H&HN
HOSPITALS & HEALTH NETWORKS

In Common Cause for Quality Part 1: New Hospital-Physician Collaborations

10.10.2006 By, Alice G. Gosfield, Esq., and James L. Reinertsen, M.D.

Contrary to the beliefs about Stark and antikickback statutes, there are many legal hospital-physician collaborations that improve quality.

Editor's note: *This is the first part of a two-part presentation on physician engagement in quality. In part 1, the authors offer 13 strategies for quality-driven hospital-physician collaboration. Next week, in part 2, the presentation describes Prometheus Payment--a model that provides a new option to propel quality and collaboration--and concludes with some principles of engagement to enhance all of these strategies.*

The call for improved quality dominates the health care landscape. The Institute of Medicine's *Crossing the Quality Chasm*, a dramatic increase in transparency, the advent of pay for performance and the 100,000 Lives Campaign are pressing all types of health care providers to make powerful improvements in quality and safety. For hospitals, these demands have particular significance because of the unique role physicians play in delivering care. It is the physicians who admit patients, order services and discharge patients. Virtually everything that happens in a hospital is ultimately derivative of a physician's order.

Hospitals have long understood that without physicians, they have no business. Over the years they have sought to bond with them, own them, employ them and joint venture with them. Few of these initiatives have had quality as the driving force. Some might argue that hospitals and physicians are more at loggerheads than ever before, in adopting and fighting economic credentialing, loyalty oaths, conflict of interest policies and competitive business ventures. In quality terms, this helps no one--least of all patients.

Physician engagement in quality is essential for improved hospital quality results. While physicians need not always be present at the birth of all hospital quality initiatives, physicians can bring initiatives they do not support to a grinding halt. Virtually all reports of world-class advances in quality count the engagement of physicians as critical.

Delivering quality care is the common bond between hospitals and physicians. It provides a platform for new and better relationships. Both sides of this connection will benefit if they help each other do better on quality. And patients will be the ultimate beneficiaries.

Debunking Legal Myths

A significant barrier to creative hospital-physician collaborations is lawyers who abet hospital anxieties about the Stark and antikickback statutes. Myths and misunderstanding play a role here. It is simply not true that these laws prohibit creative financial relationships between hospitals and their referring physicians. Both statutes allow the hospital to pay physicians fair market value for time spent on the hospital's behalf. The hospital needs the services of physicians to fulfill hospital quality mandates. Paying for those services is not precluded by either statute. It is also not true that antitrust laws stand in the way of hospital-physician solidarity; the laws in fact offer a significant lever to better relationships.

The Stark regulations now establish limits on the hourly pay rates for the work of referring physicians. It is true that permitted dollar amounts are much less than the physician's lost opportunity time. A cardiologist who's paid the equivalent of $400 an hour for a procedure certainly cannot command that from the hospital for quality work.

Within this legal context, there are two primary methods to gain the support of physicians to improve hospital-quality results: Save them time and give them an economic benefit for their time, which does not always mean merely paying them for their services. All but one of the strategies below incorporate one or both of these critical approaches. Many methods to improve quality save time for physicians even when that is not their primary purpose. Giving physicians more time in their day is not merely a quality of life issue for doctors. It can also be a quality of care issue for patients. Time is essential to permit physicians to craft the art of medicine for each patient.

Helping Physicians

Hospitals and physicians face separate business demands, but both confront a strong quality mandate. Hospitals can advance their own business case with activities that promote improved physician quality while addressing physicians' business needs.

Clinical integration. When providers work together--without merging or taking joint financial risk--to standardize their care explicitly in accordance with clinical practice guidelines (CPGs), invest in infrastructure to evaluate their behavior, monitor care, take action against those participants who are falling behind and share data with payers, they are considered clinically integrated. As such, the antitrust rules permit these otherwise competing physicians to bid together for rates. They will be protected in many ways from antitrust enforcement for what would be anticompetitive behavior without the quality purpose for their actions.

Clinical integration is not just about bargaining for better rates. It is about improving quality and efficiency of care delivery through standardization of clinical processes. This saves physicians time and improves their financial margins. Hospitals can join with physicians to engage in clinical integration.

The Federal Trade Commission and the Department of Justice do not specify the modes of clinical integration. They expect some creativity. Hospitals can facilitate clinical integration for those physicians who do not want to merge their practices by helping them identify CPGs to use, facilitating access to hospital infrastructure for profiling, and helping them determine effective rates for negotiation. Joining with them in a network is also permissible.

Information technology support. Stemming from the advent of Medicare Part D, the Office of the Inspector General (OIG) and the Centers for Medicare & Medicaid Services (CMS) have issued regulations to permit hospitals to provide their physicians with electronic record systems that include an e-prescribing component. Most modern quality initiatives are improved by the use of electronic data mechanisms.

Compliance training. Here, astonishingly, it is the Stark regulations that provide the opportunity for collaboration. The hospital is explicitly permitted to pay for compliance training for its medical staff members in traditional compliance issues such as documentation, false claims avoidance, medical necessity and appropriate referral relationships. But this exception goes further, since it allows

education on legal and regulatory requirements. Clinical integration rules are a legal issue. As the Medicare laws have incorporated performance measurement, standardized processes and pay for performance, almost anything that feeds these initiatives can fall under this little known provision of the law (42 CFR 411.357(s)).

Staffing services. A significant challenge for hospitals is how to garner the loyalties of community-based physicians who refer to the hospital but do not spend time there. Many of these physicians would like to draw on the services of a physician extender, but cannot afford to hire one full time. The hospital can become a staffing service for them, leasing hospital-employed nurse practitioners and physicians' assistants to physicians at an hourly rate. The physicians can then bill Medicare at 85 percent of the fee schedule amount.

When these non-physicians are trained in evidence-based medicine, particularly in chronic care, their work not only gives the physicians money in their pockets immediately, it can also advance quality and a standardized continuum of treatment for those patients.

Recruiting for quality. The Stark regulations permit hospitals to subsidize physician recruitment to existing medical practices. If that recruitment were focused specifically on quality, a young physician would work in the practice but spend part of his time working for the hospital directly in quality initiatives, apart from any payments made to the group as recruitment subsidies. After time, as his practice builds, he transitions to full-time work for the recruiting group. This way the hospital would have, in effect, trained a trainer to help the community-based practice incorporate better quality techniques that are more consistent with the hospital's programmatic goals as well.

Physicians Helping the Hospital

A number of strategies that directly meet the hospital's business needs can also be helpful to physicians while improving the hospital's quality results.

Adopt "lean" processes. Lean production is the Toyota manufacturing technique that systematically roots out and eliminates processes and operations that do not directly contribute to value for the patient. Leaner processes are more efficient while they enhance quality. Almost invariably they save physicians time in their day.

Improve "flow." Getting the patient to the right bed at the right time, with few delays and unnecessary handoffs, prevents errors, improves quality results and increases patient satisfaction. Better flow improves both quality and throughput for the hospital and saves time and reduces frustrations for physicians.

Standardize and expand standing order sets. Standing order sets reduce complexity-driven errors, improve evidence-based medicine, and permit standardized nursing and pharmacy processes based on them. They work only with strong physician support. Performed correctly, order sets save physicians time by speeding documentation while improving reliability and safety.

Empower nurses. Hackensack University Medical Center in New Jersey got the highest payment in the first year of the CMS-Premier Hospital Pay for Performance program. Its leaders had learned some years earlier that by empowering nurses, particularly in the specialty units, to intervene and manage specified

events, in accordance with protocols collaboratively designed with physicians, they would save time for physicians who otherwise would have to come to the hospital. This type of initiative relates as well to the "rapid response team" plank of the 100,000 Lives Campaign.

Pay for medical staff work. Even among those physicians who do most of their work at the hospital, it is getting harder to garner medical staff attendance at meetings or committees. The days when sitting on hospital committees and serving as medical staff leaders were considered an honorific are long over.

To pay physicians for this work is entirely appropriate when done within the framework of the Stark regulation definition of fair market value. However, should all medical staff activities be paid for by the hospital? No. And some medical staffs would be opposed to payment out of fear of administration co-optation of those who are paid. For the continued willingness of physicians to perform these functions enthusiastically and without compensation, the following change would help.

Make the medical staff work more meaningful to the physicians. The organized medical staff in the typical hospital spends most of its quality time on administrative aspects of credentialing and on breaking up food fights over privileges. The hospital can facilitate a different way of thinking about how to make the work of the organized medical staff more pertinent to *real* quality issues, such as lowering the number of preventable hospital deaths through the implementation of the six planks of the 100,000 Lives Campaign. Where the administration explicitly seeks a significant role for the physicians in really advancing hospital quality, the work of the medical staff can change to something with far broader importance than credentialing and privileging. For that work, the physicians will be more likely to contribute their time and be truly engaged.

Institute gainsharing. Gainsharing as approved by the OIG is a program to pay physicians to standardize the use of supplies in procedure-based hospital care. In the approved programs, the payments to physicians are limited to a specific period of time. Gainsharing is a very short-term strategy, but it can improve standardization while briefly enhancing physician revenues.

Pay for on-call services. On-call physicians are asked to provide care to an increasingly underinsured, indigent and litigious populace. The attraction of taking on-call coverage has waned considerably. Physician professionalism has traditionally motivated on-call service, but today, on-call services are little but trouble for physicians. It will increasingly be the case that only higher levels of compensation to on-call physicians will solve this problem.

Next week: The 13 strategies discussed in part 1 of this presentation advance quality and provide a far more positive basis for hospital-physician collaboration. Another major improvement would be a better payment system, which is described in part 2.

Alice G. Gosfield, Esq., *is an attorney in private practice with Alice G. Gosfield and Associates, PC, in Philadelphia.* ***James L. Reinertsen, M.D.,*** *leads The Reinertsen Group of Alta, Wyo., and is a senior fellow at the Institute for Healthcare Improvement.*

H&HN
HOSPITALS & HEALTH NETWORKS

Resources

Gosfield, "In Common Cause for Quality," *Health Law Handbook,* 2006 ed. (WestGroup), www.gosfield.com/PDF/commoncausequalityDraft.pdf.

Gosfield, "Quality and Clinical Culture: The Critical Role of Physicians in Accountable Healthcare Organizations" (1998), www.ama-assn.org/ama1/pub/upload/mm/21/quality_culture.pdf.

Gosfield and Reinertsen, "Doing Well by Doing Good: Improving the Business Case for Quality," June 2003, www.gosfield.com/PDF/uft-a_White_Paper_060103.PDF.

Gosfield and Reinertsen, "The 100,000 Lives Campaign: Crystallizing Standards of Care for Hospitals," *Health Affairs* (Nov./Dec. 2005), pp. 1560-1570, www.gosfield.com/publications.htm.

Leibenluft and Weir, "Clinical Integration: Assessing the Antitrust Risks," *Health Law Handbook,* 2004 ed. (WestGroup), www.gosfield.com/PDF/ch1PDF.pdf.