Physician/Hospital Relationships:
Reflecting Back, Looking Forward

With the new year upon us, we interviewed four industry influencers to share their thoughts on top issues facing physicians and hospitals, and the opportunities for their collaboration.

Larry R. Kaiser, MD, FACS
Dr. Larry Kaiser is the leading health sciences executive at Temple University in Philadelphia. He serves as president and chief executive officer of the Temple University Health System, Senior Executive Vice-President for Health Affairs and The Lewis Katz Dean of the Lewis Katz School of Medicine at Temple University.

Michael K. Koehler MD, FACG
Dr. Michael K. Koehler practices as part of University Hospitals Medical practices with Gastroenterology Associates. Board certified in internal medicine and gastroenterology, he performs procedures at The Endoscopy Center at Bainbridge and University Suburban Endoscopy Center.

James Saxton, ESQ.
James Saxton, CEO of Saxton & Stump, has sustained an active health law and healthcare litigation practice for more than 30 years. Jim is a nationally known speaker on healthcare issues and has presented to many prominent healthcare organizations including the Society of American Gastrointestinal and Endoscopic Surgeons and American College of Surgeons.

Amber Walsh, JD
Amber McGraw Walsh is a partner at McGuireWoods in Chicago. She is the chair of the firm’s healthcare department. Named to “Illinois Rising Stars,” Healthcare, Super Lawyers, by Thomson Reuters, Amber focuses on corporate healthcare transactional work and regulatory matters.

Q: What are the most significant challenges physicians and hospitals faced in 2017?

Larry Kaiser (LK): There are many challenges that we have faced and will continue to face as we move forward through 2018. It remains unclear what will happen in Washington, D.C., especially with the further dismantling of the Affordable Care Act through the elimination of the individual mandate. The lack of the individual mandate will likely result in insurance companies increasing premiums, certainly in the individual market and perhaps in their other products. There will also likely be an increase in the number of those previously insured who will now again be uninsured, thus putting more pressure on providers, especially safety net hospitals.

The proposed cuts to the 340B Drug Discount Program will have a major effect on safety net hospitals, which depend on the revenue that accrues from this program to partially fund their efforts in providing care of the
underserved. All hospitals continue to come to grips with increasing expenses, primarily for pharmaceuticals and supplies in addition to increased cost for personnel.

With the continued push from payers, including the federal government, to move care out of the inpatient setting, revenues will continue to decline, thus making expense control that much more critical.

Physicians have had to contend with the implementation of the electronic health record (EHR) that has increased the amount of time spent entering data while they are also being pushed to see more patients. This, as much as any other factor, has contributed significantly to physician burnout, a problem becoming much more prevalent. In addition, physicians continue to face increasing regulatory burdens while seeing reimbursement decline.

**Michael Koehler (MK):** The biggest challenges facing both physicians and hospitals concern the changing landscape of health care. There is tremendous uncertainty with the future of reimbursements to providers and health systems with the Affordable Care Act. Physician offices and hospitals are under pressure to practice cost-effective medicine while maintaining the highest quality level of care. Tightening reimbursement strains the practitioner in the office setting to see more people in less time in order to be more productive and maintain their practice revenue at the status quo. Hospitals are trying to find ways to achieve the leanest operation from an overhead standpoint. Everyone is being pushed to deliver more for less without sacrificing quality—which is easier said than done.

**James Saxton (JS):** One of the most significant challenges we have seen are market forces leading to consolidation—not only in the provider market but also in the payer market. Concurrently with GI practices feeling financial pressure to join a hospital or health system, there is a changing landscape in the payer market. In December, CVS announced its plan to buy Aetna. Locally and regionally, health systems are creating dual roles as both payer and provider. While this adds an unprecedented level of complexity for GI providers, it also creates new and innovative opportunities. The key to effectively navigating these new risks and opportunities lies in creating, managing and deploying an individual “value story.” Simply put, GI practices that can make a credible argument that they are high value in terms of quality, safety and patient engagement will be the most attractive and financially successful. The days of simply boasting about value without showing proof are gone. Your story must be backed up by data.

**Amber Walsh (AW):** I believe that the most significant challenge is the present environment created by several converging phenomena. This includes the much-discussed reimbursement pressure coupled with service to a patient population that is more informed, has higher expectations, views their health care from more of a consumer standpoint, and is more empowered to openly express their satisfaction—or lack thereof—on social media and in other forums. And this confluence exists in a world where cyber security threats are greater than ever.

This can be a daunting collective of phenomena for many providers, but it also presents an opportunity for hospitals and physicians who have invested in quality innovation to address patient demands, minimize costs and guard against such threats to distinguish themselves from their fellow providers.

**Q:** What strategies should hospitals consider as they plan for the future of their GI services line?

**JS:** Understanding new kinds of opportunities for collaboration and
innovation will be key. Being first to the market with a robust, credible, third-party-validated value story will create a competitive advantage in the market place.

The creation of a value story starts with measurement and quantifying of certain GI-specific value metrics. In the past, practices had to rely on payer measurements of quality, cost and value. With the adoption of EHRs and innovative measuring tools, some providers gained the capacity to oversee additional measures.

Measurement is becoming a key contributing factor to the success of GI practices. This goes beyond the traditional focus on age-old metrics and requires a new focus on the patient experience and on patient engagement.

LK: There will be increasing pressure by payers to move outpatient endoscopic procedures out of the inpatient setting because of the very significant differential in reimbursement between the settings. Hospitals will need to consider how to increase access to outpatient GI procedures, specifically for a procedure like a screening colonoscopy by not requiring a pre-procedure visit. Patients should be able to schedule their colonoscopy, have the prep procedure sent to them and then present for the procedure.

Looking at GI service lines, patients are concerned with their individual complaint and need to be directed to the physician best suited to deal with the problem. The concept of a GI institute, where physicians from multiple specialties who deal with GI problems are co-located, is a concept whose time has come. A major part of this initiative needs to be access to clinical trials where important questions may be answered. We need to be focused on the needs of patients more so than the convenience of our physicians. Patients need to be seen at times that infusion centers or other ancillaries, would be optimal.

The bottom line is that well-run GI service lines through a collaborative effort would benefit all parties. Physician leaders and hospital leadership know how to be cost-effective, meet quality benchmarks and deliver the best quality care. If they work together, it would be a win-win for everyone.

Q: How should hospitals and physicians work more cohesively to manage the patient population in their markets?

MK: In working together, there must be a model where you consider bringing hospital-based employed GI physicians with community-based GI physicians who share the same goal. This can frequently be done with joint-venture opportunities in endoscopy. This way, you are not setting up a competition between the hospital-based and community-based physicians. Rather, you are creating one team, so to speak, with the shared goal of offering what is best for patients in terms of an ancillary service such as endoscopy.

Further collaboration is often seen in a digestive health institute model where both hospital-based and community GI physicians participate together to provide the highest quality care at the lowest cost. Such a model, which benefits all parties, should be led by people who have expertise and knowledge of quality and GI care paths, which is frequently a physician leader. Within that institute model,

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LARRY KAISER, MD
agreements allow hospitals to retain sole ownership of their outpatient GI service lines but secure much-needed efficiency and quality improvement leadership from private physicians.

Finally, many hospitals and physicians have successfully established clinically integrated networks. These essentially allow physicians to stay private but integrate certain clinical systems to establish collaboration for the sharing of data and to improve quality and performance in an efficient manner.

All three techniques involve different types of relationships from a financial standpoint and have different legal requirements for proper establishment, but all are alternatives to traditional employment relationships geared toward improving care to the hospital’s and physicians’ GI patient population.

JS: This all goes back to engagement, which means different things to different people, but what I am referencing here is patients’ understanding their treatment plan, including their role and responsibilities in managing their health. Do they understand endoscopy prep instructions? Is there clear follow up when a return visit is necessary?

Making patients partners in their care and creating accountability on their part has multiple benefits to the provider and patient. This partnership does not just happen. It requires time and sincere effort. Providers must take initiative and work toward developing a true partnership with their patients by using very specific tools and strategies.

By taking targeted actions, providers can truly engage and inspire their patients to work collaboratively toward quality care and hold themselves accountable. Each of these actions should be measured, as should the engagement level of the patient. The data uncovered through these efforts can provide actionable insights to help guide positive change and can be a true differentiator.

LK: Close alignment between physicians and hospitals is perhaps more important now than ever. Over 40 percent of physicians are fully employed by hospitals or health systems, and many others have at least some employment relationship. If we are to reduce clinical variation, provide more timely and efficient care and do so at lower cost, physicians will have to be engaged with hospitals. This is particularly important as we see the further implementation of alternative payment models, such as bundled payments, shared savings or fully capitated models.

Accurate and complete documentation with optimal coding will allow hospitals and physicians to be appropriately compensated for the level of care provided and specifically for the level of patient complexity. Physicians will need to work closely with other health professionals, including nurses, physician assistants, dieticians, physical therapists and pharmacists, to proactively manage patients to promote wellness and anticipate problems in certain patient populations.

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