

# Aligning Hospitals and Physicians: Formulating Strategy in a Changing Environment



Structuring healthy partnerships between hospitals and physicians has become an imperative for hospital/health system boards and executives. This special section covers specific considerations related to aligning hospitals and physicians:

- The major forces reshaping the traditional relationships that have existed between hospitals and physicians
- The need for hospitals to re-examine some traditional thinking about hospital–physician relationships and the benefits of increased alignment
- Leading-edge hospital/health system alignment strategies
- Building on a foundation of mutual trust to frame a true strategic approach to planning

The following is an excerpt from The Governance Institute’s Fall White Paper: *Aligning Hospitals and Physicians: Formulating Strategy in a Changing Environment*.<sup>1</sup> The white paper will be released in early November.

## Understanding the Changes in Hospital–Physician Relationships

The days of loose cooperation—and sometimes competition—between hospitals and their medical staff members in private practice are quickly coming to an end. Only hospitals that are tightly aligned or integrated with a critical mass of physicians will be able to organize their delivery system to meet payer/consumer demands for price, quality, efficiency, and community service. Hospitals that lack a strong relationship with a group of aligned doctors will not survive on their own.

Alignment means that the traditional relationships and structures connecting hospitals and physicians must change, from loosely coupled to tightly coupled arrangements. Organized delivery systems will need physicians—whether they are employed, contracted, or independent—who are aligned with the system’s hospitals and other physicians.

Employment of physicians by the hospital or a hospital-owned medical group can facili-

**Hospital–physician alignment:**  
a close working relationship in which a hospital and physicians place a priority on working toward common goals and avoiding conduct that damages the other.

tate—but does not guarantee—alignment, nor is employment the *only* way to align with physicians. Joint ventures, professional services agreements or contracts, medical directorships, and physician–hospital organizations also offer the ability to align with physicians to varying degrees.

*Behavior*, rather than structure, defines whether a hospital or health system and a physician or physician group are aligned. Alignment exists when:

- Physicians, other clinicians, and managers subscribe to and practice according

to common values such as respect, trust, collaboration, and commitment to excellence.

- Physicians and the hospital or system share a common vision they developed together.
- Physicians are *actively* engaged in leadership roles in organization-wide strategic planning and in planning or co-managing hospital product and service lines.
- Physicians *actively* participate in programs to increase hospital efficiency including timely turnaround of test results and operating rooms for physicians, and lower lengths of stay and resource use. These efforts include an effective hospitalist program.
- Physician compensation is based on their productivity, participation in organizational leadership, and achievement of *shared* hospital/physician economic and quality goals.

<sup>1</sup> The white paper was written by Governance Institute advisors Barry S. Bader, Edward A. Kazemek, and Pamela R. Knecht, with additional contributors: Dan Grauman and John Harris of DGA Partners, William F. Jessee, M.D., FACMPE, Medical Group Management Association, and Governance Institute advisor Donald W. Seymour of Don Seymour & Associates.

- Physicians can recruit new colleagues without taking financial risk. The hospital can legally implement programs that help physicians achieve economic security, reward them for productivity and quality, and help them live a more predictable and balanced professional and personal life.
- Physicians and hospitals take responsibility to help each other comply with quality and safety standards and implement best practices.
- Physicians keep patient referrals within the system as much as possible.
- Physicians and the hospital can bid for and manage bundled payments, and they participate together in pay-for-performance arrangements.
- The formal medical staff leadership structure is populated by aligned physicians.
- Patients are managed seamlessly across the continuum from physicians' offices to the hospital.

The challenge for a health system or hospital is to attract a critical mass of aligned physicians to fulfill its mission and sustain financial viability. To do that, boards and executives need to look at the world through a physician's eyes and offer an alignment model or options that meet physicians' needs. Otherwise, their efforts at alignment will look like veiled attempts to "control" doctors and meet with little enthusiasm.

If hospitals and physicians are to move toward greater alignment, each will need to reassess old economic assumptions and adopt fresh approaches based on new realities. They will need to:

- Alter hospital-centric thinking to understand the perspectives of three different components of their medical staffs.
- Draw lessons from failed hospital efforts to employ physicians.
- Think about physician alignment as a multi-faceted set of strategies, not a single, one-size-fits-all program.

## Understanding Different Segments of the Physician Population

In developing strategies to better align hospital and physician interests, it is useful to

segment the physician population into sub-groups.

### "Hospital-Dependent" Physicians

These physicians practice primarily within the walls of the hospital and are most economically dependent upon the hospital. This includes physicians in the traditional hospital-based specialties (anesthesiology, emergency medicine, pathology, radiology); those in newer hospital-based specialties (hospital medicine, critical care medicine, neonatology); and a variety of physicians who are either employed or under contract to provide medical director services to various hospital departments or units (for example, the ICU medical director). It can also include a variety of physicians of any specialty who are employees of the hospital. Many hospital-dependent physicians are formerly independent practitioners who have sold their practices to the hospital (or a hospital-owned subsidiary) and have elected to become employees—often in response to the economic pressures discussed earlier.

The economic fate of these physicians is deeply enmeshed with that of the hospital. Accordingly, they have a strong interest in the hospital's economic success and, as a result, are more likely to be actively involved in hospital initiatives designed to improve safety and quality, reduce waste, and enhance patient satisfaction. Their involvement can be incorporated into their compensation plan or contract, so they are not penalized for taking time from their practice.

### "Hospital-Independent" Physicians

This segment consists of physicians who spend a substantial amount of their professional time caring for hospital inpatients, but who also have extensive office-based practices. Often, these physicians will have privileges at several hospitals, but will generally concentrate most of their admissions in one.

A number of specialties are common among this group, and all of them are characterized by a substantial degree of economic dependence on their office-based practices, as well as a need for access to a hospital (and sometimes an ambulatory surgical center) in which they perform procedures. Examples include physicians practicing orthopedics,

cardiology, otolaryngology, gastroenterology, pulmonary medicine, and obstetrics and gynecology.

"Hospital-independent" physicians are particularly concerned with the efficiency with which their time at the hospital is used, because much of their income depends upon their availability to see patients in their office. They may be particularly difficult to convince to take hospital emergency call without compensation—having to leave their office to see a patient in the hospital can both reduce their income and produce significant problems with patient dissatisfaction. They also are reluctant to commit time for activities such as medical staff governance, peer review, and quality assurance because every hour they volunteer is an hour unavailable for income production or family time. Their loyalty to the hospital is particularly tenuous. If they are unhappy with the hospital, they may threaten to move their patients to a competitor.

### "Completely Office-Based" Physicians

A third distinct sub-group includes physicians who rarely if ever provide care to hospital inpatients. This segment includes a steadily increasing proportion of primary care physicians (internists, family physicians, and pediatricians) as well as physicians in a number of other specialties (dermatology, psychiatry, allergy, occupational medicine, etc.).

While these physicians usually have privileges at a hospital, they are rarely seen at the hospital and have little or no significant involvement in medical staff governance, peer review, or quality assurance activities. As many as 38 percent of physicians fall into this group.

For these physicians, the hospital is not particularly important to their practice; accordingly, they are unlikely to want to invest time and energy into hospital activities. However, integrated delivery systems need a critical mass of aligned, primary care physicians to attract patients, manage care, and drive referrals to their specialists. Hospitals cannot contract with employers or health plans to fully manage a patient population without an aligned primary care network. Therefore, some hospitals will need to attract some completely office-based physicians to a

hospital-owned setting or network. Hospitals cannot ignore the needs of this group.

## Aligning Hospitals with Diverse Physician Groups

Each of the three segments of the physician population requires a very different approach to achieving alignment with the interests and needs of the hospital. Perhaps the most easily “aligned” interest group is the hospital-dependent physicians. Whether they are employees or contractors, they depend on the hospital’s success for their own economic and professional success. This group can usually be tapped for leadership positions in hospital clinical governance, quality improvement, and patient safety.

Achieving alignment with the “hospital-independent” group can be more challenging. The primary objective of these physicians is the business success of their own practices, and while the hospital may be an important factor in that success, it is definitely in a secondary role. These physicians are also most likely to become hospital competitors as they strive to develop new revenue streams in response to the continued downward pressures on their own fees. It is common for physicians in this group to add ancillary services such as imaging and other diagnostic testing to their practice, thereby attracting revenues to their practice that were previously going to hospitals.

The entrepreneurial spirit is strong among these physicians, and they may become investors in ambulatory surgery centers, specialty hospitals, and other specialized treatment facilities that compete directly with general hospitals. In addition, they are not hesitant to threaten to move its business elsewhere—and sometimes will carry through on the threat—if the hospital makes decisions that they feel infringe on their professional autonomy or adversely affect their practice.

The same entrepreneurial spirit that may pose problems for the hospital should these physicians choose to become competitors may also offer unique opportunities for the creation of “win/win” business partnerships. For example, joint ventures between the hospital and physicians from this popula-

tion are becoming increasingly common. If a joint venture is created with a selected group of physicians, there may well be a backlash from other physicians who see themselves as disadvantaged by their exclusion. Further, the complex web of laws and regulations governing such ventures makes good legal advice on their creation essential.

### Achieving strategic alignment between a hospital and physicians

- Learn as much as possible about the economics of physician practices.
- Develop segmented strategies for different physician sub-groups based upon their economic interests.
- Look for opportunities to create initiatives that are “win/win” for both physicians and the hospital.
- When launching joint ventures with select physicians, anticipate and proactively manage opposition from physicians who are not involved in that venture.
- Communicate to excess.
- Develop relationships with administrative leaders of physician groups.

The “completely office-based” physician group requires yet a different strategy to achieve alignment. Many of these physicians—especially underpaid and overworked primary care physicians including internists, family practitioners, pediatricians, and obstetricians—may be interested in selling their practices to the hospital and becoming hospital employees (moving them into the “hospital-dependent” category). But others will cherish their independence and require a different approach.

Strategies that may be particularly useful in achieving alignment with this physician population are those that can help them increase the efficiency (i.e., lowered operating costs) of their practices. Examples might include the provision of practice management services through a hospital-owned management services organization (MSO), access to hospital

purchasing contracts that offer favorable pricing, and assistance with electronic health records implementation in their offices.

## Case Studies of Hospital-Physician Alignment

The authors and the research staff of The Governance Institute interviewed leaders of hospitals/health systems at various stages of aligning their hospital(s) and physicians. From these interviews, the authors hypothesized an “Alignment Continuum.”

The continuum is designed to help leaders think about where they are today *vis à vis* hospital-physician alignment, where they want to be in the future, and the steps they should take together to achieve their shared vision.

Each of the health systems we examined is at its own place along the continuum, reflecting its community needs, market pressures, vision, and beliefs, but all have lessons to share.<sup>2</sup>

### Moving Along the Alignment Path: Hoag Memorial Hospital Presbyterian, Newport Beach, CA

Hoag Memorial Hospital Presbyterian in Newport Beach, CA has a more than 50-year tradition of a voluntary, independent, at-will medical staff. The hospital bases its physician relationship/integration on the traditional medical staff model; that is, independent practitioners join a medical staff and work through departments within the hospital. It has yielded a successful, symbiotic relationship over the years. The president and CEO, Richard Afable, M.D., attributes this success to “the quality of the physicians, the quality of the hospital, and trust.”

This model, although still necessary and important, is no longer sufficient to ensure long term success for the physicians and the hospital, according to Dr. Afable. “Today, in terms of aligning physicians, there is a recognition that we are at a point of transition,” says Dr. Afable. The elements of the transition are many, and involve complementing the existing model by opening a diverse portfolio of relationship arrangements to ensure sustainable, mutual success.

<sup>2</sup> Case studies have been abbreviated for this publication. Complete versions are in the white paper.

The state of California prohibits employing physicians, so different arrangements have been put in place or are in the planning stage—fostering good relationships with medical members; medical directorships for certain services; management/professional services agreements (often including on-call agreements) with private practice physicians for hospitalists, anesthesia, ED, pathology, and other hospital-based services; information technology cooperation; joint ventures; a hospital outpatient department; and, down the road, a medical foundation that will employ physicians.

**Alignment Continuum Diagram**  
Approximate Percentage of Active Staff Who are “Aligned Physicians”



### Key:

**Fully independent:** We function in separate worlds and sometimes/often compete. The hospital and physicians are fully independent both economically and organizationally.

**Cooperative and separate:** We get along most of the time and work together some of the time with most of our physicians, but have problems with competition and lack of physician engagement.

**Collaborating and more organized:** We're implementing a co-developed strategic plan to align our interests using various mechanisms, including physician employment, joint ventures, and professional services contracts. We have a policy to address physician competition.

**Partially integrated:** We have implemented a “preferred” alignment model and are far along toward engaging aligned physicians into system-wide strategic planning, co-management of clinical service lines, quality improvement activities, and joint contracting.

**Fully integrated:** The hospitals and physicians operate as a single integrated enterprise, with physician leadership and professional management, resulting in integrated strategic planning, financial incentives, quality goals, and contracting with health plans. The hospitals and physicians are tied economically and function in organized systems of care delivery.

What does Hoag do about medical staff members who compete with the hospital? “We are taking the high road as it relates to competition,” Dr. Afable says. A partnership relationship with the hospital is and will be a more valuable and sustainable model than doctors going into their own enterprise and, therefore, they would prefer to go *with* Hoag Hospital rather than compete with Hoag Hospital. “If they choose to compete, the hospital wishes them well and good luck.”

Afable cites two critical success factors for Hoag (and hospitals in general):

- *The hospital with the “most best” doctors wins*—not in the sense of victory vs. defeat, but rather in being able to maintain and carry out the hospital’s mission.
- *You have to give to get.*

Hoag Hospital works very hard at applying and building on these two critical success factors. It wants to have “the most best doctors” and plans to achieve that through “very generous arrangements with our physicians—arrangements that are legal, meet regulatory require-

ments, and align our mutual interests. *So we look for sustainable, mutual benefit in everything.*”

### A Pluralistic Approach: OhioHealth, Columbus, OH

“You can’t just have one alignment strategy, because you’ve got physicians of different ages working in different markets, feeling different pressures, so it can’t be one size fits all,” says David Blom, president & CEO of OhioHealth.

When Ohio’s certificate of need law was abolished in 1997, it opened the flood gates of competition and led OhioHealth into new directions in physician alignment and relationships. “We have about 10 joint ventures with physicians that are working quite nicely, ranging from surgery centers to urgent care centers to imaging, real estate, and sleep centers. That has proven to be a good alignment strategy.”

OhioHealth also has undertaken the following initiatives to more closely align the system with its physicians:

- Professional service agreements for hospital-based services
- Annual assessment of physician satisfaction
- An IT strategy developed with physician input
- Increasing number of employed physicians
- Physician governance as a key strategy (specifically to help define the performance and vision for employed physicians)
- Physician board members on the OhioHealth board of directors
- Clinical councils at some of its hospitals

OhioHealth’s approach to physician competition? Management takes a pretty hard line. Physicians who invest in and admit their patients to a specialty hospital are not granted privileges at OhioHealth hospitals. Management tries to work with physicians before the situation gets to the competition stage, and tries to offer something better or more secure than if they were to go out on their own.



Blom shares these critical success factors from OhioHealth's journey:

- Open, transparent communication.
- Understanding the pressures physicians feel, putting yourselves in their shoes, to stay half a step ahead of what the physicians need and want rather than being purely responsive.
- Looking for solutions that are flexible for the future, not just satisfying today's needs.
- *Trust is critical.*

### Using a Physician–Hospital Organization as the Centerpiece of Alignment: DeKalb Medical Center, Decatur, GA

In the mid-1990s, DeKalb Medical Center created a 50–50 joint venture hospital–physician network/PHO, explains Eric Norwood, FACHE, president & CEO. “We took a clinical integration approach,” working together on information technology, best practices, clinical performance targets, and so forth. About 80 percent of the physicians on the medical staff are part of the PHO, which is legally organized as a joint venture.

At one point, the hospital board decided to close the medical staff to new specialists and just use the PHO, but that proved “troublesome,” according to Norwood, because it sent a message to the medical community that the hospital was a closed shop. “This is the kind of disconnect that can happen if a board's strategy isn't clearly understood and related to integrating with physicians.” The medical staff was “reopened” in 2003.

The PHO established a foundation for working together that helped DeKalb executives think about other alignment strategies. It employs about 25 primary care physicians and a few specialists (a GYN/oncologist, two radiation oncologists, an endovascular surgeon, and four neurologists), and expects that number will grow. Employed physicians are assured of getting a seat in the PHO—that's one benefit of coming in as an employee of the hospital.

How is DeKalb addressing physician competition? Georgia still has a certificate of need (CON) law, but Norwood anticipates physician competition will grow anyway. Increasingly, physicians approach the hospital with propositions for joint ventures or other

business deals. To develop a more consistent and strategic approach, DeKalb engaged a law firm to develop a “playbook” of essentially a dozen generic models of how the hospital can work with physicians.

The board signed off on the playbook up front, and it gave the administrative/management team the ability to enter into an early dialogue with a physician or group of physicians who have an idea, or if management wanted to engage them in a joint venture, and thereby mitigate the alternative (competition). “This is serving us well,” Norwood says.

Competition is real. “We're not going to put handcuffs on the physicians and say, ‘stop competing.’ We would rather come forward with ideas that are in our mutual self-interest. Then when we go into a joint venture, physicians cannot have an interest in another competing venture. They have to choose, and we put it right out in front in the contract. That has been an acceptable solution for many of our physicians.”

### Increasing Reliance on Employed Physicians: Eastern Maine Medical Center, Bangor, ME

Eastern Maine Medical Center (EMMC) has a combination of relationships with physicians,” says Deborah Johnson, president & CEO. It began employing physicians about seven years ago, starting with primary care. Today, EMMC employs about 50 percent of the medical staff (about 240 physicians). Of those, there are 35 hospitalists, 18 surgical specialists (trauma, orthopedic, and general), and 20 other types of specialists. For adult intensivist coverage, EMMC contracts with a private pulmonary group for 24/7 in-house coverage, and employs intensivists for pediatrics and neonatal intensive care.

It has only one joint venture, a sleep lab, with a pulmonary group.

Among the non-employed physicians, there is some competition, even with Maine's CON law. A small surgical suite across the street from the hospital is owned by a group of orthopedic surgeons who all practice on the medical staff, and a large, private cardiology group provides basically a full menu of non-interventional cardiac diagnostic services.

“Obviously, trust is key,” Johnson says. EMMC has structured its relationships with employed physicians by setting them up with an identified lead physician in their practice, who works with the vice president for physician practices and the practice managers, and then heads a steering committee for that practice/group. The hospital tried to preserve as much participation and decision making (on the physician side) as possible, and the groups make their own hiring/recruiting decisions.

“The employed physicians are all on incentive plans, so we are very open and transparent with all of the financials associated with both the physician practice and the service lines,” Johnson says.

Management team and board communication with the medical staff also is very important. There is a patient care administrative liaison in addition to the vice president for physician practices. The hospital encourages some of the major service lines to have an annual strategic planning retreat. At those retreats, Johnson, the CMO, other chiefs or key positions, and other administrative staff go through a process of, “what's working, what's not, where are we going, and so forth. It gives them some high-level attention.”

### Physician Leadership of an Owned Medical Group: Aurora Health Care, Milwaukee, WI

Aurora Health Care (AHC) includes 14 hospitals in five regions in Wisconsin, a 750-member Aurora Medical Group (AMG), and affiliations with several other medical groups. AMG has approximately 115 different sites and is 55 percent primary care and 45 percent specialists. System wide, AMG accounts for 73 percent of AHC's volume.

In rural markets, AMG is multi-specialty and accounts for nearly all hospital volumes. In Milwaukee, AMG has mostly employed primary care practitioners (PCPs) because specialists have had less interest in employment there, so AMG's physicians refer to independent specialists with privileges at the system's two Milwaukee-area hospitals, St. Luke's and Sinai.

Aurora's physician alignment has been driven by an explicit strategic plan. The

number of physicians increased from 3 to 750 between 1992 and 2007, and AMG is now the largest non-academic group in Wisconsin and seventh largest in the U.S. AMG recorded 2.4 million patient visits in 2007 and total revenues of \$668 million in 2008.

Physician governance is an important element of AMG and is organized at three levels with successively broader physician involvement:

- The AMG board of directors with global governance authority and the policy setting body for the medical group. It includes 12 physician leaders as well as AMG's president (a physician) and vice president/chief operating officer, and Aurora's executive vice president & COO.
- A Physician Leadership Council that brings broad input/communication from 37 AMG physicians and AMG's administrative and operations leaders.
- Clinic Management Committees that provide local physician leadership at each site. These typically have an elected physician leader from the site and five to seven members elected from group, plus the site administrator as a non-voting member.

Dr. Eliot Huxley, retired senior vice president and chairman of the board of Aurora Health Care, identifies the following key elements and success factors for Aurora Health's physician integration journey:

- Vision that an integrated system "is a better way to provide healthcare"
- Paired physician/administrative leaders at every level
- Operational integration, built around IT, getting the right team in place, single practice management system, standardized processes, fee schedule management, staff FTE management, and a physician productivity initiative
- Developing a physician group culture built around quality and service standards, recruiting and retaining the "right doctors" aligned with AMG's values, setting and communicating expectations and AMG's philosophy to new recruits, and holding everyone accountable

### The Integrated Physician as Partner at the Table: Essentia Health, Duluth, MN

Essentia Health, based in Duluth, MN, consists of 10 hospitals, 700 fully integrated physicians (employed and through other means), and 14,000 employees spread among four regions in Minnesota, Wisconsin, and North Dakota. Legally, Essentia is a supporting organization with strong reserved powers over the entire health system. Integration and alignment are designed to extend throughout the system to all its corporations, physicians, and clinics, says Peter E. Person, M.D., CEO and chief architect of the strategy.

Essentia's strategy is based on its leaders' shared belief that full hospital-physician alignment, with a strong focus on integrated care management and coordination, is the only viable strategy for rural healthcare delivery. Person said that for Essentia and many other systems, the physician employment model will ultimately prove superior to what he calls the "portfolio of deals" model.

**Physician as partner:** All physicians are employed by the system via contract. Because everything is so integrated, physicians don't perceive they work for a hospital—"they see us like Mayo because physicians are in charge of the system and the group that employs them," says Person.

Person views what Essentia is doing as a radical shift in thinking about how to work with physicians in an integrated delivery system. It has been a culture change process based on the concept that physicians should be viewed *not* as employees, but as *partners*. As he puts it: "physicians make awful employees but great partners."

As partners, physicians are fully integrated into management and governance roles. The system strives for physicians to compose up to half of all boards (fiduciary and operating). After a number of years in practice with the system, a physician is *expected* to assume some type of leadership position in the system. Person recognizes that having a physician as CEO gives the system a leg up in establishing credibility with doctors that it's not out to "control" them. But that alone isn't sufficient. Having physicians move up in leadership roles through the system builds a shared sense of vision and goals and cements strong interpersonal relationships that in turn

facilitate integrated patient care and administrative processes.

Physician leaders (assuming they have the requisite management and leadership skills) bring an important, extra dimension to leading a health system that strives to be completely aligned with physicians. Above all else, "Trust is essential among the parties—without it, no arrangement will be successful," Person says.

### Common Themes along the Alignment Continuum

Each health system profiled here has moved to more tightly coupled arrangements over time. From their experiences, we draw the following common themes and lessons learned for others in search of increased hospital-physician alignment:

- Trust and shared values are the bedrocks for all forms of hospital-physician alignment.
- Quality improvement and patient-centered care delivery often emerge as shared, core values and as such, can be major focal points of activities designed to foster trust and increased alignment.
- To become more tightly aligned with its physicians, a health system's leadership should engage physicians in a process to co-develop a shared mission, vision, and strategic plan for increased integration.
- System and physician leaders should co-develop guiding principles to establish the structure and culture for integration mechanisms.
- More fully integrated systems have come to the conclusion that employing physicians in a group practice model, rather than having a "portfolio of deals" with aligned but independent physicians, makes it easier to align a myriad of operational and quality/safety activities.
- Many physicians are not ready to be employed by a hospital-owned group, but employment will be more attractive to physicians if they can join a "physician-led organization," with true physician leadership coupled with professional management.
- More fully integrated systems have extensive physician involvement in governance,

but they make a distinction between *board* governance (e.g., setting policy, establishing strategy, and making financial decisions) and *practice* governance (i.e., decisions affecting medical practice and operations).

- Integrated systems adopt system-wide measures of performance that are used for budgeting, planning, compensation, and performance evaluation.
- In more fully integrated systems, physician compensation is aligned with productivity and system-wide performance goals, and physicians are compensated for leadership and administrative activities.
- Other specific initiatives implemented to build alignment and a shared culture include: a common information technology platform; standardized HR/personnel policies, scheduling policies, billing, and integrated performance improvement teams; joint contracting; common medical group and hospital committees; and common medical group and hospital department chairs and service line leaders.
- Allow time for the culture of the integrated organization to evolve and develop.

## Getting to “Yes” with Your Doctors: Formulating an Alignment Strategy

The systems we studied are doing well on their alignment journey, as measured by their financial performance, market position, and quality of care. By contrast, many other health systems and physicians are achieving varying degrees of success. Most resemble a partly constructed puzzle in which some parts fit together, but connecting pieces are missing and the puzzle can't be completed. As a result, the full potential benefits of hospital–physician alignment are not being achieved.

Most hospitals and medical groups plan for alignment in the short-term, oppor-

tunistically or defensively. But for most, synergy is elusive. What's missing is often one or more of the following:

- A foundation of trust and communication
- A culture of true physician engagement in decisions that affect them
- A clear understanding of possible alignment methods
- A central focus on the quality and efficiency of patient care as the factor unifying a hospital and physicians
- A multi-year strategic plan of carefully chosen, key alignment initiatives with measurable goals and milestones developed in a highly participative manner
- Strategically aligned governance policy decisions in areas of controversy from on-call compensation to physician employment (also developed with physician input)

We offer two common threads: 1) no effort to align physicians and hospitals will be completely successful without a high level of trust among the parties; and, 2) physicians cannot be viewed and treated as if they are a monolithic block that can be “aligned” using a single, magical approach.

To help hospitals and prospective physician partners craft their unique approach to alignment, we have drawn on our research and experience to suggest a simple formula for achieving successful physician–hospital alignment:<sup>3</sup>

$$\begin{array}{c} \diamond \\ \diamond \\ \diamond \\ \diamond \end{array} \quad \begin{array}{c} \text{(PM + AM) x T = LA} \\ \text{(Physician Motivators [PM] + Alignment Methods [AM]) x Trust [T]} \\ \text{= Lasting Alignment [LA]} \end{array} \quad \begin{array}{c} \diamond \\ \diamond \\ \diamond \\ \diamond \end{array}$$

Based on a thorough understanding of the variety of *physician motivators*, leaders can study and choose from an array of *alignment methods* (business arrangements and other engagement approaches) that are appealing, responsive to physician motivators, and able to be deployed in a targeted manner.

The formula positions trust as the *multiplier*—the variable that expands and accelerates the combination of physician motivation with appropriate alignment methods.

### The “Trust Effect”

Offering a variety of alignment opportunities based on physician needs and motivations, while necessary, will not guarantee lasting alignment, no matter how clever the arrangements may be at avoiding legal problems.

The formula for long-term success requires a reasonable amount of trust among the parties. The greater the trust is, the more likely the alignment method will be successful. In fact, pursuing business deals at the right end of the Alignment Continuum without a foundation of trust established is a high-risk strategy that could lead to disastrous results including lawsuits, regulatory challenges, loss of patients, and a negative impact on quality and customer service.

### Applying the Lessons Learned

The case examples presented above provide a wealth of approaches to build trust-based alignment between physicians and hospitals. The most striking feature of these examples is that they each have unique elements, reflecting the organizational and cultural dynamics present in each market.

The common aspect of all of the examples is that the hospitals responded to the physicians' needs (motivators), not just their own, with appropriate alignment methods, and intense focus was placed on building trust between the hospitals and the physicians.

<sup>3</sup> This is covered in detail in the full white paper.

To summarize some of the lessons learned when it comes to hospitals aligning with physicians using the formula for success, we offer the following ideas:

- Create and articulate a clear vision for the hospital–physician relationship, including the underlying values shared by both sides, with special emphasis on the quality of patient care and efficient practice of medicine.
- Spend time defining the potential benefits of alignment and the likely consequences of not aligning.
- Develop a deep understanding of the various physicians groups and their motivations—engage in intense interaction in the process.
- Ensure that physicians are afforded a “seat at the table” in making decisions that affect them by creating leadership roles for physicians on operating committees, quality initiatives, and the board—rather than selling them on the decisions after they have been made by management and the board.
- Demonstrate trust by practicing “open book” management; for example, share hospital information, especially regarding any business deal being contemplated.
- Look for ways to show that the hospital is genuinely concerned about the physicians’ situation by making it easier to practice medicine in the community.
- Make it clear that the hospital and physicians are “partners” in the healthcare enterprise and partners must begin to trust one another.
- Engineer frequent opportunities for formal and informal interaction among physicians, management, and the board to create a strong social environment which helps to build trust.
- Do not be sidetracked by disappointments or some who take advantage of the effort to build trust—effective leadership stays the course.

## Questions the Board Should Ask

Because the issue of hospital–physician alignment is both a critical strategic issue and part of a board’s core responsibility to build and maintain relationships with key stakeholders, boards should devote a significant amount of time to discussing their current and desired alignment. For many boards, the ideal setting for this conversation is an off-site retreat where the board, physicians, and management team can take a full day to delve into the relevant issues and make decisions.

Whether in a retreat setting or as part of a regularly scheduled board meeting, boards should ask at least the following questions:

### Questions about Trust and Conflicts of Interest

- What is the current level of trust among our physicians, administration, and board?
- What can we, the board, do to help build stronger, trusting relationships with physicians?
- What guidance should the board offer to management as it works to partner with physicians?
- Do we have a formal, written board policy (“playbook”) regarding our relationship with physicians? Does it include our philosophical approach to physician competition as well as physician partnering?

### Questions about Strategic Planning

- Have we developed a shared vision for physician–hospital alignment, and is it clearly articulated in our strategic plan document?
- Does that vision state that we are aligning with physicians to improve quality and transform patient care (as opposed to financial reasons)?
- Do our formal values include the expectation that we will partner with physicians and other caregivers?
- Is our vision and policy regarding physician alignment understood by/communicated to all key stakeholders?

- Where are we currently on the physician–hospital alignment continuum? What percentage of our physicians are in solo practice, group practice, employment, or contractual relationships?
- Where on the alignment continuum do we want or need to be in the future? Why?
- Do we need to develop segmented strategies for different physician sub-groups, based on their motivations and interests?
- How can we continue to engage physicians who are not part of the formal physician alignment/integration model?
- How will the board monitor the implementation (and success or failure) of the alignment strategy?

### Questions about Management and Physician Leadership of an Integrated Enterprise

- Have we paired administrative and physician executives in key areas?
- Has management developed a complete business analysis of the potential risks and rewards of the chosen alignment method?
- Do our legal corporate, governance, and management structures support our vision of hospital–physician alignment?
- Have we created effective governance and management structures for a physician corporation or division?
- What changes in the medical staff structure might be required, given our selected hospital–physician alignment method?
- Have we aligned incentives including those of senior management (within the law and regulatory constraints) to ensure alignment?
- How can we ensure that physician–hospital alignment provides mutual benefit?

Boards have a critical role to play in helping management and physicians determine how best to work together to fulfill the organization’s mission. This conversation should be a priority for all boards.