

Medical Staff Briefing

A TRAINING RESOURCE FOR MEDICAL STAFF LEADERS AND PROFESSIONALS

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.

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—Michael Callahan, Esq.

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 soon as possible and allow them a grace period to become compliant, says **Carrie Bradford, RHIA, CPMSM, CPCS**, senior director of professional

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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 system-wide 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.

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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 by-laws 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. ■

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