Publications

Health Care Alert: Life After COVID-19 - What About Unified Hospital Medical Staffs?

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By now we're all aware that the COVID-19 pandemic created an unprecedented need for hospitals and health systems to quickly implement infrastructure changes to allow for resource reallocation and the expansion of clinical staff. Virtually overnight, hospitals saw the need to implement emergency operations plans and invoke disaster privileging processes to increase the number of available physicians and other independent licensed practitioners. For health systems with multiple independently certified hospitals and independent medical staffs, this process was complicated by a lack of mechanisms to allow credentialed and privileged physicians to provide care across all of the system's facilities. Awaiting guidance from the Centers for Medicare & Medicaid Services (CMS) and the Joint Commission, many systems were forced to enact new policies and procedures to meet the growing demand for health care workers while complying with existing accreditation and regulatory requirements. On the other hand, health systems with unified medical staffs and centralized and uniform credentialing and privileging were able to quickly and efficiently deploy practitioners to serve at each of their hospitals and facilities, without the cumbersome implementation requirements of ad hoc or emergency credentialing and privileging. This begs the question: should large health systems with multiple, independent medical staffs consider unification?

Hospital medical staffs provide essential oversight over the quality of care, treatment, and services delivered by credentialed and privileged practitioners. Historically, each separately Medicare-certified hospital was required to have its own, independent medical staff. Effective July 11, 2014, CMS amended applicable hospital regulations to allow hospitals that are part of a health system to have a unified and integrated medical staff for some or all of their separate hospitals. In making this change, CMS noted that many hospital systems – having misinterpreted the language of the relevant regulation – already utilized a unified medical staff model with no adverse impact on patients or decrease in the quality of care delivered. Rather, CMS noted that unified medical staffs could achieve a number of benefits, including: a lower rate of healthcare-associated infections (HAIs); a

reduction in hospital-acquired conditions (HACs); lower readmission rates; and, by providing a more collaborative and nimble medical staff, improved patient safety and outcomes. Additionally, a unified system medical staff typically would be better suited to standardizing best practices and implementing quality improvements than would the more fragmented structure of separate medical staffs. Finally, a unified medical staff across a multi-hospital system would allow for smoother and more reliable practitioner deployment in response to public health crises and situations like COVID-19.

However, establishing and maintaining a unified medical staff is not without its challenges and hurdles. The following are some considerations health systems should evaluate when contemplating a unified medical staff structure.

Governance Considerations

CMS conditions of participation for hospitals require that a single governing body bear legal responsibility for the functions of the hospital related to the oversight of the medical staff. Accordingly, any set of separately certified hospitals that shares a single, unified medical staff must also share a single governing body. Because, historically, most hospitals with separate medical staffs also have had separate governing bodies, unification of the medical staffs may require significant restructuring of existing hospital governing bodies for some systems. However, assuming a palatable governance solution is identified (e.g., a single governing body/board with individual facility-based committees), there may be significant practical advantages to having a single process and location for all credentialing, privileging, quality, and practitioner review activities.

Political Considerations

Typically, neither the governing body nor the medical staff is empowered to unilaterally move to a system-wide, unified medical staff. Instead, a particular certified hospital in a multi-hospital system may become part of a unified medical staff only upon: (1) election of the unified medical staff option by the hospital's governing body; ***and*** (2) acceptance by a majority of the medical staff members who hold privileges to practice at that particular hospital, voting in accordance with its medical staff bylaws. The respective medical staffs and governing bodies of all hospitals involved must work together closely if they desire to achieve a unified structure.

Although neither the medical staff nor the governing body can unilaterally adopt a unified medical staff structure, the medical staff can unilaterally opt-out of a previously-adopted unified medical staff. Specifically, if a majority of medical staff members holding privileges to practice at a particular hospital vote, in accordance with the unified medical staff bylaws, to opt-out of an existing unified medical staff, that hospital must establish a separate medical staff. A hospital may not set up bylaws that unduly restrict the rights of medical staff members when voting on the issue of accepting or opting out of a unified medical staff. That said, a hospital may establish a minimum interval between acceptance or opt-out votes (e.g., a vote may be permitted not more than once every two years).

Because opt-out votes for a particular hospital can be cast only by unified medical staff members who hold privileges at that hospital, health systems cannot privilege all practitioners at each hospital location as a matter of course. Instead, privileges must be granted on a hospital-specific basis to practitioners who actually practice or are likely to practice at that hospital, considering both qualifications of individual

practitioners and services provided at each hospital. For example, it would not make sense for an OB/GYN to hold privileges at a psychiatric hospital, or for a physician to hold privileges at a hospital location far from his or her usual practice location.

Even though privileges must be granted on a hospital-specific basis, having a centralized, uniform system for privileging and credentialing would necessarily streamline efforts to expand privileges in emergency scenarios. Given the potential for a second wave of COVID-19 this fall or winter, now may be the ideal time for a health system to evaluate the transition to a unified medical staff.

Unique Hospital and Medical Staff Circumstances

The unified medical staff must be established in a manner that takes into account each hospital's or facility's unique circumstances, as well as any significant differences in patient populations and services offered in each hospital.

Additionally, the unified medical staff must have written policies and procedures that address how members can raise local concerns and needs with the leadership of the unified medical staff and how leadership will review and address those concerns and needs. For example, physicians practicing in a children's hospital may have concerns about having certain protocols for medication administration that reflect specific pediatric patient needs, or physicians practicing in a small rural hospital may have concerns about how to get timely telemedicine consults from their colleagues in urban areas. Systems with a wide variety of separate hospitals serving distinct patient needs with varied service lines will need to thoughtfully craft bylaws, rules and regulations to ensure local needs are evaluated and met.

New Medical Staff Bylaws

If all parties opt to create a unified medical staff, they must adopt and approve a new set of medical staff bylaws that describes processes for self-governance, appointment, credentialing, privileging, and oversight, as well as peer review policies and due process rights guarantees. In particular, the bylaws must include the process for members of the medical staff of each separately certified hospital to be advised of their rights to opt-out of the unified medical staff as discussed above. It may be possible to start with one hospital's current bylaws, but significant revisions will be necessary to account for these changes, as well as changes to the composition of the medical executive committee, medical staff officers, staff categories, and similar considerations.

Potential Disenfranchisement

Medical staff members from a smaller hospital within a larger system may feel disenfranchised as part of a unified medical staff or worry about the loss of local governance. Health systems contemplating such a change should provide opportunities for individual medical staffs to voice concerns about unification and evaluate workable solutions.

Payment Issues

When evaluating the option of utilizing a unified medical staff and single governing body, health systems should also consider any impact to Medicare reimbursement applicable to certain types of hospitals, such as non-grandfathered Hospitals-within-Hospitals and Hospital Satellites. Where the hospital system owns both the tenant and host hospital, using a single governing body for both hospitals could jeopardize the payment status of a hospital that is being paid by Medicare under a payment system excluded from the Inpatient Prospective Payment System (IPPS). In these situations, hospitals should closely evaluate any unintended reimbursement impact when considering a unified medical staff structure.

Although there are many strategic issues to consider when evaluating the appropriateness of a unified medical staff structure in any particular instance, certain long-term benefits may outweigh the immediate administrative and operational hurdles, such as:

- Improved patient safety through shared credentialing and privileging;
- More efficient sharing of knowledge and innovations among medical staff members;
- Increased opportunity to improve peer review processes; and
- More efficient coordination of emergency preparedness and community health planning.

If your system is considering a move to a more unified medical staff structure, your Vorys attorney is here to help.

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Vorys COVID-19 Task Force

Vorys attorneys and professionals are counseling our clients in the myriad issues related to the coronavirus (COVID-19) outbreak. We have also established a comprehensive Coronavirus Task Force, which includes attorneys with deep experience in the niche disciplines that we have been and expect to continue receiving questions regarding coronavirus. Learn more and see the latest updates from the task force at vorys.com/coronavirus.