Physician/Hospital Integration: Challenges and Opportunities for Small and Rural Hospitals

Small and Rural Hospital Conference
Charlotte, NC
November 12, 2013

Facilitated by:
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The Halley Consulting Group, Inc.
Agenda

• An Uncertain Future
  - The Perfect Storm
  - Small Community Impact

• Positioning for Uncertainty
  - The Integration Imperative
  - Primary Care - Market Share
  - The Integration Pyramid

• Questions
A “Perfect Storm”
A Perfect Storm...

Unprecedented Demand

Declining Reimbursement

Increasing Regulation & Costs
Industry Trend Implications

- Lower reimbursement
- More regulation
- Focus on “quality” and P4P
- Increased financial risk
- Fewer, larger systems of providers
- Market management
- Increased competition for the “right” patients
- Emphasis on cost and productivity performance improvement
- Technology driven
- Business “rigor”
Today’s Strategic Imperatives

• Controlling Market Share (Referral Path Strategy)
  - Primary Care = Market Share Strategy
  - Specialist of Choice
  - Hospital of Choice

• Demonstrating Quality (Value Proposition)
  - Service Quality
  - Clinical Quality
  - Utilization

• Access to Capital (Sustainability)
  - Human resources
  - Technology
  - Facilities

• Productivity (Access and Revenue)
  - Efficiency
  - Effectiveness
  - Access

Changing Forever

“We believe the changes in healthcare are irreversible. There will be fewer independent medical providers in the future, employed physicians will increasingly dominate medical staffs and competitive lines will be drawn and rarely crossed. Independent providers that try to remain neutral will be marginalized by larger integrated systems where patient referrals are directed to generate capital, to share risk and to coordinate care.”
Small Community Impact
Small Community Challenges

- Access challenges - the foundation of clinical quality and service quality
- Shortage of PCPs - bookends for functional integration
- Ability to sustain subspecialty services
- Ability to recruit to a small community
- Provider resource costs - “over a barrel”
- Ability to remove clinical or behavioral “C” players
Small Community Challenges

- Ability to participate in new risk-based payment models (volume and value)
- Patient outmigration to larger population centers - “retail” strategy
- Spartan staffing and administration
- Inability to reduce cost structure further
- Aging and shrinking population (inability to grow the pie)
- Percentage of population below the poverty line
Small Community Challenges

- Low health literacy; poor health habits
- High rates of chronic disease
- High rate of social issues
- Community perception of clinical quality
- Large regional competitors
- Networking Challenge
  - Parochialism
  - Desire for local care
  - Often largest community employer
  - Local market differences
Critical Access Hospital Outlook

- Not protected from sequestration
  - 2 percent reduction in Medicare reimbursements applies to CAHs as well. Will continue at least through March of 2014.

- Physician recruitment challenges expected to continue
  - Increased demand for primary care physicians, in particular
  - 20% of the population lives in rural areas but only 9% of physicians practice there

- Targeted under Healthcare Reform
  - Recertification being considered; only hospitals that meet original CAH standards would be recertified (e.g., distance).
  - Estimated that 50-66 percent would lose CAH status.
The Integration Imperative
“Partnership Led”

“The days of the traditional ‘build it and they will come’ hospital administrator are gone. So, too, are the days of the traditional small group practice where the ‘young guys’ fund the retirement of their predecessors.

Today, success requires the ability to capture and retain market share in primary care practices, the ability to attract that market share to specialists and hospitals of choice, and the ability to amass and reinvest capital in the entire community health system. Physicians and hospitals can only achieve these objectives by working in partnership to ensure the success of all ‘stakeholders’ for the benefit of the communities served.”

Hospital/Health System Consolidation Trends

- Thus far, rural/sole community hospitals have been under-represented in hospital consolidations / mergers.
- Only 10 percent of all mergers between 2007 and 2012 involved a community hospital.
Physician Integration Economics

Capture & Retain Market Share

Potential Capital Loss

Referral Path

Market Manager

Hospital Capital Generator

Primary Care

Potential Capital Drain

Specialty Physicians

Potential Capital Drain

Capital Preservation & Investment

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Common Integration Options (Multiple “Plugs”)
Primary Care = Market Share
Primary Care - Market Share Connection

Fairbanks has a population of 32,258 and is expected to grow by 3.38% to a population of 33,349 over the next five years.

Fairbanks residents will require the services of 19 primary care physicians to handle 77,420 primary care visits per year, which will result in about 8,500 referrals to specialists and 12,000 referrals for diagnostic services. And will result in 3,387 inpatient admissions.

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# Primary Care - Market Share Connection

## Referral Rate

<table>
<thead>
<tr>
<th>Region</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>West</td>
<td>12.86%</td>
</tr>
<tr>
<td>Northeast</td>
<td>11.32%</td>
</tr>
<tr>
<td>South</td>
<td>10.19%</td>
</tr>
<tr>
<td>Midwest</td>
<td>9.50%</td>
</tr>
</tbody>
</table>

## Top 15 Referred-to Specialties (by FPs as a % of Total Referral Rate)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Work</td>
<td>1.60%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>1.40%</td>
</tr>
<tr>
<td>Cardiology: General</td>
<td>0.90%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>0.70%</td>
</tr>
<tr>
<td>Endocrinology/Metabolism</td>
<td>0.70%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>0.70%</td>
</tr>
<tr>
<td>Ophthalmology: General</td>
<td>0.50%</td>
</tr>
<tr>
<td>Otohinalaryngology</td>
<td>0.50%</td>
</tr>
<tr>
<td>Dietician/Nutritionist</td>
<td>0.50%</td>
</tr>
<tr>
<td>Neurology</td>
<td>0.50%</td>
</tr>
<tr>
<td>Urology</td>
<td>0.50%</td>
</tr>
<tr>
<td>Psychiatry: General</td>
<td>0.40%</td>
</tr>
<tr>
<td>Psychiatry: General</td>
<td>0.40%</td>
</tr>
<tr>
<td>Optometrist</td>
<td>0.40%</td>
</tr>
<tr>
<td>Optometrist</td>
<td>0.30%</td>
</tr>
</tbody>
</table>

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How well aligned is your Network?
Three Critical Questions

Where *is* my market share?

Who *holds* my market share?

What are they *doing* with it?
Referral Path Management

Fundamental Tenets

1. “Referrals Follow Relationships”

2. “All Relationships Atrophy Over Time”

3. See Fundamental Tenet #1
Heat Mapping Draw Areas...
The Integration Pyramid
Think Big, Act Small!

“The delivery of medical care is a very personal, relationship-driven, trust-based, local phenomenon. The intimate relationship between a caregiver and a patient occurs in small places like examination rooms, procedure rooms, operating rooms, hospital rooms, and in other similar settings. When “bigness” trumps rather than supports “smallness” - whether in the name of efficiency, economy, policy, branding, reimbursement or even compliance - that most important and intimate relationship is violated, damaging both clinical care and caring.”

“Functional integrated medical care begins and ends in the primary care office.”
Integration Pyramid

- Clinical integration leads to population health management
  - Population-centered care
  - Chronic disease prevention & management
  - Statistical performance improvement
  - Value and outcomes
  - Capitation risk

- Clinical Integration
  - Focus on clinical quality & credentialing
  - Service quality commitments
  - Choreographed care
  - Transparent flow of clinical information across care continuum
  - Managing an episode of care with clinical metrics as the compass
  - Motivation and accountability for all to live by established metrics

- Functional Integration
  - Basic form of integration
  - Coordinated care
  - Legal structure/Organization chart
  - Payroll driven
  - Frequent referral leakage

- Structural Integration
  - Cooperative care
  - Blocking and tackling - PCMH, “Choice” Initiatives
  - Vital behaviors - “We”/“Our”
  - Extension of referring provider’s office
  - Referral measurement & management

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Questions...