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INNOVATIVE PHYSICIAN- HOSPITAL COLLABORATION:

Beyond Employment and Recruitment

Rowland-Hite Health Planning Seminar

May 5, 2011

Presented by

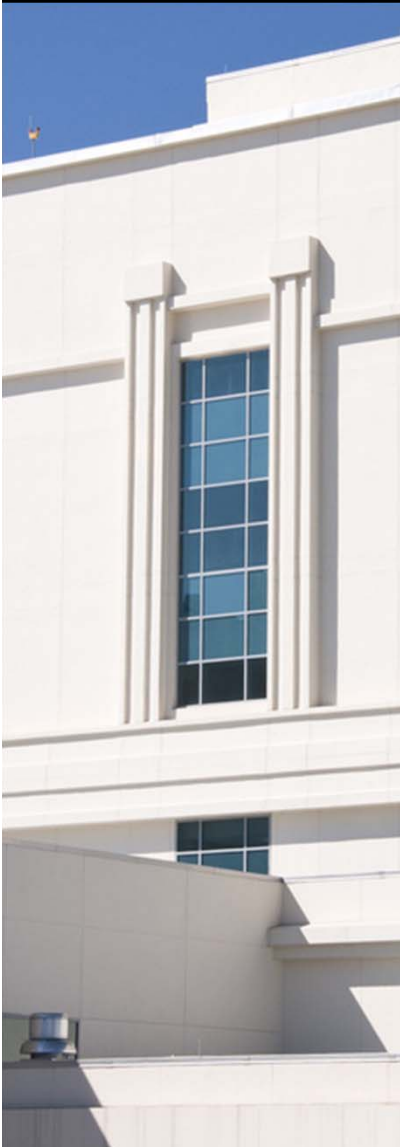
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Introduction

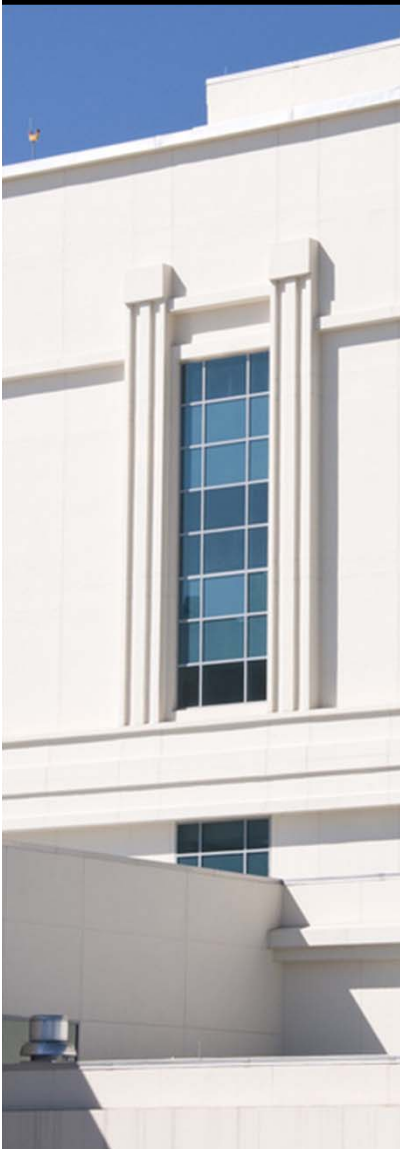


- Innovative physician-hospital collaboration beyond traditional models
- Challenges and developments requiring new approaches to collaboration
- Problems with traditional models
- Today's reality
- What hospitals and physicians can do to respond
- The payor challenge
- New generation relationships

Setting the Stage...

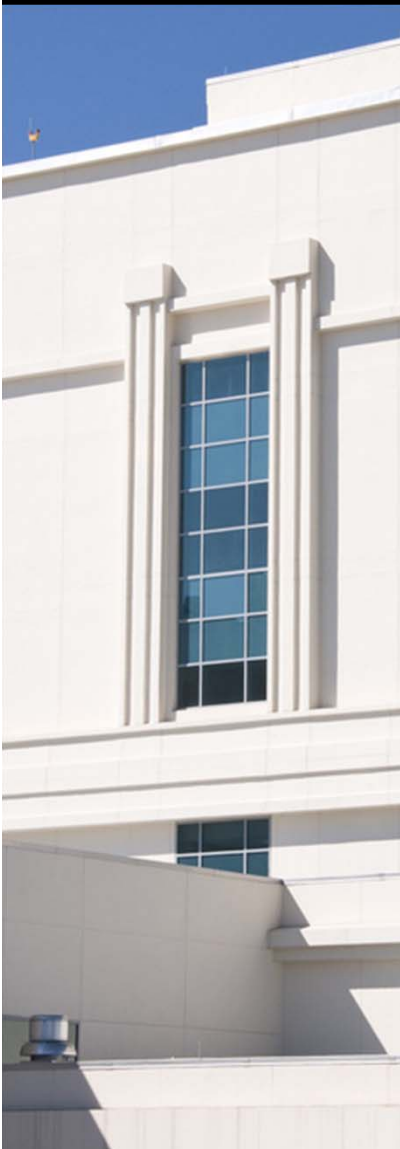


Synergistic Relationship



- Hospitals don't admit patients, don't diagnose patients, and don't perform medical procedures
- Physicians generally don't own and operate large physical plants or employ hundreds or thousands of employees that hospitals require
- Physicians must have a place to practice, and hospitals need physicians to bring and treat their sick patients

Synergistic Relationship



It's a classic synergistic relationship, and is one that has become increasingly difficult and, at times, even hostile.

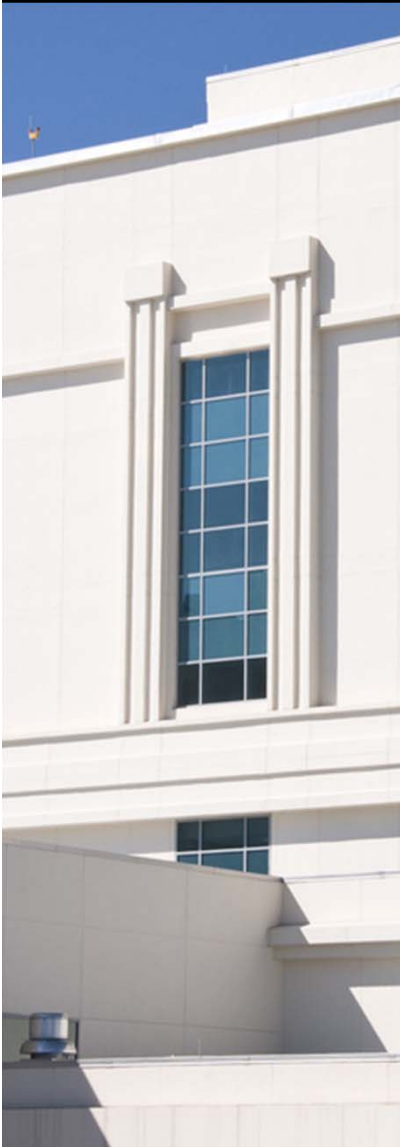
...And, it's probably not satisfactory for meeting the demands of the current marketplace...

What influences this relationship?



- Not necessarily what hospitals and physicians prefer, but more by societal, governmental, and commercial influences
- Traditionally, most physicians were in private practice and were independent members of a hospital's medical staff
- Now, in increasing numbers, physicians are interested in a wide range of integration models with hospitals

Our Goal Today...

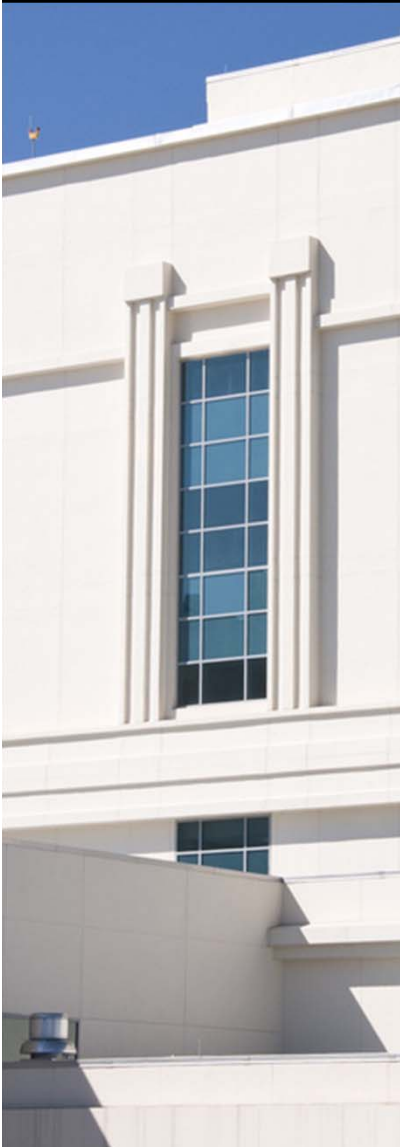


...Is to explore whether the current relationships are effective, in light of changes to health care, and whether new, innovative collaboration strategies might be better oriented to these changes.

Challenges and Developments

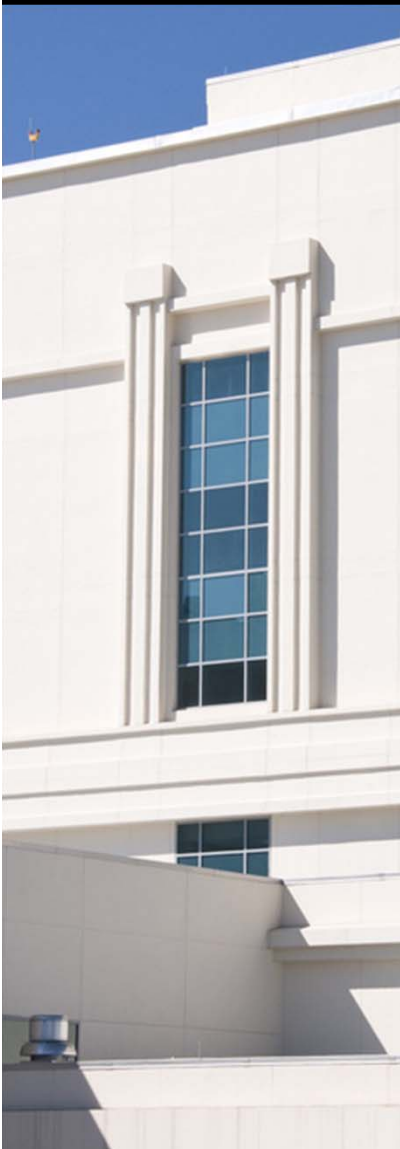


Societal, Governmental, and Commercial Developments



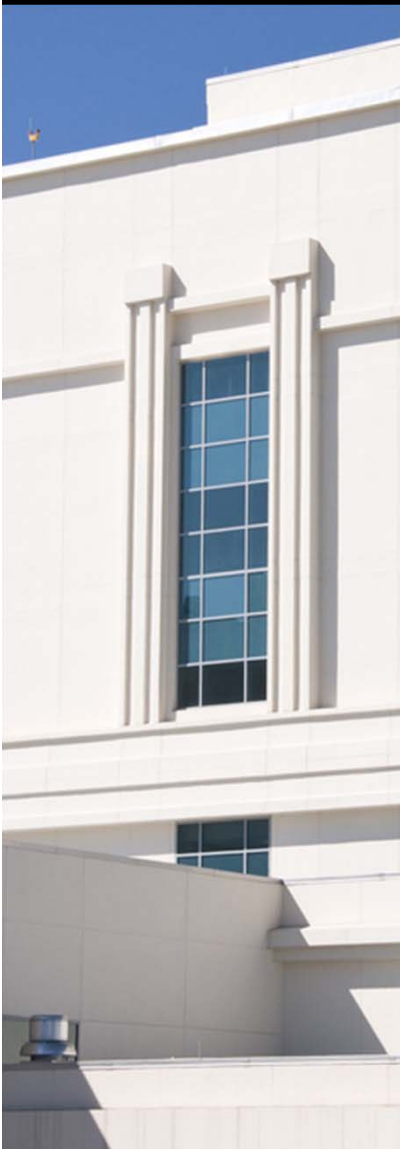
- Consumers object to the commoditization of medicine and want personal service; they want time and attention from their physician – concierge medicine exemplifies this trend
- Consumers want convenience and simplicity – this is reflected in the rapid growth of urgent care centers

Societal, Governmental, and Commercial Developments



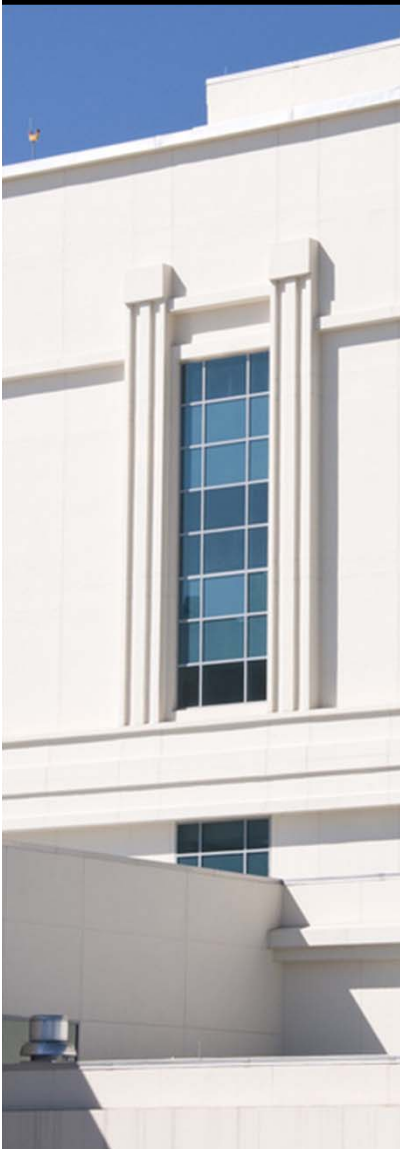
- Governmental and commercial payors want higher quality, less variance, and lower cost from the health care industry – these demands have produced upcoming Medicare ACOs and the return to risk contracting by commercial payors
- Governmental and commercial payors are demanding greater transparency in reporting quality data and cost data from providers

Societal, Governmental, and Commercial Developments



- Younger physicians prefer a reasonable life-style with regular hours, and wish to avoid burdens of small business ownership
- Established physicians are concerned about fee schedule reductions and burdens of operating their own businesses

Societal, Governmental, and Commercial Developments



- Hospitals are unsure about physicians' commitment to their long-term viability and to their quality and efficiency
- Hospitals may be direct competitors in certain key areas: imaging and other diagnostics, out-patient surgery, and therapies
- Hospitals recognize that primary care physicians are the entry portal for patients and employment of PCP's is key to participating in new governmental and commercial payor programs

Today's Reality



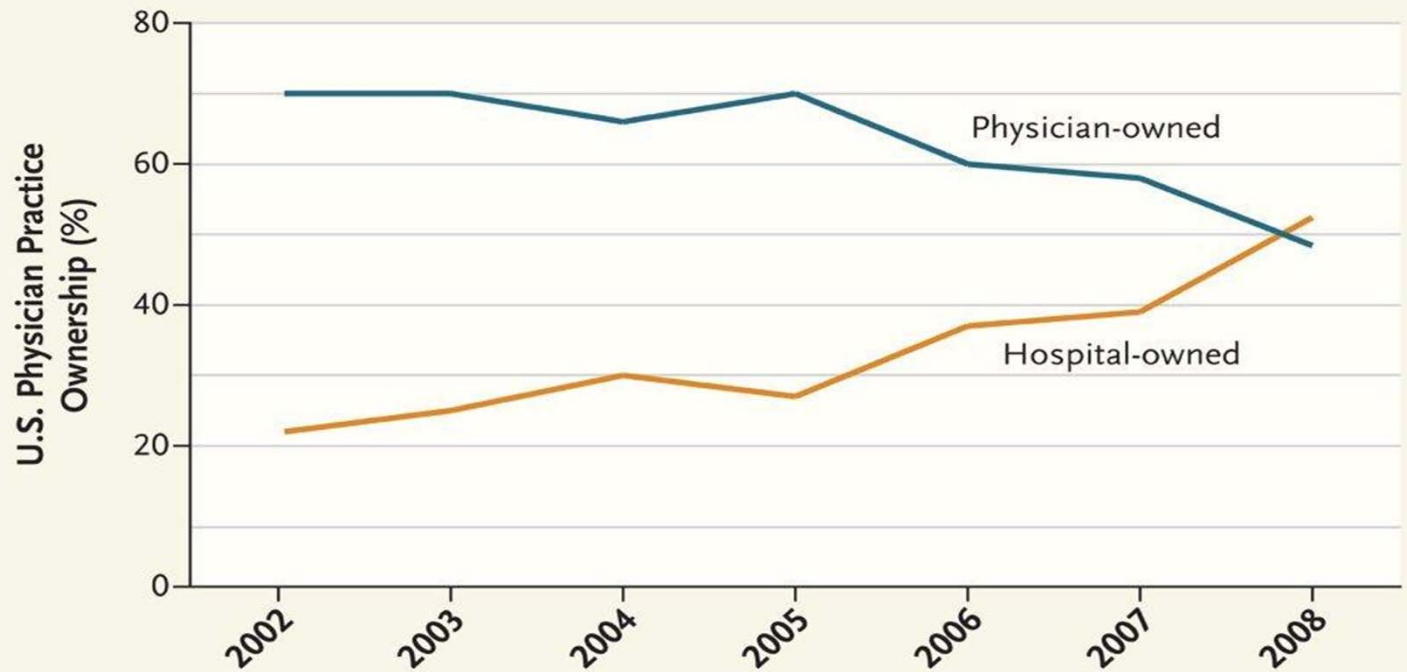
Employment is Accelerating



- Employment models are proliferating in order to address the societal, governmental, and commercial forces we talked about
- More than half of practicing physicians in U.S. are now employed by hospitals or integrated delivery systems, according to the *New England Journal of Medicine*

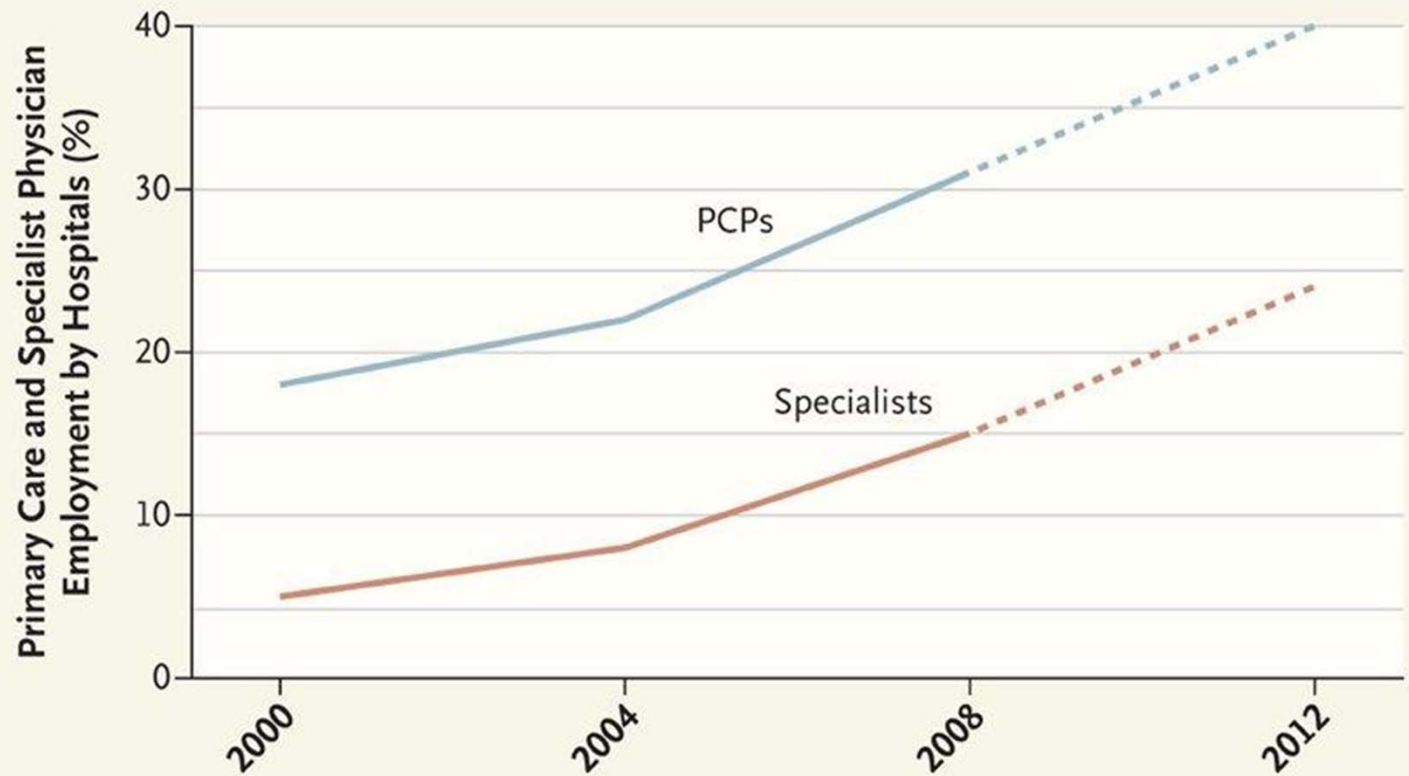
Employment is Accelerating

Percentages of U.S. Physician Practices Owned by Physicians and by Hospitals
2002-2008
New England Journal of Medicine, March 30, 2011

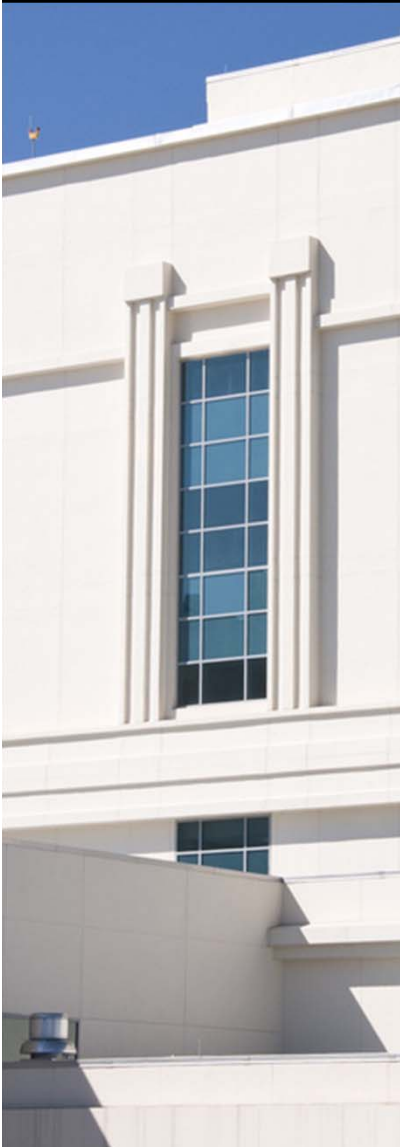


Employment is Accelerating

Percentages of Active U.S. Primary Care Physicians and Specialist Physicians
Employed by Hospitals, 2000-2012
New England Journal of Medicine, March 30, 2011

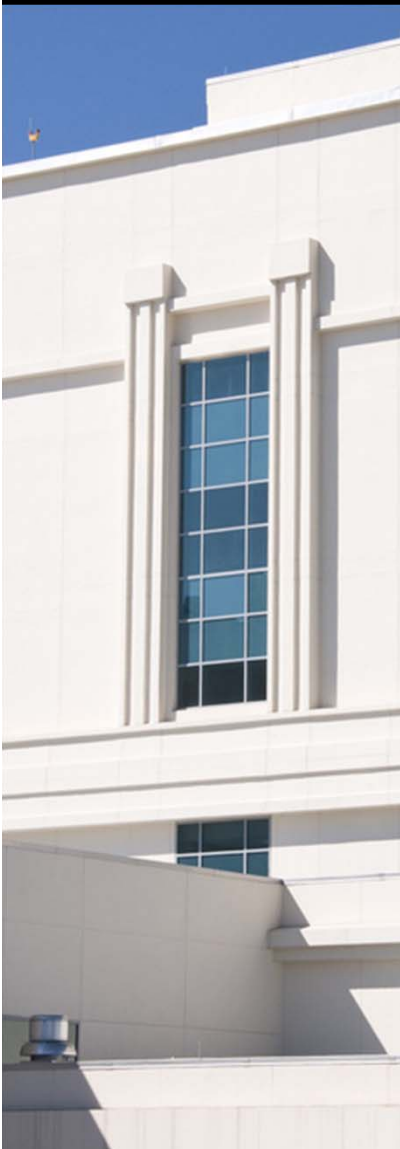


Employment is Accelerating



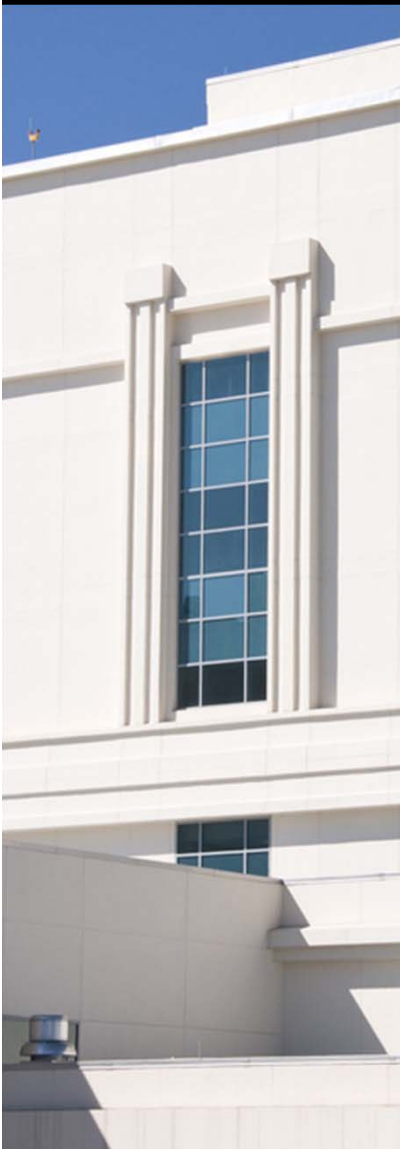
Critical to success is the creation of common goals; systems without a track record of employing physicians may find the transition to that model more difficult...

Employment is Accelerating



- Primary care physicians are in short supply and hospitals need their referrals
- Specialists are more expensive propositions; also in short supply
- Employment of PCPs and traditional hospital-based specialties could further divide the physician community
 - Ophthalmologists, orthopedists, and urologists will likely utilize ambulatory settings

Employment is Accelerating



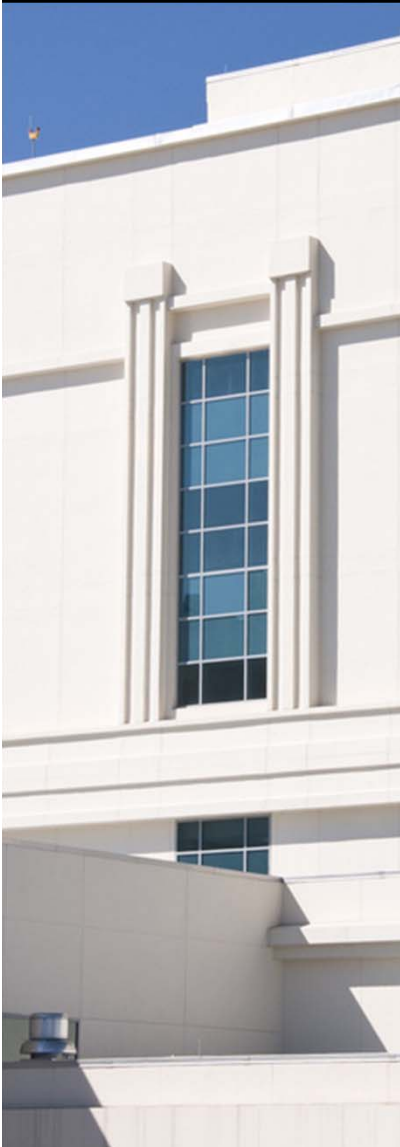
- PCPs may have divided loyalties, thereby undermining the goals of physician employment by hospitals
- Substantial pressure by government and commercial payors will force hospitals and physicians to improve quality *and* contain costs
- Will movement toward population health management and risk-based reimbursement shift patients away from hospital-based practices??

Employment is Accelerating



- Buying physician practices can be expensive for hospitals
- Employment agreements usually are “locked-in” for 2-3 years
- Despite learning the lessons of the 1990’s, employing physicians by hospitals remains a money-losing proposition...
- Can hospitals afford the continuing subsidy that physicians are seeking?

Employment is Accelerating

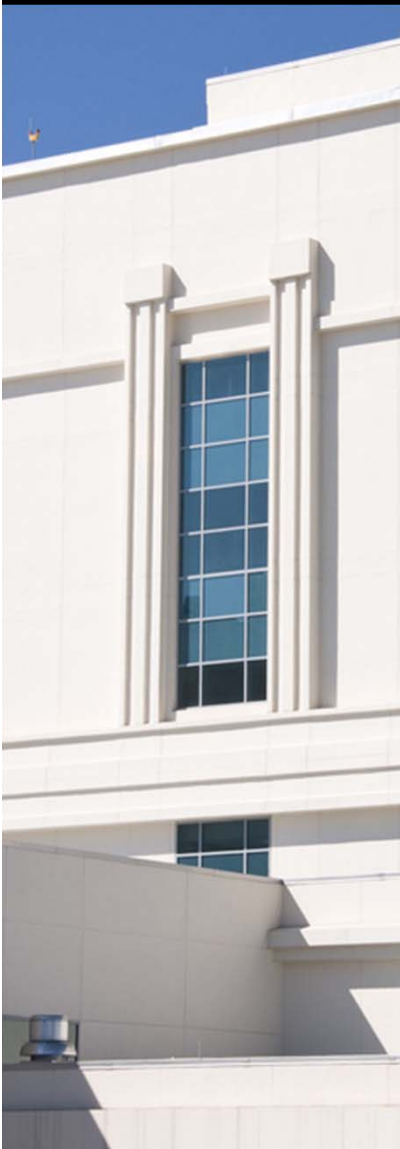


Effective collaboration therefore will be even more crucial to achieve in the future...

Existing Integration Models

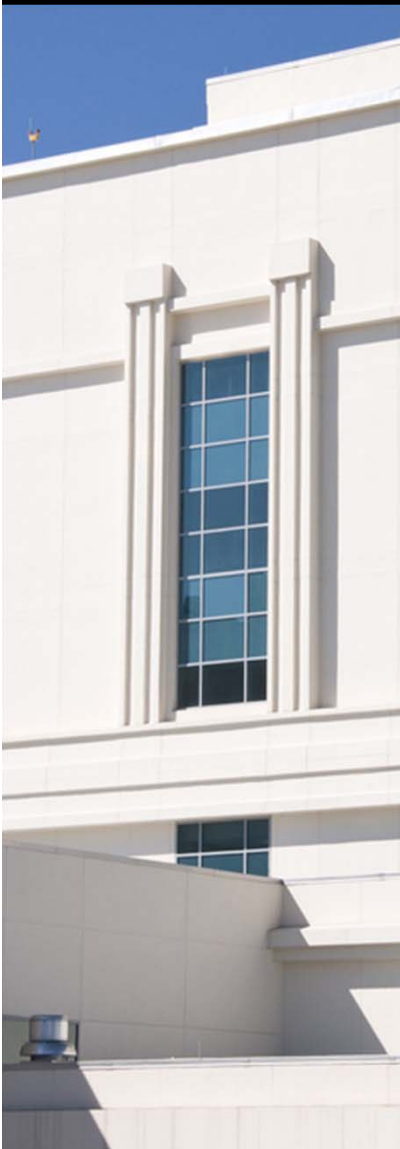


Physician Perceptions on Hospital Integration



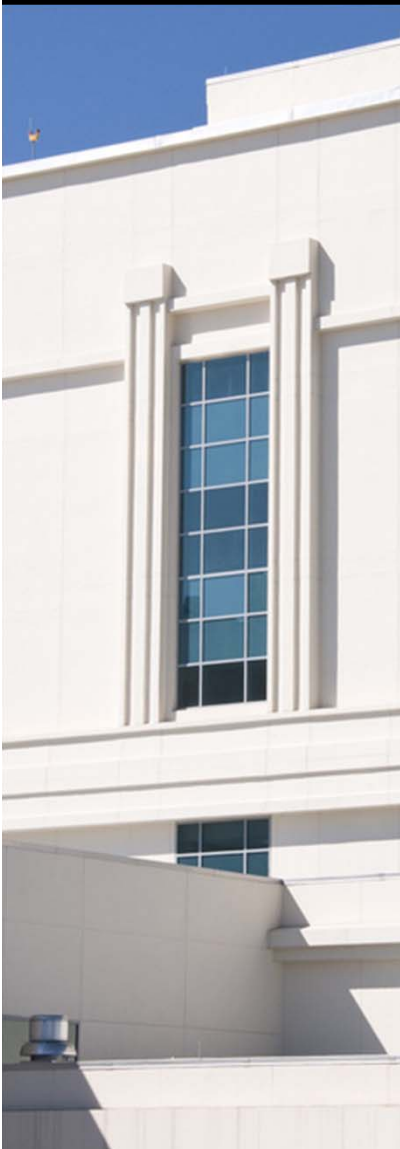
- Price Waterhouse Coopers 2010 Report, “From courtship to marriage: Why health reform is driving physicians and hospitals together.”
- Surveys for PWC report published in *Becker’s Hospital Review*, December 7, 2010

Physician Perceptions on Hospital Integration



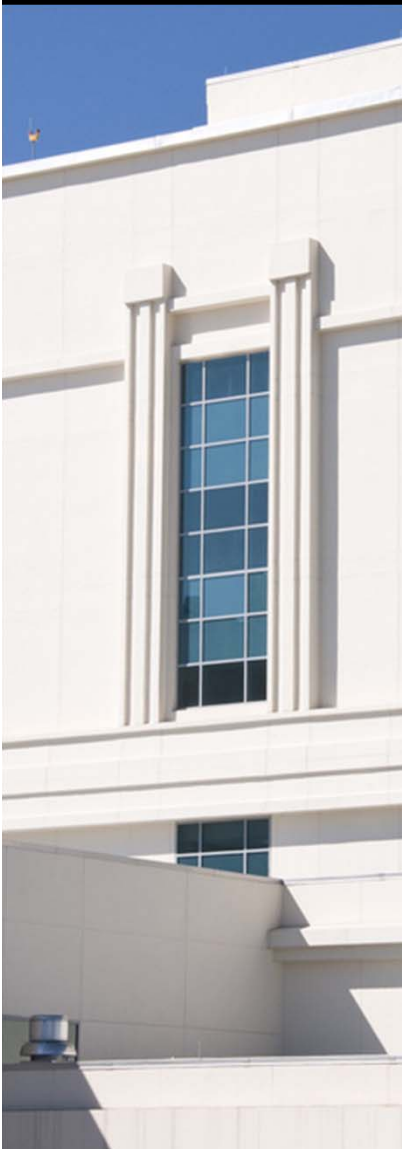
- Nearly three-fourths of physicians surveyed are already in financial relationships with hospitals
- 24% of physicians surveyed are already working in hospital practice settings
- When asked whether they trust hospitals, 20% of physicians surveyed said “no,” and 57% said “sometimes”
- Physicians practicing in large groups are 2 to 3 times more likely to express interest in hospital integration strategies than sole practitioners
- 66% of physicians said hospitals are dependent on them to reduce costs and improve efficiency

Physician Perceptions on Hospital Integration



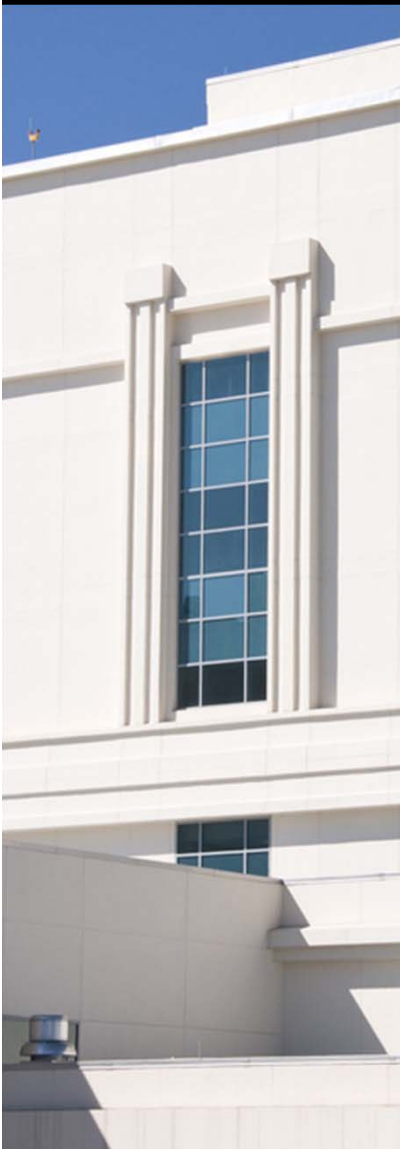
- More than one-third of physicians surveyed said hospital alignment would decrease administrative burdens such as HIT requirements
- 63% of cardiologists were interested in hospital employment
- 48% of PCPs were interested in hospital employment
- 45% of specialists (combined) were interested in hospital employment

Physician Interest in Specific Integration Models



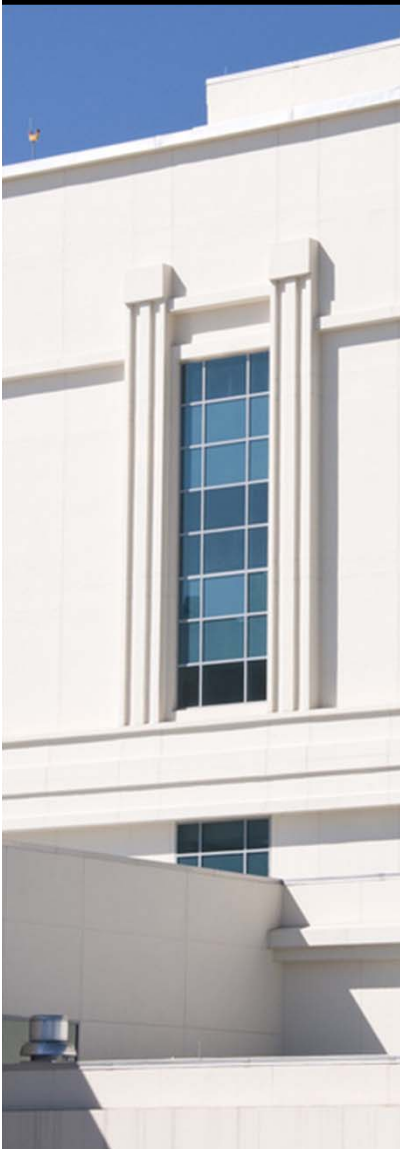
- Employment
 - 44% of physicians (in this survey) are currently employed by a hospital, medical foundation, provider-based clinic, faculty practice plan, or group practice
 - 46% of physicians are most interested in pursuing this model over the next 2 years

Physician Interest in Specific Integration Models



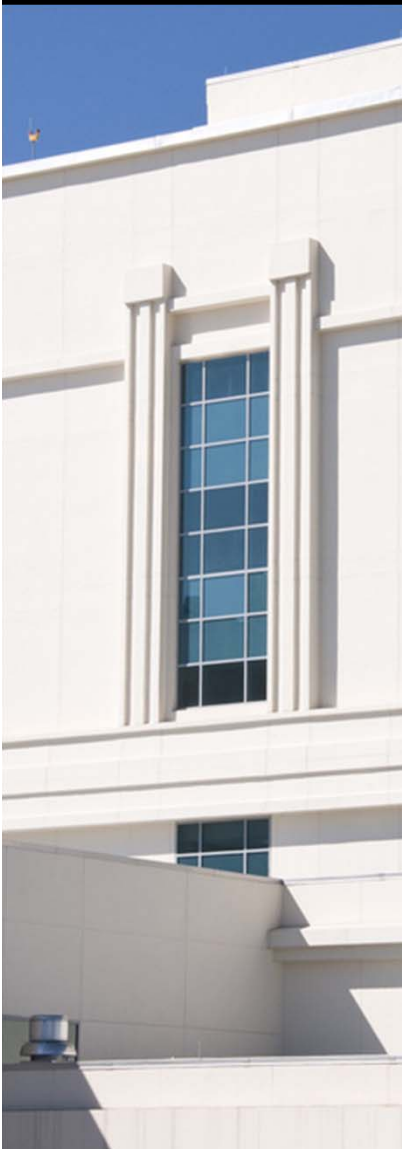
- Directorships, stipends, or management contracts
 - 24% of physicians are currently aligned in this model
 - 51% of physicians are most interested in pursuing this model over the next 2 years

Physician Interest in Specific Integration Models



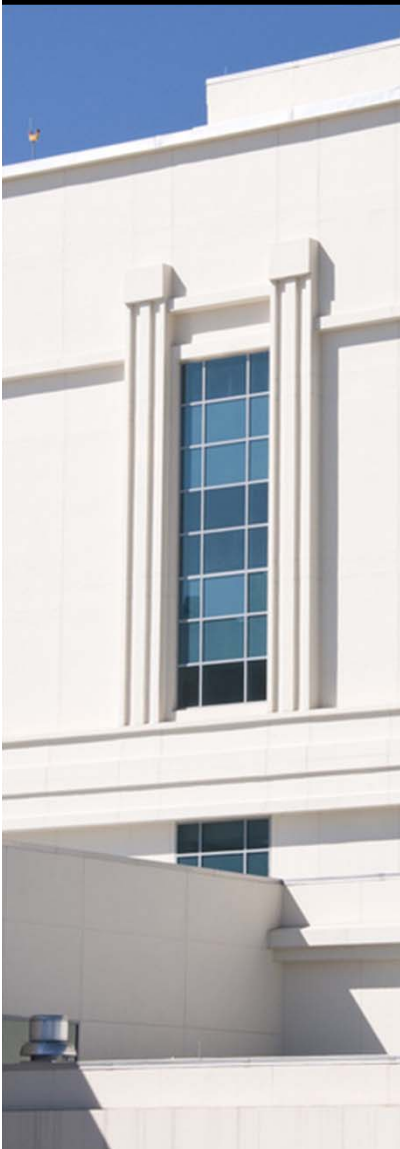
- Joint ventures
 - 8% of physicians are currently aligned in a joint venture
 - 38% of physicians are most interested in pursuing this model over the next 2 years

Physician Interest in Specific Integration Models



- Co-management
 - 8% of physicians are currently aligned in this model
 - 34% of physicians are most interested in pursuing co-management over the next 2 years

Physician Interest in Specific Integration Models



- Leasing arrangement
 - 9% of physicians are currently aligned in this arrangement
 - 21% of physicians are most interested in pursuing this model over the next 2 years

The Payor Challenge



The Payor Challenge



“Coming Soon to Your Neighborhood!”

...Medicare and Commercial Payors are seeking quality increases and cost predictability/reduction.

The Payor Challenge - Medicare



- Medicare Accountable Care Organizations
 - Core concepts
 - Provider controlled organization
 - Contracts with CMS for coverage on Medicare population defined by participating PCPs

The Payor Challenge - Medicare



- Medicare Accountable Care Organizations
 - Core concepts
 - Organization must track and report on 65 quality measures
 - Organization rewarded by share of savings (above minimum threshold) for aggregate spending below base line
 - All contracting organizations will participate in losses (expenditures above adjusted base line) at least by 3rd year

The Payor Challenge - Commercial



Coronary Artery Bypass Graft (CABG)
Episodic Case Rates and costs for services for
admission and 30 days post discharge
Conventional Method

The following table shows actual costs incurred by
major payor at a mid-America medical center...

The Payor Challenge - Commercial



Bucket	Avg	Min	Max
Facil Anesthesia	3,408.52	1,293.39	8,124.50
Facil Blood	2,043.27	-	20,040.00
Facil Diagnostic testing	26,142.55	4,464.09	82,200.40
	893.45	-	27,618.75
Facil Dialysis	15,790.70	2,267.80	45,156.12
Facil Drugs	433.90	-	2,640.75
Facil ED	4,678.53	-	33,090.00
Facil Implants	369.87	-	3,331.00
Facil Misc.	14,098.26	2,788.00	72,927.00
Facil Room and Board	12,963.53	1,423.35	41,371.16
Facil Supplies	35,602.53	9,022.70	70,666.85
Facil Surgery	4,236.58	-	15,518.55
Facil Therapy	98.39	-	1,190.00
IP	244.69	-	6,360.00
OMS	240.67	-	7,964.65
OP	23,802.70	379.12	58,444.73
Prof			
Grand Total	145,048.11	51,523.75	425,531.59
Readmissions	12,764.23	4,534.09	37,446.78
Total Episode Costs	163,179.12	57,964.22	478,723.04
Est. paid (assuming 50% discount)	81,589.56	28,982.11	239,361.52

The Payor Challenge - Commercial



- Issue: How do providers re-configure their relationships and actions to reduce variation and produce predictable financial results?
- Several Tentative Answers
 - Medical Home (*i.e.*, paying primary care physician to oversee entire process of specialist services and referrals)
 - Bundled payment (*i.e.*, achieving predictability by fixing the price for identifiable care episodes)
 - Risk Contracting
 - Establishing aggregate budgets
 - Adjusting fee schedules based on \pm spending by providers
 - Gain (or loss) sharing based on spending below (or above) negotiated range

The Payor Challenge

- Medicare *and* Commercial



Will primary care and specialty physicians be ready to (1) work on quality issues, (2) engage in clinical integration, (3) “turn off” or at least slow down the production machine, and (4) be attentive to cost reduction?

New Generation Relationships



Goals



- Clinical integration-PCPs, specialty physicians, hospital
- Predictable cost/reduced cost
- Commitment to effective patient management
- Elimination of “Never” Events
- Quality Improvement
- Patient responsiveness, convenience, access
- Implementation of EHR

Co-management Arrangements



- Arrangement in which physicians or physician group is paid to manage a hospital department or service line
- Physicians implement efficiencies and quality improvements
- Requires substantial communication, planning, and buy-in by hospital executives and board leadership, as well as by physicians
- Management for way to include incentive element related to quality metrics and achieving budgetary performance

Management Service Organizations



- MSOs permit a “bridge” between employment model and affiliation or alignment strategy
- Permits hospitals and physicians to share expenses for practice and business functions
 - Purchasing supplies
 - Practice management
 - EHR

Management Service Organizations



- MSOs may be contractually-based
- MSOs may be equity models
 - Physician ownership an option
- MSOs may be a vehicle increasing physician commitment to hospital system but does not provide integration for joint managed care contracting or sharing of otherwise competitive information

New Governance Structures - A



- Ad hoc physician councils may be set up to emphasize physician-oriented decision-making outside of medical staff hierarchy
- “Super-joint conference committee”
- Purposes
 - To give physicians added role in mediating concerns that divide
 - To provide a forum for discussion of problems
 - To provide involvement in system strategic planning

New Governance Structures - A



- Purposes
 - To assist with care planning, critical paths, evidence-based medicine
 - To identify cost efficiencies
 - Discuss HIT developments
- Physicians may be compensated

New Governance Structures - B



- Physician involvement at all layers and departments in organization
- Cleveland Clinic Model: dual personnel (MD and MBA) at all key posts
- Recognition that physician decisions drive costs of organization as well as service quality
- Recognition that organizational structure and decisions drive physician ability to deliver high-quality services
- Physicians are employees; compensation not based on individual production

Employment - Primary Care Physicians



- PCPs as Employees
 - Continued employment
 - Compensation not simply function of production
 - Involvement of quality factors
 - Involvement of efficiency factors
 - Involvement of factors relating to organizational performance

Employment - Primary Care Physicians



- New Medical Practice Responsibilities
 - Concierge medicine
 - Medical Home programs
 - Supervision of urgent care centers, non-physician practitioners
 - Implications for compensation

Employment - Specialty Physicians



- Specialty physicians
 - Employment –selective or comprehensive?
 - Avoidance of permanent subsidy
 - Compensation significantly oriented to quality, efficiency, and health system performance

Networks



- Network-type arrangements
 - Allows for relationships with specialty physicians who are independent
 - Clinical integration program
 - Involvement in commercial risk contracting
 - Loyalty arises from hospital's control over referrals from PCPs

Conclusion



- Innovative physician-hospital collaboration beyond traditional models
- Challenges and developments requiring new approaches to collaboration
- Problems with traditional models
- Today's reality
- What hospitals and physicians can do to respond
- The payor challenge
- New generation relationships

Questions??





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