

# Getting Ready for EHR, RHIOs and Next-Generation Co-Management Agreements

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## In this article...

Imagine how the proposed medical information highway will impact health care in the next five years.

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The infusion of federal money into a planned nationwide electronic health record (EHR) system gives one a perfect reason to become more active in planning for the near-term changes, and opportunities, in your region's health care marketplace.

The drive toward a "medical information highway" by 2014 will provide ways for medical practices to upgrade their electronic health records, and, more importantly, give you the motivation to plan how best to integrate your practice into the enhanced information-sharing network that EHR will create.

The EHR incentive will be accompanied by federal and private payer financial incentives for integrated practice management to reduce medical errors and costs and improve efficiencies. Medical practices with a vision to become market leaders in working together will likely thrive in this atmosphere.

The medical information highway coupled with next generation co-management agreements will allow innovative hospital and physician leaders to come together for a dual purpose—to provide comprehensive health care and the greatest value to the community and the patient, and to create new income streams.

Many hospitals and physician practices have participated in co-management agreements to manage a service line in a specific hospital. This is a good start but does not go far enough in part because such agreements aren't integrated into the coming medical information highway.

The next generation co-management leaders will have the vision to go beyond silos of care and provide a continuum of care of evidence-based best practices and allows for real time dissemination of protected health information for the provider and the patient.

## Map it

Picture your metropolitan area's medical marketplace as a plat on the map, and draw a circle around the region. That circle will be the loop on the information highway, and be interconnected to the information highway, with its many other loops.

Within this metropolitan area are the hospitals and other service providers, and all of the other consumers, the total of people who might become patients of your practice. In the cold light of reality, answer this question: do the hospital(s) in your metro attract patients to travel into the marketplace to become potential consumers?

Now that you've defined the geographic market, ask yourself whether your practice is a likely candidate to become a co-manager with other forward-thinking providers. These future co-managers will be the select group in each community who should be planning now to work together.

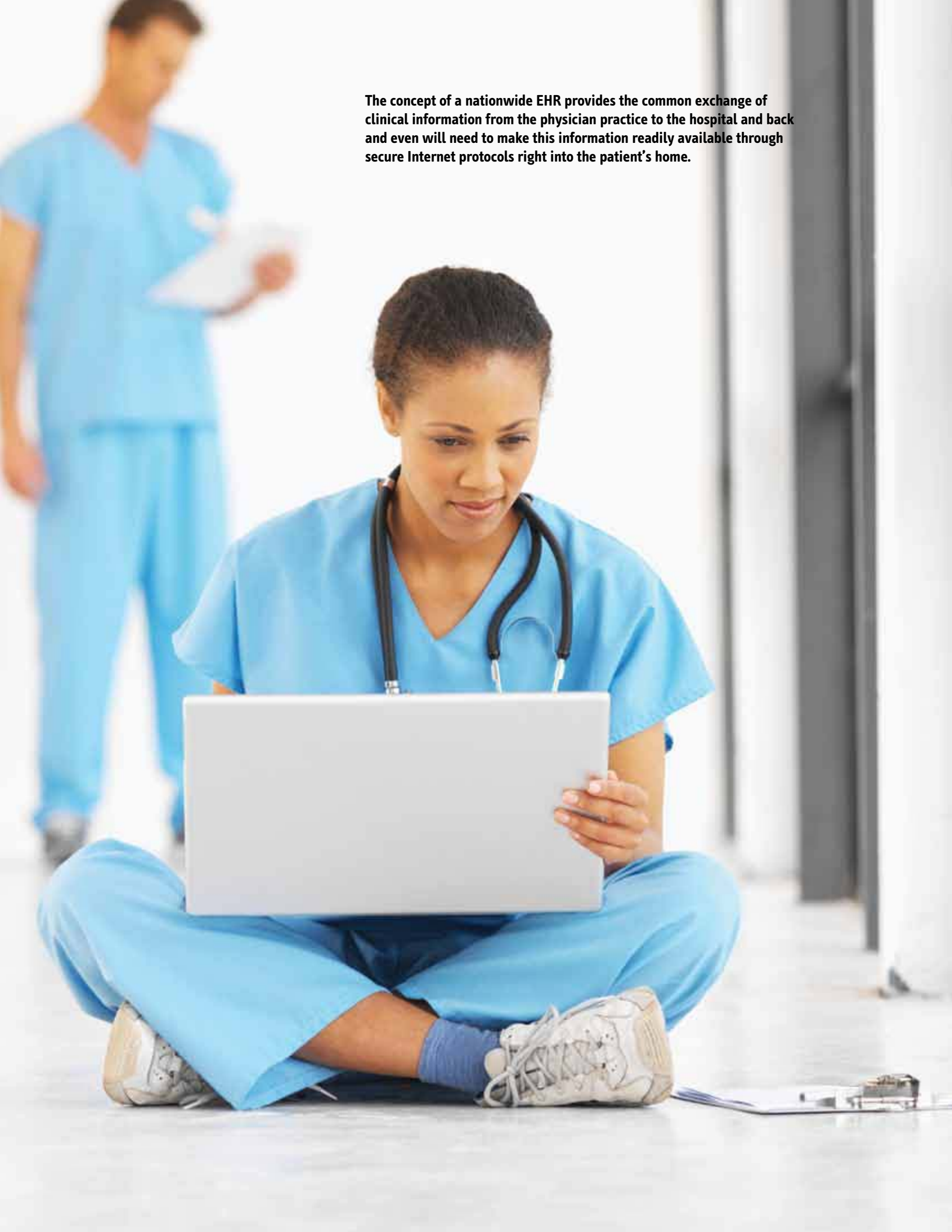
EHR systems will require myriad new HIPAA security and privacy solutions, and as practices form interest groups to deal with these issues, they should be thinking about others ways to cooperate.

There are many vehicles available under the broader co-management label—medical directorships, gainsharing, employment and management services—and the next generation co-managers will chose from this buffet of choices for near-term alignments.

Co-management agreements are early in evolution and have been developed with some hospitals and physicians to manage service lines. These agreements have had mixed results but have proven in some instances to be a first step in aligning hospital and physician incentives to improve patient care in the community.

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The next generation of co-management agreements will leverage this technology and provide the greatest value by co-managing health care resources for the community. These co-management agreements may manage service lines across multiple hospitals and may provide an integration of services starting in the physician practice into the hospital and into the patient's home.

For example, today's cardiovascular service line co-management agreement could be reasonably expanded to provide oversight of patient care during home therapy sessions.

The next generation co-management train is already loading on the express track, as organizations at the local, regional, and state-wide level are now setting up regional health information organizations (RHIOs), as not-for-profit entities to organize provider/end users of the medical information Internet.

Every metropolitan market and rural health network will have the opportunity to develop RHIOs: in some, hospitals will be the directors of the RHIO; in others, medical groups will be coming together to pool information technology and platforms and become the directors of their RHIO, and ideally administrative and physician leaders will come together as co-managers in a mutuality of trust and cooperation to lead the RHIO initiatives.

While RHIOs are not, per se, medical co-management entities, since monies generated from patient care are clearly beyond their purview, we view RHIOs as a crucial first step in creating an atmosphere that fosters co-management: an integrated information loop that can lead to an integrative delivery of care loop.

## Benchmarks and metrics

Co-managers will see that RHIOs can be the platform for medical co-management opportunities. As EHR systems mature, pay-for-performance

and other financial opportunities will emerge, but, in every metropolitan area or even rural area, a medical practice or group of practices, in concert with a hospital or hospitals, will have to create the benchmarks and metrics, work on evidence-based practice guidelines and develop best practice parameters.

In other words, these co-managers will need to work together to create a seamless patient-based practice model, and then work together on the compliance and other reporting overlays that will be needed for performance improvement, and bonus-based compensation.

A real and enduring co-management relationship is built on shared risk and mutuality of interest and obligation. Since neither doctors nor hospitals see information technology as their primary line of business, it is relatively easy to draft an agreement on sharing patient health information, but much more difficult to create an enduring co-management relationship regarding patient care.

Many co-management agreements sour because physicians come to realize that their hospital partners are not interested in physician input on systems issues; some hospitals retort that managing physicians is akin to herding cats. There is truth in each of these expressions of j'accuse.

There are physicians, after all, who don't function well as "organization men" (trained to be experts and not necessarily team players), and there are hospitals without sufficient management infrastructure to handle employed physicians, much less a cohort of co-manager physicians.

Hospitals need to undertake a self-evaluation exercise before venturing into physician alignments, whether employment or co-management, and too few of them do so. Questions they should ask include:

- Are we ready to jointly lead with physicians?

- Do we have competent service line managers who are ready to work jointly with physician leaders and understand the different business cultures of medical practices and hospitals?
- Have we identified our own weaknesses, so that we are comfortable bringing in physicians to help build those areas?
- Are there physicians with the skill sets and community commitment to be put in leadership positions?
- Have we developed a common vision with our medical staff to provide the greatest value to our patients and community?

Other, related, questions concern the existence (or creation) of the appropriate governance vehicle, the identification of financial and quality metrics and, the agreement upon performance benchmarks and goals.

While it is said that the foregoing analysis will determine whether the physician hospital alignment will thrive in an atmosphere of trust and shared goals, it is important to remember that fully 50 percent of marriages end in divorce, and that those relationships were initially built upon love, devotion and physical attraction.

So, in order to pay psychic and financial dividends, a co-management relationship sometimes requires a credible third-party facilitator. There may be a need to appoint a performance facilitator to move the process forward, and keep the relationship from Balkanizing.

For example, a service line agreement may contain a management governance structure of three physician participants, three hospital participants and a schedule of monthly meetings to review the manager's performance.

The credible facilitator can prevent a decision freeze in the event of a deadlock. In the life of a co-management agreement of a multi-million

dollar service line, with a seven figure management fee, how many deadlocks would have to occur regarding management decisions before the parties divorce in frustration? A co-management atmosphere needs gravity to hold it in place, and the agreement must be held together to give success a chance.

A hospital that hasn't self-assessed its managerial capability and needs will be unable to delineate properly the breadth of management services to be provided by the physician-owned management company, and its appointed manager. This will lead, inexorably, to frustration in the monthly management governance meetings.

Here is an example of just some of common management services and responsibilities that can be necessary within the construct of a co-management agreement:

- Hire and manage non-physician personnel in the service line.
- Set staffing schedules, wage scales and personnel policies.
- Provide medical directors in service and sub-service areas.
- Assist in credentialing issues.
- Assist in developing operating policies.
- Develop and implement process improvements.
- Provide standard charting, invoicing, order entry policies.
- Assist in the purchase, lease, etc. of supplies and equipment.
- Develop best practice standards, benchmarks and performance review processes.
- Develop a marketing plan to improve physician and community relations.
- Educate referring physicians, the community, and the nursing staff regarding services rendered and best practices.

- Assist in strategic planning for the entity.

With a delineation of such duties, necessarily general and broad, hospital executives and physician service line co-managers may, in the beginning, act like scorpions in a bottle, and will need the credible, knowledgeable facilitator to break ties at the governance level.

However, in time, as the co-management arrangement delivers its benefits, these intractable deadlocks will begin to diminish, once improved quality, savings and better financial performance and outcomes are reported.

## Incentives

Setting compensation, especially the incentive management fee, often augurs the arrival of disputes, since a third party—the government—sits at the bargaining table.

The OIG and CMS warn of incentives to reduce services, ration care, and the Stark Law needle has to be threaded with care. On the other hand, CMS has listed quality measures, The Joint Commission has published principles for pay-for-performance programs, and OIG has begun to issue policy guidance on pay-for-performance; by 2011, two percent of Medicare payments will be based upon performance.

With the movement toward funding of electronic health records, medical practices will have a unique opportunity to find common ground with hospitals and begin to plan for the future.

Even with the uncertainties to come, the health care marketplace is healthier than the banking, financial and housing sectors; and at this writing the federal government hasn't yet moved to cap salaries and bonuses of physicians or health care executives.

The health care industry is not as stratified as the banking, financial and housing sectors and that diversity

is our strength. We have solo practice physicians who spurn hospital affiliations, general surgeons who travel to hospitals like the circuit judges who held court in the western territories, and suburban, multi-location specialty practices with surgical and diagnostic buildings.

To a great extent, medical metros or rural health networks will have broad discretion in planning and partnering to move into the EHR era, but medical practices may not have unlimited time to plan.

If you want to be a leader or participant in the next generation of co-management agreements in your metro or even rural area, this is the time to get started.

There is definite folly in attempting to accurately predict the future. Nonetheless, at the very least it would appear that there is a constellation of issues coming to bear in health care delivery that will put a premium on physicians, hospitals and other components of the health care delivery system to adapt and work collaboratively as has not been the case previously.

Tools such as information technology (EHR, RHIO, etc.) and tactics such as co-management agreements will be but a few of the motifs, variations on the theme and methods available to health care leadership. Will it work? Will it be as we currently envision it?

Abraham Lincoln was said to have told the story of a king who ordered his wisemen to come up with a single sentence that could be predictive and never false. Their solution, which Lincoln stated as chastening and consoling, was said to have covered all the contingencies: "And this, too, shall pass away."

But in the current economic climate and flavored by many years of past experience in health care delivery perhaps the way to predict or encompass all possible futures for health care delivery would be: "Hope for the best, expect the unexpected, plan for the worst."

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