

# A Strategic Perspective on Physician-Hospital Alignment

**A successful strategy to align physician and hospital interests starts with an overarching goal with four components: quality improvement, patient satisfaction, growth, and productivity.**

Physician alignment is a key strategic issue for most if not all hospitals today, and it will remain so for the foreseeable future. Although many prescriptions have been offered to strengthen the physician-hospital relationship and align the interests of physicians and hospitals more closely, virtually all fall short because they seek operational as opposed to strategic fixes to a complex, long-term problem. As a result, they address the problem too narrowly, focusing only on money and short-term solutions such as equity joint ventures and pay for call. Taking a step back to assess underlying assumptions about the “problem” would help many hospital leaders take a better run at a solution.



## Counterintuitive Assumptions

Strategy is at least as much art as it is science and therefore must be based on assumptions. Most executives are adept at discussing “fact-based” assumptions about such things as physician supply and payment, and these are important to the planning process. But qualitative assumptions are important as well. Executives who are developing strategies for physician-hospital alignment may want to consider the following strategic-level conclusions we’ve drawn from working with physicians and hospitals.

- Forget about loyalty. Physicians have their own problems regarding income, trust, respect, and time. Accusing them of disloyalty is like rearranging the headstones in a cemetery; it won’t accomplish anything positive, and it is likely to annoy the residents.
- Hanging out a shingle is no guarantee of referrals, which, for the most part, are still based on the decades-old premise of the “three As.” If a physician expects to be busy, she had better be able, accessible, and affable, not necessarily in that order.
- If it’s ambulatory, it’s fair game. There is no 11th Commandment dictating that certain procedures can only be done by the hospital. Physicians are moving into ambulatory care because they need to replace some of the revenues they have lost to changes in government reimbursement.
- From a physician’s perspective, physician-hospital business initiatives frequently have little to do with the expected revenues. Think about it: Would you be excited about a single-digit, pretax return on a risky investment? More often physicians are driven by productivity, convenience, decision-making involvement, and quality improvement as their motivation for initiating new ventures.
- It has been estimated that as much as 50 percent of patient care is suboptimal. If that’s even half true, then someone somewhere is messing up, and the chances are good that

one or more of those “someones” is in your hospital. Too many hospitals spend too much time reading their own press releases about quality of care, and not enough time identifying and fixing problems.

- “Medical staff structure” is an oxymoron. There is virtually no command-and-control in place and, as every hospital executive knows, not even much communication across the medical staff.
- No one individual speaks for the medical staff. Too often, hospitals fall into the trap of believing the opposite. They think that if they develop strong relationships with key physicians, the rest of the medical staff will follow their lead.
- Adding more physician board seats may be a good thing for providing clinical insights, but it is not a cure-all for resolving all physician-hospital issues, and it can create conflict-of-interest problems.
- Despite many executives’ claims to the contrary, many if not most physicians are willing to help the hospital. They just need to be sure that the time they spend on this activity will also enhance their practice, assist their patients, or improve the overall health of the communities they serve.
- Physician “volunteer time” is increasingly an anachronism.

Once they have defined their qualitative and quantitative assumptions, hospital executives should be in a better position to develop their own approach to improving physician-hospital relationships.

## A Comprehensive Approach

Strategy is focused on achieving an end game or vision. Hospital leaders should consider adopting an overarching

- vision for physician alignment that has four components:
1. Quality improvement: relentlessly improving the quality and safety of patient care
  2. Patient satisfaction: continually delighting patients and families
  3. Growth: increasing volume
  4. Productivity: maximizing efficiency and margin

With an overarching vision for physician-hospital alignment in place, successful models of alignment can be developed around the following six components:

**1. Clinical priority setting.** It is becoming increasingly difficult for any hospital to be all things to all people, and no one hospital is going to be the best at everything. Hospitals should engage their physicians in specialty-by-specialty clinical assessments to identify anticipated changes in clinical practice and to set priorities for quality improvement, patient satisfaction, growth, and productivity. These assessments should also address the resources (buildings and equipment, physician recruitment, support staff, etc.) required to support the clinical priorities.

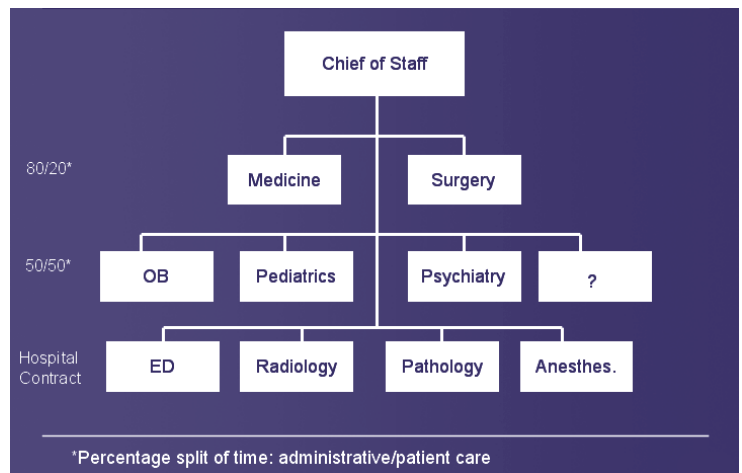
**2. Customer support.** Most if not all hospitals could do a better job of assisting physicians in their efforts to efficiently provide the “best” possible patient care. A physician customer support plan that accounts for the diminished presence of primary care physicians in the hospital and the growing roles of physician extenders, hospitalists, and intensivists is required. Fixing the disarray that exists in most operating suites is one example of an opportunity for the hospital to improve physician productivity. Another good example of the type of support hospitals should provide is the timely provision of information in the patient chart.

**3. Hospital clinical leadership.** The existing medical staff leadership structure is an artifact of the 1950s that, on average across the country, probably rates a gentleman’s C. Most medical executive committees (at least in private with the tape recorder turned off) will admit that there is room for improvement in their primary job of credentialing, privileging, and peer review.

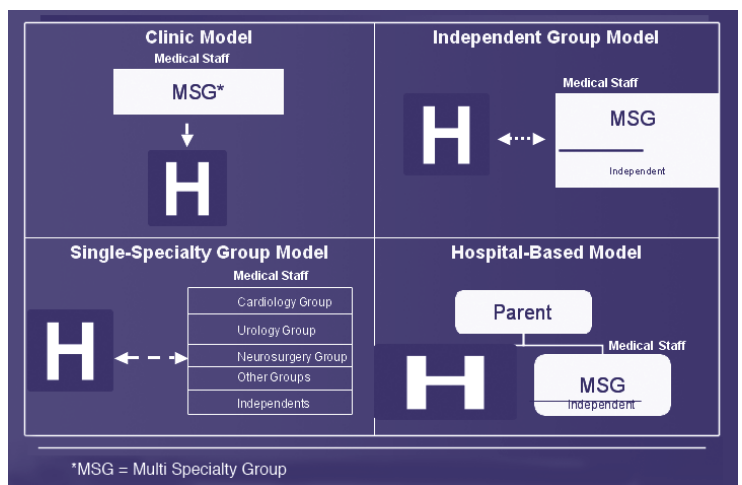
Hospitals need to assess their current situation and develop more suitable leadership models for the future. In many hospitals this reassessment is likely to lead to a structure such as that depicted in Figure 1, where at least the medicine and surgery chairs are employed on a full-time basis by the hospital, with a negotiated allocation of department chair time between administration and patient care.

**4. Physician recruitment and employment.** Boomer physicians are aging, and those coming out of training are seeking a balance between lifestyle and work. Simply stated, they do not want to be entrepreneurs engaged in running a business; they want to be good clinicians with secure employment. The era of the independent physician who provided services to the hospital on a voluntary basis is in its twilight. Over the next five to ten years, physicians will increasingly transition from small, mom-and-pop entities to single-specialty and multispecialty group practices.

**Figure 1. A Medical Staff Employment Model**



**Figure 2. Four Medical Staff Organizational Models**



Accordingly, hospitals will need to select the organizational model(s) they believe will be most successful (see Figure 2) while developing a transition plan that continues to embrace and support those physicians who wish to remain in private practice. These are typically older, well-established members of the current medical staff.

**5. Contracting and practice support.** Regardless of the employment model of the future, each hospital needs to have an appropriate mechanism for joint insurance contracting with physicians, such as a Physician-Hospital Organization. For those physicians desiring it, the hospital should also consider providing practice support services through a Management Services Organization that provides, for example, financial services, information technology support, and staffing and scheduling assistance.

**6. Business ventures.** Hospitals have many opportunities to enter into risk/reward arrangements with members of their medical staff through such vehicles as economic joint ventures and participating bond transactions. Although these should not be assumed to be the best solution to every problem, hospitals should have a clear understanding of what is in the toolkit and when a particular tool is suited to a particular job.

*continued on page 6*

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(continued from page 5)

### The Role of Governance

For executives to address physician alignment issues without appropriate involvement of the hospital's trustees is potentially a career-limiting decision. Additionally, and perhaps more importantly, because the board is ultimately responsible for quality and patient safety, it needs to be appropriately involved.

Trustee education about physician-hospital issues is important, but insufficient. Trustees must also create governance policies that clearly articulate the board's expectations regarding, for example:

- The desired state of hospital-physician relationships in general.
- A definition of physician conflict of interest and expectations of management regarding competition from physicians.
- The belief that physicians and other clinicians should be the drivers of quality and patient safety goal-setting and improvement efforts.
- An assertive stance on recruitment, stating that the needs of the community for additional services and physicians will always trump the competitive concerns of incumbent physicians.
- Physician employment options, advocating a triple-option approach: (1) right of first refusal to incumbents who want to add partners; (2) start-up support for physicians seeking it; and (3) hospital-based employment as required.
- Physicians' role in governance (e.g., service on boards and committees, role of the chief of staff in governance, qualifications for board and committee service) and in other decision-making processes.

In summary, the root causes of misalignment between physician and hospital interests are many, and none are going away soon. Physician shortages will be with us for at least the next ten years, the federal government won't be increasing payment per increment of service anytime soon, and clinical innovation is expected to continue apace. Acute interventions are sometimes necessary, but they need to be undertaken with the understanding that the situation they are addressing is chronic. Chronic conditions are complex, so their resolution requires an accurate assessment by a multidisciplinary team that includes trustees, executives, and physician leaders. Physician-hospital alignment strategies must be developed with participation from all the members of the team. 

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### April 16

Webcast: "The Best of the Annual Conference Series: Internet Update for Senior Healthcare Professionals"

### April 30–May 2

"Essentials of Healthcare Marketing,"  
Wyndham Chicago Hotel, Chicago

### May 1–2

"Essentials of Healthcare Strategic Planning,"  
Wyndham Chicago Hotel, Chicago

### May 1–2

"Essentials of Healthcare Communications and Public Relations," Wyndham Chicago Hotel, Chicago

### May 12

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### May 12–14

New! "The 2.0 Series: Raising the Bar in Healthcare Strategic Planning Performance,"  
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### June 2–15

SHSMD U: "Healthcare Advertising: Strategies for Success" (online course with 24/7 access)

### June 11

Webcast: "The Best of the Annual Conference Series: Creating a Patient Feedback System"

### July 15

Webcast: "The Hot Topics Series: Structuring and Communicating Transparency"

### August 26

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### October 2

Webcast: "The Hot Topics Series: Using Communications to Manage Customer Loyalty"

### October 27–November 9

SHSMD U: "Healthcare Strategic Planning" (online course with 24/7 access)

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