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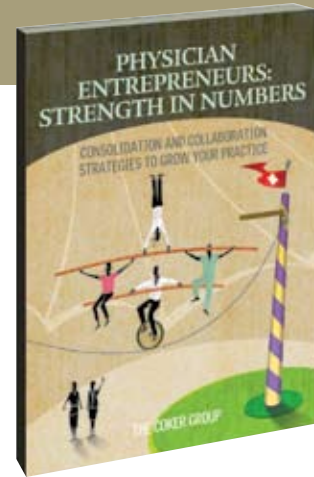
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# Information Technology Focused Alliances

*by Jeffery Daigrepont*

Many healthcare alliances today are driven out of the need to improve technology and/or become clinically integrated, or to reduce the cost of information technology spending. All of the alliances and partnerships discussed in this book must include a cohesive technology strategy to be successful. The recent improvements in healthcare technology, specifically electronic health records (EHR), have created opportunities for multiple stakeholders—including competitors—to collaborate. Many trends have developed based on IT collaboration and affiliations over the past several years. Figure 11.1 features a few examples of these affiliations.

**Figure 11.1:** Types of IT affiliations

Types of IT affiliations	Description
<b>Regional health information organization (RHIO)</b>	<p>RHIOs are most commonly multistakeholder organizations responsible for clinical integration and information exchange. Generally, these stakeholders develop a RHIO to affect the safety, quality, and efficiency of healthcare as well as access to healthcare information. RHIOs are always regional or state-adopted and typically include payers, hospitals, physicians, and local employers. It is common for a RHIO to adopt a single EHR as a central repository for clinical data. Security and user profiles (rights to access information) are critical in the setup of any RHIO. Although RHIOs offer many benefits, many fail due to financial instability. Initially, most RHIO funding comes from grants, but thereafter the stakeholders must contribute financially. Without critical mass numbers of participants, the cost can become too much to bear in the long term due to the technology infrastructure required to support a RHIO.</p>
<b>Health information exchange (HIE)</b>	<p>Similar to RHIOs, HIE is defined as the mobilization of healthcare information electronically across organizations within a region or community. Software commonly known as a master patient/person index (MPI) is always required for HIE to exist. Without getting too technical, MPI creates a common identifier to which all other databases map. This allows information to move across multiple locations of care and across multiple platforms. It also allows clinical information to move electronically between disparate healthcare information systems, assuming each health system can build a trust between the data being exchanged. A “trust,” as a technical term, is the ability to verify the integrity of the data being exchanged, hence the need for the MPI. A secondary use of HIE can be for the purposes of public health, clinical, biomedical, and consumer health informatics research as well as institution and provider quality assessment and improvement.</p>
<b>Community health record (CHR)</b>	<p>A CHR is an EHR shared among several provider/medical practices in a single community. Most often, the CHR is provided by the hospital to both its employed and nonemployed medical staffs. CHRs grew in popularity after the relaxation of the Stark laws, discussed later in this chapter. CHRs may or may not include a practice management system, however, if the hospital operates a management services organization (MSO).</p>

**Figure 11.1:** Types of IT affiliations (cont.)

Types of IT affiliations	Description
<b>Application service provider (ASP)</b>	ASP is basically a spin-off of a data center. However, with the widespread adoption of the Internet and the development of Web-enabled and Web-based applications, software can now be delivered economically from a central server over the Internet. In some cases, physicians or hospitals will create their own ASP or contract with an ASP to deliver the application among all the stakeholders. The requirements are generally an Internet connection and a PC. Payment for services is typically a two- to three-year subscription based on a per-provider, per-month hosting fee. Although ASPs offer affordability, one must accept some loss of control and ownership. All data is stored off-site. Many ASPs will also provide revenue cycle management services.
<b>Management services organization</b>	MSOs have been around for many years and generally exist to allow hospitals to provide services to their medical staff as an alternative to ownership of the practices. They provide a blend of contract management and practice management services designed to maximize the efficiency and productivity of physician practices. An MSO can also decrease overhead costs by providing IT services and IT systems such as practice management software or an EHR.
<b>Joint ventures and mergers</b>	One of the primary reasons for considering a joint venture or merger is the ability to consolidate expenses and share overhead. Joint ventures can entail myriad configurations that may or may not include a common IT infrastructure; however, in the case of a merger, consolidation of the IT systems is typical. Conversion and transition planning is the greatest challenge. Mergers are similar to people who get married after living on their own for a while and end up with two of everything. All of the duplicate IT systems, specifically the practice management software and EHR software, must be consolidated into a single system. There must also be a strategy to retire the legacy systems and to complete data conversions. As medical practices become clinically automated, merging three or four disjointed EHRs into a single solution will become a challenge. Most physicians are very reluctant to give up an EHR that is working well, especially to move to one that they believe is inferior.

## Factors Affecting All Affiliations

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Although the affiliation strategies outlined in Figure 11.1 have unique features, they all have one thing in common: sharing or participating in a single data repository. Ownership of the data can vary significantly; however, it is critical to understand who controls the data and how it will be used, as well as the terms and conditions of the affiliation. In most affiliations involving IT, there is a fee to acquire services. The payment method is generally a monthly hosting fee, although upfront payment may be required as well. The hosting fee is sometimes determined by distributing the cost among all the stakeholders and can entail some remarkable economies of scale with greater numbers of participants.

If your goal is to create and develop one of the affiliations explained in Figure 11.1, you will need to establish terms and conditions for its members. If your interest is to join or participate in any of these alliances, knowing what terms to require will be essential. Although they may seem contrary, Figure 11.2 addresses such terms from both perspectives.

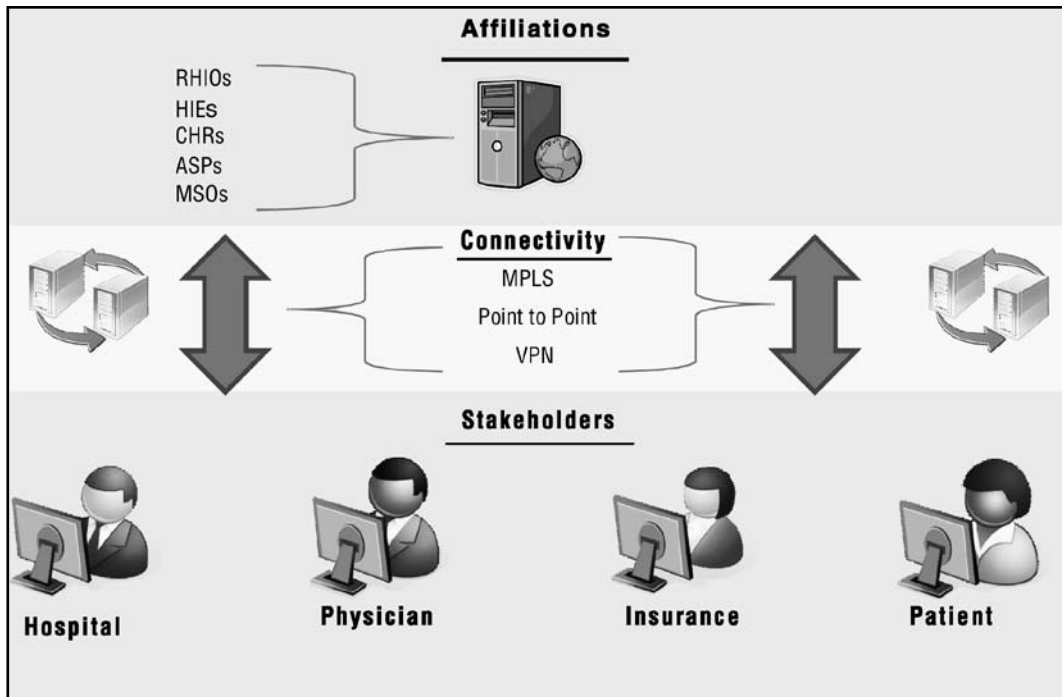
**Figure 11.2:** Terms to know before affiliating

Terms for owners developing an alliance	Terms for members participating
<b>Must require members to pay a set-up fee.</b>	Must get a guaranteed amount not to exceed and create payment terms based on project deliverable.
<b>Must require members to pay a recurring hosting fee.</b>	Establish a term that prevents the alliance from increasing the hosting fee without notice and/or that exceeds the consumer price index.
<b>Must establish terms to charge for out-of-scope services.</b>	Unauthorized services will not be covered expenses.
<b>Must develop a user-acceptance policy; specifically, this should restrict software modifications and unauthorized access.</b>	Ask to see the user-acceptance policy in advance. There may be some restrictions, especially with customization and modifications. Consider any access restrictions, especially from other hospitals.
<b>Must create policies and procedures, including user manuals.</b>	Restrict unauthorized use of your data and make sure liabilities are understood, especially if sharing a common medical record.
<b>Must have the ability to monitor and audit.</b>	Require some notice prior to being audited.
<b>Updates and new releases should require some terms for acceptance and associated fees.</b>	Require some testing before accepting updates. All updates should be included in the annual hosting fee.
<b>May want to limit assignment or require a transfer fee.</b>	Do not enter into a contract unless the alliance will sign over the rights to use the software or provide you with the ability to transfer your support over to the software developer. The developer is the company who owns the software and may operate under a different name. You should always find out who owns the software code. As with any transfer, there will be added expenses and the need to purchase your own server to run the system independent of the alliance.

**Connectivity**

Another common trait of these affiliations is connectivity. In most cases, each stakeholder will need to establish its own connectivity to the central servers or join a network that has been preestablished on behalf of the members. Figure 11.3 is a simple technical illustration of how these affiliations become networked together.

**Figure 11.3:** Affiliations networking model



**MPLS:** Multiprotocol label switching  
**VPN:** Virtual private network

### ***Relaxation of Stark and Anti-kickback Statute***

On August 1, 2006, the Centers for Medicare & Medicaid Services and the Office of Inspector General of the U.S. Department of Health and Human Services (HHS) relaxed Stark and anti-kickback laws for the furnishing of electronic prescribing and EHR technology by creating a safe harbor.

Under the new Stark law, hospitals can provide financial assistance for the electronic prescribing technology and for EHR technology for its nonemployed medical staff under certain conditions.

**Electronic prescribing**—The exception and safe harbor for electronic prescribing technology protects the furnishing of hardware, software, or IT and training services that are necessary and are used solely to receive and transmit electronic prescription information. In addition, the items or services must be provided as part of, or used to access, an electronic prescription drug program that meets the applicable standards under Medicare Part D.

**EHR**—The exception and safe harbor for EHR technology protects the furnishing of EHR software or IT and training services that are necessary and are used predominantly to create, maintain, transmit, or receive EHR.<sup>1</sup>

The arrangement may also be referred to as a donation and may be in the form of shared infrastructure and software already used by the hospital. In these cases, the incremental costs of sharing software such as a community health record are shared among the participants and stakeholders. For example, the hospital may have already purchased an EHR for its employed

physicians and will have invested in the IT infrastructure. If this system is later shared or offered to the hospital's nonemployed medical staff, the incremental cost is usually whatever the vendor charges for the additional software license and the professional fees to implement the system in additional locations. In some cases, the hospital may use its staff to implement the system. Figure 11.4 illustrates what can and cannot be provided under the donation.

**Figure 11.4:** Donation guidelines

Donation category	In	Out
<b>Services</b>	<ul style="list-style-type: none"> <li>• Training</li> <li>• Help desk</li> </ul>	<ul style="list-style-type: none"> <li>• Office staffing</li> <li>• Prior EHR conversion</li> <li>• Abstracting/scanning</li> </ul>
<b>Software licenses</b>	<ul style="list-style-type: none"> <li>• EHR, including integrated practice management</li> </ul>	<ul style="list-style-type: none"> <li>• Nonintegrated practice management or unrelated software</li> </ul>
<b>Hardware and telecommunications</b>	<ul style="list-style-type: none"> <li>• Central hardware refresh</li> <li>• Connectivity</li> </ul>	<ul style="list-style-type: none"> <li>• Office hardware</li> </ul>
<b>Maintenance</b>	<ul style="list-style-type: none"> <li>• EHR, including integrated practice management</li> </ul>	Not applicable

As stated previously, certain conditions must apply for any donations to be allowed. Such conditions include, but are not limited to, the following:

- The EHR must contain an electronic prescribing capability that meets the applicable standards established under Medicare Part D.
- The arrangement must contain a cost-sharing component; the recipient must pay a minimum of 15% of the donor's cost for the EHR technology and professional services.

- The EHR must be interoperable at the time it is provided. The term interoperable is defined as being able to “communicate and exchange data accurately, effectively, securely, and consistently with different information technology systems, software applications, and networks, in various settings; and exchange data such that the clinical or operational purpose and meaning of the data are preserved and unaltered.”<sup>2</sup> Alternatively, software will be deemed interoperable if a certifying body recognized by HHS has certified the software no more than 12 months prior to the date it is furnished. On August 4, 2006, HHS announced that it had recognized the Certification Commission for Healthcare Information Technology (CCHIT) as a certifying body. To qualify for certification by CCHIT and be deemed interoperable for purposes of the exceptions and safe harbors, the software must meet specific standards in four areas: functionality, interoperability, security, and reliability. The standards for each area are available at [www.hhs.gov/healthit/documents/AEHRRecognizedCertCriteria.pdf](http://www.hhs.gov/healthit/documents/AEHRRecognizedCertCriteria.pdf).

The new safe harbors create opportunities for hospitals to provide technology to physicians and other healthcare providers; however, there are limitations. Most important is the need for the hospital to fully disclose all costs associated with these initiatives so that the proper donation can be calculated. Staff members such as those required to develop interfaces, set up servers, manage the project, conduct training, and assist with implementation should also be factored into the cost. It is also recommended that some third-party validation, preferably by someone who has formed similar organizations, is performed to ensure that the calculations are done correctly. Finally, the hospital and

practice must determine the governance of the partnership, developing contracts, terms, and conditions, in particular.

## **IT Barriers**

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In 2004, President George W. Bush publicly endorsed the use of EHRs. Since then, myriad Washington-based policy groups have been working on standards and policies for adopting EHRs and other forms of automation, such as e-prescribing. The changes in the Stark laws, as discussed earlier, are an example of some of the policy changes. However, the cost to implement such technology and the lack of financial incentives remain significant barriers to adoption. According to available statistics, the initial cost for a physician or nurse practitioner to adopt EHR can range from \$37,000–\$63,000.<sup>3</sup> Accordingly, alliances are considered as lower-cost alternatives to purchasing healthcare IT alone.

Although these alliances are generally crafted around positive benefits such as cost reductions and the need to become clinically integrated, there are potential pitfalls. Specifically, if the alliances do not work out, ownership and control of the data must be fully understood, and both parties should agree to a well-defined exit strategy.

A hospital, for example, may offer an EHR to its nonemployed medical staff at a very attractive price. However, the medical practice can never own and operate the system independently because the hospital will likely contract with an acute care vendor that does not sell products to ambulatory practices. Even if the hospital agrees to return the practice's data should the arrangement not

work out, the practice will probably not be able to read it without the hospital-provided software application. Further, the data is unlikely to be easily transferable to another EHR.

Accepting EHR donations can also be problematic if you have to cover more than one hospital or plan to develop your own ancillaries. Hospitals will often design their community EHRs to optimize the use of their services and will not support interfaces to other entities or devices, such as a neighboring hospital or your own radiology department, as doing so would be counterproductive to increasing their revenues.

## **Case Studies**

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The following two case studies illustrate real examples of IT collaborations and alliances. The first is Sentara Healthcare, a large integrated delivery network (IDN) located in Southern Virginia. The second involves nine private group practices that came together to form a network for management services and shared IT infrastructure. In both cases, outside professionals such as consultants, attorneys, and industry advisors were enlisted in the formation of these entities. Additionally, each organization made considerable resource and staffing commitments.

### ***Case study 1: Sentara Healthcare***

Sentara Healthcare is a \$28 billion nonprofit IDN located in the southern corner of Virginia, called the Tidewater area. Sentara consists of seven hospitals, 10 long-term care facilities, 300 employed physicians, and a 312,000-member

health plan. Sentara has enjoyed a 13.5% compounded annual growth rate in top-line revenue.

Immediately following Y2K, Sentara executives directed their IT resources to investigate the value of implementing computerized physician order entry (CPOE) within the health system. The logic for the initiative was typical of the time: to reduce errors, improve legibility, reduce the “hunting and gathering” of information that occurs on the units, and improve handoffs between caregivers.

Sentara’s philosophy was that implementation/transformation began as soon as the idea for change was initiated. Hence, the selection/review process had high participation, involving approximately 2,400 employees and 600 physicians. The methods used to review solution sets were somewhat unique as well. In lieu of the typical request for proposal process, Sentara used a series of “screens” or preestablished criteria to help narrow the field of vendors. Requests for information and educational demonstrations were used to initiate the process, but the centerpiece to the Sentara review focused on several clinical scripts from which vendors needed to strictly demonstrate their product’s functionality. These scripted demos were then videotaped so that Sentara could compare the solution sets provided by the vendors for each clinical transaction side by side. Sentara ultimately chose Epic Systems Corporation as its vendor.

As a result of this review and analysis, Sentara dramatically changed its direction from pursuing a CPOE system to that of implementing an integrated EHR solution for the entire community because of the following perceived benefits:

- \$37 million in cost reduction and new revenue
- Decreased duplicate testing
- Reduced hospital lengths of stay
- Reduced adverse drug events
- Different skill mix for nursing units
- Reduced risk management claims
- Reduced payment denials
- Improved coding
- Reduction of \$20,000 per physician costs within a practice related to transcription, charts, supplies, and other expenses resulting from paper usage
- Improved medical loss ratio at the health plan

Creating a tightly knit technical environment among primary care, specialties, hospitals, emergency departments, home care, long-term care, and the health plan makes the IT benefits more easily achievable. The ability to avoid technological isolation within the community, the robustness of the Epic software, and the ability to provide financial assistance to community practices make the broader implementation within the community-based practices both practical and reasonable.

Some natural forces were at play within the Tidewater community and the state of Virginia that pressured freestanding community physicians' practices to adopt Epic. Two of the larger IDNs within the state, Carilion and Bon Secours, have also selected Epic. Three of Bon Secours' hospitals are in the

Tidewater market, and discussions are underway among the three IDNs to tie the three Epic implementations together to help achieve some level of interoperability, which makes good business sense and better serves the patients and communities in the area.<sup>4</sup>

### ***Case study 2: Women's Healthcare Network***

Women's Healthcare Network, LLC (WHN), a Kansas limited liability company, is an association of nine independent physician practices in the specialty of OB/GYN. Since 1996, WHN has provided physicians in the Kansas City metropolitan area services that are designed to bring efficiencies and cost savings, while the practice focuses its attention on providing quality patient care. Today, WHN is recognized as one of the premier physician organizations in the area.

Its story began in the mid-1990s: Managed care was growing in the Kansas City market, and physicians were beginning to understand that a downward spiral in income was imminent. While hospitals were aligning themselves and positioning for market share, physicians overall remained status quo and reactive. They understood that something needed to be done, but they were unsure in which direction to go.

WHN evolved when leading practices in OB/GYN came together to find solutions to common problems. Because revenues were going down, costs had to be reduced as well. Therefore, the group formed a centralized billing office, which today processes about 14,000 claims per month. Instead of buying professional liability insurance separately, the group came together and purchased

the insurance through a common source, saving close to \$30,000 per physician in one year. Instead of purchasing separate computer systems and software, the group agreed to use the same practice management system. An automated system to call and remind patients of upcoming office visits led to decreased “no-shows” and cost savings.

Today, WHN is introducing a new practice management and EHR system to its practices. Armed with this integrated technology, the practices are evaluating work flows and redesigning internal systems to allow for more efficiency to the patient care experience.

WHN engaged The Coker Group to develop a specialized contract based on project goals and objectives and to negotiate with the vendor. The contract had to be modified significantly based on the unique delivery model and the caveat of having a shared system.

Although the practices remain autonomous and operate independently of each other, all practices benefit, regardless of their size. Each practice pays a proportionate share of the expense, based on the number of physicians in the practice. As a result, all practices are able to purchase quality technologies and gain benefits in price, services, training, and support.

WHN operates as a “hub and spoke” network. As the hub, WHN has purchased the necessary server technologies to allow it to host the practice management and EHR software applications that the network practices will be using. Because each practice site will access the servers through a central site,

they do not need to purchase their own servers, resulting in a significant savings.

The central site brings added value as the network uses a cohosting technology site, where premises security, fire protection, environmental controls, Internet access, and utilities safeguards are available. In most cases, it would be cost-prohibitive for a medical practice to build or have available similar safeguards for its IT equipment and data depository.

IT staff expertise is a shared expense, too. As most groups could not afford an internal IT staff, WHN makes the IT support available to all of its affiliated practices. This has led to identifying common problems and developing training solutions among the groups.

Although reducing expense is a prime factor for groups coming together, it is the ability to tackle difficult problems and bring more resources to those problems that is not otherwise available to individual medical practices.<sup>5</sup>

## Summary

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None of the alliances discussed in this book can be successful without an IT strategy. As with any new trends, the laws and best practice models regarding how to form these entities and how to pay for them tend to lag behind their availability. Unfortunately, this gap can create some barriers to adoption. This is especially true when it comes to sharing IT systems, as there is generally a

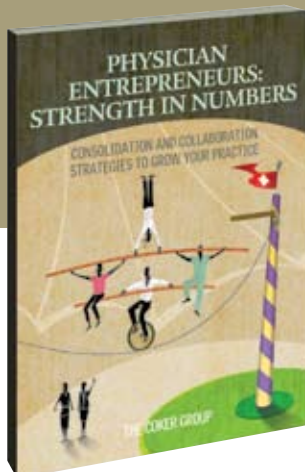
significant financial investment for which scrutiny often follows, particularly for hospitals offering EHR to its nonemployed medical staff.

Alliances formed around technology should be well thought out and weighed against the risk and the benefits. As with any partnership, terms and conditions must be understood and there should be some room for flexibility. IT is rapidly changing and so are the policies and laws that govern our utilization of these systems. For those who are comfortable with sharing resources and are willing to accept certain tradeoffs, these alliances are worth considering and they provide considerable cost reductions when managed correctly. Those who require more control or have strategic endeavors that do not support collaboration are not likely to be good fits for these types of alliances.

## Endnotes

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4. Case study contributed by Bert Reese, CIO, VP of Sentara Healthcare, and Elise Spoto, director.
5. Case study contributed by Gary Stanton, executive director, Women’s Healthcare Network, LLC.



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