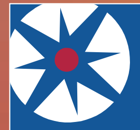
Hospital-Physician Clinical Integration

The American Hospital Association's



CENTER FOR HEALTHCARE GOVERNANCE™

Monograph Series

About the Authors

John H. (Hank) Duffy is the founder and president of the JHD Group, an Addison, TX-based consulting firm that assists large physician organizations to improve market position, operations and financial results. He has 33 years of experience in Management Consulting including as the National Director and COO of American Practice Management, Inc. (APM, Inc.), and the National Managing Partner for Coopers & Lybrand's Healthcare Consulting business. His direct experience includes hospital and physician management, strategic planning, mergers and operations improvement. He has led the reengineering of large academic medical centers, facilitated the merger of multiple hospital systems, managed the operation of multiple large physician groups, and provided post merger integration for multiple provider organizations. Mr. Duffy has MBA and BS degrees, a Certificate of Public Accounting, and a Certificate of Management Accounting. He can be reached at hduffy@jhdgroup.com

Trent Green is a director with Navigant Consulting. He came to Navigant through the acquisition of Tiber Group in April 2005, where he was a partner. Prior to beginning his consulting career, he completed a two-year administrative fellowship with the Mayo Clinic. Currently, Mr. Green provides leadership to the firm's Physician Strategy practice. His consulting experience has included development of system strategic plans, including strategic facility plans, for a number of academic and community-based health care organizations, as well as the formulation of medical staff development plans and physician-hospital collaboration initiatives. He can be reached at tgreen@navigantconsulting.com.

About the Center for Healthcare Governance

The American Hospital Association's Center for Healthcare Governance is a community of board members, executives and thought leaders dedicated to advancing excellence, innovation and accountability in health care governance. The Center offers new and seasoned board members, executive staff and clinical leaders a host of resources designed to progressively build knowledge, skills and competencies tailored to specific leadership roles, environments and needs.

Hospital-Physician Clinical Integration

The American Hospital Association's

CENTER FOR HEALTHCARE GOVERNANCE™

Center for Healthcare Governance
One North Franklin, Suite 2800
Chicago, Illinois 60606
Phone: (888)540-6111
www.americangovernance.com

©2007 Center for Healthcare Governance

Overview

As long as there have been hospitals; the topic of improving hospital-physician relationships has been a focus for trustees. Today, however, the conversation has both a heightened sense of urgency and a wider scope of alternatives than ever before. An industry journal or a board meeting without some discussion about what physicians are planning, doing, or wanting is hard to find. Despite all the talk and ink, both physicians and hospitals are concerned that how they work together has not improved and both entities will be increasingly disadvantaged and at odds. This comes at a time when, new pressures are being exerted on providers, such as quality/outcomes reporting, reductions in professional and technical fee reimbursement, and a tightening of the regulatory belt.

If there is a single correct solution which hospitals should implement tomorrow, it has not yet been revealed. In fact, no "one size strategy" fits all. Most of today's strategies are similar to the strategies employed in the late 1980s and early 1990s. However, the approach to implementing these strategies and ensuring their success in today's market is very different.

That said, one new clinical integration model has emerged very recently that has been catalyzed, and is being advanced by, federal health policy. In October 2006, the federal government enacted a "Safe Harbor" policy related to the Stark Regulations, allowing hospitals to donate Electronic Medical Record (EMR) related hardware, software, Internet connectivity, and training and support services to physicians. Recipients of the donation must contribute 15 percent toward the donor's cost of the items and services provided.

While the use of an EMR as an integration vehicle comes at a time when many hospitals are struggling to produce a positive return on investment (ROI) on information technology, the opportunity cuts right to the foundation on which hospital-physician integration should be based, that is, the care of patients and patient information. Specifically, this approach provides an opportunity for physicians and hospitals to improve the cost efficiency and effectiveness of care delivery to patients—the bedrock of the health care system.

Ultimately, this type of clinical integration promises to facilitate: 1) quality and outcomes tracking and reporting, thus improving quality of care and potentially increasing reimbursement (under pay-for-performance); 2) information sharing, quickly and seamlessly, thereby improving care continuity and reducing the risk of medical errors; 3) cost management at the patient level, rather than the encounter level, reducing overall expenditures; and 4) community-level disease management, thus improving overall health.

This monograph provides an assessment of the current hospital-physician landscape and outlines an innovative vehicle for advancing hospital-physician relationships that has the potential to improve care delivery and coordination, clinical quality, and patient cost. Our findings and recommendations are organized to address:

- Changes in the market place.
- The concept of an integrated medical staff model.
- The role of operational clinical integration, enabled by an Electronic Medical Record, toward creating virtual medical staffs.
- Benefits to the hospital, physicians, patients and community.
- What boards and senior management can do to move toward the model.

"Let us not seek to fix the blame for the past. Let us accept our own responsibility for the future."

—John F. Kennedy

Hospital-Physician Integration Has a Checkered History

Historically, physicians have maintained autonomy from hospitals, practicing in a voluntary arrangement with little to no financial ties. This relationship was usually mutually beneficial. Hospitals needed physicians to admit and care for patients, and physicians needed the hospital and its resources to deliver care.

As a result, an unwritten social contract emerged to meet the needs of the two parties. In the end, the relationship was amicable. Physicians would provide on-call services (such as, surgical backup and emergency department coverage, among others) and attend various committee meetings to address patient care coordination and provide strategic input. In return, hospitals would provide nursing staff, operating and other procedural rooms, and necessary clinical technology.

Worth noting, however, are several exceptions to this independent or voluntary practice model:

- Faculty practice plans organized around incentives unique to an academic environment;
- Clinic club members (such as, Carle Clinic, Mayo Clinic, Cleveland Clinic) that are physician-led and physician-developed delivery models; and
- Kaiser Permanente, which was created as a pre-payment plan for medical care services and emphasized prevention.

The common thread among these exceptions is that by design they were all highly integrated. They were closed systems where the physicians and hospital operated as one fully integrated delivery system.

Beginning in the late 1980s and through the mid 1990s, the industry moved toward increased delivery system cost control, much of it fueled by the proposed Clinton health reform and the onset of capitation. The result was a rush by many hospitals and physicians to develop Integrated Delivery Networks (IDNs) to control cost and protect market share. While the intent at the time was to integrate, the reality was more like a network of providers than a truly integrated system. The original promise of IDNs—to rationalize the distribution of care and provide continuity of care—was seldom realized.

A key building block of the IDN was physician integration, specifically, physician employment. As a result, hospitals and newly formed Physician Practice Management Companies (PPMCs) began to purchase physician groups rapidly and at previously unheard of prices. The goal was to integrate clinical delivery into a model that provided the hospital with greater control over admissions and cost.

This structural attempt at integration failed, at times dramatically, but not because it was a bad idea. In fact, many are revisiting the idea today, despite the oath that some hospital CEOs and board members once took to never again employ a physician. The failures were mostly because of 1) a buying craze driven by PPMCs, which drove up valuations for physician practices; 2) a lack of know-how among hospitals related to managing physician practices; and 3) the merely superficial level of clinical integration

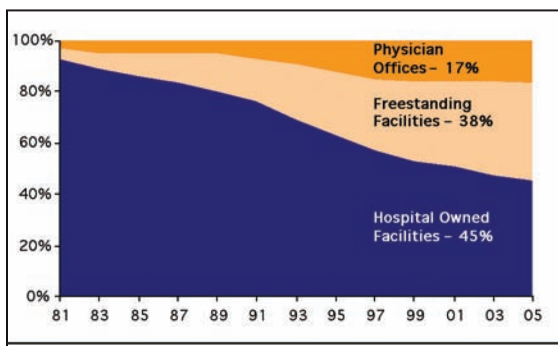
and resulting value that was achieved. As a result, significant financial losses followed this strategy and subsequently, many physicians have been "privatized" back into voluntary/independent practice.

In addition to the physician employment strategy, the Physician Hospital Organizations (PHOs) and Management Services Organizations (MSOs) that accompanied the IDN activity have largely been disbanded or become shells.

The Transition to Ambulatory Services Has Divided Hospitals and Physicians

For more than 20 years, health care delivery has been migrating toward low cost and convenience. This has been a movement away from the hospital, and generally with some level of physician economic involvement. It reflects the fact that outpatient services tend to be closer to the physician's business model than to the traditional inpatient model. In the mid 1990s, the pace of moving the patient from an inpatient setting to a freestanding surgery center or a physician's office increased dramatically (see chart titled Percent of Outpatient Surgeries by Facility Type 1981-2005).

Percent of Outpatient Surgeries by Facility Type, 1981–2005

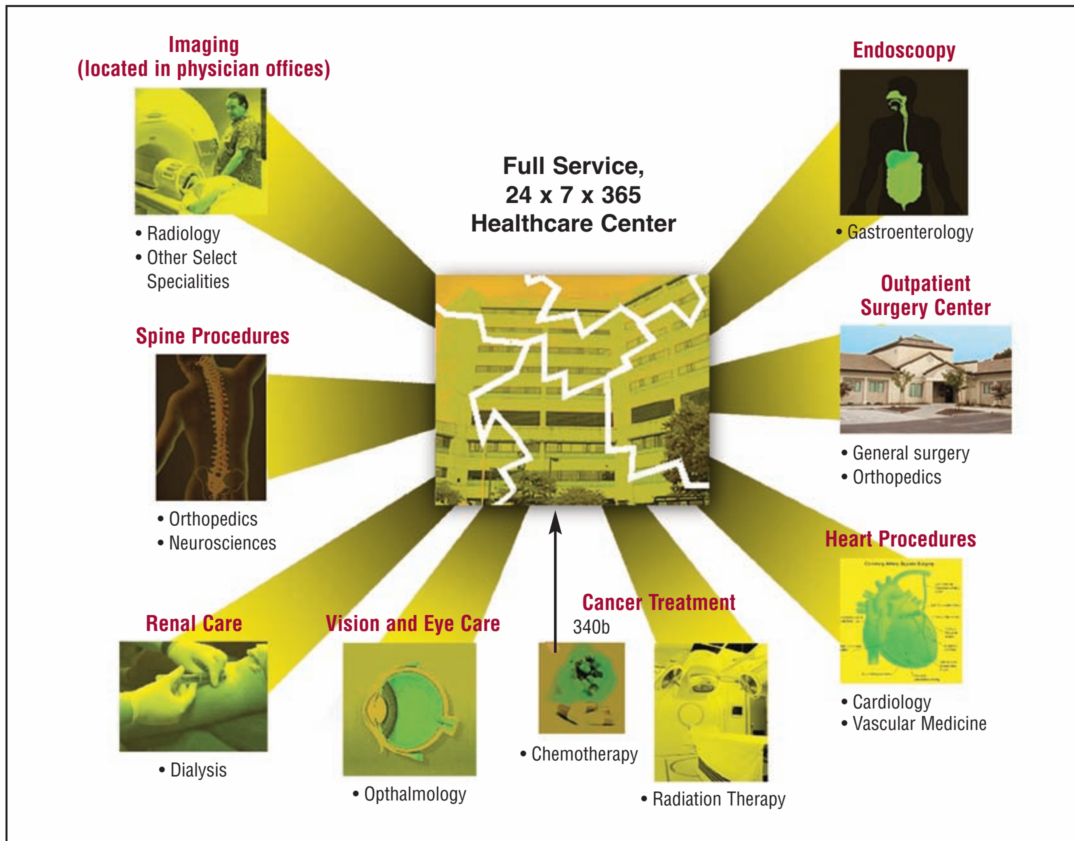


Source: Verispan

Few hospitals are positioned to address the threat that this move presents or, more importantly, to pursue its opportunities. As technology continues to improve in terms of quality and cost and further facilitates care migration to an outpatient setting, hospitals increasingly find themselves disadvantaged relative to physicians and other innovators.

As reimbursement pressure has increased on physicians, there has been a corollary increase in physician entrepreneurialism, which has further fueled the migration of services from inpatient to outpatient settings. Soon after the physician employment challenges experienced by many hospitals, the carving out of services historically performed in hospitals became an early point of conflict between the interests of hospitals and physicians, a conflict that persists today.

Hospital Disaggregation Risks



Source: Navigant Consulting

In the end, these trends led to a disaggregation of hospital services. Almost all services have the potential to be disaggregated from the historic full-service hospital, with imaging, ambulatory procedures, and surgery being the leaders (see chart titled Hospital Disaggregation Risks). In some markets, hospitals are struggling to maintain the volume of their most profitable services.

As a result, the traditional role of the hospital as the physician's workshop is changing. Hospitals continuing to operate in this traditional way risk irrelevance. While many have argued for a "focused factory" approach to care, there is value in aggregating services at some level. Therefore, hospitals are once again realizing the need to integrate with physicians in order to define new care delivery models that support the value of aggregation.

> "The best way to predict the future is to invent it."
>
> *—Bill Gates*

The federal government is recognizing the industry challenges associated with the proliferation of a disaggregated care delivery model. In July 2007, the Centers for Medicare and Medicaid Services (CMS) took a swipe at reimbursement rates for in-office and freestanding imaging and issued a series of regulations to revise the payment system for Ambulatory Service Centers, setting a compensation rate of 65 percent of what hospital outpatient departments are paid under Medicare. As a result, physician appetite for some level of hospital integration that results in hospital-based pricing has returned.

Market Forces Once Again Converging Around Need for More Physician-Hospital Integration

Today's market realities are driving the need for more hospital-physician integration with several considerations that will impact hospital-physician relationships and market strategies:

- Unsustainable growth in health care costs due to structural issues, such as an aging population and a failure of the managed care paradigm, which is likely to create a crisis as health care insurance premiums for families reach $2,500 a month.
- Rapid technological advances in medical devices and drug delivery, particularly in interventional surgery and radiology, which further accelerates the role of ambulatory services.
- The move by the federal government and commercial payers to value-based reimbursement, including the CMS program for risk-adjusted reimbursement, pay-for-performance programs, and economic credentialing, without increasing (and in some cases decreasing) the total funds available for provider reimbursement.
- Significant shifts in provider demographics, including the nursing shortage and the noticeable shift toward quality-of-life requirements by younger physicians.
- Provider fee schedules and other medical cost information becoming increasingly transparent, feeding the movement to consumerism.
- The unpredictable political environment and the impact of events such as the Massachusetts Experiment, which is seeking to cover the uninsured by mandating insurance, and the recent movie "Sicko."

In addition to these trends, the regulations governing physician-hospital integration have changed as the federal government becomes more directive toward hospitals and physicians. Examples include the Office of the Inspector General's advisory opinion on gain-sharing, new Stark II regulations related to physician recruitment, and more recently, the Internal Revenue Service's approval of information technology subsidies.

When all of these considerations are assessed, a growing movement to improve clinical integration is apparent. The movement may include many of the physician integration vehicles of the past but with a focus on minimizing clinical risk, improving quality outcomes, reducing the total cost of health care at the patient level, and improving the patient experience.

Haves and Have Nots in a Time of Plenty

The market forces highlighted above in many ways mandate that hospitals rethink their physician strategy and approach to integration, and quickly. During the last six years, the hospital industry has enjoyed record profits (totaling $28.9 billion in 2005 according to the AHA) and a return to pre-BBA (Balanced Budget Act) operating margin performance in the mid-five-percent range. However, there is a widening gap between hospitals that have the resources to grow and those that do not. In the most challenging situations several, if not all, of the following characteristics are present: 1) case mix index is not ideal, with more medical than surgical cases; 2) ambulatory share is declining; 3) payer mix is deteriorating, especially with an increase in self-pay (with its multiplier effect on repelling private physicians); and 4) medical staff is made up of splitters and cherry pickers.

These characteristics may be exacerbated in stable to declining markets by adverse population demographics; little to no regulatory protection, such as Certificate of Need; and highly organized physicians. Hospitals exhibiting these characteristics are often rapidly on the decline absent some significant attention to the one variable that they can potentially affect—physician relationships/integration.

The starting point for developing a new model is to understand the continuum of market development in terms of market growth rate, consolidation and effective care delivery integration (see table titled Market Drivers to Integration on page 10).

Market Drivers to Integration

Category	Market Characteristics		
	Fragmented	Emerging - Growth	Mature - Competitive
General Profile	Markets fundamentally local, many small and medium sized hospitals, no clear leader or source of leverage.	Markets become regional, product features become more standardized, rules of competition take shape, handfuls of contender systems emerge.	Few large systems, competitive positions solidify, increase in service line competition.
Growth Rate	Varies	High/Medium	Local Population Specific
Level of Integration	Minimal affiliations based on local and traditional relationships with independent physicians.	• Larger medical groups evolve • Merger/acquisition activity begins • Hold-out by communities to keep their own programs, limiting rationalization opportunities and creating excess capacity.	• Vertical integration pursued to achieve superior outcome management • Full horizontal hospital integration imperative for survival of inpatient facilities.
Key Drivers	• Location • Transportation costs • Fee-for-service (FFS) payors	• Location for time-sensitive services • Technology for product differentiation • FFS/Capitated payor mix • Shift to outpatient care	• Trend toward "hub and spoke" systems • Contracting leverage/ systemization • Technology for outcomes/ disease management • Clinical Product Center of Excellence Focus

Source: JHD Group

The concept of starting with an understanding of a hospital's position in the market continuum recognizes that there is no "silver bullet" solution, and that each hospital will, at the strategic level, need to develop a fabric of solutions specific to its situation.

An Integrated Medical Staff Model: A Back to the Future Approach

Recently, employment of physicians has again become a major phenomenon both in highly competitive and insular markets, for a combination of reasons:

- Improving clinical and economic alignment around hospital goals, with an emphasis on enhancing quality, safety, satisfaction, and the growth of Center of Excellence service lines, such as heart, cancer, women's health, orthopedics, neurology, and geriatric care.
- Advancing systems with consistent resources and the core competencies necessary to effectively support identified Centers of Excellence.
- Achieving a critical mass of primary care physicians.

Why has this strategy been reprised? Currently, physicians and hospitals are motivated to enter the employed model for several reasons:

- **Physician** – Difficult malpractice insurance environments in many states, the need to achieve target incomes in a stable and secure fashion, and the desire for greater predictability and balance in caseload and life, particularly among younger physicians entering the market.
- **Hospital** – Overcoming physician shortages, supporting Emergency Department call and indigent/Medicaid cases, assuring strength in strategically important clinical services (cardiac surgery, orthopedics, urology, and others), securing a primary care base that provides a reliable source of admissions, protection against entrepreneurial physicians who compete with the hospital for profitable services, and the desire to strengthen clinical services and reputation via recruitment/affiliation with physicians.
- **Hospital and Physician** – the need to demonstrate improved quality and outcomes, the need to share patient information quickly and seamlessly (which requires integrated/shared information systems), and payer consolidation, which means less leverage for hospitals and physicians in contract negotiations.

The approach to hospitals employing physicians varies, but includes building, assembling and acquiring physician practices (paying only for hard assets). The building approach involves recruiting physicians one at a time and gradually organizing them into functional service lines for example, cardiology. The assembly approach involves a combination of buying existing practices and merging them with newly employed or existing physicians to form a service line or working group. With the build and assembly options, a practice management infrastructure usually needs to be developed to support the service line or group. When buying an established practice, the infrastructure usually comes with the practice.

As hospitals seek to make the employed physician strategy work, they improve the odds of success by being selective (a shortage of willing providers is unlikely, but the quality of the provider as an employee/partner will vary), not overpaying for practices, ensuring that compensation is tied to productivity and quality, and linking the primary care physician/specialist mix to the hospital service line strategy.

Regardless of the approach, the essential long-term outcome from building a new and unified medical staff model is effective clinical integration, focusing on:

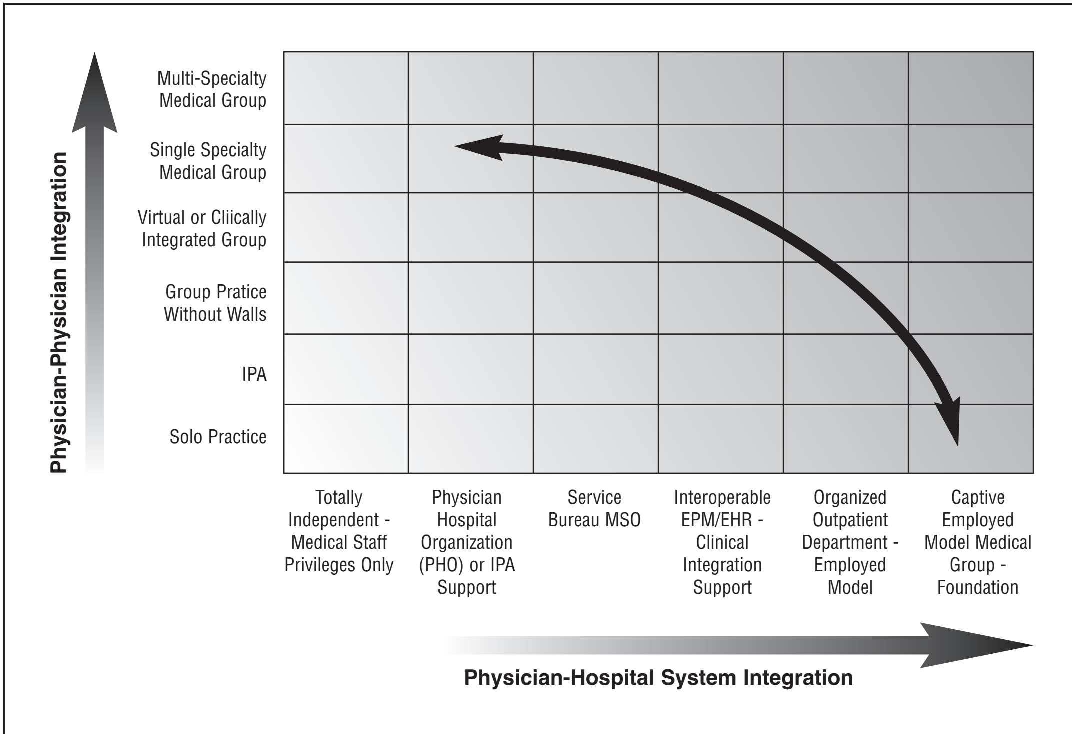
- Quality of care that reduces errors, enables increased disease management and supports measures of quality outcomes.
- Superior coordination of care for activities such as referral management, patient scheduling, test management, and medical record access.
- A rationalized delivery system that caters to convenience and cost effectiveness, not only for inpatient and outpatient care, but also for urgent and chronic care.
- Data primarily at the patient level rather than the encounter level, which supports managing the care of the patient cost effectively and provides the foundation to start managing the health of communities.
- Differentiating Centers of Excellence such as cancer, women's health, geriatrics, and heart wellness.
- Incentives that focus on patient satisfaction, access and clinical measures, while strengthening physician loyalty.

An Integrated Medical Staff Model: A Virtual Approach

Ultimately, true clinical integration is most likely to come from a combination of an employed physician model operationally integrated with community physicians to create a virtual group model. This approach takes advantage of a movement in the market toward increased integration, which is taking two tracks: (1) developing larger physician-owned groups or virtual groups and (2) increasing integration within hospital-driven organizations, with growing service contracts between hospitals and private/virtual groups (see chart titled Range of Integration Options on page 13).

Even as hospitals have been developing more integrated physician staff models, they continue to support community physicians and private specialty groups. However for this virtual group model to work, it must be reinforced with a supporting infrastructure of systems, data, incentives, and governance that encourages clinical co-management, participation in economic gains and the operating benefits of scale (excellent scheduling, electronic medical records, and order entry/results reporting systems). Lastly, and this is where hospitals failed so badly in the mid 1990s, performance metrics must be established that link the physician contribution to care delivery to a framework of legal incentives.

Range of Integration Options



Source: JHD Group

A New Vehicle for Fostering Hospital-Physician Integration

While many of the historical considerations, such as physician independence, that made clinical integration problematic still exist, the effective introduction of Electronic Medical Record (EMR) technology offers a new and powerful platform for hospital-physician integration. The EMR is a tool with the potential to be a hospital-physician bonding mechanism, providing needed functionality (see chart titled Electronic Medical Record Functionality on page 14), which directly enhances the ability of physicians and hospitals to work together around the needs of the patients.

> "Would you tell me, please which way I ought to go from here?" "That depends a good deal on where you want to get to."
>
> ***—From Lewis Carroll's Alice's Adventure in Wonderland***

The EMR adoption rate has significantly increased in recent years. The federal government and a wide range of industry trade groups have announced initiatives to encourage physicians to adopt EMRs. State and

Electronic Medical Record Functionality

- Workflow Tasking
- Physician Notes
  - Problem
  - Allergy
  - Medication Lists
- Documentation
- Electronic Prescribing/ Medication Management
  - Drug-to-Drug Interaction
  - Contra-Indication
  - Electronic Transmission
- Imaging/Scanning
- Charge Capture
- Alerts
- Order Entry
- Results Reporting
  - Laboratory
  - Radiology
  - Facesheets
  - Transcription
  - Discharge Summaries
- Dictation/Voice Recognition
- Health Management
  - Patient Care Reminders (i.e. Immunizations, Annual Exams, etc.)
  - Treatment Plans
  - Trending Analysis
  - Care Plans
  - Long Term Chronic Disease Management
- Reporting
  - HEDIS
  - Pay-for-Performance
  - Quality Control Measures
  - Contracting
  - Patient Outcomes
  - Disease Management
- Practice Management Interfacing
  - Authorizations
  - Case Management
  - Scheduling
  - Insurance Capture/ Eligibility
  - Billing/AR
  - Encounter Reporting
- Additional Connectivity
  - Patient Reminder Systems
  - Finance

Source: JHD Group

federal governments see the EMR as one solution to address both dramatic budget deficits stemming from raising health care costs, for example for Medicare and Medicaid, and preventable medical errors. Employer groups also have endorsed the movement to EMRs, largely to have access to data for improving disease management and reducing health benefit costs. Payers are developing pay-for-performance incentives, which will depend on systematically securing data from the EMR. Lastly, Medicare has announced that EMRs will be required by 2014 in order to participate in Medicare programs.

More importantly, from the physician perspective, significant empirical findings demonstrate the benefits of an EMR. A survey by *Medical Economics* (January 21, 2005) found that most EMR owners are bullish about the return on investment from their EMR systems. Of those with EMRs, 53 percent say that the system sped up their work, although only half of the EMRs in use exchange data with laboratories and hospitals. More than 87 percent of physicians implementing an EMR are neutral to very satisfied with the results to date.

In October 2006, the Federal government provided another incentive for adoption of EMRs by enacting a Safe Harbor to the Stark Regulations, allowing hospitals to donate hardware, software, Internet connectivity, and training and support services to physicians. Effective May 11, 2007, the Internal Revenue Service released a memorandum supporting the provision that such financial assistance to referral sources (the Health and Human Services I regulations) will not pose a threat to the tax-exempt status of a hospital donor. The exceptions for donations of EMRs require that such donations be "items and services necessary and used predominantly to create, maintain, transmit, or receive" patient clinical information. The software must be interoperable (able to work with hospital systems and other medical record systems) or deemed as such by a recognized certifying body. Permissible donors are entities that furnish Stark-designated health services. Recipients can and should be the physicians, as long as the criteria used for participation in the Safe Harbor initiative do not take into account the volume or value of referrals or other business between the parties. Recipients of donated technology must contribute 15 percent of the donor's cost of the items and services provided. The overall arrangement must be subject to written agreement, must have e-Prescribing capabilities and can be provided by a donor to physicians through December 31, 2013.

With the Stark Safe Harbor, hospitals, particularly in competitive markets, are in the process of organizing to offer this capability to physicians as a means to bond physicians to the hospital, in effect, creating virtual groups. The merit of the virtual group concept is that it creates a solid connection between the hospital and physician through a common medical record and ease in populating the record with lab and imaging results, discharge notes, and inpatient scheduling, all of which make for better care delivery and less hassle for physicians. Additionally, a virtual group with an integrated medical record has more opportunity to negotiate favorable rates with payers and/or demonstrate the quality data necessary to support pay-for-performance.

The benefits of implementing an EMR, particularly to physicians, are considerable:

- **Revenue enhancement** through improved coding, supported by appropriate documentation, such as capturing data via templates, macros, and pulling information from other portions of the chart; documenting results for quality

incentives; and enhancing proactive health maintenance, which impacts both volume of services and quality of care, for example, contacting Vioxx patients to alter treatment.

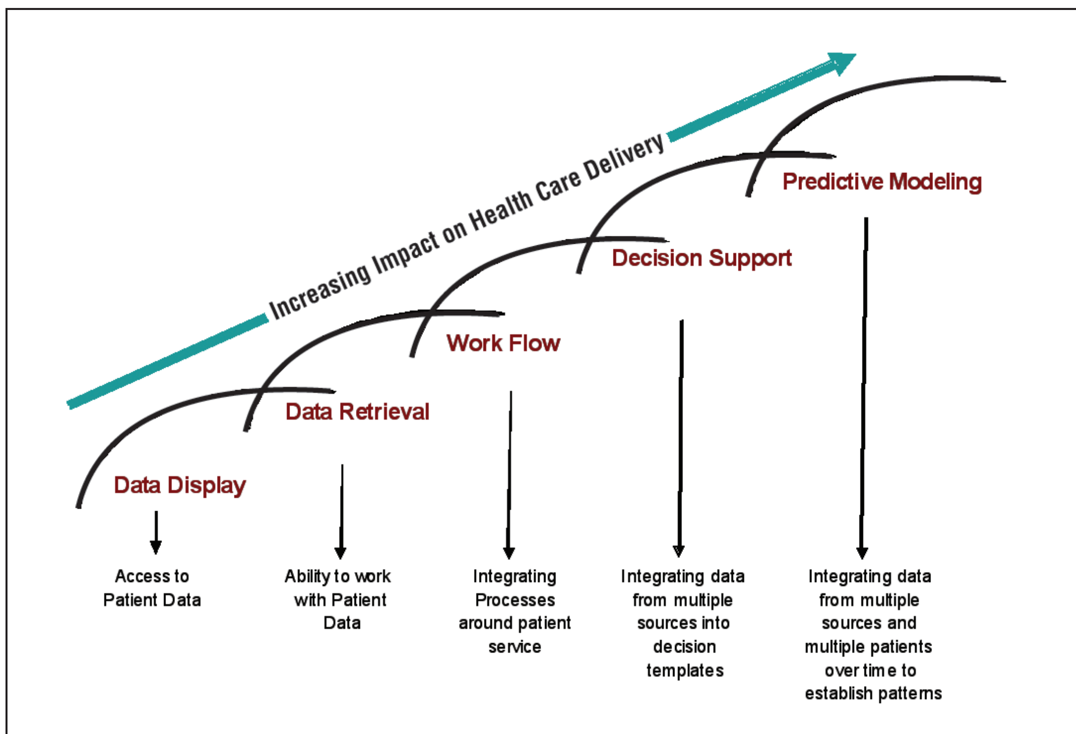
- **Increased physician office efficiency** through fewer chart pulls; easier filing interfaces to labs and hospitals; access to charts from office, hospital or home; reduction in "phone tag;" legible prescriptions; automatic drug-to-drug interaction checking; more efficient signing of charts; and easier compliance with chart requests and chart audits.
- **Cost reduction** through labor savings related to less manual processing of files and fewer phone calls; reduced malpractice premiums due to improved risk profiles; and lower paper and storage expense.
- **Improved patient care and service** due to higher quality documentation through built-in protocols and reminders; diagnosis-specific templates, guides/ reminders of special protocols and tests; ability to proactively query patient database for overdue items and send reminder letters; and increased patient education and involvement opportunities.
- **Enabling group contracting,** even with multiple tax IDs. There are certain situations where the FTC has ruled (FTC vs. Brown and Toland) that there is sufficient basis for payer non-risk contracting where there is a good faith effort to clinically integrate through the use of an EMR.

At the strategic level, as EMRs integrate with hospital and pharmacy systems, they will in effect become Electronic Health Records (EHRs) and will be expected to substantially enhance the value of clinical integration (see chart titled Electronic Health Record Value Curve on page 17). The role of the EHR will evolve from simply providing more easily available data to a tool that can be used to more proactively manage the health of individuals and the community. At the hospital level it will provide seamless communication and health information exchange, in the patient's interest and across multiple provider entities (physician and hospital), and it will enhance quality service and the effectiveness of the hospital's clinical offerings. For the individual physician, it will improve patient care and service at the practice level through improved referral management, enhanced revenue opportunities and reduced physician/office hassle. At the community level, it will provide the foundation for more cost-effective care, better patient service, and the ability to manage the prevalent diseases in the community.

Most hospitals already have substantial inpatient Electronic Medical Record initiatives underway, and some are developing ambulatory solutions. The ambulatory solution is more complex for several reasons including a lack of well-developed ambulatory software from traditional inpatient software vendors and reluctance on the part of community or independent physicians to invest in EMR technology.

However, the recent Stark Safe Harbor is dramatically changing the market dynamic by allowing hospitals to subsidize community physician adoption of EMRs, and as a result, both expedite the creation of an integrated clinical delivery system and effectively bond the physicians to the hospital. Many have suggested that an effective EMR strategy is similar to an effective Medical Office Building strategy in that it places physicians in close proximity to the hospital not in terms of geography, but in terms of shared information. Based on a recent survey by CHIME (College of Healthcare Information Management Executives), 35 to 40 percent of the hospitals surveyed were actively considering assisting physicians with EMRs, or were already organizing physician EMR programs.

Electronic Health Record Value Curve



Source: JHD Group

Collaboration in developing EMRs can provide a new core for true clinical integration within the hospital–physician structure. When combined with traditional management services organization (MSO) services and governance based on clinical co-management, the virtual group model can seamlessly integrate employed physicians into the hospital medical staff. This form of physician engagement focuses on a comprehensive view of clinical and service quality and sets the stage for the hospital-physician team to evolve into a cost-effective and integrated provider and coordinator of care.

New Model for Clinical Integration

Integrating the independent community physicians into a virtual group model through the Stark law Safe Harbor involves the hospital providing technology and services, usually on a subscription basis and at a discount to the physicians. For the physicians, most of them in individual practice or in groups of two or three, it means they will realize the benefits of electronic records sooner than they would have otherwise and avoid the upfront costs. For hospitals, a community physician EMR becomes a vehicle to bond the physicians more effectively to the hospital and provides the platform for real clinical integration with continuity of care. It also is an effective market defensive vehicle if the hospital is at risk of having referring physicians lured away by a competing hospital, and it can be a solid enabler for a staff community-based clinical Center of Excellence strategy. In some highly competitive markets, there can be a first–to-market phenomenon, where the hospital with the most attractive and cohesive community physician EMR initiative is more likely to lock in key physicians. Examples of specific hospital strategies drawing on a community physician EMR initiative appear below.

- *500-bed community hospital:* This hospital is successful and has a very strong market position in an affluent community. It is developing its own version of a virtual group model using an EMR as a means to strengthen its Center of Excellence strategy. The hospital is targeting the 200-300 specialty physicians in the community who can add substantial value to its programs—women's health, cancer, orthopedics, and cardiology. The hospital is going to substantially subsidize the implementation of an integrated Electronic Medical Record and Practice Management System with the intent of allowing three or four sponsored vendors to participate, but with strong standards to assure interoperability. The project is

expected to take two to three years but will provide for a robust community integrated medical staff model around the selected clinical service lines.

- *200-bed community hospital:* This hospital is surrounded by major integrated delivery systems, does not have a strong base of community physicians and needs to find a way to reinvent itself. In order to strengthen its market position, the hospital is going to offer an integrated Electronic Medical Record and Practice Management System to its community physicians, with an emphasis on primary care physicians, toward creating greater hospital–physician cohesion.
- *Large national hospital system:* This system is selectively using a community physician EMR strategy based on the conditions in its individual markets. In markets where there is substantial competition, and high risk of having physicians approached by a competitor, the system is offering an aggressive package of subsidies, but with the intent of assuring physician critical mass in each market. In markets with little competition, the system is taking a more gradual position, or considering supporting a community EMR project on a total-cost pass-through basis.

While the actual execution will vary, there are a few common approaches for integrating community physicians into a hospital-sponsored EMR model:

- The hospital purchases the initial pool of licenses and amortizes them over a three- or five-year period back to the physician practices. As a result, there is no up-front cost to the physician practices with the exception of physician and staff commitment of training time and in-office hardware acquisition/upgrade (if necessary).
- In addition to the EMR licenses, the hospital provides the implementation and information technology support, including training, interfaces to the hospital, the servers to support the EMR software, the communications network and help desk support.
- The hospital can subsidize the cost to the physicians, up to 85 percent of most costs; the extent of specific subsidies, if any, can be determined by hospital management.
- The hospital enters into a management services agreement with the physicians and charges them a monthly subscription fee which includes EMR license and maintenance fees, costs for implementation, upgrades, required interfaces, help desk and application support, servers and hosting, and network performance monitoring.

- Physician practices are responsible for assuring the recommended connectivity to their respective offices, arranging for their staff to participate in training and the conversion of paper medical records.

The actual approach to providing a subsidy to the physicians can draw on one of three basic models:

- **Pass-Through Model.** The hospital provides the technical and management support for implementation but passes all of the costs along to the physicians.
- **Financed Model.** The hospital amortizes the one-time costs, such as licenses, implementation cost, central IT center hardware, over several years, passing through the operating costs as incurred.
- **Subsidized Model.** The hospital subsidizes up to 85 percent of the cost for physicians to acquire and implement an EMR.

The actual implementation and operating costs to the physicians will depend on the size, location and operating condition of the individual practice. Depending on the

Sample Community Physician Subsidy Options

COST CATEGORIES	**Model 1** - Costs to Physician Practices As Incurred			**Model 2** - Costs to Physician Practices with Amortization			**Model 3** - Costs to Physician Practices with AHS Subsidy		
	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
Physician One-Time Cost	$38,000	$0	$0	$8,000	$0	$0	$8,000	$0	$0
Physician Operating Cost Per Month									
ASP/Hosting	$350	$350	$350	$350	$350	$350	$100	$100	$100
Software	$250	$250	$250	$250	$250	$250	$85	$85	$85
Recapture of Front-end Costs	$0	$0	$0	$470	$470	$470	$70	$70	$70
Clearinghouse Fees	$100	$100	$100	$100	$100	$100	$100	$100	$100
Subtotal without Connectivity	$700	$700	$700	$1,170	$1,170	$1,170	$355	$355	$355
Connectivity	$550	$550	$550	$550	$550	$550	$110	$110	$110
Total Physician Operating Cost	$1,250	$1,250	$1,250	$1,720	$1,720	$1,720	$465	$465	$465
Total Cost Per Year									
Hospital Up-Front Costs (12)	$0	$0	$0	$29,000	$0	$0	$29,000	$0	$0
Hospital Subsidy	$0	$0	$0	$0	$0	$0	$12,043	$12,043	$12,043

Source: JHD Group

subsidy strategy taken by the hospital, the monthly cost to the physicians can range from $300 to $1,500. In all cases, the physicians will be required to pay for any equipment or upgrades in their offices. The table titled Sample Community Physician Subsidy Options on page 20 depicts how alternative approaches can be developed (the numbers are samples only and are not intended to represent actual investment or cost levels, which are subject to a wide range of variables).

The key to achieving clinical integration is a commitment to common standards including Enterprise Master Patient Index (EMPI), Enterprise Continuity of Care Record (ECCR), Interconnectivity Standards, Information Security Standards, and common interfaces, such as with the laboratory and radiology, to assure interoperability.

As of this writing, the movement to an EMR-based virtual group model is just beginning, and the jury is still out on the actual results achieved. However, this approach to hospital-physician integration finally focuses on the patient and the clinical process, which, when effectively implemented, positions the hospital and its physicians to succeed.

> "Leadership is the capacity to translate vision into reality."
>
> —***Warren G. Bennis***

Making it Work: A Road Map for Board and Hospital Leadership

To make this strategy successful, each hospital board must thoughtfully assess how this model fits into the organization's market strategy and ability to successfully execute. Key considerations include expected impact on the hospital's market position; probability of and a timeline for success; cost/capital requirements; and necessary supporting capabilities. Our recommended approach is to:

- **Assess the Market's Readiness.** Conduct a straightforward survey of the community physicians to determine their willingness to participate, their readiness to make the transition to an EMR, and the price point considerations. The results will provide insight into what is necessary to make the initiative successful, to what extent there are existing EMRs in place or in process, and the identification of potential early adopters.
- **Develop the Business Plan.** Based on the data collected and the insights developed, the next step is to organize the analysis in a building-block approach that addresses a number of considerations:

- *Focus:* While the EMR offering may be made to all physicians in the community, the hospital may choose to focus on certain physicians important to the hospital's mission and strategy. One rule which needs to be clearly followed is that the selection of physicians cannot be based on current or prospective referrals alone.
- *Multiple EMR Vendors/Interoperability:* The nature of the physician community and the predilection of physicians may require a multiple vendor approach.
- *Common Standards:* A commitment to common standards, such as Enterprise Master Patient Index (EMPI), Enterprise Continuity of Care Record (ECCR), Interconnectivity Standards, and Information Security Standards, is crucial.
- *Data Exchange:* Physicians must be willing to share data as a part of the initiative, and the approach to data will need to facilitate future Regional Health Information Organizations (RHIOs) as they develop.
- *Practice Management System:* The hospital may need to support a limited number of Practice Management Systems or may require the use of a single integrated system, which is the preferred approach versus building multiple interfaces.
- *Cost Sharing:* The hospital may choose to subsidize the incurred cost up to 85 percent for costs such as:
  - Software license (non-recurring purchase);
  - Software maintenance (monthly fee);
  - Network connectivity (monthly data line fees);
  - Network hardware (routers, hubs, modems);
  - Servers/server hosting;
  - Implementation services;
  - Operational restructuring;
  - End-user training;
  - Help desk/application support;
  - Software customization/template development;
  - Interface/interoperability costs.
- *On-Going Support:* The hospital will likely need to provide comprehensive support to physicians in order to sustain a cost-effective model with common standards.

- **Implement with a Sense of Urgency.** Assure a rollout plan with a schedule that will keep participating physicians and staff focused on making the EMR work and work well.

In determining what will work most effectively, alternative delivery approaches should be considered. A hospital's information technology department may already be at capacity, or its capabilities may not be suited for a significant ambulatory project. Or, community physicians may be uncomfortable with direct dependence on the hospital. In such cases, another approach is to form an independent entity to provide a turnkey EMR support service for physicians. At some later date the capability could be merged into the hospital's information technology function. This approach may enable the process to move quickly to address physician needs, not being subject to hospital processes, and may have a perception of greater independence than if it were attached to the hospital.

The Payoff

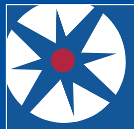
The virtual group model using an EMR centers the clinical delivery process around the patient. It complements the strategies of structurally employing physicians and developing a fabric of collaborations, such as joint ventures, management agreements and PHOs. In this context, it addresses the reality that most hospitals will always rely on a mix of employed and community physicians.

When successfully implemented, this model provides for a wide range of benefits, both in the short- and long-term. It provides the operations foundation to support clinical cost management at the patient level, rather than the encounter level; it provides the data to support incentive/acuity-based revenue, such as from mechanisms such as pay-for-performance, HEDIS quality incentives, and Risk Adjusted Coding; and it increases patient satisfaction through continuity of care, fewer redundant tests and greater knowledge of the patient.

The consideration of this significant strategy should be undertaken by the board and senior management. If approached as a project for the information technology department, it will certainly disappoint. This is an opportunity to reinvent clinical integration in the interest of the patient and in the interest of more effective and efficient delivery of care.

For additional copies of this publication call the Center for Healthcare Governance at (888) 540-6111.

The American Hospital Association's



CENTER FOR HEALTHCARE GOVERNANCE™