

SEPTEMBER 2011

# CREATING SUCCESSFUL MATERNAL FETAL MEDICINE PARTNERSHIPS



**THE CHARTIS GROUP**  
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For additional information or further discussion related to this report please contact the author:

Raphe Schwartz                      303.709.5576  
*Director*                                      [rschwartz@chartis.com](mailto:rschwartz@chartis.com)

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# Creating Successful Maternal Fetal Medicine Partnerships

Authored by:

**Raphe Schwartz, Director**

Children’s hospitals are facing a period of dramatic change that is causing many of these organizations to redefine their role and strategic direction in the areas of maternal fetal care and neonatology. Technology is allowing for more accurate *in utero* diagnosis of fetal anomalies and malformations while accountable care is compelling some large adult healthcare systems to invest in maternal and pediatric programs. Medical practice has also changed over the past twenty years such that high-risk mothers are now often transferred to centers with strong neonatal capabilities prior to delivery; in the past, many of these deliveries occurred in community settings and neonates were transferred to regional neonatal centers often found located within area children’s hospitals. The continued success of children’s hospitals increasingly depends on their ability to identify and manage the care of expectant mothers with high-risk infants. Children’s hospitals that successfully develop perinatal networks with their adult-care partners will be better able to screen expectant mothers with high-risk infants, thereby ensuring that these women receive the highest quality perinatal care while also securing their opportunity to serve as the specialty care provider for their infants. Children’s hospitals that do not join with partners to build perinatal networks may fail to thrive as they watch competitors strengthen their referral networks in perinatal care, grow their neonatal business, advance their pediatric surgery capabilities and eventually control fetal diagnostics and intervention across the region. Children’s hospitals have historically faced challenges in building regional perinatal networks independently; the most successful programs utilize collaborative approaches with university and regional health system partners. This paper describes the key success factors and approaches being used in developing successful MFM partnerships.

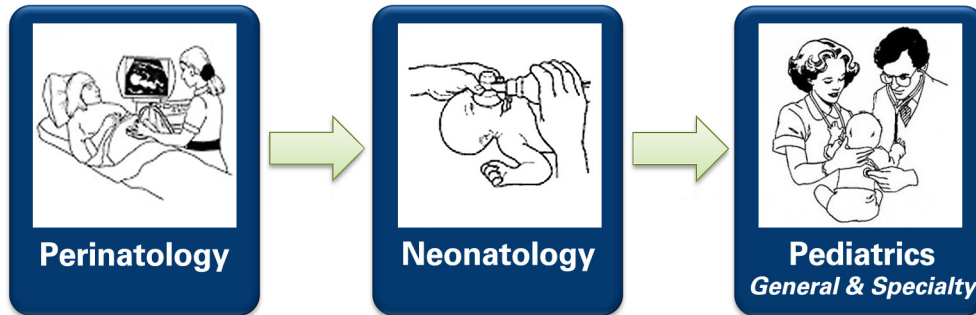
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## The Strategic Importance of Perinatology for Children’s Hospitals

Maternal fetal medicine (MFM) or perinatology is the branch of obstetrics that focuses on the medical and surgical management of high-risk pregnancies. MFM physicians have advanced their field dramatically over the past decade and can now identify expectant mothers carrying fetuses with anomalies and malformations more

accurately than ever before. MFM programs can drive significant patient volume and revenue to children’s hospitals. High-risk pregnancies generate a disproportionate number of complex neonatal admissions. Within 18 months of being born, infants treated in neonatal intensive care units (NICUs) frequently require follow-on care at pediatric intensive care units (PICUs) including pediatric surgeries and other complex treatments. MFM programs also drive significant numbers of sub-specialty consults (see Figure 1).

FIG. 1 **Downstream Impact of MFM Services**



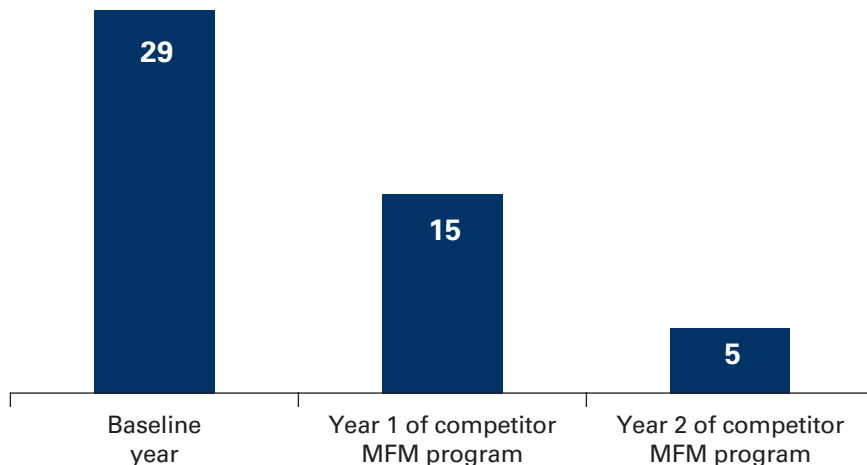
The regionalization of high-risk maternity care leads to regionalization of neonatal services where high-risk mothers and their infants are cared for together.

In many cities, health systems and their physicians have built regional perinatal networks that serve high-risk mothers, referring a percentage of these mothers to deliver at a facility positioned to provide complex maternity and neonatal care. The regionalization of high-risk maternity care leads to regionalization of neonatal services where high-risk mothers and their infants are cared for together. Maintaining access to high-risk mothers and infants is important to community health systems. Neonatology remains one of the most profitable service lines in healthcare, and community health systems value the impact that a strong perinatal program has on growing neonatal volumes and on the organization’s image and reputation in women’s health overall. The movement towards accountable care is also encouraging community health systems to expand their geographic coverage and aggregate hospital and provider scale through acquisitions and mergers. Large health systems able to assume accountability for outcomes and cost for an entire population will attempt to provide comprehensive services including perinatal, neonatal and pediatric programs. They will try to limit perinatal and neonatal referrals to high-cost children’s and adult specialty hospitals as they build their own networks (Figure 2).

As an example, one large regional health system has partnered with a national physician group to build a perinatal network of 10 MFM physicians and a dozen mid-level providers. They serve more than ten hospitals and many obstetrics groups in the region. This perinatal network, coupled with transfers from other hospitals within the same health system, has enabled this hospital to build and maintain an eighty-plus-bed NICU. The expansion of NICU patients returning for complex pediatric care has allowed the hospital to recruit and retain more specialists in highly profitable pediatric subspecialties. This hospital now has several pediatric cardiologists and cardiac surgeons, creating a barrier that discourages many parents from seeking

infant evaluations at other hospitals. This pattern is evident in several healthcare markets including Boston, Chicago, Dallas, Denver, Detroit, and San Francisco.

**FIG. 2 Case Example: Impact of a Regional MFM Network on Neonatal Transfers to a Children’s Hospital**



The freestanding organizational model of many children’s hospitals creates economic challenges that often dissuade children’s hospitals and adult hospitals from constructing perinatal networks.

### The Challenge of Going It Alone

The freestanding organizational model of many children’s hospitals creates economic challenges that often dissuade children’s hospitals and adult hospitals from constructing perinatal networks. Children’s hospitals that choose to independently make the entire investment to build a perinatal network will likely share the downstream benefits with adult hospitals, thereby diluting their return on investment. For example, adult hospitals will often treat very low birth-weight babies first identified by MFM physicians, with the adult hospitals accruing the financial benefit of these patients. Conversely, if adult hospitals make the entire investment, they may not be in position to treat nor realize the financial benefit from neonatal patients requiring surgery unless they have also invested in a neonatal surgical program. In addition, children’s hospitals do not typically have obstetrical departments or employ MFM physicians. As a result, independently building an MFM group often puts children’s hospitals into competition with their adult partners.

Children’s and university hospitals that have attempted to construct joint perinatal networks have encountered strategic and economic conflicts in several markets. Most university-employed MFM physicians have a balanced set of mission interests. While they perform top-tier clinical work, they also commit significant time to academic and research achievements, core elements of academic MFM programs. Building service-oriented regional MFM networks sometimes requires more clinically-oriented faculty. These physicians need to focus on geographic outreach and cultivate referring physician relationships and other referral channels in a broad region. Recruiting and retaining clinically oriented MFM physicians may also create compensation inequities. The average MFM salary in 2010 was above \$450,000<sup>1</sup>, significantly higher than average faculty pay at many academic medical centers.

Some children's hospitals are proceeding independently. While several children's hospitals deliver babies and others have tried to establish their own perinatal networks, both of these models encounter challenges. Children's hospitals that independently deliver high-risk babies in their own hospitals often do not have the scale to support the range of adult specialists required to care for expectant mothers. Children's hospitals that have substantial programs for healthy mothers and babies are sometimes perceived as competitors to adult health systems in the region that refer neonatal infants. Finally, children's hospitals that build their own perinatal networks without destination delivery programs miss the opportunity to deliver and treat infants that require non-surgical, but still complex, care which is often available at regional community hospitals.

## Children's and Adult Hospital Perinatal Collaboration: A Highly Effective Strategy

Several leading children's hospitals are exploring innovative approaches that clinically and financially integrate MFM and neonatal programs of children's and adult hospitals so they can jointly grow perinatal networks and expand fetal medicine capabilities. These collaborative programs are able to bring a full range of services to market faster than those developed by a single institution. The partnership approach can leverage the existing resources already in place. For example, many adult hospitals have initiated development of an MFM network while having the adult specialists available to serve at-risk mothers. Most children's hospitals are well-positioned to treat both fetuses and infants that require specialty care before and after birth.

When jointly developing the program as an integrated service line, both children's and adult hospital partners can often better justify the costly MFM physicians and other investments required to grow a perinatal network. As mentioned earlier, independently investing to build these programs is costly, and can result in insufficient returns on investment due to dilution of benefits to non-investing parties. Through affiliations, children's and adult hospitals can dramatically change the economics, merging the revenues and direct expenses for all maternal and neonatal volumes at both campuses. A joint program accrues all the revenues from obstetrics, perinatology and neonatology while funding the direct expenses associated with its patients. Determining which entity earns the revenues or expends the costs becomes much less important because the finances are accounted for jointly. The program's contribution margin can then be distributed in such a way that both the children's and adult hospital partners preserve their historic margins and simultaneously share in incremental profits.

However, economic alignment alone is not sufficient for these programs to succeed in the long term. The most critical success factor for both entities and their respective medical staffs is to define a shared vision and objectives for such a program at the outset. Achieving consensus on the vision and strategic direction and understanding the potential benefits and risks for each participant is perhaps the most important milestone in establishing these joint programs. Together, the parties must agree on the scope, size, approach, and investment required to construct the perinatal network

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and recruit the needed specialists. They must jointly identify and pursue geographic, hospital and physician group relationships for outreach and perinatal agreements.

Once the vision and strategic direction are determined, the specific financial model for the relationship should be established. While each collaborative we have helped to establish is unique, our experience has shown that there are six fundamental economic principles that should be considered to achieve both parties' financial objectives and enable long term success:

**Economic neutrality** – Revenue and direct expenses for qualifying patients in the program should be combined. This approach enables the partners to jointly accrue all the margins and makes it easier to make significant investments in building a robust MFM network.

**Retention payment** – Each party receives an annual retention payment from the program's proceeds equal to the historical value each entity brought to the partnership. The joint program returns a contribution margin equal to each party's combined obstetrics, perinatology and neonatology historic program contribution margins.

**Future Investment** – The joint program must reinvest a meaningful portion of the remaining contribution margin into strategic investments. A co-managed oversight body for the program determines how to allocate funds to recruit MFM, fetal, and pediatric physicians and to make other investments to strengthen the venture. Both parties should be committed to building recognized perinatal and neonatal centers of excellence.

**Repayment of new capital** – The oversight body is also responsible for sourcing capital necessary to expand the program. Investments could involve new technologies, new facilities or other capital needs. Given that these capital investments will be used to earn the joint program incremental margins, the joint program should repay the investing party.

**Sharing of growth** – After the joint program has repaid historic contribution margins and capital investments and has invested in its strategic growth, both parties should share in the remaining margins at an agreed upon percentage.

**Sharing the risk** – The parties may need to make significant programmatic investments in the early years to develop the regional perinatal network. If the joint program does not have a sufficient contribution margin to repay capital or make historical retention payments at 100% during this development period, payments should be made at the same reduced percentage and differences should be carried over to succeeding years until paid in full.

Once the parties become partners focused on strengthening the program's overall financial performance, the organizations are liberated to optimize clinical decision making and quality. Hypothetically, the parties may decide that very low birth-weight (VLB) babies have better outcomes at the adult hospital. Rather than transferring incoming VLB infants to the children's hospital, the parties could decide to admit them to the adult partner hospital. Similarly, there may be other cohorts of patients that have better outcomes at children's hospitals; this economic model encourages patients with these conditions to be consolidated there.

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## Making the Move

Children's hospitals that develop robust perinatal networks in partnership with adult hospital partners can use these strategic and economic principles to rapidly regionalize perinatal and neonatal care. Collectively caring for high-risk mothers and infants will also allow the parties to advance fetal medicine capabilities while growing pediatric surgery and intensive care programs. Children's hospitals can no longer rely on downstream referrals from area NICUs as their only introduction to complex neonatal patients. They must use collaborative MFM networks to develop prenatal relationships with families and more rapidly identify complex neonatal patients early, allowing them to better retain and serve these patients in their programs.

Children's hospitals can no longer rely on downstream referrals from area NICUs as their only introduction to complex neonatal patients.

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**Boston**  
60 State Street  
Suite 700  
Boston, MA 02109

**Chicago**  
220 West Kinzie Street  
5th Floor  
Chicago, Illinois 60654

**New York**  
140 Broadway  
46th Floor  
New York, NY 10005

**San Francisco**  
1 Market Street  
36th Floor  
San Francisco, CA 94105

877.667.4700  
[www.chartis.com](http://www.chartis.com)