

Community Health Center and Academic Medical Center Residency Program Collaborations

RYAN CENTER
William F. Ryan Community Health Network



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Session Objectives

- **Identify Benefits of Collaboration**
- **Understand Key Considerations**
- **Recognize the Importance of the Planning Process**
- **Lessons Learned**
- **Understand Billing Requirements**
- **Learn about Teaching Health Center Funding Opportunities**

Who Are the Partners?

- William F. Ryan Community Health Network
- St. Luke's-Roosevelt Hospital Center
- Currently, the William F. Ryan Community Health Network consists of sixteen service sites with four main sites:

William F. Ryan
Community Health
Center, 110 West
9th Street, NY, NY

Ryan-NENA
Community Health
Center, 279 East
Third Street, NY,
NY

Thelma C.
Davidson
Adair/William F.
Ryan Community
Health Center, 565
Manhattan
Avenue, NY, NY

Ryan/Chelsea-
Clinton
Community Health
Center, 645 Tenth
Avenue, NY, NY

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- The St. Luke's-Roosevelt Hospital Center is a 1,076-bed, full service community and tertiary care hospital.
 - The Hospital's academic partner is Columbia University College of Physicians and Surgeons.

The Partnership:

- Six Phases of Transaction

1. Ryan/Chelsea-Clinton CHC took over Roosevelt Hospital's Pediatric Outpatient Clinic – '06
2. Ryan/Chelsea-Clinton CHC took over Roosevelt Hospital's Internal Medicine Outpatient Clinic (ambulatory rotation site for Internal Medicine residency program) – '07
3. Thelma C. Davidson Adair Center became an Internal Medicine residency program rotation site for residents from St. Luke's Hospital – '09
4. William F. Ryan CHC took over St. Luke's Hospital's Pediatric Outpatient Clinic -- '10
5. Ryan/Chelsea-Clinton CHC took over Roosevelt Hospital's Dermatology Outpatient Clinic (Dermatology rotation site) – '10
6. William F. Ryan CHC taking over St. Luke's Hospital's Internal Medicine Outpatient (ambulatory rotation site for Internal Medicine residency program) – Anticipated completion 1st 1/4 2011



Key Considerations:

- Does it make sense legally, financially and programmatically?
- Can you maintain and improve primary and preventive care delivery?
- Have you conducted comprehensive due diligence?

Due Diligence Process:

- Clearly understand scope of deal.
- Understand Hospital's respective outpatient clinic visit volume and payor mix.
- Determine number of residents & residency mix levels (PGY 1's, 2's, 3's).
- Determine number of residency session rotations.
- Determine what clinical and administrative interfaces will be required.
- Determine current organizational capacity and fully understand what expanded capacity will be required.

Financial Due Diligence:

- As a first step, develop financial pro-formas showing clinic/program performance under FQHC auspice (and potentially current clinic/program performance in order to identify net change. *Often this is hospital's/program's first look at clinic total performance.*)
- Pro-formas serve as objective basis for determination of Community Benefit Grant support as well as agreed-upon set of assumptions
 - Dependent upon reliable data from both partners
 - Transparency is critical

Financial Due Diligence – Key Considerations

- Clearly define services to be included in arrangement
- Ensuring appropriate segregation between teaching and non-teaching expenses
 - GME rules require GME recipient to cover all or substantially all of training costs
 - FQHC grant and patient service revenue should not subsidize teaching expense
- Ensuring adequate coverage of FQHC costs
 - Health center needs to ensure equal access to all services
 - Enabling, ancillary, overhead costs



Financial Due Diligence – Key Considerations

- Identification of annual operational expense as well as one-time, transition expenses
 - Conduct site visit to determine whether upgrades/enhancements are required
 - Work through how things will work operationally to determine financial implications (e.g. HR/personnel, IT/systems, etc.)
- Consider enhanced utilization of resources due to presence of residents

Key Considerations:

- Upon completion of due diligence and understanding the financial consequences of transaction – negotiate community benefit grant with Hospital to help offset portion of uncompensated costs (w/o restriction to patient's right to choose)
- What are the Employment Considerations (hiring of additional staff, re-location of staff, union considerations)



Process

- Creation of Term Sheet – outlining preliminary understandings and key principles of transaction. Serves as basis for negotiation.
- Prepare confidentiality agreement relative to sharing of information between parties.
- Formation of Workgroups.
- Workplan and timeline developed for respective workgroups.
- Executive Committee reviews recommendations from Workgroups and codifies agreements in contractual documents.

Lessons Learned

- Overcoming organizational resistance of both partners
- Interfacing two clinical cultures
- Fiscal well-being of both partners
- Defining roles relative to supervision of Hospital staff on site at CHC
- Credentialing and Privileging
- Planning for new patient demographics
- Medical Records
- IT and IT systems interface
- Productivity – meeting expectations of both partners.
- Patient Continuity



Clinical Aspects of Affiliation

Culture Shift

Clinical Aspects of Affiliation

- Who pays for the clinical staff?
 - Precepting Staff
 - Contracted employees from the hospital
 - Current FQHC staff in same discipline
 - Newly hired FQHC staff
 - FTCA implications
- Medical Students

Clinical Aspects of Affiliation

- Know the stakeholders and decision makers, and make sure they are at the pre-affiliation discussion meetings
 - Residency Director
 - Clinical Leader of Precepting Staff
 - Role of the Chief Resident(s)
 - Nursing



Clinical Aspects of Affiliation

- Regulations
 - Residency Regulations
 - FQHC Regulations
 - Crosswalk

Clinical Aspects of Affiliation

- Discipline
 - Residents
 - Preceptors
 - What role does clinical leadership at the FQHC play regarding disciplinary action?
 - Termination of a resident or preceptor

Clinical Aspects of Affiliation

- Insurance Credentialing
 - Precepting providers need to be on-par with your insurance plans and have the correct Locator ID
- Privileging
 - Preceptors and Residents need to be privileged to work at your FQHC, including all primary source verification
 - Hospital as a Credentialing Verification Organization (CVO)

Clinical Operations

- How many additional patients do you expect?
- How many exam rooms will you need?
- What about precepting rooms?
- Additional equipment
- Additional support staff, both clinical and administrative
- Any staff coming from hospital?
- Union issues

Clinical Operations

- Scheduling
 - Preceptors
 - Residents
 - Patients
 - Considerations: first few months of PGY-1 year
 - Various visit types
 - Time built in to precept
 - Productivity expectations
- Changes in Preceptor/Resident Schedules
- On-Call Schedule



Clinical Operations

- Practice Management
- Medical Documentation
- Medical Records from Hospital



Clinical Operations

- Patient Continuity



Performance Improvement

- Involvement of residents and preceptors in FQHC's Performance Improvement (PI) activities
- PI activities underway at the hospital at time of affiliation
- Information Exchange

Coding

- Provider education regarding compliant coding practices
- Acceptable E&M levels of coding
- Primary Care Exception Waiver

Teaching Physician Primary Care Exception Rule Requirements

- Applies to lower and mid-level E/M services (99201-99203, 99211-99213 and G3044)
- Teaching Physician (TP) may not supervise more than four (4) learners, residents and students, at any given time
- Care must be directed from such proximity to constitute immediate availability
- No other responsibilities assigned at the time service was furnished by the resident
- Primary medical responsibility for patients cared by residents
- Ensure care furnished is reasonable and necessary

E/M Services Documentation Guidelines

- Combined entries into the medical record by the TP and resident constitute the documentation for the service and together must support medical necessity.
- TP must document at minimum the extent of the teaching physician's participation in the review and direction of the services furnished to each patient.

Billing Requirements

- Selection of the appropriate E/M service & ICD-9 supported by chart documentation
- TP NPI - billing provider
- Visits with improper documentation do not qualify as a billable visit (i.e. chart only contains resident documentation of TP presence)

Cautions:

- Ask – Is this transaction VALUE ADDED. Be prepared to walk away if it is not.
- Clearly understand why this is in the Center's and patients' best interests.
- Conduct your due diligence – make sure to have good legal and financial counsel.
- Assure buy-in at all levels.





Outcomes:

- Since entering partnership we have expanded our capacity to serve patients.
- Improved patients' in our communities continuity of care.
- Expanded Network's mission to include teaching future primary care providers in a community health center setting. Enriched residents' medical education.
- Helped with physician recruitment.
- Improved payor mix.

Q&A

