Writing the Script: Integrated Partnerships Are the New Medicine for Hospital-Physician Relations
Put aside thoughts of healthcare reform legislation for a moment. Shift your attention to the larger economic perspective and the way in which healthcare organizations and physicians structure their relationships. A new approach to creating integrated partnerships—one that often starts with physician employment and then builds—is the real locus of reform within the healthcare field.

So says Daniel K. Zismer, PhD, associate professor and director of the Master in Healthcare Administration Program, Division of Health Policy and Management, University of Minnesota School of Public Health, Minneapolis. According to Zismer, “Physicians and hospitals are holding their breath to see what happens with healthcare reform legislation. I don’t think that’s the most important issue. The most important issue is the macroeconomics of healthcare.”

Drivers of Macroeconomic Change
The macroeconomics of healthcare will continue to change regardless of what happens in Washington, D.C., Zismer contends. As payors, including the government, seek to transfer financial risk to providers, “we’re seeing rapid consolidation among providers and fewer, larger systems. It’s going to be very difficult for the smaller independent hospitals and physicians to compete in that kind of marketplace,” he says.

He adds that it’s also going to be difficult for hospitals and health systems that are still living in a “piecwork” fee-for-service world—an untenable recipe for inefficiency that has disaggregated the delivery system and fragmented the marketplace. “We’re moving to a much more integrated, sophisticated clinical model to deal with a changing set of incentives from the payor side,” says Zismer. “You need size, scale, depth and breadth for that. The more mature,
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integrated systems are starting to do better financially, and I expect them to outpace the traditional model.”

That model includes attempts over the past decade by hospitals and health systems to cobble together relationships with physicians in a seemingly endless array of deals—rather than enhancing the system’s overall performance.

Also driving macroeconomic change is the growing difficulty of independent practices to stay afloat, let alone compete with health systems for the shrinking pool of new physicians.

According to a survey of 32 CFOs conducted by Zismer, 85 percent predicted that half, and possibly all, of their physicians would be employed within the next three years. “I wouldn’t go so far as to say there will be no such thing as a physician in private practice, but it’s going to be far more the exception than the rule,” he says.

Partnership Models in Action
The cornerstone of the new paradigm for hospital-physician relationships is the formation of true partnerships.

Rather than bringing physicians together under shared incentives, the trend among health systems has been to develop portfolios of individual agreements with relatively small doctor groups, each with its own conditions, incentives, and legal and tax risks. These arrangements, which often run at cross purposes, frequently end up detracting from efforts that have fueled the current inefficiencies in healthcare delivery, Zismer notes.

“Right now, we’re coming out of the ‘101 ways to do a deal with a doctor’ phase,” he says. “We’ve tried every imaginable way to get hospitals and physicians to work together, and they have proven not to be sustainable.”

Bozeman Deaconess Hospital
A dyadic model of hospital-physician cooperation has taken root at Bozeman (Mont.) Deaconess Hospital, an 86-bed organization
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serving southwest Montana that currently employs 50 of its 160 medical staff members. “I look at it as a partnership, where the physicians are charting their own destiny, albeit within the larger organization, rather than as physician employment,” says John A. Nordwick, FACHE, president and CEO of Bozeman Deaconess.

The employed primary care and specialty physicians have been integrated with the hospital since 2005 under the Bozeman Deaconess Health Group clinics. Driving the integration was the development of a partnership that gives physicians as much authority and responsibility as possible within the context of the organization as a whole. To support that goal, the hospital and Health Group clinics created a group executive committee of physicians that makes recommendations to the hospital board of directors on budget, compensation, planning and other matters. “The idea was to provide the physicians with the responsibility and authority they needed to manage themselves,” Nordwick says.

In 2011, the Health Group clinics became the first in Montana to earn Level III Medical Home Recognition from the National Committee for Quality Assurance for using evidence-based, patient-centered processes and demonstrating highly coordinated care and long-term participative relationships.

The sense of unity that emerged from the integration did not happen overnight. “You have to look at it as a partnership and a collaborative effort, and you have to have patience,” Nordwick says. “When you have individual groups coming together, you can’t expect them to think immediately like a bigger group. You have to go through this evolution whether you want to or not. It’s a gradual process of building trust. You’ll have some missteps along the way, but with patience and commitment, you can work through them.”

Iowa Health System

The same type of unifying transformation seen at Bozeman Deaconess is under way at Iowa Health System (IHS), Des Moines, a 26-hospital provider and the fifth largest non-denominational system in the country. IHS is transitioning from a traditional aggregation of hospitals in seven major markets throughout Iowa and Illinois, each with its own portfolio of agreements with physicians, to one visible medical group under one leadership team that is integrated with the senior management teams of the hospitals. The medical group, internally referred to as the NewGroup, functions as an equal partner with the hospitals.

“If the only paradigm we know right now is change and movement toward some sort of value-based contracting,” notes Alan S. Kaplan, MD, FACHE, FACPE, vice president and CMO. But regardless of whether value-based contracting eventually manifests in pay for performance, ACO shared savings, partial or global capitation, or some other configuration, “we believe that if anything positions us for success, it is to think differently about physician alignment,” he says.

“If we keep trying to be ‘physician-friendly,’ focus on referrals and cling to the status quo, we will continue to have uncommitted medical staff (who) want to be paid for everything from call to community involvement, and we will see very little return on that investment,” Kaplan says.

For IHS, that acknowledgment has meant changing from a hospital-driven to a physician-driven...
organization. “If you don’t align the physicians strategically and operationally, you can almost count on never executing the strategies you need to carry out,” says Kaplan.

“It’s not about physicians being in charge; it’s about physicians being integral partners,” he stresses. However, Kaplan admits that achieving this level of integration can be tough. Physician groups come to the arrangement with their own cultures, governance structures and compensation models. They also are likely to have shared a less-than-pleasant history of competition or to have experienced previous failed attempts to merge, which means that a new group of employed physicians usually has some problems to work through. It’s a process that takes time.

To surmount these obstacles, IHS did not even try to merge the disparate cultures; it empowered the physicians to create their own organization from scratch. The system employed a senate model: every physician group and region was allocated two representatives, whether the group had 300 members or 20. These physician representatives convened with a consultant to craft a governance structure and organizational structure. Then, instead of merging their practices, physicians joined the NewGroup.

According to Kaplan, the physicians readily accepted the new coalition because they had created it. This sense of ownership also bolstered their ability to win support from their colleagues. As of Jan. 1, 2012, 450 providers have joined the NewGroup. The remaining 250-plus employed providers have signed letters of intent to join later in the year.

“We put out the offer that if the physicians could come together in a meaningful way, then NewGroup would become a senior affiliate of the system,” notes Kaplan. That has happened, he says. “The physician group functions as an equal, integral partner at all levels.”

The NewGroup has its own board of directors and representation on the IHS parent board. It also has representation in each of IHS’ eight regional divisions. Each division is led by a physician and nonphysician executive dyad. These executive pairs serve as members of the senior administrative teams of their respective regions.

A partnership like the one created at IHS requires a commitment from top leadership, Kaplan says. “A critical reason this integration has been successful so far is that we have a CEO who believes in it and has worked to gain the support of the board and our hospital CEOs.”

Kaplan hopes healthcare executives will embrace rather than fear the formation of similar partnerships. “You’ve got to be thoughtful about how you do it, but if you empower the physicians and bring them in as partners, they will make you more successful than you ever dreamed,” he says.
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One Partner That Does More
Shore Health System
Shore Health System, Easton, Md., a provider serving the state’s Mid-Shore region, has encountered an array of factors working both for and against its efforts to forge a partnership with the medical staff. On the plus side are some natural positives, including the system’s position as the sole provider in its service area of approximately 100,000 (competition coming only from the community’s fringes), few turf struggles among physician groups, a strong sense of community involvement on the part of the medical staff, and a shared commitment by the health system and the physicians to serve as the community’s provider.

“We are a community health system in every sense of the word,” says Michael C. Tooke, MD, FACP, senior vice president and CMO of Shore Health System. “The physicians are our neighbors, friends and family. The fact that they all live in this community is key.”

On the minus side of the partnership effort equation, physician reimbursement in Maryland tends to be low despite the state’s overall wealth. “That’s a tough spot for our physicians to be in,” Tooke says. Recruitment is also a challenge. “We are trying to understand what we need to do to bring quality physicians across the bay from Baltimore and D.C.” to replace retiring physicians and to meet the area’s increasing demand for services as the population ages.

The system employs 35 physicians, the majority of them specialists. The next step, according to Tooke, is to develop a cohesive identity as a group. “We want to encourage that kind of thinking because it will make the physicians a more robust partner in integration as opposed to employing each physician individually,” Tooke says. “Our success is enhanced if the group succeeds.”

“One definition of integration is that when the system succeeds, happen, and the winners benefit from it. If you are a truly integrated system, everyone benefits because all of the pieces fit together based on productivity and value, not finance.”

Like Bozeman Deaconess’ Nordwick and Iowa Health System’s Kaplan, Tooke recognizes the challenges of reaching that level of integration. “There’s the integration on paper and there’s the integration that comes because you’ve worked together and made decisions over time and built trust and respect,” he says. “It’s a different relationship in which you really are partners making decisions together. Reaching a comfort level with that takes time.”

In 2010, the Maryland Health Services Cost Review Commission entered into an agreement with several hospitals statewide, guaranteeing...
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revenue at a certain level. As a result, Shore Health System switched from a volume-driven to a nonvolume-driven business model.

“If we put programs into place that result in decreased utilization, we don’t sacrifice revenue,” Tooke says. “On the other hand, if utilization goes up, our revenue is fixed and we won’t gain from that.” To deal with this changing scenario, Shore Health System has explored new ways to align with its physicians.

For example, the system discovered that many patients who return to the hospital within 30 days of discharge do so because their doctors were unavailable when they called to schedule a follow-up visit. To address this problem, it developed a program in conjunction with the National Collaborative on Healthcare Quality of the American Hospital Association in which it purchases slots of physicians’ time and pays them for that time even if those slots are not filled by Shore Health patients.

“We already had an information system that allowed us to identify patients who had been hospitalized multiple times,” Tooke says. “We just needed that last piece, which was access to the community physicians. That’s integration. That’s what worked for us. And those physicians aren’t necessarily employed. But they’ve already integrated themselves with us by virtue of a physician-hospital organization that they’ve worked with for the past 10 years. There’s no reason to force the employment model if you can get to something that accomplishes your goal.”

“In three years, we would like to see even more integration of our medical staff into our planning and operations framework so we move forward in this environment together,” adds Kenneth D. Kozel, FACHE, president and CEO, Shore Health System. “Our strategy is simple: always bring the physicians to the table, hear what they have to say and demonstrate to them that their input is invaluable. At the same time, it is important that we are mindful of the challenges our physicians face in their practices. We must do what we can to help them thrive in the local community.”

According to Tooke, the system is exploring the best ways to make sure it supports its physicians as the reimbursement model changes. “We can’t just say ‘things are tough, doctors.’ They’re taking care of our community. We want to keep them here. They need to feel like we really mean it,” he says.

States Nordwick, “I have tremendous respect for how viscerally concerned physicians are about their patients and the health of the community. If physicians have the right information and support, they are going to make decisions in the best interests of patients. The evolution is to a patient-driven organization. Why does any one group have to be in charge? I see it as a group of professionals coming together to work for the populations we serve. We have much more in common when we’re working together for a shared purpose.”

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Ask the Expert

Have a question on this topic? Continue the discussion on the ACHE Message Board. Daniel K. Zismer, PhD, associate professor and director of the Master in Healthcare Administration Program, Division of Health Policy and Management, University of Minnesota School of Public Health, Minneapolis, will take your questions on ACHE’s Message Board from Jan. 1 to Feb. 1. Responses will be posted each Monday. Visit ache.org/MessageBoard to post your question and view his response. When you post your question, please title the subject “HE Mag/Jan/Feb/Hospital-Physician [question here].”
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