Size matters when talking governance in IDS

Understanding the “little g” in “governance” is increasingly important as more medical groups integrate with hospitals and healthcare systems. While board members of health systems are charged with “big G” governance to fulfill fiduciary obligations, “little g” governance is equally important.

The key to successful physician/hospital integration efforts rests on creating a successful governance structure with effective physician and nonphysician leaders and empowered committee structures that represent, solicit, empower and work well with hospitals to create a valuable healthcare system.

A key consideration for successful integration is how to establish or provide input and structure to an organization.

Physician groups want to make sure they are still involved in the decision-making process and can positively impact the health system. To accomplish this, physicians must have an organizational tie to the health system, which might come from promotions to positions such as physician medical leader (vice president of medical groups), who acts at the same hierarchical level as the chief medical officer of the hospital. In an integrated delivery system (IDS), a physician executive would have responsibility for the physician network of acquired practices and would manage the groups with an administrator for the physician division to create a management dyad. These executives could report to the chief operating officer of the hospital/health system. Together, these leaders would represent the physicians division, a key constituency in the health system’s strategy.

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Key committees drive success

1. Executive committee/board of directors

The organization must have stellar leaders who are carefully chosen, have various skills and are empowered to fulfill their fiduciary responsibilities. This group focuses on charting the course for the organization with a clear strategy. The group needs to establish clear guidelines by setting responsibilities, and it should supervise and monitor the system's businesses. The three legally mandated duties are centered on the concepts of care, obedience and loyalty. Outside these key duties and responsibilities, the organization must create a committee whose members have a good understanding of the IDS subsystems or entities because they are responsible for communicating with the board or executive committee. Often, this committee is called the operations committee.

2. Operations committee

This committee, which communicates information about practice activities within the IDS, serves several functions. While no two operating committees are identical, some key areas include:

- Monitoring the operations of the member medical groups and the system of groups
- Recommending policies and procedures for the medical practices to the executive committee to achieve a high degree of standardization

This committee is best represented by key physicians or a few medical directors from various medical practices, a hospital or health system representative, the medical group executive director and a handful of office managers.

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Size matters when talking governance in IDS

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Other committees

Information technology (IT), compensation and quality committees will be created out of necessity or blossom once the organization establishes a solid foundation. They will either be project-based or permanent, depending on their charge and the willingness and ability of members.

The IDS may also need to create regional or local practice committees. When a system grows and expands into other areas, local or regional operations committees that report to the main system's operations committee are important because healthcare is local, and there are differences between providers in urban and rural areas. It is important to have committee structures, as outlined below, so members understand the issues and can thrive in different environments.
This decade represents the second time around for the hospital/medical group affiliation scenario. And while there were survivors from the first go-around in the late 1980s to mid-1990s, there is a sense that perhaps this time we will get it right.

I believe the real test is yet to come. Up to now, things seem to have been rocking along pretty well. Hospital and health systems seem to have been conscientious in developing and maintaining a physician-friendly environment. There have been complaints, but many of them have been related to unrealistic expectations.

The integration trend has progressed to a point where it is of major market consequence. Alternatively, there are a number of physician-owned medical groups and independent practices that wish to remain independent. Some of these groups have grown in size and developed a strategic organizational structure so they are in a position of equals when larger accountable care organizations develop.

As hospital/physician groups evolve, many professionals ask, “What happens now?” Will integration mean that previously independent hospitals and physician practices bond, or will a period of one-upmanship begin? I have observed signals to support each option. To encourage seamless integration, consider the following issues:

- **Physician compensation.** New reimbursement initiatives have been introduced to recognize quality, safety, patient service and cost competitiveness. In turn, compensation arrangements among physicians that have been tied to volume or productivity, such as charges or work RVUs, are being re-evaluated. As reimbursement methodology changes, professionals must modify incentives accordingly and carefully to avoid implementation problems. I suggest a slow startup progression with adequate education and dry-run transitional periods. Anything that smacks of a big system forcing transitions will not bode well. Physician pushback has already been observed.

- **State of confusion.** The federal government seems to be heading toward unrealistic expectations with regard to compliance and reporting. This might be described as a state of mixed-up priorities that seem to be directed toward documentation vs. actual patient care. IDS leadership will need to exercise care in establishing and implementing transitional changes to avoid a “shoot the messenger” interpretation.

- **Financial reporting.** Until IDS reporting systems are altered to reflect true physician responsibility, leaders and boards are likely to arrive at unrealistic conclusions. The “red-ink syndrome” describes financial statements that report operating losses when previously profitable group practices are assimilated into a hospital system. It happens when revenue-producing departments, such as ancillary services, are excluded but costs assigned to the system’s operations are not. If this syndrome prevails and reflects financial losses by physician, integrated groups will be placed in the untenable position of being “losers” and erroneously identified as drains on the system. Board members and professionals in C-suites are likely to view physician compensation and support costs as an opportunity to offset system losses.

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Is your integration a marriage of equals?

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• **Strategic or major financial planning.** Integration suggests that a partnership will prevail. Although most integrated systems have created operating partnerships with practices, this concept has not yet transcended to global or major system organizational planning. Are savvy, entrepreneurial docs going to be involved in developing systems that impact their destiny? If not, what signal does this send?

• **Current negotiations.** It appears that some structural deals do not have the same favorable orientation as they enjoyed in the past, but it’s too early to call it a trend. Instead of offering a market-based compensation arrangement, a break-even type of philosophy is offered. If break-even concepts are based on hospital-developed accounting systems, which create a margin deficit different from classic medical groups, reduction in physician compensation is probable. If this is a trend, the basic concept of predictable market-based compensation, which represented a major affiliation driver in the past, may be revisited with major consequences.

For true integration, there must be an organizational marriage between physicians and hospitals. The current structure, which is based on physician employment, suggests absence of a true cultural merger with joint participation. I will leave the potential fallout if hospitals and physicians do not bond and function as equals up to your imagination.

**Note:**

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**MGMA Health Care Consulting Group chimes in**

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