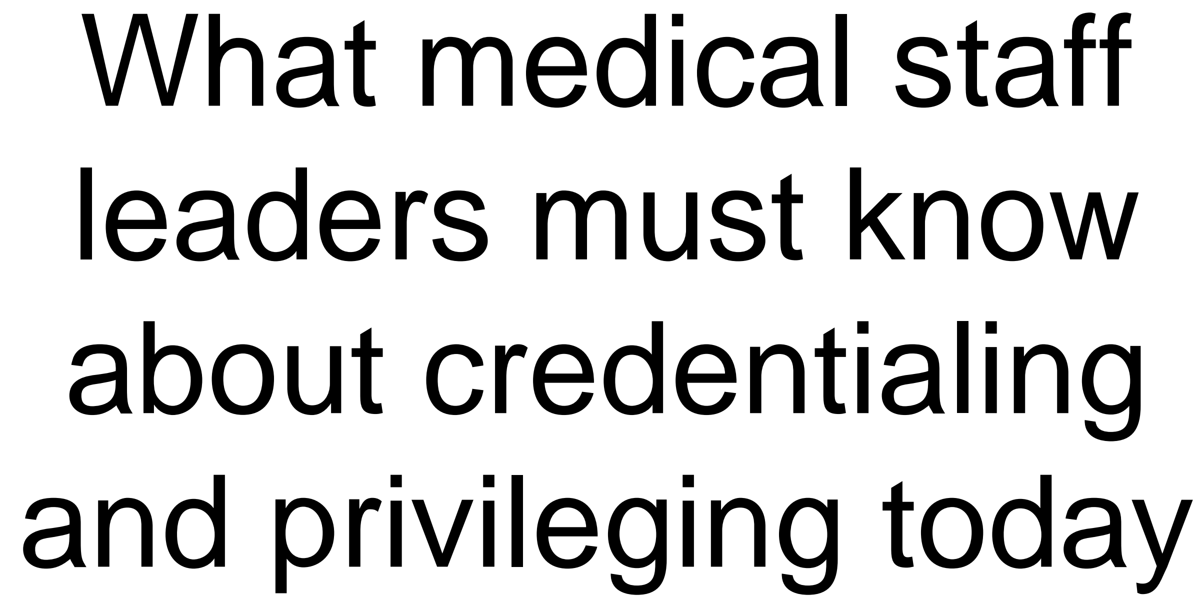
Medical Executive Committee Institute

Essential Training for All Medical Staff Leaders

Greeley
HCPro



Greeley HCPro

Case study

The medical staff president is called by a large group practice concerned that its new gastroenterologist needs to be credentialed by tomorrow so she can take call. It has already given her a signed contract and salary guarantee. The chair of the department has reviewed the file and found an unusually high number of malpractice cases.

What should the president do?

Credentialing principle #1

- Credentialing exists to protect patients.

Corollary

- Credentialing done poorly puts patients, doctors, and hospitals at risk!

What is the problem?
The facts

- Approximately 800,000 physicians in the United States
- 466,000 board-certified
- 100,000 awaiting board certification
- Approximately 50% sued for malpractice
- Thousands sued greater than 10 times
- Tens of thousands with license restrictions

The facts

- Thousands sanctioned by Medicare/ Medicaid
- Tens of thousands have received hospital disciplinary action
- Thousands convicted of felonies (fraud, homicide, drug possession/sales)
- Approximately 40,000 potentially impaired providers

THE *NEW YORK TIMES* BESTSELLER

Blind Eye

THE TERRIFYING STORY OF A DOCTOR WHO GOT AWAY WITH MURDER

UPDATED BY THE AUTHOR

"Chillingly thorough. . . . Wonderfully done. . . . An elaborate journalistic reconstruction that has the fascination of an acutely observed and troubling novel." —Lance Morrow, *The New York Times Book Review*

James B. Stewart

AUTHOR OF *DEN OF THIEVES* AND WINNER OF THE PULITZER PRIZE

What is credentialing?

- Verification of credentials to practice medicine
- Whenever feasible, information should be verified from the original or primary source of the credential (e.g., institution that issued the document)
- This is time and labor intensive but is an important requirement

What is privileging?

- What is a provider authorized to do to a patient?
- The challenge is to match privileges granted to demonstrated current competence
- The Joint Commission requires that privileging be an objective, evidence-based process

Case study

A busy orthopedist has hired a new PA. The PA begins accompanying the orthopedist on rounds, initially just following along. Then the PA begins taking out staples and changing casts. One day the PA writes an order for pain medication at the instruction of the orthopedist. The pharmacy calls the surgery chair to ask who the PA is and whether he or she has privileges to write orders.

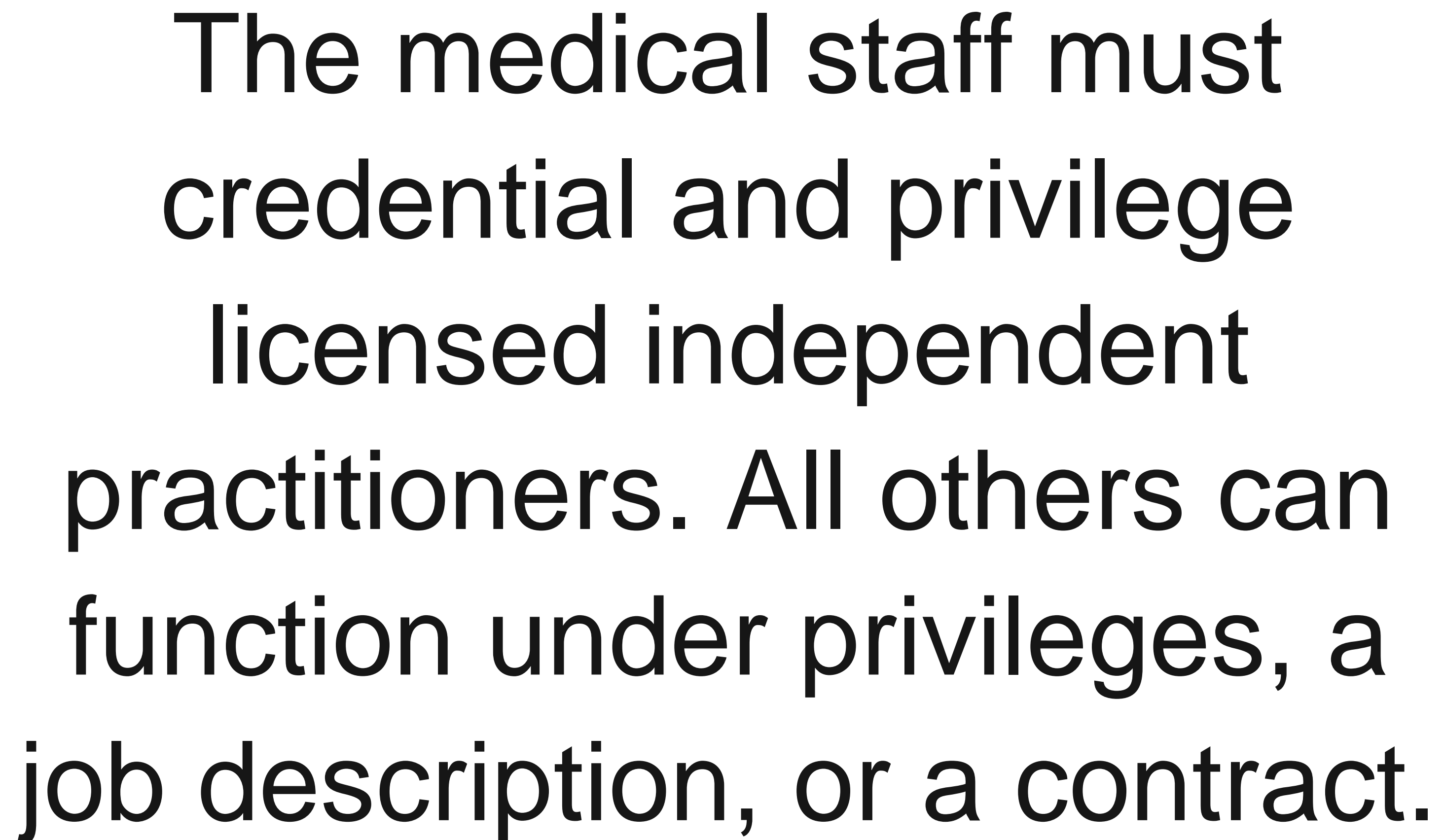
What should the chair do?

Credentialing principle #2

- Nobody works without a ticket!

Three kinds of tickets

- Medical staff privileges, with quality monitoring through the medical staff
- Job description, with supervision and annual performance evaluation
- Contract with scope-of-service agreement


The medical staff must credential and privilege licensed independent practitioners. All others can function under privileges, a job description, or a contract.

Case study

The medical staff president is called by the family practice department chair regarding a new applicant. She has reviewed the file and found several references with questions raised regarding the applicant's ability to exercise obstetrical privileges unsupervised.

What should the president do?

Credentialing principle #3

- Beware of the two types of credentialing errors:
  - Information errors
  - Decision errors

Credentialing errors

- **Information error:** Information existed that could have been known but wasn't, and the information would have impacted a credentialing decision
- **Decision error:** The necessary information was known, but leaders failed to make the wise decision

Corollary

- Resolve all concerns *to your satisfaction* before making any recommendations for membership or privileges.

Credentialing principle #4

- Credentialing is composed of four distinct steps.

Credentialing is composed of four steps

Step 1: Establish policies and rules

– Credentials committee, MEC, medical staff, and governing board

Step 2: Collect and summarize information

– Management and medical staff leaders

Step 3: Evaluate and recommend

– Department chairs, credentials committee, and MEC

Step 4: Grant, deny, or modify

– Governing board or designated agent(s)

Case study

A competent, respected ENT surgeon decides that doing cosmetic breast surgery would be a profitable line of work, takes a two-week course, receives great references from the instructor, and requests privileges for breast augmentation and reduction.

What should you do?

Credentialing principle #5

Follow the five Ps:

Our Policy is to follow our Policy. In the absence of a Policy, our Policy is to create a Policy.

Do you have clear policies?

- Expedited credentialing
- New technology
- Privileging disputes
- Telemedicine
- Temporary privileges
- Low/no volume practitioners
- Allied Health Professional

Case study

A physician with a history of disruptive behavior at a neighboring hospital applies to your medical staff.

What is the FIRST thing you should do?

Credentialing principle #6

- Excellent credentialing requires clear criteria, which are consistently applied.

Membership criteria

- License
- Training
- Character and ethics
- Behavior
- Malpractice insurance
- Board certification?
- Office/home location?

Case study

A cardiologist applies to the medical staff. A reference from the previous department chair rates her as excellent clinically and acceptable for behavior.

How should you answer?

Credentialing principle
number 7

- Getting value from references requires thoughtful design, careful reading, and use of the telephone

Case study (cont)

As department chair, you call the previous chair to ask why the behavior assessment is not excellent. He asks, "Is this on the record or off the record?"

How should you answer?

Case study (cont.)

You answer that this is on the record and the previous chair says, “Then I can’t tell you anything more.”

What should you do now?

Credentialing principle #8

- Place the burden on the applicant.

Case study (cont.)

The hospital receives a letter from the cardiologist's attorney threatening to sue the hospital on the grounds that these special requests are being made only for his client and not other applicants, demonstrating anti-trust and prejudicial behavior on the part of the hospital and the medical staff.
What should you do now?

Credentialing principle #9

- Treat like physicians in a like manner

Case study

A general surgeon newly out of training initially requested and was granted privileges for hysterectomies because he had done an adequate number during residency. Over the past six years, he hasn't done any hysterectomies. He is now up for reappointment and demands that he be granted hysterectomy privileges again, saying the hospital can't take away his privileges.

What should you do?

The goal of privileging

- To match privileges granted with demonstrated practitioner competence.

Joint Commission (MS.06.01.05)

- The decision to grant or deny a privilege, and/or to renew an existing privilege, is an objective, evidenced-based process.

Myths about privileges

- Clinical privileges are owned by physicians
- Clinical privileges are defined, determined, and granted by the clinical department
- A physician is entitled to all clinical privileges requested, unless not sufficiently trained or qualified
- There are textbook criteria available

Privileging criteria

- License or certification
- Training (privilege-specific)
- Experience
- Ability to perform
- Evidence of current competence

Credentialing principle #10

- Before granting privileges, solve the Competency Equation.

The Competency Equation

Current competency =

Evidence you've done enough of it recently

+

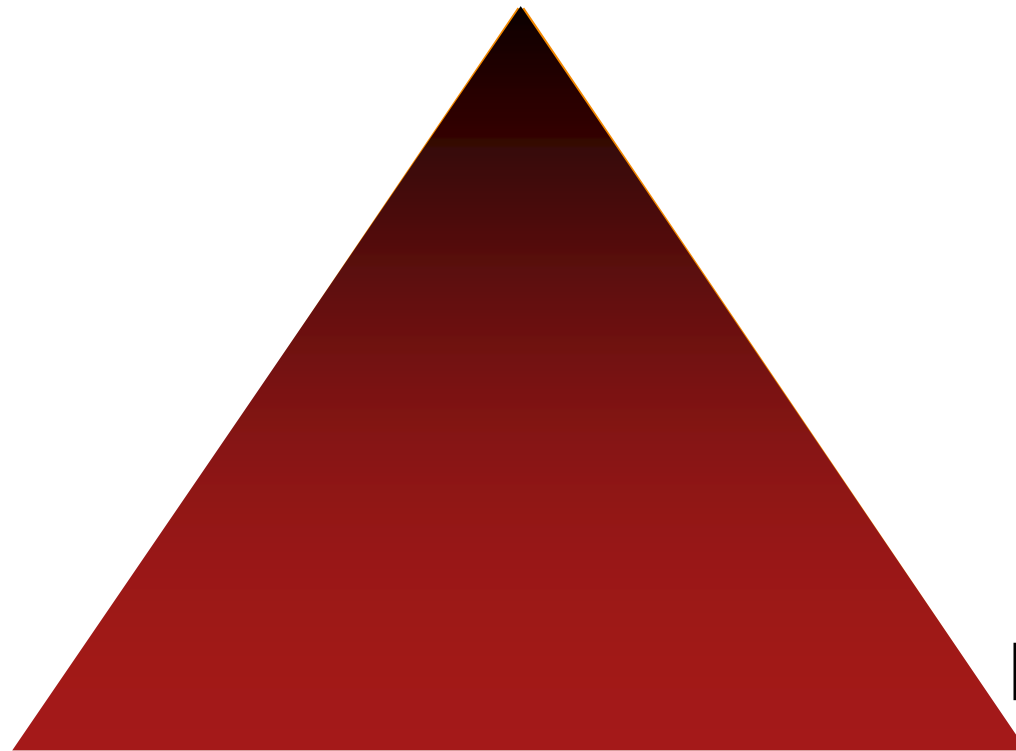
Evidence that when you did it, you did it well

Credentialing principle #11

- To match competency with privileges, use the *Competency Triangle*.

The Competency Triangle

Privilege
Delineation



Eligibility
Criteria

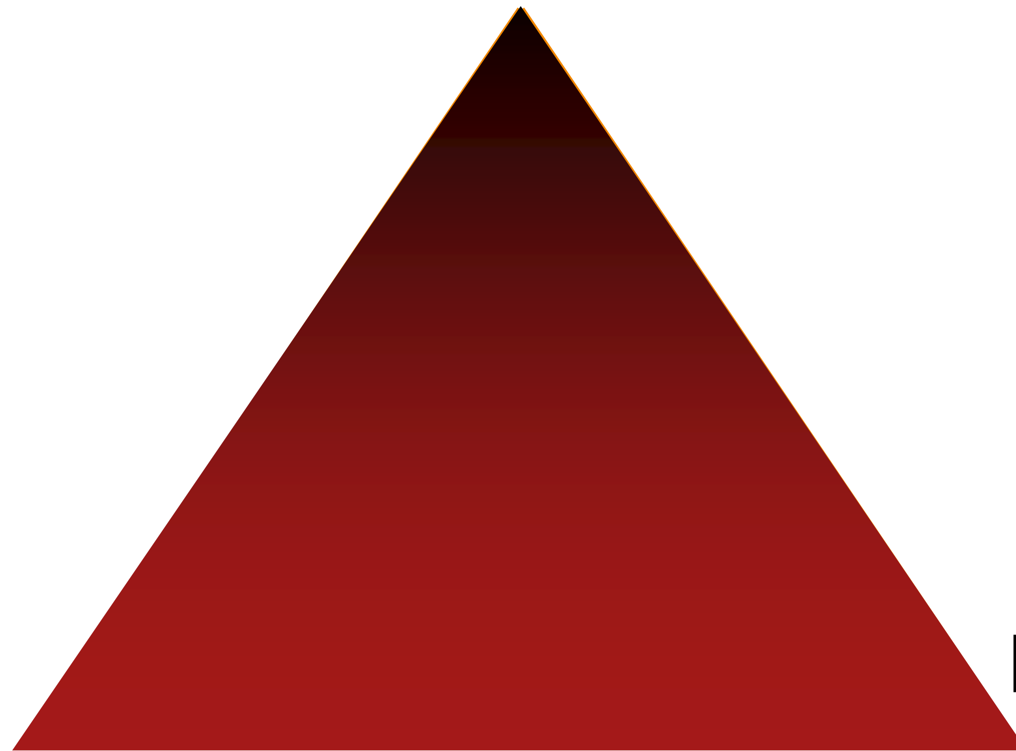
Peer Review
Results

Privileges delineation: The lumper-splitter challenge

- Lumper = General privileges
- Splitter = Laundry lists
- Lumper = Core privileges
- Splitter = Competency Clusters

The Competency Triangle

Privilege
Delineation



Eligibility
Criteria

Peer Review
Results

Case study

A general internist applies for privileges in oncology, despite never completing an oncology fellowship. The department chair does not feel that he is qualified.

What should the chair do?

Credentialing principle #12

- Never deny unnecessarily!

Case study

An internist who has been loyal to the hospital for many years has started referring all her patients to the hospitalist service. At the next reappointment cycle, she applies for the same privileges, but has not done any work in the hospital during the past two years.

What should you do?

What are the goals of a low/no volume provider policy?

- Clinical
  - How to protect patients
  - How to determine current competency
- Strategic
  - How to support physician-hospital relationships
  - How to enhance physician-hospital alignment

Credentialing principle #13

- Do not confuse membership with privileges.

Credentialing principle #14

- Base credentialing and privileging decisions on the affirmation of competence and conduct, not the absence of negative information

Just in case you thought this was new …

“There is no more controversial question in medical practice than who may be granted hospital privileges and to what extent.”

Kenneth Babcock, MD
Director JCAH (1962)

Raising the bar:
Today's new expectations for physician performance

Greeley HCPro

ACGME/Joint Commission General Competencies

- The standard requires that these be measured
- The implication is that these are expectations of physician performance

ACGME/Joint Commission General Competencies

- Patient care: Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life
- Medical/clinical knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, as well as the application of that knowledge to patient care and the education of others

ACGME/Joint Commission General Competencies

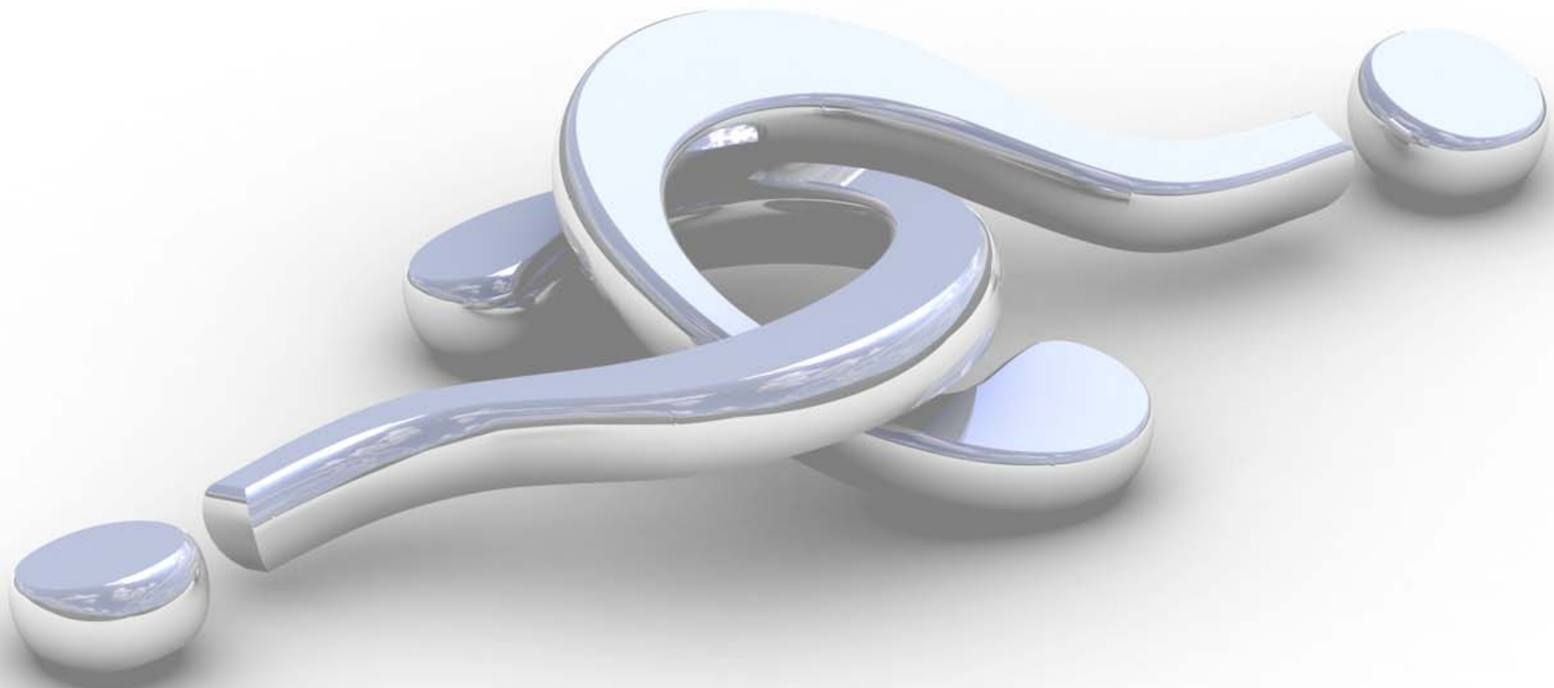
- **Practice-based learning and improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care
- **Interpersonal and communication skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams

ACGME/Joint Commission General Competencies

- **Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society
- **Systems-based practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare

ACGME/Joint Commission General Competencies in practical English

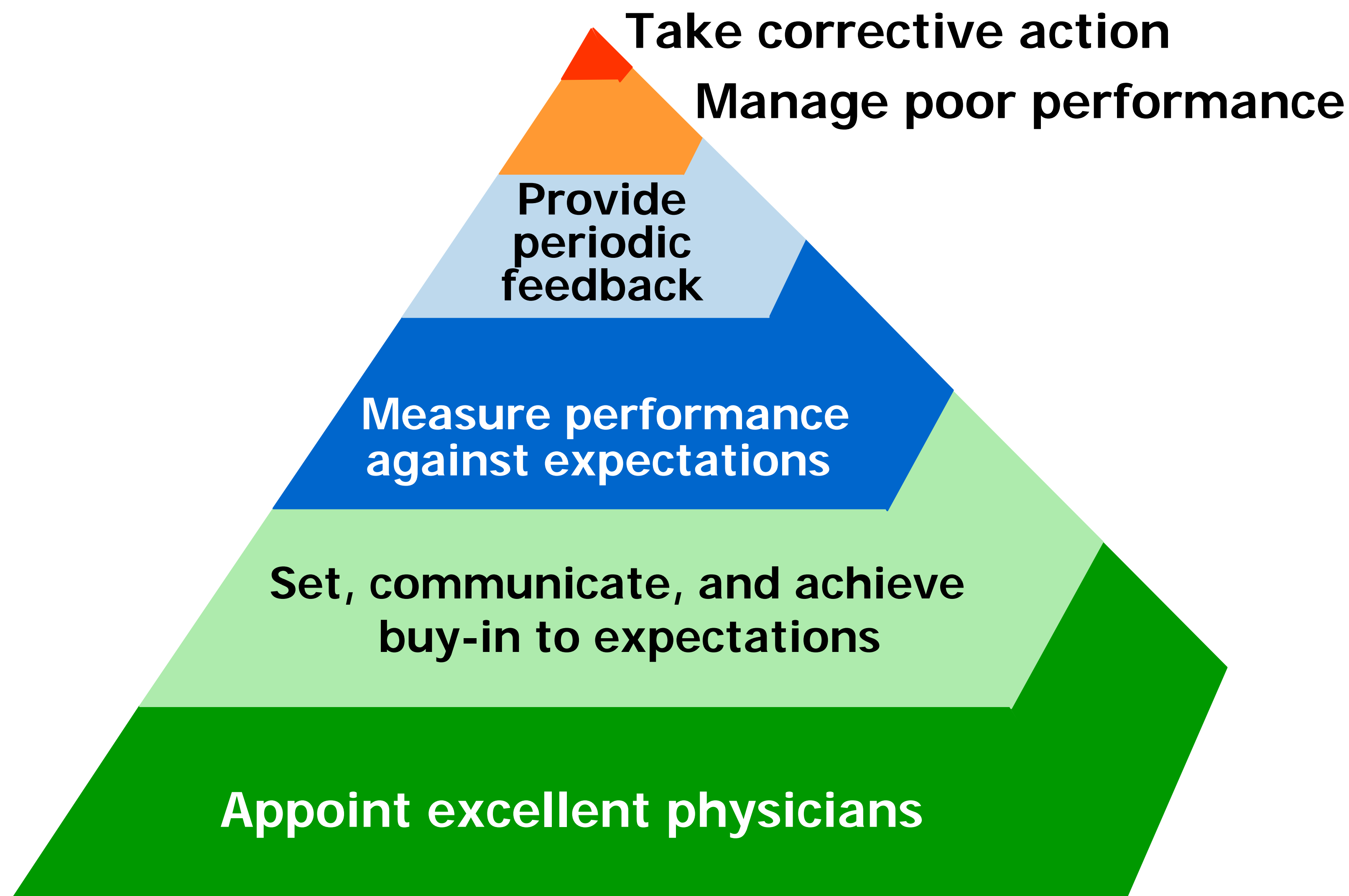
- Patient care: How do we use our specific clinical privileges and general medical skills?
- Medical/clinical knowledge: What must we know?
- Interpersonal and communication skills: What should we say and how should we say it?
- Professionalism: How should we behave?
- Systems-based practice: Who do we depend on and who depends on us?
- Practice-based learning and improvement: How have we improved? How will we continue to improve?



How will you get physicians to comply with these expectations?

The Power of the Pyramid

Achieving great physician performance



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Who sets the standards for hospitals?

- State statutes
- Medicare *Conditions of Participation (CoP)*
- Federal statutes

Who enforces these standards?

- State departments of public health (for state statutes and *CoP*s)
- HHS Office of Inspector General
- FBI
- Federal department of justice
- State attorney generals

Hospitals accredited by three organizations are deemed to meet the CoPs (deeming status)

- The Joint Commission (JC)
- Healthcare Facilities Accreditation Program (HFAP)
- Det Norske Veritas (DNV)

The Joint Commission

15,000 Organizations, ~4000 hospitals

PROs

- Largest accrediting body with highest brand recognition
- Driven by focus on improving quality and patient safety
- Surveyors on-site once/3 yrs with self-assessment in between
- Accredits Critical Access Hospitals
- New leadership

CONs

- Frequent changes to standards
- Standards often exceed CoP minimum requirements
- Cost

HFAP

400 Organizations

PROs

- Standards closely follow CoPs
- Cost slightly lower than others
- Surveyed once/3 yrs
- Approved for Critical Access Hospitals

CONs

- Uses older CMS standards and survey process
- Spend most of survey reviewing documents and not as much actual care processes

DNV Healthcare Inc.

> 27 Organizations

PROs

- Requires robust quality management program that creates value for the organization
- Years of experience in international arena
- Standard changes likely to be infrequent (tied to changes in CoPs and ISO 9000 requirements)

CONs

- New to healthcare accreditation (2008)
- Accreditation cost slightly above TJC
- Yearly cost to ramp up for ISO 9000 certification up to $60,000/yr
- Annual survey required
- Currently not approved for Critical Access Hospitals

CMS

PROs

- No cost
- Standards change infrequently (only when CoPs change)
- Hospitals must meet CoPs anyway, so no extra standards to meet

CONs

- CoPs do not reflect current best practices
- May require up to annual survey
- No easy appeal process
- Focus is enforcing the law, not performance improvement
- Adverse findings can lead to fines or loss of Medicare reimbursement
- Depending on state, unable to determine survey frequency

Why does a hospital want to be accredited?

- Reimbursement
- Residency training programs
- Reputation
- Improve quality and patient safety?

Joint Commission standards that apply to medical staff leaders

- Primary focus
  - Medical staff
  - Leadership
  - National patient safety goals
- Secondary focus
  - Performance improvement
  - Infection control
  - Record of care, treatment, and services
  - Rights and responsibilities of the individual

Hot button medical staff issues

- What needs to be in the bylaws vs. policies (MS.01.01.01) (Deferred enforcement)
- General competencies (MS.06.01.03)
- FPPE: Focused professional practice evaluation (MS.08.01.01)
- OPPE: Ongoing professional practice evaluation (MS.08.01.03)
- Privileging is an "objective, evidence-based process" (MS.01.01.05)

Hot button medical staff issues

- Temporary privileges (MS.06.01.13)
- Criteria-based privileging (MS.06.01.05)
- Telemedicine (MS.13.01.01)
- Conflict of interest (LD.02.02.01)
- Conflict management (LD.02.04.01)
- Culture of safety and quality (LD.03.01.01)
- Management of disruptive behavior (LD.03.01.01)

The frustrating 5% (physician-related)

- Hand hygiene
- Medication reconciliation
- Admitting H&P
- Restraints (behavioral and med-surg)
- Review of pre-printed orders
- Anticoagulation program
- Rapid response to change in patient condition
- Labeling of solutions in procedure areas
- Pre-procedure H&P, with update
- Informed consent

The frustrating 5%
(physician-related) (cont.)

- Post-operative note
- Site marking by person performing procedure
- Contract oversight
- FPPE
- OPPE
- Culture of safety implementation
- Countersigning verbal and telephone orders
- Date, time, and authentication of entries
- Prohibited entries
- Setting specific privileges

How can physician leaders help?

- Support the goal of regulatory and accreditation compliance
- Seek flexible ways to interpret standards that allow simple approaches to good patient care
- Participate in continuous survey readiness
- Respond promptly and constructively to noncompliance
- Practice good “survey etiquette”

The Revolution in Public Accountability for Quality

Moving from a cottage industry to an organized industry

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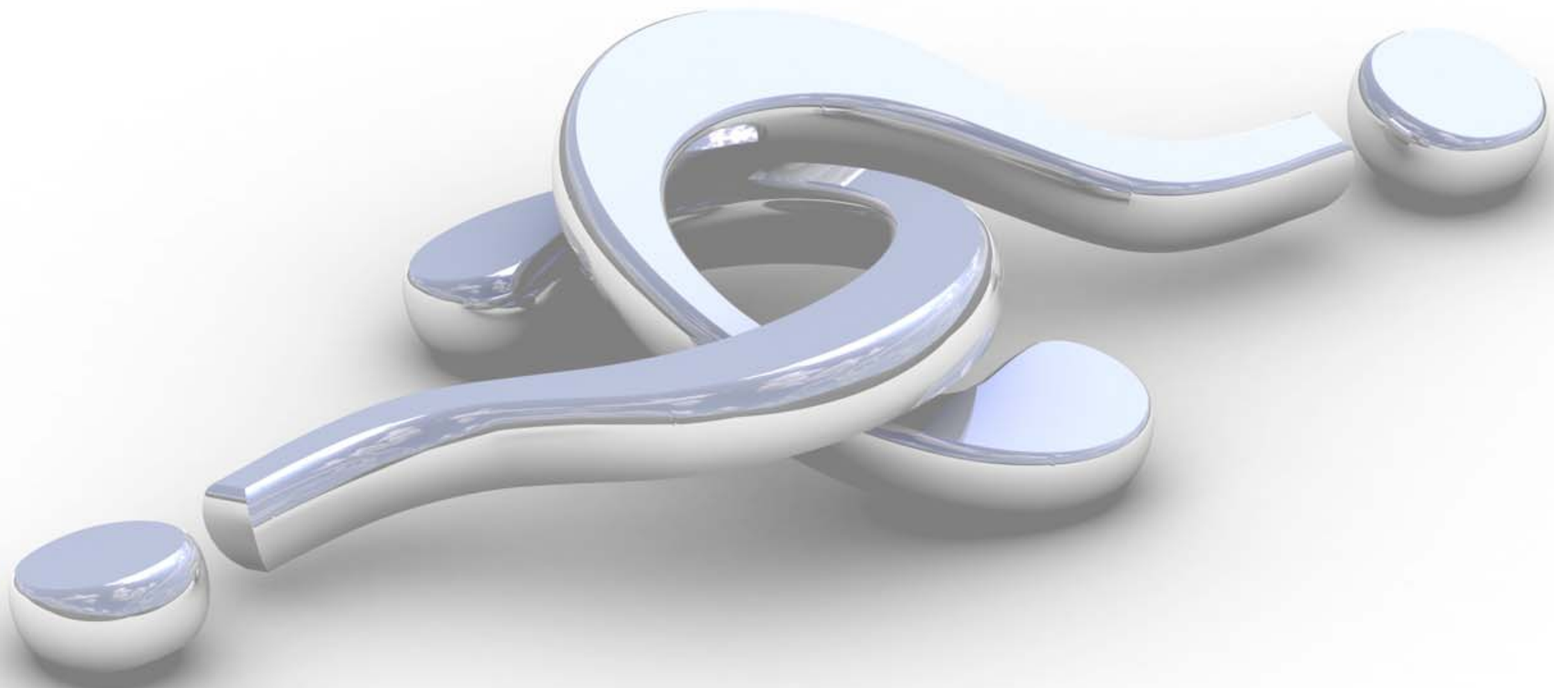
Healthcare accountability in a cottage industry

- Licensure
- Plaintiff attorneys
- Regulators
- Case-based peer review

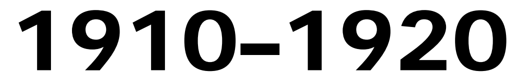
- Non-value-added variation

The Second Curve: Managing at the Velocity of Change

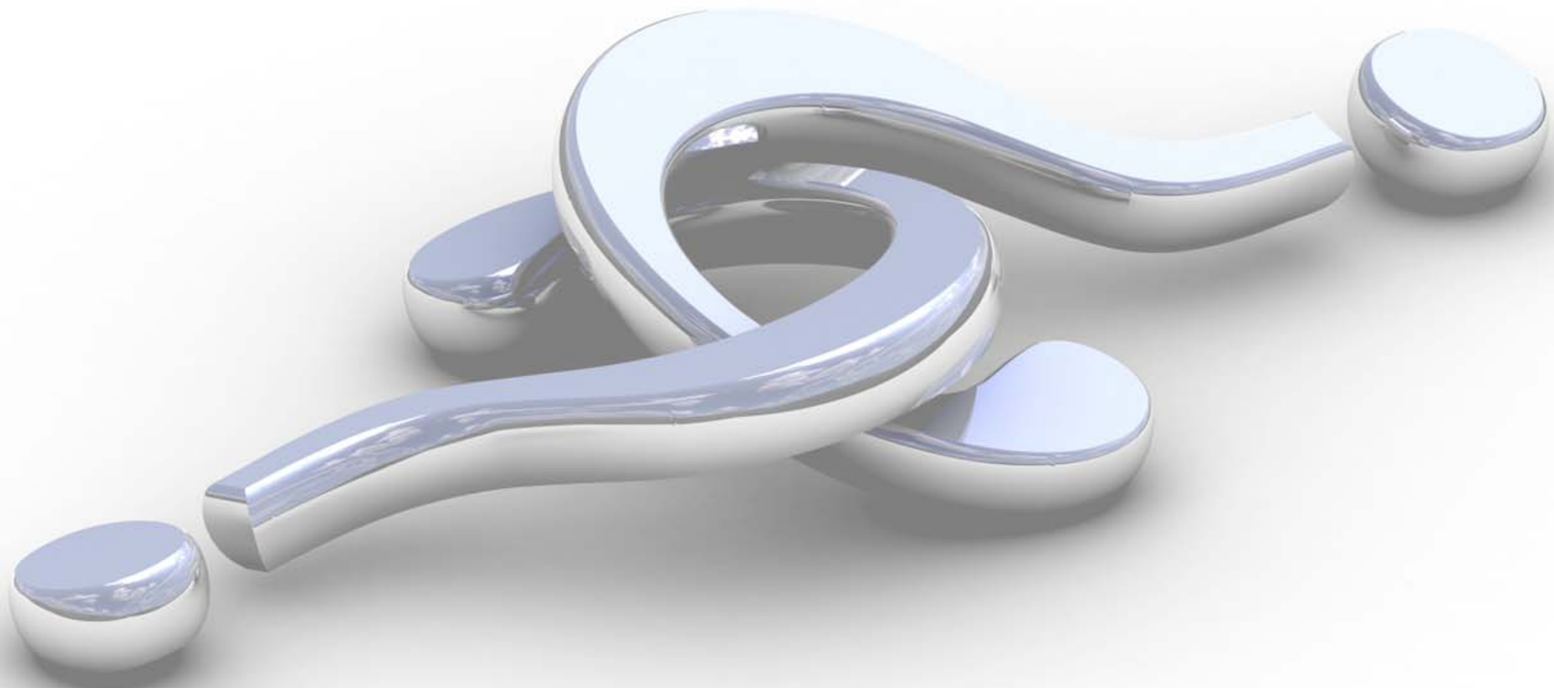
- Anticipate the pace of change
- Identify your industry's new direction
- Know when to jump onto the second curve



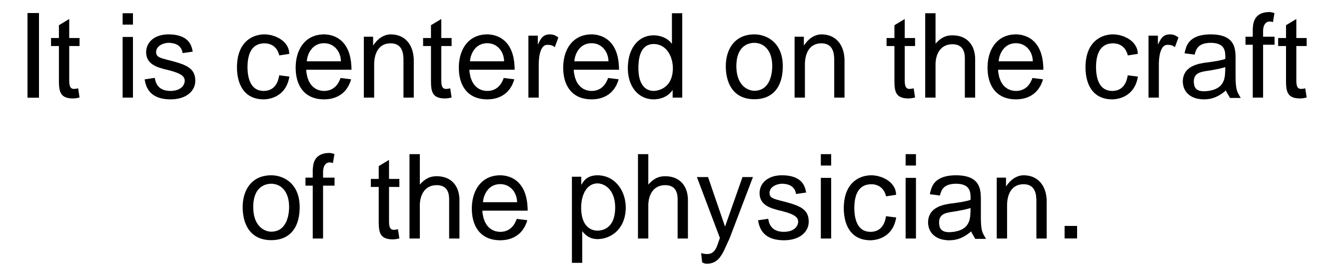
When did American medicine's first curve begin?



- Flexner report
- Johns Hopkins Medical School
- American College of Surgeons



What characterizes American medicine's first curve?

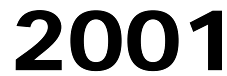

It is centered on the craft
of the physician.

Assumptions of a craft-based culture*

- The craftperson defines quality
- "Quality" is what emanates from the applied skills, dedication, and vigilance of the craftperson.
- Quality flows from building processes around the craftperson
- "Quality assurance" is best achieved by craftpersons checking on other craftpersons (peer review)
- If something goes wrong, someone (a craftsperson) is at fault

**Developed by Dr. Martin Merry*

The IOM report, *To Err is Human,* documenting 44,000-98,000 iatrogenic hospital deaths per year, marks the beginning of the end of American medicine's first curve



The IOM report, *Crossing the Quality Chasm,* establishes the direction for American medicine's second curve

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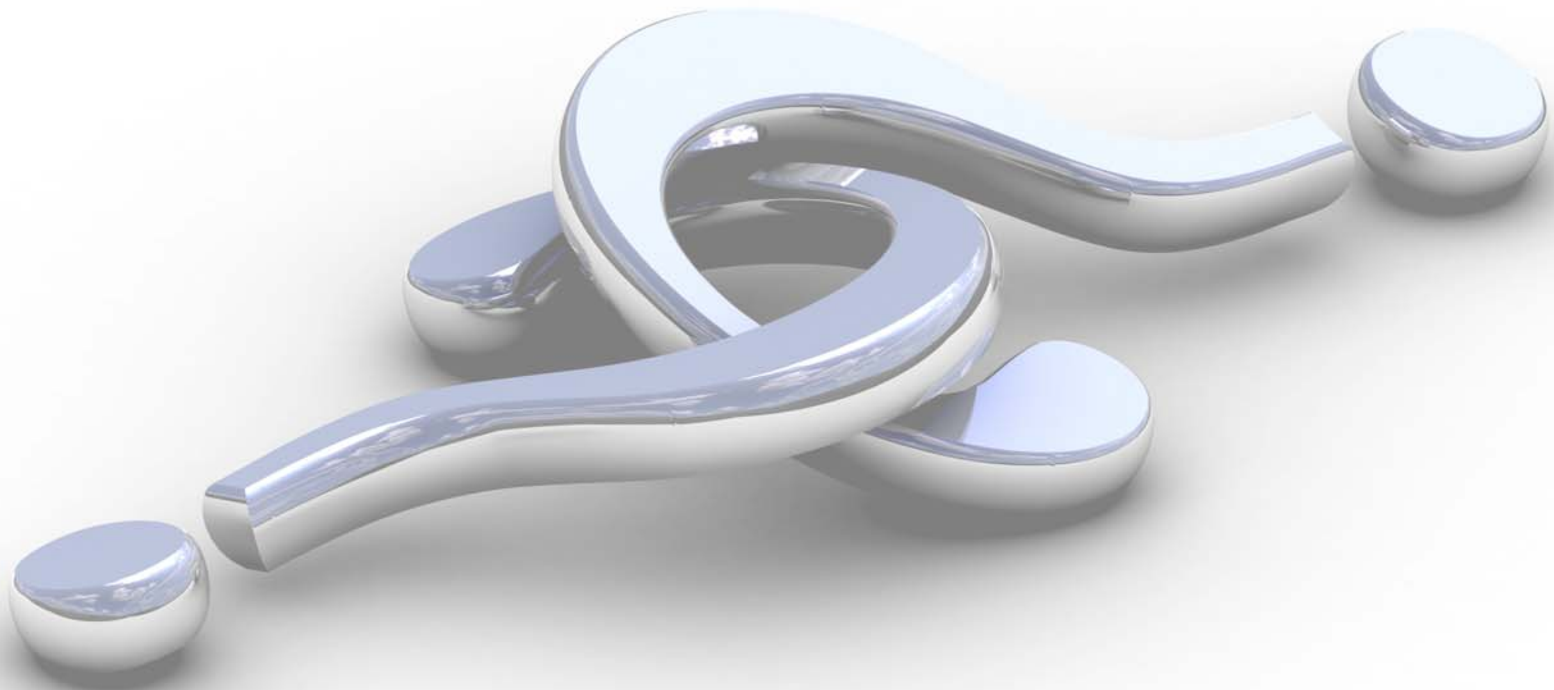
American medicine's second curve

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable



What will kick-start American medicine's second curve?

Public data, pay for performance,
and consumer-driven
healthcare

The rubber meets the road for physicians

- Governing board accountability
- Consumer-driven healthcare
- Electronic medical records
- Evidence-based medicine

Physician implications

We either do this ourselves or it will be done to us by others!

Physician implications (cont.)

- Clearer expectations of performance
- Tighter accountability systems to meet expectations
- Follow the money
- Teach to the test
- Faster adoption of best practices
- More responsive culture
- Focus on physician performance and process improvements

In other words …

A shift from manage loose to manage tight

The pendulum can swing too far

- Consistency should be present where consistency adds value
- Variation should be present where variation adds value

Patient Safety and Performance Improvement

What physician leaders must know to drive quality care

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CMS/Joint Commission Core Measures

- Surgical care improvement project (SCIP)
- MI
- CHF
- Pneumonia
- Pregnancy
- Hospital outpatient department
- Children's asthma care
- Hospital inpatient psychiatric care
- Venous thromboembolism

National Patient Safety Goals

1. Improve the accuracy of patient identification
2. Improve the effectiveness of communication among caregivers
3. Improve the safety of using medications
4. Reduce the risk of healthcare-associated infections
5. Accurately and completely reconcile medications across the continuum of care
6. Reduce the risk of patient harm resulting from falls

National Patient Safety Goals (cont.)

7. Encourage patients' active involvement in their own care as a patient safety strategy
8. Prevent healthcare-associated pressure ulcers
9. The organization identifies safety risks inherent in its patient population
10. Improve recognition and response to changes in a patient's condition

Which is more effective, fixing people or fixing systems?

- 94% of organization problems are due to systems, not people
- Three types of systems:
  - Operational systems
  - Training systems
  - Accountability systems

Current frameworks for healthcare system performance improvement

- Total Quality Management
- Malcolm Baldridge Award
- ISO 9000
- Six Sigma
- Lean Enterprise

Essential elements of all performance improvement models

- Organized
- Teams
- Cycles
- Measurement
- Improvement, not perfection

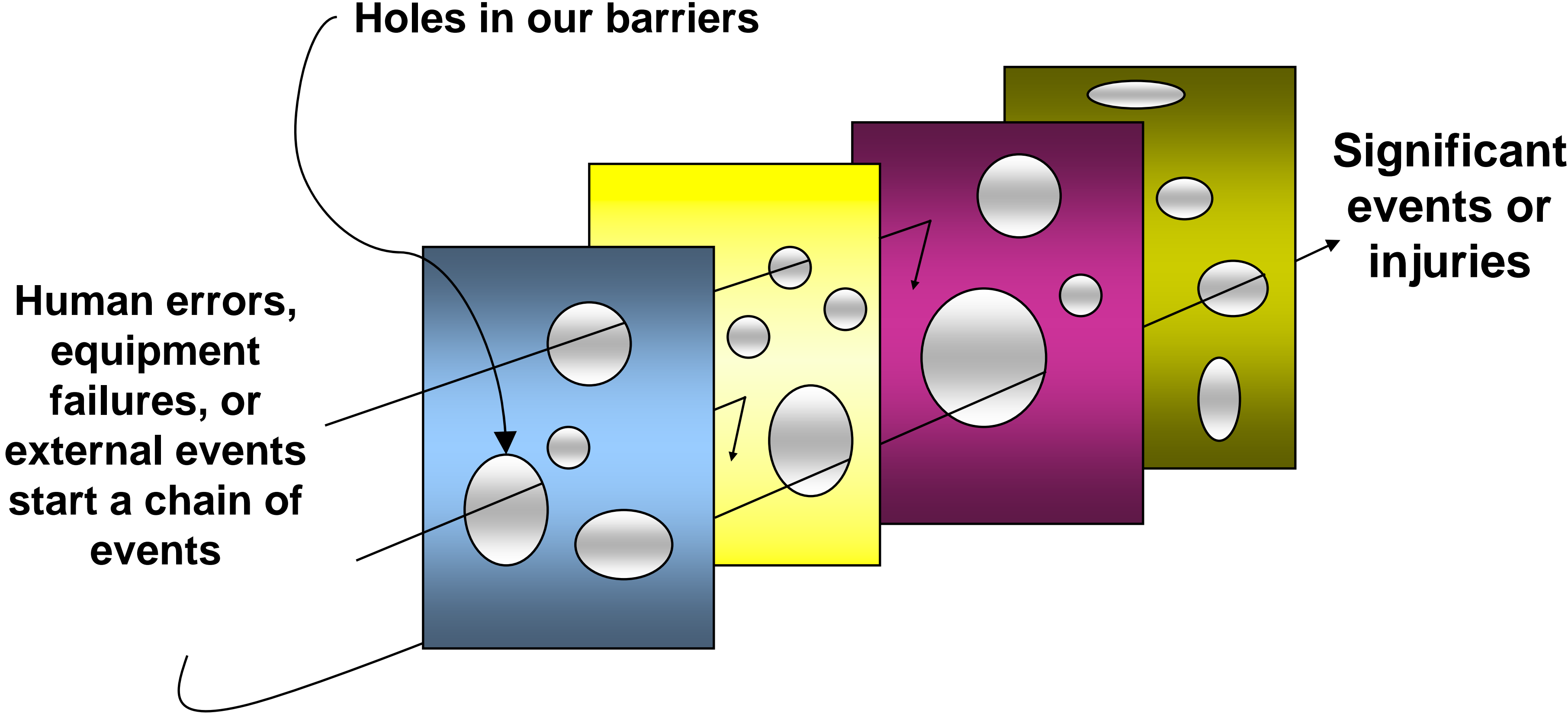
How can physician leaders help improve organization performance?

- Understand and use the organization's performance improvement (PI) methods
- Help define clear goals for PI projects
- Participate in organizational PI oversight to prioritize PI efforts
- Participate in organizational PI teams
- Champion PI projects
- Drive for high reliability, not just error reduction

How to achieve high reliability through a culture of safety

- Understand human error
- Set expectations for safety
- Provide tools to reduce errors
- Ensure accountability

Why do events happen?

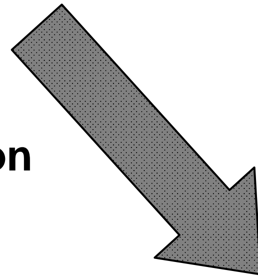


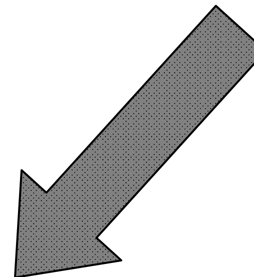
Based on Dr. James Reason, *Managing the Risks of Organizational Accidents*, 1997

How do we improve patient safety?

Reactive Improvements

Root Cause Analysis & Common Cause Analysis





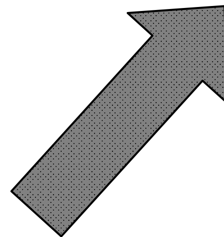
Proactive Improvements

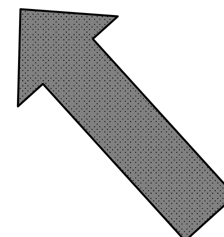
Failure Modes & Effects Analysis

Specific improvements for a process or situation

High reliability

Changes in our underlying culture of safety





Behavioral Expectations

Error Reduction Tools

Communication, Critical Rules, Checking, Critical Thinking, Coaching & Collaboration, Compliance & Accountability

SBAR: Example of an error reduction tool

Situation

Background

Assessment

Recommendation

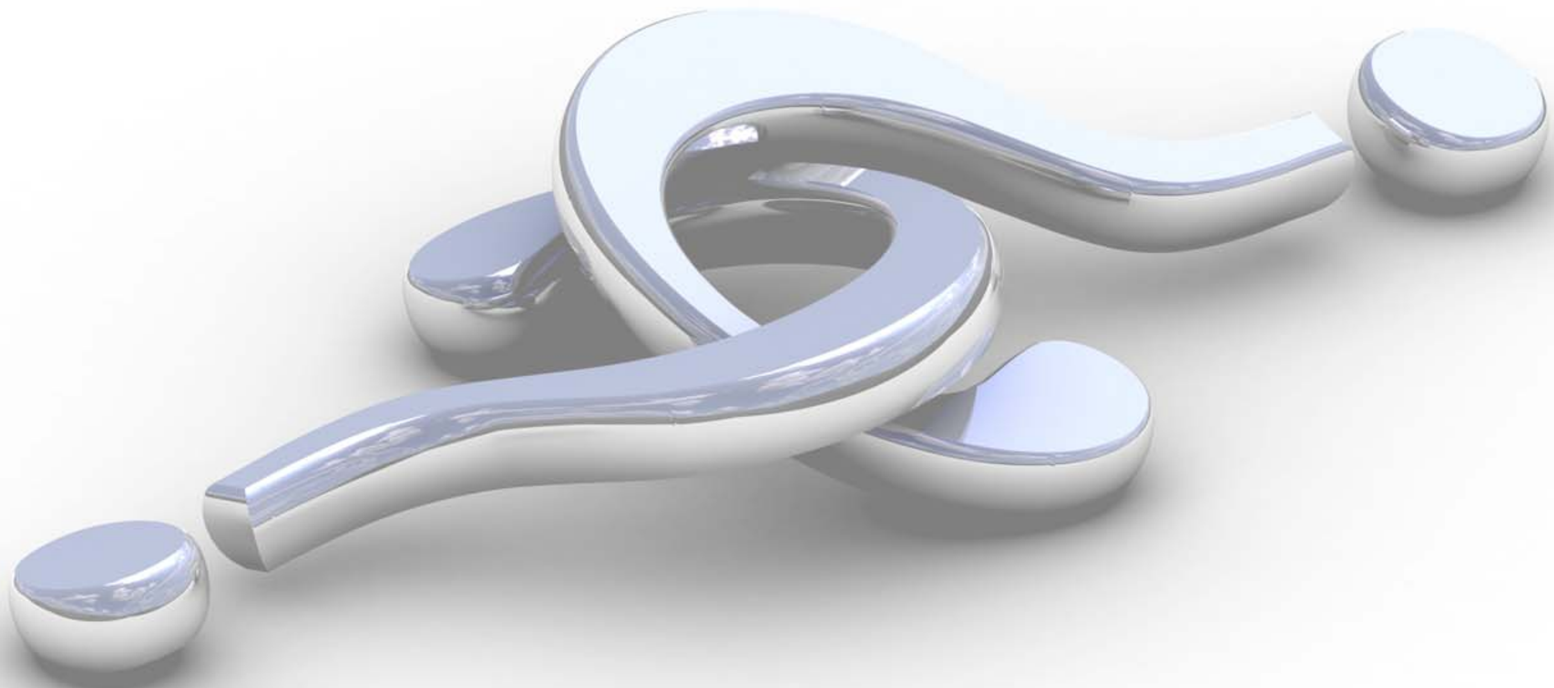
Engaging your medical staff in hospital patient safety

- Acceptance of the culture of safety
- Compliance with safety methods
- Leadership within the healthcare team

How can physicians help achieve high reliability

- Support patient safety habits in hospital staff
- Participate in error reduction analyses
- Define medical staff safety expectations and tools
- Receive training on safety tools
- Adopt and maintain practices that decrease medical errors
- Lead the effort

FOLLOW THE MONEY: WHAT MEDICAL STAFF LEADERS NEED TO KNOW ABOUT HEALTHCARE FINANCE

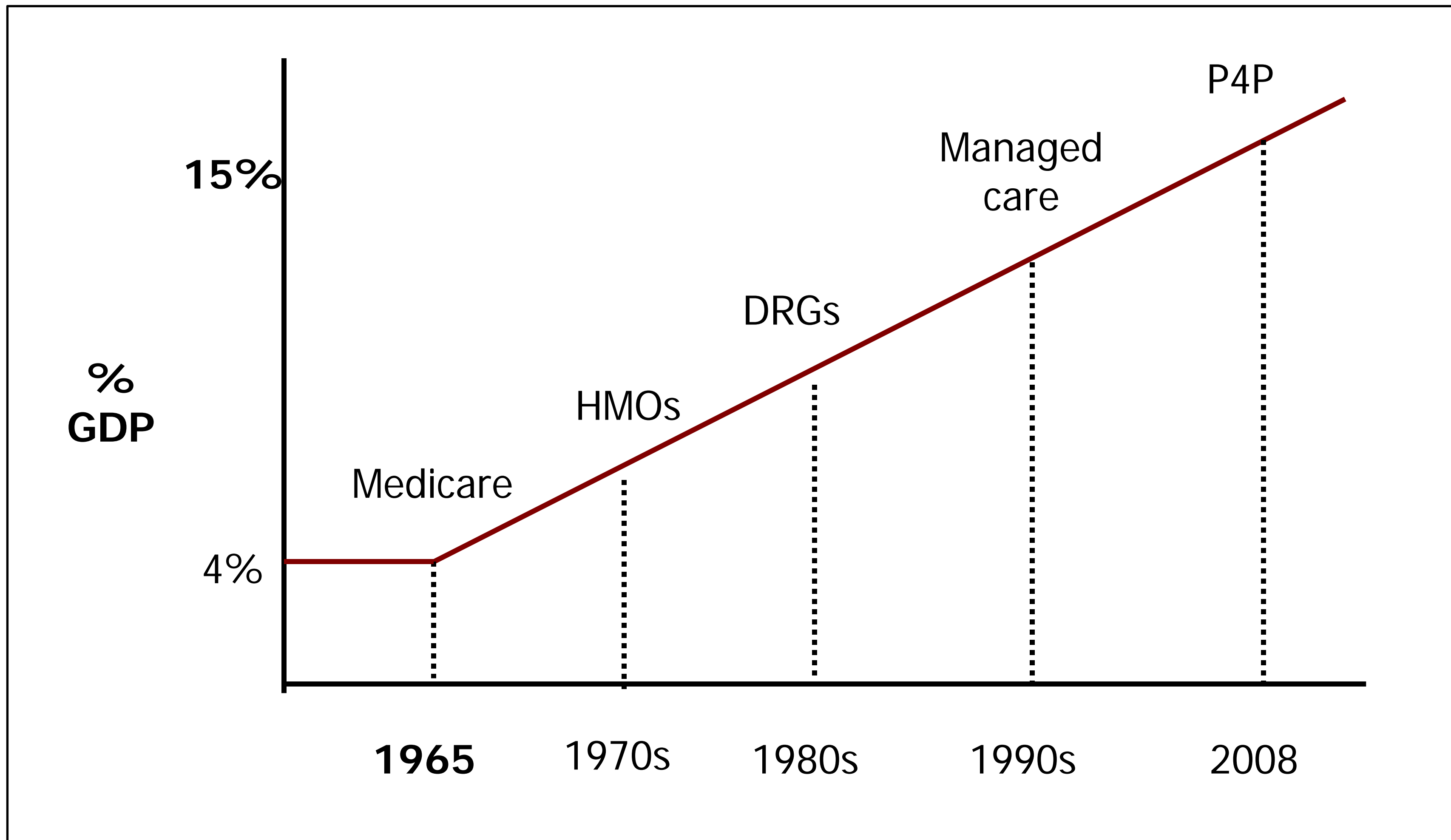


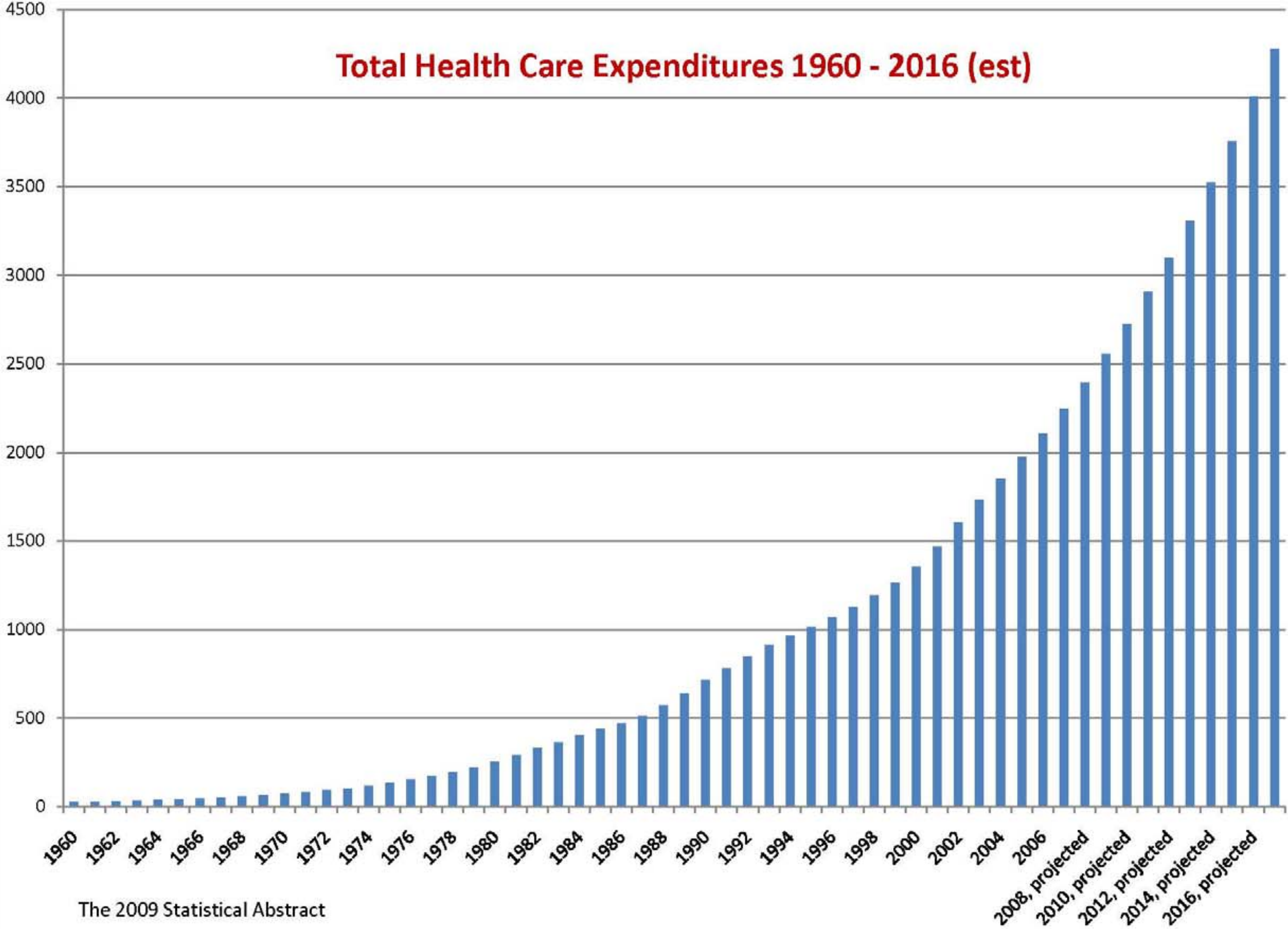
Which is more important, quality or cost?

Hospital finance and the medical staff

- How are the financial pressures on hospitals and doctors affecting hospital–medical staff relationships?
- Why should the medical staff care whether the hospital is successful at meeting its financial goals?
- What does the medical staff need from the hospital that involves financial resources?

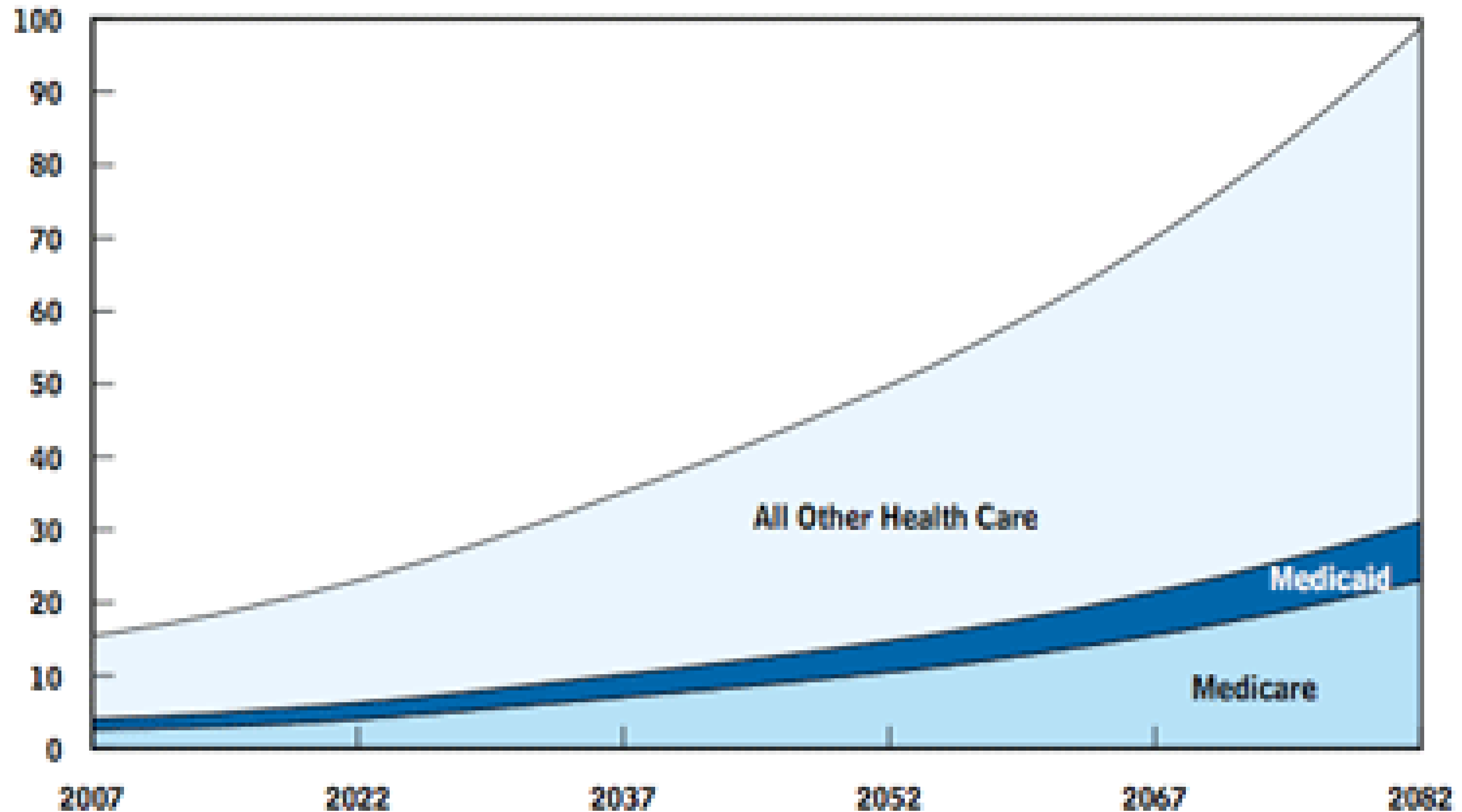
It's all about the money …




Total Health Care Expenditures 1960 - 2016 (est)
4500
4000
3500
3000
2500
2000
1500
1000
500
0
1960
1962
1964
1966
1968
1970
1972
1974
1976
1978
1980
1982
1984
1986
1988
1990
1992
1994
1996
1998
2000
2002
2004
2006
2008, projected
2010, projected
2012, projected
2014, projected
2016, projected
The 2009 Statistical Abstract

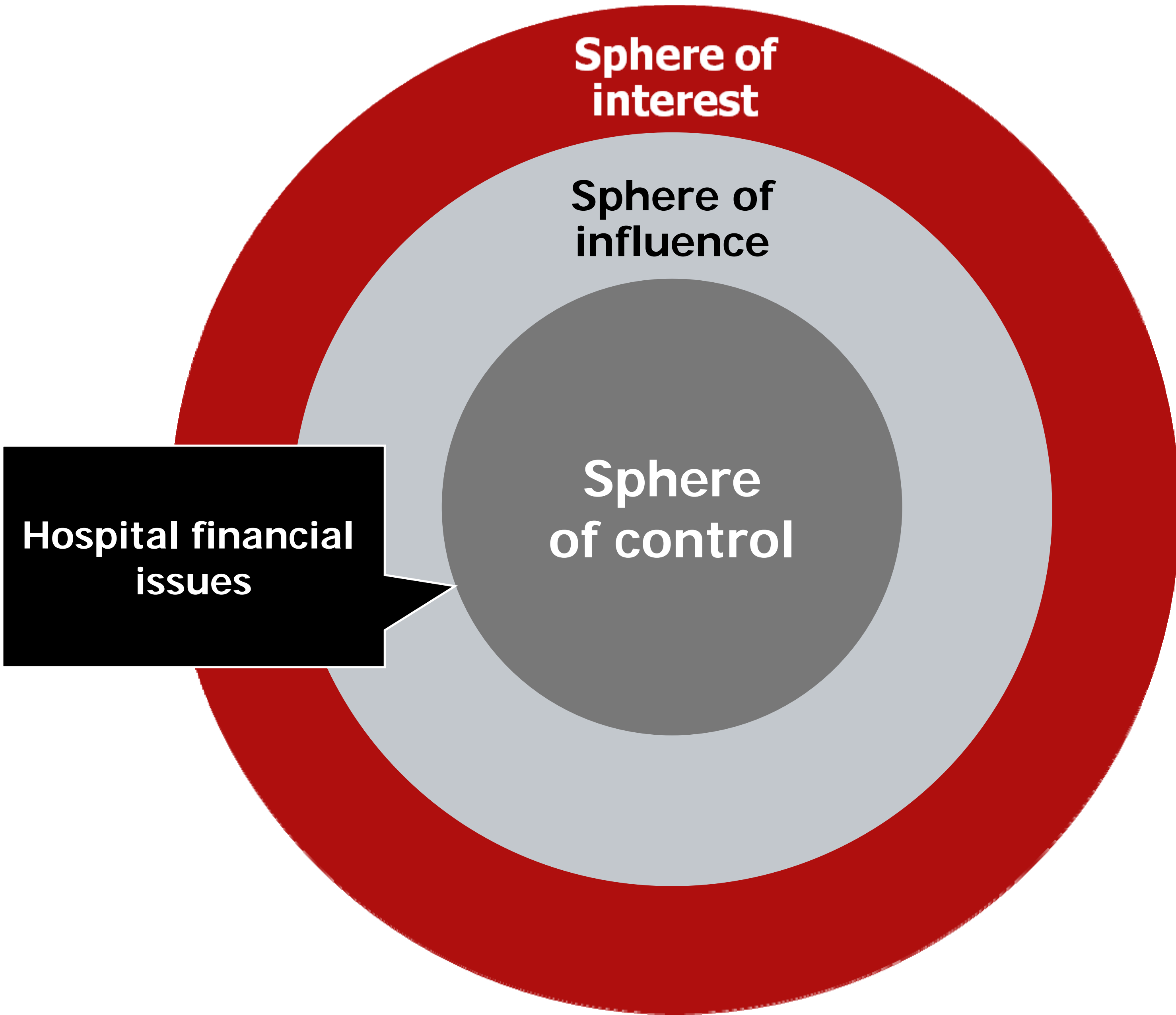
Projected Spending on Health Care Under an Assumption That Excess Cost Growth Continues at Historical Averages

(Percentage of gross domestic product)



Source: Congressional Budget Office.

The physician-hospital partnership=


Sphere of
interest
Sphere of
influence
Sphere
of control
Hospital financial
issues

Healthcare Expenditures:

$2 trillion dollars is a lot of money!

$2,000,000,000,000

- **Where does healthcare $$$ come from?**
- **Where does it go?**

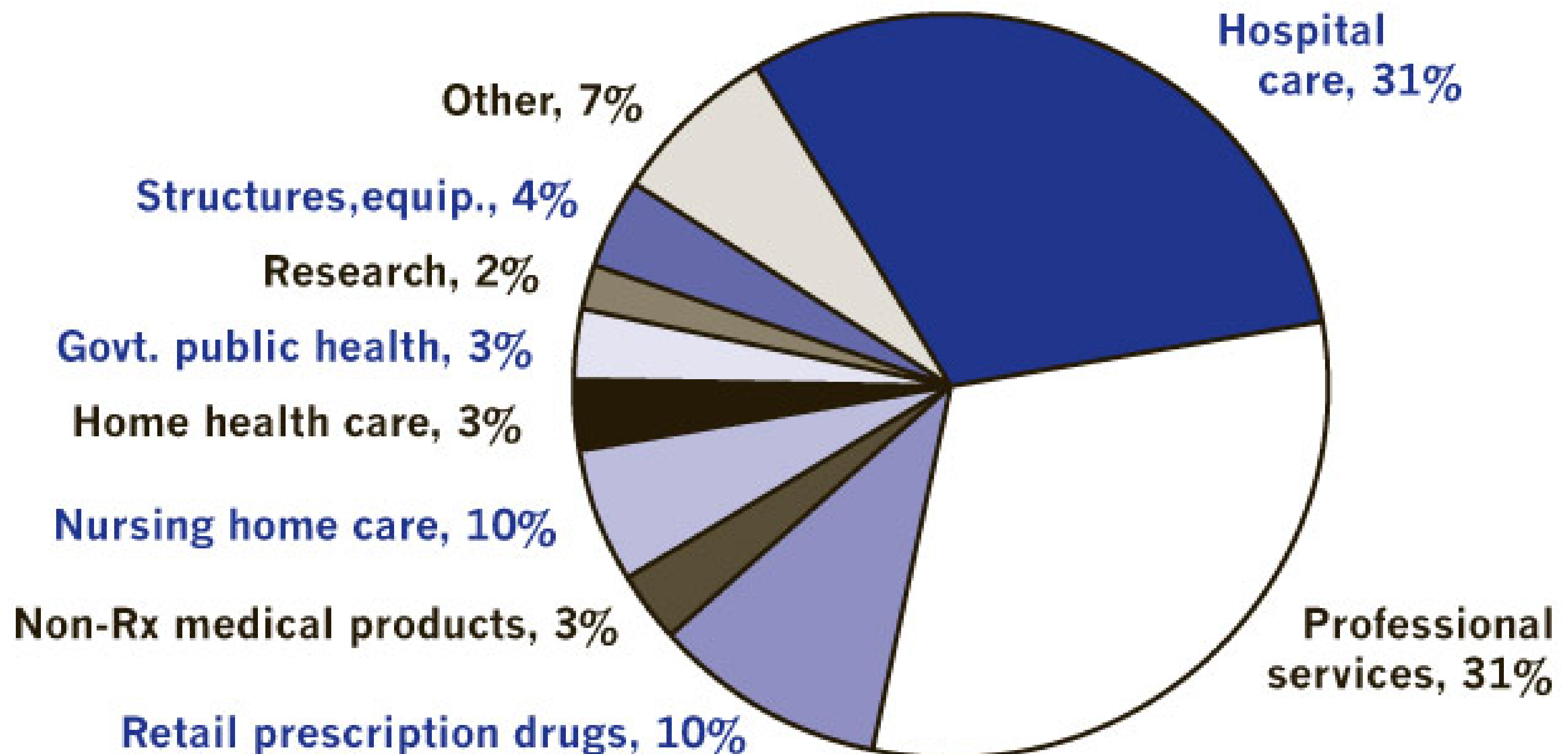
The healthcare dollar

Source: Modern Healthcare.

Where it came from ...

Private insurance	35¢
Medicare	17¢
Medicaid/SCHIP	16¢
Out-of-pocket	13¢
Other public [1]	13¢
Other private [2]	7¢

Where the Health Care Dollar Goes



Source: Hartman, Micah; Martin, Anne; McDonnell, Patricia et al. (2009). "National Health Spending in 2007: Slower Drug Spending Contributes to Lowest Rate of Overall Growth Since 1998." Health Affairs, Jan/Feb., p. 247. (www.healthaffairs.org).

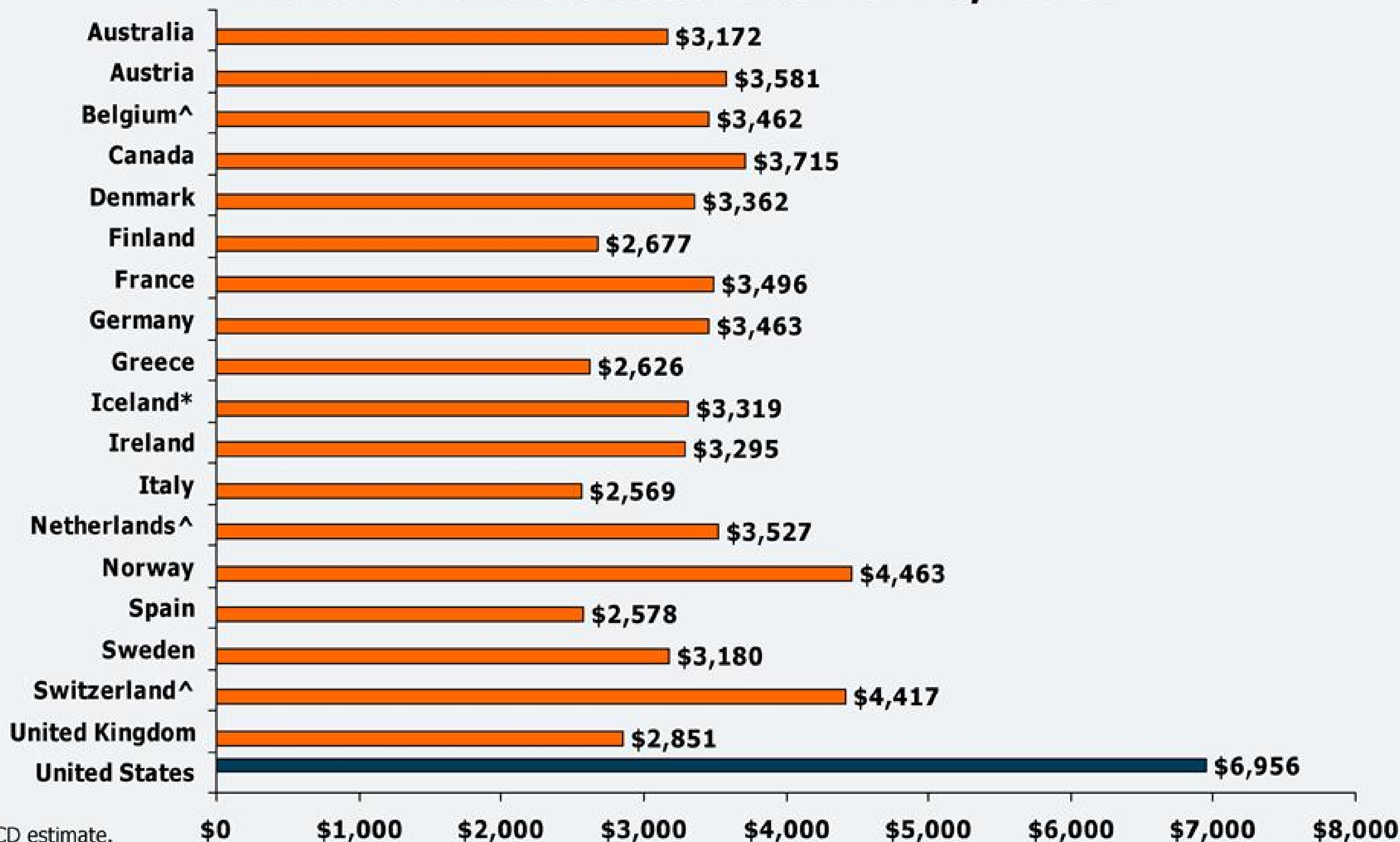
Healthcare and the GDP

Healthcare expenditures as % of the gross domestic product

(figures for 2010 and beyond are projected)

Source: Modern Healthcare.

Per Capita Total Current Health Care Expenditures, U.S. and Selected Countries, 2007



*Differences in methodology.

Notes: Amounts in U.S.$ Purchasing Power Parity, see www.oecd.org/std/ppp; includes only countries over $2,500. OECD defines Total Current Expenditures on Health as the sum of expenditures on personal health care, preventive and public health services, and health administration and health insurance; it excludes investment.

Source: Organisation for Economic Co-operation and Development. OECD Health Data 2009, from the SourceOECD Internet subscription database updated November 2009. Copyright OECD 2009, http://www.oecd.org/health/healthdata. Data accessed on 11/13/2009.

THE HENRY J. KAISER FAMILY FOUNDATION

Mirror, mirror on the wall: Outcomes measures

- Quality care
  - Right care
  - Safe care
  - Coordinated care
  - Patient-centered care
- Access
- Efficiency
- Equity
- Healthy lives

Source: Commonwealth Fund, May 2009.

Mirror, mirror on the wall: Results on outcomes measures

• United Kingdom	1
• Germany	2
• Australia	3.5 (tie)
• New Zealand	3.5
• Canada	5
• United States	6

Source: Commonwealth Fund, May 2009.

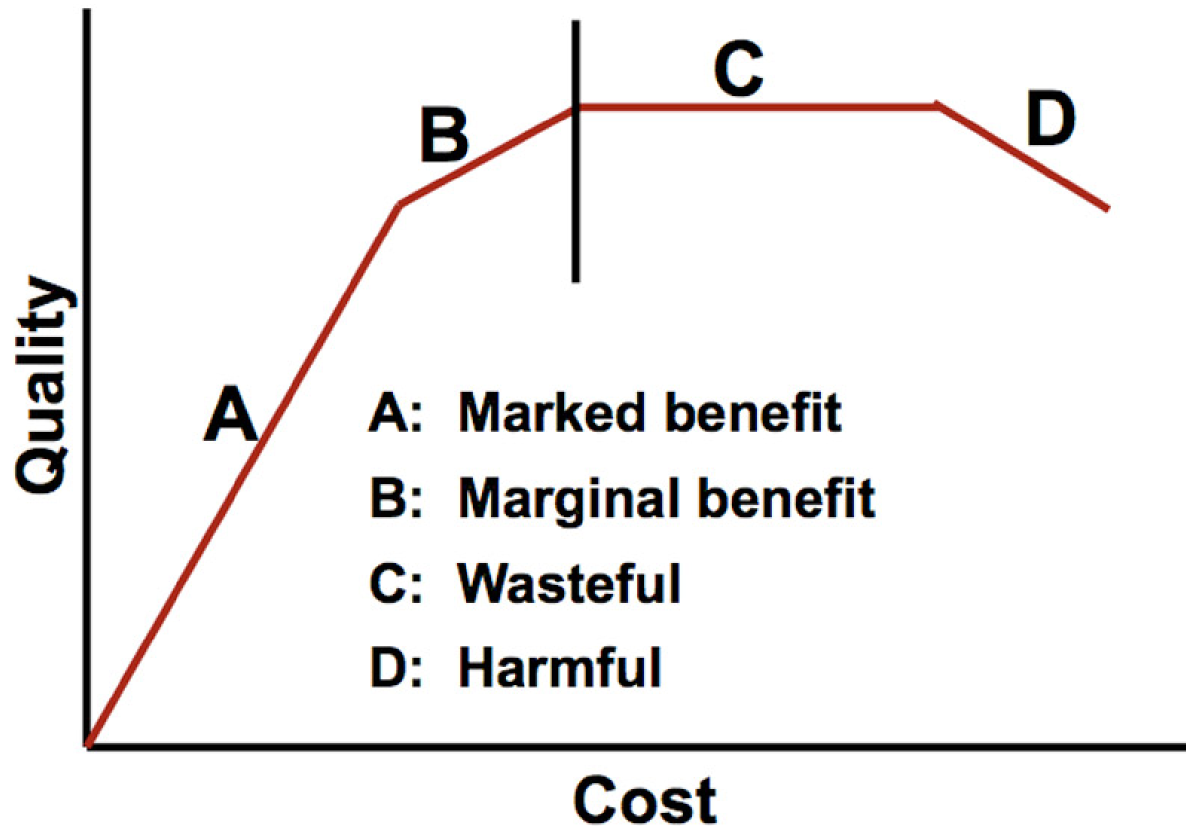
What the United States gets for its extra per capita health spending

- More high-tech procedures sooner
- Efficacious meds available later
- More specialist physicians and non-physicians
- More provider-level administration
- Richer physicians, administrators, and other providers

What the United States gets for its extra per capita health spending

- Substantial levels of amenities
- Sufficient idle capacity to eliminate the vast majority of queues
- A unique tort liability system
- Significant defensive medicine
- A (too) large private insurance industry with attendant administrative costs and arrays of choices

The cost-quality curve



Non-value-added variation

Recognize the lack of economic alignment between physicians and hospitals:

- Different reimbursement methodologies reward different behaviors
- These behaviors often cause conflict between physicians and hospitals

Understanding hospital payments = PROSPECTIVE

- Medicare Part A
- Payment = DRG relative weight x hospital blended rate
- DRG relative weight
  - Insurance cost factor
  - Reflects degree of resource utilization
- Blended rate
  - Case-mix index
  - Teaching hospital
- Outlier payments with incentives to discharge sooner

Understanding hospital payments

- Case-mix index (CMI)

CMI is used to adjust the hospital's blended rate

CMI = sum of all DRG relative weights/
total # of Medicare inpatient
cases for the hospital

Conclusion: a lower CMI = lower blended rate
= lower reimbursement for the same DRG

Understanding physician payments = RETROSPECTIVE

- Medicare Part B
- Driven by CPT codes
- Retrospective
- Contracted rate
- Incentive to keep inpatient longer

How can the medical staff support reduced lengths of stay and improved outcomes?

- Intentional/multi-disciplinary rounds
- Discharge patients by mid-morning
- Use effective handoffs to ensure better weekend and holiday care plans
- Support evidence based bundles, pathways and patient safety initiatives
- Support smoothed elective surgical admissions

How can management support reduced lengths of stays and improved outcomes?

- Support 24/7 case management and discharge planning
- Schedule elective discharges
- Smooth elective surgical admissions
- Eliminate bed holds and develop a room turnaround strategy

How can management support reduced lengths of stays and improved outcomes?

- Adopt acuity adjustable beds and rooms to reduce internal transfers
- Adhere to utilization criteria for specialty beds (ICU, PACU, telemetry etc.)
- Optimize staffing ratios
- Do not staff to peak demand

Sustainable growth rate (SGR) formula:

- Historical 1-2% increase per year for Medicare, part B with potential reductions when costs exceed budgeted allotments
- Cumulative loss in reimbursement over time relative to consumer price index (CPI)
- Gap between practice costs (MEI) and actual payments now 21.2% and estimated to go to >30% by 2016
- Threatens access for Medicare patients

Hospitals require capital to face the future

- 41% of medical institutions are not investing enough capital to keep pace with asset depreciation.
  —*AMA News*, January 26, 2004
- What physicians want hospitals to do that requires capital:
  - Latest medical technology (better than competitors')
  - Latest IT
  - User-/patient-friendly physical plants
  - Adequate staffing/payment for call coverage
  - Resources to joint venture or legally support physician community

Importance of hospital operating margins

% operating margin needed to replace current equipment/structure = 2%

2009 hospital average 3.9%

Importance of hospital operating margins

% of operating margin needed to expand current equipment/structure	= 5%
2009 hospital average	3.9%

To invest in the future, hospitals need margins >5%

- Key drivers for 5% margin:
  - Operational efficiency
  - Cost shifting
  - Focus on the right services
  - Efficient and effective clinical management
  - Consistent application of best practices (evidence-based, not eminence-based medicine)
- Which of these requires collaboration among the medical staff?

Financial capability

- The amount of capital a hospital can invest at an acceptable level of risk
- Two components:
  - Debt capacity: the ability to borrow or finance (in part, a function of operating income)
  - Available investment balances that can be used for capital expenditure (while maintaining desired cash position):
    - From operations
    - From philanthropy and contributions
    - From earnings on investment portfolio
    - From any unrestricted endowments

Debt Capacity Determinants

- Bond rating (Moody's, Standard and Poors, Fitch etc.) determines credit "worthiness" and the cost of capital
- AAA, AA, A, BBB, BB, B, CCC, CC, C, D
- Based upon operating budget, operating margin, current debt, and cash flow
- Can vary the interest rate of debt by >100%

Investment capacity determinants

- Fluctuations in the market!
- Net income for current year
- Restricted, semi-restricted, and un-restricted fund balances (equity)
- Hospital development programs

The bottom line to having a successful hospital

- The institution must be doing more than just breaking even
- The interests of physicians and the hospital must be adequately aligned
- Physicians, management, and the board must be working collaboratively to achieve the strategic plan
- Physician leaders must become familiar with the basic concepts of financial planning

P4P: Definition

- Physician/hospital reimbursement rates based on performance
- Designed to drive fundamental changes in quality and payment for healthcare
- Designed to encourage physician participation in creating value (for the consumer and the payer):
  - Quality of care
  - Customer satisfaction
  - Efficient delivery systems

P4P: Why do it?

- Shortfalls in the quality of care
- Healthcare costs continue to increase
- Need to marry cost and quality (increase value or outcomes/cost)
- Measures spur meaningful improvement
- Incentives are not aligned: Hospitals and providers are paid more when mistakes are made (unintentional rewards)

P4P: Payers

- Programs increasing
  - 2005: 107 programs covering 53 million
  - 2008: 160 programs covering 85 million
- Not all providers affected equally
  - 95% include PCPs
  - 52% include specialists (cardiology, ortho, OB/GYN, and endocrine most common)
  - 33% include hospitals
  - 64% measure and reward individual physician performance, not just group performance
- Electronic health infrastructure critical to collecting, reporting, analyzing, and improving P4P indicators

P4P: The challenges

- Effectiveness: Health services research is needed
- Ethical implementation: AMA guidelines set the operational boundaries and ethical rules for physicians, payers, vendors, and patients
- Incentives as a percent of physician revenue
- The right mix of measures
- Avoid neglecting non-measured aspects of care
- Physician resistance: The rich get richer
- Small and solo practices don't have the capability or resources to measure and report
- Unintended consequences!!!

No pay for poor quality:

The flip side of P4P

OR

Using the power of the purse to build a business case for quality and safety

MS-DRGs: The process

- Current 538 DRGs reduced to 335 base MS-DRGs
- Of these 335, 106 split into two subgroups, and 152 split into three subgroups, arriving at 745 total MS-DRGs
- Subgroups determined on presence of:
  - Complications and comorbidities (CC)
  - Major CCs (MCC)

MS-DRG for heart failure

DRG number	Weight	Payment
DRG 127	1.0490	$5,561.29
MS-DRG 291	1.4850	$7,923.02
MS-DRG 292	1.0216	$5,450.61
MS-DRG 293	0.7317	$3,903.89

MS-DRG: The bottom line

- The level of severity for MS-DRG determination and, hence, inpatient hospital payment, will be based on admission level of severity, rather than discharge level of severity as of present.

No can do … “never events”

- Hospital-acquired conditions for which Medicare will no longer pay to treat:
  - Air embolism
  - Blood incompatibility
  - Catheter-associated UTI
  - Hospital-acquired injuries (patient falls)
  - Object left in surgery
  - Pressure ulcers
  - Surgical site infections
  - Vascular catheter–associated infections

Become familiar with financial metrics

- Income statements
- Balance sheets
- Statement of cash flows
- Variance reports
- Financial ratios
- Margin
- Fund balance
- Depreciation

Recovery Audit Contractors (RAC)

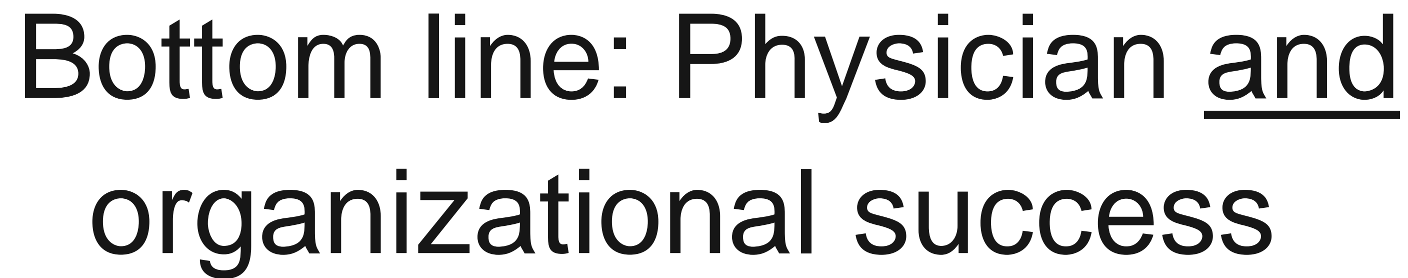
- Created by CMS to track improper payments by the federal government
- Initial demonstration projects in NY, CA, and FL recovered $54.1 million (3.9% of total Medicare payments) due to inappropriate “up-coding”
- 3.9% of Medicare costs in 2007 = $10.8 billion
- Cost of program only $0.22 for each $1 recovered
- All states currently audited!

Where does the medical staff fit in with RACs and financial integrity?

- Perform only medically necessary procedures and services
- Valid and timely orders
- Optimum and timely documentation
- Advisory role to management (medical necessity, appropriate setting, automating documentation processes to minimize physician burden, etc.)

The bottom line- align medical staff and hospital interests

- Contract for alignment (quality and financial goals)
- Include financial performance as an MEC agenda item
- Include medical staff leaders on finance committee of BOT to better understand the financial implications of clinical decisions


Bottom line: Physician and organizational success

Medical Executive Committee Institute

Essential Training for All Medical Staff Leaders

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