physician alignment
the right strategy, the right mind-set

Integration—both economical and clinical—will be critical in an environment of lower payment rates and demand for improved outcomes and quality of care.

As the dust settles on the debate over healthcare reform, healthcare leaders are thinking seriously about the potential impact of the Affordable Care Act on their organizations. Will the expansion of coverage benefit hospitals and health systems, or will the increased volumes that may result from reform be overshadowed by reductions in payment? How will hospitals fare under Medicare’s value-based purchasing program? How pervasive will bundled payments become, and what form will accountable care organizations (ACOs) ultimately take?

Although the answers to these questions are not yet clear, we do know that providers will increasingly be rewarded for efficiency and outcomes of care, and that payment will not keep pace with increases in costs. As a result, now is the time for hospitals and health systems to align with physicians—not just economically, but also clinically—so that they can achieve clinical integration and accommodate upcoming changes in payment mechanisms.

**Developing the Right Mind-Set**

*Clinical integration* is the coordination of patient care across conditions, providers, and settings. It is characterized by a high degree of interdependence among hospitals and physicians, and involves the establishment of agreed-upon clinical protocols across a broad spectrum of diagnoses and procedures, the development of sophisticated revenue distribution/compensation methodologies to align incentives, and the integration of IT and reporting capabilities among healthcare organizations and physicians.

To achieve clinical integration and prepare for value-based payment, collaboration between hospitals and physicians to improve coordination of care and produce better outcomes will be critical. Past efforts at integration, such as joint venture initiatives in the 1990s, fell short of the collaborative structures that will be needed in an era of reform. Execution of an effective integration strategy requires the development of the right mind-set for collaboration—one that takes into consideration the organization’s market position and customer base, the type of structure that best complements the hospital’s culture, the incentives needed to drive alignment, and the tools to share credible data related to utilization, cost, and quality, and the need for shared control.

Gaining a realistic understanding of an organization’s capabilities compared with its future needs
in an era of reform is a good starting point for developing an effective integration strategy. Key considerations include the following.

**Changes to the organization’s revenue base under reform.** In the past, efforts to integrate with physicians focused on securing referrals for hospital services. Although this may once have been a reasonable approach, it is a recipe for failure in the future, as ACOs, bundled payments, and value-based payment methodologies replace fee-for-service as the predominant reimbursement models. In this environment, hospitals and health systems will have powerful economic incentives to work with physicians to provide high-quality care and service. There may be a confusing transition period during which some revenue will be based on service volume and other revenue will be based on value. Hospitals should be prepared to educate and manage their stakeholders through this conflicting period.

**The need to reduce costs as payment decreases.** Organizations that do not successfully align themselves with physicians will face limitations in their ability to affect cost, quality, and outcomes. To be at all successful, they will need to become masters of cost reduction. They may also need to consider joining an ACO or pursuing affiliation with a larger health system. Without an aligned physician enterprise, these organizations will not be able to hold and effectively manage the type of value-based contracts that the Centers for Medicare & Medicaid Services is contemplating. As such, they will be relegated to the status of a vendor, with little control over their own destiny.

This is the default option for those organizations that are unwilling or unable to adapt to changing realities.

In one southern California market, a strategy of aggressive consolidation is being undertaken by several large, well-organized, and well-capitalized players. These organizations are positioning themselves to become ACOs and are now accepting global capitation. Based on their increasing ability to steer patients and control premium dollars, they are perceived as a major threat by some hospital administrators whose organizations lack an aligned physician enterprise and fear that they may be forced into accepting below-cost reimbursement.

**The need to share control with physicians.** Perhaps the biggest obstacle to achieving a stronger alignment between hospitals and physicians is cultural, particularly as it relates to control. Hospital administrators are often risk-averse by nature and feel a need to maintain control over their organizations’ operations and strategic direction. Unfortunately, this desire for control often conflicts with an equally deep-rooted need on the part of physicians for autonomy and professional self-determination. Most physicians are trained early on to think and act independently when providing patient care, and these habits often shape their perspective on administrative matters. However, clinical integration requires a very different set of operating activities that are broader in scope, encompassing all inpatient and outpatient care and applicable to a much larger and more varied population than hospitals or physician groups have served in the past. Addressing this larger scope of activity will be difficult even for the most advanced systems. To be successful, both parties should recognize that each brings critical and unique skills to the table and is likely to expect a role in both the management and governance of collaborative efforts.

To achieve true alignment between hospitals and physicians, it will be imperative for both sides to adjust to these cultural differences. Each party should understand that the other’s perspective is legitimate and deserving of accommodation. For
hospitals, this means giving up a measure of control and allowing physicians—both employed and independent—to have a real voice not only in matters pertaining directly to them, but also in matters relating to the direction of the organization itself.

**Developing the Right Strategy**

For many hospitals, the most obvious path to alignment is through physician employment. This approach has made a real comeback in recent years, with a surge in transactions whereby hospitals acquire large multispecialty groups outright. In some instances, this is an excellent strategy, particularly if the parties to the transaction already have close working relationships with one another and have developed a sense of mutual trust and respect.

For many organizations, large-scale physician employment is not a realistic option, at least not within a reasonable time frame. Indeed, in states such as California, Texas, and others where prohibitions against the corporate practice of medicine exist, physician employment on any scale is not possible.

Employment of physicians is not the only way for hospitals and health systems to achieve a significant degree of clinical integration. There is no

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**Integrating with Physicians to Manage Costs**

To understand why alignment with physicians is increasingly important to hospitals’ financial success, it first must be understood that overall reimbursement levels are not going to increase. Therefore, the management of costs in three categories will be critical.

*Traditional areas for cost reduction (such as labor, supply chain, and outsourcing of select services).* Many organizations do a reasonably good job of controlling costs in areas that have typically been the focus of cost reduction initiatives, and additional targets of opportunity exist within this category.

*Reduction of the cost of care per unit of service (for example, reducing unnecessary services or coordinating patient throughput when the hospital is reimbursed on a DRG basis).* Increased interest in gainsharing arrangements in recent years indicates that the potential for cost savings from economic integration with physicians could be significant. The shared-savings programs to be implemented in 2012 will require additional alignment with physicians to control costs by episode of care.

*Reduction of the total cost of care for a given disease or population.* This reduction is accomplished by eliminating unnecessary care, choosing more cost-effective treatments, and/or selecting conservative therapy rather than more costly interventions.

It’s worth noting that most hospitals are well versed in the first category for cost reduction, somewhat able to manage the second, and completely unequipped to do anything about the third. This is because the need for collaboration with physicians increases with each step in cost management. Hospitals may not need physicians to help them obtain better pricing on surgical supplies, but they absolutely need their leadership to efficiently manage chronic conditions. Notably, it is the third category, reduction of total costs of care, that is the focus of healthcare reform—and this is where providers can have the greatest impact.
single solution or single organizational structure for collaboration and integration.

Consider the following case studies of community hospitals that have taken different routes to successfully collaborate with physicians. One organization employs the majority of the physicians who practice at the hospital, while the other does not employ physicians and has a fragmented medical staff of independent physicians.

**Organization 1: Specialty Hospital**

Organization 1 is a community hospital that does not employ physicians but has nonetheless made great strides in furthering its relationships with the physicians on its medical staff. This organization’s CEO has made clear his vision of transforming the hospital from an inpatient-centered organization to one that focuses on providing superior, more cost-effective care across the full spectrum of inpatient and outpatient services, and he has moved aggressively to align the hospital with its physicians on a number of fronts. These efforts have included the development of clinical centers of excellence, initial planning for a state medical foundation, and several outpatient clinical joint ventures.

The most innovative of these arrangements is the development of an orthopedic hospital that is a joint venture between the hospital and several groups of physician investors. Discussions for this venture began several years ago, while the hospital was considering new construction on its main campus in an attempt to accommodate increasing inpatient capacity needs. The prospect of new construction was financially daunting, as the hospital’s campus was already quite crowded, and real estate prices in the immediate surrounding area were extremely high.

After considering the options, the hospital decided that the best course would be to develop, in conjunction with two orthopedic groups, an orthopedic specialty hospital that would be the premier tertiary care orthopedic program in a broad geographic area. The vision of the hospital was to differentiate itself in this broad market by:

- Integrating diagnostic, surgical, and rehabilitative services
- Providing the highest quality of care
- Leveraging the reputation of the hospital and its physician partners to become a branded destination center for orthopedic care
- Attracting the best clinicians

The resulting organization encompasses inpatient and outpatient surgical services on the main campus, outpatient surgery in two offsite ambulatory surgical centers, physical rehabilitation, and a full array of diagnostic services.

Although physicians have a major ownership interest in this model, the same level of alignment of incentives is possible under a value-based payment system. For example, Organization 1 projects that it will realize significant savings through implant price reductions, a decrease in the frequency of premium implant use, and reduced length of stay. These are all areas where physician decisions play a major role in determining costs. This hospital took aggressive steps toward economic alignment with physicians without employing them. The organization has thus created an effective platform for future clinical integration initiatives.

**Organization 2: Full Integration**

Organization 2 is a community hospital with a large, employed, multispecialty physician group and a health plan that has a strong presence in the hospital’s service area. The employed physician group was previously an independent, multispecialty medical group that was closely affiliated with the hospital. The two organizations had enjoyed a close and successful working
relationship for many years prior to integrating, including a number of joint ventures and other business relationships. Many physicians from the group also had held leadership positions on the hospital’s medical staff and therefore had preexisting working relationships with the hospital’s administrators, which greatly assisted in the integration process.

Although the hospital was the acquiring organization, hospital leaders had the foresight to recognize that simply buying the group’s assets and employing the physicians would not yield the full benefits of integration. Accordingly, hospital leaders took the unusual step of giving physicians a major role in the direction of the integrated organization. For example:

> Leaders in the physician group assumed several executive positions within the hospital management structure, with significant operational responsibility.
> Dyad management teams that paired physician leaders with administrative managers were created to oversee clinical operations.
> A physician advisory body was established to provide input on strategic- and physician employment-related matters.

This organization is in the unusual and fortunate position of having all of the major elements of an integrated delivery system: a large physician component encompassing a full range of specialties, a large clinic with multiple satellite facilities, a community hospital offering general acute and tertiary care services, and a health plan with significant local market presence.

Although this integrated organization has considerable advantages, there is still much work to be done in order to realize its potential. As an example, the organization is still in the process of learning how to function as a unified institution and create a common culture. Roles and responsibilities of key administrative positions are still being refined as the leadership structure becomes more fully integrated. The various committees and their schedule of recurring meetings, which is where the day-to-day work of managing the organization occurs, will need time to settle into a smooth operating rhythm. Also, physician compensation plans will need to be revised to include incentive components based on the financial performance of the integrated organization, rather than just individual productivity. All of these activities, while challenging, will promote efficient management structures and help to create a common culture over time.

More challenging still will be the efforts needed to transform the organization’s model of care so that it can better manage costs and to improve quality, patient safety, and outcomes. Here again, the organization has a good head start, particularly given its health plan’s claims data and reporting capabilities. However, clinical transformation has less to do with technical capabilities and more to do with the ability to effect cultural change, because it involves a fundamental shift in the way that care is provided—one that is foreign to most physicians. This change will take time, but the organization has the vision and the will to make it happen.

A Transformation of Many Years
Given the major cultural differences between hospitals and physicians, achieving clinical integration is one of the most difficult challenges that either party will ever undertake. Physicians need to have confidence that the hospital will be a competent and committed employer and/or business partner—and establishing such credibility requires time. Most hospitals and health systems with substantial, closely aligned physician enterprises have built a high level of trust with their physicians over the course of many years and, in some cases, several decades. Organizations that
have not yet started down this path in earnest will need to move much more aggressively to prepare for the post-fee-for-service world.

The Time for Action Is Now
At this juncture, it would be reasonable for hospital and health system leaders to ask, “Do we really need to address this now?” After all, many of the payment reforms that are being proposed sound a lot like good old-fashioned capitation—and we saw what happened with the managed care frenzy in the 1990s. We also witnessed many disastrous attempts by hospitals and health systems to employ physicians during the same period. Finally, with so much that remains unknown about payment reform, it might seem foolhardy to embark on a major strategic redirection until greater clarity can be gained.

These are all legitimate concerns, and there are hospitals that have consciously adopted a wait-and-see approach. However, in light of major reforms that will be enacted to control costs and spur improvements in quality of care, hospitals and health systems should not delay pursuit of physician alignment and clinical integration.

Reform will require closer collaboration between hospitals and physicians, particularly as value-based payment comprises a significant share of providers’ revenue streams. Focused effort and attention regarding a strategy for integration will better prepare healthcare organizations for success in the future. Now is the time for hospitals and health systems to consider new, collaborative business and organizational models with physicians that reflect the interdependence required to coordinate care and, ultimately, to contract under a single signature for risk and commercial business.

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