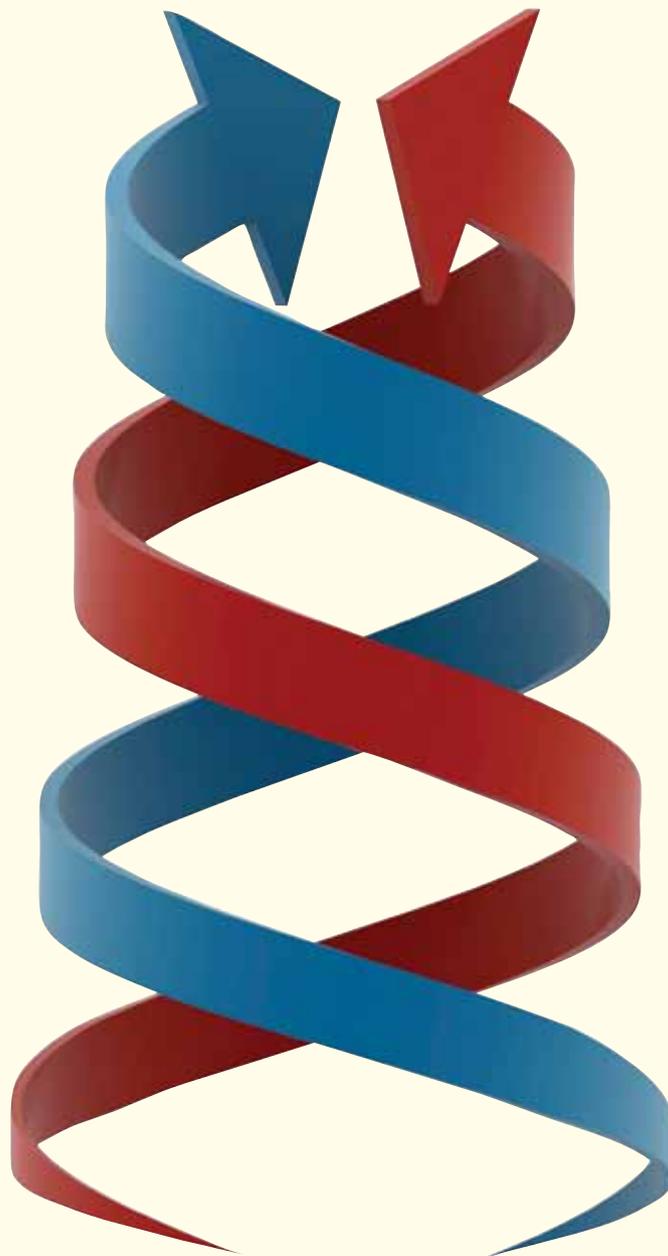


The New Era for Hospital-Physician Alignment



In a healthcare environment wracked by uncertain economics, shifting patient demographics, changing clinician attitudes, and reform-minded regulators, today's forward-thinking hospitals and physicians recognize there's only one way to successfully move forward: *together*. Drawing on the sometimes painful lessons of managed care in the 1990s, the new era of hospital-physician alignment is embracing collaboration, improving accountability, and lowering costs while improving patient outcomes.

How well is your organization prepared for this new era?

An examination of factors driving the push for hospital-physician alignment, strategies being employed successfully by some providers—and lessons learned—suggests what will be needed to best position for success.

Why Alignment—and Why Now?

According to many market-watchers, there are a range of forces that will eventually drive hospitals and physicians closer together. Key among them are growing physician capital needs, the changing competitive landscape, shifts in physician lifestyle, and payment changes focusing on care delivery outside of the hospital's walls.

Growing capital needs. Collaboration is increasingly appealing to physicians as they face economic challenges, particularly large amounts of capital needed for electronic records. "Physicians are looking around and recognizing that with decreasing reimbursements on the horizon and a greater demand for technology to improve both operational efficiency and clinical efficacy, the investment requirements are too large to be economically feasible for them to handle on their own," says Robert Bonar, president and CEO of Dell Children's Medical Center of Central Texas.

Changing competitive landscape. Also of note is widespread consolidation across the industry. Increasingly, only the strong—and large—organizations will survive, says Vince Schmitz, senior vice president and CFO of MultiCare Health System, Tacoma, Wash.

More than ever, hospitals will be seeking connections with other hospitals and large medical groups with solid financial positions, wide-ranging expertise, and strong referral bases in outpatient areas.

"In the new era of health care, the winners will be able to provide hospital-physician integration, care coordination, IT sophistication, cost control, and service distribution to cover at least 1 million people," says Schmitz, citing successful integrated providers such as Kaiser Permanente and Catholic Health Initiatives. "If you're a standalone hospital, I have some doubts about whether you're viable in this new environment."

With the ratio of inpatient-to-outpatient activity skewing toward outpatient treatments, more care will be provided away from the hospital, he says. This shift puts an even tighter clamp on revenues and heightens the importance of deep physician connections.

Shifting physician interests. Many physicians lack the desire to manage today's increasingly complex business operations. "With all of the regulations and billing complexities, running a medical practice is a far, far different proposition than even 10 years ago," says Thomas C. Royer, MD, president and CEO at CHRISTUS Health. "Physicians for the most part want to focus on clinical practice, not running a business or hiring IT staff."

Schmitz shares this view. "Think about it," he says. "You're 27 years old and have invested \$200,000 in school. It's a bit overwhelming to then have to go start a complete business—without any real background in IT, human resources, law, or contracting. These are smart people—but even for them, it's daunting. If you don't have millions to invest, how do you do it? I mean, if you wanted to be a CEO, you would have gone to business school, not medical school, right? Today, it's increasingly untenable to hang your own shingle or join a two- to three-person practice."

According to Jeff Limbocker, CFO of Our Lady of the Lake Regional Medical Center in Baton Rouge, La., business dynamics are only one factor in physician thinking. "We're increasingly finding that lifestyle choices are mattering a great deal to younger physicians coming out of residency," he says.

"Today's generation is different—physicians from this generation want more work/life balance," Limbocker says. "Although they are every bit as committed to high-quality care, they have a greater need than those before them to balance work commitments with the desire to be with their families and pursue personal interests."

Payment based on care coordination. Perhaps the greatest catalyst driving the new era of hospital-physician alignment is the emergence of care models dependent on strong hospital-physician relationships. One example is the accountable care organization (ACO). ACOs provide health services across the continuum of care and in different settings. Payment is provided in a lump fee that is allocated across the ACO delivery chain. Dollars are applied to the event, not on a fee-for-service basis.

Similarly, the patient-centered medical home is reshaping how physicians and hospitals interact. Under the medical home model, a primary care provider and members of his or her team are paid to coordinate all of a patient's health needs, including management of chronic conditions, visits to specialists, hospital admissions, and patient reminders for check-ups and tests. The medical home model is designed to allow for better access to health care, increase satisfaction with care, and improve health by improving coordination of care.

Payment changes under current care delivery models also are creating greater needs for hospital-physician collaboration. Whether focusing on preventable hospital readmissions or bundled services, many reform measures seeking to reward outcomes, minimize duplication of services, and enhance efficiencies are supporting an environment of hospital-physician collaboration.

What Will Be Different This Time?

Of course, market drivers aren't enough for alignment to be successful. Given the industry's failed experiments with integrated care in the past, it's crucial that the new era of alignment doesn't repeat these mistakes. Key will be establishing clinically driven relationships that are focused on the patient and have a financial foundation.

According to Royer, success starts by understanding changes in the hospital-physician relationship. "In 'the old days,' the hospital viewed the physician as its customer—complete with the physicians' dining room and preferred parking spaces," he says. "Maybe that made sense 30 to 40 years ago—but that era is long over."

In recent years, physicians have gone from being customers to competitors. "So much of the great medical technology became safer, cheaper, and smaller—and that encouraged many doctors to move out of hospitals and

into self-contained clinics," notes Royer. "Unfortunately, this competition didn't improve quality or costs. It only motivated everyone to overutilize the resources."

Now, with ACOs and medical homes, hospitals and physicians are achieving the right level of *collaboration*, he says. "The clinicians are becoming our partners," he says. "Yes, the dollar is driving this, but it's about getting more value for that dollar. We're working together to develop evidence-based protocols because the ACO is accountable not just for costs, like managed care, but also for coordinated care and quality outcomes."

Because today's relationships are clinically driven, it's *not* about "controlling" the physician this time around. "It's about getting physicians integrated with all other healthcare providers and programs to determine the best protocols, medications, and studies to conduct," Royer says. "Those are the things that get physicians' attention, respect, and engagement—and they should be the heart of any alignment initiatives. Instead of insisting on changing behaviors, it's

CREATING THE RIGHT CULTURE

Culture should be an important consideration when determining the best integration structure adopted by an organization. According to *Integration in a Reform Environment: Strategies for Success*, a recent HFMA report, hospitals pursuing integrated organizational structures should take several actions to support a common culture that embraces high-quality, low-cost care.

- Apply system goals consistently across all areas of the organization, both clinical and non-clinical.
- Develop a cadre of clinical and non-clinical leaders who can adopt an integrated, collaborative view in working with physicians.
- Create a strong brand identity for the organization with a theme that is easy for every member of the organization to grasp and rally around, such as putting the patient first in all that the organization does.
- Encourage a close partnership between physician leaders and members of the executive team, with all members embracing the shared goals of the organization.

To read the report in its entirety, search by title at www.hfma.org.

best to just present empirical data, compare behaviors and outcomes, and let the physicians make the right decisions. True alignment means you need to treat them like the partners that they are.”

Also different today is appreciation for the patient dynamic. Alignment strategies are bringing hospitals and physicians together in ways that focus on aiding the patient instead of focusing on the individual provider, as was done in the past.

Patients value the ability to more easily navigate through multiple doctors, specialists, clinics, and hospitals to receive care. Organizations with hospital-physician alignment are able to leverage such capabilities for competitive advantage. As technologies connect patient information across inpatient and outpatient sites, all parties benefit from easier scheduling, elimination of redundancies, and unified billing and financial assistance screening.

Patients—particularly those with chronic conditions that require involvement of several physicians—also benefit from unified, coordinated care that reflects agreed upon practice protocols for diagnosis and treatment. Incentives for patient compliance with these protocols and outcomes-based payment are making it easier for hospitals and physicians to see benefit from the collaboration of care as well.

But the road to alignment isn’t an easy one. Sometimes acquisition of independent practices or clinics is mistakenly viewed as an automatic path to hospital-physician alignment. However, past mistakes show acquisition should be viewed as simply a tool, rather than the strategy itself.

“You can’t put a bunch of smaller, ineffective organizations together and magically expect them to be a smooth-running, unified machine,” Royer says. “You need to invest in creating a common infrastructure that is flexible and accessible to everyone.”

Also, efforts must be taken to ensure both parties agree on overall mission and business orientation. Cultural clashes are the most difficult to get around, notes Bonar. “Sometimes there’s a mismatch between an acquired practice and the hospital’s mission statement. To be honest, hospitals don’t have a lot of experience dealing with outpatient clinics. Hospital leadership may not appreciate that a clinic may live and die by the \$35 co-pay, since the hospital has been focusing on \$500,000 NICU [neonatal intensive care unit] receivables.”

Parties that are too dissimilar won’t optimize the collaborative opportunities available. Explains Schmitz: “If you’re not careful, you can create an inhibiting bureaucracy and internal politics that divert you from the alignment mission.”

Strategies to Support Alignment

So what will hospital and physician leaders need to move forward? Several strategies can support hospital-physician alignment, although no single strategy is right for every situation.

Formalize relationships. Throughout the industry, hospitals and physicians are reviewing and, in many cases, formalizing their relationships. At one end of the spectrum, some organizations are hiring physicians as a means to address alignment effectively. After all, health systems have successfully employed nurses, lab techs, and select physicians such as hospitalists and anesthesiologists for years.

“At first, a physician might not love this model,” Schmitz says. “But, really, what are the alternatives?” When you add in the financial stability they enjoy, even as reimbursement rates decline, it can become a very compelling proposition.

“Hospitals can tell the physician, ‘You don’t have to invest your capital, and we promise to pay you in the 75th percentile if you meet your quality and outcome metrics.’ For a lot of people, that security is persuasive,” he says.

Patient outcomes enter the decision as well. “Whether it’s in an inpatient or outpatient setting, physicians want the most qualified people providing high-quality care for their patient,” says Royer, noting that surgeons will recognize their OR work is important, but also that the correct diagnosis and the proper pre-operative and post-operative treatment are critical, too. “By signing an employment agreement with a hospital, physicians have greater access to a complete continuum of care for their patients,” Royer says. “They have greater control over the system, and they have increased input over the clinical process. All of these things are tremendous incentives.”

Other organizations are formalizing physician relationships by creating clinically integrated groups or operating under affiliated service models. Such models allow for independence while still having structures that support some degree of clinical and/or technological collaboration.

READY FOR INTEGRATION?

For hospitals weighing an integration strategy, HFMA suggests the following considerations.

Market Analysis

A clear view of the market position is essential. Key questions include:

- What are the primary and secondary markets of each entity?
- How do customers view each entity, and how are they likely to view the combined organization?
- What competitive response, if any, is the integration likely to elicit in the market?

Goal Setting

Success also depends on setting realistic goals based on organizational capabilities and an assessment of market and customer base. Key questions include:

- What are the most effective techniques for assessing the capabilities of newly integrated organizations?
- What key areas should goal setting cover?
- What is the role of the financial executive in shaping goals for an integrated organization?

Physician Leaders/Champions

Developing key physician leaders/champions is critical to driving high performance. Key questions include:

- Are there optimal structures to solicit physician leaders?
- How should physician leaders engage with employed clinicians and community staff?

Data Sharing

Credible data on utilization, cost, and quality should inform decisions on system composition, process, and incentives. Key questions include:

- What data should be shared to build an effective integrated relationship?
- What are the barriers to obtaining and sharing this information?
- How can the integrated organization best transform data into useful knowledge that drives action?

Compensation/Incentives

Compensation policies and other incentives are powerful tools to align interests. Key questions include:

- How do you establish integrated goals amenable to compensation/economic incentives?

- How do you tailor compensation/economic incentives to stakeholders and ensure that major goals are accomplished?

Engagement/Cultural Blending

Cultural differences contributed to failed integration attempts in the 1990s. Sources for disconnect may include rural versus urban cultures, religious versus secular views, or simply the demographic differences among the customers an organization serves. Key questions include:

- Are engagement/cultural blending planning, analyses, and processes owned by human resources departments?
- Can engagement/cultural blending be measured? What are reasonable goals for success?
- What strategies have proven effective in smoothing the transition into a truly integrated organization?

Technology

IT can be a unifying force by providing a common syntax and means for examining performance. Key questions include:

- How can the disparate needs of stakeholders be accommodated while still implementing standardized platforms?
- What organizational structures and processes have proven effective in planning, implementing, and maintaining enterprisewide IT systems?
- What can finance professionals do to foster effective investment and processes around technology?

Process Improvement

Continuous process improvement requires education, sound tools to measure processes, a culture that encourages “outside-the-box” thinking, and accountability. Key questions include:

- What are the best ways to engage stakeholders in thinking about both clinical and administrative process improvement?
- What role do finance professionals play in process improvement?
- How does an organization make sound decisions on the portfolio of process improvement initiatives it undertakes (balancing between those with positive ROI and those that are mission related)?

Source: Adapted from *Healthcare Payment Reform: Accelerating Success*, HFMA, March 2010.

Less integrated than these options are models where physicians receive staff privileges or where they establish independent practice associations (IPAs), groups that support negotiating and administering contracts. These models may support enhanced hospital/physician communication and compliance with contractually agreed upon care practices, but still maintain at their core independence in business and clinical approach.

Establish a culture of collaboration. A cultural shift also may be necessary to achieve the right level of hospital-physician alignment. It's important for hospital leaders to elevate the importance of teamwork and focus on team-building dynamics.

"The truth is, most physicians see themselves as independent practitioners," Royer says. "But it's essential to remember that health care can't be provided by one person. A physician can't make decisions independently. He needs labs. He needs X-rays. He needs good discharge planning. Health care today is much more complex and requires much more coordination. For physicians—especially older physicians who have worked in a very independent manner—alignment represents another shift in their style and practice."

Schmitz holds a similar view. "From now on, medicine needs to be a team sport," he says. "You need to have teams of clinicians, with physician assistants and nurse practitioners and even 'e-consults.' It's a whole new game. Hospitals should use this dynamic to involve physicians and make them true partners. When that happens, alignment is possible. But if you don't talk to—and listen to—physicians, then you're headed for trouble."

Leverage technology. A key challenge to hospital-physician collaboration is the need to work from a common base of shared, updated, and accurate information. For MultiCare's Schmitz, it all comes back to electronic health records (EHRs), which his institution has been carefully deploying for several years as part of a 10-year, \$150 million "journey."

"Few medical practices are going to have the capital to deploy the kind of system that will be a requirement in just a few years," Schmitz says. "We think EHRs will be a huge reason for physicians to be coming to us for employment, acquisition, or co-management—and we welcome that."

"We have 90 sites of care on both sides of Puget Sound. Today, we're a Stage VI HIMMS institution—putting us in the top 1 percent of the health systems in the country. We already qualify for 'meaningful-use' reimbursement, which gives us about \$40,000 per-physician in added incentives—which is a great recruiting tool—and we've qualified for millions more in campus improvements. Of course, our investments dwarf these figures, but we view this as primarily a quality-driven, not financially driven, imperative. The simple fact is this: If you don't have an integrated EHR, you can't create a true continuum of care. You don't have the alignment you need. And if you're going to get paid on health status and outcomes—and not output—this is a must."

Royer also views the EHR as a requirement for effective alignment. "If we expect good alignment and coordination, we need shared data," he says. "It's really the only way we can avoid duplicating lab work and tests. That's critically important to stopping the escalation of costs. With an EHR, the physician can see prior diagnoses and prescriptions to help avoid wasted time and money. And when you have this framework in place, you can audit the clinical protocols being followed, so there is a consistent level of excellence being pursued and practiced."

"The driver for all of this at our health system is not healthcare reform," Royer adds. "We've spent \$90 to \$100 million a year for the past five years—but we're not doing this for reimbursement. We're doing it for quality."

"Yes, if our quality is high, then we'll get higher levels of reimbursement," he says. "Payers will drive patients to us, and physicians will view our organization as the best place to practice. But it all starts with quality."

Explore payment pilots that support collaboration. Providing higher-quality care at lowest cost depends on hospital-physician coordination—something payers are starting to recognize and reward. "We're facing the same problems year after year because of fundamental, systemic flaws," notes Royer. "It's pretty simple: We have huge expenses in our system because we are not coordinating care among independent, disparate providers, and that's leading to overuse of treatments and medications. If we can use financial incentives to trim that waste, we'll not only save money, but also improve quality of care."

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SHAPING YOUR ALIGNMENT STRATEGY

J.R. Thomas, president and CEO, MedSynergies, Inc., describes the fundamentals of developing—and successfully executing—an alignment strategy with physicians

Q What do you see as the foundation of an effective hospital-physician alignment strategy?

A The overarching concept of an effective strategy is grounded in the mission. For a hospital-physician strategy to work, all parties must agree on the mission and that mission must be seen as bigger than the needs of the individual. In addition, this adoption of a mission must be actionable.

In our experience, pursuits successful in establishing this mission tend to be:

- Investing in the local market healthcare delivery system
- Increasing the depth and breadth of healthcare services and points of care entry
- Measuring and increasing the quality of total healthcare delivery in a financially responsible manner

Also key is building a foundation of trust, which is a result of consistency, transparency, and the belief that patient interests come before those of the provider.

Q What key steps are involved in building a successful alignment strategy?

A First, hospital leaders need a thorough understanding of existing physician relationships. Hospitals should take an inventory of current physician relationships that includes total number of physicians, tenure of the relationships, terms of the agreements, geographic and specialty coverage, and review of legal considerations—to name just a few. Leadership

also should inventory physician services needs. For example, what do the physicians need to operate their business on a daily basis? What technology, applications, and infrastructure do they have in place to support accounting, payroll, benefits, banking, practice management applications? What clinical systems do they use, require, and desire?

With this perspective, hospital leadership can then take the key steps of executing a financial and process assessment for each practice; forming a physician-service organization exclusively focused on physician practice business services and management; recognizing the opportunity for practice development and continuation—either through practice acquisition and physician employment models or practice service models; constructing a systemwide plan that incorporates common systems, analytics, and benchmarks; and building a hospital-physician plan that includes financial commitment from both hospitals and physicians.

Q What is the biggest pitfall to avoid once the strategy is in place?

A Hospitals and health systems generally operate on a different scale and response time than physician organizations, which can create issues in communication. As the strategy takes hold, extra care must be taken to ensure clear, concise information necessary for execution is disseminated swiftly, with full transparency and no surprises.

Source: MedSynergies, Inc.

Hospitals and physicians may find common ground through participating in payer-supported efforts such as pay-for-performance initiatives or bundled payment pilots that offer incentives for working together to cut costs and enhance clinical quality.

Your Approach to Alignment

It's not enough to simply encourage more frequent and goal-focused relationships between hospitals and physicians.

True alignment must reflect new and smarter thinking that creates financial efficiencies, technological innovations, and clinical improvements without falling into traps of the past.

Reaching this state will require an open and honest exchange of information. For true alignment to occur, both parties must develop a mutual foundation of trust and understanding.

With this in mind, regardless of an organization's particular goals for alignment, it's vital for leadership to adopt the following approach.¹

Be transparent. Hospital and physician leaders should develop a comprehensive plan for the relationship and have open, inclusive communications on what will be needed for its adoption. Also, at every level, individuals on both sides should have a clear idea of what is happening and why, what to expect, and how they will play a role in making the new relationship succeed.

Seek consistency. Organizations with the greatest collaborative success tend to share a common mission, vision, and goals. With this shared orientation, it becomes far easier to come to an agreement on such issues as clinical practice, business process, or technology.

Build momentum. Start with easy and rapid collaborative “wins.” When physicians see direct and immediate benefits from alignment, such as improved access to hospital lab work, it is far easier to gain their buy-in when it comes to more complex or controversial matters of clinical or business process reconciliation.

Invest for success. In many ways, market demand is underestimated for facilities developed through hospital and physician alignment. Financial viability of the relationship should be a goal at the outset. To help make this happen, hospitals should provide physician practices with appropriate resources and market these relationships for competitive advantage.

Robert Bonar, president and CEO of Dell Children’s Medical Center, sees such actions as key to succeeding in the new era of hospital-physician alignment.

“There’s no wrong way to aggregate physicians and start aligning processes and behaviors,” says Bonar. “No matter what strategy you choose, this alignment is going to be crucial. The only mistake you can make is to sit by and do nothing.”

Endnote

¹ Adapted from “Physician Hospital Alignment (PHA): A New Era?” HFMA webcast, presented by Robert Bonar, President and CEO, Dell Children’s Medical Center, and J.R. Thomas, CEO, MedSynergies, Inc.



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