

MEDICAL STAFF 2.0

Revolutionizing the Hospital-Physician Relationship



Introduction

To hit the mark on the “triple aim,” hospitals and physicians must together target improvements in quality and efficiency. Leaders must collaborate in new and imaginative ways, integrating business acumen and clinical expertise.

But first, we must deal with the 900-pound gorilla in the room: the archaic organized medical staff structure. Practically everything about this legal construct runs counter to collaborative relationships.

Under processes detailed in hundreds of pages of regulations, accreditation standards, and medical staff bylaws, a hospital and its medical staff are forced into opposing camps. Hospital leaders are required to police physician performance within the confines of due process requirements. While both the lay leadership and the professional medical staff share responsibility to assure the competence of the hospital’s medical staff, they are forced to awkwardly joust with one another to fulfill their respective duties.

In most cases, the parties spend more energy and time arguing about the rules and defining their respective roles than addressing alleged misconduct, much less pursuing opportunities for organizational improvement. The resulting tension and distrust poses significant obstacles to improving the healthcare delivery system to better address population health. Until hospital leaders and physicians find new ways to relate to each other, the enormous effort now underway to transform care systems will be stymied.

It’s time to parley under a white flag of truce. Hospitals and their physician staffs must be in aligned to confront change together.



Hospital vs. Physicians: Estranged Partners

Had we been deliberate in our approach, the healthcare industry could not have created a structure for hospital-physician interaction more antithetical to the best interests of our nation's healthcare system. Following World War II, physicians practicing independently in their offices sought a place where surgeries could be performed, babies birthed, and the medically ill nursed back to health. In most communities, physicians relied on the good intentions of local governments or the goodwill and investment of religious institutions to provide their workshops.

Focused on their clinical practices, physicians raised few objections to administrative staff managing hospital operations under the direction of a governing board typically composed of community leaders. As the number of professional lawsuits grew, however, the board needed the hospital's affiliated physicians to establish and enforce standards of care to ensure the clinical competency of those granted permission to practice at the facility. This left hospital administration to assume the role of policeman and prosecutor, monitoring physicians' performance in the hospital and bringing charges of misconduct to their peers. The board assumed the role of the jury, the adjudicator of disciplinary action.

Thus was born the organized medical staff, the formal structure through which the hospital's physicians make recommendations to the governing board regarding medical

staff membership and disciplinary action against members accused of having violated the community standard of care. Around this structure, a set of complex rules and regulations emerged and were institutionalized – at least initially intended to protect physicians from unfounded challenges to their clinical competence.

Given this inherent conflict between the hospital and its medical staff – the regulator versus the regulated – it should come as no surprise that physicians are frequently not included or inclined to actively participate in the hospital's strategic and operational decision-making. Physicians facing pressures from decreasing reimbursement and increasing regulation are often reluctant to volunteer for medical staff leadership positions. For those that are willing to serve, practice responsibilities leave little time for the education and training necessary to give them the tools to perform the work asked of them. Often, just as a physician leader gains sufficient experience to be effective in the medical staff leadership position, his or her tenure is over and the cycle begins again.

The Challenge

While the current medical staff model separates hospital administration from the medical staff and often puts them at odds with each other, the evolving healthcare industry is increasingly demanding concerted and collaborative action. The transformation of the healthcare system demands clinical efficiency and improved outcomes. **To thrive under new payment and delivery models, the traditional structure of the organized medical staff must be reorganized and integrated into the hospital's operational team.**

Hospitals + Physicians: Creating a Culture of Collaboration

The challenge, therefore, is developing a hospital/medical staff structure which assures the preservation of the fundamental functions required of the professional staff while promoting and sustaining a culture of collaboration that will take the healthcare delivery organism into the value-focused future.

Note the use of the word “organism” – a living entity composed of interdependent parts which cannot survive on their own. That word is chosen deliberately to contrast with today’s hospital organization, which is composed of various constituencies that do not necessarily share the same vision of healthcare delivery, nor work in harmony to deliver highly efficient and effective care. Shifting many hospitals from organizations composed of siloed component parts working together in limited ways to organisms of interdependent parts working in harmony requires substantial, if not complete, culture change.

Two things are required to overcome such a significant challenge to cultural change: (1) creation of sufficient motivation among key stakeholders to engage diverse personalities and talents in the hard work required by fundamental change, and (2) creation of an organizational structure and environment of trust within which to manage that change.

MARSHALING MOTIVATION

One might readily conclude the uncertainty in the healthcare environment would be sufficient motivation for all the players to frantically seek life vests as they and their organizations traverse the stormy seas of industry reform. Yet while the waters churn, some healthcare leaders have remained in what may be described as a state of semi-shock, knowing change is upon them, but uncertain which way to turn or which strategy to follow.

That state of anxiety certainly imparts a readiness to take action and implement a strategy, but significant education and engagement is the first critical step so that leaders are able to discern a path forward. An effective education process will convince key stakeholders that healthcare reform is real, it is happening now, and the pace of reform is accelerating. Education will reveal the demands of the new payment and delivery system and the consequences of inaction. Education will impress upon wise leaders the need to coordinate with other key components of the organization to find common solutions and leverage the diverse talents within the organization.

The education and engagement process needs to be focused, inclusive, and transparent. Articulation of the common challenges faced by physicians and administrators is key. Openness about the shared challenges and recognition of diverse talents each brings are paramount to the process of divining solutions.

The independent components of hospital operations can no longer be viewed as independent boats in an armada, traveling separately, but generally in the same direction. The new environment of healthcare demands all interdependent components of hospital operations be in the same boat, confronting the same challenges, sharing the same risks, all at the same time – a single organism.

The process begins with the collaborative articulation of the objectives of the process the hospital and its professional staff are undertaking together – an honest examination of how they can mutually define the future of the organism upon which they are both dependent for their professional success.

Administrators bring to the table knowledge of administrative and governance process, business acumen, access to capital, management capabilities, knowledge of organizational structure, political and community connections, and the ability to engage hospital staff to support the clinical operations directed by the professional staff. Medical staff members are in the unique position to define the parameters of the very function for which the organism exists – the provision of medical care. They are plenary licensed and have the broadest scope of practice of all the clinicians providing services to the organism's patients. All clinical activity provided for patients and communicated to patients flows through medical staff members.

Motivating the administrative and professional staff to action generally starts with the administrative leadership, with the full support and commitment of the governing body. Administrative leadership must convey its desire for concerted education and discernment and engage the medical staff in the urgency of their mutual undertaking. Administrators must be persuasive, demonstrating to physicians that the medical staff will be honored, trusted, and regarded as an essential partner in each step of the journey. They must empower the medical staff with real decision-making authority and input even as the administrative staff designs the process and provides the means to undertake the journey toward discernment.

BUILDING TRUST

The administrative leadership and governing board must first give trust to secure the medical staff's trust. The first step may be the simple recognition that trust has been broken and that affirmative steps are needed to repair it. Trust may have waned from indifference. It may have been damaged when shared plans don't materialize or mistakes are made. It may have been actually broken by betrayal and acts of treachery. Regardless, the status of the trust relationship

between hospital administration and the medical staff must be examined honestly and addressed forthrightly.

Even the most egregious breaches of trust can and must be confronted. Perhaps indifference is overcome simply by an acknowledgment and a pledge to do better. Mistakes and thwarted plans may require a more profound apology and discussion to fix. Obviously, rebuilding trust destroyed by a perceived betrayal requires much more time and effort to repair.

Developing trust is always a process, not an event. It must be reinforced with repeated and constant communication and transparency of process. Sometimes it requires an outside, independent agent to serve as counselor, intermediary, and mediator to help with the communication and to shield the two sides from inadvertent and hurtful words or actions. Trust can be erased in an instant if a promise is not fulfilled or an expectation goes unmet.

When reconciliation is required, the process must be structured and deliberate. Each step of the process must be carefully orchestrated. A structure for decision-making must be established and its rules of operation agreed upon. Decisions reached through mutual deliberation should be documented and reaffirmed to assure there is no misunderstanding. Building and keeping trust in the hospital/medical staff relationship, like any relationship, requires intentional hard work. Mutual success is impossible without it.

STRUCTURING FOR SUCCESS

When developing an organizational structure, form always follows function. The process of education and culture change described above is essential to gaining acceptance of a new way of doing business – recognizing that the professional and administrative staffs of the hospital organism are in the boat together and committed to row in the same direction. That process is essential to defining the “function” of the transformed organizational structure that will take the organism into the future and position it for success.

Regardless of the exact organizational structure ultimately created, the “form” of the reorganized organization will have two distinct components which directly address the hospital/medical staff relationship: (1) a professional oversight responsibility, and (2) a clinical integration capability. Each component must be separately organized and staffed, but both will have a fully integrated governance and reporting relationship with the hospital administrative staff.

PROFESSIONAL OVERSIGHT. This component will fulfill the current obligation of the medical staff as defined by law, regulation, and administrative standards to assure the quality of the medical staff and the clinical services offered at the hospital. Rather than a separate organizational structure governed and managed strictly by volunteer members of the medical staff, we suggest that the professional oversight responsibility be established as a department of the hospital and governed by members of the medical staff, the hospital administrative staff, and the hospital board. It should be permanently staffed by physicians who are trained and paid for their responsibilities to assure professional standards are consistently monitored and maintained.

Sharing the governance of this professional oversight function with the hospital board, administration, and the professional staff honors and institutionalizes the shared responsibility of those parties to assure the quality of the hospital’s professional staff. The medical professionals on staff would continue to perform credentialing and peer review functions and carry out quality and safety initiatives instituted on behalf of the hospital.

The physicians engaged in this activity would continue to represent the professional staff, but they would work in harmony with administration to achieve the organism’s overall objective of providing high quality, efficient clinical services. Those physician leaders, as employed members of the hospital administrative staff, would bring stability and professional acumen to this critically important organizational activity. Such physician leadership is now emerging in larger

hospitals and systems. Educational programs designed to train physician leaders are being created and curricula are being designed to meet the demands of the evolving healthcare industry.

CLINICAL INTEGRATION. This second function of the restructured medical staff is fundamental to succeeding in the new value-based healthcare environment. To thrive as our healthcare economy transforms, hospitals must find a way to institutionalize medical staff engagement to develop and deploy protocol, improve outcomes, and reduce costs.



Full and effective engagement of the medical staff requires continued economic integration between the hospital and its medical staff. The organism must move beyond quasi-independent hospital/physician entities, competing for diminishing healthcare reimbursement. Rather, those competing entities must work in harmony to improve hospital and clinical operations. Shared processes will lead to shared efficiencies which will yield shared revenues and shared success for the hospital and the medical staff. The ultimate beneficiary will be the patient population they serve which will enjoy the fruits of coordinated care, reduced costs, and improved outcomes.

Operationalizing this function will require a governance structure that includes physicians and hospital administrators in an environment of trust—one which facilitates effective decision-making by giving participants a sense of balanced power, effort, financial investment, and benefit resulting from the mutual endeavor.

While much of the sense of trust is engendered through shared participation in governance, trust is truly institutionalized through the shared effort of creating the clinically integrated network (CIN). More than through board votes, clinical integration is accomplished through a common vision, executed through a robust committee structure. Clinicians must design the clinical process that yields the efficiencies and effectiveness underpinning success. Clinicians engaged in the hard work of the committees will feel a part of the organism that embraces them in the meaningful process that produces standardized protocol. As a result, they will be much more likely to own, implement, and enforce the protocols through collaborative professional processes.

MODELS TO EMULATE. Hospitals and hospital systems are still struggling to engage their professional staffs in collaborative processes, but some historical examples provide guidance. For years, the Kaiser Health Plan has coordinated separate hospital, physician, and insurance plan organizations working in concert to offer comprehensive, cost-effective health services to employer groups. The Cleveland Clinic and Mayo Clinic Health System also have succeeded in their respective markets as clinician-lead organizations.

An emerging model for hospital/medical staff organization was highlighted in our white paper “[From Zero to CIN](#),” published December 2013. It describes how Flagler Hospital in St. Augustine, Florida, created a clinically integrated network with its medical staff predominantly composed of independent community physicians. The process Flagler used to engage the 200+ physician members of its organized medical staff is similar to the process described above.

Flagler’s board and administration, challenged by community employers to offer more cost-effective services, in turn challenged its medical staff to develop a recommendation on how the hospital and physicians could become more integrated and produce the efficiencies demanded. The physicians initially worked within the medical staff structure to respond. Ultimately, however, they broke free of that organizational constraint, overcame long-standing conflicts and competition among the community physicians, and developed a proposal that created a new organizational structure co-owned and operated by the hospital and a large majority of those independent community physicians.

The hospital board accepted the physicians’ proposal and facilitated its implementation. The CIN which ultimately emerged, First Coast Health Alliance, combines the resources and expertise of the hospital and the physicians. The hospital provides management expertise, access to capital, experience with process, and administrative support. The physicians provide clinical expertise through committees focused on information technology needs, clinical guideline development and deployment, care coordination, and pursuit of contracts with health plans.



First Coast Health Alliance also spawned a new environment of collaboration within the Flagler healthcare community. For example, the CIN has been a vehicle for physicians to work directly with administration to measurably improve hospital efficiency, with the physicians sharing in the realized savings. The traditional medical staff organization remains intact to perform its traditional peer monitoring functions, but the CIN is the foundation for an integrated healthcare system designed to meet the challenges of the future.

Conclusion

The traditional medical staff organization has lost its relevancy; it is a dinosaur from a reimbursement and legal system that is being replaced by a system demanding value and collaboration. The competition and distrust inherent in the current system is antithetical to a reforming healthcare system which requires hospitals and their professional staff to work in harmony as an organism composed of interdependent parts.

To survive the challenges of healthcare reform, hospitals and physicians must climb in the boat together and learn to row, in the same direction, and in unison. Meeting that

challenge will require courageous, dynamic leadership that recognizes it needs all hands on deck to create and successfully pursue a vision for transforming the organization's culture. (See our white paper "[Dynamic Leadership for Dynamic Times](#)," published October 2014.) The administrative and clinical expertise that exists in the hospital organization must be harnessed, integrated, and motivated to overcome mistrust.

Hospital boards, administrators, and their medical staff must understand that their respective future success is inextricably co-dependent. Collaboration and integration of processes is the path to mutual success.

PYA can assist your organization in exploring and implementing a new medical staff model to promote clinical integration, quality improvement, and enhanced efficiencies.

To learn more, please contact:

David McMillan
dmcmillan@pyapc.com
(800) 270.9629

Jeff Ellis
jellis@pyapc.com
(800) 270.9629

Laura Bond
lbond@pyapc.com
(800) 270.9629

