# Medical Staff Briefing

## Case study: Is your organization on board with your onboarding process?

### How a Lean Six Sigma Green Belt project turned into a complete overhaul of provider onboarding at Johns Hopkins All Children's Hospital

*Editor's note: This case study was a finalist in the 2017 Credentialing Resource Center Symposium Case Study Competition.*

Practitioner onboarding means different things to different people, depending on which department of the healthcare organization they work in. It can be hard to take a step back and look at the overall picture of provider onboarding when you are focused on your piece and meeting your own deadlines and responsibilities. However, taking the time to analyze this big picture can completely transform the onboarding process and ultimately improve everyone's view of the healthcare organization—including patients'.

"The process really comes together [when] you have robust teamwork focused around the practitioner to deliver the end product of onboarding," says **Evalynn Buczkowski, RN, BSN, MS,** senior consulting director for clinical operations at Vizient. Buczkowski is currently contracted by Johns Hopkins All Children's Hospital (JHACH) in St. Petersburg, Florida, to offer clinical operations consulting in the medical staff services and the patient safety and quality departments. "At the beginning, everyone felt like they belonged to one distinct and separate part, so we changed the mentality. The actual work product and outcome we focused on was the practitioner. Even to a greater extent, it is the patient who wants to be treated by the practitioner."

Without timely enrollment in health plans, JHACH was dealing with patients who, upon coming from out of state to see a particular practitioner, either had their scheduled visit delayed or had to see someone else—which led to practitioner and patient dissatisfaction.

The total transformation of JHACH's onboarding process began with **Kristine Kirstein, MHA,** academic program manager for Johns Hopkins University at JHACH. Kirstein was completing her Lean Six Sigma Green Belt certification process and needed a capstone project. Her boss suggested that Kirstein look into the provider enrollment process because it was slow and inefficient, with an average enrollment time of six months.

"As a physician myself, it is really frustrating when you start in a new place and you cannot see patients right away," says **Brigitta U. Mueller, MD, MHCM,** vice president of medical affairs and chief patient safety officer for JHACH. "Usually, medical staff credentialing is ahead of the game. That is usually in place by the time you join the organization, but then you have to wait to get credentialed with all of the payers. Depending on where you work, it can be weeks to months. During that time, you are very restricted in what you can do.

"From the perspective of the business, it is really frustrating," she adds. "You have x number of physicians on staff, but not all of them can be scheduled to take call or see patients in clinic."

In investigating the hospital's provider enrollment process, Kirstein used the Lean Six Sigma tool of workflow to depict the entire onboarding process. Kirstein started realizing that data (sometimes duplicative) was housed in many places. "Providers were getting really confused and, I think, frustrated with the entire process. We heard from providers, 'I have given you that piece of information five times.' "

So Kirstein decided to gather the provider enrollment and medical staff services departments at the table to discuss their parts in the process and the information they collected. The group compared the two processes to understand when and where certain pieces of information were collected and to identify commonalities.

### Combining provider enrollment and medical staff services

As Kirstein learned more about the duplicative components of provider enrollment and medical staff credentialing, she wondered whether combining the two departments could improve efficiencies. She started cold calling other hospitals to see if they had tried this tactic.

"I talked to a couple organizations that had combined or were thinking about it. But there weren't many out there that had done it," says Kirstein.

That doesn’t surprise Buczkowski. She says the field is just beginning to talk about and understand how to roll provider enrollment into medical staff services—traditionally two siloed functions.

After talking with outside organizations and leaders from her own hospital, then weighing the pros and cons, Kirstein says it became clear that medical staff services and provider enrollment should be brought together.

“The more we looked into it, the information that the medical staff office gathers really impacts the enrollment team. If one piece of information is wrong, or they don’t gather it because they don’t need it, but another group needs it down the line,” that can be a problem, says Kirstein. “They are both gathering the same type of information from providers, and they were both on the same system (MSOW), but they didn’t have access to each other’s information. There were only five to seven fields that crossed over. So, for the large majority, they were operating in silos, when at the end of the day they are working with the same providers.”

“The right hand did not know what the left hand was doing. There was a lot of duplicity asking for the same materials,” says Mueller. “It is so much better now; they really have created efficiencies.”

However, although on paper it made sense to bring provider enrollment under medical staff services, getting two siloed departments to truly work together presented a challenge.

“At first, I would say it was difficult—as anything is—because you have two different groups, two different processes, and they are operating in silos. People get comfortable; we were being disruptive,” says Kirstein.

JHACH started by co-locating the departments. The two provider enrollment specialists moved into the medical staff office and reported to the head of medical staff services. However, the medical staff services director left the organization during this transition, leaving the group without leadership. Kirstein unofficially took on the leadership role, but because she didn’t work in medical staff services or provider enrollment, the shoes were hard for her to fill.

“This group didn’t have anyone to lead them through this transition; that was a piece that was missing,” says Buczkowski.

As previously mentioned, the hospital hired Vizient to assess all of the departments that report to Mueller, including medical staff services. After providing JHACH with its assessment, the hospital decided to contract Buczkowski to serve as a clinical consultant in the medical staff services area as well as patient safety and quality. She also took on the missing leadership piece.

Based on the assessment work, it was clear to Buczkowski that provider enrollment and medical staff services were still operating independently.

“You would walk into the office and sense that although co-located, they were not working together. Workflows were still separate, which created redundancies in practitioner contacts and requests for documents,” says Buczkowski. “Even though Kristine had done the workflows to remove redundancies, there was a big gap in implementation and adoption when I got here. I wanted to take off on the work Kristine had started. It was my goal to break down the barriers between departments and actually function as one and move as much upstream as possible so we could focus on streamlining processes for provider enrollment and credentialing and privileging.”

Buczkowski focused on team building and getting everyone to realize that they were all working toward the same goal—onboarding practitioners effectively and efficiently.

The process starts with recruitment sending out the medical staff application to the provider—a change that was also implemented through Kirstein’s research. She notes that previously, when the medical staff services department sent out the application, the provider had already committed days or weeks earlier to come to the hospital.

“Why did the medical staff office have to send out the application? Why couldn’t recruitment send it out? So we decided to teach recruitment how to send the application out,” she says.

Now when practitioners return their contract, they are asked to also send some pieces of demographic information. Recruitment enters this information into the credentialing system and immediately sends the medical staff application to the practitioner. According to Kirstein, this change shaved at least a week or two off of the credentialing process.

Provider enrollment and medical staff credentialing are run as parallel processing. The group that is doing credentialing and intake, is doing things that might normally be done by provider enrollment. According to Buczkowski, enrollment was moved to the front end, so by the time a practitioner starts, “we are aiming to have provider enrollment, credentialing, and privileging all done so there is no loss of revenue or access issues for patients.”

Kirstein says once the group had a true leader, they started working together and improving the onboarding process.

## Meetings

When Kirstein started her project, the payer enrollment supervisor held weekly meetings with provider enrollment and recruitment. As Kirstein started dissecting the onboarding process and working with Buczkowski, they realized more improvements could be made if they involved anyone who had a hand in the provider onboarding process. This developed into a 45-minute biweekly meeting involving:

- Medical staff services
- Provider enrollment
- Recruitment
- Billing/revenue cycle
- Operations/practice management
- Human resources
- Marketing
- Risk management
- Department chairs and institute/department leadership
- Health services
- Medical staff leadership

During these meetings, every provider who is in the midst of the onboarding process is discussed. That way, if a department has a piece of pertinent information about the provider or process to share with the group, everyone who needs to know is there to hear it.

For example, a few weeks ago, the hospital needed to get a psychologist on staff as soon as possible—one of its psychologists was going on maternity leave, and there was no one to provide coverage. “It was a 30-day start, but everyone in the room was aware of it and knew it was a priority, so they made it happen. Just having that conversation and everyone hearing the ‘why is this important’ has helped so much. The way they interact now versus the way they interacted when they first started, it is night and day,” says Kirstein.

The biweekly meetings have also helped cut down on the frequency of communication with the practitioner—but also making sure that the appropriate person reaches out to the practitioner when communication *is* necessary.

If a provider has not returned his or her application and the medical staff services department has reached out to the provider twice, then the matter is discussed in the meeting, and it goes to the person recruiting the provider, then to the department head, and even sometimes the institute leader. “That follow-up comes from someone higher, and it honestly makes things happen faster. You might ignore the medical staff coordinator, but when your new boss says, ‘You are not starting here until you do this,’ you whip yourself into shape. That interaction has been very helpful and helped move things along,” says Kirstein.

Mueller says the meetings and streamlined process have also helped reduce the use of unnecessary temporary privileges. There is a timeline for bringing providers on board, and once all of the materials are in place, the file can immediately go to the credentials committee for approval. The hospital has also created a subgroup of the governing board that can act on behalf of the board to approve a provider. However, this doesn’t happen often since the onboarding process is more succinct. “All of the committees meet monthly, so we can walk someone through all approvals within a month or two. And we are now so ahead of the game in terms of planning that it is doable in regards to their start date,” says Mueller.

“Before, we were very reactionary. We kind of did things as they came, instead of prioritizing by start date. That is the day they are supposed to start; that is the day they need to be ready. I think it has helped everyone prioritize,” says Kirstein.

The meetings also serve as an outlet to announce any changes being made to the onboarding process. The first five minutes of the meeting are reserved for announcements or gathering input into the onboarding process. Recently it was brought to the team’s attention that the provider termination process was difficult to manage, so the team brainstormed a few ideas and ended up adding a termination tab to its onboarding tool.

The meetings have grown so big that the group no longer fits in the conference room where it normally meets. Kirstein sees this as a good problem. The meetings have not gotten too unruly, and the onboarding tool the group created helps structure the gatherings.

## Onboarding tool

As more departments became involved in the onboarding meetings, the group realized it needed a tracking tool to

keep an eye on what was going on. The group built a tracking spreadsheet. It has four key areas that must be filled out:

1. **Recruitment:** Applicant's practice area, estimated start date, date recruitment sent out medical staff application, date payer enrollment paperwork sent, date the practitioner is scheduled for employee health, state the practitioner is coming from, scheduled start date
2. **Department/institute:** Whether the provider is a new provider or a replacement provider, other hospital privileges required
3. **Medical staff:** Date medical staff application received, Florida license, DEA certificate, and certificate of insurance confirmed
4. **Managed care:** Date enrollment packet was received, fingerprints complete, Medicaid application date, commercial application date

During the meeting, the group goes through the tool line by line for each practitioner to update any necessary information; it is sorted by start date. The spreadsheet is a live document that everyone on the onboarding team has access to and can update.

"No longer are people scrambling or freaking out to onboard a new provider because everyone knows what day we are working toward. If a start date changes, it is on the spreadsheet and everyone knows. It is a great tool. I get requests for people to have access to this tool weekly," says Kirstein.

Buczkowski would like to create a version that has real-time metrics, eliminating the need for departments to look up the status of other departments' onboarding pieces.

"There is probably not a day that goes by that being here in the trenches I look and think, 'aha, that is something we can eliminate as a redundancy or change and move upstream or move downstream.' It takes constant oversight to maintain that sustainable practice," says Buczkowski.

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## Payer enrollment metrics

At Johns Hopkins All Children's Hospital (JHACH):

- The top 12 payers make up 95% of patient encounters.
- The hospital successfully cut enrollment days in half for eight of the top 12 payers.
- The four difficult payers led to a majority of the delays in achieving active provider participation status. Without these four payers, JHACH would be at 90% payers approved, 5% payers submitted, and 5% payers in queue
- In February 2015, less than 50% of all employed providers were active with payers. By February 2016, this increased by 20 percentage points.
- By end of 2016, over 77% of employed providers were active with payers, while the volume of providers continuously increased.
- In February 2015, over half of the provider applications were in the queue (non-participating provider status). By end of 2016, only 13% remained in the queue, which is a decrease of 38 percentage points

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## Four steps to improve onboarding

According to **Kristine Kirstein, MHA,** academic program manager for John Hopkins University at John Hopkins All Children's Hospital Kirstein, the key steps to successfully improving the hospital's onboarding process were:

1. Establishing a biweekly time to connect with all individuals involved in onboarding. This ensured all questions were addressed in real time and decisions were made with the appropriate people present.
2. Having the right people in the room or on the phone. The team established a conference line, which increased participation because some participants only needed to hear about 1-2 incoming providers. The conference call made it easier for them.
3. Developing a tool that supported the key milestones of the onboarding process.
4. Ensuring access to the tool for continual updates/edits.

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## Cleaning up enrollment

Now that John Hopkins All Children's Hospital (JHACH) has streamlined its provider enrollment process and realized greater efficiencies, it has time to focus on other lingering enrollment issues.

The organization is now retroactively going through all of the divisions, looking at providers that have been on

staff for a while, and filling any holes regarding their payer credentialing. According to **Brigitta U. Mueller, MD, MHCM,** vice president of medical affairs and chief patient safety officer for JHACH, there was not a good system in place before, and the hospital did not have a good handle on who was credentialed with whom. This made it difficult for individual divisions because some providers could see any patient and some were limited based on the patient's health plan.

"It is amazing once you start digging how many holes you discover in the process," says Mueller. "And once you stop duplicating efforts, it is amazing what you can achieve. That is only possible because we have [enrollment and medical staff services] under one leadership."

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## Delegated credentialing

Combining provider enrollment and medical staff services helped John Hopkins All Children's Hospital (JHACH) achieve delegated credentialing with some of its payers.

As the workgroup that was revising the onboarding process continued looking for efficiencies, one of their goals was to achieve delegated credentialing with payers. Health plans also credential providers before allowing them to enroll in the plan. Delegated credentialing means that the health plan allows medical staff services to perform the credentialing functions that the health plan would normally perform.

"As we started to look into it and the NCQA requirements for delegated credentialing, a lot of the requirements, like primary source verification, were things our medical staff office was already doing. We were closer than we originally thought to achieving our goal, but some key steps still needed to be made," says **Kristine Kirstein, MHA,** academic program manager for John Hopkins University at JHACH.

Trying to achieve delegated credentialing with payers forced the organization to deal with the fact that they "didn't have a single source of truth for provider data" in the hospital. Kirstein says information like provider demographics and payer information was strewn across multiple spreadsheets, and because the information in the system was so disjointed, people did not always trust it.

"We reorganized all of the data," she says. "During our weekly check-ins, we spent a lot of time deciding what needed to be cleaned up. We started with office listings."

One reason the hospital focused on office listings is because health plans want a roster of providers, including their demographic information. Kirstein says JHACH could only run a manual roster, which took a long time to create. Thanks to the efforts of the workgroup, it's now possible to click a button and run a roster.

"We made a lot of goals like that—to clean up the system and make everyone feel confident in it again," says Kirstein. "We have done a lot, not just for those two departments, but for the entire organization."