

# Network Collaboration of an Academic Institution and a Community Health Organization

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Academic radiology has experienced significant economic pressures over the past decade. In response to increases in imaging studies and costs [1], with research showing little added clinical value [2], insurance payers curbed utilization by implementation of preauthorizations and radiology benefits management [3]. Additionally, government and private insurance payers have systematically reduced their payment schedules for professional and technical services for radiology [4]. As a result, imaging services peaked in aggregate cost and utilization in 2008, then decreased from 2009 to 2013 [5]. After the introduction of health care reform, the traditional fee-for-service reimbursement model is being dismantled and increasingly replaced by value-centered alternative payment models [6]. Meanwhile, faculty compensation has remained generally steady [7].

In response to these economic pressures, academic centers are strategizing expansion into the community [3], moving away from the traditional “ivory tower” model. Economies of scale are realized by serving a larger patient base without a full capital investment, therefore reducing cost per procedure. This expansion aligns with aims of health care reform by seeking to increase patient access in expanded geographies, reduce disparity by

offering subspecialty radiology services to all served populations, and improve clinical outcomes such as earlier cancer detection and diagnosis of breast cancer. The overarching goal of this strategy is to bring value to the community.

Compared with classic brick-and-mortar and acquisition expansion replicas, partnership-based models represent a new strategy for community expansion [3].

## WHAT WAS DONE

The University of Texas MD Anderson Cancer Center (MD Anderson) has strong oncology service line brand recognition. Since the survey was launched in 1990, MD Anderson has been ranked the number 1 hospital for cancer care in the nation by *U.S. News & World Report's* “Best Hospitals” survey 11 times over the past 14 years [8]. With a large national and international reputation for clinical excellence and novel clinical trials for cancer care, MD Anderson has established a large national and international clientele and referral base.

Market analysis demonstrated that only 15% to 20% of the Houston breast cancer cases were diagnosed by the radiology department at the MD Anderson main campus. The majority of these patients were previously diagnosed with cancer coming for treatments or

second opinions. Specifically, patients in the outskirts of Houston would come to MD Anderson for a second opinion but pursue their care closer to home. For patients to come to the MD Anderson main campus, they would have to deal with the commute time, often involving traffic from the suburbs, and cost of parking. In surveys, patients voiced their preference for local convenience and access as opposed to coming to the main campus in the heart of the city.

The mission of MD Anderson is to eliminate cancer in Texas, the nation, and the world [9]. To achieve this mission, a cultural focus shift from strictly treatment to prevention was needed. The value equation has changed, looking toward population health and accountable care organizations. Shifting upstream was necessary to open direct access channels to patients in the community. Geographic access is associated with increased screening mammography by patients [10]. Locating closer to primary physicians and obstetricians/gynecologists in a familiar and convenient location was strategically prudent.

One expansion strategy would be for MD Anderson to follow a historical brick-and-mortar model [3] and build its own freestanding breast imaging centers. The Houston market is currently saturated with

health care systems, established practices, and referral patterns. A significant capital investment would be required to build these imaging centers, with time needed to establish new relations with referring physicians. Another model of expansion would be to acquire preexisting breast imaging centers, but this option would again require significant capital investment with associated risk of reduced downstream referrals [3].

Memorial Hermann Health System (MHHS) is a predominantly community-based health system that is the largest not-for-profit hospital system in Houston, Texas, and consists of 13 hospitals. The organization is nationally recognized as a leader in value-based care with the Memorial Hermann Medicare Shared Savings Accountable Care Organization, which in its first year of performance saved CMS \$58,000,000, sharing half of that amount with the government [11].

The key business strategy for MHHS in the collaboration was to leverage the MD Anderson brand name to develop business and grow volume in the Houston suburbs. Breast imaging services in the community setting are of relatively low margin but high visibility. With more than 100,000 women receiving screening mammograms every year in the Houston area under the MHHS umbrella, initial patient contacts are established. From screening, additional patient visits are generated from the breast imaging flow of diagnostic mammograms for recalls and breast intervention. If patients have a positive experience and stay for treatment, downstream revenue from surgery and oncology can potentially be realized by the organization. In addition, women tend to make health care decisions

for the rest of their families [12], which can generate more business for the organization.

The second strategy behind the collaboration for MHHS was the desire to consolidate interpretation of breast imaging across the MHHS Houston locations. Historically, professional services for breast imaging at MHHS were performed by three groups of private practice community-based radiologists as well as an MHHS academic partner. The business goals of all groups were not always aligned with the health system. Performance among the groups varied, with some degree of variation within groups. Some of these radiologists were not fellowship-trained in breast imaging, and some covered other subspecialties in radiology. Referring clinicians and patients in the community perceived that fellowship training reflected added expertise in breast imaging, similar to other subspecialties in radiology.

The novel option that was pursued was to collaborate with a preexisting community-based organization, MHHS. This is different from a traditional radiology department contracting with a Veterans Administration hospital because of subspecialty deployment coexisting with other radiology groups, with goals of service line enhancement and co-branding.

The timeline from strategic discussions to the projected start date required recruitment of 12 fellowship-trained breast radiologists in less than six months for five breast centers. All physicians were hired initially with a split of 80% clinical time and 20% nonclinical time. This rapid recruitment posed risks of understaffing resulting from new academic radiologists keeping up with workflow and overstaffing

secondary to lower volumes from decreased referrals. Credentialing was a major concern, as the new radiologists would need to receive privileges for both the academic and community-based organizations to practice. The credentialing could not be done concurrently, based on an agreement between both organizations.

The core challenge for the academic organization in the collaborative model was execution risk. The radiologists in the new community environment would need to acclimate to higher daily volumes and more efficient clinical pace with a larger percentage of screening examinations and lower percentage of diagnostic studies. The technologists and staff whom the radiologists would work with would be employees of the community organization. An effective shared approach to patient care and operational effectiveness would have to be a core commitment. The technologists would need to be taught and adopt the MD Anderson mammography, breast ultrasound, and MRI protocols. Follow-up mentorship and supervision by the radiologists would also be required.

The new referring physicians, especially the surgeons and oncologists, may feel threatened by the introduction of an academic physician practice in the new environment. Again, a shared commitment and culture aligned around optimization of patient care would have to be established. In multidisciplinary tumor boards, the academic radiologists would need to meet community expectations.

Another potential risk for the academic organization was brand confusion. To help standardize quality of breast imaging by the academic radiologists in the community to that

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