

Chief Medical Officers,

To assist with consistent communication, the below are common questions that have been asked at medical executive committee meetings. Please share and contact Scott Hardin with questions.

Thank you,

Dr. Scott Hardin

The following is an overview of why a unified medical staff structure has been suggested.

Situation:

The Aurora Health Care Medical Group (AHCMG) requested a deeper review of the only solution to simplify privileging and credentialing, OPPE and FPPE, which is a unified medical staff across all Aurora hospitals.

Background:

Leadership researched and created a draft structure for consideration by the Medical Staff Committees (MEC). Aurora has two unified medical staffs within the current structure (one with 5 hospitals and one with 2). Their unification journey was taken into consideration when creating the drafted unified structure and drafted unified bylaws. Fourteen hospitals are invited to review the draft proposal, share feedback, and consider voting on the bylaws to create a unified medical staff. Joint Ventures – Aurora BayCare and Aurora BayArea – which have independent governing boards, are not eligible to join the unified medical staff structure.

Next Step:

The MECs at each hospital are asked to bring the newly drafted bylaws to a vote by the end of the year 2018.

FAQ

The following are questions identified during the medical staff unification discussions.

Accreditation recommendations

- Will this be okay with CMS? Does this affect The Joint Commission?

Response- This is aligned with CMS regulations and will not conflict with Joint Commission surveys.

- What are CMS requirements on the sites opting in/out?

Response- CMS requires that each hospital that is part of a unified medical staff be given the opportunity, in specified intervals, of requesting a vote to opt out of the unified structure. The opt-out option is built into Article 12 of the draft Bylaws.

Billing Questions

- Does this change have any collection or billing issues with CMS?

Response- No, the billing and collection process will not change since billing is done based upon each hospital's Medicare number and each hospital will retain their separate Medicare number under a unified medical staff structure. Note that the unification of the Metro medical staffs (done many years ago) and of the Burlington/Lakeland medical staffs (done about a year and a half ago) did not change the billing practices.

- Does this change have any collection or billing issues with commercial payers?

Response - No. In fact, it may make it easier to meet certain medical staff requirements of certain commercial payers.

Emergency Call Coverage Concerns:

A unified medical staff structure can enable emergency call coverage; however, there is the potential for call to be assigned inappropriately if desired. The Department Chair at each site will assign emergency call but we would like to have certain guardrails built into the Bylaws to minimize the potential of emergency call being assigned inappropriately.

- Can a provider really be “forced” to cover emergency call at another hospital? If so, can there be a geographical mileage requirement within the Bylaws?

Response- Before answering in the proposed state, it is important to understand present state. Right now, if you are on staff at any hospital in our system and you have a staff category that is eligible to take emergency call, then you can be placed on the emergency call schedule simply because you are on staff at that hospital and have a staff category status eligible to take emergency call. Generally, only physicians who actively practice at a hospital are placed on the emergency call schedule and so we rarely run into a situation where someone has been placed on the call schedule at a hospital “against their will,” but it does happen now. This situation does not change with the unified structure; however, the proposed bylaws include a section titled “Emergency Department On-Call Coverage” to attempt to mitigate this concern. The proposed bylaws explain that a staff member must participate in emergency call if they reside within thirty (30) miles of the site. This language serves as a guardrail to safeguard against inappropriately assigned call (as well as ensuring adequate patient care by not having physicians who respond to emergencies being located too far away to appropriately respond to the emergency need). However, being outside of 30 miles is not an absolute exclusion from being able to take call if the practitioner and the medical staff agree that being on emergency call is OK. Staff members outside of the thirty (30) miles can work with their corresponding Site Leadership Council to determine emergency call needs so that if you reside outside of the 30 mile radius but you want to take call and the Medical Staff Leadership at the site wants you to take call, then you will be able to take call.

- Can a provider be on medical staff but without clinical privileges?

Response - Yes. Presently, there are different ways that our medical staffs around the system manage this designation. Some use the staff category of “affiliate.” Others use a category of “honorary.” No matter the terminology used, there is a way to assign a staff category without privileges.

Collection and allocation of Dues and Fees:

- How will Dues/Fees be assessed? When will they be collected?

Response- Dues and Fees are collected by the majority of sites and used at that site's discretion. The main use of the funds is philanthropy work and medical staff functions.

Three options were shared and determined that there will be 'no change' on how to handle Dues/Fees in a unified structure:

- No change:
 - Sites continue to individually determine the staff members that will pay dues, the amount of dues charged and how those dollars are allocated, in the same fashion they do in the current state.

Medical Staff Office Structure

- Will the Unified Medical Staff change the work for the medical staff office at the site? What will the structure look like for the medical staff office? What about sites that do not have fulltime personnel?

Response- We do not expect that unifying the medical staffs will affect the presence or number of Medical Staff Services Professionals at the sites; they will continue to support Medical Staff functions, governance, and other important local work, and will be physically located at the hospital(s) they support. Their work may look different in that they will collaborate significantly with their colleagues at other sites to conduct the work of a unified Medical Staff. After voting is complete, the Medical Staff Services Professionals at the participating sites will convene and determine how to operationalize any work that needs to be unified. We will need to determine operationally what the flow of the work will look like, how we leverage our credentialing software, eliminate duplicative work and contacts to applicants, use a single contact approach for requirements such as annual education and other requirements, etc. A personal relationship with the hospital's Medical Staff leaders and Administration is critical to the work of the Medical Staff Professionals and we are committed to ensuring that local presence remains.

- Will unification affect my site's Medical Staff Services' support?

Response- No. Our Medical Staff Services professionals play an integral role in the operations of our Medical Staff and their work at the sites is critical. This includes remaining present in the hospitals to support our Medical Staff leaders and members. Medical Staff Services will not be relocated or put in a centralized location. As they continue to support you in your hospital, they will also provide their expertise, along with their colleagues across the system, to identify opportunities to reduce burdens on our Medical Staff members as it relates to duplication of communications or requirements (such as different versions of annual education received by physicians at different sites, or receipt of multiple communications on the same topic).

Meeting logistics:

- How will meetings occur? Location and time requirements are a concern.

Response- There are presently multiple meetings with larger memberships that encompass the entire Aurora footprint that function quite well utilizing technological solutions such as video conferencing, Lync, Skype, etc. We expect this meeting would have a main room with multiple videoconferencing sites available, as well as a call in option.

Location:

- The use of video conferencing would be an option. Some departments such as radiology have been successful with this approach and the technology is available.

Time requirements:

- What is the mechanism that will ensure site participation at these meetings in the event of an absence or unavailability of the appointed site representative? Would there be an alternate member appointed/elected? Would the primary member select an alternate as necessary?

Response- These are generally issues that are not covered in the Bylaws and would be addressed by the newly formed MEC. The approaches mentioned in the question are possible but would not be prescribed in the Bylaws.

PEER Review and process

- Explain the System PEC structure verses the Site PEC structure.
 - How will System PEER review interact with the site teams
 - What will the System team be responsible for compared to the sites
 - How will OPPE/FPPE work across the System?

Response-The site peer review committees will still be needed and will continue to operate pretty much exactly as they are now, performing the case based peer review, monitoring performance of the PEC indicators and OPPE metrics, identifying the need for and developing monitoring agreements and performance improvement plans, etc. The OPPE metrics and PEC metrics themselves will be determined by the new system PEC, obviously with input from all of the chairs of the departments and chairs of the PECs at all of the sites. In addition, the system PEC will review and “approve” the performance improvement plans and monitoring agreements, but “approve” gives the impression that they can also “not approve” them, and while that may be technically possible, practically that is not the role the system PEC really has. In its capacity of reviewing all PIPs and monitoring agreements, what is really done is the facilitation of a robust discussion of the situation for possible modification of the plans and

review of the practice at other sites of the practitioner involved to ensure that there are no other/similar issues at those sites that should be included in the PIP, as well.

- Who has the authority to suspend immediately?

Response- Summary suspension may be imposed by Site Leadership Council Presidents, the Site Administrators, the Chief of Staff, a majority of the Medical Executive Committee, or a majority of the Governing Body.

- What is the process for managing a suspended practitioner after the suspension has occurred?

Response- Once the suspension occurs, then the matter is further discussed at the applicable Site Leadership Council with guidance from the MEC. In the event a formal Request for Investigation is filed, then the procedures in Article 4 will take place (that process also begins with the Site Leadership Council).

- Where does the appeals/hearing process occur? Who is responsible for the investigations? Who must be involved in these types of decisions and at what time?

Response- The initial investigation is completed by the applicable Site Leadership Council (i.e. the affected Staff Member's Primary Site or the Site at which a specific incident which led to the request took place). The Site Leadership Council's recommended actions from the investigation are forwarded to the Medical Executive Committee for review and approval.

In the event the Medical Executive Committee recommends an Adverse Action to the Governing Body, then the affected Staff Member will be provided hearing and appeal rights. If the Staff Member exercises his/her hearing rights, the hearing would be presented to a hearing committee made up of Active Staff Members from the medical staff. If the Staff Member loses the hearing and wishes to appeal, such appeal is heard by an Appellate Review Committee made up of not less than 3 Governing Body members. This mirrors the current hearing and appeals process at all Sites.

Primary site questions

- How is primary site identified?

Response- With initial privileging, the practitioner will identify his/her primary site, which is based upon volume of expected clinical activity. Realizing that practice locations can, and do, change, upon recredentialing, volume reports will be run and any practitioner who has higher volume at a site other than the identified primary site will be asked if the primary site should be changed to the site with the greater volume.

- While we don't have a reliable way to capture how many physicians are on staff at multiple sites, we do know that it is very common for a physician to hold privileges at multiple Aurora hospitals. We also know that approximately 58% of the physicians on

staff at Aurora hospitals are employed by Aurora, and approximately 42% are independent.

Privileging and credentialing questions

- How will physicians/ providers request privileges?

Response- Paperwork for initial appointment only need be completed once, no matter the number of Site at which a practitioner plans on activating clinical privileges. For re-credentialing, paperwork only need be completed once, no matter how many hospitals at which a practitioner is on staff, and reappointment paperwork only need be completed once every two years thereafter.

- What does it take to activate privileges at another hospital if needed? Can they be deactivated just as quickly?

Response- The request needs to be in writing, so an email to the medical staff office professionals requesting that privileges be activated is all that is required.

- If on staff at all sites due to this unified medical staff – when completing an application or paperwork that requires a listing of all hospital affiliations would we list just one or would we have to list all Aurora sites? Or just the site that is your Primary?

Response- The primary site is responsible for the review.

- If one Site has a concern regarding an applicant and this provider is requesting privilege activation at another location how will sites communicate?

Response- The System PEC is charged with monitoring identified clinical concerns that are pending with Staff Members. If a pending concern is severe enough that a Staff Member shouldn't activate privileges at another site, then the System PEC will work with the Primary Site PEC and leaders at the Primary Site to initiate an appropriate performance improvement plan prior to a Staff Member's clinical privileges being activated at a new Site.

Representation concerns

- Fear of the losing their voice (ensure each hospital has a voice at the System level).

Response- The structure is organized so that every Site has equal representation on each system committee. This has worked well in the Metro system to avoid any one hospital having a louder voice than another. In addition, several safety features are built into the Bylaws to further enforce the concept that something cannot happen at a Site without the committee member(s) from that site voting for the action to occur.

- Fear of having unwanted regulations/protocols forced onto a site by another site.

Response- The draft unified bylaws address this with a guardrail in Section 6.3.3 Voting on Matters that Only Affect a Specific Site. This language mirrors what is currently included in the Metro unified bylaws.

The Medical Executive Committee may not take action on a matter that relates to or impacts only a single Site unless: (i) the matter is contained in the agenda provided pursuant to Section 6.3.5 below and (ii) the Site Representative from the affected Site is present at the meeting and votes in favor of the matter.

- What is considered quorum and majority for voting?

Response- The bylaws provide that quorum shall consist of at least fifty percent (50%) of the Medical Executive Committee's voting members. If a quorum exists, action on a matter shall be approved if the votes cast within the voting group favoring the action exceed the votes cast opposing the action.

- A physician that is active at two locations (50/50) and is assigned primary site at one location however would not want to lose their voice with voting at the other location. How will this be addressed?

Response- Our goal is to give each Active Medical Staff Member an equal voice in Medical Staff governance. Providing voting rights at any site in which a Staff Member activities clinical privileges would lead to some Staff Members having multiple votes for certain items. However, for site-specific elections (i.e. Clinical Chairpersons, Site Leadership Council positions), Sites may opt to define the eligible voters as all Active Staff Members with activated clinical privileges. We will defer to the Sites on whether to expand voting rights for site issues or to limit voting rights to just those Staff Members who have designated the Site their Primary Site.

- Credential committee at the System level might become heavy on a specific specialty. How will this be avoided?

Response- Initial review of applications will continue to begin with Clinical Chairpersons who will have the requisite specialty to review the applicants. In the event the Credentials Committee feels it is not in a position to adequately review an applicant of a certain specialty, they will make that known to the MEC and the MEC will determine how to appropriately ensure the application/applicant are appropriately vetted.

General Questions:

- Does the merger with Advocate affect the unification work?

Response- Currently, the Advocate merger does not affect the unification project, nor do we expect it to anytime in the near future. Legacy Advocate hospitals are likely to begin the process of creating consistent Bylaws and medical staff processes on their own, similar to what Aurora started back around 2009. Even in the event Advocate reaches the stage in which a unified Medical Staff would be an option, we foresee it would be two medical staffs: Aurora and Advocate, given the regional and governing body split. Any unification beyond what we have proposed would require a full vote of the Active Medical Staff Members of the newly unified Medical Staff.

- Every 7 years Aurora has an itch to change their organizational structure. How will this proposed change be effected by future changes?

Response- I believe the characterization of this question misses the underlying goal of past and currently proposed organizational changes. Those changes have sought to create consistent and efficient processes that take advantage of our position as an integrated health system filled with talented human resources. The goal is to eliminate duplicative efforts, maximize the potential of our team members, and increase quality while keeping care affordable.

- Would unification have any impact on the employed physicians' non-competes – would they be changed to state they couldn't work in any geographic area within a certain distance of ANY Aurora facility, since it would now be one unified medical staff?

Response- Non-competes will not be effected by this unification. Non-competes are calculated from either one specific location or all locations at which the physician practices a certain amount of time (usually 20% or more). That calculation remains the same. No non-compete ties the restricted radius to "all sites at which the physician is on the medical staff." Wisconsin law would prohibit such a clause as overbroad and unenforceable.

- Can unification occur between service lines?

Response- This is up to Aurora Health Care Medical Group if they wish to further integrate services lines. Many service lines have already done so. We don't foresee that hospital departments will "unify" given the administrative burdens would likely outweigh any gained efficiencies. However, our hope is that a unified medical staff may lead to additional opportunities for departments at different sites to use each other as a resource for collaboration, learning, and developing best practices.

- Can a site continue to have exclusive contract arrangements with defined services lines?

Response-Yes, the contractual arrangements are made with the hospital legal entity, not the individual medical staffs. Accordingly, Sites may continue to enter exclusive arrangements if it is in the best interest of the individual hospital. Note that such arrangements would allow a hospital to not allow an Active Medical Staff Member to activate his/her clinical privileges at the Site if that Site has an exclusive arrangement with a different physician/medical group.