How to Credential and Privilege in a Clinically Integrated Network (CIN)

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“Credentialing and Privileging for Clinically Integrated Networks (CINs)”

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September 19, 2016

The Healthcare Transformation Journey: Moving from a....

• ‘Sickness’ to a ‘healthcare’ industry
• ‘Fee for service’ to a ‘risk based capitation’ business model
• Cottage to a standardized industry
• Hospital/physician office to healthcare system (CIN)

Your New Healthcare System!
Large Employers are Driving these Changes!

1. Greater cost sharing from defined benefit to defined contribution towards purchase on public/private insurance exchanges
2. Create and contract through narrow/tiered networks for high quality/low cost providers
3. Provide disease management programs for high risk pool and health wellness programs for all to reduce costs and enhance productivity
4. Reference based prices for high cost procedures/care
5. Utilize navigators/registries to guide employees through the system
6. Create and contract through ‘centers of excellence bundled payment program

“Domestic Medical Tourism”

Walmart’s “Centers of Excellence” for all heart, spine, and transplant surgeries for its 2.2 million associates ($466.1 billion in revenues):

1. Cleveland Clinic, Cleveland, OH
2. Geisinger Medical Center, Danville, PA
3. Mayo Clinic in Rochester, MN/Scottsdale, AZ/Jacksonville, FL
4. Mercy Hospital Springfield, Springfield, MO
5. Scott and White Memorial Hospital, Temple, TX
6. Virginia Mason Medical Center, Seattle, WA

How did ‘Patients’ become ‘Consumers’?

• Cost/risk shifting from defined benefits to defined contribution ($338B (2014) to $413.5B (2019) out of pocket expenses)
• High deductible policies and health savings accounts (HSAs)
• Squeezed out of the traditional market (25% of disposable family income)
• Frustrated and ‘value starved’ from complexity, cost, and physician/hospital centered system
Consumers are moving forward...

Global competition for world class quality, safety, service at the lowest possible cost

Medical Tourism is the fastest growing industry in healthcare (2006-2012: $20 billion to $120 billion and expected to double every two years)

www.patientsbeyondborders.com

Typical story:

Paul H., Texas: Executive needing meniscus surgery of knee. Couldn’t find facility to do it under $32,000 or with epidural. Went to JCI accredited hospital in Monterrey, Mexico and paid $6,200 (including first class travel/accommodations/nursing) for Texas trained surgeon/anesthesiologist to perform procedure under epidural

What do you consider your service area? Your home town, your State, or the world?

Is there a difference in performance when physicians work together?

<table>
<thead>
<tr>
<th>Measurement</th>
<th>MHMD CI Physicians</th>
<th>Crimson-All Hospitals</th>
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</thead>
<tbody>
<tr>
<td>LOS</td>
<td>4.52 (5%)</td>
<td>4.74</td>
</tr>
<tr>
<td>HAIs</td>
<td>0.68% (91%)</td>
<td>7.56%</td>
</tr>
<tr>
<td>General Complications</td>
<td>1.24% (66%)</td>
<td>2.82%</td>
</tr>
<tr>
<td>30 Day Readmissions</td>
<td>5.92% (43%)</td>
<td>10.38%</td>
</tr>
<tr>
<td>Mortality</td>
<td>1.95% (23%)</td>
<td>2.52%</td>
</tr>
</tbody>
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Third party payers are moving forward

What AETNA did when it saw this data:
1. Requested to negotiate a new contract with MHMD
2. Offered a 8% increase in FFS payment with a guarantee of 3% next year minimum
3. With 10% movement of ‘share’ to the system, committed $7.5 million to physician pool and $8.0 million to system pool in bonuses
4. Committed to invest in a comprehensive marketing program to compete with United and BCBS

Even CMS is moving forward: Post SGR Physician Reimbursement Model (Medicare Access CHIP Reauthorization Act) or MACRA

<table>
<thead>
<tr>
<th></th>
<th>FFS</th>
<th>Advanced</th>
<th>Alternative Payment Models</th>
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<tbody>
<tr>
<td>2016-2018</td>
<td>0.5%</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>2019-2024</td>
<td>0</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>2025-2026</td>
<td>0.25% merit</td>
<td>5% + 0.75% merit</td>
<td>2019 differential: 5% between highest and lowest</td>
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More MACRA! MIPS = Measures for Quality, Resource Use, Clinical Practice Improvement, and Advancing Care Information

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<tr>
<th></th>
<th>FFS</th>
<th>Medicare Incentive Payment System</th>
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</thead>
<tbody>
<tr>
<td>2016-2018</td>
<td>0.5%</td>
<td>-4% to +4% (up to 8%)</td>
</tr>
<tr>
<td>2019</td>
<td>0</td>
<td>-5% to +5% (up to 10%)</td>
</tr>
<tr>
<td>2020</td>
<td>0</td>
<td>-7% to +7% (up to 14%)</td>
</tr>
<tr>
<td>2021</td>
<td>0</td>
<td>-9% to +9% (up to 18%)</td>
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Note: 2019 data based upon 2017 performance!
The New Reality

1. Average performance is not enough
2. Bottom decile performers will subsidize top decile performers
3. Top decile performers will earn disproportionate market share
4. Physicians must lead clinical + operational + financial performance with management support
5. Credentialing and privileging will need to reflect this 'higher' and more 'comprehensive' standard

Traditional Medical Staff-Hospital Relations

Physician Employment Led to This:
§ 482.12: Single Governing Board
§ 482.22: Single Medical Staff

- May have a single governing board for each hospital, one for the system as a whole, or a corporate board with advisory boards for each hospital
- Must have a single medical staff for each hospital
- There is an opportunity to standardize medical staff structures and processes, even with legally separate medical staffs (integrated and unified medical staff)

What is an ‘Integrated and Unified Medical Staff’?

HCA HealthOne, Denver, Colorado:
Eight aligned facilities (8 MECs and medical staffs, 8 advisory boards reporting to a single corporate board)
- One set of bylaws
- One set of credentialing/privileging policies/procedures with a single CVO
- One peer review process
- One OPPE/FPPE process and reporting structure (Organized Healthcare Arrangement (OHCA) under HIPAA)

Credentialing and Privileging Implications

- One set of credentialing and privileging criteria for each clinical specialty/sub-specialty (except in the case of exclusive agreements or ‘carve outs’)
- Different facilities have different acuities therefore are matched with different criteria (outpatient v. inpatient v. critical care)
- Each practitioner is automatically assigned as a member of all eight facilities
- Each practitioner is automatically privileged at every facility that s/he is qualified to be privileged at
**System Wide Committees ('Super Committees')**

- MEC (8 MS Presidents/CMOs/MSSPs) reports to corporate board
- Credentials (8 Credentials Chairs/CMOs/MSSPs) reports to system MEC
- Peer Review (8 PR Chairs/CMOs/MSSPs) reports to system MEC

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**Credentialing and Privileging is now a System Wide Activity**

- Inpatient and outpatient privileges
- Self-employed physicians must be aligned with the system/organization through some form of contractual arrangement! (co-management, professional services, medical director, leasing etc.)

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**What would Self-Employed and Employed Physicians be interested in?**

1. Enterprise partnership
2. Hospital based revenue (leveraged contracts)
3. Access to GPO (supply chain costs)
4. Access to IT (HITECH)
5. Revenue cycle management (RCM) support
6. Access to investment capital
7. Access to preferential referrals
8. Input/increasing control at the highest levels of the organization
What are the non-negotiable quid pro quos of such a partnership?

1. Standardize regulatory quality, safety, service and cost effectiveness
2. Work with management to drive down operating costs
3. Work with management to achieve strategic goals/objectives (e.g. service culture, population health etc.)

Key Issues with these Arrangements!

1. Cultural alignment (the relationship) precedes….
2. Economic alignment (the contract) precedes…
3. Clinical alignment (at risk contract)

Give Physicians a Choice to go ‘At Risk’:

• 90%tile MGMA
• 75%tile MGMA
• 50%tile MGMA: Minimum wRVU, quality, safety, service, cost-effectiveness expectations with a potential downside
• 25%tile MGMA
• 10%tile MGMA
Example of a management contract (ED):

- 50% base pay (10%tile MGMA compensation)
- 10% quality program and performance (2% bonus for every 20% departmental compliance with agreed upon quality targets)
- 10% patient satisfaction (2% for each 10%tile above 30%tile Press-Ganey departmental scores)
- 10% physician satisfaction (2% for each 10%tile above 40%tile for hospital survey of physicians)
- 10% corporate compliance (e.g. medical records) (2% for every 10% compliance over 50%tile)
- 10% evaluation by President MS and CEO (top potential pay – 90%tile MGMA compensation)

Credentialing Challenges in CINs:

- Delegated credentialing (or not)
- Clinical v. economic credentialing (participating agreements)
- Credentialing elements (TJC/DNV/HFAP/CMS v. NCQA)
- NPDB report when practitioner is excluded from a CIN entity (e.g. ACO) but not the medical staff
- MSO v. CVO (for CIN)
- Credentialing software-what to track?
- Delegated arrangements with health plans/payers

What are you measuring today for OPPE and FPPE?

- Core/SCIP measures?
- Compliance with clinical/functional pathways?
- Adverse behavioral or administrative events?
- Patient or administrative complaints/referrals?
- All deaths or complications?
- All unexpected returns to the….?

What is the challenge with all of these?
What is regulatory quality?

- Core measures
- SCIP measures
- Specialty specific measures (e.g. STS, ACC etc.)
- NQF ‘never events’
- Patient safety measures
- HEDIS measures

Why are these important and what do you want to do with them?

Hardwire regulatory quality!

- Clinical and functional pathways
- Standardize communications (e.g. SBAR) in high risk situations
- Manual checklists (pre-software)
- Decision support software and default functions
- Clinical and business analytics to monitor for variance (audit!)
- Many organizations are hitting 100% all of the time!

Regulatory quality is necessary and insufficient!

- You can no longer differentiate yourself based upon 100%tile for ‘core/SCIP etc. measures’; they are assumed and expected!
- Our increasingly mobile society will travel anywhere to find high quality and lost cost care
- How will you differentiate yourself from everybody else?
What is the typical 'disconnect'?

- There is little organizational alignment between the performance goals/objectives of governance, management, physicians, and staff.
- Performance measures have little to do with the major quality/safety/service issues.
- Executive management inadvertently incentivizes physicians to defeat the organization’s strategic initiatives (e.g. wRVUs).

Step 1: Create a MS Strategic Plan

- Co-authored by physician and executive leaders and approved by the governing board.
- Articulates and prioritizes key medical staff goals/objectives for the coming year and beyond consistent with organizational strategic priorities.

Step 2: Create a MS Operations Plan

- Audit the current organizational structures (e.g. committees, leadership skill set, time spent performing functions etc.) to determine if it will optimally serve the MS’ goals/objectives.
- Redesign the MS structures/processes to ensure optimal performance (outcomes).
- Create tactics to accomplish specific goals/objectives.
**Step 3: Articulate specific performance expectations**

- Categorize by performance dimension (e.g. patient care, professionalism etc.)
- Tie directly to prioritized strategic operational goals and objectives
- Should be specialty specific and generic
- Discuss at department/general/service line meetings to secure agreement and ‘buy in’
- All performance expectations should be memorialized in contracts

**Step 4: Create Performance Metrics with Targets**

- Delegate to MS Quality/Peer Review Committee with input from departments/service lines
- Separate those measures that will or won’t be considered for credentialing/privileging and peer review
- Ensure that metrics and targets are consistent with organizational strategy

**Step 5: Create MS and MS Committee Work Plans to support Performance**

- The work of the medical staff should be consistent with what it is trying to accomplish (present/future) not what it accomplished in the past
- All physician/physician leader performance should support and be supported by executive management and governance
Step #6: Measure Performance

- Ensure that data is credible before ‘going live’
- Best practice: Data Management Committee for larger organizations/systems
- Emphasis should be on trends and patterns and not on statistical significance

Step #6a: Imbed the Performance Management Process in all contracts!

- The medical staff bylaws should inform all contracts (e.g. “When the bylaws and contract are in conflict, the contract shall prevail”)
- The contracts should inform the medical staff bylaws (e.g. clean sweep provisions? etc.)
- Coordinate performance management between employer and medical staff

Step #7: Provide supportive and timely feedback

- Emphasis on improvement (PI) and not the identification of negative outliers (QA)
- Supportive, objective and data driven
- Collaborative between practitioner and physician leader (both should be accountable!)
- Address potential conflicts and conflicts of interest
- This requires training and expertise!
Step #8: Create Improvement Plans for Marginal Performance

• Does the practitioner understand the ‘why’?

• Measurable expectations with specific timeframe and mutual accountabilities

• Ensure support for individuals and the ‘system’ (self-fulfilling prophecy)

• Explicit positive and negative consequences for outcome

Step #9: Create MS Scorecards/Dashboards to Report Performance

• Part of the President of the MS’s monthly report to the board

• Part of OPPE/FPPE

• Remember to focus on both sides of the curve (hardwire outstanding performance and improve marginal performance)

• Performance may be appropriately reported within teams (e.g. hospitalists, service line etc.)

Step #10: MS Performance informs the Credentialing and Privileging process

• Part of the internal analysis to develop the updated credentialing/privileging policies and procedures

• Part of ongoing evolution of credentialing and privileging criteria

• Part of strategic medical staff development planning
Strategic medical staff development plan

Board approved policy that recommends the specific:

a. Numbers of practitioners for each clinical specialty
b. Qualifications required within each clinical specialty
c. Economic relationship within each clinical specialty (e.g., employed, member of service line, exclusive agreement etc.)
d. Organizational fit (e.g., organizational culture, values, goals, objectives)
e. Personal and professional fit (compatibility of practitioner with organization)

Economic Credentialing:

- The use of ‘non-competence’ related criteria for membership on a medical staff or in a healthcare organization
- Point of contention with AMA, physician groups, attorneys, and healthcare organizations (e.g., Murphy v. Baptist Health and Rosenblum v. Tallahassee Memorial Regional Medical Center, Friedman v. Delaware County Memorial Hospital-2009)
- Growing necessity due to evolution of ‘at-risk’ reimbursement methodologies (e.g., shared savings)
- Best approach is to always link ‘economic’ criteria to quality (e.g., utilization management), community need and maintain a clear moral compass with regard to patient and community interests

Sample ‘economic’ credentialing and privileging criteria

Cardiologist:

- Complete an accredited residency in internal medicine and two year fellowship in interventional cardiology
- Board certified in cardiology
- Employed by hospital based cardiology group and service line
- Willing to comply with all medical staff and organizational requirements
- Willing to adopt and utilize evolving evidence based clinical, safety, service, and cost-effective practices as determined by the cardiology group and service line
Sample ‘economic’ credentialing and privileging criteria

Family Physician:
• Complete an accredited residency in family medicine
• Board certified in family medicine
• Employed by hospital based patient centered medical home and integrated practice
• Willing to comply with all medical staff and organizational requirements
• Willing to adopt and utilize evolving evidence based clinical, safety, service, and cost-effective practices as determined by the PCMH and integrated practice

Work with your legal counsel!

• Can the board open and close categories of membership and clinical privileges on the medical staff based upon community need?
• Can the board restrict membership and privileges to those party to exclusive agreements and contracts?
• Can management create ‘clean sweep’ provisions in all practitioner contracts?
• Can the medical staff and board create credentialing/privileging criteria based upon willingness to comply with EBM and practices?

The High Performing Medical Staff:

1. Completely employed or contracted practitioners in a closed system
2. High level of professionalism/service with clear demarcation between professional and personal life
3. Professional leaders at all levels of the organization
4. Patient centric management environment with complete integration of operations and clinical services (support logistics + in/out patient services)
5. Consolidated system of high reliability, continual improvement, and elimination of non-value added variation
Many are “Raising the Bar”:

University of Virginia, Charlottesville, VA MS Bylaws:

“Any practitioner who does not embrace evidence based practices and a high level of professional conduct as determined by the clinical specialties and MEC is hereby ineligible to apply or reapply to this medical staff.”

What happens at reappointment?

Key Non-Negotiable Components of ‘At Risk’ Contracts with Physicians (Intermountain Health):

1. Be willing to participate in ‘at risk’ contracts based upon strategic goals/objectives developed and approved by physicians and management
2. Comply with clinical and business ‘best practices’ as determined by peer group/management (and be willing to be peer audited for exceptions)
3. Agree to un-blinded transparency of all clinical and financial data/analytics
4. Be willing to comply with value analysis process
5. Disclose all potential conflicts of interest and accept determination of deliberative physician bodies

General Principles:

1. Credentialing and privileging criteria should support your organization’s strategic quality, safety, service and cost-effective initiatives to promote health (not sickness)
2. Credentialing and privileging will be system wide (not hospital based)
3. Higher criteria for both membership and privileges may be established by sub-units of the organization
4. The credentialing/privileging process should play an active and proactive role in performance management (reappointment is too late!) to achieve optimal healthcare outcomes
5. Competency is no longer good enough!
6. The best is yet to come!
Thank You for Joining Us!
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