Culbert
HEALTHCARE SOLUTIONS

HOSPITAL/PHYSICIAN ALIGNMENT STRATEGIES:
An innovative blueprint for successful integration

At the heart of most current healthcare reform initiatives is an emphasis on patient-centered, continuum-wide care. From the accountable care organization (ACO) to the patient-centered medical home (PCHM), most contemporary models of care have one common requirement: the alignment of hospitals with their community physicians. Each model seeks to improve healthcare quality and control cost through better, more proactive care coordination among all providers.

With increasing impetus toward such integration, many hospitals, health systems, and physicians have begun to evaluate their alignment options. There are many crucial factors to consider. In each situation, a successful alliance will require a careful assessment of unique market and organizational complexities.

Beware those who advocate a "one-size-fits-all" approach to hospital/physician alignment. Those who do fail to appreciate the lessons of the past.

Alignment strategies of the past: a brief history

For many in the healthcare industry, hospital/physician integration is nothing new. As recently as the 1990s, hospitals began acquiring primary care practices to meet managed care and other "gate keeper" models of care.

At the time, many practices were purchased by hospital organizations for multiples of their revenue. Physicians commonly received three- to five-year salary guarantees equal to their salaries at the time of purchase. Small, efficient practices typically were upgraded to hospital-owned real estate, consolidating them at a much hirer rent. Physician employees earned hospital benefits.

Minimal physician involvement in organizational decision-making, however, proved to be an Achilles heel for many of these organizations. With few work incentives tied to their incomes and little voice in practice operations, human nature prevailed. Physician productivity sank.

As the trend continued through the 1990s and losses mounted, hospitals increasingly succumbed to pressure from board members to dismantle their medical groups and divest themselves of employed physicians. Physicians were restored to their own practices, while hospitals continued to emphasize inpatient operations.

For the next decade, Stark laws and other regulatory limitations sharply curtailed the support hospitals could provide for practices. Hospitals and health systems typically took responsibility for streamlining the credentialing process and providing community infrastructure—operating rooms and technology, for instance.

Meanwhile, supply-and-demand economics encouraged physicians to enter high-demand specialties and practice in communities where competition was limited. While dependent on each other, neither physicians nor hospitals were responsible for one another.

Unfortunately, this business model has fallen prey to its own set of shortcomings. While costs have risen exponentially, quality gains have stagnated. Most industry analysts deem both the cost and the quality of patient care to be unsustainable.

The current landscape: Why alignment strategies are gaining force again

Cost control and quality improvement are the two main drivers behind ACOs, PCMHs, and other contemporary models of hospital/physician alignment. However, a host of secondary factors play crucial roles as well. Changing workforce expectations, patient needs, and technology advancements also are propelling hospitals and community physicians into a new era of strategic alliances.

Changing workforce expectations

Of all the reasons for the renewed interest in physician/hospital alignment, one of the most subtle may involve the career expectations of healthcare providers themselves. For many, generational and gender shifts are altering what it means to be a doctor.

Fifty-one percent of medical school students now are female—a marked departure for a career historically dominated by men. In addition, newer physicians tend to be driven by different goals than those of older generations. Private practice no longer is viewed as the only professional option available. Rather than taking on long hours and excessive call as a badge of honor, younger physicians prefer to balance professional growth against personal development, family life and security. Many eschew the business risks inherent in practice ownership, desiring instead a financial package with a strong base salary and better fringe benefits.

Increasing financial pressures

Expenses within private practice continue to rise at a rate beyond the annual increase (and threatened decrease) of insurance fee schedules. It all adds up: the expenditure for necessary technology; the costs to employ practice managers; and the expense for medical insurance, benefits, and rent. Many providers question whether private practice is still financially viable.

Malpractice coverage also is problematic for some specialties. Many obstetricians, for instance, no longer feel they can afford to deliver babies. Similarly, many neurosurgeons limit their practice to less-risky spine conditions.

As financial pressures affect practices, they also force hospitals to seek new ways to provide these services. Employing physicians allows hospitals to ensure stability for key service lines—neurosurgery and orthopedics, for example—without worrying about the cost of on-call pay or competing ambulatory surgery centers (ASCs).

Community healthcare needs

Practices squeezed by increasing overhead and sliding reimbursement increasingly are turning to hospitals to provide services that either are not covered or are poorly reimbursed by payers. The historic relationship between community primary care providers (PCPs) and hospitals has significantly changed in the last ten years. Hospitalist programs now keep PCPs in their offices, removing the opportunity for physicians and administration to interact.

Many physicians—particularly in surgical specialties—are sub-specializing in an attempt to limit their scope of practice and reduce their call burden. Unfortunately, this only further exacerbates the on-call burden for other physicians, and can result in small communities going "bare" (i.e., no coverage for certain specialties on certain days or weeks). Physician groups unable to offer competitive recruitment packages to new providers may find themselves working harder and taking call more frequently.

By employing physicians, hospitals can provide services not otherwise offered by community providers.

Pay-for-performance initiatives

"Pay-for-performance" is a fairly generic term that encompasses a number of care models currently being espoused, including ACOs and PCMHs. But all are designed to promote less-expensive, better-quality preventive measures rather than more costly acute care. In the case of ACOs, for example, the goal is to improve care to Medicare beneficiaries and lower its cost through shared responsibility and reimbursement across the continuum of care.

While still in their infancy, these models of care nevertheless push hospitals and physicians toward more collaborative, coordinated operations. Pay-for-performance initiatives currently comprise only about one percent to two percent of healthcare reimbursement. However, what happens when that figure rises to a significant

portion of revenue? Hospitals and physicians then will be mutually dependent on the ability of each to achieve stellar patient outcomes.

Technology advancements

Information technology (IT) is perhaps the single greatest variance between the strategic hospital/physician alliances of today and those of past decades. Indeed, the opportunities offered by electronic health record (EHR) technology are requisite for the success of any continuum-wide model of care. Enterprise IT systems allow both hospitals and physicians to drive better performance and outcomes.

Consider: Practices up until now typically have managed fairly basic office IT needs—PCs, Internet access, a billing system. Now they have the capability through EHR systems to exchange data and make all providers more accountable for patient care. However, practices now also need round-the-clock technology support, disaster recovery protection, and other data management capabilities. Conversely, most hospitals are well-versed in data management, but they now need to protect revenue streams by tapping into the kind of care typically provided in the practice setting.

The growing expectation is that healthcare organizations will have solid clinical IT systems through which to share data and work together toward improved patient outcomes. IT, in fact, provides the supporting backbone for ACOs, PCMHs, and other data-driven models of patient care. Combined with the lessons of the past, it can help forge stronger, more viable hospital/physician connections.

Lessons learned: Developing a successful hospital/physician alignment strategy

The biggest challenge in any hospital/physician dynamic is to effectively co-mingle alignment strategy with existing organizational culture. Regardless of ownership structure, the alliance must be a win-win situation that allows each party to leverage the relationship to better serve patients.

One size does not fit all. Successful affiliation requires tailoring a strategic plan appropriate to each unique corporate situation. In the high-tech, high-stakes world of healthcare coalition, one critical factor is decidedly low-tech: the relationship between the hospital and the community physicians involved.

This, in fact, was the single greatest problem to beset earlier attempts at hospital/physician integration. By precluding physicians from governance roles, health systems often alienated their community physicians. Those that heed this lesson from the past understand that shared management responsibility is essential.

The relationship among all parties must be strengthened by ensuring that all sides contribute to physician governance. Clinicians must be given some control over practice operations, and physicians must be provided a voice in the future direction of the healthcare entity being created.

Physician involvement can take many forms—executive titles, committee leadership roles, ownership stakes. For their part, however, physicians must be prepared to relinquish some of the autonomy inherent in the management of a completely independent practice. On both sides, organizational culture will dictate the best route toward shared governance.

Placing a management structure in the middle of the organization—through a management services organization (MSO), for example—often facilitates equality in decision-making processes. A third party can help objectively sort through all of the underlying cultural issues that come into play.

An effective management unit will:

- **Hire or appoint the right personnel**. Executives with the proper skill sets must be appointed to oversee practice operations.
- **Evaluate competitive dynamics**. Hospital/physician alignment can take many forms. How to best proceed depends on many external market factors, as well as the financial status of the practices and hospitals involved.
- **Maintain flexibility**. As an alignment strategy progresses and the market changes, all parties must remain adaptable. Sometimes, achieving the ultimate goal requires altering original plans in reaction to competitive pressures.

The ability to proactively and objectively evaluate market forces is one benefit of creating an independent management structure. Another is the capacity to articulate both hospital and

physician interests. The power to identify common ground issues—which often start with IT, quality goals, governance and contract management—is yet a third benefit.

However, it is not the only effective management model. Some systems find it better to form joint ventures without physician employment. Others may prefer 100 percent employment, with physicians becoming a division within the hospital. It might make sense for a heart hospital, for instance, to fully incorporate a large cardiology practice.

Again, organizational culture and goals dictate the most appropriate alignment strategy. Just as no two physicians or patients are alike, neither are any two healthcare institutions. A successful alliance requires crafting a model that fully recognizes and leverages each situation's unique assets.

Case study: The Reading Hospital Medical Group

The Reading Hospital Medical Group (TRHMG) is a network of more than 100 physicians and other healthcare providers delivering primary care services throughout Berks County, Pa., and the surrounding area. It is a non-profit affiliate of The Reading Hospital, governed by its own Board of Directors. But it had to be built from the ground up.

When The Reading Hospital faced the task of creating a medical group, it turned to Culbert Healthcare Solutions (CHS) for interim management, financial, technical, and operations assistance. TRHMG was an integral component of the hospital's strategy to align with community physicians. However, the new group needed to be built quickly and offer physicians a range of revenue cycle, administrative and technology services.

Strategic and operational decisions required flawless execution because the hospital had set an aggressive timeline for opening a new clinical facility. Integrating the newly acquired practices into TRHMG posed numerous human resources challenges—and the strategy had to be accomplished without negatively impacting TRHMG's revenue cycle performance.

CHS was engaged to provide interim management as well as financial, technical, and operations support for the creation of TRHMG's infrastructure. Tasks included physician practice acquisition and transition activities, construction design and build-out, Central Billing Office (CBO) development, revenue cycle management, hiring and training of new employees, merging the practices into a single tax-ID and implementing a practice management system that supported the newly acquired practices.

The goal was to execute the strategic plan and develop the concept into a fully operational enterprise. In partnership with TRHMG and hospital leadership, CHS consultants worked to ensure that the plan was properly executed and that all project milestones were achieved on time and within budget.

In the end, the collaborative approach was integral to TRHMG's success. The first phase of the endeavor brought together 44 physicians and their staffs, which were previously scattered across 17 locations. As a result of the leadership and infrastructure provided by CHS, TRHMG has continued to increase in size and now includes over 150 primary care and specialty physicians.

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