What to do when medical staffs join forces after a merger or acquisition

When two medical staffs are forced to integrate as the result of a hospital merger or acquisition, medical staff leaders and MSPs may feel overwhelmed by the questions cascading through their minds. Which facility’s bylaws will take precedence? Who will be the new medical staff leaders? Will the credentialing processes change?

Whether your hospital is acquiring or being acquired by another facility, these tips should help ease the transition of merging medical staffs.

Which medical staff’s bylaws and policies take precedence?

If a healthcare system is acquiring a stand-alone hospital, typically the system’s bylaws take precedence, says Michael Callahan, Esq., partner at Katten Muchin Rosenman, LLP, in Chicago. If two hospitals of a similar size merge, the CEOs of the hospitals must agree on which set of bylaws should take precedence or decide whether the medical staffs must cooperatively draft a new set of bylaws that apply to both facilities.

All hospitals involved in the merger or acquisition ideally should be governed by the same set of bylaws, says Callahan. “At some point, you want the same application, the same appointment/reappointment process, and the same standards to apply to everyone. Creating different standards can result in legal liability and confusion,” he says.

However, there are exceptions to this rule. Advocate Health in Oak Brook, IL, has 12 hospitals under its umbrella, and each has an independent medical staff with distinct bylaws, although some were edited slightly to comply with Advocate’s standards. According to James Dan, MD, FACP, president of physician and ambulatory services at Advocate Health, which recently purchased two hospitals, one medical staff’s bylaws aren’t so radically different from another’s that they would interfere with operational integration.

The majority of differences are in the medical staff policies and procedures and rules and regulations, says Callahan. For example, some hospitals may require physicians to be board-certified; others may not.

The acquiring facility should give copies of the bylaws, rules and regulations, and policies and procedures to the MSPs and medical staff leaders of the acquired hospital as soon as possible and allow them a grace period to become compliant, says Carrie Bradford, RHIA, CPMSM, CPC, senior director of professional services.
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staff services and credentialing at NorthShore University Health System in Evanston, IL, which has acquired two hospitals in recent years. This gives physicians time to become board-certified (if they are not already) or obtain any additional training or certifications they need to qualify for medical staff membership and/or privileges.

Will privileging procedures change?

When it comes to physicians at the facility being acquired who may not meet the acquiring facility’s privileging standards, best practice is for the acquiring facility to offer a grace period of one or two years to allow existing physicians to maintain their livelihood as they obtain the necessary training and education to maintain their privileges. The acquiring facility can immediately revoke the privileges of physicians who don’t meet its established criteria, but doing so might alienate physicians and hurt referrals.

Although offering a grace period is the most physician-friendly approach, it also represents a risk. If a physician under a grace period has a bad outcome and the patient sues, the plaintiff would likely prevail. The plaintiff’s attorney would argue that because the hospital allowed the physician to keep his or her privileges despite not meeting the hospital’s standards, the poor outcome is the hospital’s fault, says Callahan.

“Medical staffs understand they are running some risk by letting a physician continue to do certain procedures, so they may want to impose some type of monitoring on the physician,” he says. This monitoring may include focused professional practice evaluation.

The hospitals involved in the merger or acquisition must also decide whether privileges will extend systemwide or remain site-specific. Allowing physicians to have systemwide privileges is helpful when a particular specialty is in high demand because specialists can see patients at multiple sites without the hassle of applying for privileges at each institution.

NorthShore allows for systemwide credentialing due to a single medical staff model across all of its four hospitals. A physician who has privileges to perform bariatric surgery can perform that surgery at any of NorthShore’s sites that are designated for that service. When the system acquired a hospital last year, the medical staff services department (MSSD) had to assess each new physician’s privileges and match them with its own, explains Bradford.

Advocate, meanwhile, maintains site-specific privileges. If a physician with bariatric privileges at Advocate BroMenn wants to perform surgery at Advocate Condell, for example, he or she must also apply for privileges at Advocate Condell.

Keeping privileging site-specific allows the individual sites to evaluate physician performance and make privileging decisions based on their personal knowledge. “A piece of paper shows us great credentials, but doctors in the community know other doctors in the community, and we want that personal knowledge,” says Dan.
Callahan adds that site-specific privileging might be the best route if not all hospitals in a given system provide the same services. “If Hospital A doesn’t provide all the services that Hospital B does, you have to make those site-specific adjustments.”

**How do we reconcile credentialing standards?**

It is quite possible that the acquired facility will be subject to the acquiring hospital’s credentialing standards. At Advocate, although each of its 12 medical staffs are independent and have separate medical staff bylaws, they all must abide by systemwide credentialing standards. For example, the system requires all physicians to be board-certified, regardless of the facility at which they primarily work. When Advocate acquired another facility, it allowed the acquired physicians two years to become board-certified.

**How do we combine medical staff leadership?**

Medical staff leaders at the acquired facility can assume they will no longer hold their medical staff leadership positions, at least in the same capacity they have in the past. However, that doesn’t mean they will be left out in the cold.

During the acquisition or merger process, the acquiring facility would be smart to include the medical staff leaders of the acquired facility in discussions. “We were very deliberate when engaging the medical staff leadership up front through the process,” says Dan of Advocate’s most recent acquisition. “We had open forums for the medical staff so people could come and say what was worrying them to the senior leadership of Advocate.”

Similarly, NorthShore engaged members from both sides of the merger; it created a task force made up of medical staff leaders and MSPs from both parties. “We would meet regularly and vet some of the anticipated problems,” says Bradford.

After the merger, it is important to continue to include the medical staff leadership from the acquired organization. Advocate has a council made up of the medical staff presidents of each of its hospitals that meets monthly. During those meetings, Advocate’s CEO and other leaders at the system level share system-level initiatives with council, and the council members offer their input.

According to Dan, Advocate’s job is to set high-level initiatives, but it gives medical staff leaders at each of its facilities leeway regarding how they choose to meet those standards. “We respect the diverse markets and communities. We are not a system that rubber stamps and standardizes local healthcare delivery,” he says.

At NorthShore, which is made up of several facilities but a single medical staff (and thus one peer review committee, one pharmacy and therapeutics committee, etc.), medical staff leaders at the acquired facilities were asked to participate in system-level leadership activities. For example, the former chair of the pharmacy and therapeutics committee at an acquired hospital was asked to become a member of the pharmacy and therapeutics committee at the system level.

**How do we handle physicians with exclusive contracts?**

If the acquired hospital has an exclusive contract with an anesthesiology group, and the system acquiring the hospital has an exclusive contract with another anesthesiology group, which contract survives the merger or acquisition?

“What typically happens is that the doctors at the merged hospital have the opportunity to join the group that is contracted with the system, or the contract with the hospital being acquired is terminated,” says Callahan.

The situation is similar to when a hospital brings on an exclusive contract group and then offers the existing independent medical staff members the opportunity to join the group or resign from the medical staff.

Decisions regarding exclusive contracts are not in the medical staff’s purview. Rather, it is a business decision that the administration of the facilities involved in the acquisition or merger must make.

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To protect the rights of the physicians, the exclusive contract will detail how much notice medical staff members should receive of any possible termination and the process for termination.

Do we merge MSSDs, too?

If the acquiring hospital and the acquired hospital create a single medical staff, it is likely that they will also create a single MSSD. The unfortunate truth is that, as with any merger or acquisition, some MSPs may lose their jobs.

NorthShore does not have a separate MSSD in each facility. Rather, it conducts its credentialing activities from its corporate headquarters. After its most recent acquisition, the MSSD at the acquired facility shut down.

Some physicians in the acquired hospital had a difficult time adjusting to the absence of an MSSD. Many were used to getting their questions answered in person and working directly with MSPs on projects. To make the transition easier, NorthShore assigned one or two MSPs to each department.

“"If you are a physician in family medicine, you are always going to deal with the same [MSP] in my department, so there is that consistency," says Bradford.

The MSSD of the acquiring facility must consider a few factors when absorbing another MSSD, including electronic versus paper systems, data integration, collaboration, and reappointment.

For example, the acquiring hospital may have a paperless system, but the facility being acquired may still be using a paper-based system. The leaders of both MSSDs must collaborate to decide what papers to keep and what to archive. The acquiring facility also must decide what data to integrate into its electronic system.

“You have to ask yourself, ‘Is the quality of the data okay?’" says Bradford. If the data of the acquired facility are out of date or not as comprehensive as the acquiring facility’s data (e.g., the acquired facility failed to update physicians’ continuing medical education training), the acquiring facility may need to fill in some documentation gaps.

During the months leading up to the acquisition, Bradford trained MSPs at the acquired facility how to use NorthShore’s electronic system to help the facility get a jump start on inputting credentialing, privileging, and demographic data.

It’s always a good idea for MSP leaders at the acquiring facility to start working with the MSPs at the facility being acquired several months prior to the merger or acquisition date. This allows the acquiring facility to learn the other facility’s processes and gauge how the puzzle pieces fit together. However, there may be some barriers to work around.

For example, Bradford recalls being allowed to view the bylaws of the facility being acquired, but she could not view the physicians’ credentials file until much later in the process. “"Legally, we weren’t allowed to do that," she says. "It was more of an information-sharing exercise so I could get a feel for how that office ran."

Bradford says the biggest difference between NorthShore’s and the acquired facility’s MSSDs is the reappointment schedule. The acquired facility reappointed a group of physicians every month, but NorthShore is too big to handle that reappointment schedule. “"We have over 2,000 doctors, so we have two cycles every year," she says. As a result, NorthShore coordinated those monthly reappointment schedules into its semiannual schedule.

We allow AHPs on our medical staff, but the other facility doesn’t. What do we do?

The acquired facility must abide by the acquiring facility’s policies regarding whether AHPs are considered members of the medical staff. For example, the facility that NorthShore acquired allowed various AHPs on their medical staff, but NorthShore does not. It only allows physician assistants and advanced practice nurses, by corporate policy. Because the smaller facility was
absorbed into the NorthShore system, it had to abide by NorthShore’s policies; thus, some AHPs at that facility, such as clinical assistants, were not allowed on the medical staff.

“That was the biggest differentiation between our bylaws and theirs,” says Bradford. Hospitals tend to vary on their policies regarding AHPs because The Joint Commission (formerly JCAHO) and other accreditation organizations do not dictate whether hospitals should allow AHPs on the medical staff.

Our facility is Joint Commission–accredited, but the other facility uses DNV. Do we need to change accreditation providers?

Medical staff and administrative leaders must decide whether it is more beneficial for the parties involved to maintain separate accreditation providers or adopt the same one. “Arguably, if you applied the same standards across the board, you would be in compliance with The Joint Commission, Healthcare Facilities Accreditation Program, and DNV,” says Callahan.

Although the standards are similar between the three providers, differences exist. For example, The Joint Commission requires reappointment every two years, whereas DNV allows for three years. Medical staff and administrative leaders must take these differences into account when deciding whether to require all facilities to use the same accrediting agency. Keep in mind that this decision may be based on the organization’s culture and familiarity with the various accreditation standards. Leaders should involve MSPs from the start, as they have a solid grasp of these standards.

Should all the facilities under our umbrella have the same Medicare provider number?

Generally, one Medicare provider number equals one medical staff. For example, if a system puts all of its hospitals under the same provider number, it technically has only one medical staff for the entire system. Systems such as Advocate can also allow each site under its umbrella to have its own Medicare provider number, meaning each site has its own medical staff.

How hospital systems structure their Medicare provider numbers is the chief financial officer’s responsibility and comes down to what will make the hospital more money, Callahan says. If Hospital A acquires Hospital B and Hospital A has a higher Medicare rate, it may make sense for Hospital B to adopt Hospital A’s Medicare provider number so both facilities can benefit from the higher rate.

“If you run the numbers and figure out you are going to lose $2 million in reimbursement, it doesn’t make any sense to change provider numbers,” he says.

Merging medical staffs isn’t easy, and your facility may face some lofty challenges, but these tips should provide you with a solid foundation to make the process as smooth as possible.
It seems like an unwinnable game of cops and robbers. Physicians demand to be compensated for ED call, and the hospital refuses to meet those demands because it will eat the bottom line. Physicians retort with threats to cease providing service if the hospital does not meet their demands, and the hospital shoots back with threats to employ physicians, thus creating competition with independent members of the medical staff.

Like many hospitals, contention regarding ED call at Fairfield Medical Center in Lancaster, OH, was just a symptom of deeper systemic problems, and Fairfield almost lost its OB service before the problems were diagnosed and treated.

Dilemmas and deals

Fairfield’s medical staff is made up primarily of independent physicians in solo practice or small groups. Several years ago, these physicians dismissed the hospital’s offer to hire hospitalists for fear that the hospitalists would intrude on the businesses that they worked so hard to build. However, they soon changed their tune when the ED call burden became too heavy to carry.

“Over three years, we saw physicians wanting to get more into broad call groups or delegate their practice call coverage—not their unassigned—to the larger groups who wanted to do in-house work,” says Mina Ubbing, CEO of Fairfield.

To alleviate fears of hospitalists stealing the independent physicians’ patients, Fairfield hired an external group of physicians that practiced in-house to cover adult primary care cases; none had private practices. Although it helped family practitioners with their ED call schedule, physicians in other specialties began asking, “What about me?”

Soon thereafter, OBs approached Ubbing, demanding that the hospital hire a laborist (an OB hospitalist) to cover their late night deliveries. “The cost of the laborist for a hospital that does 1,000 deliveries a year, the majority of which are Medicaid, is just not practical,” says Ubbing.

The hospital hired a single OB but learned the hard way that it wouldn’t help the situation. Rather, independent OBs felt that because the employed OB got paid regardless of whether he or she was called to the ED, independent OBs felt they should also get paid for taking ED call. It wasn’t long before the independent OBs laid down the gauntlet and threatened to stop taking emergency call unless they received compensation.

“We thought our choices were to shut down the OB service or to keep the service and pay for call. We didn’t feel like it served our community well to deliver babies in the ED, so we agreed to pay,” says Ubbing.

Within hours of agreeing to pay OB for call, Ubbing received a petition signed by physicians from nine other departments demanding to be paid for ED call. “Quick math on the nine specialties would have cost us more than our bottom line,” she says.

Although it was not administration’s intent to conduct an under-the-table deal with OB, the medical executive committee perceived it as such.

Assigning a dollar value to ED call burden

It took a committee of 20 people and several meetings over eight weeks to come to an ED call compensation resolution that everyone at Fairfield could accept. It also took the wherewithal of a handful of physician champions to lead the way.

“I helped serve as a voice of reason because some of the other departments were being less than reasonable in terms of their expectations of what the hospital could and should provide for coverage,” says Robin Rhodes, MD, FAAP, former chair of the pediatrics
Physicians viewed their relationship with the hospital as an adversarial one, rather than a partnership.

The consultants also found that many of the grudges that fed misalignment were decades old. With the help of a mediator, all parties decided that although some issues still needed to be resolved, they would agree to let the past go.

Before the organization could work on resolving past issues and aligning physicians with its financial and operational goals, it needed to keep its word on previous promises. For example, the OB physicians expected the hospital to nullify their contracts and pull them into another ED call compensation model.

“I had an opportunity to make an announcement in front of everyone that we honor our existing contracts. That was a moment of credibility and truth, and it helped,” said Ubbing.

Ubbing framed the alignment effort as “getting to ‘we.’” If Fairfield couldn’t align physicians with its financial and operational goals, it couldn’t afford to pay physicians for ED call, she says.

“The point the hospital made was that this needs to be a give-and-take. If the hospital is going to pay for ED call, the physicians need to contribute to the bottom line,” adds Rhodes.

The organization began looking for ways for physicians to partner with the organization, such as reducing length of stay or ordering lab work at the hospital instead of an outside vendor. “We looked for mutually satisfying arrangements whereby the hospital benefits, the patients benefit, and the physicians benefit from streamlining care,” says Rhodes. For example, if a physician has a higher-than-average length of stay, that physician is encouraged to compare his or her practices to those of peers and find ways of practicing more efficiently.

In the end, an ED call compensation package that was sure to put the hospital in the red was doable thanks to better performance resulting from alignment. “The fact that Fairfield is a strong medical center that attracts a broader base of payers helps physicians be more successful,” says Rhodes.

Getting to “we”

Greeley consultants interviewed medical staff members, board members, and administrative staff to get to the bottom of the contention over ED call compensation. They found that lack of alignment was the real issue. Physicians who weren’t being affected significantly in terms of the number of times they were being called or how onerous the interaction was were sometimes being the most demanding in terms of reimbursement.”

To find out just how much burden each specialty shouldered, Fairfield, with the help of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, collected two weeks of ED data for each specialty. (See “ED burden of call by specialty” on p. 8 for a sample breakdown.)

“We performed a detailed analysis of medical records for all patients coming into the ED, along with coding what the physicians did by CPT [current procedural terminology] code and payer, to determine for each specialty precisely what the burden of call is and how much physicians are likely to bill and collect for what they did,” says Richard A. Sheff, MD, CMSL, chair and executive director of The Greeley Company.

The analysis included frequency of call, intensity of physicians’ tasks when on call, malpractice liability risk, and follow-up referrals to physicians’ offices.

Analyzing data in this way enabled Fairfield to assign a dollar value to the level of burden for each specialty. For example, “The GI doctor doesn’t have to come in right away, but the pediatrician for the emergency C-section has to be within 10 minutes of the hospital the whole time they are on call,” says Rhodes.

Fortunately, the numbers Fairfield determined were close to the numbers reported in the Medical Group Management Association’s Physician Compensation and Production Survey. Having that external data helped mitigate emotion and ground physicians whose perception of their ED call burden might have been skewed.
## ED burden of call by specialty

<table>
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<tr>
<th>Specialty</th>
<th>Distinct MDs coded (study period)</th>
<th>Monthly average specialty case count</th>
<th>Monthly average RVUs delivered</th>
<th>RVUs per specialty case</th>
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Create a culture of tolerance

Inclusive antidiscrimination language in medical staff bylaws offers legal protections for LGBT physicians

As of July 1, The Joint Commission added antidiscrimination language into the medical staff chapter of the Comprehensive Accreditation Manual for Hospitals (CAMH). Previous antidiscrimination language was deleted in 2003 because the accrediting organization believed it to be covered elsewhere in the CAMH, but it later realized that additional language was necessary.

The reintroduced antidiscrimination language prohibits discrimination in the granting of medical staff membership and clinical privileges based on gender, race, creed, and national origin. However, it does not address sexual orientation or gender identity.

“At this time, there are no plans to address sexual orientation in the medical staff standards,” said Kenneth Powers, media relations manager at The Joint Commission, in a written statement to HCPro.

The Joint Commission’s (formerly JCAHO) silence on the issue begs the question, “Is antidiscrimination language pertaining to sexual orientation and gender identity necessary to include in the medical staff bylaws?”

Benefits of inclusive language

With more physicians seeking employment arrangements with hospitals, hospitals may wish to demonstrate through policies and bylaws that they base their credentialing and privileging decisions purely on a physician’s competence and clinical abilities to avoid employment discrimination lawsuits.

Even for nonemployed physicians, antidiscrimination language in the bylaws is important, as it sets a tone of tolerance throughout the organization.

In addition, although a hospital may not directly employ a physician, if a physician files suit because he or she believes that he or she was denied medical staff membership or clinical privileges because of sexual orientation or gender identity, the court (depending on the state and specific circumstances) may find that the hospital was acting as an employer and impose employment laws, says Tara Borelli, staff attorney at Lambda Legal in Los Angeles. Legal issues pertaining to employment are subject to the Civil Rights Act of 1964, which aims to prevent discrimination in the workplace.

Moreover, inclusive policies and medical staff bylaws language sets the stage for good patient care, because discrimination can prevent patients from speaking up. For example, if a patient overhears a physician make a discriminatory remark about a gay coworker, the patient might hesitate to tell the physician that she is a lesbian.

“When medical providers don’t have that information, they might be missing a key piece of information that might help them look for particular risk factors or keep other medical considerations in mind,” says Borelli.

The best place for antidiscrimination language is in your hospital’s human resources policies and in the medical staff bylaws. The Joint Commission’s limited antidiscrimination language is located in standard MS.06.01.07, element of performance (EP) 3 (granting of privileges) and MS.07.01.01, EP 4 (medical staff appointment). Strive to establish inclusive antidiscrimination language in the sections of your medical staff bylaws that correlate to those two standards.

Current LGBT protections

The discrimination protections afforded to the lesbian/gay/bisexual/transgender (LGBT) community are limited, but they do exist. If your hospital and medical staff choose to establish inclusive antidiscrimination language in policies and bylaws, it is important to know what other protections are out there:

► Federal law. According to Borelli, there are no federal employment protections specific to sexual
orientation or gender identity. The Civil Rights Act protects against employment discrimination based on race, color, religion, sex, or national origin, but does not include language specific to sexual orientation or gender identity. However, it is a hallmark standard to refer to when drafting antidiscrimination language in your own medical staff bylaws. Check out the Equal Employment Opportunity Commission’s website (www.eeoc.gov) to learn more about equal opportunity and antidiscrimination laws.

➤ State law. Some states include sexual orientation and gender identity in their antidiscrimination statutes, but some do not, so check with your local state employment laws to see what protections are afforded the LGBT community.

➤ The AMA. The AMA updated its policies in 2007 to include sexual orientation and gender identity. Currently, its policy states, “Membership in any category of the AMA or in any of its constituent associations shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status, or professional activities.”

➤ The Healthcare Equality Index. More healthcare institutions are including sexual orientation and gender identity in their human resources policies and/or medical staff bylaws. According to the Healthcare Equality Index (HEI), an annual report issued by the Human Rights Campaign, more hospitals are adding language pertaining to sexual orientation and gender identity in policies for both patients and employees. The HEI measures hospitals on several criteria, including language related to the following:
  – “Sexual orientation” in patients’ bill of rights and/or nondiscrimination policy
  – “Gender identity” in patients’ bill of rights and/or nondiscrimination policy
  – Equal visitation access for same-sex couples
  – Equal visitation access for same-sex parents
  – LGBT cultural competency training for staff
  – “Sexual orientation” in equal employment opportunity policy
  – “Gender identity” in equal employment opportunity policy

“Having language to protect the LGBT community in the medical staff bylaws is a point of competitive advantage. It benefits the hospital to say, ‘We have a perfect score on the Healthcare Equality Index,’ ” says Rebecca Allison, MD, president of the volunteer board of directors of the San Francisco–based Gay and Lesbian Medical Association.


Better to be safe than sorry

Some legal experts argue that with all the protections listed above, it isn’t necessary for medical staffs to include antidiscrimination language in the bylaws. “What The Joint Commission has done is try to reemphasize that you can’t discriminate in your credentialing process,” says James “Mac” Stewart, Esq., with Stewart Stimmel, LLP, in Dallas. “I think most medical staffs are aware—even without The Joint Commission saying it—not to run afoul of the Civil Rights Act because they lose their immunity.”

Another reason specific language in the bylaws may be unnecessary is that a physician’s gender identity or sexual orientation aren’t revealed during the credentialing process, which is based on the physician’s credentials and practice experience. The medical staff might not even meet a physician candidate until after he or she has been credentialed and granted medical staff membership and clinical privileges. In short, the topic doesn’t come up often, thereby making the antidiscrimination language moot.
Regulators prohibit medical staffs from terminating a physician’s medical staff privileges or medical staff membership or reporting a physician to the National Practitioner Data Bank for reasons unrelated to clinical competence. Therefore, terminating a physician on the basis of his or her sexual orientation or gender identity puts the hospital at risk of losing its accreditation status.

“No hospital is forced to adopt [antidiscrimination] verbiage into their bylaws as far as the medical staff is concerned,” says Allison. However, she feels a sense of security knowing that her employer, CIGNA Healthcare, has inclusive antidiscrimination policies. “The risk that someone who has a problem with gay or transgender people could come along and put my job in jeopardy would be very real if those protections were not in place,” Allison says, adding that inclusive bylaws language may give other physicians the same sense of security.

Put policy into action

Medical staffs that opt to include antidiscrimination bylaws language addressing sexual orientation and gender identity must put mechanisms in place to enforce it. The first step to enforcing the language is to develop an effective grievance procedure, says Borelli.

“Because this is a hospital corporate compliance issue, I recommend that concerns go through medical staff leadership directly up to both senior management—CMO/VPMA and CEO—and the medical executive committee to discuss. The hospital’s legal counsel and corporate compliance officer will be involved,” says Jonathan H. Burroughs, MD, MBA, FACPE, FACEP, CMSL, senior consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA.

In addition to internal steps, physicians who live in states that have antidiscrimination employment statutes may also choose to follow the grievance procedures offered by the state. “In some states, the physician can bring the grievance directly to the court, and in other states, they have to go through a process called ‘exhausting administrative remedies,’ ” says Borelli.

Allison says that it is also helpful for a heterosexual member of the medical staff to champion the enforcement of the antidiscrimination policy. During medical staff meetings, that champion can briefly remind medical staff members of the policy and behaviors that are not acceptable, such as jokes or inappropriate comments about LGBT people.

“It is important to have allies in the straight community. Such allies may be able to influence the opinions of those who might not otherwise accept and support gay physicians,” she says.

Definition of terms

Medical staffs will draft better antidiscrimination bylaws language and be able to enforce policies more effectively with a full understanding of terms relating to the LGBT community. The Gay and Lesbian Alliance Against Defamation’s (GLAAD) Media Reference Guide, Eighth Edition (available for download at www.glaad.org), offers a list of offensive terms to avoid along with the following definitions of appropriate terms:

**Sexual orientation:** The scientifically accurate term for an individual’s enduring physical, romantic, and/or emotional attraction to another person.

**Gender identity:** One’s internal, personal sense of being a man or a woman. For transgender people, their birth-assigned sex and their internal sense of gender identity do not match.

**Gender expression:** External manifestation of one’s gender identity, generally expressed through “masculine,” “feminine,” or gender-variant behavior.

**Transgender:** An umbrella term for people whose gender identity and/or gender expression differs from the sex they were assigned at birth. The term may include, but is not limited to, transsexuals, cross-dressers, and other gender-variant people.

**LGBT/GLBT:** An acronym for lesbian, gay, bisexual, and transgender. Both acronyms are often used because they are more inclusive of the diversity of the community.

Choosing the right medical staff model
New medical staff models: Putting it all together

by William K. Cors, MD, MMM, FACPE, CMSL, senior consultant at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA

This column concludes a series devoted to the many medical staff models that have cropped up in recent years. This series has also discussed how you can implement these models in your own medical staffs.

During the past 12 months, we have examined physician-hospital organizations, joint ventures, clinical service lines, bundled payments, physician councils, clinical service lines, employment models, and best practices for self-governed medical staffs.

These models are all valuable in their own right when implemented and maintained correctly. Regardless of which model you employ, there are some key takeaway points for physicians and hospitals:

➤ **Use multiple models.** For the foreseeable future, most hospitals will manage multiple medical staff models simultaneously, including the ones discussed in this series, plus others as outlined in *The Greeley Guide to New Medical Staff Models: Solutions for Changing Physician-Hospital Relations*. The ability to successfully navigate these complex models is critical to better alignment between physicians and hospitals.

➤ **Pick a fair model that’s right for you.** Physicians and hospitals must thoughtfully and proactively analyze the various models and choose the ones that are right for them. Successful organizations acknowledge that one size does not fit all.

Medical staffs must create a strategic plan to help physicians and hospitals achieve great patient care, physician success, and hospital success.

Medical staffs must educate their members on the various available options. Make them aware that medical staff members will be treated fairly, but not necessarily equally, in terms of the business options the hospital offers. For many organizations, this represents a cultural change that the medical staff needs to address up front.

➤ **Don’t abandon the self-governed medical staff too soon.** The self-governed medical staff is a regulatory requirement that, if designed and nurtured appropriately, can be a true asset to the organization. Physicians are responsible for the quality of care they and their peers render, and they are able to influence many of the other functions in the hospital in which they have an interest.

➤ **Seek physicians with executive training.** Physician executives help make all models more effective because they help drive the changes necessary to succeed in an increasingly unforgiving environment. This is a primary reason why more organizations are seeking physicians with management expertise and training.

➤ **Embrace strong leadership.** Finally, regardless of which model(s) are implemented, all medical staffs require strong leadership. Successful organizations have invested in medical staff leadership development. In contrast, many hospitals that fail to make that investment desperately look for that leadership during a crisis, only to find that it just isn’t there.

Leland Kaiser, a healthcare futurist, stated, “All models fail and all models succeed. But we must have models.”

I hope that this series has stimulated discussion about moving your organization forward and leaving a legacy of great care and stakeholder success.
Although hospitalists are well aware of their programs’ resource utilization and case management goals, they may lose sight of those goals during the course of their busy days. They may feel like they need an extra set of arms and legs and a guiding voice to keep them on track.

To provide that extra set of arms and legs, hospitalist program leaders may want to consider implementing a dyad hospitalist model. A dyad model pairs a medical director who oversees clinical operations and high-level administrative initiatives with a nurse director who oversees day-to-day administrative operations.

The following describes the role of the nurse director and the results Reid Hospital in Richmond, IN, has seen since implementing the dyad model, including millions of dollars in savings.

What are the nurse director’s responsibilities?

Adding a nurse director position can result in significant improvements in efficiency. For example, a physician who doesn’t have the time to make alternate arrangements might allow a patient whose family is from out of town to stay in the hospital another day, whereas the nurse director might arrange for the patient to be discharged to a skilled nursing facility, where the cost of care is less. If a physician orders an MRI, the nurse might question whether a less expensive CAT scan would offer the same results.

“Doctors like to be independent and do things their own way, and they very easily wander off on their own path and have a little trouble keeping on track with organizational priorities,” says Thomas Huth, MD, vice president of medical affairs at Reid Hospital and Health Care Services. “The nurse director role is important to make sure that everyone is on task with the priorities.”

Nurse directors are generally RNs, although some have master’s degrees. Their clinical background is important to working with physicians, but they do not provide care to patients. Their main focus is coordinating care and services for patients served by the hospitalist unit—they do not assist non-hospital-based physicians.

“I think of the nurse director as wearing multiple hats. They are part marketing director, part schedule keeper, part liaison to other parts of the organization. But most importantly, they are the orchestra conductor who makes sure everyone is working together and has the same priorities,” says Huth.

Dyad hospitalist programs can assign work based on the number of staff members (e.g., one nurse director for every five hospitalists) or by patient volume (e.g., one nurse director for every 50 patients). Some programs with more than one nurse director assign each nurse to a group of physicians,
thus forming a continuous working relationship. Other programs assign the workload to the nurse directors as patients are admitted, regardless of who their physicians are, explains Kirk Mathews, CEO of Inpatient Management, Inc., (IMI) a St. Louis–based hospitalist consulting firm that worked with Reid to implement the dyad model.

Nurse directors supplement communication between hospitalists and practitioners in the community. For example, because nurse directors round with the hospitalists, if a PCP calls a hospitalist to discuss a patient and the hospitalist is not available, the nurse director can update the PCP on the patient’s status.

In addition to being the hospitalists’ shadow, nurse directors provide the hospital program with key marketing services. They reach out to community physicians who use the hospital program to obtain feedback and determine methods to improve the program’s performance.

They also reach out to physicians in the community who do not use the program to educate them on the benefits of referring patients to the program.

“One afternoon a week, our nurses are out in the field calling on physicians, educating them and their staffs about the benefits of the hospitalist program, and we’ve had outstanding results,” says Mathews.

Mathews says that IMI looks for nurse directors with significant case management experience and an understanding of payer relationships and contracts. Nurse directors should also have a thorough understanding of hospital operations because they interact with many departments within the hospital. For example, a nurse director might regularly communicate with admitting, radiology, laboratory, case management, and social services.

In addition to these attributes, personality is key to the nurse director role.

“You have to be really confident, have a thick skin, and not be afraid to stand up to the doctors. Not all nurses can fulfill that role,” says Huth.

What are the financial benefits of having a nurse director?

According to Huth, having two nurse directors for Reid’s 14-provider hospitalist program added about $1.5 million back into the hospital’s bottom line by:

➤ Reducing average length of stay by .75 days
➤ Reducing the average cost per case by $1,500
➤ Improving documentation for severity of illness
➤ Achieving 96% patient satisfaction scores
Increasing outpatient referrals to local primary care and specialty providers

Shifting some testing and procedures to the outpatient setting

Improving recruitment of outpatient-only PCPs

IMI has introduced the dyad model to existing programs many times, and hospitalists are inevitably skeptical.

“It is important in these cases that the nurse director takes the attitude of ‘servant leadership.’ When the physicians see how much leverage the nurse provides, the trust builds quickly,” says Mathews.

After the nurse director and the medical director establish trust, the medical director is often happy for the nurse to take on more responsibility.

Is the dyad model appropriate for hospitalist programs of all sizes?

The dyad hospitalist model can yield results in hospitalist programs of almost any size, says Mathews. However, it may not be as cost-effective in critical access hospitals as it is in community-based or academic hospitals.

“We have typically not staffed critical access hospitals with hospitalist programs, and the application of a nurse director in that setting might not be feasible financially,” he says. “But we have programs in small hospitals that only have two full-time hospitalists, and the nurse directors there are paying for themselves.”

The dyad hospitalist model might not be the perfect solution for every hospitalist program, but this model or a version of it may help your hospitalist program achieve the efficiencies it has been striving for.

Does adding a nurse director change the culture of the hospitalist program?

Having a nurse director serving side by side with the medical director poses cultural challenges. Physicians who are accustomed to a hierarchical relationship with nurses must adjust to a collegial relationship. For Reid, the transition was made easier by the fact that its hospitalist program was brand-new; Huth wasn’t introducing the nurse director role into an established program.

“What helps is for me and for IMI to be constantly affirming that this is the reality: The nurse director’s job is to question things,” says Huth.

Plan a successful transition to geographic units

Editor’s note: The July HLA discussed the benefits of geographic units. This month, we continue the conversation about creating a successful plan to avoid potential pitfalls.

Although some hospitalist programs have embraced unit-based patient care delivery methods (known as unit-based rounds, or geographic units) to reap the benefits of greater physician-nurse communication, increased efficiency, and more personalized patient care, others have dismissed the idea. They believe that although the benefits look nice on paper, unit-based rounds just don’t fit their program’s culture. “People like the idea, but changing the culture seems daunting to them, so they don’t try it,” says Burke Kealey, MD, FHM, associate medical director of Health Partners, headquartered in Minneapolis.
Geographic units < continued from p. 3

One of the biggest hurdles hospitalist programs face when implementing unit-based rounds is the unequal distribution of patient volume. For example, one hospitalist in the pediatric unit might be assigned 20 patients, but another hospitalist in the cardiac unit might only see 12 patients.

Another drawback has to do with academic settings. Creating geographic units may limit the breadth of clinical exposure residents receive.

“When you go to a geographic model, you naturally start segregating patient types so that they better match nursing skill levels,” says Kealey. “You may end up with a [resident] who is supposed to be there for general medical experience, but ends up spending a month on the oncology unit.”

However, such challenges aren’t insurmountable. The following four steps will help your program transition to geographic units smoothly.

Step 1: Collect data

The first step is to demonstrate to stakeholders, particularly hospitalists, that the current patient care delivery model is less than ideal.

“For us, that was doing some baseline data collection, and we found that nurses and physicians frequently do not know each other’s names and they did not communicate with one another about their patients’ plan of care,” says Kevin O’Leary, MD, MS, associate chief of the division of hospital medicine at Northwestern University Medical Center in Chicago. “It didn’t take long to convince people that we needed to take some steps to get physicians and nurses on the same page.”

Step 2: Meet with stakeholders

The second step in ensuring a successful transition to geographic rounds is to gather all stakeholders together regularly. Stakeholders include hospitalists, bed assignment specialists, ED physicians, residency program managers (if applicable), and nurses.

The transition requires the bed assignment process to change to a system in which a patient is assigned a bed first and a physician second, rather than vice versa. Therefore, it is important to involve everyone who plays a role in the admission process.

Plan for the transition to take three to four months, says O’Leary, and start meeting with stakeholders several months before the launch date. After the launch, stakeholders should continue to meet to discuss improvements and drawbacks and tweak processes when necessary. “You shouldn’t expect it to be perfect right off the bat. There may be revisions needed,” he says.

Step 3: Track progress

The third step is to keep track of your program’s progress and share those results with stakeholders during the post-launch meetings so that they can see their efforts pay off.

For example, in O’Leary’s study, “Impact of Localizing Physicians to Hospital Units on Nurse-Physician Communication and Agreement on the Plan of Care,” published in the August Journal of General Internal Medicine, results showed that after switching to unit-based rounds, nurses and physicians more often correctly identified one another and reported more frequent communication.

Step 4: Set goals

The fourth step is to aim for a reasonable goal. Hospitalist program leaders should not strive to assign 100% of patients to a geographic unit. Assigning 85% of patients to localized units is reasonable, but even if you only get to 50%, it’s still an improvement, according to O’Leary.

“Some of our units are only 50% localized, where the hospitalist is in one of two units. Fifty percent is still so much better than zero,” he says. “If you set a target that is unachievable, people think it is a failure if you don’t reach it, even though it has done a whole lot of good.”