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Developing a Hospital-Physician Alignment Strategy

Employment Is Not the Only Answer

By Barry S. Bader

Hospital-physician relationships have been on a roller coaster of change for several decades.

A new white paper from The Governance Institute declares that a major transformation is underway: "The days of loose cooperation—and sometimes competition—between hospitals and their medical staff members in private practice are quickly coming to an end," it says. "Only hospitals that are tightly aligned or integrated with a critical mass of physicians will be able to organize their delivery systems to meet the demands for price, quality, efficiency, and community service from private payers, government, and empowered consumers. Some independent physicians and physician groups will have a secure niche and survive on their own, but hospitals that lack a strong relationship with a critical mass of aligned doctors will not."

How Did We Get Here?

Until the 1960s, community hospitals and physicians lived separate but symbiotic lives: hospitals were the "doctors' workshop" and in turn physicians supported hospital finances by admitting patients. In the 1970s and 1980s, as hospital competition grew, the buzzword was "bonding" as hospitals catered to physicians as "valuable customers" in order to attract their "loyalty."

In the 1990s, believing that managed care and capitation loomed, hospitals built integrated networks and

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bought primary care practices by the dozen to ensure a flow of "covered lives" to their hospitals and networks of specialists. When capitation fizzled, many hospitals were left with big losses on their physician practices. Most said "never again" and swore off employing physicians except as a last resort to meet community or hospital needs.

Here and there, though, some health systems such Aurora Health Care in Wisconsin, Sentara Healthcare in Virginia, Mayo Health System in the Midwest, and Sutter Health in California pressed forward with their integrated delivery models including system-owned or affiliated medical group practices. They're now market leaders and national models.

Ed Howe, the now-retired CEO who built Aurora, recently wrote in his blog: "I continue to support integrated delivery as the best organizational solution. Some hospitals look at the employment model as a way to fill hospital beds. Successful integrated systems such as Aurora Healthcare, Mayo Clinic, Cleveland Clinic, and Geisinger Health System do not share that view. Rather, the central focus is on how to deliver the best care to patients. Good doctors want to practice good medicine—not fill hospital beds. Good care should reduce the need for and use of inpatient care."

Many others agree. In a recent survey of more than 200 healthcare leaders by the Commonwealth Fund and Modern Healthcare, nearly nine of 10 respondents said "the way the delivery system is organized needs an overhaul." Of those favoring a major overhaul, 88 percent think it is "likely or very likely that integrated delivery systems or large multispecialty groups are the best means to achieve effective care delivery." Just 27 percent think "independent practice associations" of physicians are the best answer to providing effective and efficient care, and just 23 percent think "virtual connections" such as common information systems and payment incentives such as gain sharing will be sufficient.

Today, with hospitals and doctors each facing unprecedented economic pressures (see the sidebar "12 Signs You Need a Hospital-Physician Alignment Strategy"), hospitals and physicians are rediscovering the benefits of combining forces, gradually in some markets and more rapidly in others.

White Paper Describes New Era of Hospital-Physician Alignment

The white paper entitled "Aligning Hospitals and Physicians: Formulating Strategy in a Changing Environment" (by Barry S. Bader, Edward A. Kazemek, and Pamela R. Knecht, with contributions from

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12 Signs You Need a Hospital-Physician Alignment Strategy

1. **Shortage of primary care physicians.**
2. **Difficulty recruiting physician specialists.**
3. **On-call coverage problems in the emergency department.**
4. **Insufficient engagement of physicians in hospital-wide strategic planning.**
5. **Insufficient engagement of physicians in managing hospital product and service lines.**
6. **Insufficient engagement of physicians in hospital programs to improve efficiency, clinical quality, and patient safety.**
7. **Disconnected silos of currently employed physicians, owned practices, and joint ventures that don't collaborate to manage costs and quality.**
8. **Hospitals lack options for private practice physicians not interested in employment.**
9. **Medical staff organization isn't an effective forum for aligning interests.**
10. **Physicians are unwilling to volunteer for medical staff leadership roles.**
11. **Inability to respond to market demands for bundled pricing.**
12. **Inability to create a single hospital-physician "brand."**

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William F. Jessee, Donald S. Seymour, Dan Grauman, and John Harris), emphasizes that "alignment does not necessarily require employment of physicians by the hospital or a hospital-owned medical group (or in states like California, by a medical foundation)." However, alignment does mean that "the traditional relationships and structures connecting hospitals and physicians must change from loosely coupled to tightly coupled arrangements."

"Hospital-physician alignment" may be defined as a close working relationship in which a hospital and physicians place a priority on working toward common economic and patient-centered goals, and they each avoid conduct that damages the other.

Employment of physicians by the hospital or a hospital-owned medical group can facilitate but does not guarantee alignment, nor is employment the only way to align with physicians. Joint ventures, professional services agreements or contracts, medical directorships, clinical institutes, medical service organizations (MSOs), and physician-hospital organizations (PHOs) also offer the ability to align with physicians to varying degrees. So, who is an "aligned physician?"

"Hospital-physician alignment" may be defined as a close working relationship in which a hospital and physicians place a priority on working toward common economic and patient-centered goals, and they each avoid conduct that damages the other.

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

- ☞ Physicians and the hospital or system share a common vision and strategic plan that they developed together.
- ☞ Physicians and the hospital or system practice according to common values, such as respect, trust, collaboration, and a commitment to excellence.
- ☞ 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.
- ☞ Physicians can recruit new colleagues without taking financial risk. The hospital can legally implement programs that help them live more predictable lives that balance professional and personal time.
- ☞ Physicians' compensation is based on their productivity, participation in organizational leadership, and achievement of shared economic and quality goals.
- ☞ 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 participate together in pay-for-performance arrangements, and they can successfully bid for and manage bundled hospital-physician payments to care for particular conditions or treatments, such as joint replacements or cardiac surgery.
- ☞ The hospital medical staff leadership structure is populated by aligned, compensated physicians who are interested and trained in leadership, not by reluctant volunteers whose "turn" it is to chair a department or committee.
- ☞ Patients experience easy access and consistent standards of quality across the system, from physicians' offices and outpatient facilities to hospital inpatient care and sub-acute services such as rehabilitation and home care.

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Why Alignment Now?

Hospitals seek tighter physician ties to collaborate on pay-for-performance, quality improvement and efficiency projects, to maintain or grow market share, and to meet community needs such as on-call coverage in the emergency department.

At the same time, physicians are knocking on hospitals' doors seeking closer relationships, for a variety of reasons:

☞ Economic security. Declining reimbursement, higher malpractice costs, and increased regulatory burdens and practice expenses stress the financial viability of many physician practices. So do demands that practices invest in information systems in order to bill Medicare and private health plans. Many doctors are working harder and earning less, and thus are readier than ever for the economic security of an employment relationship.

☞ Retirement planning. Some medical practices want to recruit more physicians to meet rising community demand and to replace retiring physicians, but independent physicians and groups may be reluctant to risk the capital needed to recruit and support new physicians while they build a practice.

☞ New physicians' expectations. Many recently trained physicians are more interested in predictable hours and a guaranteed income than in becoming entrepreneurs in private practice. Some want support for teaching and research. In markets where hospitals and large group practices offer these benefits, smaller groups and independent physicians are challenged to offer competitive packages and flexible scheduling to attract newly minted doctors.

☞ Payment system changes. Large employers and Medicare are moving toward bundled payments, single price contacting and pay-for-performance, but independent physician practices lack the capital and infrastructure needed to respond to these opportunities.

> "Over the next 10-20 years, it is likely that most physicians will be employed by systems, hospitals, or medical groups."

In the 1990s, physician interest in selling practices was motivated by fear and greed—fear that unless they joined an integrated system they'd be left out in the cold by managed care plans and greed when they saw colleagues get fat checks for "good will" when they sold their practices. The fear of freeze-out proved unfounded when capitated managed care floundered, and many practices that sold out experienced financial reverses or even bankruptcy. Some hospitals that bought practices spun them off or renegotiated physician compensation.

What's different this time around? Hospitals understand what it takes to run a viable physician practice. They aren't paying inflated prices to buy practices, and income guarantees have been replaced by physician compensation plans that reward productivity and quality. Physicians' expectations are more realistic. Physician compensation plans also recognize that practices which refer patients to hospital-based ancillary services and specialists are net gainers, not losers, for the system.

In addition, there's widespread agreement the healthcare system is broken and needs fundamental change from Congress to control rising costs while reducing the number of uninsured. Whatever legislation comes out of Congress is likely to tighten the screws on providers' revenues. So will interim steps by public and private payers. Pressures to manage expenses, improve efficiency, and meet quality standards will grow, driving further consolidation of hospitals and tighter relationships with physicians to manage care, costs, and quality.

"Over the next 10-20 years, it is likely that most physicians will be employed by systems, hospitals, or medical groups," says the white paper.

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Developing the Right Alignment Strategy for Your Hospital

The challenge for a health system or hospital is to attract a critical mass of aligned physicians at a time when many physicians are still hesitant to relinquish their independence and become employed by a hospital. In response, hospitals are opening their tool kit of alignment vehicles, hiring doctors and buying practices, and also forming joint ventures, contracting with hospital-based physicians, experimenting with gain sharing, and so forth.

The risk is that all these deals will prove too costly, saddling systems with financial losses, and adding up to less than the sum of their parts, with a delivery system that's too weak to manage costs and quality.

To manage the risks, hospitals and health systems need to develop a strategic plan for physician alignment that is an integral part of the organization's overall strategic plan. The planning process should be inclusive, bringing board, senior management, and physicians together for education and discussion that builds mutual understanding and trust.

Many physicians, trustees, and even executives think alignment requires employment. Therefore, the planning process should incorporate education on the various alignment mechanisms that are available, including but not limited to:

- ☞ Employment, either by the hospital or by a hospital-owned medical group.
- ☞ Joint ventures for specific services and facilities.
- ☞ Professional services contracts for specific services.
- ☞ Gain sharing plans for inpatient services.
- ☞ Clinical institutes co-owned or co-managed by the system and physicians.
- ☞ Medical Services Organizations (MSOs) and Physician Hospital Organizations (PHOs) that offer support services to affiliated private physicians and organize providers to work jointly to manage clinical care quality and efficiency.
- ☞ IT linkages to physician offices.
- ☞ Collaboration on patient-centered quality improvement projects.
- ☞ "Physician Cabinet" of active clinicians in various specialties to provide advice on clinical priorities, strategic plans, and medical capital spending.
- ☞ Full-time clinical department chairs and medical directors.
- ☞ Restructured medical staff organization.

Education should examine the pros and cons of each alignment option. For example, although joint ventures for specific services and facilities, such as an outpatient surgery center, can be effective in maintaining or growing market share in one service line, they don't improve the hospital's broader ability to partner with physicians to manage quality and costs in all inpatient and outpatient facilities, or to provide ED coverage or fill medical staff leadership roles.

Figure 1, based on the white paper, presents an alignment continuum that illustrates how as a system employs increasing numbers of doctors, implements other alignment strategies, and builds a common culture among once competing independent practices, it increases the percentage of its physicians who are aligned.

- ☞ At the extreme left of the continuum, hospitals and physicians are "fully independent," economically and organizationally.
- ☞ In the middle, integration increases through multiple mechanisms such as employed physician leaders, joint ventures, and a small number of system-owned, physician practices.
- ☞ At the extreme right, hospitals and physicians are "fully integrated" clinically and economically, often in a system-owned multispecialty group practice or practices.

In a strategic planning process, leaders can determine where their organization stands today on the continuum, where it hopes to be in three to five years, and how it plans to achieve its targets.

Five Key Elements of a Strategic Plan for Physician Alignment

The physician alignment plan should include at least these elements:

1. Vision statement that is quality- or patient-centered. Hospitals and physicians share a common interest in providing better quality and safer, more accessible patient care. The vision statement should excite

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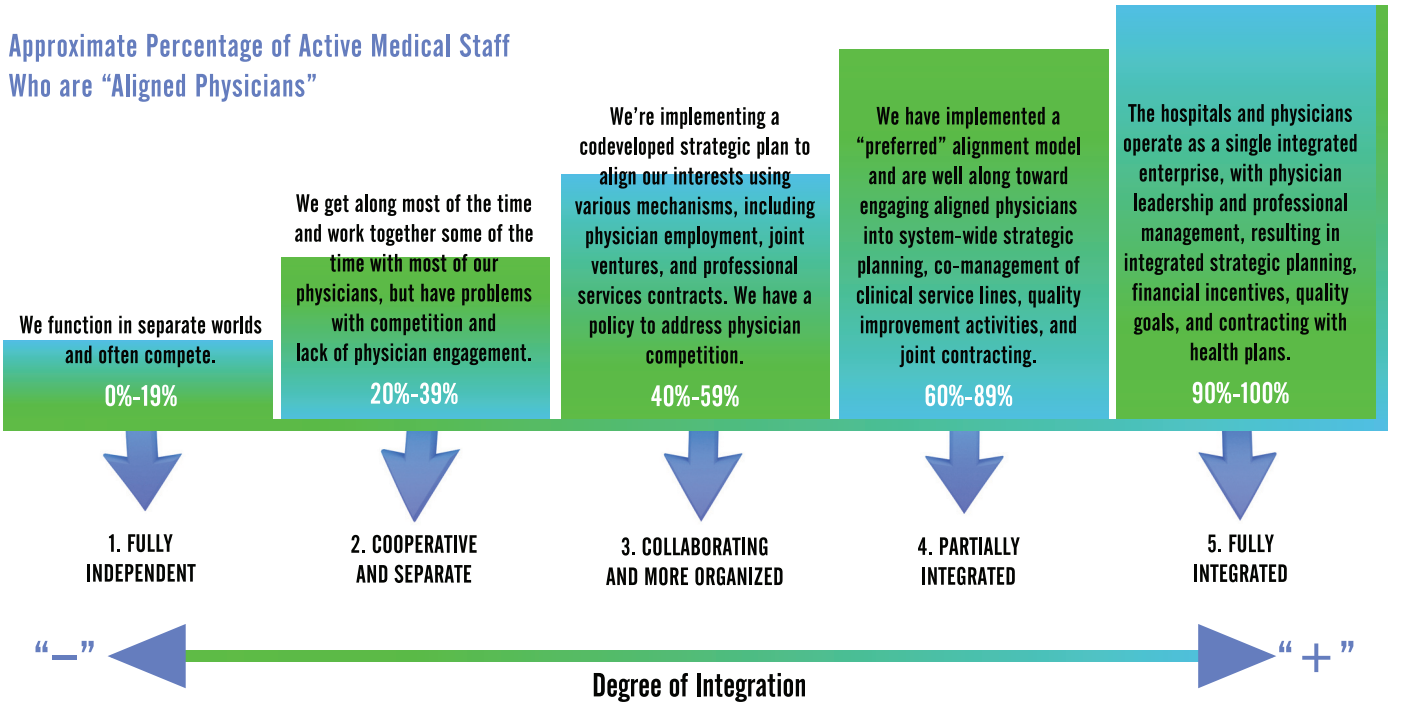
Figure 1. Hospital-Physician Alignment Continuum



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prospective physician partners about the benefits to their patients of aligning with the hospital, as well as the economic benefits physicians and the hospital will receive.

2. Rationale for alignment. The plan should review the major environmental forces that are driving hospitals and physicians to develop closer ties.

3. High level and measurable strategic goals. The plan should answer the question, "What will our integrated system look like in five years if we are successful?" For example, how many physicians will be aligned, and what percentage of system revenues will be generated by aligned physicians? What will be our market share? How will our quality scores improve?

4. Clearly defined alignment model. The plan should indicate whether the hospital has a "preferred alignment model," such as a multi-specialty group practice, and whether it will consider alternatives such as joint ventures and professional services contracts.

5. Major strategic initiatives. Under each strategic goal, the plan should describe specific strategic initiatives and identify a timeline and assignment of responsibility.

Examples include:

- ☞ Organize employed physicians and hospital-owned groups into a single group practice within one year.
- ☞ Recruit 50-75 new physicians to the community in specialties identified in the medical staff development plan.
- ☞ Develop a hospitalist program.
- ☞ Develop an intensivist program.
- ☞ Meet with medical groups in targeted specialties to identify their interest in employment, a joint venture, or other alignment entity, and proceed accordingly.

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Employment: Is It the End Game?

The white paper profiles a number of health systems that are in varying stages of physician alignment. In all of them, trust was a foundational element, and each is pursuing alignment in ways suited to its local market and physician culture:

☞ DeKalb Medical in Decatur, Ga., employs only 25 primary care physicians but it's using a PHO that includes 80 percent of medical staff members to team up on joint information technology, best practices, and performance improvement projects.

☞ Eastern Maine Medical Center employs 50 percent of its physicians—a trend in many Maine systems—and has just one joint venture. All employed physicians are on incentive plans that align physician and system goals, and the financial results of every service line are transparent to build trust with doctors.

☞ Aurora Health Care in Milwaukee, Wis., generates 73 percent of system volume from aligned physicians, including the 750-member Aurora Medical Group. The system was built on "the vision that an integrated system is a better way to deliver care," says retired Aurora executive Elliott Huxley, M.D.

☞ Sentara Healthcare in Norfolk, Va., employs 360 physicians in its medical group today and is on an aggressive path to reach more than 500 by 2012. Sentara still has private practice physicians, but it promotes employment in the physician-led group as its "preferred model."

☞ Essentia Health in Duluth, Minn. has 10 hospitals and has 700 fully integrated physicians, most of them employed.

The integrated systems profiled in the white paper and several others, including St. John's Health System in Springfield, Mo.; Mayo Health System based in Rochester, Minn.; and Guthrie Clinic in Sayre, Pa., all have made physician engagement in governance and leadership a cornerstone of their integrated organizations.

"We say we are 'physician-driven and professionally managed,'" says Don Sorensen, a senior executive with St. John's. It's that partnership that's made St. John's one of the nation's highest-ranked integrated systems in recent Solucient surveys of top systems.

Peter Person, M.D., CEO of Essentia Health, says in the long run, employment of physicians by health systems will prove to be the "superior" model at managing care and costs, in comparison to the "portfolio of deals" many health systems are pursuing. However, Person cautions that unless physicians are viewed as "full partners" in the clinical enterprise, not "just employees," the employment model will fail. To cement a partnership built on trust, Essentia embeds physicians throughout the system's leadership. The CEO is a doctor, four physicians serve on the 15-member system board, and physician-administrator teams manage each of Essentia's three regions and every system service line.

"The goal is to streamline the organization," says Person. "Complexity (the kind of complexity that results from multiple deals with doctors) brings the potential for conflicts and internecine warfare."

Employment may well be the end game, but when independent physicians simply aren't interested in employment, then agreeing to a joint venture or contractual relationship may be better than losing the physicians or turning their practice into a competitor. Hospitals and physicians who join together to craft a strategic plan for alignment that's right for their situation will have a leg up in addressing the massive changes in healthcare that lie ahead.

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Bader & Associates can assist your board and leadership team to explore and develop or update a hospital-physician alignment strategy. For more information, contact Barry Bader at 480-614-0422 greatboards@gmail.com

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