Physician Hospital Integration

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Old Model

- Adversarial
  - Docs & Hospital in Chess Game
  - Deal with Multiple Hospitals

Old Model

- Hospitals provide a facility
- Docs work at the hospital
- Incentives not aligned
- Everyone responsible for their aspect of patient care

New Model

- COOPERATIVE
- Docs & Hospitals on same side of the table
- Align Incentives

New Model

- If Hospital does well – physicians share benefit
- If physicians bring more patients - Hospital does well

New Model

- Requires a Paradigm Shift
- Both Sides Need to Change
- Need to Pick a Partner
- Requires a Level of Trust

Why do this?

- Improve Quality of Care & Outcome
- Revenue Stream from Inpatient Service Line

Physician Hospital Integration is a Spectrum

- Low End — Medical Directorship & Staff Support
- High End — Equity Ownership
- In Between — Clinical Co-management Agreement; Gain Sharing

Medical Directorship

- Pros
  - Easy
  - Legal
  - Multiple Hospitals
  - 1st Stop
- Cons
  - Limited Control
  - Limited Quality Improvement
  - Limited Revenue
  - Revenue Only to Individual

Staff Support

- Hospital pays for P.A. or other employee

Clinical Co-management (CCM) Goals

- Align Economic Incentives
- Improve Operating & Capital Efficiencies
- Improve Clinical Quality & Outcomes
- Improve Customer Satisfaction

Two Methods of Compensation

- Hourly Compensation for Program Supervision
- Performance Bonus Based on Meeting Clinical & Quality Benchmarks.

CCM - Pros

- More Physician Control Over Operations
- Increased Hospital Engagement
- Physicians Compensated for Effort
- Opportunity to Improve the Product
- Spread Revenue to Entire Group

CCM - Cons

- Complicated Legal Structure
- No Guarantee of Making Bonus
- No Equity Value
- Must Manage Cultural Values

These can work, and everyone benefits, especially the patient.