The Leadership Institute RoundTable

Current Physician Alignment Challenges for Health Systems

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What is the current status of the “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

Is Unification of Medical Staffs Allowed?

2014 Updated CMS Medicare Conditions of Participation:

Allowed hospitals operating under a health system board to unify medical staff if:

- Permitted under state law
- Each constituent hospital's medical staff decides voluntarily to merge into a unified medical staff entity & 4 conditions met:
  1. The medical staff of each hospital must have voted by majority in accordance with its bylaws to join, or to opt out of, the unified staff;
  2. The unified staff must have bylaws, rules, and requirements describing its processes for self-governance, credentialing, peer review and due process and which have an opt-out mechanism;
  3. The unified medical staff must be established in a manner that takes into account each hospital's unique circumstances with respect to any significant differences in patient populations and hospital service;
  4. The unified medical staff must operate in a way that gives due consideration to the needs and concerns of all members of the medical staff, regardless of their practice or location, to ensure that local issues applicable to particular hospital are duly considered and addressed.

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

Why Combine Medical Staffs across Hospitals?

- Fewer silos and 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 and restructure physician leadership across all aspects of the integrated delivery system

Downsides to Medical Staff Consolidation

- Less focus on local hospital campus issues
- Fewer physicians engaged in the development of leadership skills
- Short-term political costs
- Creates a need to ramp up efforts at effective communication

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?

Credentialing Challenges Posed By "New" and "Young" Physicians

"When I was a boy of 14, my father was so ignorant I could hardly stand to have the old man around. But when I got to be 21, I was astonished at how much the old man had learned in seven years."

Mark Twain

"Doctor, have you any advice to offer a young man who would love to be a physician but whose crowded schedule simply doesn't permit time for medical school?"

How do hospitals assure newly graduated residents have adequate skills to perform in ‘the real world’?

Why Are ‘Late-Career’ Physicians A Concern?

- Demographic changes in the physician workforce
- A high percentage of doctors plan poorly for retirement and find it necessary to work longer than they would like
- A high percentage of late career physicians work part time and are thereby becoming ‘low volume’ practitioners
- Evidence links quality of care and patient safety concerns to late career practitioners
- Colleagues often reluctant to challenge the quality of a long-standing member of their medical community, either because they don’t want to tarnish that individual’s reputation at the end of his career or because such persons may be influential and often are in positions of seniority.

An Aging Physician Population

AMA estimate of number of active physicians in 2020 by age:

- > 65 years of age: 189,000 (18%)
- > 55 years of age: 409,500 (39%)

Hospitals Under Increasing Pressure To ‘Cut Corners’ When It Comes to Individual Physician Qualifications

Increasing Challenge of Physician

Recruitment & Retention

versus

Maintenance of Demanding Standards

for Competency & Quality

The Long Decline:

- Research suggests an inverse relationship between age and quality of performance.
- Over half the studies investigating age related performance of doctors find a very gradual decrease in clinical skill as one gets further from residency, with the decline accelerating after age 60.
- Additionally, state medical licensing board data show an increase in complaints and disciplinary actions for older physicians.

Physician's Self-Assessment

Meta analysis of physician self-assessment studies:

"A number of studies found the worst accuracy in self-assessment among physicians who were the least skilled and those who were the most confident. These results are consistent with those found in other professions."

Meta analysis conclusion:

"… the preponderance of evidence suggests that physicians have a limited ability to accurately self-assess. The processes currently used to undertake professional development and evaluate competence may need to focus more on external assessment.

- Davis, et. al. JAMA 2006: 296(9)

Traditional Approaches to Competency Assessment of Older Practitioners

- Almost none for outpatient practitioners
- Medical staff peer review for those holding medical staff privileges
- Focused assessments after poor care discovered: ordered by medical staff or a licensing body
- No proactive competency assessments unless attempting to return to practice and reactivate a license. Most people are surprised to learn that medicine is not regulated to protect the public from aging practitioners. This is unlike other industries (e.g. pilots) or practice in some other countries (e.g. mandatory retirement ages for surgeons).