CHAPTER 1

Begin with the End in Mind

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The healthcare industry has recently seen a dramatic increase in activity related to hospital–physician alignment, with the most notable changes occurring in the acquisition of physician practices. Typically, practice acquisition means physician employment, although employment-like models also exist in which the medical group remains a separate legal entity, such as medical foundations (particularly in states that have corporate-practice-of-medicine prohibitions). In the interest of simplicity, this chapter treats both models as employment arrangements.

Regardless of the type of arrangement, hospitals often feel pressure to acquire practices quickly, either because they face direct competition from other hospitals in acquiring those practices or because the physicians are anxious, for a host of reasons, to sell their practices. Unfortunately, in the rush to get the deal done, longer-term planning around the hospital–physician relationship tends to take a backseat to the urgent demands of completing the transaction. Thinking in terms of the transactional versus relational elements of the arrangement is therefore useful (Exhibit 1.1).

Ideally, the discussions between the hospital and the physicians would strike an appropriate balance between transactional considerations and the relational elements that focus on how physicians and hospital leadership will work together post-integration. The challenge is to take the time to define and establish these relational elements before the deal is done, rather than deferring these difficult decisions until later. If issues are left open or subject to interpretation by either party, they are likely to emerge during times of stress—for example, when the organization is struggling with operational changes or financial losses. By then, however, both the physicians and the hospital will be frustrated and will invariably find it much more difficult to introduce, discuss, and resolve problems in their relationship. When

Exhibit 1.1 Transactional Versus Relational Considerations of Practice Integration

Transactional Considerations	Relational Considerations
Financial analysis	Vision
Asset valuations	Leadership and management
Due diligence	Decision making
Compensation and benefits	Culture
Legal document preparation	Communication
Lease and contract assignments	Medical staff relationships
Day 1 operational provisions	Joint strategic planning

the acquisition occurs prior to the planning, the integrated entity can find itself in a difficult position (Exhibit 1.2).

Obviously, this path is a painful one to follow. Taking a more effective approach provides opportunity for a long-term, stable relationship between the hospital and employed physicians. The key is to commit to a comprehensive planning process prior to engaging in acquisition or employment negotiations. This planning process will build the foundation for a highly successful and healthy long-term relationship with physician partners. The ideal path includes three phases—planning and strategy, business development, and execution (Exhibit 1.3). The remainder of this chapter focuses on the first two phases of this development path. The third phase, execution, is addressed in Chapter 5.

Exhibit 1.2 Typical Development Path (Practices Acquired Prior to Planning)

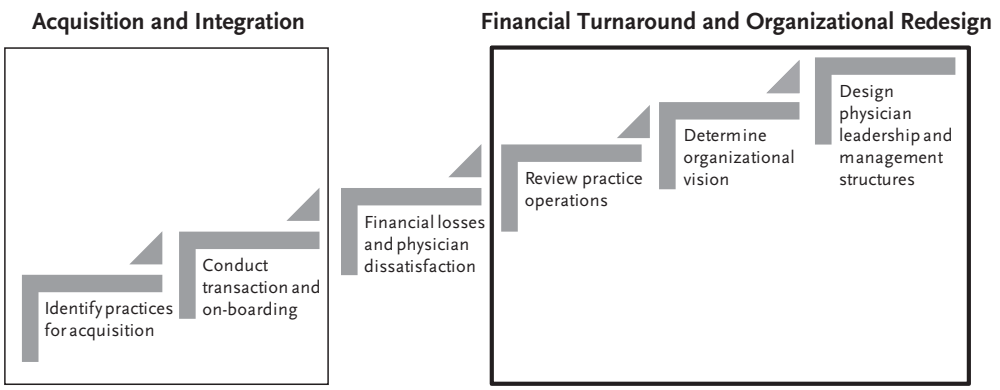
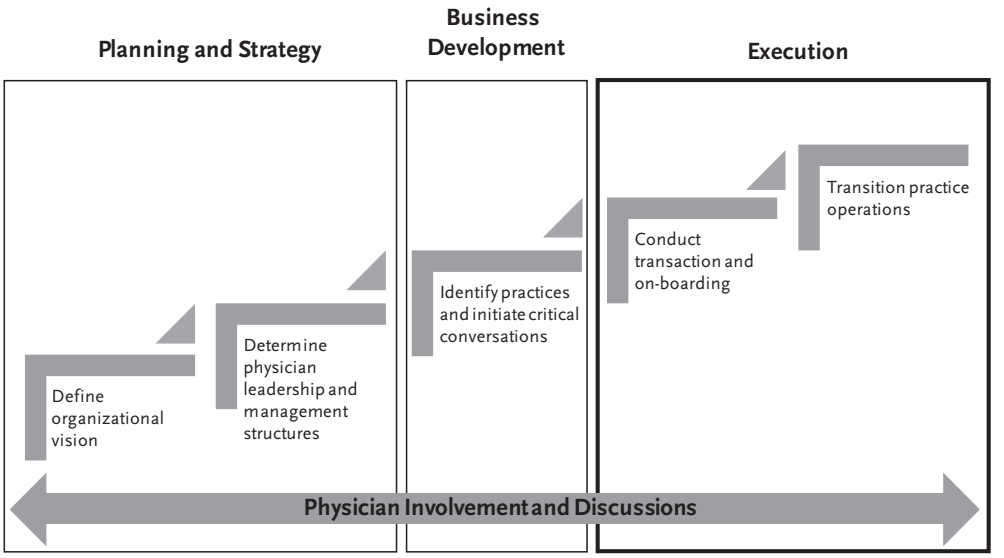


Exhibit 1.3 Desired Development Path (Practices Acquired After Planning)



Defining the physician alignment approach and establishing key elements of the health system employment strategy—such as physician leadership, compensation philosophy, and management infrastructure—are critical first steps a hospital needs to take before entering into more detailed employment discussions with physicians.

Although the first two phases of the planning process are internal to the health system, involving medical staff leadership in these discussions is crucial. Doing so engages key physician leaders in strategic thinking and can also help mitigate potential negative reactions from independent medical staff members later. During these first two phases, using a third-party facilitator to keep the conversations on track and to achieve desired objectives can sometimes be beneficial.

PHASE I: PLAN FOR SUCCESS

Start with a Vision

If a hospital wants to employ physicians on anything more than a strictly ad hoc, opportunistic basis, the hospital must begin with a clear understanding of what the physician enterprise is intended to accomplish and how it fits into the larger organization. For most hospitals, this means developing a strategy that redefines the organization as an integrated health system rather than a hospital-centric entity that just so happens to employ physicians. In the absence of such a strategy, the

tendency is usually to treat the physician practices as little more than a hospital department or ancillary business—which may result in some degree of tactical success, such as stabilizing a portion of the medical staff or providing a needed service that the community could not support in private practice, but not much more. Therefore, hospitals must dedicate sufficient time up front to set the tone of the relationship, form the foundation of the health system's employment strategy, and establish the guiding principles for a successful, long-term relationship. Typically, the physician strategy is informed by the larger strategic goals of the healthcare system; without a solid understanding of what the system is trying to accomplish, the physician strategy cannot be tailored to support the vision of the larger entity. In developing its strategy, the hospital should explicitly address several topics (see Exhibit 1.4 for examples).

Plan for a Common Culture

Hospitals or health systems sometimes assume that employed physicians will conform to their culture and behavioral expectations. However, this assumption is dangerous, for a variety of reasons. Physicians are trained to think and act independently and are usually not inclined to modify the way they do things simply because their employment arrangement has changed. Whereas the first loyalty of administrators is usually to the organization, physicians may have many loyalties, including to their patients, to their fellow physicians, and perhaps only then to the organization. Additionally, physicians are fully aware that the hospital's business model is completely dependent on the patient–physician relationship, and they will be protective of this relationship. Without up-front relationship building and discussion of expectations, employment of physicians will not result in a more integrated or unified relationship. Many health system managers have difficulty understanding that employed physicians don't wear the home-team colors just because they are employed.

To achieve a more stable and successful partnership, the physician enterprise should be regarded as an integral part of the organization, on an equal footing with the hospital. Success is difficult, if not impossible, to achieve if the hospital treats physicians as rank-and-file employees and tries to impose existing policies, procedures, and culture on them. Instead, a more effective approach allows a blended culture to emerge that respects the physician perspective and involves physicians in decision making at all levels of the organization. This approach requires hospital senior management to accept that it must change and share decision-making power, and that this change can actually be beneficial.

Exhibit 1.4 Key Questions When Planning the Physician Enterprise

Key Question	Potential Answers
What do we want to achieve?	◆ Performance under risk-based contracts ◆ Geographic expansion ◆ Meeting of community need for specialty-specific services ◆ Succession for aging medical staff ◆ Strengthening of market position ◆ Stabilization of the medical community
How extensively will we employ physicians?	◆ On an opportunistic basis only ◆ As a key feature of our strategy ◆ As the definition of who we are
How will we define success?	◆ Physician recruitment and retention ◆ Expansion of services and locations ◆ Improvement in clinical quality measures ◆ Financial performance relative to budget
How will the physician enterprise be organized and governed?	◆ Physician-led and professionally managed ◆ Physician division or enterprise ◆ Provider-based designation

Include Physicians in Management

Hospitals that employ physicians should actively seek ways to tap into physicians' knowledge and expertise by involving them in the management of the organization. For a hospital to achieve the goals identified during the early planning and strategy sessions, the missing link can be the involvement of physician partners who are committed to the organization, understand patient care, and have shared incentives. Physicians who seek employment generally want to shape their future, and many of them are anxious to take on leadership roles and facilitate better coordination of patient care in the community. Shared decision making does not often come naturally to hospital executives, who tend to be risk averse and believe their job is to maintain control over all aspects of the organization's strategic direction and operations. In some cases, this risk aversion may be fueled by a need to avoid upsetting the independent members of the medical staff, who may feel threatened by the prospect of employed physicians holding leadership positions within the physician enterprise or health system.

These concerns are valid, but to realize the full benefits of integration, physicians and hospital executives must acknowledge that the integrated organization

has a much broader scope of activity, encompassing inpatient and outpatient care, for a larger and more varied population than either party has served in the past. Addressing this larger scope is difficult even for the most advanced systems. To be successful, hospitals and physicians need to recognize that each party brings critical and unique skills to the table and that these skills should be respected and nurtured. Shared decision making leverages the strength of both clinical and administrative leadership and will promote physician satisfaction and unity. It can also facilitate accountability and engagement of physician leaders. Most important, physician leadership is needed to influence physician behavior that will lead to quality improvement—a primary goal of integration. Additional information on specific leadership and management structures involving physicians is provided in Chapter 3.

Understand the Economic and Operational Realities

When defining its vision, the hospital must understand how an acquired physician network will affect the integrated organization. The hospital should be prepared to accept many operational realities that it may not have anticipated. The following are some examples:

- **Erosion of payer mix:** Following the acquisition, the employed physicians' payer mix will likely shift away from commercially insured patients and toward Medicare, Medicaid, and self-pay. Because most employed physician compensation plans are based on work relative value units (RVUs) and thus are payer neutral, physicians are insulated from the economics of their payer mix and therefore may become more willing to accept these patients than when they were in private practice—especially within health systems that require their employed physicians to treat all patients regardless of payer. Furthermore, independent community physicians frequently begin referring these patients to their health system–employed colleagues.
- **Decline in physician productivity:** A decrease in physician productivity is not uncommon when physicians become employed. In many cases, the decrease is a direct result of compensation arrangements that include a large salary component or guaranteed income amount. Another reason is that when physicians accept employment by the hospital, they typically are able to negotiate higher compensation levels for themselves. Even if the compensation is structured with appropriate incentives, many physicians may determine that under the new, more generous compensation arrangements, they can earn

acceptable levels of income without having to produce as much. An additional factor that can lower physician productivity is the previously mentioned change in payer mix. Physicians, in particular those in primary care, often find that the increase in Medicare, Medicaid, and uninsured patients requires more physician–patient time because this population is more complex, in terms of both acuity and social factors that affect their health. Finally, lower physician productivity can result from new work-flow processes introduced to the practice staff by the health system. These new processes could be driven by electronic health record (EHR) adoption, accreditation requirements, and hospital policies and procedures. If staff are less efficient as they adjust to a new work flow, this slowdown can affect physician productivity. Obviously, ensuring that the new processes are really required and add value to the patient visit should be an important consideration.

- **Greater infrastructure costs:** Infrastructure requirements are typically greater for hospital-owned practices than for private practices. Most acquired practices will need to be transitioned to the hospital's practice management and EHR systems, which is costly not only as a hard-dollar investment but also in terms of lost physician productivity during the transition period. Most private practices have little or no compliance infrastructure, yet in a hospital-owned environment, this infrastructure is essential and requires specialized skills. Similarly, an effective revenue cycle operation calls for a level of management and a decision support and reporting infrastructure that are seldom encountered in private practice and will therefore have to be developed. Health system–driven infrastructure requirements—for example, meeting accreditation standards or transitioning to and administering provider-based billing—are a source of added costs. More significant are new cost allocations for system-wide shared services, such as information systems, human resources, finance, facilities, legal, and risk and compliance. These allocations can add a layer of cost that does not exist in private practice.
- **Higher staff salaries and benefit costs:** Salaries and benefit costs typically increase when practices are transitioned to hospital ownership. Because hospitals' benefit plans are almost always more robust than those provided by private practice physicians, transitioning physicians and staff to the hospital's benefit plan usually involves substantial incremental costs. A less obvious impact is that most hospitals allocate benefit costs as a standard percentage of direct compensation, and the high income of physicians results in significant increases in allocated (versus actual) benefit costs. Although hospitals tend to have higher pay scales for staff, higher staff salaries are not always a fact of life. For instance, nurses typically earn less in the clinic setting than in the hospital

setting. In some cases, the practice nursing staff is even accreted to the hospital's bargaining unit, an arrangement that has a significant impact on wages.

Developing realistic financial projections that factor in the post-acquisition realities is the best way to manage the expectations of hospital leadership and physicians. At the same time, the health system leadership absolutely must view these economic and operational realities in the broader context of the strategic importance of the alignment.

Get the Right Talent

Health system leadership may be tempted to identify a bright, promising hospital administrator to manage the physician enterprise in addition to her other hospital responsibilities. A word of caution: Managing a physician enterprise requires a different skill set and perspective than does managing a hospital or even a hospital outpatient department. Physicians need to believe that their administrators speak their language and understand their world. The person leading the physician enterprise should be an experienced practice administrator and well versed in all of the practice's operational and staff functions. Certain areas of vulnerability pose challenges for physician practices, and a seasoned administrator will recognize warning signs early on. Areas of vulnerability include the following:

- **Physician productivity and compensation:** An environment must be created in which productivity can be optimized while compensation levels are sustained and compliance risk is avoided. See Chapter 4 for further information on this topic.
- **Revenue cycle:** Stringent compliance rules regarding physician billing and coding require expert oversight. The higher-volume, lower-dollar physician office–based claims receive less attention and follow-up when they are managed by a hospital's accounts receivable team, which leads to lower collections. See Chapter 6 for further information on this topic.
- **Ongoing clinic operations:** Hospital operations leaders lack an understanding of medical practice operations, benchmarks, and performance metrics and often try to apply hospital metrics to the physician practice. This misapplication can leave important practice metrics unmonitored and negative trends unrecognized until the problem has become significant. See Chapter 5 for further information on this topic.

- **Office-based staffing:** Staffing requirements and scope of practice are different in an office than in an acute care setting. When this distinction is not understood at a management level, it can affect staffing levels and physician productivity.

A professional practice manager will understand which performance and productivity metrics are relevant to physician practice operations and will know how to work with physicians to achieve appropriate performance levels. Recruiting an individual who has worked in a mature, integrated health system and who can bring experience and knowledge to the position will help avoid the pitfalls along the journey.

PHASE II: BUSINESS DEVELOPMENT

Develop a Structured Approach for Hiring

Having established the overarching strategy for physician employment and the management and organizational structure under which the physicians will operate, hospital leadership needs to develop effective policies, procedures, and infrastructure to execute on practice acquisitions. In the absence of such policies and procedures, acquisitions tend to be a series of one-off transactions, each unique and with inconsistent terms. One common misstep is to use individualized (nonstandard) employment contracts, which introduce a variety of employment terms and compensation arrangements. Not only are individualized contracts extremely challenging to administer, but the lack of consistency is soon discovered by the physicians, who can quickly become dissatisfied because most will assume they are being shortchanged while others are getting a better deal. This inconsistency and ensuing dissatisfaction are particularly detrimental to efforts to build a cohesive group of employed physicians.

In many cases, the hospital ends up with practices it should never have acquired in the first place, because the implications weren't properly thought through or because the lack of a standard approach and evaluation criteria makes it harder to walk away when there is not a fit between the practice and the larger organization. This situation can be mitigated by establishing criteria for determining whether there is a fit. These criteria need to be established in advance, within the context of a well-constructed plan and without a particular acquisition in mind, so that they will be untainted by the "tyranny of the urgent." Of course, maintaining the

organizational discipline to abide by these criteria is also essential. The criteria should be documented in writing and referred to faithfully before, during, and after every practice acquisition so that they are never forgotten or ignored. To that end, creating a formal assessment tool to evaluate the rationale for each acquisition is helpful. Exhibit 1.5 provides examples of criteria for evaluating whether a physician or practice would make a good partner.

Develop a Compensation Philosophy

A properly structured compensation methodology is essential to building a well-functioning physician enterprise. This methodology begins by establishing the organization's philosophy regarding physician compensation during the planning and strategy phase and ends with designing a compensation plan (discussed in Chapter 4). A compensation philosophy is a statement of principles that will serve to communicate how the health system intends to address physician compensation; this philosophy will ultimately guide the development of a compensation plan. A reasonable compensation philosophy might include the following guiding principles:

- Median compensation for median work effort
- Emphasis on and incentives for individual productivity
- Payer neutrality
- Incentives based on outcomes, quality performance, behavior, and group citizenship
- Income protection for specialties that are needed to sustain a minimum number of specialists in the community
- A common compensation structure across all specialties wherever possible
- Compensation that is easily understandable and reasonable to administer

These principles do not address the details of how compensation will be calculated, but they do provide physicians with a reasonable understanding of what to expect if they become employed by the health system. Establishing a compensation philosophy in advance will help in the development of the right compensation plan.

In addition to structuring appropriate incentives, health systems should strive to maintain as much consistency as possible within the compensation methodology. Obviously, there is no one-size-fits-all formula, and some variation in methodology for certain specialties is needed to ensure that market-based compensation is provided across the board. Typically, this variation is accomplished by tying compensation to appropriate benchmarks, such as specialty-specific compensation

Exhibit 1.5 Physician or Practice Evaluation Criteria

Criterion	Questions to Ask
Quality	◆ What do the medical staff say about the physician's skills? ◆ Is the physician a clinical leader? Is she well respected among peers? ◆ What is the group's malpractice history? ◆ How busy is the practice? What are the practice's sources of referrals, and how long has the practice had those sources? ◆ What does a chart review reveal about clinical quality?
Success in private practice	◆ Has there been unusually high staff turnover? ◆ How successful has the practice been in hiring and retaining top physician talent? ◆ What payer contract terms has the practice been able to negotiate? ◆ What does the physician compensation history reveal? How competitive are compensation levels? ◆ How does the practice compare to national benchmarks for best practices?
Citizenship	◆ How actively do group members participate in medical staff or hospital leadership activities? Do they show evidence of thinking beyond themselves? ◆ What is the potential for practice members to create a positive influence on their fellow physicians? ◆ How well do the physicians get along with one another and with community physicians? ◆ How easy or difficult are the physicians to deal with?
Strategic fit	◆ What is the hospital's strategic need for this specialty? ◆ Does the business case justify the acquisition? ◆ What other alignment models might satisfy both parties' needs? ◆ How will the independent physicians react to this acquisition?
Retirement horizon	◆ What are the physicians' retirement plans? Will they be with the organization long enough to make the acquisition worthwhile? ◆ What is the succession plan for the senior partners? ◆ How critical is the retiring physicians' involvement in transitioning their patients to new physicians?

per work RVU. Tying compensation to benchmarks does not work in all cases, however, particularly with hospital-based specialties such as anesthesiology or critical care, which do not generate their own patient volumes and are based largely on the hospital's coverage needs.

That said, preventing the unnecessary proliferation of compensation methodologies that lack a consistent, overarching design is critical. Keeping methodologies to a minimum can be difficult and requires considerable managerial discipline, because there will always be reasons, some of them valid, why a given group of physicians should have its own compensation plan. Allowing compensation methodologies to proliferate not only creates a difficult administrative burden; it also breeds disunity and distrust among the physicians.

Manage Physician Expectations from the Outset

The manner in which physician practices are acquired and integrated will set the tone of the relationship for a long time to come. Unfortunately, this transition is often not a smooth one from the physicians' perspective. Just as things change for the hospital, physicians' lives will change dramatically as a result of integration.

Ultimately, making physicians understand things will change is the hospital's responsibility. While the physicians have a level of responsibility to conduct their own due diligence and ask the right questions, many physicians have little experience in selling their practices and need to be guided through the process. Because physicians' business acumen and sophistication vary tremendously, some may not think to ask about any number of topics. Therefore, helping physicians make an informed decision about integration so they are realistic about the extent of change—and not overpromising—will pay dividends by creating a sound foundation for the future relationship. The way to manage physicians' expectations is by being open and frank with them about these matters in the early stages of the discussions. Without effective, frequent communication, physicians can inadvertently be given false expectations about what it means to be an employed physician. They may wrongly assume that little will change under the new arrangement and that they will retain roughly the same level of autonomy they enjoyed in private practice. This expectation can play out through a myriad of unpleasant surprises relating to staffing decisions, productivity or work schedule expectations, capital allocation, compliance, and so forth.

Both sides should go out of their way to fully disclose their future vision as well as their commitments to, and expectations of, the other party. Formalizing this process by drafting a compact between the hospital and physicians to document the agreement would even be reasonable. Drafting a compact takes time and may be difficult when the pressure is on to get the deal done, but addressing issues sooner rather than later will make life much easier for both parties and will set the tone for how issues should be resolved after integration takes place. In some cases, scheduling a facilitated retreat may ensure that sufficient time and attention are

dedicated to developing a common understanding of how the parties will function as an integrated entity. Exhibit 1.6 outlines some key areas that should be discussed and decided early on in the process. Each of these issues needs to be discussed in the context of an integrated health system and not solely from a hospital-centric or physician-centric point of view.

For this communication to be effective, close coordination between the individuals charged with negotiating the transaction and those who will ultimately manage day-to-day practice operations is important. If these functions exist in

Exhibit 1.6 Key Integration Topics of Discussion

Area	Topic
Organization	◆ Organizational and management structure of the physician enterprise ◆ Degree of decision-making authority delegated to the physician enterprise ◆ Roles of the physicians and hospital in leadership and management of the integrated entity ◆ Recruitment plan, including anticipated changes in the mix of services or specialties
Financial management	◆ Expected financial performance of the physician enterprise ◆ Access to capital and capital allocation process ◆ Financial reporting, such as changes in funds flow that will alter the clinic's bottom line (e.g., overhead allocation, credit for ancillary profitability) ◆ Method for determining changes to the physician compensation formula ◆ Billing policies and procedures ◆ Patient financial assistance program, which may change to match the hospital's program ◆ Changes to payer mix
Operations	◆ Use of EHRs and deciding which system (hospital's or practice's) will prevail ◆ Conversion of ancillary services to provider-based ◆ Corporate compliance and accreditation requirements ◆ Clinical quality initiatives ◆ Changes to staffing mix as a hospital-based clinic pursuant to accreditation requirements (e.g., certain tasks or procedures done by licensed nursing staff only) ◆ Provider work hours and productivity expectations ◆ Changes in the peer review process as a hospital-based clinic

silos, then the opportunity for miscommunication and physician dissatisfaction is rife. Accordingly, overall responsibility for physician acquisitions—from the identification of practices through the on-boarding process—is best assigned to a single individual. Depending on the anticipated volume of practice acquisitions, establishing a position specifically for this purpose may be helpful.

Anticipate Medical Staff Reaction

In the absence of a clearly defined and properly communicated physician strategy, hospital executives often encounter animosity from the independent members of the medical staff, who may perceive that the hospital is now competing with them. They may also perceive that limited hospital resources will be shifted away from hospital operations to focus on the development of the employed physician group. These perceptions can create an uncomfortable divide between the employed physicians and the other medical staff. In an effort to appease the independent physicians, the hospital may be tempted to respond by acquiescing to their demands, sometimes at the expense of the employed physicians. For example, the hospital may cancel plans that newly employed physicians had to recruit in a given specialty, if such recruitment might antagonize independent medical staff members in that specialty. Hospitals may also look for creative ways to shift money to the independent physicians via granting directorships, creating leadership roles, or paying for call coverage. While shifting funds may have a short-term benefit, it sets precedents that are very costly not only financially but also with respect to the relationship between the hospital and its physicians, both independent and employed.

Hospital leadership should also be prepared to deal with negative behaviors that independent medical staff members sometimes exhibit when they are poorly prepared for the introduction of employed physicians. For example, independent physicians commonly divert poorly insured or uninsured patients to the employed medical group. In extreme cases, independent physicians are openly hostile to the employed physicians, eventually driving them out of business by spreading false rumors or shutting them out of the call schedule. To ward off this type of reaction, hospitals must gain the support of the medical staff leadership by including them early in the pre-acquisition planning and by creating a forum for them to voice their concerns appropriately.

NOT JUST A HOSPITAL ANYMORE

For many hospital executives, the prospect of employing physicians is little more than a necessary evil, but one that involves a lot of hard work, a substantial investment, the surrender of control, and potentially significant financial losses. If the undertaking is less than fully embraced, then these fears are likely to become a reality. However, if it is approached with a well-thought-out plan and within the context of an integrated system rather than a hospital-dominated system, the prospects for realizing the benefits of integration are strong. In the post-reform world, if integration is done correctly, hospitals and physicians can achieve together what they cannot accomplish separately, and everyone, including the broader community, will benefit.

Having this mind-set makes all the difference between a true hospital–physician partnership and an environment in which the physicians are dissatisfied, not engaged, and only too willing to share their woes with other physicians in the community. The remainder of this book describes in greater detail the key areas that need to be addressed to create this partnership.