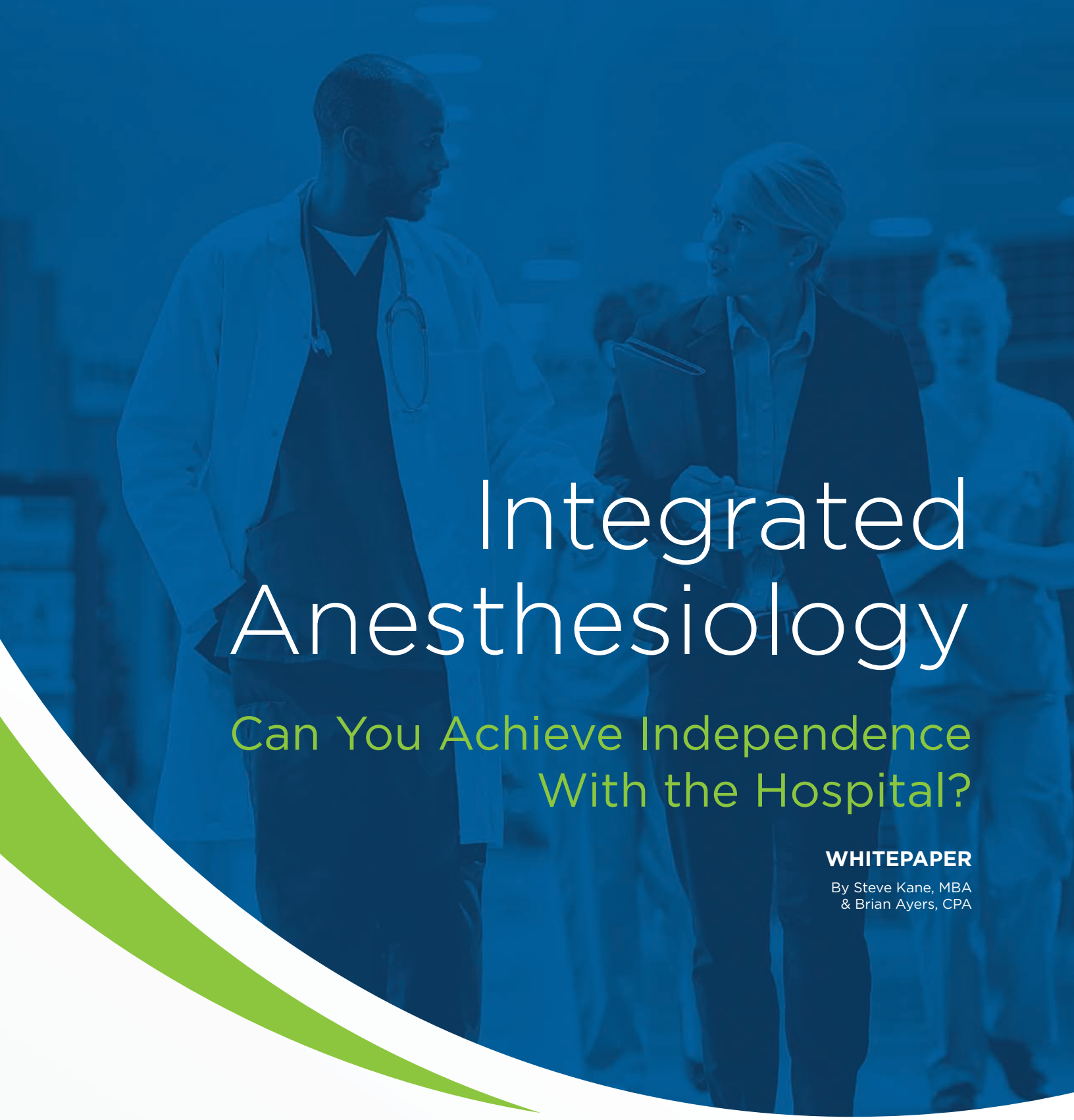

Integrated Anesthesiology

Can You Achieve Independence With the Hospital?

WHITEPAPER

By Steve Kane, MBA
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Integrated Anesthesiology:

Can You Achieve Independence With the Hospital?

Anesthesiology practices are in a new climate of increasing competition that requires self analysis and more in-depth views of market trends that can be compared to their own business models. Whether it is the emergence of accountable care organizations (ACOs), the surgical home and integrated service models, the ongoing relationship between anesthesiology groups and hospitals, competitive hospital contract bids or the independent formation of anesthesiology groups, more and more anesthesiology practices are realizing the time for "doing what has always been done" is over.

Market trends reveal many hospitals' immediate focus is on non-traditional service options. With increasing regulation, practices are finding inconsistent application of new policies and funding problems that are leading to a tightening cash flow. One thing is certain: traditional anesthesiology practice models are now being pressed from multiple directions.

In a complex era of health care reform, every practice arrangement must be built on true clinical integration; and whether an anesthesiology practice is independent or employed by the hospital – nothing is sustainable without it. The advent of accountable care models, bundled payments and quality reporting, and payment initiatives will force integration.

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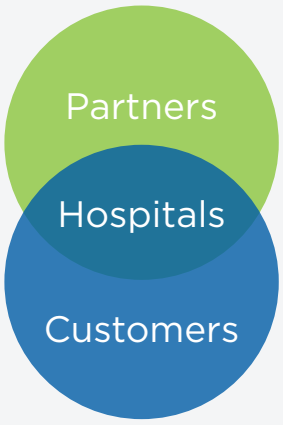


Hospitals as Partners and Customers

Hospitals are indeed looking ahead as they consider ACOs and integrated service delivery. Today's hospital environment is comprised of reduced reimbursement, and it often offers pay for performance incentives for its physicians – either for those employed directly or through a contract. There are also increasing employment alternatives for hospitals, especially if they consider employment-based physician staffing in place of a traditional contract model with an anesthesiology practice.

Emerging trends suggest that more hospital employment of physician groups has occurred during the last five years, even though the American Medical Association's (AMA) 2012 Physician Practice Benchmark Survey reported that 60 percent of physicians work in physician-owned practices, and about 53 percent were self-employed. Conversely, only 23 percent work for practices partially owned by hospitals and nearly 6 percent worked solely for a hospital[1] It has been well documented that employed physicians are not as productive as those who are independent, and hospitals also face recruiting challenges in this sense.

All of these reasons give anesthesiology practices the need to improve their relationships with hospitals in an effort to maintain autonomy. Hospitals should be viewed as both partners and customers in the minds of anesthesiology practice stakeholders and leadership.

Want Versus Need

What should groups do first? Consider what it is hospitals have always wanted from groups, such as on-time surgery cases or more coverage of anesthesiology services, given Medicaid expansion and the advent of insurance exchanges.

Not only does the hospital have wants a practice must take into consideration, but also there are requirements:

- Economic pressures are creating an adversarial climate in some areas and pushing physicians and hospitals together in others. Competition of services is a hot button issue and often, hospitals require strategic alignment from groups with no competing or outside ventures.
- As the health care community tries to transform itself from a volume-based to a value-based system, costs are even more constrained. To succeed, hospital leaders must manage costs by identifying effective resources and integrating service distribution plans. The anesthesiology group must ensure the staff modeling is economical. The correct mixture of CRNAs and anesthesiologists is the key.
- Of late, many hospitals require committee participation and strategic planning involvement from its physician partners. This means health systems are encouraging physicians to be on various boards and committees at every level of the organization, and physicians are stepping up to do so. Some health systems have dedicated physician organizations to provide direction to the institution, while others have physician leadership training programs to ensure they have doctors with the skills to fill key roles.
- Finally, patient and surgeon satisfaction still is and has always been the largest hospital requirement of anesthesiology groups.

Management of the Operating Rooms

Anesthesia groups are equipped to assist hospitals in the management of the operating rooms (ORs). Anesthesiologists understand the reasons for delays and how to improve the efficiency of the ORs. Data from the billing system provides information that can assist in determining the OR utilization. In addition, a surgeon's length of cases compared to peers can be analyzed to improve efficiency. If a surgeon chronically has longer case times, it impacts the flow of the OR. Strong relationships with surgeons enable the anesthesiologists to have frank and honest conversations with surgeons regarding solutions.

The group needs to select an appropriate doctor as the OR director. The anesthesiologist should be respected by the hospital administration, surgeons, the OR staff and other anesthesiologists. The director must be impartial in the decision making process. Any appearance of favoritism towards the anesthesia group will result in lack of cooperation from the other parties. Successful OR directors have improved OR utilization, patient and surgeon satisfaction, on-time starts, and case cancellations. Involvement in the management of ORs further cements the group's position with the hospital and community.

Redefining Your Group Culture

Remembering there are more options for hospitals now than ever before, anesthesiologists working in independent groups can become sensitive to these issues, which bleeds into the psyche of the entire staff. Societal changes are often reflected in physician behavior. The competitive and threatening atmosphere between hospitals, payers and other groups can foster bad moral for independent groups, and in turn this moral lends to unintended group consequences. For example, anesthesiologists who feel threatened can exhibit behavior that affect group health, including rudeness, tardiness, incompetence, weak skills, poor work ethic or confidentiality breaches.

This is hard for groups, especially since physicians are not usually confrontational with their own staff and often have the blind faith that the behavior will correct itself or simply go away. In the end, many groups do not seem to understand the consequences these problems can bring. There is often a lack of process available to deal with these behaviors or to stop them from occurring from the start. Groups that are considering a change or a solution to an existing problem with their anesthesiologists might want to consider:

- Creating a discipline policy
- Establish policies that deal with actions instead of individuals
- Be consistent in applying policies that are established
- Not be too punitive or too permissive with those exhibiting "bad behavior"
- Create an employment agreement with clauses, such as termination without cause
- Reinvent the culture of the group

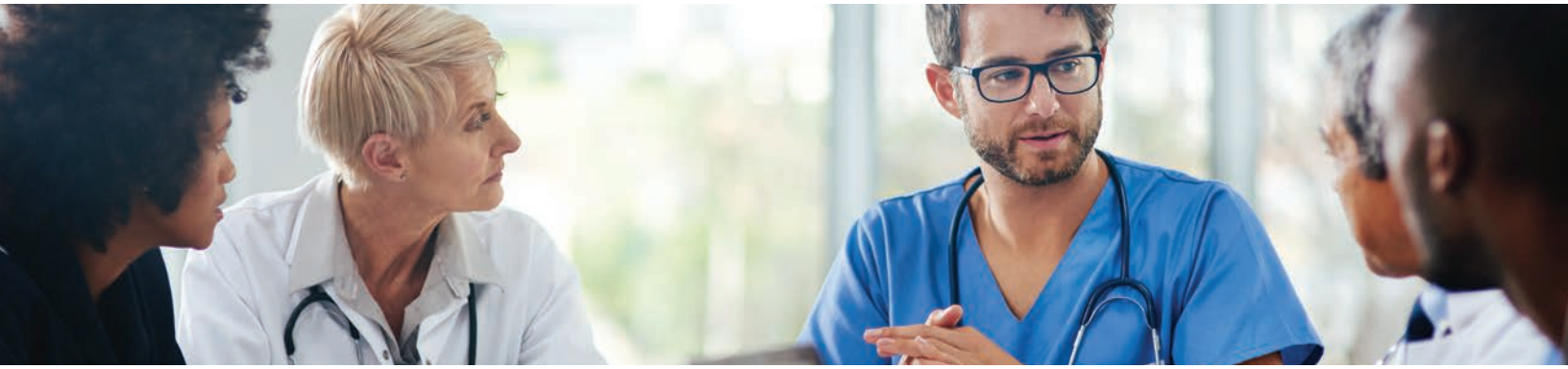
Strategic Planning Makes a Sound Business

Once a practice has firmly established it is willing to improve its culture in an effort to help the hospital meet its needs, it must also focus on its own growth and diversify with effective outpatient and system strategies. Using service execution, finding new sources of revenue, and growing its core business are a few ways it can do so. Aligning with the hospital is also crucial to its growth, especially in the planning of physician management and recruitment efforts. Most important is that a practice should always plan for financial security and any risks/losses associated therein.

The anesthesiology group can strategically build its relationship with the hospital by first adding market value where it is needed. Performing clinical integration and reporting the value therein is a great first step, while also striving to meet the customer-focused service the hospital demands. Meeting the needs of other specialists and generalists are also ways anesthesiologists can build relationships outside of the hospital's leadership, helping them to develop a greater network communications strategy and gain market leadership.

Exclusive of the hospital's needs and wants, anesthesiology practices that operate in a businesslike manner can showcase more confidence in both leadership and service execution. In addition, contrary to the beliefs of many physicians, just because a practice runs in a business fashion, does not mean patient care is forgotten. Patient care is a practice's business!

Soundly run businesses that can operate in an independent manner will garner hospital respect and admiration from the start. The bottom line is that for an ideal hospital relationship to emerge with an anesthesiology practice, a combination of service, trust, financial viability and common goals must be shared – which is where an ideal integrated model comes into play.



There are multiple alignment models for physicians and hospitals that can give each the perceived benefits of closer alignment while allowing doctors to remain autonomous. Limited alignments give physicians more autonomy but modest financial rewards. With full alignment, autonomy is low but financial gains are likely to be higher. Moderate alignments fall in between. The more limited the deal, the easier it is to get out.

One such example of a moderate alignment is clinical co-management, whereby hospitals and physician groups are working toward shared goals such as lowering costs for particular services. Historically, gain-sharing arrangements have been against federal law. But with the advancement of ACOs, the concept has received more of a push as incentives are created to help physicians and hospitals save money and improve care.

Independence that Yields Integration

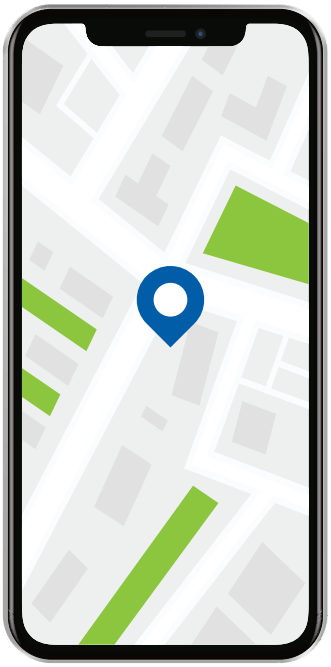
A co-management agreement is when physicians are engaged through a contract to provide management services in concert with hospitals for programs or services. The agreement usually has some form of fixed fee-for-services, as well as performance incentives based on predefined quality, satisfaction and/or efficiency metrics that help the hospital meet its goals.

The purpose of clinical co-management is to ensure collaboration between a hospital and physician group in developing, managing and improving the quality and efficiency of the hospital. The goal is ultimately to increase hospital-physician alignment, while maintaining the independence of the physician group.

This is the best option for the practice that does not desire complete hospital control or a “divorce” from the hospital. In this agreement, both the hospital and the practice agree on how they will play ball and each can agree to provisions that are mutually beneficial. It can provide for the performance of a variety of services, including, for example, medical director services, strategic planning, scheduling and staffing, and human resources duties.

The layout of a co-management agreement starts with a shared governance structure with an agreement on complete transparency of data. Physicians are still in control, but also commit to the care of the hospital’s resources. Performance metrics include evidence based protocols and quality measures for baseline and readjustment. All services are set at a fixed price and incentive compensation must be fair market value. All of which ultimately leads to increased value.

A quality co-management service agreement should reflect a clear understanding between the hospital and the anesthesiology group as to what the effect the hospital's retained governance authority will have on the group's ability to perform the management services it is responsible for under the agreement. Provided the parties to a co-management service agreement clearly understand their respective rights and responsibilities, the arrangement contemplated by the agreement can have the benefit of enhancing the physician group's satisfaction with its hospital alignment by allowing it to participate in the operational and strategic efforts of the hospital. The hospital on the other hand can gain from possible cost reductions, increased Medicare payments based on clinical quality, and securing the services of a valuable physician group in an important service line of the hospital.



Risks and Safeguards

The operational risks associated with such arrangements can be minimized by making sure the parties' enter into a co-management service agreement that clearly describes what the hospital is willing to let the physician group manage and the specific tasks and functions the physician group will be responsible for performing. For example, in its final Advisory Opinion of 2012 (OIG Advisory Opinion 12-22, issued: Dec. 31, 2012), the Office of Inspector General (OIG) provides a useful road map for structuring a co-management arrangement to comply with applicable law. In that Opinion, the OIG approved a co-management arrangement in which a hospital paid a cardiology group to manage the hospital's cardiac catheterization laboratories (Arrangement). The compensation paid by the hospital included a fixed management fee and a performance bonus, based upon achieving certain quality and costs savings benchmarks in connection with operation of the catheter labs.

The Office of Inspector General (OIG) provides a useful road map for structuring a co-management arrangement to comply with applicable law.

The OIG determined that, although the Arrangement (1) could potentially constitute an improper payment to induce the reduction or limitation of health care services, in violation of the Civil Monetary Penalties Statute, and (2) could potentially generate prohibited remuneration in exchange for referrals under the Anti-Kickback Statute, the presence of certain "safeguards" minimized the possibility of violation of the applicable statutes. Because the likelihood of violation of these statutes was minimal, the OIG stated it would not seek to impose sanctions against the parties.

There are, however some safeguards for groups as indicated in the OIG opinion. The hospital's certification that both the fixed fee and the performance bonus represented fair market value compensation for the services performed. The compensation paid to the physicians did not vary with the number of patients treated. The Arrangement would not serve as an incentive for the physicians to refer patients to the hospital instead of to a competing facility. Instead it was designed to improve quality rather than to reward referrals, and the Arrangement had a limited duration.

Urgency in Health Care Reform

As health care reform spurs the industry to focus on cost control and the delivery of high quality care, improving hospital-physician relationships requires immediate attention. While there are a variety of ways to structure a relationship and/or contract with a hospital partner, groups that move forward with a co-management agreement can position the hospital as the customer, taking an approach that will yield increased value, quality and harmony. There are no guarantees in any hospital employment agreement, and an arrangement that “goes bad” is very difficult and expensive to unwind.

Regardless of how an arrangement is structured, anesthesiologists must remember these current instabilities and relationship woes will not be solved by the health care market or the government. Anesthesiologists must seek ways to reinvent their culture from within and approach new integrated care delivery with meaningful strategies if they want to maintain independence and sustainability.

References

AMA Releases New Study of Physician Practice Arrangement, Sept. 17, 2013 - http://www.ama-assn.org/ama/pub/news/news/2013/2013-09-17-new-study-physician-practice-arrangements.page

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