THE HOSPITAL-PHYSICIAN INTEGRATION CHALLENGE

Successful hospital-physician integration is considered a core element of any successful response to mounting demands for higher-quality, lower-cost patient care. Turn the page to find a challenging—and rewarding—route to this still elusive destination.

Hospital-Physician Integration Strategies

For more in-depth descriptions of the following strategies, visit hfma.org/leadership, Fall/Winter 2013 issue

1 **Hospitalists and professional service agreements (PSAs).** Some hospitals directly employ hospitalists. Others use PSAs. Under PSAs, hospitals typically contract with an existing medical group or a new group formed under a single tax ID through the consolidation of existing physician practices, according to an August 2012 *hfm* article.

2 **Compensating physicians for time spent in improvement activities.** Franciscan St. Francis Health added a citizenship score to its physician compensation model, according to the 2011 PwC report *From Courtship to Marriage*. This citizenship score is based on the time physicians spend participating in hospital and medical group committees.

3 **Sharing performance data with physicians.** An August 2012 *hfm* article recommends several strategies, including show the assumptions behind the data and explain the rationale behind the assumptions.

4 **Gainsharing example.** In gainsharing, hospitals share savings from performance improvement activities with physicians or others. According to a July 2013 *hfm* article, St. Luke's Health System used gainsharing to save $11.2 million in cardiovascular, orthopedic, and spine costs between 2007 and 2012.

5 **Legal obstacles to gainsharing.** In 1999, the U.S. Office of Inspector General (OIG) released a special advisory bulletin stating that the government could impose a civil monetary penalty on a hospital that pays a physician or physicians for reducing or limiting services to Medicare or Medicaid beneficiaries under their care, according to a July 2013 *hfm* article. However, the December 2012 OIG opinion approved a comanagement agreement that included a performance bonus program that would reward physicians based on their scores for patient service, quality of care, and cost savings.

6 **Management service organizations (MSOs).** MSOs provide practice management services, IT support, and other services to physicians. Health systems can offer MSO services for free or at market rates to affiliated physicians as an alignment strategy. In some cases, these services are provided through an IPA or PHO. Some PHOs require MDs to meet certain quality targets before being allowed to join the PHO.

7 **Joint ventures.** A successful joint venture between Summa Health System and Summa Physicians, Inc., brought together Summa's orthopedic service line with Crystal Clinic, which includes an ambulatory surgery center and 30 physicians at seven sites, according to a 2010 HFMA roundtable discussion.

8 **Integrated ambulatory EHR.** St. John Providence Health System worked with its PHO to develop a comprehensive ambulatory clinical IT strategy, which includes a health information exchange, electronic health record, disease registry, and a patient portal, according to a Fall 2011 *Leadership* article.

9 **Comanagement.** Lee Memorial Hospital credits its comanagement agreement with 24 orthopedic surgeons for reducing readmissions for knee replacement patients and other improvements, according to a case study in the Summer 2013 *Leadership*.

10 **Legal challenges to comanagement.** Under the Stark and anti-kickback laws, any compensation paid for achieving comanagement goals are required to be set at fair market value, according to a September CFO Forum article. In addition, not-for-profit hospitals have other IRS restrictions.

11 **Physician leadership academy.** In 2010, UnityPoint Health launched an academy to prepare promising physicians for future leadership roles in the organization, according to a May 2012 *Leadership* article.

12 **Organizing medical groups into a single group.** UnityPoint Health is transitioning more than 900 employed physicians into an aligned medical group, according to a Summer 2013 *Leadership* article.

13 **Patient-centered medical homes.** Seeking to learn more about how to succeed in an accountable care framework, Adventist HealthCare piloted a medical home delivery model, which has resulted in a 35 percent reduction in per-member-per-month costs.

14 **Employed physician compensation methods.** Many leaders interviewed for a 2010 HFMA Thought Leadership Retreat report said their organizations use or are moving toward a relative value unit (RVU)-based compensation package that includes a pay-for-performance bonus.

15 **Clinically integrated network.** Advocate's Clinical Integration Program brings physicians together with the health system to address the quality and costs associated with an entire episode of care, according to a November 2010 *hfm* article.

16 **Population health management.** Advocate and Blue Cross Blue Shield of Illinois worked together to develop a three-year shared savings agreement with upside and downside risk for the network.

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The exact journey to hospital-physician integration will depend on a number of factors, including the amount of consolidation in your marketplace and your organization's mission, vision, and values. The following route reflects common strategies pursued by many hospitals and physicians across the country as they experiment with varying degrees of integration (loose, partial, and full).

DRIVING FORCES FOR HOSPITALS & HEALTH SYSTEMS

- Improve value equation for purchasers
- Recruit the right blend of physicians
- Meet community needs (e.g., on-call ED coverage)
- Maintain or grow services
- Enhance continuity of care

DRIVING FORCES FOR PHYSICIANS

- Ensure patient access to continuum of care
- Increase or secure consistent income
- Pursue better work-life balance
- Lessen administrative and IT burden
- Pursue value-based contracting

START

THE PLAYERS: CURRENT STATUS

- Independent hospital or health system
- 85%-95% of medical staff currently independent
- IPA mainly used for payer contracting

Develop Integrated Vision & Goals

QUESTIONS TO CONSIDER

- How will we need to change over the next five years to adapt to market-place changes?
- What are our major strategic goals?

Determine Relationship Structure

EXAMPLES

- IPA leaders named to health system board and Medical Executive Committee
- A physician advisory committee is chaired by hospital and IPA CEOs

Select Initial Improvement Priorities

EXAMPLES

- Improve cardiology outcomes and costs
- Address OR scheduling problems
- Reduce unnecessary readmissions

Identify MD Champions

Add Hospitalists to Handle Call Coverage & Manage Care Transitions[1]

Celebrate Performance Improvement Success

EXAMPLE

- Cardiology LOS down
- Quality up

Identify Performance Metrics to Track

Regularly Share Performance Data with MDs

Compensate MDs for Time Spent in Improvement Activities[2]

DETOUR

Try again. Physicians did not trust data[3]

Give Gainsharing a Try[4]

Stuck here until determine Stark implications[5]

TRAFFIC JAM

Reframe IPA for future needs and include MSO[6]

Merge with Multispecialty Group

DETOUR

A competitor aligns with hospital's first-choice medical group. Merge with 2nd choice

TRAFFIC JAM

MD practice integration takes longer than estimated

Recruit Needed Primary Care Physicians

TRAFFIC JAM

Recruitment is difficult due to scarcity of PCPs in area

Off Ramp

LOOSE INTEGRATION DESTINATION 1

On Ramp

THE PLAYERS: CURRENT STATUS

- Health system or hospital that owns some medical groups and clinics
- 25% of medical staff employed; 40% interested in employment or tighter affiliation
- IPA/PHO that provides MSO services and is positioned for joint contracting

SCENIC BYWAY

Trust and Communication Grows

DETOUR

Physicians take longer to adopt computerized physician order entry than expected

Launch Integrated Ambulatory EHR[8]

Discuss Joint Venture: Co-owned ASC[7]

Pursue Comanagement of Service Lines[9]

Name a CMO and Other MD Leaders

SCENIC BYWAY

Collect Meaningful Use Incentives

DETOUR

Determine best route around comanagement legal challenges[10]

Launch a Physician Leadership Academy[11]

Organize MD Groups Into a Single Group[12]

Participate in Patient-Centered Medical Home Pilot[13]

SCENIC BYWAY

Secure Value-Based Payment Contracts

Off Ramp

PARTIAL INTEGRATION DESTINATION 2

On Ramp

THE PLAYERS: CURRENT STATUS

- Integrated delivery system/ emerging ACO
- 50% employed physicians; 40% interested in affiliation
- A well-established PHO with experience in value-based payment structures

Re-examine Employed MD Compensation Model[14]

Strengthen Business Intelligence and Performance Reporting

Solidify Clinically Integrated Network[15]

Pilot Population Health Management[16]

SCENIC BYWAY

Significantly Reduce Readmissions and Healthcare-Acquired Conditions

Launch an ACO

Off Ramp

FULL INTEGRATION DESTINATION 3

SCENIC BYWAY

Participate in Federal and Commercial ACO Pilots

Turn to page 60 for footnotes and examples of the strategies that are highlighted. For more in-depth examples, visit hfma.org/leadership, Fall/Winter 2013 issue.

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Why

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