
Well-Balanced
Partnerships

Achieving Physician-Hospital Alignment

by Ellen Lanser May

Sometimes fragile, often rewarding, hospital-physician relationships figure prominently in an organization's well-being. To the degree that hospitals can partner with their physicians, the opportunities for clinical and economic improvement are plentiful.

With health reform, alignment is more critical than ever. Following are several proven models for bringing together physician and hospital interests to reach clinical quality and economic goals.

Physician Employment

With more doctors seeking partnerships with hospitals and health systems, physician employment is the alignment strategy gaining the most momentum. In 2009 hospital-owned practices were the most successful at attracting physicians: 65 percent of established physicians were placed in hospital-owned practices, and 49 percent of physicians hired out of residency or fellowship were placed within hospital-owned practices, according to the Medical Group Management Association.

Physicians appreciate the stability in salary and hours and reduced overhead costs experienced with a hospital-owned practice versus a private practice. Hospitals, on the other hand, believe employed physicians will facilitate the coordination and improvement of patient care and help leverage the marketplace to negotiate better payor rates. For both groups, health reform will reward those who deliver more efficient, high-quality healthcare—and employment offers the highest degree of alignment to reach that end.

Strategic Components

Ken E. Mack, FACHE, principal of Ken Mack and Associates, Brecksville, Ohio, and a long-time ACHE faculty member who specializes in hospital-physician relations, believes a strategically successful employment model is based on the following principles:

Physicians should have a voice in governance. Memorial Healthcare System—a five-hospital, 1,800-bed system in Hollywood, Fla.—currently employs about 150 of the system's approximately 1,700 physicians. "Historically, our employment strategy has been a bit piecemeal," says Frank V. Sacco, FACHE, the system's CEO. "Recently, we established a self-governance model that is helping us to clinically integrate all of our physicians—employed and voluntary." Memorial Healthcare's employed physicians have formed a 15-member advisory board with a number of significant committees, ranging from finance to academic affairs to clinical effectiveness. These committees will play a critical role as the system works to set up order sets, care paths and quality and outcomes goals as part of its overall clinical integration strategy. Having physician collaboration in these areas has built enormous trust with the hospital's employed physicians and is also winning over voluntary doctors.

Hospitals should work toward creating robust medical records and transparent data. From a pragmatic perspective, physicians desire transparent data that show the business details of the practice, including costs, collections and comparison to their peers. "Furthermore, an electronic medical record aids physicians in their own lifestyle issues," says Mack. "At the end of the day, they are able to spend time with the family and finish their charting from their homes at night." Clinically, physicians want and need reliable information to guide their own practice of medicine and to help them formulate performance guidelines.

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>
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> Genesys Regional Medical Center

The Cardiology Department at Southwest General Health Center, a 354-bed hospital in Middleburg Heights, Ohio, has been recognized by Thomson Reuters for five straight years as part of its "Top 100 Hospitals: Cardiovascular Benchmarks for Success" annual study. Thomas Selden, FACHE, president and CEO, attributes this success, in part, to the continued collaboration with medical staff, both employed and independent. "Our success with our cardiology program did not come about because we employ our physicians," says Selden. "But employment is one of the many tools we have in our toolkit to achieve alignment. When physicians move from private practice to employment, they want to maintain a high level of control and involvement. We aren't struggling with our doctors in determining and achieving best practices. Our transparency and emphasis on measuring and collecting data enhances doctors' engagement and sense of position."

Take-home compensation should come as close as possible to cash received. In a private practice, physicians' compensation is typically based on collections less their expenses; therefore, if they work more—or less—so goes their take-home pay. For employed physicians, the closer their compensation is to net collections, the more likely it is that they will take ownership of details related to the

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practice. "If you offer your employed physicians a straight salary, normally productivity will drop," says Mack. "In other words, like for many of us, if there is no downside to not working harder, then why do it?" Some hospitals adjust their employed physicians' salaries every quarter, reflecting a running six-month average of net collections. However, Mack suggests keeping it simple: The closer physician compensation is tied to net collections after direct expenses, the more invested physicians will be.

Clinical Comanagement

An alternative to broad-based medical directorships, the comanagement model is based on a hospital contracting with physicians to manage a specific service line. As a model for alignment, clinical comanagement is piquing the interest of physicians and hospitals alike. In the summer of 2010, a PwC (formerly known as PricewaterhouseCoopers) survey of more than 1,000 physicians (balanced by age, gender, practice type and specialty) showed that while only 8 percent of surveyed physicians were currently aligned via a comanagement company, 34 percent were most interested in pursuing one during the next two years.

"Comanagement works so well because it offers physicians a stake in how the service line is actually run," says James C. Bonnette, MD, CMO at Genesys Regional Medical Center in Grand Blanc, Mich. Genesys has formed three comanagement companies—cardiovascular, general surgery and orthopedics/neurosurgery—and is in the process of developing a fourth for women's and children's services. Bonnette reports that the comanagement model has been extremely successful in helping the hospital improve quality metrics and throughput.

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> Southwest General Health Center

"This model has given our physicians a new fire," he says. "They want to make changes; they want to improve. The comanagement arrangement gives doctors an opportunity to be directly involved in driving quality."

In fact, Bonnette believes comanagement provides the most intense level of engagement between physicians and hospitals. "It is superior to any other method I've seen in terms of alignment and active participation," he says. "It's a win-win for both the physicians and the hospitals: physicians have an active voice in how the business is managed and how quality is improved, while executives are given a chance to educate their physicians on what it takes to run a hospital and initiate process improvements."

Collaboration to Meet Community Needs

CHRISTUS St. Vincent Regional Medical Center in Santa Fe, N.M., has a medical staff of 380 providers covering 34 specialties and serving more than 300,000 residents in the community. About 100 of the hospital's providers have been employed for several years—many of them in subspecialties—with a successful, solid infrastructure in place to support them. With its employment model thriving, St. Vincent's decided to venture into the comanagement arena by approaching its independent gastroenterology (GI) group.

"Initially, the hospital's relationship with the GI group was based on a need to coexist rather than to be mutually beneficial," says Bruce J. Tassin, COO at St. Vincent's. In their quest for stronger physician alignment, Tassin and other

hospital leaders met with the GI group and discovered that it was challenged in meeting its community's needs, with a lengthy three-month wait time for appointments. "We had two options: either the hospital would have to grow its own department and recruit competing GI physicians into the community, or we could work with the GI group to recruit and re-establish the service line so that community needs could be met," says Tassin.

Choosing the latter route, the hospital and the GI physicians initially entered into a medical director agreement so they could develop the comanagement company and explore issues such as infrastructure and protocol development. Now, almost one year into the comanagement model, the hospital and the physician group have designed a new GI center, recruited a new physician—the only one in the area who is able to perform endoscopic ultrasound (EUS)—and purchased new equipment to support her.

"Before, our patients had to drive to Albuquerque for an EUS," says Tassin. "But because of our collaboration, we have enhanced services for our community on many levels." With its successful GI comanagement model in place, St. Vincent's is currently working with a local oncology group toward a similar arrangement.

Clinical Institutes

The clinical institute model is typically based on the alignment and integration of physicians and a hospital to develop evidence-based clinical practice guidelines and deliver best-practice medicine to patients. Institutes usually offer one service, such as ophthalmology or vascular surgery, and in most cases, there is no separate corporation and no equity.

"In many ways, a clinical institute is something like a hospital 'club' that takes on meaning and value by improving care outcomes," says Mack. For example, many institutes require physicians to have completed a certain number of procedures in order to participate,

Where to Build Trust

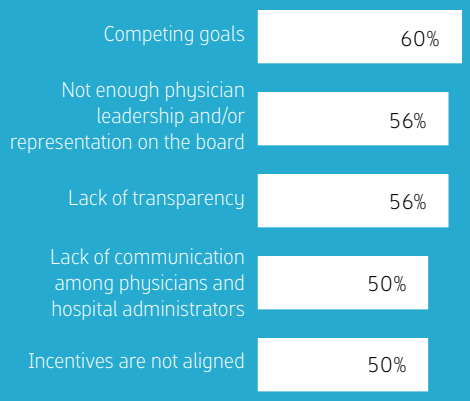
The Patient Protection and Affordable Care Act provides dozen of new incentives—both positive and negative—for hospitals and physicians to align. But where is the trust?

In a 2010 study by the PwC Health Research Institute ("From Courtship to Marriage, Part I: Why Health Reform Is Driving Physicians and Hospitals Closer Together"), which included a survey of more than 1,000 physicians, 20 percent of physicians said they do not trust hospitals. See the chart, at right, for the top five reasons identified by that 20 percent.*

Under health reform, hospitals and physicians have the opportunity to focus on new approaches to care delivery, care coordination and payment. These data can serve as a useful starting point for hospital and health system leaders to overcome barriers and work together as well-balanced partners.

*Participants were asked to select all of the statements that best describe why they do not generally trust hospitals as partners.

Why Physicians Don't Trust Hospitals as Partners



Source: PwC Health Research Institute

thus demonstrating the quality of their practitioners.

While clinical institutes may vary in structure, Mack has identified four consistent components of a clinical institute:

1. A clinical component to measurably improve care
2. A business component to grow profitable market share
3. An educational component that can range from conducting clinical trials to sponsoring community education
4. A philanthropic component that attracts support because the institute is uniquely equipped to manage a condition in a way that its competitors cannot

The clinical institute model is effective with both employed and independent physicians. In the case of independent physicians, the hospital cannot promote the individual's practice; however, it can highlight the physician as a way to promote the institute itself.

ACOs and the Future of Healthcare

In addition to the models discussed above, physicians and hospitals continue to successfully align themselves through joint ventures, leasing, directorships, stipends and management contracts. But the model generating the most conversation today is the accountable care organization (ACO).

Some organizations believe they are already ACOs; others have established task forces to pursue the issue. Regardless, ACOs are coming. Through ACOs, hospitals and physicians integrate to share risk and proactively manage the health of their patient population. By definition, ACOs will require collaboration and cooperation as hospitals and physicians are bound together clinically and financially.

Hospitals with well-developed disease management programs, solid infrastructures and physician practice guidelines will be poised to succeed in an accountable care environment. But even for hospitals without high levels of integration, strong, productive relationships with physicians will be a prerequisite for future success.

"It is absolutely essential to have a close working relationship with your medical staff," says Southwest General's Selden. "Under the bundled payment efforts in the healthcare reform act, only organizations that can work together to deliver high-quality, cost-effective care will be considered a viable partner in an ACO. Those who can't could simply be bypassed."

Although ACOs will play an important role in the way healthcare is delivered, other models for alignment will continue to help provide high-quality, efficient care. Regardless of how the relationship is structured, successful interactions with physicians require the following:

A Physician Leader: Selden views his strong physician leaders as central to the hospital's achievements. "Identifying, engaging and working with the physicians who were most interested in raising the standard of care made collaboration with all of our doctors much easier," he says.

Without a physician leader, the chances of any alignment strategy working are slim. "For every 10 physicians you want to engage, you need one physician leader—someone who is high functioning and held in esteem by his or her

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Reference: 1. Ford D, Luttrell N. Leadership in patient safety: IV pump auto-programming. Presented at Cerner Health Conference; October 2009.

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peers," says Mack. "Physicians tend to be very independent. They may not follow a 'lay person,' but they will listen to a respected peer."

Flexibility: As part of its clinical integration work, leaders at Memorial Healthcare offered all its physicians—including independents—the opportunity to integrate their EMRs with the hospital's health information exchange (HIE). Initially, the hospital provided only two options for the EMR, which did not sit well with physicians.

"We finally decided to let our physicians choose and implement the program that worked best for them," says Memorial Healthcare's Sacco. "As long as their records tied to our HIE and gave us a linear, digital record that followed the patient, we could be flexible. That willingness to change gears gave us credibility and built trust in the eyes of our doctors. Flexibility in general has been a huge asset in engaging our physicians."

Strong Communication: Memorial Healthcare has created a Physician Relationship Management program through which each of its five hospitals has a dedicated staff member who focuses on recruiting and retaining physicians. Each hospital also has six to 20 individuals who schedule monthly or quarterly one-on-one meetings with doctors who have the largest admission and utilization rates. "This has helped us be transparent and deal with issues head on," says Sacco.

Genesys Regional's Bonnette believes the way information is communicated is also important. "Always put the patient first," he says. "Try to approach your physicians in terms of how you can work with them to make care for patients better. This is a critical factor in earning physicians' trust."

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Follow Through: St. Vincent's Tassin believes trust is developed by carrying out requests and reporting back on progress—especially as related to service lines in a comanagement arrangement. "If a physician makes a request, you don't always have to have the answer they want or have it at that very moment," he says. "But in my experience, physicians do expect you to get back to them with an answer." Furthermore, Bonnette notes that physician buy-in is more easily gained when you follow through as partners. "In general, physicians don't want to be told what is going to happen *to* them or what you can do *for* them," he says. "They want to be seen as an important part of the equation—as a partner who can work *with* you."

A Continuously Open Mind: Tassin also has found that approaching a situation on its own terms—with a blank slate—can help break through challenges that were once perceived as insurmountable. "When we started talking about meeting with the independent GI group, countless people told me it was useless to approach them," Tassin says. "There was also some hesitation about involvement with the medical oncology group. But giving both groups the benefit of the doubt when we wanted to try a comanagement model ended up serving the organization and the community very well."

Ultimately, any alignment model can work when physicians and hospitals consider themselves well-balanced partners. "If they are intertwined clinically and economically, then they will be partners for the long term," says Mack. "The goal in being a partner on both sides is to capture each other's minds and bottom lines."

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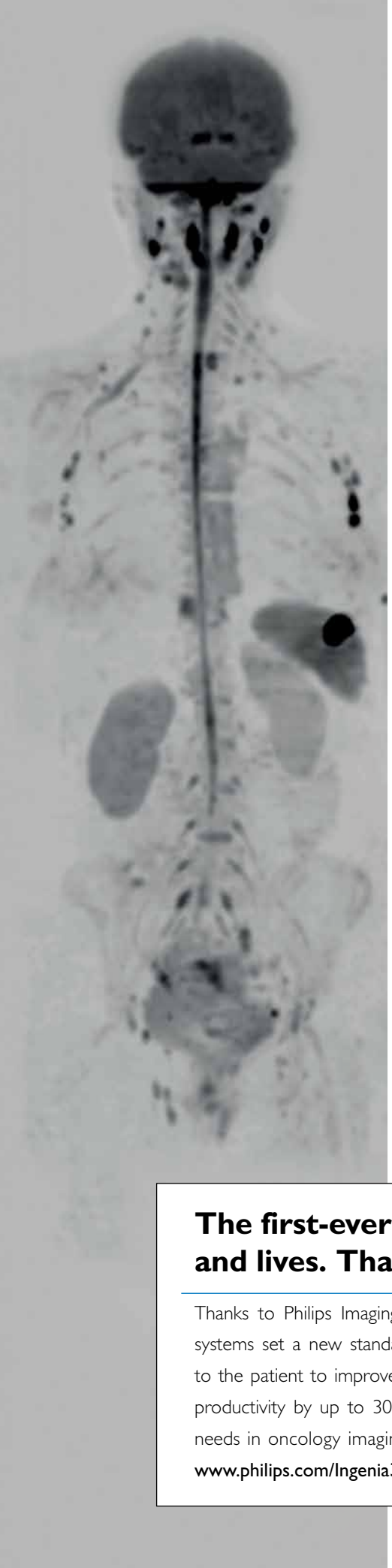

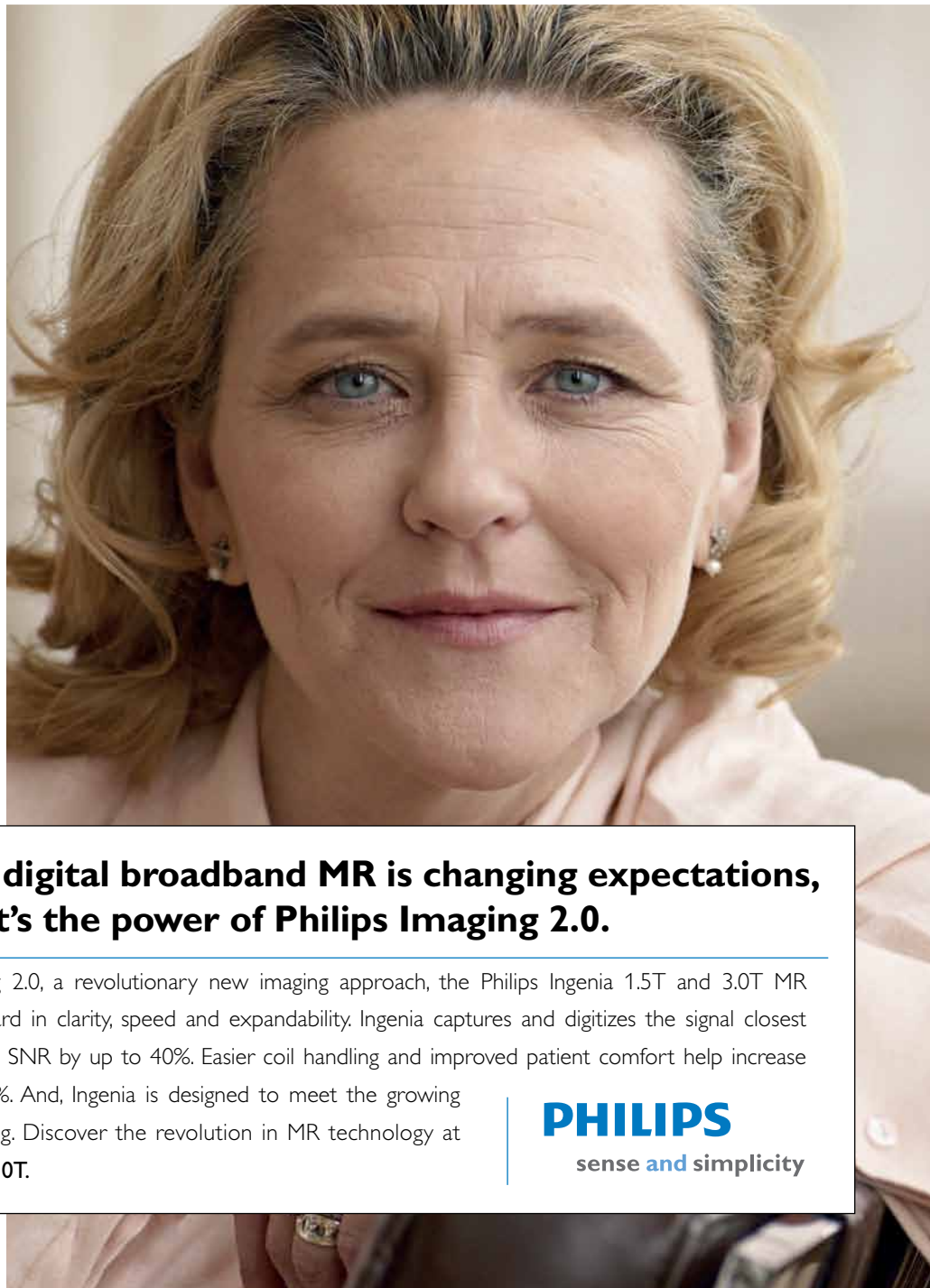

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