Successful Hospital-Physician Integration

Shared governance and decision-making help a California integrated health care network thrive

As we enter the brave new world of health system reform, pressure is growing from public and private payers to coordinate care. The expectation is that better coordination will improve patient outcomes and community health status by more consistently providing preventive care and treating chronic conditions. Many also believe better coordination will slow health care cost growth by reducing duplicate services and avoiding unnecessary tests, preventable inpatient admissions and inappropriate emergency department use. Indeed, the Obama administration's budget proposal for the next decade counts on such savings along with payment reforms to offset half of the added expense of covering most currently uninsured Americans.

While all the details of how payers will promote care coordination are not settled, the broad outlines are clear. Medicare payment incentives—and eventually penalties—are already lined up to encourage adoption and "meaningful use" of interoperable electronic health records. The administration considers this essential infrastructure to enable care coordination.

Also hot are global payments for episodes of care that cover both inpatient and ambulatory services, including physician fees. Private insurers already have introduced such payments in some markets. Moving government programs to global episode-of-care payments is a prominent feature of several health reform proposals put forward by Congress and the administration.

The bottom line: Provider survival will likely hinge on adapting to these incentives. Integrating hospital, physician and other provider operations and financing is becoming an economic necessity. But experience shows that hospital-physician integration is far easier said than done. Many more attempts fail than succeed.

Hospital and health system boards can improve the odds. Our experience with a successful 15-year-old hospital-physician partnership demonstrates the value of shared governance in creating effective integrated systems. It creates opportunities to reconcile competing interests, formulate long-term goals and strategies, and provide the long-term support that such ventures require to succeed.

Lessons From Past Reforms

This is not the first time payers have resorted to powerful financial pressure to encourage cost containment through care coordination. The managed care tsunami that swept the nation in the early 1990s resulted in numerous attempts to integrate hospitals and medical groups in order to cope with global capitation, restrictive provider networks and severe downward pressure on provider fees.

Despite these extreme financial incentives, many, if not most, integrated networks collapsed. In our home of Orange County, Calif., several attempted integrations fell apart during the past 15 years. Some hospitals closed in the wake of these failures. Many of their affiliated medical groups withered because they couldn't attract young physicians in what remains one of the nation's most competitive managed care markets.

Our integration has proven an exception. Consisting of St. Jude Medical Center, St. Jude Heritage Medical Group and St. Jude Heritage Healthcare Foundation, this Fullerton, Calif.-based medical practice foundation model has grown into the leading provider network in the market since its founding in 1994.

Because the hospital and foundation built a stable economic environment with state-of-the-art facilities and technology, it has effectively supported both primary and specialist physicians, and it has consistently been able to recruit new physicians. Growing from an original core of 54 physicians, the medical group

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currently employs 150 physicians in 21 specialties and 30 physician extenders in 15 ambulatory locations. The hospital consistently generates a positive operating margin and the foundation is close to breaking even. Most important, the interdependence of the hospital, foundation and medical group have improved continuity of care for patients, enabling all three to do a better job of fulfilling their community service missions.

Shared governance and board support have played a crucial role in building this tightly integrated system. They helped promote the trust necessary to effectively integrate physician and hospital operations. They also created continuity that sustained the system through challenging economic times and management changes. Based on this experience, we believe that integrating governance is essential to the long-term success of hospital-physician partnerships—and possibly their survival under emerging market conditions.

Fostering Understanding and Operational Integration

Leaders of the three entities making up the St. Jude integration recognized the importance of understanding each others' needs and creating forums for reconciling conflicting interests. They knew that the system overall could only succeed by truly collaborating to achieve long-term system goals that might conflict with their individual perceived short-term interests. This level of collaboration required that all three parties give up their natural tendency to try to control the system in favor of accepting the idea—and the reality—of interdependence. Overlapping governance among the organizations was key to achieving this change in orientation.

Interdependence is a difficult concept for hospitals and physicians to embrace. The cultural chasm between them is wide. Hospitals tend to believe that because they are the partner with the capital and management resources and the community service mission, they should control resources and strategy. Physicians observe that they alone are trained and licensed to practice medicine. This gives them great power over system revenue streams and costs, but it also often leads them to conclude they should have sole control.

These divergent perspectives are reinforced by the different needs and financial and business models of the two groups. As institutions, hospitals must amass and preserve large quantities of capital, and they generate most of their revenues from high-dollar, low-volume transactions. As individuals, physicians are discouraged from amassing capital in private practices by the tax code and their personal financial needs, and most depend on low-dollar, high-volume business. These differences create fundamental strategic and operational incompatibilities that are difficult to reconcile. And they don't disappear when the two groups integrate.

Surviving global episode-of-care payments, new electronic records and quality reporting standards will require true integration of clinical and financial operations. This in turn requires that the real differences between hospital and physician cultures, incentives and operations be openly acknowledged and continuously managed.

Shared governance helps make this possible. But shared governance means more than just pro forma overlapping board memberships. It means that hospital leaders and medical group leaders must take an active role in the governance of the entire integrated system. Organizational goals and strategies, as well as major decisions, must be jointly determined and agreed to by hospital and physician leaders.

In our situation, St. Jude hospital leaders are on the foundation board and sit in ex officio on the group board. Medical group leaders are on the hospital and foundation boards. More importantly, all group, foundation and hospital leaders attend all governance meetings involving major decisions. Their participation is more than reading a report—in fact, the report from hospital management is the last item on the agenda of a group or foundation meeting. Before that, hospital leaders provide input and discussion on all group matters, helping resolve issues before they become problems.

Having medical group leaders on the hospital board helps them gain valuable insights into the hospital's global strategies, issues and others' points of view. This helps reinforce the collaborative nature of the enterprise and facilitates a greater appreciation of the shared mission, vision and values of the entire organization. Having foundation physician leaders on the hospital board can also keep nonfoundation physician comments in balance and sometimes helps defuse nonproductive discussions.

Special efforts are made to involve younger physicians in group, foundation and hospital governance. Young physicians are rotated through group practice committees and board seats. They are also rotated through the foundation and hospital boards as seats are available. Exposure to the collaborative decision-making processes of the entities helps inculcate newer physicians in the culture and values of the system as a whole. It also helps them see and appreciate the tangible benefits the system provides in terms of lifestyle, services, stability and negotiating strength with payers.

Over time, shared governance has contributed to a profound shift in the tenor of the relationship between the hospital and medical group. In fact, in an unprecedented move, the group encouraged the hospital CEO to also serve as the foundation CEO. This allowed the hospital to manage foundation resources and operations. In turn, this gave the hospital increased exposure to the ambulatory environment and enabled it to achieve a greater understanding of its needs and priorities as it related to an integrated system.

This ultimate display of trust resulted in the relationship among the entities improving each year and created a framework for building the closely integrated operational and administrative infrastructure that exists today. Shared governance resulting in shared administrative leadership has created multiple forums for strengthening the system through collaborative decision-making. The advantages and disadvantages for each party are openly addressed, and decisions are rendered in the best interests of the system as a whole.

Issues early in the relationship that were settled in adversarial confrontations over the professional services agreement governing the partnership are now routinely and amicably dispatched in regularly scheduled management and governance meetings. The breadth and depth of governance and leadership integration has helped the collaboration remain strong through leadership

transitions, including the replacement of the retiring hospital CEO.

Long-term Strategy Requires Long-term Support

Because the differences between physician and hospital organizations are so deep-seated, it takes time for trusting relationships to develop. In this case, the ice didn't break for at least five years, which left the foundation venture far short of its early financial and strategic goals. Governance support from both the hospital and the hospital's parent, St. Joseph Health System, was essential to success.

The turning point came in the fifth year, when the hospital backed the foundation despite heavy losses. This helped convince many still-skeptical physicians that the hospital could be trusted and was in the relationship for the long haul. The St. Joseph system stood behind St. Jude's continuing efforts because the system realized that a foundation integration model is truly a long-term, if not permanent, partnership strategy whose payoff is a sustainable market presence. This is very different from joint ventures for outpatient surgery centers or other project-oriented bonding strategies that have a limited life and always leave the physicians looking for more.

The St. Joseph system is attempting wherever possible to replicate the St. Jude experience to build competitive ventures in other markets. The long-term strategy is to build a more effective and efficient health care system for the community in accordance with its mission statement. This should be the criteria for integration success.

Benefits Reinforce Positive Relationships

The collaboration that emerged at St. Jude produced many benefits. For example, at one point the foundation extended its contract with a major payer for a year without taking an increase to synchronize its renewal cycle with the hospital contract. The foundation and the medical group also supported the hospital in negotiations by refusing to sign contracts with payers that did not include the hospital. As a result, both parties won more equitable payment terms. These outcomes would not be possible without a high level of trust between medical group and hospital leaders.

Collaboration also allowed consolidation of inpatient and ambulatory lab services. This not only removed an operational friction point, it reduced total overhead and cut down on duplicate testing. Administrative, financial operations and leadership also have been combined where possible, and billing activities are closely coordinated between the foundation and the hospital. This helped improve contract cost management, sped up accounts receivable and reduced claims denials and lost charges for both parties.

Collaboration enabled the consolidation of electronic medical records across 15 ambulatory locations. This reduced costs for handling paper charts and helped contain treatment costs by avoiding duplicate services. More importantly, it facilitated communication between physicians and therefore improved care. This connection creates incredible opportunities for disease management, clinical trials, strategic planning, community benefit and outreach that can only be accomplished on an integrated basis. The system also helps with contracting by documenting Healthcare Effectiveness Data and Information Set, pay-for-performance and compliance with other quality measures.

These benefits reinforce physician and hospital commitment to the partnership. They also leave the St. Jude system well positioned for the next round of system reform.

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Principles for Successful Integration

Our experience at St. Jude taught us the following principles for successful integration:

- *Interdependence is key.* All parties must understand and commit themselves to the idea that success depends on cooperation and they should make decisions accordingly.
- *Relationships are primary*. Trusting relationships between hospital and group leaders enable quick and effective decision-making followed by widespread support for decisions made. The resulting visible improvement in structures, processes and performances reinforces trusting relationships and builds organizational strength.
- *Trust takes time to develop.* Boards must recognize that integrating with a physician group is a permanent bonding strategy that will take long-term support to accomplish.
- *Recognize and respect cultural differences.* Successful integration requires openly acknowledging and continually managing the legitimate divergent interests of hospitals and physicians, and among various service locations.
- *Accountability and transparency are essential to maintain performance.* Resource allocation decisions, including physician income distribution, must be based on objective data and with active input from physician and hospital leaders. All parties also must be held accountable to objective performance measures.
- *Medical groups must understand that the hospital has other relationships.* While a system's affiliated medical group may be its most important partner, it must understand that relationships with independent physicians on its medical staff and specialty centers of excellence are essential to the success of the system as a whole, and allow the hospital to pursue and maintain them.

Shared governance and management structures are essential to create and reinforce the values and goals that make such collaboration possible. It is necessary to achieve a truly interdepen-

dent culture in which both the hospital and medical group can prosper. However, an integrated structure is inherently risky. Making it work is a constant challenge that will test the core competencies and motivations of all parties. Shared governance mitigates this risk. Organizations that succeed with this approach will be well-positioned to respond as our society demands better outcomes and value from health care services. **T**

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