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Perspectives of Health System and Physician Practice Integration Representatives Regarding Successful Integration Factors

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PERSPECTIVES OF HEALTH SYSTEM AND PHYSICIAN PRACTICE INTEGRATION REPRESENTATIVES REGARDING SUCCESSFUL INTEGRATION FACTORS

BY

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A doctoral project submitted to the faculty of the Medical University of South Carolina in partial fulfillment of the requirements for the degree Doctor of Health Administration In the College of Health Professions

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Abstract

This qualitative study explored the perspectives of three health system integration representatives and three physician practice integration representatives regarding successful integration factors. The study indicated that a teamwork approach should be utilized throughout the integration process and be ongoing in nature.

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Chapter 1

Nature and Significance of the Study

Introduction

Healthcare reform has been an important focus for a number of years and has been promoted and influenced by a number of Presidents. One of the first major changes occurred in 1965 when Medicare and Medicaid were established under the Johnson administration. The 1980's brought with it the establishment of the Emergency Medical Treatment and Active Labor Act as well as the Consolidated Omnibus Budget Reconciliation Act. During the administration of President George H.W. Bush, Stark 1 "which prohibited physician "self-referrals" for clinical laboratory services" was established (Taylor, 2014). Clinton's administration is credited with establishing "the Health Insurance Portability and Accountability Act, a significant expansion of the Stark physician self-referral law Stark II, and the State Children's Health Insurance Program" (Taylor, 2014). Under George W. Bush the Medicare Drug Improvement and Modernization Act of 2003, one of the largest expansions of Medicare ever was instituted. Finally, on March 23, 2010, "Obama's PPACA was signed into law which among numerous other changes was the creation of state healthcare exchanges, federal financial subsidies for low income individuals, and prohibitions against denials of coverage based on pre-existing conditions and against lifetime benefit limits" (Taylor, 2014).

In spite of this, most agree and there is no question that the current system is broken and that something must be done about the high costs related to healthcare as well as a need for coverage to those who in the past did not have this benefit. Stratienko (2011) noted that the United States cannot compete in a global economy while it spends 16% of its gross domestic product on health care, while other industrialized countries spend an average of 9%. Whether a Democrat, Independent, Republican or Tea Party, like it or not, reform is here to stay. As such, its existence must be acknowledged and dealt with accordingly. Health System-Physician integration has occurred over the years due to various changes within the industry with the most recent change, the Affordable Care Act, having occurred under the Obama administration. "Pressure to control admissions and costs drove the hospital industry, beginning in the late 1980s and through the mid-1990's, toward physician-hospital integration" (Chang, 2015). The healthcare industry has expanded over the years in an attempt to reduce costs, attain greater economies of scale, and offer more services to more people.

Background and Need

While legislation over the years has impacted all aspects of healthcare and all types of stake-holders, it seriously impacted the private cardiology practice in a negative manner. Vertical organization appears to have been the intended direction of the White House administration (Stratienko, 2011). Bundling and decreases in Medicare reimbursement rates severely affected profitability and left them scrambling to figure out ways to sustain in a bleak economy while battling lower rates and ever increasing operating costs. Overhead increased due to complexities in billing, malpractice

insurance, and implementation of electronic medical records (Wann, 2010). Cardiologists were expected to provide quality care and utilize best practices, yet it wasn't as simple as it sounded. Challenges included a larger patient base due to the expansion of healthcare to more people, fewer resources, a shrinking pool of specialists, and a significant decline in non-invasive testing rates (Heck, 2010). Hospitals were reimbursed at a higher rate for testing compared to a private cardiology practice and this, most likely, was the result of powerful hospital lobbyist groups. The American College of Cardiology noted in 2012 that larger practices were more likely to integrate as a result and, as such, the number of cardiovascular professionals working for hospitals also increased.

Hospitals however, were not without their own challenges, including a shortage of cardiology specialists such as interventionalists and electrophysiologists (Heck, 2010). This resulted in stiff competition between hospitals, who were vying for these high demand specialists. It, in turn, led to another challenge for hospitals to retain the specialists that they had while seeking additional prospects to fill much needed vacancies. In addition to competition, Satiani (2010) notes that hospitals were also responding to pressures from payers, consumer organizations, and the government to have a seamless, continuous, and quality-conscious system. According to a 2012 American College of Cardiology survey, "24% of cardiology practices are hospital owned as compared to 8% in 2007" (ACC.org, 2017).

Physicians are now attempting to achieve more financial stability within hospital integration as opposed to functioning independently as a private practice. Integration

does not have to be viewed negatively and can be beneficial for all parties involved provided agreed upon goals and objectives can be met. Operational teamwork has been an essential aspect of success within private practice, and it is just as essential in an integrated system involving the hospital.

Problem Statement

While there have been a number of integration waves in the healthcare industry over the years, it is predicted that CMS' Medicare access, the Chip reauthorization act and merit-based incentive payment system will bring yet another wave. It is therefore essential that those who have previously integrated, as well as future integrators, have plans in place that will help ensure integration is successful. Historically, barriers to alignment have included changing public policy, differences of priority, conflicting payment incentives, divisive productivity incentives, and lack of physician leadership (Budetti, 2002). On top of these barriers are the unexpected costs associated with monitoring, coordinating, and cooperating (Chang, 2015). Additionally, a 2012 survey conducted by the American College of Cardiology noted, while "68 percent reported the practice climate is either better or about the same, some of the biggest challenges facing hospital-owned practices are workflow management, hospital/practice alignment, reimbursement, Medicare cuts and health information technology implementation" (ACC.org, 2017). The Bon Secours Health System has faced the

challenges and struggles associated with acquiring physician practices. In 2013, the not-for-profit system suffered $158 million in losses as a result of its physician employment strategy, according to Moody's Investor's Service. The median loss for employing a physician in 2012 was $176,463 according to a 2013 report from the Medical Group Management Association.

Immediately preceding integration, the Northeast Georgia Heart Center was a 21 physician owned cardiology practice. Clinical operations included four full-time offices and three part-time satellite offices. Cardiologists within the practice made rounds at six local area hospitals while advanced practitioners were involved in only two of those. Services offered included "Arrhythmia Management/Electrophysiology, Cardiac MRI, Cardiac PET, Cardiac Research, Cardiovascular Imaging, Heart Health for Women program, Heart Failure and Transplant Program, Interventional Cardiology and Peripheral Vascular Program, as well as Structural Heart Disease Management" (2013, NGHC website).

Purpose

The purpose of this research is to gain more information regarding successful integration factors from the perspectives of health system and practice integration representatives who have experience in this process. The study focuses in particular on post integration of Northeast Georgia Health System and Northeast Georgia Heart Center.

Research Question

The research question for this study is "what factors do health system and practice integration representatives deem as essential for successful post integration?"

Population

The population of interest for this study includes both health system and physician practice integration representatives. These individuals played significant roles throughout the integration process to include pre and post integration.

Definition of Terms

The following terminology is important in identifying the focus of this research:

Centers for Medicare and Medicaid Services (CMS)

"CMS is part of the Department of Health and Human Services (HHS) that administers Medicare, Medicaid, the Children's Health Insurance program (CHIP), and the Health Insurance Marketplace" (*CMS Mission, Vision, Goals and Objectives, 2017).*

MACRA

"The Quality Payment Program focuses on care quality and ends the Sustainable Growth Rate formula and gives new tools, models, and resources to help give patients the best possible care" (*CMS Mission, Vision, Goals and Objectives, 2017). "*It is composed of two differing tracks MIPS which is a merit based incentive payment system and APMs which is an advanced alternative payment model" (*CMS Mission, Vision, Goals and Objectives, 2017).*

Assumptions

In conducting this study, a basic assumption is that both hospital and physician practice integration representatives will have the knowledge and insight of factors essential to successful post integration factors. Further, it is assumed that each of the representatives that were selected and willing to participate in the study will be upfront and honest about their integration experience.

This introductory chapter has presented the background as well as the significance of the study and has identified the research question that guides it. The next chapter will present a review of relevant literature.

The Negotiators

The Northeast Georgia Health System is a not-for-profit community health system which employs over 500 physicians. “Led by volunteer boards made up of community leaders, the 557-inpatient, 261-skilled nursing bed health system serves almost 800,000 people in more than 13 counties across Northeast Georgia” (2013, NGHS website). Historically the system has been very aggressive in its pursuit of purchasing private physician practices.

Bargaining Perspective/Position Analysis

The NGHC brought with it a number of impressive accomplishments and had much to offer to any hospital system. It began as a two physician practice in 2000 and grew to 21 physicians and 11 advanced practitioners. The competing heart group was a small practice of 4; therefore NGHC offered the majority of staffing/support to the Northeast Georgia Health System for cardiac services. Special service areas of focus, which the competing group did not provide, included a heart failure and transplant program, cardiac MRI, cardiac Pet, Transcranial doppler testing and cardiac research. The Northeast Georgia Heart Center established their Research department in 2002 and have been "involved in both national and global research, participating in an average of 30 clinical trials per year" (2013, NGHC website). They were also in the process of establishing the NGHC School of Cardiovascular Technology which later came to fruition after integration and focused on areas of cardiac and vascular ultrasound, as well as transcranial doppler testing.

The Northeast Georgia Health System also brought with it significant factors to the bargaining table. In 2013 it was nominated as "one of America's 50 Best Hospitals (according to Healthgrades ®) and among only twenty large community hospitals named to Truven Healthcare's list of the nation's 100 Top Hospitals" (2013, NHGS website). It is "also recognized as #1 in Georgia and top 5% in the nation for cardiology, coronary interventions, general surgery, gastrointestinal care, and top 5% in the nation for critical care, pulmonary services, and women's health" (2013, NGHS website).

Together, (NGHC and NGHS) have successfully paved the way for the use of new and exciting technology via cardiac research. They are one of seven groups around the world involved in robotic angioplasty, they also perform transcatheter aortic valve replacement via in incision in the leg for older at risk patients, and are the only center in Georgia to participate in the Analyze ST trial which enables the detection of a heart attack at the earliest stages for electrophysiology patients (2013, NGHC website).

Negotiation Plan

First and foremost to any other action was the need for a practice valuation performed by an outside consulting group. This important tool is utilized to value the worth of the practice to be absorbed and is important to both the practice, as well as the purchasing health system. Types of valuation can include income valuation, market approach, and asset methodology (2009, Carlson). “Because the asset approach is divided into tangible and intangible assets, it is usually the fairest approach” (2009, Carlson).

With a move to hospital ownership, private practice cardiologists have had many concerns. Among those noted are management of their practice, professional billing, existing employees, and satellite offices (Heck, 2010). The practice can be run utilizing either a service agreement or co-management model while employment may be based on equality/equal shares, production based compensation, or the physician enterprise model where physicians maintain ownership but their services are leased by the hospital (Heck, 2010).

Physician compensation should be based on volume, productivity, goals and objectives, as well as quality care (Hunter, 2010). All of these metrics should be clear and understood by all parties involved as well as reflected thru all daily operations. This of course would include aspects such as billing, electronic medical records, collections, and compliance (Hunter, 2010).

Chapter 2

Review of Literature

This chapter presents a review of the literature related to the perspective of health system and practice integration representatives regarding what factors they deem as essential for successful post integration. Its purpose is to determine the quantity and substance of information published on the topic and to ascertain whether any conclusions can be drawn as to necessary factors for successful post integration.

The key terms used to search literature databases included healthcare reform, hospital-physician alignment, hospital-physician integration, and successful hospital-physician integration. The following articles were important for my literature review because the discussions focused on hospital-physician integration. The 38 articles meeting the criteria for this review were divided into four categories. The first category included eight articles that discussed the history of healthcare reform. Next, ten articles that discussed hospital-physician alignment. The third category included ten articles involving hospital-physician integration. The fourth category focused on successful hospital-physician integration and included ten articles. The literature review is organized around these topics.

History of Healthcare Reform

According to Witt (2010) there are four distinct periods which can be identified in physician-hospital integration, and each with particular economic and market characteristics. The Camden Group summarizes the 1990's as an expansion period, followed by a four year shake-out/retrenchment, a four year focus on market share, and finally payment reform. From the early 2000's to now, practice costs have increased over time while Medicare payments have declined.

Burtley (2012) built on Witt's 2010 paper and forecasted that changes in CMS' future focus on better population health, better patient experience, and reduced health care costs would elicit a new wave of integration. According to Wann (2010), the trend toward hospital employment became a stampede on January 1st, when CMS enacted drastically reduced payments for in-office echocardiograms and nuclear stress tests, and eliminated codes for consultations. Stratienko (2011) reiterated payment reductions by noting that from 2007 to 2010 in Tennessee, CMS reduced office-based myocardial perfusion imaging fees by 23% and echocardiographic fees by 31%. Stratienko goes on to relay that CMS increased reimbursements for hospital-based outpatient myocardial perfusion imaging by 31% and echocardiographic imaging fees by 22% during the same interval and thus created a large disparity in payments for identical services performed in different venues.

The expected outcome of reform and the Affordable Care Act is ultimately to increase patient access to care, the quality of that care, as well as offer up reduction in costs. Do physicians see it the same way? A 2015 National Survey of Primary Care Providers conducted by The Kaiser Family Foundation/Commonwealth Fund relayed differences in physician views. Table 1 depicts physician disagreement regarding negative versus no impact on a number of issues while most agree reform enabled more access to health care and insurance.

Table 1

Physician Views on the Impact of Health Care Reform				
	Not Sure	Negative Impact	No Impact	Positive Impact
Your medical practice overall	9%	36%	31%	23%
The quality of care your patients receive	6%	25%	50%	18%
The ability of your practice to meet patient demand	10%	35%	44%	10%
The cost of healthcare for your patients	16%	44%	17%	21%
Access to health care and insurance	14%	24%	12%	48%

Hospital-Physician Alignment

Hospital-Physician alignment goes beyond integration. Dr. Bard from the Bard Group wrote an article on Trinity Health System, a large national Catholic system and their successful alignment goals. Bard (2008) discovered that the six key attributes of their successful hospital-physician alignment model are as follows:

- Believe in the mission

- Share decision-making
- Trust one another
- Steward the resources
- Allow freedom to serve
- Never rest on laurels

Bonar (2011) notes that goals should be realistic, data should be shared, and process improvement should be continual. An HFMA (2014) survey of senior financial executives found that collaborative decision making was the most important skill to develop in physician leaders. The survey went on to relay the following results:

- Collaborative decision making (selected by 46 percent)
- Performance measurement (36 percent)
- Quality improvement (35 percent)
- Strategic thinking (31 percent)
- Change management (30 percent)
- Financial management (24 percent)

Fields (2011) however highlights the 7 reasons that hospitals struggle to align with physicians as:

- Physicians are trained to be individualists
- Employment may not be enough to spur engagement
- Physicians come to meetings as figureheads, not participants
- Physicians and administrators treat problem-solving differently

- Definition of “long-term” varies
- Hospitals may not make expectations clear up-front
- Physician mentors are under-utilized

Physician expectations according to Kauk (2013) include improvement of customer service, enhancement of clinical performance and innovative products and services.

Hospital-Physician Integration

Prior to integration Satiani (2010) recommends the following strategic factors to be considered by hospitals and physicians prior to integration:

- Supply/demand
- Economical viability
- Regulatory complexities, practice management
- Ancillary and outpatient revenues
- Quality of care, work-life balance
- Reimbursement, need for capital
- Volumes

One of the most important steps in hospital-physician integration is ensuring a proper fit, which involves evaluation of financial health as well as cultural fit, according to Aston (2013). Hirschfeld (2011) recommends the following process for ensuring both entities are culturally aligned:

- Develop a compelling and measureable vision for the integrated enterprise, creating a context for developing strategic plans and day-to-day activities.
- Understand the covenant and perspectives of leadership, staff, patients, and providers.
- Develop and implement an organizational communications plan cascading the vision, strategic initiatives, and measures through the entire organization. Transparency is critical.
- Use leadership and organizational survey tools to understand engagement and buy-in to the vision.
- Analyze and understand the implications of the results as they relate to staff engagement and its impact on clinical, business, and strategic objectives.
- Develop an action plan to manage gaps in engagement.
- Implement the action plan by involving the entire organization.
- Measure and innovate until you achieved cultural alignment, then repeat.

Anderson (2012) states that there are four distinct phases of physician integration that must be managed. They are network expansion, operational excellence, clinical coordination, and physician partnership. Satiani (2010) stressed the importance of physician participation on the basis of a 2007 Press Ganey survey that revealed the number one issue for physicians was how the administration responded to their ideas, needs, and concerns.

Also of importance is a proactive plan with regard to acknowledgement of potential barriers. According to Budetti *(2002)*, the most common barriers are ever changing public policies, differences of priority, lack of focus on "physicians' issues", conflicting payment incentives, divisive productivity incentives, and lack of physician leadership. Another aspect to be aware of are costs incurred post integration. Cho *(2015)* reveals that monitoring, coordination, and cooperation costs are among the top unexpected. Monitoring encompasses all aspects such as labor and systems that are involved in the tracking of various physician benchmarks. An absence of both coordination and cooperation amongst differing departments and providers, could lead to decreased efficiency and increased costs.

Successful Hospital-Physician Integration

The ultimate goal in hospital and physician integration is ensuring that the outcome is successful. According to the AMA (2015) the six principals of success for integrated leadership between hospitals and physicians are unity, collaborative decision-making, presence of clinical physician and hospital leadership at all levels, a partnership built on trust, open and transparent sharing of clinical and business information, and a clinical information system infrastructure that is useful. Butcher (2013) relays the top strategy of several differing health systems. Geisinger Health System utilizes physician pay for performance which has served to increase their overall clinical revenue. UnityPoint Health however chose to focus on aligning physicians with organizational goals and vision while Catholic Health Initiatives stresses the importance of accountability. Out of the gate, the system should focus on attaining physician buy-in

and proceed in fostering physician growth via leadership training (MacDonald, 2014). Of importance to both sides of the aisle should be a focus on clinical outcomes. Dr. Peggy Naas, vice president of physician strategies at VHA suggests a unified plan for delivering clinical outcomes efficiently and in a way that benefits the entire organization (Rodak, 2011).

Ultimately it is the health system and physician relationship status that can make or break a successful integration. According to Cullen (2012) physicians comprise less than 30 percent of senior leadership teams in 88 percent of organizations; 36 percent of organizations report no physicians on the senior leadership team. The first step in constructing an effective relationship is an understanding of personality characteristics of hospital leaders as compared to that of physicians. Table 2 was presented in an online article *How Hospital Leaders Can Build Good Working Relationship with Physicians* (2013) at the Center for Rural Health Policy Analysis website. The table reflects distinct differences in roles and personalities of hospital leaders as compared to physicians.

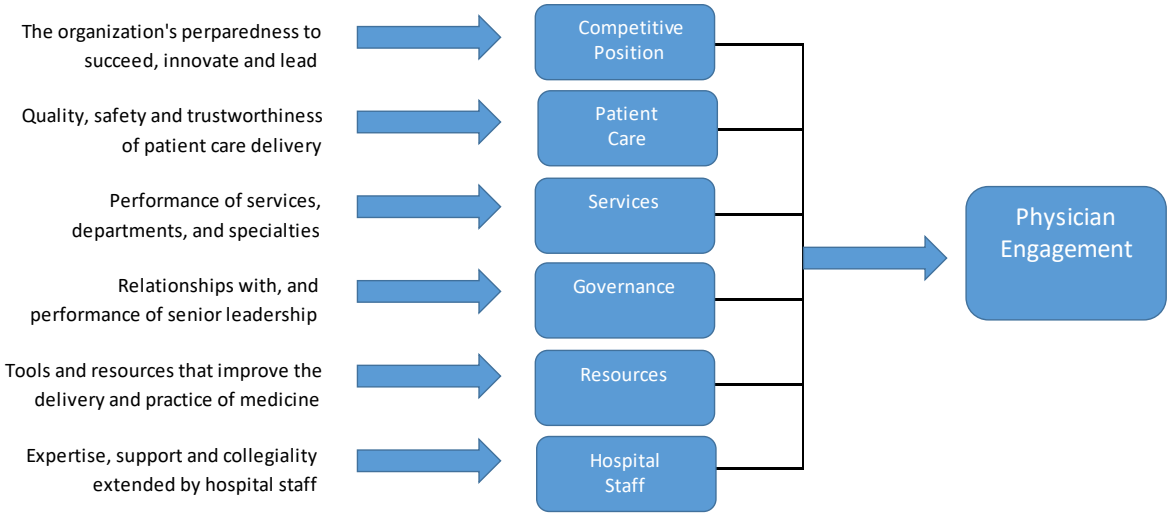
Table 2

Roles and Personality Characteristics of Hospital Leaders and Physicians	
Hospital Leader	Physician
Delegator	Doer
Planner/Designer	Solution Oriented
1:N Interaction	1:1 Interaction
Collaborative	Autonomous
Organizational Identification	Professional Identification
Organization Advocate	Patient Advocate

The article goes on to suggest numerous tools that serve to foster the relationship and engage physicians through utilizing face to face meetings, implementation of physician satisfaction surveys and physician lead task forces, as well as consistent solicitation of physician input. An American Hospital Association article (2012) reflects the major factors that influence physician engagement in table 3.

Table 3

Common Key Influencers of Physician Engagement



Chapter 3

Research Design and Methodology

Chapter Three describes the methodology utilized in this study. Included in the discussion are the justification for the research design, the selection of participants, data collection and data analysis components, the limitations and delimitations of the study and the procedures for ensuring the protection of human subjects.

Research Design

The research question for this study is "what factors do health system and practice integration representatives deem as essential for successful post integration?"

This study was exploratory in nature utilizing qualitative research methodology. This approach was appropriate to answer the research question as there was very little theory and statistical data available, as well as varying views.

A general inductive approach was utilized, which according to Thomas (2006) involves (a) condensing raw textual data into a brief, summary format; (b) establishing clear links between the evaluation or research objectives and the summary findings derived from the raw data; and (c) developing a framework of the underlying structure of experiences or processes that are evident in the raw data. This research explored both the perspectives of those who encompass experience and knowledge with health system and practice integration and who gained insight and understanding as it relates to the benefits of the post integration process. Specifically, this study investigated the perspectives of key integration players from both the health system and the cardiology practice that were intimately involved in the integration process. The Executive Director, Director of Finance - Physician Groups, and Director of Physician Hospital Integration made up those interviewed from the health system. Two physicians and the Chief Executive Officer made up those interviewed from the cardiology practice.

It is essential to frame a research question in a manner that provides the flexibility and freedom to explore a phenomenon in depth (Strauss & Corbin, 1998). As a result, this design was an exploratory, qualitative study, which utilized interviews to investigate the perceptions of both health system and physician practice individuals regarding successful integration.

In addition to framing a research question, this study also required boundary setting. Depoy and Gitlin (1998) state that boundary setting begins with the investigator determining an entry point into the inquiry. Past integration history was utilized with each of these individuals in order to set appropriate boundaries. Depoy and Gitlin (1998)

go on to state that boundary setting begins inductively, and as concepts emerge and theory development proceeds, the researcher assumes a more deductive way of selecting individuals. Boundaries were tailored throughout the groundwork, and permanent boundary setting occurred when repetition or saturation was achieved

Selection of Participants

To begin, six integration experienced individuals were purposefully selected for the interviews. Three represented the health system and the other three represented the physician practice. It was essential for representation from both sides so as not to bias the case by not excluding the viewpoints of a key stakeholder group. The selected respondents played vital roles in the integration process and as a result encompassed knowledge regarding the topic. The participants from the health system included the Executive Director, Director of Finance – Physician Groups, and Director of Physician Hospital Integration. The participants from the physician practice included two physicians and the Chief Executive Officer. Strauss and Corbin (1998) propose that professional experience frequently leads to the judgment that some features of the profession or its practice are less than effective, efficient, human, equitable.

Data Collection/Procedure

This research study used semi-structured interview questions posed through participant telephone interviews. In July 2018, a letter was emailed to selected individuals inviting them to participate. See Appendix I for a copy of the letter. Six recruitment letters were sent and confirmation was received from all six participants.

This research used semi-structured interviews. Some prepared questions were used to begin the discussion, but discussion moved to other topics related to successful integration. See Appendix II for the interview protocol. The questions used in the interview process were intended to be general enough to allow the participants to share their perceptions but were presented in eight segments so that all aspects of the survey process were addressed.

The first segment focused on the number of years of experience that the participant has in their current position to provide me with an understanding of the extent of the participant's organizational history particularly as it pertains to the survey process. The second segment focused on the benefits and challenges involved in integration. The third segment focused on outside barriers and unexpected costs of integration. The fourth segment focused on alignment of culture and strategy. The fifth segment focused on physician leadership engagement and relationships. The sixth segment focused on integration goals. The seventh segment focused on physician productivity and metrics. The eighth segment focused on integration process improvement and recommendations. Kvale (1996) states that a good interview question should contribute thematically to knowledge production and dynamically to promoting a good interview interaction.

A briefing and debriefing were provided to the interviewee. The purpose of the briefing was to reiterate what the interview process would entail and to provide a context for the interview. See Appendix III for the interview briefing. The briefing was not recorded so that the interviewee could ask questions or communicate any concerns

regarding the research process. None of the participants had any initial questions or concerns. The purpose of the debriefing was to put closure to the interview and offer the interviewee the opportunity for any concluding remarks. See Appendix IV for interview debriefing. The debriefing was not recorded to encourage any further dialogue that would be useful for the purpose of insight and enlightenment of the interview and would not have been used as actual analysis in the findings. Upon turning off the recorder, however, none of the participants offered any additional information. Kvale (1996), notes that the interviewees should be provided with a context for the interview by a briefing before and a debriefing afterward.

Interviews were tape recorded, and responses were transcribed verbatim. The data collection and analysis processes used in qualitative research is an integrated process. Data gathering involved seeking the perspective of those specific individuals who possessed distinct knowledge that was important to obtain for the study. The process of interviewing begins with broad questions that become more focused as trends, recurrent patterns and themes emerge, and in turn asking more probing questions, verifying impressions and clarifying details. (Depoy & Gitlin, 1998) They additionally note that transcription is essential so that the researcher can note perceptions, biases or opinions and begin to group information into meaningful categories that describe the phenomenon of interest.

Once the interview was concluded, time was set aside to record reflections regarding what had just transpired. This reflection was transcribed separately from the interview transcript because the interview transcript was used in conjunction with

qualitative software to identify themes as a result of what was directly stated by the participants. The reflection transcript, however, contained a reference to the interview for subsequent analysis. These immediate impressions, based on the interviewer's empathic access to the meanings communicated, may in the form of notes or simply recorded onto the interview tape, provide valuable context for the later analysis of transcripts (Kvale, 1996)

Data Analysis

Transcription is the first step in preparing data for analysis. (Depoy & Gitlin, 1998). All audiotapes therefore were imported into MAXQDA software. Transcription instructions are reflected in Appendix V.

Next, relevant material from the literature review was re-examined. The purpose of this re-examination was to compare themes or issues with what was relayed in the interviews as well as discover additional themes or issues that have not been addressed.

Transcriptions were then coded by question and initially by individual respondent. Responses were then combined for summarization by question to reflect the group as well as frequency.

The final step in determining recurring and emerging themes was the review of transcript summaries. This step was important for validation as well as ensuring insights were not missed in the preceding steps.

In organizing information, a log was established for each recording, along with recording date, key passages, and coding. Depoy and Gitlin (1998) state that an audit trail is important because it leaves a path of thinking and action processes so that others can clearly follow the logic and manner in which knowledge was developed. Coding decisions were then documented so that others may evaluate this study's final analyses.

The purpose of analysis is primarily to yield descriptive data, hunches, or initial interpretive schemes (Depoy & Gitlin, 1998). In performing the data analysis, there was a focus on emerging themes, as suggested by qualitative researchers (Denzkin & Lincoln, 2000; Depoy & Gitlin, 1998; Strauss & Corbin, 1998). Each interview is then compared to determine similarities and differences (Depoy & Gitlin, 1998).

Limitations/Delimitations

This research was limited in its sources as only six representatives were interviewed. Qualitative research is intended to gather insightful and meaningful knowledge about a particular topic. The findings may then be utilized by those who find the information useful. There may be relevance in exploring the perspectives of others who also have integration experience.

The second limitation is that all but two interviews were conducted over the phone. The lack of a face to face interview may have decreased the opportunity to establish a personal link with the participants. It also impacted the ability to gauge facial expressions.

Protection of Human Subjects

On May 30, 2018 the study was determined to be classified as quality improvement by the MUSC IRB. Please see Appendix VI for the survey responses.

Chapter 4

Results

The purpose of this research was to gain more information regarding successful integration factors from the perspectives of health system and practice integration representatives who have experience in this process. The study focused in particular on post integration.

Findings

Profile of the Participants

The study involved the Executive Director, Director of Finance- Physician Groups, and Director of Physician Hospital Integration from the health system. It also involved one physician that was part of the integration committee, one physician that was not, and the Chief Executive Officer of the physician practice.

Participant A

This participant has served in the present position as Executive Director of the Heart & Vascular Services for three years and has served on numerous joint committees directly related to the Cardiology practice.

Participant B

This participant has served in the present position as Director of Finance - Physician Groups for the system for five years.

Participant C

This participant has served in the present position as Director, Physician Hospital Integration for three years and has served on numerous health system joint committees directly related to the cardiology practice.

Participant D

This participant has served in the present position as Chief Executive Officer of the Cardiology Practice for five years and has served on numerous joint committees directly related to the Cardiology practice.

Participant E

This participant has served in the present position as Cardiologist prior to and after integration and has served on numerous joint committees directly related to the Cardiology practice.

Participant F

This participant has served in the present position as Cardiologist prior to and after integration.

A summary of participants is presented in Table 4.

Table 4

Participant Profile			
Participant	***Title***	***Years in Role***	***Role in Integration***
A	Executive Director	3	Leads operations of integrated practice
B	Director of Finance - Physicians Groups	5	Financials of integrated physician groups
C	Director of Physician Hospital Integration	3	Pre and Post integration of physician groups
D	Chief Executive Officer	5	Led physician group pre and briefly post integration
E	Cardiologist	18	Physician, an sat on joint committees post integration
F	Cardiologist	25	Physician

Emerging and recurring themes

Benefits of Integration

The most cited benefit of integration was increased sustainability for the integrating practice. One respondent stated, “There has been an increase in patients that aren’t paying” and attributes part of that problem to “a decline in the patient’s purchase of Medicare Part B which covers provider care.” A lack of carrying this aspect of Medicare therefore increases the patient portion owed. The respondent attributed another aspect to patients relaying a belief that healthcare is a right and therefore they don’t have to pay. Other respondents credited the health system’s billings and collections resources as well as strategy for increased sustainability of the practice. Integration allows for increased efficiencies and increased buying power, as one respondent summed up sustainability as “Having economies of scale.”

The second most cited benefit of integration was better patient care. Those who participated in integration perceived that it enabled not only an increase in resources but also increased coordination of care. Participants stated, “Theoretically having the

strength of an institution can help physicians focus on taking care of patients a little bit more." "The main benefit would be alignment of services which leads to better care for patients."

Challenges of integration

Lack of communication was the top cited challenge of integration. This is due to the organizational complexity and increased number of stakeholders within the structure of a health system as compared to a stand-alone practice. Participants stated, "Unless you have all parties at the table, there could be some misconceptions and misunderstandings that ideally would be avoided if everyone is on the same page." "I think the biggest challenge from my perspective is that we had a lot more layers of administration we had to go through to just communicate about vision and implement change."

Outside barriers

In addition to barriers within the organizations, respondents identified external barriers that require recognition. Independent referring physicians was the top cited barrier to integration. One participant questioned, "Will other independent physicians refer to you because you joined a health system?" Another participant stated, "The health system is sometimes perceived as buying out all of the practices and becoming a monopoly even though the majority of the practices have come to them wanting to be bought or integrated." "That is one barrier with the remaining practices that don't

integrate, that has part of the community feeling like they are competing with this group who refers within and they're going to miss referrals."

Unexpected costs

The most cited unexpected cost of integration related to the upgrading of practice equipment and technology. Technology expenses could include computer and telephone equipment as well as software. One of the participants stated, "When the former practice's assets were aged out, there was a need to immediately upgrade things such as computer technologies, software platforms, to transition providers from the former EMR which was GEMMS, onto the hospital's EMR Epic and there was a significant cost associated with that." These costs can relate to other challenges of the integration process. Practice stakeholders mentioned the "Loss of autonomy" when making a purchasing decision and no longer having the "Freedom to spend" as additional unexpected costs of the practice.

Alignment of culture

Collaboration and shared decision making was noted as essential to alignment of culture. One of the participants stated, "I think that there should be shared power, meaning that no one group whether it is hospital administration or the physicians should have a majority of the power to implement change or to make major decisions like financial decisions and things like that." "I think if you don't have that parity you end up basically having issues with trust and such." "You need to have a joint operating

committee which makes all of the decisions that are major as far as implementing change, and the hiring and firing of physicians." With decision making is the existence of compromise. Another participant stated, "If either party is not willing to compromise or be willing to come to an agreement, you can't accomplish anything."

Strategy alignment

The use of a dyad model and transparency were cited equally as the top recommendations for strategy alignment. A dyad model includes both health system administration representatives and physician representatives for the decision making process and is usually in the form of committees. Examples of committees would include financial, operational, and quality and safety. Participants stated, "For an effective integration, it is important to establish operational governance that includes physician leadership and open feedback." "I think having physicians and administration of the hospital involved in the governance has helped significantly."

With regard to transparency, Participants stated, "In terms of strategy, administration needs to be transparent together with physicians to set goals and agree upon metrics." "I think there has to be transparency to all physicians and not just leadership physicians, and transparency with everything such as operational issues, finances, and work rvu's.

Physician leadership engagement

In covering the topic of physician leadership engagement, half of the participants felt that empowering the physicians to lead was the most important aspect. Participants

stated “Empowering the physicians to be able to make decisions and effect change is the major factor”. “They need to feel like more than a worker bee.” “Physicians in administrative roles however need to continue to see patients to retain credibility with their physician peers.”

Physician compensation was cited as a motivator of physician leadership engagement by a third of participants.

Physician/health system relationships

Three themes that arose as being of equal importance in successful physician/health system relationships was trust, a willingness to understand the other side’s point of view, and transparency. One participant stated, “There has to be a high degree of trust between the physician, the practice leaders, and health system administrators.” “There has to be a willingness to understand how we’re going to fit in and each party’s responsibility within an overarching alignment or integration.” Other participants stated, “I think patience, understanding, willingness to learn something new and gain a new perspective” is essential. “It goes back to transparency and visibility again. For example getting them actionable data, and data they can understand, and making sure that whatever is presented to them is presented in a way that they understand.”

Differences in goals

The main differences noted in goals by participants was that physicians are more focused on practice outcomes whereas the health system has a global focus with regard

to strategy and mission. Half of the participants felt that physicians carried with them their past “for-profit outlook”. “In my experience physician practice tends to be more oriented to net revenue based and making sure that revenue in adjustment of expense produces compensation that is what the physician can live with.” Two of the participants however felt there were no differences in goals. “In general both have the same goals which are safety, quality, and the bottom line.” “I think sometimes the system has initiatives that we need to do that don’t necessarily make sense to us or puts a strain on man power.” Another participant stated, “Goals are similar however priorities are different.”

Physician productivity

With regard to the topic of physician productivity, four participants observed an increase in productivity after integration whereas two participants observed no difference in productivity. They cited differing reasons however for the boost. One participant stated, “It is not that the physicians are working harder, I think some of the barriers post integration were removed so that they could become more efficient.” Another participant however stated, “They are more productive post integration due to they are now paid on work rvu’s.” “The key is if you bring in a physician that’s in a profitable practice currently, you have to bring them in on a productivity compensation model.” “If you bring them in as a guarantee, then you will see productivity decline.” Another participant however stated, “I think if a physician’s going to be productive, he or she is productive in either model.”

Metrics

On the topic of metrics, all participants felt tracking was essential however there was a variance in the type of metrics suggested. The most frequently cited metric by three of the participants was financial related. Specific examples relayed included cost per case, cost per visit, and payer mix. Productivity, patient satisfaction, quality, and access to care all came in equally second.

Improvements

When asked how the post integration process could be improved, half of respondents suggested better communication and transparency was mentioned again. “I think that in general we need to have more honest discussions as far as what is working, what’s not working, what communication channels are there, and how do you make sure everyone’s on the same page as far as how we’re approaching problems and improving programs.”

Recommendations

When asked about recommendations to others considering integration, half of the participants noted the establishment of a post integration governance structure as key and one third of participants relayed due diligence in picking a partner to integrate with. “I think the most important consideration is to have shared governance with equal power and without that the fundamentals, are not solid.” “Integration is like a marriage so my recommendation is to thoroughly vet your partner before you make that commitment.”

Conclusion

This chapter presents the findings of this research which was organized around successful integration factors that emerged. Direct quotes from participants were used to enable readers to gain a better under understanding of the perspective of the participants. The next chapter presents a discussion of these findings.

Chapter 5

Discussion

This chapter presents a discussion of findings. First, findings will be discussed as they relate to the literature. Secondly, conclusions will be presented as they relate to the research question. Finally, implications of the results as well as the conclusion for suggested areas for further research will be presented.

Related Findings to the Literature

In general, participants relayed a mutual understanding that the benefits of integration was both an increase in sustainability and better patient care. This was consistent with observations of the impacts of the affordable care act noted by both Burtley (2012) and Wann (2010). When it comes to the challenges of integration however, participants shared a belief that communication took the lead. This corresponds to a recommendation by Hirschfield (2011) for health systems to develop and implement an organizational communication plan. Also of consensus from the participants were integration costs related to the upgrading of equipment and technology. Witt (2010) listed technology along with a number of other types of costs that increased as a direct result of integration.

When speaking with participants about how to better align cultures, they felt that both collaboration and shared decision making were essential elements. Bonar (2011) and Burtley (2012) relayed the importance of establishing a culture of collaboration while Burtley (2012) also emphasized the need for collaborative decision

making. In addition to an alignment of culture is a need for the alignment of strategy as well. Transparency and the use of a dyad structured governance were both of equal importance to participants. Hirschfield (2011) attributed alignment to transparency in communication every step of the way. According to Witt (2010) the governance structure must facilitate ongoing physician involvement in decision making. Bard (2008) also stressed the importance of shared decision making and cited an example of Saint Mary's Health Care having utilized a 50-50 governance split of administration and physicians for planning, operations, and growth decisions.

Hand in hand with collaboration and decision making is the emergence of physician leadership engagement. Half of the participants felt that empowering physicians to lead was the most important aspect. BothTrybou (2011) and the American Hospital Association (2012) echoed that belief with regard to physician involvement in planning as well as in decision making.

On the topic of physician and health system relationships, establishment of trust was imperative according to participants. Bard (2008) recognizes that in order to establish trust, both hospitals and physicians must have a relationship based on mutual respect, a sense of value, and a personal investment in the improvement of care. Thomas (2009) however felt that trust is the result of consistency, transparency, and the belief that the patient's interest is above the provider.

When asked about recommendations for others considering integration, participants felt due diligence should be utilized in order to choose the appropriate

partner. Aston (2013) stated that it is an absolute necessity and should encompass evaluating financial health as well as cultural fit.

Conclusions of Research Study

Based on the people interviewed, there are numerous factors deemed essential for successful post integration. The conclusion therefore is based on the following:

1. Acknowledgement of sustainability and better patient care as beneficial aspects of integration.
2. Recognition that constant communication is a key component, and it should be ongoing in nature.
3. Sensitivity to independent referring physicians as potential barriers.
4. Realization that while costs for equipment and technology may have increased significantly initially, the ultimate benefit is most likely overall better patient care.
5. Collaboration and shared decision making is essential for alignment of culture.
6. Transparency in all things and the use of a dyad model are critical for strategy alignment.
7. Empowering physicians to lead is vital.
8. Trust, transparency and a willingness to understand each other's point of view lead to a healthy physician/health system relationship.
9. Sensitivity to differing priorities of similar goals.

10. Utilization of various metrics including financial, productivity, quality, engagement, satisfaction, and access to care.

Implications of the Results

In order to ensure successful integration, a number of activities must occur by both parties. There must be an acknowledgement and understanding as to the basis and benefits that the integration was built upon. Continuous communication is essential in all aspects of the integration and utilization of a communication plan is highly recommended. There should be sensitivity with regard to independent referring physicians as potential barriers. The integrated health system should be proactive with regard to fostering a positive relationship with independent physicians and utilize their public relations and/or marketing department to bridge any gaps. Due diligence should be utilized with regard to equipment and technology purchases to ensure that each result in greater efficiency and/or better patient care. There should be a focus on creating a collaborative culture with regard to vision and strategy. It is essential that both parties are at the table and joint decision making should be employed. Transparency should exist in all aspects of the relationship. Utilization of a dyad model is vital, and a joint committee should be established for governing and decision making. Additionally a finance committee, an operations committee, and a quality committee should be established. Each of these should report up to the joint committee. Both parties need to be at each of these tables. Physicians should hold leadership roles within the joint and each sub-committee which will enable and foster physician engagement. There needs to be a proactive effort on both sides to understand each

other's point of view as it relates to the vision, goals, and strategies. The ongoing use of numerous metrics is highly recommended for gauging differing aspects of the integrated system. This will ensure that they are on track and should coincide with a balanced scorecard.

Recommendations for future research

Results from interviews with health system and physician practice representatives suggest additional opportunities for further research. One opportunity for future research would be to interview additional representatives as well as additional health systems.

A second research opportunity is to study the use of a dyad model and the success rate associated with it. A measure that could be used is the number of years integrated.

A third research opportunity is to study integrations that fell apart or disbanded in order to determine the cause or causes.

A fourth research opportunity is to study the implication of independent referring physicians as barriers.

Summary

This qualitative research project focused on the perspectives of six health system and physician practice representatives regarding factors essential for successful post integration. This research project is an important step in increasing the understanding of

what is needed from both parties in order to insure successful integration. Information received from each participant is believed to be candid and honest and resulted in a number of observations worthy of future research. The study resulted in the following conclusions; a team work approach should be utilized throughout the integration process. Open communication and transparency are essential in establishing trust. Care and sensitivity should be taken when addressing potential barriers of independent referring physicians. Due diligence should be exerted to ensure equipment and technology purchases are beneficial. Collaboration and shared decision making through the use of a dyed model are essential. Physicians should hold leadership roles within the structure in order to foster engagement. Finally, metrics should be utilized in order to ensure that essential balanced scorecard items are tracked appropriately.

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Appendix I

Dear **<Name of Participant>**

As part of my doctoral research project through the Medical University of South Carolina, I am gathering information regarding the perspectives of health system and physician practice integration representatives to better understand the essential factors for successful post integration. As someone who is familiar with such issues, I would like to request approximately one hour of your time to answer some questions and gain your expert opinion regarding such issues.

Your opinions are highly valued and will significantly help identify such characteristics to better understand the inner workings and complexities of integration. Participation in this study is voluntary and will involve an interview, either via telephone or via electronic medium such as Webex, and will be recorded with your permission. We will not share your responses in an identifiable manner with anyone outside of the research team.

If you would like to participate, I would like to schedule the interview. I will contact you to determine a few times when you would be available.

Thank you in advance for helping with this effort.

If you have any questions about this survey please contact me at the phone number or e-mail address below.

Respectfully,

Cynthia P. Stephens, MBA

Doctoral Candidate, Medical University of South Carolina

Phone: 706-499-6162

Email: cyndi136@hotmail.com

Appendix II

Introduction:

Thank you for participating in this call today. The purpose of this study is to explore the perceptions of health system and physician practice representatives regarding essential successful post integration factors.

Today I'd like to ask you to identify and talk about some of these characteristics and factors and how you see them affecting your organization. Further, I'd like to get your ideas on how you think about them singly or together and how you work to address them to best position your organization.

I just want to remind you that anything you say here today will be confidential. That means that we won't have your names or any other personal information in any records. No names will be used in any reporting. Finally, is it alright if I record our conversation to assist in accurately capturing the details? Do you have any questions before we begin?

General interview questions to both health system and physician practice integration representatives:

Experiences

1. How many years have you been in your position?

Benefits and Challenges of Integration

First I would like to learn more about the challenges and benefits of health system and physician practice integration.

2. Describe perceived benefits of integration.

3. Identify the challenges you have encountered post integration?

Outside Barriers and Unexpected Costs

The second area I would like to explore are outside barriers and unexpected costs related to integration.

4. Give examples of outside barriers that have impacted post integration.

5. What unexpected costs have been associated with post integration?

Alignment of Culture and Strategy

The third area that I would like to learn more about is the alignment of both culture and strategy.

6. What factors do you consider crucial in enabling alignment of physician practice and health system culture?
7. What recommendations would you make for an effective Physician/Health System alignment strategy?

Physician Leadership Engagement and Relationships

The fourth area that I would like to explore is physician leadership engagement and physican/health system relationships.

8. What factors foster physician leadership engagement post integration?
9. What characteristics do you consider essential for successful Physician/Health System relationships?

Integration Goals

The fifth area that I would like to learn more about are integration goals.

10. What differences have you observed in Health System goals as compared to Physician practice goals?

Productivity and Metrics

The sixth area that I would like to explore are physician productivity and metrics.

11. What has been your experience in terms of physician productivity pre and post integration?

12. Which metrics do you consider are essential to successful post integration?

Integration Process Improvement and Recommendations

The final area that I would like to learn more about are process improvement and integration recommendations.

13. How can the post integration process be improved?

14. What recommendations would you make to other practices and Health Systems considering integration?

15. Are there any topics we haven't covered that should be addressed?

Appendix III

Interview Briefing

Before turning on the tape recorder, I would like to provide you with a briefing. The purpose of this interview is to learn about your perspectives regarding Health System and Physician Practice integration. I have chosen you because I think that you will provide invaluable insight to my study. My interview encompasses the following items including your professional experience as well as topics specific to integration such as benefits, challenges, barriers, unexpected costs, alignment of culture and strategy, physician leadership engagement and relationships, goals, productivity and metrics, process improvement, and finally recommendations. You are encouraged to expand upon any of your answers and you are not limited to the above-mentioned topics.

As relayed in my letter and if you agree, your interview will be audiotape and then transcribed. The purpose of audio taping is to make certain that I have accurately represented your comments. Additionally, I will provide you with a summary of the transcript which will enable an opportunity to revise anything that you feel does not accurately depict your views. Upon request, I will also provide you with the opportunity to review the entire transcript. All recording will be destroyed after transcription and all transcriptions will be held in strictest confidence. Your transcription will be used to directly identify common themes with others being interviewed and will NOT be used to

directly identify you in my findings. Of course, you can withdraw from the project at any time and I will destroy all documents related to you.

Do you have any questions before we begin? I will now turn on the tape recorder.

Appendix IV

Interview Debriefing

Thank you for the interview. The tape recorder is now off. Is there anything else you would like to add that would provide insight and enlightenment for the interview? Your comments at this point will not be used as actual analysis in my findings.

I will send you the summary of the transcript within two weeks for your review and feedback. My timeline to complete this study is approximately three months and I will be happy to forward my findings if you would like. Please feel free at any time to ask any questions or provide any additional information if you see fit.

Thank you again for participating.

Appendix V

Instructions to Transcriber

- Transcribe using Microsoft Word software
- The entire interview must be reproduced verbatim. Do not condense or summarize those parts that may appear to contain little relevant information.
- Any pause in the conversation must be noted but emotional expressions should not be included
- Briefing before the interview must be included.
- My reflection and recall after the interview has been concluded will be transcribed under separate text referring to the specific interview.

Appendix VI

MUSC QI / Program Evaluation Self-Certification Tool

Response was added on 05/30/2018 2:30pm.

MUSC QI / Program Evaluation Self-Certification Tool Today's date 05-30-2018

This tool is to be used to assist in determining whether a project may be deemed quality improvement (QI) / program evaluation and therefore not require IRB review or approval. If you do not understand a question please refer to the [IRB website] for further information. It is important that you answer each question objectively and truthfully. Each question must be answered as either YES or NO. If, based on your responses the project is QI, a self-determination letter will be emailed to the address provided. This document can be given to individuals requesting written confirmation that IRB review of the project is not required (e.g. individuals providing data for the project, funding sources, journal editors, etc.), so the information here should include sufficient detail such that the certification can be matched to the project. Note that this tool is designed to differentiate basic QI projects from research. It is possible that your project may be QI even if the tool identifies it as possible research. If the tool provides a determination that is different from what you anticipated, please contact the IRB at 792-4148 to discuss your project in greater detail. Note that the determinations made by this tool are subject to audit by University Compliance Office.

****This guidance tool has been adapted from the University of Wisconsin-Madison's "IRB QI/Program Evaluation Self-Certification Tool"**

Name of Project Leader/Investigator Cynthia Stephens

Email of Project Leader/Investigator stephecp@musc.edu (Note: must be an MUSC email address)

Project Title PERSPECTIVES OF HEALTH SYSTEM AND PHYSICIAN PRACTICE INTEGRATION REPRESENTATIVES REGARDING SUCCESSFUL INTEGRATION FACTORS

05/30/2018 2:30pm www.projectredcap.org

Page 2 of 2

Brief Description of Project Goals The purpose of this research is to yield factors essential for successful health system and physician practice integration.

College/affiliation through which the project will be conducted: College of Dental Medicine College of Graduate Studies College of Health Professions College of Medicine College of Nursing College of Pharmacy Other

Q1. Will the project involve testing an experimental drug, device (including medical software or assays), or biologic? Yes No [More info]

Q2. Has the project received funding (e.g. federal, industry) to be conducted as a HUMAN SUBJECTS RESEARCH STUDY? Yes No [More info]

Q3. Is this a multi-site project (e.g. there is a coordinating or lead center, more than one participating, and/or a study-wide protocol)? Yes No [More info]

Q4. Is this a systematic investigation designed with Yes the intent to contribute to generalizable knowledge No (e.g. testing a hypothesis; randomization of subjects; comparison of case vs. control; observational research; comparative effectiveness research; or comparable criteria in alternative research paradigms)? [More info]

Q5. Will the results of the project be published, Yes presented or disseminated outside of the institution No conducting it? [More info]

Q6. Is the project intended to improve or evaluate Yes the practice or process within a particular No institution or a specific program? [More info]

This project appears to constitute QI and/or Program Evaluation and does not fit the federal definition of research. IRB review is not required. Click "Submit" to have your Self-certification QI Determination Letter sent to the email address indicated.