Regulatory demands were minimal
- Quality and patient safety were assumed
- Interdisciplinary care was not the norm/integrated care was
  uncommon
The ‘Organized Medical Staff’ has been an ossified entity for more than
fifty years, but is slowly evolving to fit into a changed health care world.

What does medical staff change and evolution look like?
More professionalization of roles
- More continuity
- Qualifications for positions (including availability to do the
  job adequately)
- Training and skill development
Streamlining run-away bureaucracy
- Fewer committees; Fewer categories
- Downsizing or eliminating departments/divisions/sections
- Returning to the hospital responsibilities not essentially
  medical staff duties
- Downsizing policies, eliminating rules and regulations
Physician Leadership: Largely ‘In Absentia’ in the 20th Century

Historical sources of physician ‘leadership’:
- Organized medicine
- Leaders of the ‘organized medical staff’

Physician leaders generally were not focused on quality of care, patient safety, health system improvements, access, patient centered initiatives, cost, efficiency, value, ...

Tasks for a new cadre of Physician Leaders

- Clinical care redesign
  - Delivery of more efficient/cost effective/high value care
  - Delivery of more ‘patient centered care’
  - Improved quality and patient safety
- Leadership in the development of ‘population health’ management
- Team leadership in an era of increasing integration and enhanced care coordination
- Creation of vision and values for new clinical structures (PHOs, ACOs, employed group practices, comprehensive service lines, hybrid insurance models, patient centered medical homes, perioperative surgical homes, etc.)

Good News! Physician Leadership is Playing a Growing Role in Healthcare Management

Traditional Physician Leaders:
- Medical staff officers, department and committee chairs
- Physician leaders in academic affairs

Expanding Roles for Physician Leaders:
- Physician executives (CEOs, CMOs, VPMAs, CQO, CIO, Chief Integration Office, Chief Transformation Officer, etc.)
- More physicians serving on hospital governing boards
- Physician leaders of ACOs and GINs
- Medical directors of service lines, centers of excellence
- Physician leaders of employed and contracted group practices
- Physician leaders in PCMHs, perioperative surgical homes, PACE programs, etc.
**Stronger Focus on Fundamental Medical Staff Responsibilities for which its Leaders are Accountable**

Oversight of the quality of care rendered by practitioners holding clinical privileges at the hospital or health system

- Credentialing and Privileging
- Peer Review and Corrective Action
- Collaboration with hospital on quality and patient safety initiatives
- Promotion of communication between the professional medical community and hospital management and governing bodies

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It’s not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change.

- Charles Darwin

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Hospitals have been rapidly migrating to multi-facility systems that operate across the continuum of care –

This evolution has created opportunity and challenge in the structuring of physician leadership.

A trend growing rapidly is to merge medical staffs in many multi-hospital systems.
Why Combine Medical Staffs across Hospitals?

Greater “user-friendliness” for physicians
- One application, one reappointment to track, communications from one source, fewer meetings

Efficiency
- Consolidation of medical staff offices and staff
- Effective use of physician leadership bench strength
- Fewer meetings

- Fewer silos & less fragmentation of medical staff work
- Less work for health system board
- Reduced potential for liability
- Fewer accreditation reviews
- Ability to reduce unwanted variance in policies and procedures, rules and regulations, clinical practices and operational activities
- Minimize medical staff “politics”
- Opportunity to rationalize & restructure physician leadership across all aspects of the IDS

Additional Factors for Consideration

- Geographic distances between hospitals
- Multi-state distribution of hospitals
- Historic medical staff cultures
- Number of hospitals within the health system
- Length of time hospitals have been part of health system
- Historic levels of trust between medical staffs and health system leadership
Additional Factors for Consideration

- Diversity across health system hospitals & complexity of medical staffs:
  - Academic institutions
  - Large vs. small community hospitals
  - Critical access hospitals
  - Tensions between employed and private staff physicians
  - Controversy over on-call coverage

Complete Unification or Intermediate Steps?

- Upside/downsides to “partial” unification
- What does “partial” unification look like?
- Who should consider “partial” unification?

Changes on the Way & On the Horizon

Efforts at ‘rationalization’ of proliferating physician leadership roles to reduce ‘silos’ and ‘fragmentation’
Case Studies: Streamlining Medical Staffs

- **Health System A:** 3 hospital system in California
  - From partial collaboration to unification but still complex
- **Health System B:** 4 hospital system in South Carolina
  - From partial collaboration to unification and simplification

Case Study: Rationalizing the Big Picture for Efficient Physician Leadership

- **Hospital System C:** 7 hospital system in Pennsylvania
  - System has geographic spread, mix of large and small hospitals, open & closed staffs
  - Large employed physician ‘group’ run by management
  - Historically physician leadership marginal
  - Moving to unify staffs, eliminate department bureaucracy
  - Moving to create single physician leadership group over med staffs, CIN, system service lines
Case Study: Rationalizing the Big Picture for Efficient Physician Leadership

Hospital System D: 5-hospital system in Virginia
- System has geographic spread, mix of large and small hospitals
- Large employed physician ‘group’ run by physicians with an early vision of a ‘physician-led’ organization
- Unified medical staffs in concept, but not in execution
- Vision and Practice are at Odds
  - Inadequate physician leadership development
  - Inadequate management ‘buy-in’
  - Physician engagement undermined by management

Questions/Comments?