Physician/Hospital Alignment in Pediatric Healthcare: Contemporary Alignment Strategies in the Reform Era

Third of a Six-Part Series

May 17, 2012

Audience Reminders

- Submit a question by typing it into the Question and Answer pane at the right of your screen at any time.
- Respond to audience polls by clicking on the answer of your choice.
- Provide feedback through our electronic survey following the Webinar.
Our Speakers

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Agenda

I. Physician/Hospital Alignment in Pediatrics
II. Case Study – Rady Children’s/RCSSD/UCSD
III. Case Study – Connecticut Children’s Medical Center/CCSG
IV. Conclusions
V. Questions and Answers
I. Physician/Hospital Alignment in Pediatrics

Drivers of Alignment

The current environment is driving an increased need for physician/hospital alignment.

Factors Driving Greater Alignment
- Downward pressure on professional fees.
- Physician shortages leading to escalating salaries.
- An increasing gap between professional fees and the cost of practice.
- Reliance on other sources of funding for the pediatric physician enterprise.
- The potential emergence of global payment systems.
- Care delivery reform (e.g., creation of ACOs, selected disease-specific care management efforts).
The nature of physician/hospital relationships in pediatrics is dictated, to a degree, by existing organizational structures.

<table>
<thead>
<tr>
<th>Children's Hospitals</th>
<th>Physician Group Structures</th>
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</thead>
<tbody>
<tr>
<td>Freestanding children’s hospitals.</td>
<td>Faculty practice plans encompassing both adults and children.</td>
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<tr>
<td>Children’s hospitals within AMCs.</td>
<td>Employed physicians.</td>
</tr>
<tr>
<td>Children’s hospitals within hospitals or health systems.</td>
<td>Pediatric multispecialty FPPs.</td>
</tr>
<tr>
<td>Specialty hospitals.</td>
<td>Foundation model with contracted physicians or groups.</td>
</tr>
<tr>
<td>Pediatric units/programs.</td>
<td>Private physician groups and individuals.</td>
</tr>
<tr>
<td></td>
<td>Independent school of medicine (SOM) department-based practice plans.</td>
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<td></td>
<td>Any combination of the above.</td>
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</tbody>
</table>

A variety of traditional integration mechanisms are used in pediatric organizations.

NOTE: Size of bubble = ability to meet strategic need.
I. Physician/Hospital Alignment in Pediatrics

Relationship Attributes

- True alignment in children’s hospitals is increasingly defined across four spectrums.

1. Separate/Distinct
2. Leadership Integration
3. High Integration
4. Loosely Aligned
5. Financial Integration
6. Joint Incentives
7. Parallel Processes
8. Strategic Integration
9. Joint Planning
10. Fragmented, Multiple Groups
11. Physician Organization
12. Consolidated Practice Structures

II. Legal Perspective

- There are a number of tools to achieve tighter alignment with physicians.
- These tools have both structural and financial elements.
- Determination of the appropriate alignment features will involve consideration of a number of legal issues.
I. Physician/Hospital Alignment in Pediatrics

Structural Options

- Employment/practice acquisition.
- Aligned practices (e.g., “friendly PC,” hospital-owned physician group, faculty practice plan).
- Foundation models (e.g., California H&S 1206(l)).
- Clinic models (e.g., children’s outpatient clinics).
- Joint ventures.
- Contractual – comanagement or provider services agreements.

(continued)

- Medical homes.
- ACOs.
- Clinical integration for antitrust purposes.
I. Physician/Hospital Alignment in Pediatrics

Financial Tools

- Bundled payments.
- Episode-of-care payments.
- Capitation or percentage of premium carve-outs.
- Pay-for-performance (P4P) bonuses.
  - Quality.
  - Cost.
  - Efficiency.

I. Physician/Hospital Alignment in Pediatrics

The Legal Issues

- Issues related to the relationship between nonprofit and for-profit entities.
- Issues related to the Anti-Kickback Statute (state and federal).
- Issues related to antitrust laws (state and federal).
- Thankfully, no issues related to the Stark law (Medicare only).
II. Case Study – Rady Children’s/RCSSD/UCSD

UC San Diego (UCSD) Health Sciences
Rady Children’s Hospital – San Diego (RCHSD)
Rady Children’s Specialists of San Diego (CSSD)

Update: A New Model for Pediatric Healthcare
II. Case Study – Rady Children’s/RCSSD/UCSD
(continued)

<table>
<thead>
<tr>
<th>UCSD Health Sciences</th>
<th>CSSD</th>
<th>RCHSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large AMC with two hospitals.</td>
<td>For-profit medical group.</td>
<td>Large, freestanding children’s hospital serving the region.</td>
</tr>
<tr>
<td>Medical school ranked sixth among public schools for research.</td>
<td>25 divisions.</td>
<td>297 staffed beds.</td>
</tr>
<tr>
<td>16 pediatric divisions.</td>
<td>146 physicians.</td>
<td>Nationally ranked.</td>
</tr>
<tr>
<td>54 pediatric academically oriented physicians.</td>
<td>Primary provider of pediatric subspecialty care for Greater San Diego and the region.</td>
<td>Significant clinical research through Rady Children’s Research Center.</td>
</tr>
<tr>
<td></td>
<td>Physicians involved in clinical research and training programs.</td>
<td>Significant training of fellows, residents, and medical students.</td>
</tr>
</tbody>
</table>

1 U.S. News & World Report.

II. Case Study – Rady Children’s/RCSSD/UCSD
(continued)

UCSD, RCHSD, and CSSD had sought a formal partnership for many years. RCHSD’s objective of achieving top research, teaching, and clinical programs created the imperative for change.

- In 2001, RCHSD, UCSD, and CSSD signed formal affiliation agreements.
- Affiliation included:
  - Consolidation of clinical programs and faculty onto the RCHSD campus.
  - Changes to governance of RCHSD.
  - Financing/funds flow for academic programs.
- Key challenges included:
  - Cultural clashes between clinical and academic faculty.
  - Competition over recruitment of clinicians.
  - No agreement over corporate and divisional governance.
  - No access to UCSD research infrastructure for CSSD specialists.
The medical foundation is a unique model utilized by California providers due to the state’s complicated corporate practice of medicine statute, which prohibits hospital employment of physicians.

- A California medical foundation is a nonprofit healthcare entity (exempt from federal income taxation) that provides ambulatory care to its patients who stay less than 24 hours.
- It does not employ physicians; instead, it contracts with them to provide professional services to foundation patients (it may contract with independent physicians or a medical group).
- Foundations can also be “risk-bearing organizations,” meaning that they can accept capitation and arrange for the provision of healthcare services to their patients.
- A foundation is required to perform medical research and educational services for its patients.

II. Case Study – Rady Children’s/RCSSD/UCSD

Vision – Align, integrate, and collaborate in fulfilling the missions of Rady Children’s, UCSD Health Sciences, and Children’s Specialists of San Diego (CSSD).

Purpose – Improve patient access to care and physician recruitment.
- Implement a single employment model.
- Align quality and delivery of care in outpatient and hospital settings.
- Increase research.
- Optimize training opportunities for all pediatric specialties.
- Improve coordination of payor contracting.
- Simplify professional malpractice and compliance.
II. Case Study – Rady Children’s/RCSSD/UCSD

RCSSD Measures of Success

- Form a cohesive, high-functioning entity for clinical practice, research, and teaching.
- Recruit the best and brightest physicians.
- Meet quality and patient access goals.
- Achieve excellent outcomes.
- Increase clinical research.
- Become the leading institution for postgraduate education in pediatrics and pediatric subspecialties.
- Enhance the reputation of the hospital, university, and physicians.

Medical Foundation Model

Organizational Relationships

- UCSD
- RCHSD
- RCSSD

RCSSD Foundation

A series of agreements were crafted related to clinical services, research administration, and other areas.

RCSSD Foundation is an operating unit of RCSSD.
II. Case Study – Rady Children’s/RCSSD/UCSD
Medical Foundation Model (continued)

Our Experience – Design and Initial Implementation

- There is no “one size fits all” – our model is one of a kind.
- The resulting design represents a major change in how we do business.
  - Combining private practice and academic cultures.
  - Evolving into “group practice” thought processes.
- The presence of group practice management expertise is critical.
- Commitment at all levels of each organization was a requirement for success.
- The reaction from community systems was more than expected.
- The negotiation and transition were much more time-consuming than anticipated.
- The short timeline was an ally in many respects.
II. Case Study – Rady Children’s/RCSSD/UCSD
Our Experience – Lessons Learned After the Fact

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<th>Lessons Learned</th>
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<td>Increase in extramural funding for research.</td>
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<td>Integrated approach to planning (CCS pilot site).</td>
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Outcomes

- Fabulous recruitments, clinical and academic.
- Financially sound.
- More integrated medical school relationship for teaching and research.
- Increase in extramural funding for research.
- Integrated approach to planning (CCS pilot site).
- Potential for greater integration with primary care.

Lessons Learned

- Strong leadership in all organizations is essential.
- The continued response of adult systems in the community is greater than anticipated.
- It may not be possible to bring everyone along at once.
- A mandate was required in order to accomplish the transition.
- It is essential to have qualified advisers.

III. Case Study – Connecticut Children’s Medical Center/Connecticut Children’s Specialty Group
III. Case Study – Connecticut Children’s Medical Center/CCSG

University of Connecticut School of Medicine (UConn)
Connecticut Children’s Medical Center (Children’s)
Connecticut Children’s Specialty Group (CCSG)

Children’s
- Only freestanding children’s hospital in Connecticut.
- 16 years old – built and established in 1996.

CCSG
- 25 pediatric subspecialties, including both medical and surgical.
- 140 employed physicians.
- 229 employed clinicians, including midlevels.
- Serves as the Department of Pediatrics for UConn, training medical students, residents, and fellows and providing research.
- Growth in fellowship slots.

UConn
- Supports research among faculty.
- Recent affiliation with Jackson Labs will result in $1 billion investment in genomic research.
III. Case Study – Connecticut Children’s Medical Center/CCSG (continued)

Recurring transorganizational theme – successful integration of, and with, other entities.

1996: Children’s and CCSG incorporated, begin operations. CCSG includes subspecialists from Hartford and Newington Children’s and acquires a private practice in surgery and urology group.

2002: CCSG integrates subspecialists from three disciplines (hem/onc, endocrinology, and pulmonology), all previously with another group affiliation.

2006: Children’s formally integrates CCSG into its corporate structure as a wholly owned subsidiary.


2010: Children’s integrates private cardiology group.

2011: Children’s integrates NICU from UConn Health Center in Farmington, Connecticut.

2012: Children’s jointly recruits cardiothoracic surgeon with Yale New Haven Hospital.

Governance Model

- CCSG Board is semiautonomous.
- Children’s is the sole member with rights of appointment of much of board.
- Children’s is responsible for:
  - Strategic planning – long-term and annual enterprise-wide goals and objectives with significant CCSG and physician input.
  - Approving rolled-up budget, including CCSG.
  - No direct CCSG representation on Children’s Board.

CCSG Board

- Approves CCSG budget.
- Monitors CCSG progress against strategic objectives.
- Determines faculty compensation.
- Strategic oversight of clinical operations.
- Hires/terminates president of CCSG.

To date, nonphysician administrator, recruiting for a physician administrator.
CCSG Administration

CCSG management is responsible for:

- Faculty hiring and programmatic services growth plans.
  - Development of long-term plans for rate and timing of physician hires.
    - With review by Children’s CFO and input of VP of Business Development.
  - Driving ambulatory geographic growth.
    - With significant engagement with hospital COO, VP of Business Development, and specific program leaders (e.g., PT/OT).
  - Specific faculty hires, timing, and focus of programmatic priorities.
    - Plans for all hires reviewed jointly by CCSG medical and Children’s financial leadership.
- Faculty development and mentoring.
  - Will soon work with hospital organizational development staff on a formal leadership development program.
  - Compensation programs.
    - Base compensation and incentive programs.

CCSG Administration (continued)

CCSG management is responsible for:

- Clinical operations:
  - Recently shifted line accountability for nursing to centralized nursing leadership.
- Clinical coordination:
  - Anticipate increasing support from hospital quality staff.

CCSG management structure allows for:

- Self-determination, flexibility, and engagement/idea generation at practice and program/divisional level.
- Includes senior-level physician and administrative leaders.
III. Case Study – Connecticut Children’s Medical Center/CCSG (continued)

CCSG Administration (continued)

CCSG management is responsible for:

- Contracting.
- Billing (recent transfer of accountability from CCSG).
- Benefits administration.
- Human resources.
  - Except physician recruiting and on-boarding.
- Policies.
  - With comment/input by CCSG medical and administrative leaders. Exceptions for CCSG faculty where appropriate.
- Managed care administration.
- Fund-raising.
  - Seeking active engagement and participation by faculty.

- IT support.
  - Strong connection with CMIO to optimize communications.
- Marketing, Web site, and media relations.
- Research administration and internal funding determinations.
  - Determined by CCSG physician leaders with Children’s appointment.
- Physician liaison and regional pediatric services.
  - External Referring Provider Advisory Board cochaired by a Children’s administrator and CCSG physician leader.
- Physician compensation program reporting and modeling.
III. Case Study – Connecticut Children’s Medical Center/CCSG (continued)

Challenges and Successes

Financial Reporting

Challenges:
- In the early years, there was tension, not always underlying, between hospital and practice on funds flow matters and recognition of contribution to overall bottom line.
- Practice “owned” many research expenses as culturally the approval was more readily sought/obtained.
- Practice financials were increasingly dismal.

Resolution:
- Clear accounting for funds flow.
- Organization-wide reporting of rolled-up operational financials, practice, and hospital combined.
- More explicit recognition for contributions to enterprise.

CCSG Management

- There was early recognition by hospital that practice clinical operations management is very different than hospital management.
  - Hospital has long term allowed for a great deal of autonomy in operational control.
  - This has served us well culturally through the years.

CCSG Medical Leadership

- Buy-in to strategic plan:
  - Significant practice and physician engagement in planning.
  - Engaging medical leadership and divisional leadership appropriately.
  - Shared organizational mission, vision, and strategy.
- Culture has merged and reflects strategy.
  - “Culture eats strategy for lunch.”
III. Case Study – Connecticut Children’s Medical Center/CCSG (continued)

Observations on the Current State
- Due to our roots as the product of sequential integrations, we continue to evolve from a culture of divisional autonomy to a true organizational focus.
- Relationship and responsibilities between (divisional) leaders and organizational (senior medical) leadership continues to evolve.
- Roles of division heads continue to be defined and evolve.
  - Initially to allow for our great diversity of culture, experience.
  - Upcoming faculty leadership development programming.
- Goals include creating common expectations, accountability, and leadership skills and qualities.
- Collectivity wins!
  - Important lesson for extra-organizational relationships as well.

What Might the Future Hold?
- Much more complex and challenging compensation and reward methodologies.
  - Reflecting quality and service factors, as well as other nonclinical considerations.
  - How clinical productivity will be measured as reimbursement methodologies evolve from a strictly volume basis.
- How to most effectively collaborate with referring primary care pediatricians.
  - Ownership vs. indispensability.
  - Service predicated on true collegiality.
  - The appropriate role of midlevels and the receptivity to them by referring pediatricians.
- Effective partnerships with other institutions.
What Might the Future Hold? (continued)
- How to remain attractive to recruits in an increasingly competitive environment.
  - Organizational culture.
  - Professional satisfaction/development.
  - Attractive environment for clinical educators and researchers alike – balance/diversity.
- How to deliver care in new, not just better, ways.
- The organization’s culture, strategy, and its leaders’ ability to execute must keep up with accelerated change.
  - Natural selection favors adapters, not simply the biggest or strongest.
IV. Conclusions

- The pressure will increase on children’s programs to pursue integration strategies in order to manage care on a population basis.
- There are multiple traditional and emerging organizational mechanisms possible to create better physician/hospital alignment.
- Physician/hospital alignment solutions tend to be unique as a result of legal/regulatory, organizational, cultural, financial, or other idiosyncrasies.
- Lessons learned from existing programs are similar across several main themes: leadership integration, financial alignment, strategic integration, and alignment of physician organizations.

PEDIATRIC BUSINESS AND HEALTHCARE DELIVERY SERIES

Questions & Answers

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Thank you for participating in today’s session.

Please take a moment to complete the electronic survey upon exiting today’s program.

Future Programs

We hope you will join us for future programs in the Pediatric Business and Healthcare Delivery Series, which will feature the following topics:

- Fraud and abuse compliance.
- Information technology.
- Research and teaching.
- Subspecialty physician practice – managing teaching, research, and clinical missions in the presence of shortages.