Aligning Hospitals and Physicians:

Formulating Strategy in a Changing Environment

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Introduction

This white paper is designed to help hospital and health system boards work in partnership with senior management and clinical leaders to develop a strategic approach for addressing fundamental changes in hospital–physician relationships. It is organized in four sections:

- Part I reviews the major forces that are reshaping the traditional relationships that have existed between hospitals and physicians.
- Part II examines the need for hospitals to re-examine some traditional thinking about hospital–physician relationships and underscores the benefits of increased alignment.
- Part III describes how some leading-edge hospitals and health systems are aligning more closely with their physicians to improve the quality and efficiency of patient care and to align their financial incentives for cooperation.
- Part IV describes how institutional leaders can build on a foundation of mutual trust to frame a true strategic approach to planning.

Part I: Understanding the Changes in Hospital–Physician Relationships

Change is Inevitable

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 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), but it will mean that the traditional relationships and structures connecting hospitals and physicians must change, from loosely coupled to tightly coupled arrangements. And that will be an historic change with economic and cultural ramifications.

In the overwhelming majority of U.S. hospitals, the hospital–physician relationship has been an uneasy alliance of physicians and managers, functioning under the policies and direction established by the governing board. It has been so since at least 1917, when the American College of Surgeons (forerunner of the Joint Commission) decreed a church-and-state-like separation between hospital management and the medical staff organization in the first hospital accreditation requirements. Management was to provide the facilities, hire staff, and handle the finances. The medical staff was charged with establishing clinical standards of practice, evaluating the qualifications of physicians seeking staff privileges, and overseeing physicians' quality by means of peer review. The board retained ultimate authority but in practice rarely interfered with medical staff authority.

Subsequent accreditation requirements have encouraged hospital–physician cooperation in such matters as quality assurance and physician credentialing. Legal decisions such as the *Darling* case[1]—which held hospitals liable if slipshod medical staff credentialing allowed an incompetent physician to injure a patient—led boards to exercise stronger oversight of medical staffs.

Overall, however, accreditation standards and separate payment streams have perpetuated the separation, not integration, of the hospital and the physicians who practice there. Hospitals and medical staffs have been like two countries building bridges and tunnels to cross a river between them instead of filling in the divide and functioning like one entity without borders.

Most physicians accept the medical staff's accountability to the hospital board on paper, but they zealously guard medical staff independence—from selection of their leaders and policing misconduct to writing their bylaws—in order to safeguard their right to regulate medical practice and the individual physician's right to treat his or her patients as each sees fit.

Perhaps most importantly, separate revenue streams create a powerful economic barrier to aligning financial incentives. Health insurers and the government pay hospitals and physicians separately, perpetuating their independence. Revenue enhancement or cost-cutting activity often benefits one at the expense of the other—that's no way to make friends. In recent years, payers have compounded the problem by encouraging physicians to develop their own facilities to draw lucrative business from hospital settings. Additionally, some states ban the corporate practice of medicine and effectively bar hospitals from employing physicians.

The Traditional Social Compact: A Fading Memory

Despite the separation fostered by accreditation and payment mechanisms, most hospital executives and physicians, as intelligent and committed professionals, have generally carved out a symbiotic working relationship, punctuated by occasional eruptions over policy differences, competition, and a few disruptive personalities.

Hospital–physician cooperation is based on several shared goals. First and foremost, hospitals and doctors share a common and genuine interest in the quality and continuous improvement of patient care. In addition, until recent years, most physicians relied on hospitals to provide inpatient and outpatient facilities for their patients. Physicians also need a referral and coverage network and, therefore, they want a well-equipped and staffed hospital to attract a complement of primary care physicians and specialists to set up shop in the community.

1 *Darling vs. Charleston Community Hospital,* Illinois Supreme Court, 211 N.E. 2nd 253, 1965.

So, out of enlightened self-interest, physicians have helped hospitals fulfill their accreditation, legal, and community service obligations in return for the hospital providing a workshop and community resource. Some call this the "social compact" between hospitals and doctors.

For their part, physicians have carried out hospital medical staff functions required for accreditation, accepted medical staff leadership positions, provided on-call coverage in the emergency department, and served on quality improvement teams, among other things. Until recently, physicians did these things for the hospital voluntarily, out of a sense of professional obligation, working extended hours with little or no extra compensation.

But, as Bob Dylan says, "The times they are a-changin'."

The Broken Compact

In recent years, strong economic and other forces have upset the delicate social compact that has connected physicians and hospitals.

As described in more detail later in this white paper, physicians who face rising practice expenses that outstrip increases in their reimbursement are less willing to take ED call voluntarily and serve on medical staff committees. They expect compensation for their time. Specialists increasingly compete with the hospital, taking lucrative ancillary and outpatient services from the hospital to their own offices and ambulatory care centers, but still admitting their sicker and uninsured patients to the hospital. Typical hospital responses such as recruiting physicians, hiring hospitalists and intensivists, and opening their own outpatient centers or specialty institutes often meet with stiff opposition from independent physicians who accuse the hospital of unfair competition. Physicians in search of new revenue streams are also adopting new technologies that encroach on other specialists' traditional turf; for example, radiologists are performing scans that once required invasive surgical procedures.

Symbiosis has given way to "what's in it for me?" Some physicians lament the loss of professional camaraderie as economic pressures mount. The fraying social compact is especially evident in three venues.

The Emergency Department

Many physicians are no longer willing to cover the ED unless they are paid—and some won't do it for money either. More than half—55 percent—of hospital executives surveyed by the American Hospital Association in early 2007 reported difficulties obtaining specialty coverage in the ED.[2]

A study by the American College of Emergency Physicians in 2004 found 36 percent of EDs are paying stipends to specialists for coverage, and 42 percent said specialists negotiated for less voluntary coverage time in 2005, up from 18 percent the year before.[3] A study of Oregon facilities[4] found about 40 percent of hospitals are paying for coverage in at least one specialty, at a median per diem rate of $1,000. Nationally, the American Hospital Association (AHA) reports 37 percent of hospitals surveyed are paying for coverage in general surgery, followed by neurosurgery (33 percent), orthopedics (31 percent), and obstetrics/gynecology.[5]

Even with compensation, many physicians shun call; fewer than a quarter of the physicians in Palm Beach County, Florida—883 out of 3700—take call, according to a study by the local medical society.[6]

Physician-Owned Outpatient Facilities and Specialty Hospitals[7]

Hospitals face increasing direct competition from physicians. In the 1990s, surgeons turned to owning or co-owning outpatient facilities to address economic pressures on their practices. By 2003, there were about 3,700 ambulatory

2 American Hospital Association, "AHA Survey: Hospitals experience gaps in ED coverage," *AHA News Now,* July 6, 2007.

3 Andis Robeznieks, "Docs on the do-not-call list," *Modern Healthcare,* May 28, 2007, pp. 26–28.

4 Charlotte Huff, "On Call? No Thanks," Hospitals & Health Networks, August 2007, pp. 43–46.

5 AHA, 2007.

6 Palm Beach County Medical Society Physician Census Study, February 26, 2007.

7 Unless otherwise noted, statistics in this section are from "Physician Ownership and Self-Referral in Hospitals: Research on Negative Effects Grows," *Trendwatch,* American Hospital Association, April 2008.

surgical centers in the United States, compared with 275 in 1980 and 1,450 in 1990. Radiology groups opened imaging centers with sophisticated diagnostic and treatment equipment. Oncologists provided chemotherapy in outpatient settings.

In addition, the number of physician-owned specialty hospitals rose from 68 in 2000 to 177 in 2007, with 85 more in the pipeline. These facilities can be profitable for doctors—an analysis of Medicare cost reports found that in fiscal year 2006, 57 percent of physician-owned, limited service hospitals had margins of 10 percent or more, compared with 17 percent of acute care hospitals. However, these hospitals typically do not handle emergencies, especially on evenings and weekends. They rely on 911 to take emergencies to the hospital, and they treat a smaller share of Medicaid patients than hospitals.

Policymakers who are considering legislative restrictions worry these facilities also generate higher utilization and higher costs. One study found the entry of physician-owned orthopedic hospitals into a market drove utilization of complex spinal fusion surgeries up 121 percent from 1999 to 2004, with 91 percent of the procedures being done in physician-owned centers rather than competing hospitals.[8] A study by the Medicare Payment Advisory Commission found that physician-owned orthopedic/surgical hospitals had costs 20 percent above the Medicare national average, compared with one percent of competing community hospitals.[9]

Medical Staff Organizations

Hospitals rely on medical staffs for peer review and quality functions, but the "vitality and effectiveness of (hospital) medical staff organizations [are] alarmingly low and declining rapidly," according to a study by researcher Robert Berenson.[10] Physicians, he writes, increasingly view medical staff organizations as a "political body" to foster or protect physicians' interests from encroachment from the board or administration, not as a body to assess and improve quality.

In response, although no one tracks the data, it's clear hospitals are increasingly hiring physicians in full-time and part-time executive and clinical management roles, including vice presidents for medical affairs, chief medical officers and quality directors, department chairs, directors of medical informatics, medical group practice executives, clinical service line leaders, and medical directors of clinical programs—all to ensure effective leadership and management of medical and surgical care.

Misaligned Financial Incentives

Economics aren't the sole factor determining whether hospitals and physicians love or hate each other, but financial incentives undeniably exert a powerful influence on each party's behavior and willingness to collaborate. Even mutual interests in quality of patient care and caring for the community's poor are hard to achieve when the payment system penalizes good behavior.

And that is exactly the current situation: hospitals and independent physicians have misaligned financial incentives. For example:

- Physicians are rewarded when they own or co-own outpatient centers and specialty hospitals and perform lucrative procedures in their offices, while hospitals lose the revenues from procedures and ancillary services.
- Increasingly, hospitals are recruiting physicians to meet hospital and community needs, but existing practitioners see this as unfair competition that will reduce their revenues.
- Hospitals need physician collaboration to control costs by adopting cost-effective care practices and choosing a limited number of drugs and medical devices to keep on hand, but federal law limits hospitals' ability to share the financial gains of these efforts with the physicians.
- Hospitals also have limited ability to help private physicians recruit new physicians or adopt information technology linking them to the hospital's IT system, although some safe harbors and legal means exist.

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8 Jean M. Mitchell, Ph.D., *Effects of Physician-Owned Limited Service Hospitals,* Georgetown Public Policy Institute, Georgetown University, 2007.

9 Medicare Payment Advisory Commission, *Report to the Congress: Physician-Owned Specialty Hospitals Revisited,* MedPAC, August 2006.

10 Robert A. Berenson, Paul B. Ginsburg, and Jessica H. May, "Hospital–Physician Relations: Cooperation Competition or Separation?" *Health Affairs* (Web Exclusive), Decemer 5, 2006, pp. w31–w43.

The Case for Alignment

Although they're hard to see from the trenches, a number of positive signs indicate that economic incentives may be about to change and favor hospital–physician alignment.

In particular, more and more physicians are knocking on the hospital's door seeking closer relationships, for a variety of reasons:

- Declining reimbursement, higher malpractice costs, and increased regulatory burdens and practice expenses stress the financial viability of many physician practices. Many doctors are working harder and earning less, and thus are more ready than ever for the economic security of an employment relationship.
- Some medical practices want to recruit more physicians to meet rising community demand and replace retiring physicians, but independent physicians and medical groups may be reluctant to take the personal risk to invest the capital needed to recruit and support new physicians while they build a practice.
- 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 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.
- 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.

Integrated delivery systems were ahead of their time in the 1990s and suffered financial reverses, especially on the physician practices they acquired. Today, integrated or organized delivery systems are returning. As healthcare costs keep rising faster than overall inflation, both government and private payers have clearly signaled that the end is near for blank checks to pay for annual premium increases and higher Medicare and Medicaid spending. In the future, private and public payers are likely to reward providers who can deliver value by managing both costs and quality, something integrated systems of tightly aligned hospitals and physicians can do better than fragmented, independent providers.

A report from The Commonwealth Fund published in 2008[11] found that physician group cohesion (i.e., how well physicians collaborated with each other to provide patient care), scale (the size of the physician enterprise), and affiliation of a physician group with a larger system "appear to contribute to quality," although more research is needed.

A recent survey of more than 200 healthcare leaders by The Commonwealth Fund and *Modern Healthcare*[12] found that nearly nine of ten respondents say "the way the delivery system is organized needs an overhaul, with only 8 percent saying that modest changes" will do. Of those favoring major overhaul, 88 percent think it is "likely or very likely that integrated delivery systems or large multi-specialty 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 like gainsharing will be enough.

Who Is an Aligned Physician?

Organized delivery systems will need physicians—whether they are employed, contracted, or independent—who are aligned with the system's hospitals and other physicians. "Hospital–physician alignment" may be defined as 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.

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, and physician–hospital organizations also offer the ability to align with physicians to varying degrees.

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11 Laura Tollen, Kaiser Permanente Institute for Health Policy, "Physician Organization in Relation to Quality and Efficiency of Care: A Synthesis of Recent Literature," The Commonwealth Fund, April 2008.

12 The Commonwealth Fund/*Modern Healthcare,* "Health Care Opinion Leaders Survey: Views on Health Care Delivery System Reform," March 2008.

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.
- 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.

"Hospital–physician alignment" may be defined as 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.

Over the next 10–20 years, it is likely that most physicians will be employed by systems, hospitals, or medical groups. Some medical groups will be system/hospital-owned or have symbiotic relationships with them, but others will be independent and compete with hospitals or play off one facility in town against the other.

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.

Part II: The Need to Change Traditional Thinking

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 realties. 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.

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 realties.

View from a Doc: You Have Three Medical Staffs

Historically, there have been deep interdependencies between physicians and hospitals. But as healthcare delivery has changed, hospital–physician relationships have undergone major new stresses. Unfortunately, many hospital leaders labor under significant misconceptions about physicians and medical practices. Crafting effective approaches to aligning physician and hospital interests requires gaining a better understanding of the economics of medical practice, and of the forces that influence hospital–physician relations.

Medical Practice in the First Decade of the 21st Century

The classic hospital leader's view of physicians has been that they are primarily professionals in solo or partnership practice who use the hospital as their workshop whenever inpatient care is required. Hospitals have long felt that, in return for access to these expensive facilities, physicians had a professional obligation to participate in medical staff governance, take emergency call, and otherwise assist the hospital in accomplishing its mission—all without additional compensation.

In today's world, however, such a perspective is little more than an interesting historical footnote. The reasons for the change are many. In 1975, for example, 78 percent of all physicians were, in fact, in solo or two-person practices. But by 2005 that proportion had shrunk to 32 percent.[13] The most significant changes in medical practice structure in the last few years include the following:

- Consolidation of practices into larger units
- Acquisition of practices by hospitals and integrated delivery systems
- A steady increase in the number of physicians who are employees rather than practice owners

While precise quantification of these trends is elusive, there is widespread agreement that they are, indeed, occurring.

A second major trend has been the steady increase in the proportion of physicians who no longer do any inpatient work. The emergence of the hospitalist as a distinct medical specialist is one clear manifestation of this trend, but it has been further accelerated by the growth of freestanding, non-hospital centers for surgery, endoscopy, imaging, and other services. A telling statistic is that 38 percent of physicians participating in the Medicare program in 2003 submitted *no claims* for inpatient care.[14] Accordingly, the practices of those physicians were exclusively ambulatory.

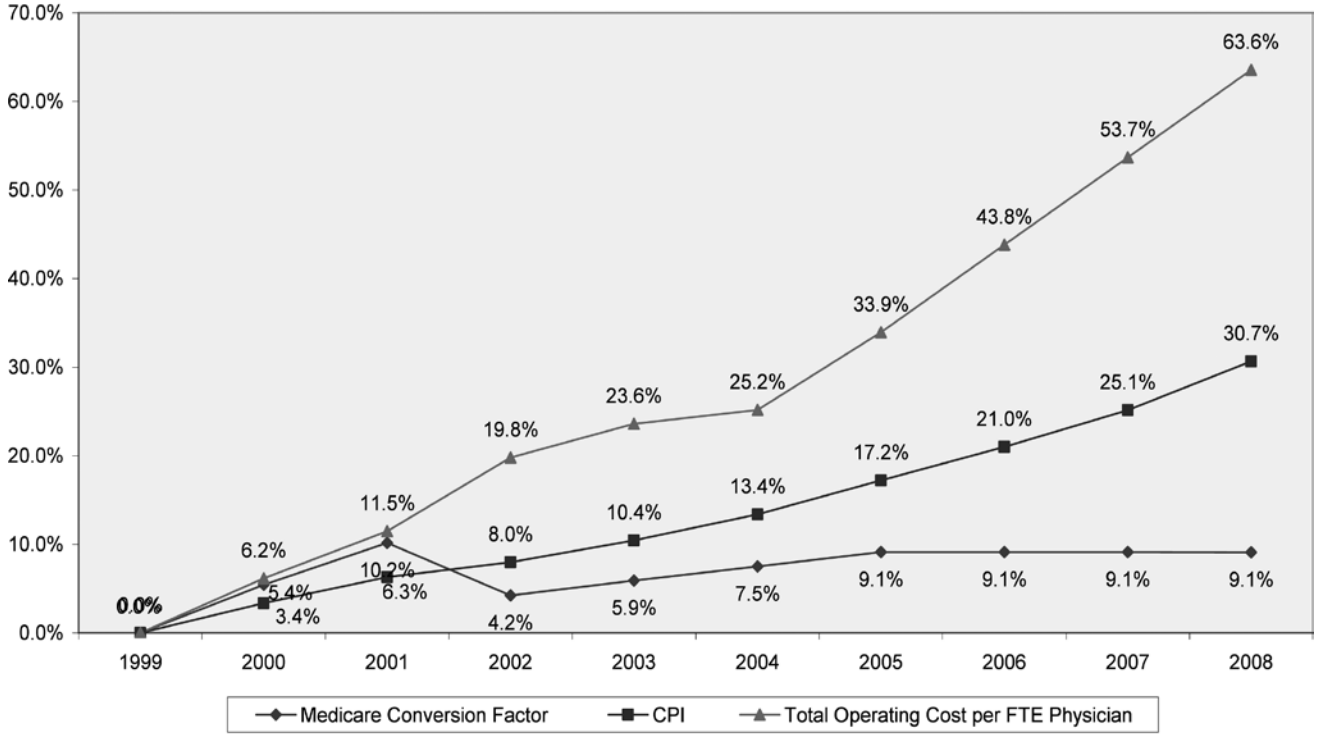
A third trend that has affected virtually every physician has been the steady reduction in payments for services, coupled with practice operating expenses that have outpaced inflation. Exhibit 1 (on the next page) illustrates this pattern quite clearly. Over the ten-year period from 1999 to 2008, the Consumer Price Index rose by about 31 percent.[15] But during that same period, practice operating expenses increased by

13 R. Cook, "Finances driving physicians out of solo practice," *American Medical News,* Sept. 10, 2007.

14 E. Fisher, D. Staiger, J. Bynum, and D. Gottlieb, "Creating Accountable Care Organizations: The Extended Hospital Medical Staff," *Health Affairs* (Web Exclusive), December 5, 2006.

15 Bureau of Labor Statistics, Consumer Price Index, accessed at www.nclis.gov/statsurv/NCES/plu/trends/cpi.html, January 27, 2008.

Exhibit 1: Cumulative Percent Change Since 1999 for the Medicare Conversion Factor, the Consumer Price Index, and Multi-Specialty Group Operating Cost per FTE Physician



almost 64 percent, while the Medicare conversion factor for physician fees rose by only 9.1 percent (and has been flat for the last four years).[16] Because most private insurers base their fees on the Medicare rates, the revenue dilemma is obvious. When operating expenses increase more than six times the increase in payment rates, financial distress follows.

Despite flat or declining payment rates and the increase in operating expenses, physician income has generally kept pace with inflation. How? Through increases in the volume of services provided. For primary care physicians, this has taken the form of more office visits of shorter duration—increasing the throughput. And for most specialists, it has taken the form of adding new ancillary services to the practice in order to capture the revenues associated with those services. While these tactics are logical responses to the economic environment, they are also the root of many of the conflicts between hospitals and physicians.

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

16 Medicare conversion factor data can be found in the Medicare Physician Payment Fee Schedule, Federal Register, July 2008 (CMS). Practice operating expense data are from *Cost Survey for Multispecialty Practices: 2008 Report Based on 2007 Data*, Medical Group Management Association (MGMA).

(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 about 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 subgroup 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, and so forth).

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 noted earlier, Medicare data indicate that 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. Because they are mostly salaried, they are less concerned about the impact on their compensation of time devoted to hospital administrative activities.

As they generally are not dependent upon physician referrals, they are also less likely to be the subjects of economic

retribution if they take action against a physician whose performance is sub-par. Alignment with specific clinical performance goals (for example, eliminating ventilator-associated pneumonias, achieving 100 percent compliance with hand hygiene standards, and so forth) can be achieved through incentive compensation for salaried employees or specific performance bonuses for contractors.

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 this group, and they may become investors in ambulatory surgery centers, specialty hospitals, and other specialized treatment facilities that compete directly with general hospitals. In addition, these physicians are not hesitant to threaten to move their 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 population to build ambulatory surgery centers, endoscopy centers, imaging centers, medical office buildings, and other similar enterprises are becoming increasingly common. Care must be taken in structuring these ventures, however, to avoid both economic and legal problems. 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, due to the complex web of laws and regulations governing such ventures, good legal advice on their creation is essential.

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 (who face prohibitive malpractice insurance premiums in some states)—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.

Achieving Strategic Alignment between a Hospital and Physicians

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

Once Burned, Twice Shy: Learning from Failed Practice Acquisitions

In order to secure access to key physician services, more and more hospitals are now employing physicians and operating medical practices. Historically, hospitals have reported losing anywhere from $50,000 to as much as $200,000 annually per physician.

Learning from the past, hospitals and health systems today are cutting losses by hiring professional managers with a background in physician (as opposed to hospital) practice management. Instead of allowing practices to maintain

redundant overhead costs, they are generating efficiencies and synergies by integrating platforms for billing, purchasing, human resources, and other administrative support services.

Perhaps most importantly, health systems that employ physicians or own practices are recognizing the importance of physician compensation to hospital–physician alignment. With properly designed compensation and thoughtful management of top-line revenues and operating expenses, practice losses can be cut in half and even eliminated in certain situations.

What's more, in some cases, a loss on the professional service revenue of particular physician practices may net better overall results for a hospital or health system—because of increased revenues for ancillary services or hospital-employed specialists, and because aligned, employed physicians may help improve efficiency and reduce expenses and over-utilization.

Compensation Design

Fair and competitive physician compensation design is the most crucial single feature in a financially sound and thriving hospital-owned practice. Compensation must reward productivity as well as quality of care. Increasingly, physicians appreciate a practice setting that rewards them as if they were in private practice. At the same time, pay-for-performance trends will require that physician compensation mechanisms become more aligned with Medicare, Medicaid, and commercial payer payment methodologies. This will inevitably require greater complexity and sophistication.

Exhibit 2: Impact of Compensation Strategies on Incentives

	Productivity	Payer mix	Billing and collections	Practice expenses
Fixed salary				
RVU's				
Collections				
Net income				

Physician has incentive to manage

Physician has no incentive to manage

In designing physician compensation methodologies, hospitals should choose the degree to which they want to buffer employed physicians from economic realities they would experience in private practice. Exhibit 2 shows the inherent incentives of four common compensation approaches and lists how each one buffers the physician from some practice risks.

Guaranteed salaries (except for start-up practices) provide too much protection and do not align physician and system incentives. Basing compensation on a physician's productivity (usually using relative value units, or RVUs, a standardized measurement for physician services and procedures) rewards physicians for volume, but buffers them from some factors that affect overall practice profitability, such as treating uninsured patients, increasing staff, and investing in new information technology systems.

On the other extreme, basing compensation on a practice's net income incentivizes physicians to be concerned with all factors that affect profitability, including payer mix and practice expenses, but it could penalize them for factors beyond their control. It is tempting and sometimes necessary in certain markets to buffer physicians from practice realities by compensating them for productivity alone, but doing this will lead to financial losses on physician practices. However, these losses could be offset elsewhere on a health system's financial statements.

Therefore, physician compensation formulas need to take into account several factors:

1. **Acknowledging the shift of ancillary revenues to the system.** Although a compensation model must provide the right incentives, it also must be market competitive or the hospital/health system won't be able to acquire practices or hire and retain physicians. Independent primary care physicians and specialists may have revenue opportunities through investment in office-based and freestanding ancillary services that are not available to hospital-employed physicians. From the perspective of the hospital, this loss of physician practice revenue is actually a benefit to hospital outpatient ancillary revenue.

   Medical Group Management Association (MGMA) reported in a 2005 study that hospital-owned specialist practices collected up to 31 percent less than their

counterparts.[17] This is caused, at least in part, by hospital-employed physicians referring their ancillary services back to the hospital.

Physician compensation should be set to recognize the shift of ancillary service activity. Although the physician practice will look like it is losing money, the hospital or health system is retaining the ancillary service volume it would otherwise lose to an independent practice. In addition, by maintaining a strong employed physician network, hospitals can fend off physician competition for ancillary services by capturing a large proportion of physician referrals for these services.

2. **A better top line.** Hospitals and large group practices have strong negotiating leverage with payers to seek favorable contracts with health plans, bringing both more patients and better payments than small practices could generate on their own. However, physician reimbursement rates are often sacrificed for better rates on inpatient or ancillary services. In designing physician compensation, hospitals must apply a balanced approach to ensure a healthy physician enterprise. A healthy revenue stream also requires accurate coding and effective collections.

3. **Allocating expenses that improve practice and system efficiency.** By joining health systems and system-owned practices, physicians benefit from the system's greater capacity to make capital investments in facilities and information technology that improve efficiency, support clinical integration, and increase quality of care. For example, electronic medical records (EMRs) can lead to better coordination of patient care among physicians, the hospital, and outpatient facilities.

   However, implementing EMRs in physician offices and other infrastructure improvements can add overhead and reduce practice profitability. Thus, physician compensation formulas have to be carefully designed not to load too much overhead onto physician practices.

Although most hospitals and health systems cannot expect to profit from employed physicians, it is possible to reduce losses and in some cases break even. Decisions about whether a practice should be allowed to lose money, and how much, should be based on market realities regarding compensation for the specialty, and the benefits the practice brings to the entire hospital enterprise.

Many Elements, Not One, Lead to Increased Alignment

Physician alignment may be a key strategic priority for most hospitals, if not all, but many find their efforts fall short because they seek operational as opposed to strategic fixes to a complex, long-term evolution from loosely coupled to more tightly coupled hospital–physician ties. As a result, they address problems reactively and narrowly, focusing more on money and partial, short-term solutions such as equity joint ventures and pay for call.

Instead, hospital leaders should consider working with current and potential aligned physicians to adopt an overarching vision and strategy for physician alignment, and then to use a mix of programs to move toward increased alignment over time.

While each hospital's vision and strategy must be unique, four common goals will form the core of most alignment strategies:

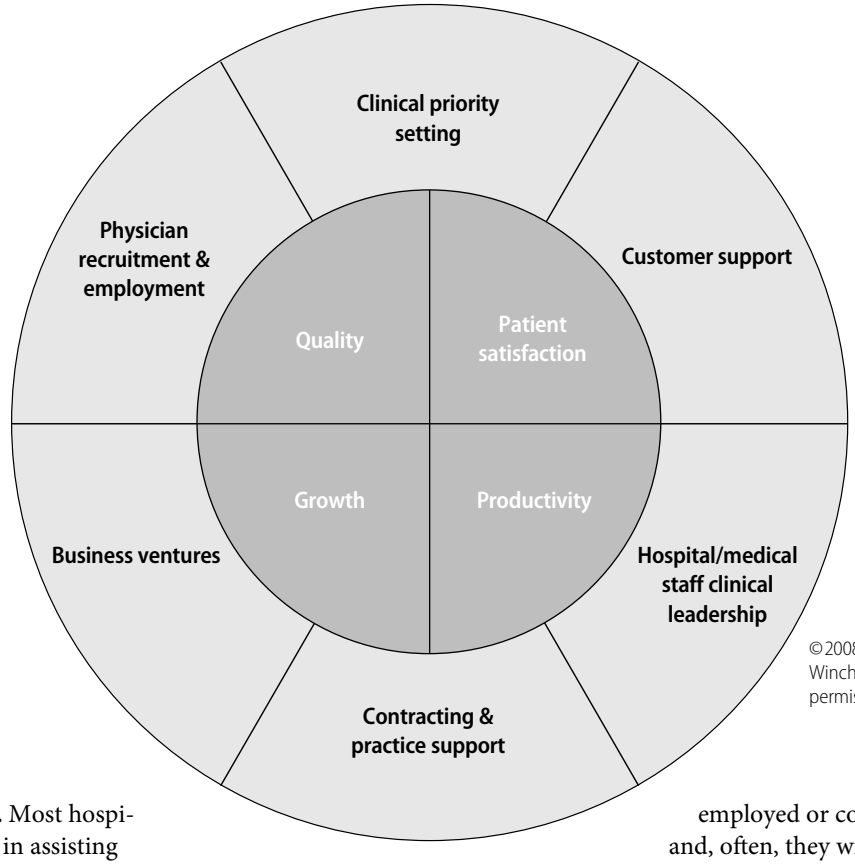
1. Quality improvement: relentlessly improving the quality and safety of patient care
2. Patient satisfaction: continually delighting patients and families
3. Growth: increasing volume consistent with community/market needs
4. Productivity: maximizing efficiency and margin

With an overarching vision and strategic plan for hospital–physician alignment in place, successful alignment initiatives can be developed around the following six components:

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

17 Marc G. Mertz, "Pay em to stay—and play: Case study: Steps towards developing a new physician compensation model," *MGMA Connection*, Volume 5, Issue 4, April 2005.

Exhibit 3: Core Goals and Common Elements of a Hospital's Physician Alignment Strategy



2. **Physician support.** Most hospitals can improve in assisting physicians in their efforts to efficiently provide the "best" possible patient care. A physician support plan that accounts for the diminished presence of primary care physicians in the hospital and the growing roles of physician extenders, hospitalists, and intensivists is required. Examples for improving productivity through physician support include fixing the disarray that exists in most operating suites and the timely provision of information in the patient chart.

3. **Hospital clinical leadership.** The existing medical staff leadership structure is an artifact of the 1950s that is, generally speaking, no longer effective. Most medical executive committees will admit there is room for improvement in their primary job of credentialing, privileging, and peer review.

   Hospitals need to assess their current situation and develop more suitable leadership models for the future. In many hospitals this reassessment is likely to lead to a structure in which at least the medicine and surgery chairs are employed on a full-time basis by the hospital, with a negotiated allocation of department chair time between administration and patient care. In addition, the leaders of major product and service lines (e.g., cardiac care, orthopedics, neurosciences) will be either employed or contracted physicians and, often, they will be co-leaders of the service line with an administrative and/or nursing leader.

4. **Contracting and practice support.** Regardless of the employment model of the future, each hospital needs to have an appropriate mechanism for joint insurance contracting with physicians, such as a physician–hospital organization (PHO). For those physicians desiring it, the hospital should also consider providing practice support services through a management services organization that provides, for example, financial services, information technology support, and staffing and scheduling assistance.

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

6. **Physician recruitment and employment.** Boomer physicians are aging, and those coming out of training are seeking a balance between lifestyle and work. Simply

stated and, in general, they do not want to be entrepreneurs engaged in running a business—they want to be good clinicians with secure employment. The era of the independent physician who provided services to the hospital on a voluntary basis is in its twilight.

Over the next five to ten years, physicians will increasingly transition from small, independent entities to single-specialty and multi-specialty group practices. Accordingly, many hospitals will provide physicians with an employment option such as a hospital-owned or affiliated medical group, while still embracing physicians who wish to remain in private practice, particularly older, well-established members of the current medical staff, or who align by partnering with the system on selective business ventures.

Employing physicians alone does not guarantee that they will be aligned with the system's incentives, or that they will operate in a coordinated fashion to attract and satisfy patients and to deliver efficient, high-quality, and safe care. Over time, system-owned practices and hospitals will need to develop a common culture built around like values and rewards. Consequently, culture development should be an implicit or explicit part of an alignment strategy.

Part III: Case Studies of Hospital-Physician Alignment

In writing this white paper, the authors and the research staff of The Governance Institute interviewed leaders of hospitals and health systems that are at various stages of aligning their hospital(s) and physicians.

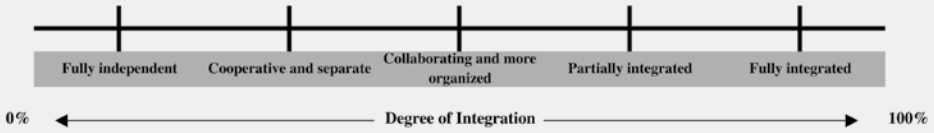
From these interviews, the authors have hypothesized an "Alignment Continuum" (see Exhibit 4). At the extreme left of the continuum, hospitals and physicians are "fully independent," economically and organizationally. At the extreme right, hospitals and physicians are "fully integrated" and are tied economically and in organized systems of care delivery. In the middle are various stages of increasing integration using such mechanisms as employed physician leaders, joint ventures, and system-owned physician practices.

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 organizations 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. (In addition to the organizations profiled below, we studied and learned from several other organizations. St. John's Health System (Springfield, MO), Guthrie Clinic (Sayre, PA), and Mayo Health System (Minneapolis, MN) represented fully integrated systems operating toward the right of the continuum. Saint Alphonsus Regional Medical Center (Boise, ID) and Borgess Health (Kalamazoo, MI) are using various physician alignment methods, including physician employment, and are in middle stages of the continuum. Space limitations prevent our fully describing these organizations.)

Exhibit 4: 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.

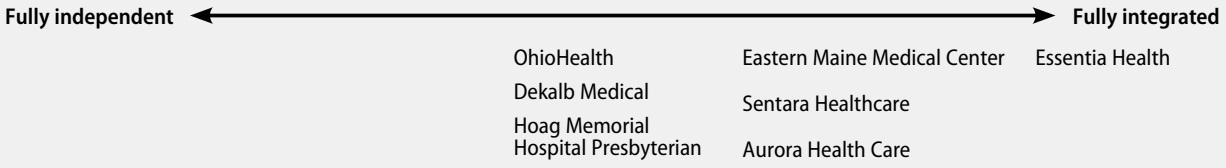
Cooperative and separate: We get along most of the time and work together some of the time with most of our physicians, but have problems with competition and lack of physician engagement.

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.

Exhibit 4a: Hospitals/Health Systems Profiled Along the Continuum



Starting Down the Alignment Path: Hoag Memorial Hospital Presbyterian

Hoag Memorial Hospital Presbyterian, 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.

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.

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 versus 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—especially to have "the most best doctors." "We plan to achieve that through very generous arrangements with our physicians—arrangements that are legal, meet regulatory requirements, and align our mutual interests," says Dr. Afable. "*So we look for sustainable, mutual benefit in everything.*"

A Pluralistic Approach: OhioHealth

"You can't just have one alignment strategy, because you have 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 in Columbus, OH.

When Ohio's certificate of need law was abolished in 1997, it opened the floodgates 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," says Mr. Blom.

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

- Professional service agreements for hospital-based services that include aligned quality metrics, service metrics, care protocol development, and management/staffing roles
- Annual assessment of physician satisfaction; executives are accountable to ensure physician satisfaction continues to improve
- An IT strategy developed with physician input
- Increasing the 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 patients to a specialty hospital (for inpatient services) are not granted privileges at OhioHealth hospitals. The management team 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.

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

- Have open, transparent communication.
- Understand the pressures physicians feel. Put yourselves in their shoes, to stay half a step ahead of what the physicians need and want rather than being purely responsive.
- Look for solutions that are flexible for the future; don't just satisfy today's needs.
- *Trust is critical*—it needs constant attention and takes time to earn.

Using a Physician–Hospital Organization as the Centerpiece of Alignment: DeKalb Medical

In the mid-1990s, DeKalb Medical in Decatur, GA 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. Approximately 80 percent of the physicians on the medical staff are part of the PHO, which is legally organized as a joint venture.

The PHO negotiates contracts on behalf of its members. While any physician can join the medical staff, PHO members must meet a higher level of performance on certain quality-of-care indicators. The PHO selects members in each specialty based on its best estimate of the capacity that specialty needs to serve the customers.

"We have built an infrastructure within our PHO that links physician members and the health system together to deliver a demonstrably higher quality product," says Mr. Norwood. The development of CPOE protocols and order sets serve as the unifying principle in this model, resulting in patients receiving a better product, payers paying for performance, and doctors and the hospital being compensated fairly for delivering a higher quality product.

The PHO established a foundation for working together that helps DeKalb executives to start thinking 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 Mr. 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 gives 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 wants to engage them in a joint venture, and thereby mitigate the alternative (competition). "This is serving us well," Mr. 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

"Eastern Maine Medical Center (EMMC) has a combination of relationships with physicians," says Deborah Johnson, president & CEO. Located in Bangor, ME, EMMC began employing physicians about seven years ago, starting with primary care. Today, it employs about 50 percent of the medical staff (roughly 240 physicians). Of those, there are 35 hospitalists, 18 surgical specialists (trauma, orthopedic, and general), and 20 other types of specialists such as cardiovascular surgeons, vascular surgeons, and ENTs. 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.

In past years, the fact that these competing physicians were also on the medical staff had been a bit contentious, but EMMC and these physicians now peacefully coexist, according to Ms. Johnson. The initial problem with a joint venture with the cardiology group involved the parties' inability to work through the financial details of the venture. Subsequently, EMMC developed a service agreement with the cardiologists that reassures them that it won't hire or recruit a competing group if they meet certain service levels for EMMC.

"Obviously, trust is key," Ms. 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," Ms. 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, Ms. 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

Aurora Health Care (AHC) includes 14 hospitals in five regions in Wisconsin, a 750-member Aurora Medical Group (AMG), and two 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 private practice specialists have had less interest in employment there (this is beginning to change), 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 three 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.

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 senior executive vice president & COO.
- A Physician Leadership Council that brings broad based input/communication from 37 AMG physicians and AMG's administrative leaders and medical directors.
- 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 of Aurora Health Care and AMG president, 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, getting the right team in place, single practice management and IT systems, standardized processes, uniform fee schedule, expense 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

Aligned Medical Group as the "Preferred Option": Sentara Healthcare

In 2006, Sentara Healthcare, Norfolk, VA, identified physician alignment as a "critical component" of its strategic plan, in order to transform healthcare delivery around best clinical practices and address critical needs for more physicians providing emergency, primary, and specialty care, explains Dr. David Maizel, vice president and executive medical director of Sentara Medical Group. The plan anticipates SMG will grow to a 500+ multi-specialty group by 2010–2012.

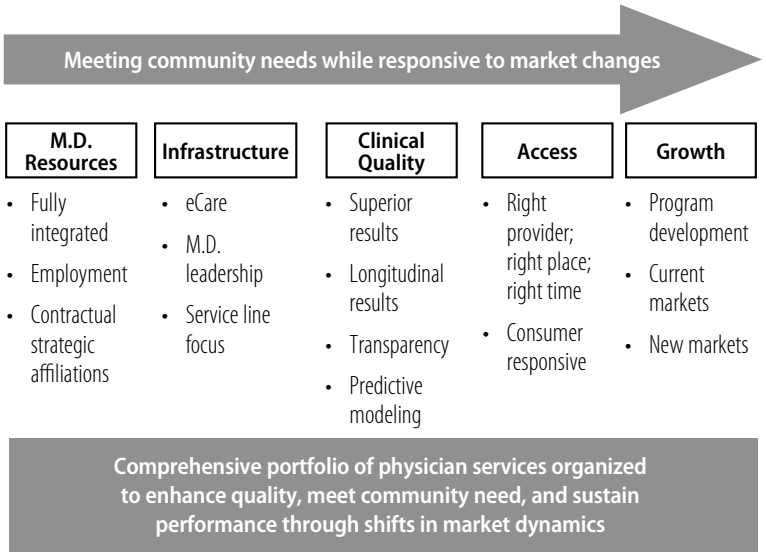
Sentara has a single board of trustees that oversees a system of eight hospitals, six freestanding outpatient centers, the Sentara Medical Group (SMG), Optima Health (a health insurance plan), and other healthcare enterprises. Driven by an explicit mission, vision, and strategic planning process centering around integration, by 2004 the Sentara Medical Group employed 216 physicians, 80 percent in primary care, at 42 practice sites, and today it numbers about 360—approximately 16 percent of physicians practicing in the communities the system serves.

Dr. Maizel stresses that Sentara's "preferred model" for physician alignment is medical group employment. He contrasts the greater ability of a medical group and hospitals to align around common quality and performance goals with the operational challenges posed by the variety of business relationships used by some other systems. Although Sentara uses joint ventures and contracts for professional services when necessary, the "deals" approach offers "little or no alignment regarding the success of an entire service line, rewards volume above all else, carries regulatory risk and complexity, and is high maintenance," he says.

By contrast, the physician employment model offers these benefits:

- Aligns the interests of the organization with a large number of physicians
- Facilitates optimization of clinical service line potential
- Offers a single, unified business model/full alignment of clinical and business models
- Provides economic balance (efficiencies) versus economic fragmentation (inefficiencies)
- Provides opportunities to enhance physician revenues that are linked to the overall success of the service lines

Exhibit 5: Sentara Medical Group Vision, 2008



Key elements of Sentara's approach include the following:

- Physician alignment is intended to achieve strategic aims for the entire health system, as illustrated in the medical group's vision for 2008 (see Exhibit 5):
  - Clinical integration
  - Superior outcomes
  - Continuity of care and improved access
  - Reduced waste
  - Growth to meet community needs
- Quality improvement and transformation of patient care are key drivers of the system.
- SMG is physician-governed, including an SMG board of up to 25 members, all of whom are elected, full-time practicing physicians except for three executives (the SMG president, SMG chief operating officer, and corporate chief medical officer).

Why Sentara Employment Is Attractive to Physicians: Sentara's Physician Alignment Strategy

From the perspective of the physician: Why Sentara?

- **History with hard data to show benefits to physicians beyond the "guarantee" period**
  - **Lower practice costs**
  - **Improved revenue**
  - **Reasonable workload**
- **Upside income potential from day one**
- **Strategic service-line vision to include physician leadership**
- **Value of fully integrated network**
- **Culture of quality, patient safety, and transparency**
- **Critical mass of providers**
- **Geography (physicians from outside the region)**
- **Better long-term alternative to "portfolio of deals"**

The Integrated Physician as Partner at the Table: Essentia Health

Essentia Health, based in Duluth, MN, consists of 10 hospitals, 700 fully integrated physicians (employed and through other means), 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.

History

Essentia's roots lie in a series of mergers in recent years. Going back to 1997, the Duluth Clinic (a 300+ physician group) merged with two St. Mary's hospitals, in Duluth and northern Wisconsin, to form the St. Mary's Duluth Clinic Health System (SMDC).

In 2001, SMDC brought in Miller Dwan Medical Center in Duluth, leaving Duluth with two competing systems—SMDC and St. Lukes. In 2004, SMDC created a new corporate parent, Essentia Health, by merging with the Benedictine Health System. Sponsored by the same Benedictine sisters who sponsor St. Mary's hospitals, the Benedictine Health System included many long-term care facilities (which have since spun off, with Essentia retaining a 20 percent interest) and several small rural hospitals. In 2008, SMDC completed the integration of the Dakota Clinic, adding approximately 200 more physicians and an additional hospital to the parent system.

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 believes that for Essentia and many other systems, the physician employment model will ultimately prove superior to what he calls the "portfolio of deals" model shown in Exhibit 6 (on the next page).

About 98 percent of SMDC's hospital admissions come from clinic physicians, although its hospitals do have an open staff and some independent physicians. In SMDC's markets, only about 5 percent of the physicians are still independent.

Essentia uses the balanced scorecard and strategy maps that cascade from the system board down to individual departments as an integrated approach to managing and monitoring the entire system. An enterprise-wide quality scorecard for hospitals and clinics focuses on clinical quality, safety, and customer service.

Cultural 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 have major leadership roles, including the CEO," says Dr. Person.

Dr. 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 that is 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 internal 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.

Dr. 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," Dr. Person says.

Governance and Management Model

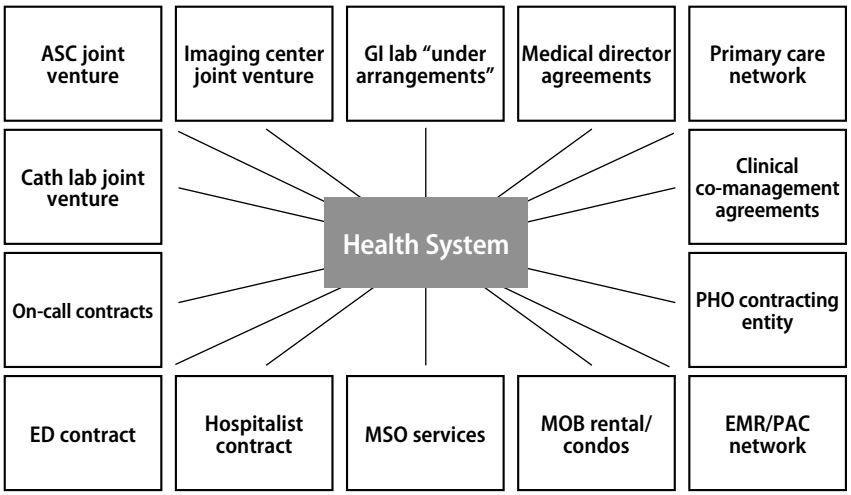
At the top, the Essentia board has four physicians from the medical group, the physician CEO, four sisters, and six community members. Below the board is the physician CEO, whose senior management team includes a physician and administrator dyad partner from each of the three regions, plus finance, legal, and the Essentia CMO.

Each region/subsidiary has a board but with limited powers to act, consistent with the system strategy, policies, and goals.

At the management/operations level, Essentia is a single, service-line driven organization in which pairs of physicians and administrators report up through a management structure to the board, which sets overall policies and strategy. "It's just like running a hospital except that physicians are at the table making strategy and decisions, with a powerful voice," says Dr. Person. "The goal is to streamline the organization. Complexity (the kind of complexity that results from multiple deals with doctors) brings the potential for conflicts and internecine warfare."

Board leadership and support are critical because the road to full integration is not smooth. For example, at one point, 11 internists (half of the department) left SMDC for its competitor over a dispute to establish a hospitalist program. SMDC took steps to soften the financial blow for specialists who lost some referrals, and over a year, it recruited 20 new

Exhibit 6: The "Portfolio of Deals" Model Followed by Many Health Systems



internists. "There will be challenges. It takes leadership to get through them," Dr. Person says.

Compensation Model

Physician compensation is a productivity/RVU based approach, adjusted as necessary to recruit needed specialties and the organization's ability to pay. The system sets expectations for productivity by section and pays a small stipend for leadership/other activities.

"One of the strategic commitments we've made is based on our belief that the current national approach to healthcare, which is fragmented, will become more dysfunctional in the next several years. Medicare and Medicaid can't sustain their current paths. We've tried to predict what will replace today's system, or short of that, what will be valued in the future payment model.

"We think the payment system will value care coordination and care management across the continuum, including disease prevention and chronic disease management in the home as well as outpatient and institutional care. We're fairly efficient now, and we've focused on assembling and managing all the pieces. We believe any delivery model that's less than fully integrated will be challenged in the future.

"That's what boards should ask: What will be valued in the future? Where will the dollars be? Too many organizations are focused on doing transactions to attract doctors, and the physicians soon grow unhappy with the controls the organization puts on them or the deal they signed. We need to paint a compelling picture of what the future will look like, and then we need put the pieces together."

—Peter Person, M.D.

Common Themes along the Alignment Continuum

Every one of the organizations profiled here was, at one time, on the far left end of the integration continuum—each 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. Start by nurturing them, and never take them for granted.
- 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. The strategic plan can then be updated every few years, with physician engagement.
- 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 financial incentives, make patient care more accessible and easier to navigate for patients, implement collaborative quality and performance improvement initiatives, and achieve efficiencies by integrating back-office functions such as physician office billing, scheduling, human resources, and purchasing.
- 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). It is typical to see a multi-layered governance structure:
  - A system board has fiduciary responsibility, makes overall strategic, financial, and quality decisions, and includes physicians, but has a majority of outside directors selected for the competencies.
  - System-owned medical groups have a practice board with a physician majority or all-physician membership that is accountable to the system board and responsible for policy making and

oversight of practice operations and quality, consistent with system-approved goals. Larger medical groups may also have boards at large clinics/practice sites, and may have some type of physician leadership council with broad representation to promote trust, communication, and collaboration.

- A high-level, operational management committee meets frequently and has equal physician/administrator participation.
- Physicians are involved in, and trained for, leadership roles throughout the organization.
- Care is taken to balance primary care and specialty physicians in leadership and decision making.
- Physicians set clear behavioral expectations (what is expected of physicians, including participation in leadership activities) that are communicated when new physicians are hired and applied during performance evaluations.

- 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, department chairs, and service line leaders.
- Allow time for the culture of the integrated organization to evolve and develop.

Part IV: 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. Aurora Health Care, for example, was the top-performing system nationally on the CMS/Premier Quality Incentive Demonstration project; it earned $376,000 in higher payments from Medicare for its performance in treating heart attacks, heart failure, and pneumonia, and performing bypass surgery and hip and knee replacements.

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, opportunistically or defensively. But for most, synergy is elusive. Often, one or more of the following elements are missing:

- 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)

A "Formula for Success"

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.

Our hypothesis at the outset was that trust between physicians and hospitals would prove to be the "keystone" for building alignment. That hypothesis has been supported by those hospitals and systems we have discussed.

We also believed that trust alone would not be sufficient to tightly couple hospitals and doctors to pursue and achieve common goals. Trusting parties would also need to choose the right alignment structures and business arrangements. But which are the "right" ones?

One vision and strategy won't fit every situation. As described earlier, a hospital–physician alignment strategy includes at least six components, and the systems we profiled are using these and other approaches. But which should be used, when, and how? How can a system move from left to right on the alignment continuum—without losing admissions and referrals from busy physicians who don't want to give up control or income or both?

Some systems such as Essentia Health have adopted a single, clear alignment mechanism (employment in a system with strong physician governance), while others such as Sentara Health have a preferred model (a system-owned, multi-specialty group practice), and others, including Aurora Health Care and OhioHealth, are achieving success with a more pluralistic set of arrangements involving employment and various business partnerships.

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 hospital–physician alignment:

$$(PM + AM) \times T = LA$$

(Physician Motivators [PM] + Alignment Methods [AM]) x Trust [T] = Lasting Alignment [LA]

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

Applying the formula requires hospital leaders to develop a deeper understanding of the various needs, expectations, and desires (physician motivators) of different physicians and groups. This understanding can only come from a high degree of interaction with physicians. The categorization of hospital-dependent, interdependent, and completely office-based physicians is a useful way to stimulate thinking and discussion.

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

Trust results when people work together on a task of great significance and produce a shared product with mutual benefit. Thus, hospital and physician leaders can strengthen trust if they co-develop alignment mechanisms through a partnership process, with complete transparency among the parties (as opposed to management, the board, and some "loyal" physicians developing them in a vacuum and then "selling" the package to other physicians). All of the organizations reported in this white paper, especially Essentia Health, OhioHealth, and Eastern Maine Medical Center, essentially used variants of this formula to build hospital–physician alignment.

Earlier this year, Saint Alphonsus Regional Medical Center in Boise, ID convened a physician integration task force to recommend a new model for hospital–physician integration to the medical center's governing board. Composed mostly of employed and independent physicians, plus several trustees and members of senior management, the task force met several times, invited presentations from leaders of more fully integrated systems, and eventually developed a set of recommendations for a new governance model, for presentation and discussion at a board retreat. "Having both employed and independent physicians in the room with board members was key to the success of the process," reflects CEO Sandra Bruce.

Physician Motivators

Some trustees and executives secretly (or openly) harbor a cynical view that physicians are motivated only by money. This is untrue and demeaning, implying that earning a good living is inherently unsavory for doctors even though executives and other professionals also have economic self-interests.

Economic pressures in healthcare have caused all providers to scramble for ways to thrive or at least maintain their status quo. Hence, physicians' focus on money should be viewed as a rational response to the time demands and financial pressures they are experiencing. But reliance on an alignment strategy that focuses *only* on responding to physicians' financial motivation appeals only to one motivator and may not result in the lasting alignment most hospitals would like to achieve.

Physicians are not getting the satisfaction they seek from medicine because economic pressures leave them feeling overworked, over regulated, and slowed down by inefficient hospital services that keep them waiting for test results or time. Higher compensation won't fix these underlying dissatisfiers.

Numerous physician surveys in the U.S. and around the world, published by the American College of Physician Executives, the *International Journal of Medical Sciences*, and others, have found that physicians (like most human beings) are motivated by a variety of things besides money. Many physicians (especially younger ones) are motivated more by a lifestyle free of the hassles of being in practice on their own and living a more balanced life with their families. Others are looking for a degree of security and support provided through a lasting alignment with a hospital or larger group practice.

Quality and a concern for patients are also physician motivators. This is not piety. To a physician, quality means having enough time to spend with patients, having the right information readily available to make accurate decisions, and getting prompt access to specialists and diagnostic and treatment facilities so that patients achieve the best possible outcomes. For many physicians, the acid test for enrolling in an alignment mechanism is whether it will result in better quality for their patients. Our research suggests a shared vision of a hospital–physician strategy should begin with or center on the common interest of aligning to improve quality.

Having an opportunity to influence decision making on matters that affect the practice of medicine drives many physicians to serve on committees and boards. For many physicians, achievement is the most powerful motivator and drives them to do research and work with hospitals that value research and teaching as fundamental components of their mission. A smaller but significant number of physicians seek power and control in their professional lives and are uncomfortable with any alignment method that relegates them to a subordinate position—if they are to join any group, it must be physician-governed. For all physicians, being treated with respect is at least as important as money.

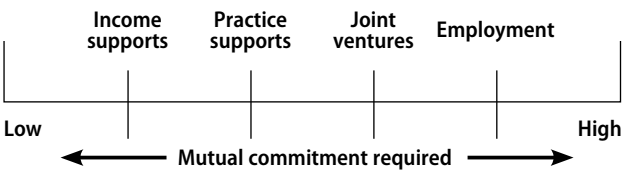
For the formula to work, management teams and boards need to start or enhance their alignment efforts by engaging physicians in discussions that focus solely on the issue of motivation before identifying various business arrangements to pursue. This will signal to the physicians that the hospital is truly interested in their needs and expectations and will enable the hospital to create a stratified menu of alignment opportunities that will appeal to a significant majority of physicians.

Alignment Methods

This is the topic that dominates the articles, publications, speeches, and marketing materials of lawyers, accountants, strategy consultants, associations, and the healthcare media. Everyone claims to have a better mousetrap for attracting and aligning with physicians. In general, alignment methods can be arrayed on a "Commitment Continuum," which ranks the various business arrangements and support provided to physicians based on the intensity of the commitment required by the physicians and the hospital (see Exhibit 7).

For example, a joint venture with a group of surgeons for an outpatient facility does little to improve their frustration with inefficient hospital services or address the hospital's need for their cooperation on efforts to improve quality and efficiency and manage costs on the inpatient side. Employing doctors may provide economic security but not job satisfaction if the employment model denies them a role in decision making.

Exhibit 7: Commitment Continuum



A plethora of alignment methods are well known throughout the healthcare industry and each of them has achieved a degree of success in creating a formal connection between physicians and the hospital. Therefore, for lasting alignment to be achieved, physicians and hospitals need to increase the intensity of their commitment to one another, such as long-term, broad based joint ventures and/or employment arrangements with physicians directly, or as part of a large, multi-specialty group of employed physicians.

Not all physicians need or desire a more permanent alignment with hospitals and/or physician groups. But they may be looking for (or motivated by) something on the lower end of the commitment continuum. Thus, a reasonably full menu of alignment methods must be available to attract the largest number of desired physicians. Physicians who start out aligning with a hospital by taking advantage of the hospital's practice management service or physician recruiting assistance and develop a degree of trust with the hospital in the process may eventually enter into joint ventures or an employment relationship in the future.

The "Trust Effect"

Offering a variety of alignment opportunities based on the needs and motivations of the physician population, while necessary, will not guarantee lasting alignment between the hospital and physicians, no matter how clever the arrangements may be at avoiding legal problems. Many hospitals have and continue to enter into complex business deals with groups of physicians out of a sense of short-term urgency with little regard to developing the kind of trust necessary for the relationship to work during both the good and rough times. And this is a two way street, with physician groups leveraging their market clout by demanding and securing lucrative business arrangements with hospitals, figuring that the relationship will somehow work out over time. These are deals ripe for confusion, conflict, dissatisfaction, and, ultimately, lawsuits.

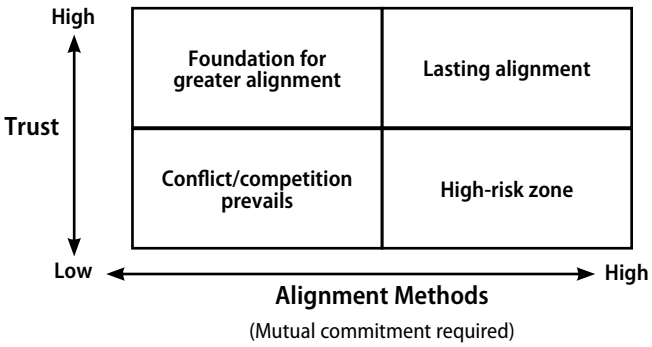
The formula for success requires a reasonable amount of trust among the parties for any alignment method to be successful over the long-term. The greater the trust, the more likely the alignment method will be successful. In fact, pursuing business deals at the right end of the continuum displayed in Exhibit 4 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.

The matrix shown in Exhibit 8 (on the next page) displays the relationship between the degree of trust among the hospital and physicians and the degree of commitment required by the alignment methods displayed in Exhibit 7. Achieving a high level of trust among the parties creates the conditions necessary to successfully implement any of the alignment methods. Hence, trust as a variable in the formula for success becomes the accelerator or multiplier that results in lasting alignment based on marrying physician motivations with the appropriate alignment method. The challenge of building the kind of trust that leads to lasting alignment starts with a clear understanding of what trust is and is not.

Trust Made Clear

We all have an intuitive grasp of the meaning of trust—the same can be said for mission, vision, values, and culture. However, trust is something that one *feels*. It is difficult to operationally define and hard to know when individuals and

Exhibit 8: Trust



groups of individuals have achieved a significant level of trust among themselves.

At the same time, trust is also a rational act where one has concluded that others will perform in a predictable manner. Webster's Dictionary defines trust as "assured reliance on the character, ability, strength, or truth of someone—one in which confidence is placed." It is often said that trust is something earned (usually over time).

There is a "catch 22" aspect of building trust in that to develop trust one has to become vulnerable to the person or group that one is trusting, and then it builds on itself over time. Yet, starting that cycle of trust building requires (you guessed it) a degree of trust at the outset.

To overcome the challenges to building trust between physicians and a hospital, a place to start is to recognize the things that cause people to *not* trust one another and to make sure that they are eliminated from the relationship completely. People do not trust those who are not honest at all times (no exceptions). Nor do people trust those who are not *competent* in what they do. It would be hard for one to trust that the other party can deliver what they promise if the party's competence is questioned.

Finally, people do not trust others whose *intentions* are not transparent. This is probably the most significant barrier to trust between physicians and hospitals. It is rare that the parties actually lie or perceive the other to be incompetent. More often, the feeling exists that one party or the other has something else planned down the road that they are not revealing. Being aware of the things that cause mistrust and avoiding them in the relationship is a good start at building trust. It's been said that, "if you do it well [build trust], people will give you the earth. If you betray them, they will hunt you to the ends of the earth."

Common Roadblocks

Alignment efforts often encounter resistance from challenges in the current environment. Two of the most common are:

- **Outdated medical staff structures.** Medical staff leaders are elected and don't necessarily represent the physicians who are most active and interested in working with the hospital on shared goals. Hospital efforts to "control" the medical staff are likely to provoke hostility and fail. A more successful approach requires patience and involves a long-term effort to jointly establish expectations for physician leadership, provide training in leadership skills to physicians, and encourage the medical staff to study and adopt a contemporary model of medical staff governance. At the same time, the hospital can retain—though employment or contractual relationships—physicians to fill key leadership positions such as vice president for medical affairs, chief quality officer, clinical chairs of major departments (e.g., medicine, surgery, primary care), service line leaders, and medical directors of major clinical programs.

- **Physician conflicts of interest.** Many hospitals use seats on the board as a means to involve physicians in strategic and policy decisions. This is a highly recommended governance practice but insufficient for the deep level of engagement needed to achieve lasting alignment with a large number of physicians on the medical staff. In addition, physician members of hospital boards may have their own economic agendas in competition with the hospital, making it difficult for the board to have candid discussions involving physician strategy. Unless the physicians who are appointed to serve on the board have been educated on and accept their fiduciary obligations before beginning their service, physician board members often view themselves as "advocates" for advancing the physicians' agenda instead of providing unselfish oversight of the hospital for the benefit of those served. Thus, having physicians serve on the board, while beneficial to the governance of the hospital, is not the best, and certainly not the only, means of advancing the hospital's physician alignment strategy. In addition, the board should work with legal counsel to ensure it has adopted and is implementing clear policies on

conflicts of interest, including a set of "disabling guidelines" defining which conflicts are so material that they disqualify a physician or other individual from serving on the board or other decision-making bodies.

Applying the Lessons Learned

The case examples in this white paper 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 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.

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 physician 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' situations by making it easier to practice medicine in the community and by cooperating with physicians to create appropriate alignment methods.
- 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 build trust.
- Do not be sidetracked by disappointments or some who take advantage of the effort to build trust—effective leadership stays the course.

Joint Planning and Decision Making

Joint planning and decision making have been identified throughout this paper as critical factors in successful hospital–physician alignment efforts. These decisions include strategic planning for the entire system or hospital, service- or product-line planning, master facilities planning, medical staff development planning, quality improvement planning, and all other discussions that involve significant resource allocation.

To build the trusting partnerships needed for true alignment, physicians need to be engaged early and often in these decisions and others that affect them and their patients. This may require a shift in management's historical approach to planning. Instead of bringing fully formulated plans to selected physicians for their feedback and/or approval, management and the board should assume that all planning efforts will include physicians from the outset.

Here are a few proven techniques for engaging physicians in planning in meaningful ways:

- Invite physicians to attend all educational sessions with the board on strategic issues, such as national healthcare industry trends, physician alignment strategies, technological advances, and quality improvement.
- Convene an annual strategic planning retreat with the board, medical staff leaders (informal and formal), and senior management.
- Conduct multiple group input sessions for physicians prior to the development of the strategic plan. Hold the sessions at times and locations convenient for the medical staff.
- Ensure that physicians comprise at least one-third of the task force or committee charged with developing the strategic plan.
- Make sure all conversations about service/product line assessment, development or growth include affected physicians.
- Hold facilitated sessions, by specialty or department, where physicians can assess the long-term strengths, weaknesses, opportunities, and threats of their area as a prelude to overall strategic planning.
- Develop a physician council to provide informal advice to the CEO.

- Include physicians on the board and board committees such as quality and safety improvement, community needs assessment, and finance (while being attentive to potentially serious conflicts of interest).
- Ensure all quality improvement task forces are led by physicians.
- Assign physicians to the master facilities planning committee.
- Practice open-book management, sharing performance information with physicians.

By investing the time and effort to engage physicians on the front end of planning processes, hospitals and health systems will model the open, trusting relationships they are trying to build, gain invaluable perspectives and expertise, and build support and gain advocates for the ultimate decisions.

Questions the Board Should Ask

Since 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 board, physician, and management members 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 hospital–physician 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 hospital–physician 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 that of senior management (within the law and regulatory constraints) to ensure alignment?
- How can we ensure that hospital–physician 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.

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