A perfect storm of circumstances has moved physician employment to the top of virtually every provider’s agenda: recent significant changes in the Medicare reimbursement fee schedule; cuts in reimbursements for ancillary services, including magnetic resonance imaging procedures, on which many private practices have come to depend; growing practice infrastructure costs; practices’ inability to negotiate premium rates with payors; the strain on hospitals of paying large stipends to physicians to ensure coverage for emergency care and other essential services; fatigue among established physicians from the demands of running their own businesses; and the demand for job security by many doctors entering the work force.

Add to the constellation of forces the recent healthcare reform legislation, which encourages physician-hospital integration as a means to improve the quality and efficiency of patient care, and it’s not hard to see why physician employment has assumed renewed prominence. “The government has said that one of the few safe harbors you have for stabilizing physician incomes is employment; as long as you pay fair market value for compensation you can employ a physician,” notes Nathan S. Kaufman, managing director, Kaufman Strategic Advisors LLC, San Diego.
LESSONS LEARNED
Hospitals and health systems learned some valuable lessons from the first big wave of physician employment in the late 1980s and 1990s—capitation’s heyday—when primary care physicians were employed in droves to serve as the gatekeepers of managed care. “During that time, the industry paid too much for practices, compensation structures were too rich, organizations were not structured properly and hospitals lost tens of millions of dollars,” Kaufman says.

In most markets, capitation lost momentum, and many hospitals found they had entered into business arrangements they did not understand and were not managing well, says C.B. Rebsamen, MD, FACHE, senior vice president, Navvis & Company, based in St. Louis. While some organizations managed to generate healthy partnerships with physicians—relationships that continue to this day—many others released physicians back into the community, triggering the entrepreneurial proliferation of freestanding, physician-owned ambulatory surgery centers and other independent enterprises of the past decade, Rebsamen says.

Ongoing reductions in reimbursements, resulting in a 25 percent decrease in pay for physicians relative to inflation in the 10-year period
ending in 2008, led physicians to pursue the “technical component”—imaging centers, for example—to bolster revenue. “As a result, hospitals found themselves to some extent in competition with their medical staff,” often resulting in more separation rather than cohesiveness, he says.

Compensation
This time around, providers have taken the lessons learned and approached physician employment differently in some key ways. For example, they have begun to compensate physicians based on value as well as productivity. Many organizations discovered the problems of focusing too narrowly on production, without incentives around performance, outcomes and quality, and they have begun to structure salary and benefit packages to address them, says Kaufman.

The most effective physician compensation models balance incentives for productivity with those meant to further the organization’s vision, whether that vision involves specific quality standards or an overall effort to become a world-class multispecialty provider, Rebsamen says. “We want to alter the incentives to focus on quality and good outcomes. Revenue is still a reality, but we shouldn’t focus on volume at the expense of the quality of the work being done. The revenue of pay for performance in the current physician employment model is going to be driven by base compensation that is altered by results.”

Compensation for senior management and physicians at the multispecialty HealthTexas Provider Network, a division of the Baylor Health Care System, one of the largest providers in northern Texas, is based in part on quality outcomes, so both groups have the same incentives, notes David Winter, MD, chairman and chief clinical officer of HealthTexas. Baylor’s involvement in physician employment began with 10 primary care physicians in 1993 as a strategy to develop an integrated delivery system, and it has endured. Today, the system employs almost 500 physicians, of which 65 percent are primary care and 35 percent are specialist providers in 125 locations. “When we want to move the quality improvement process forward, we have their attention financially,” Winter says.

Transition to Employment
Despite the lessons learned, physician employment is still inherently challenging and expensive because of the cultural upheaval, office moves, information systems installations, hiring of staff and countless other changes that go with major transitions, Kaufman says. “Whenever you do any kind of affiliation there’s always going to be a messy transitional period. When you combine that with the traditional cultural issues between physicians and hospitals, the process intensifies.”

ESSENTIAL COMPETENCIES
Some essential competencies are needed to create a physician employment model that is effective and sustainable, according to Nathan S. Kaufman, managing director, Kaufman Strategic Advisors LLC, San Diego. These include:

- Strong physician and administrative leadership
- A group culture characterized by a sense of purpose, competence, innovation and teamwork
- A production payment model that recognizes administrative time and office staff
- The ability to negotiate premium managed care rates
- Physician involvement in governance
- A strong departmental governance structure
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As a result, while physician employment’s significance in healthcare appears secure for the foreseeable future, less clear is how well providers will weather the transition and leverage the model’s potential to build meaningful relationships with physicians in order to strengthen their organizations and improve the quality of patient care.

Amid the tumult, organizations that treat employment as simply a matter of handing physicians their W-2 forms and expecting them to plug gaps in services could miss valuable opportunities and falter, Kaufman says. Rather than thinking of employment primarily as a business transaction to maintain market share, “the idea is to develop a compelling vision that transcends financial concerns, with strong physician leadership, and to coalesce these physicians into self-managed practices,” he says.

“If you don’t focus on creating a vision and a self-managed culture, the next thing you know, you will have 100 physicians in 60 different locations practicing in their own style with no standardization, some refusing to take Medicare patients because they are not as profitable. What you have essentially done is shifted where the physicians get their W-2s,” he says.

J. Patrick Dyson, FACHE, executive vice president of Borgess Health, a network of 130 care sites, including three owned and three affiliated hospitals, headquartered in Kalamazoo, Mich., attests to the need to forge a sense of common purpose among physicians and hospital staff in building a sustainable employment model. Of the system’s 600-member medical staff, 175 are currently employed or in exclusive contracts while accounting for 60 to 70 percent of inpatient volume. The number of employed physicians, both primary care physicians and specialists, including those providing care at a new integrated neuroscience service with a large spine care component, has doubled in the past two years.

Borgess Health currently is moving from the “accumulation” phase of physician employment to the meaningful clinical integration of these practices across specialties, Dyson says. “While it’s difficult to spend time on creating a culture and a common view of the future, if those ingredients aren’t there, you’ve got a more fragile relationship. We spend a fair amount of time with the physicians first, talking about what we’re trying to achieve together. If people come into the conversation and it’s only about economics, the likelihood of developing a strong relationship goes down.”

A sense of purpose that transcended economics convinced Patrick M. Battey, MD, that leaving private practice and entering into an employment relationship with Piedmont Healthcare, Atlanta, was the right thing to do. Battey, a vascular surgeon and current chairman of the Piedmont Hospital board, joined the Piedmont Heart Institute (PHI) in 2009. Founded in 2007, PHI is the first integrated cardiovascular health care delivery system affiliated with a community health system in Atlanta.

According to Battey, the formation of PHI allowed him and his colleagues to return to “the real beauty of practicing medicine” by freeing them from day-to-day business concerns but enabling them to still play a major role in shaping the institute’s strategic direction and the quality of clinical care.
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From the beginning, the nature of the relationship with Piedmont Healthcare was physician driven, and that level of physician involvement has been key to the institute’s success, he notes. “The employment model was not ‘We’ll hand you your check and you continue to practice’; it was knowing that we are achieving outcomes that are among the best in the country,” Battey says.

### Coordination of Care

A strong vision and an overall physician-driven culture have also helped the Baylor Health Care System achieve major quality and patient safety gains, says President and CEO Joel T. Allison, FACHE. “Physician employment through HealthTexas is one strategy that has given us a platform for advancing our initiatives around standardization of care, efficiency and clinical excellence.” This platform has delivered better value; efficiencies in areas such as appointments and scheduling, billing and collections and supplies; and improved patient outcomes, he says.

It has also facilitated the systemwide implementation of an electronic health record based on standardized clinical protocols and physician order sets, and it has allowed the organization to expand patient care coordination activities, “because these efforts are led by physicians who are aligned with the organization as a whole,” Allison says. “Physician alignment, in a variety of ways, is essential to our success.”

“A big part of our push right now is to make sure we coordinate care wherever the patient is in the continuum—hospital, doctor’s office or home,” adds HealthTexas’ Winter. “Being in an organization that is backed by and part of the hospital facilitates that coordination because our physicians don’t worry about accounts receivable or coding compliance; we do that for them. What they are doing is focusing on quality.” That framework has enabled the organization to drive outcomes and processes in the treatment of conditions such as congestive heart failure, asthma and hypertension to the highest standards, he says. “Most of these things we’ve done since we’ve been together. Smaller groups aren’t able to do that. Our efforts as an integrated group have allowed us to hone in on quality and patient safety.”

### Physician Engagement

Kaufman stresses that opportunities for self-management, such as those provided at PHI and HealthTexas, are essential for engaging physicians and a necessary ingredient of effective employment. “The physicians have to know that they are having input and being heard,” he says. This does not happen without physician leadership that shares a common strategic vision with the organization, can communicate that vision to the medical staff and helps them make the broader cultural transition from

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**“The idea is to develop a compelling vision that transcends financial concerns, with strong physician leadership, and to coalesce these physicians into self-managed practices.”**

—Nathan S. Kaufman, Kaufman Strategic Advisors LLC
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It also does not happen without honesty on the hospital’s part and willingness to understand the physician’s perspective, says R. Timothy Stack, FACHE, president and CEO of Piedmont Healthcare. Stack stresses the value of trust in building relationships with physicians. “It’s not easy being a physician now,” he says. “In the face of tremendous state and federal shortfalls, their hearts are still in the right places. It is so important to hear them out. They need to know that when you sit down and talk with them you will be giving them truthful answers.”

Kaufman recommends the creation of a joint policy board as a formal structure for helping physicians and hospital leaders resolve issues together. “There are always going to be conflicts, but if the doctors feel that they have a say, then they are more likely to work cohesively to support the organization’s goals.” He also advocates the formation of a clinical advisory council to unite physicians around patient care issues. “When it comes to clinical issues, you absolutely want the doctors to have this responsibility.”

Rebsamen emphasizes that the overarching strategic mission that is so critical to the development of an effective employment model requires senior management’s total involvement. “It can’t be a matter of hiring some general surgeons or some ER physicians to solve a problem with call coverage, wishing them well and then putting them off to the side in terms of processes. It’s a major strategic decision that has to be debated thoughtfully and prospectively before you even begin. It quickly becomes a significant activity on the balance statement, and senior leaders, including the board, need to be involved very early in strategic discussions. When the first major steps are being taken, the CEO’s involvement is a major asset that will mean a lot to the enterprise’s success. It’s a real demonstration of commitment when the CEO takes his or her time to be involved when the major decisions are being made.”

In some cases, that involvement can include the difficult task of communicating to physicians that employment may not be the best fit for them, Piedmont Healthcare’s Stack says. Some physicians simply are not able to make the cultural leap to the team-based decision-making model and partial relinquishment of independence for the greater good that are the hallmarks of lasting employment arrangements. In the case of PHI, “three separate groups had been doing business in different ways, and we were asking them to work in a way that all three groups could share. What you have to do is create a brand new culture.” Not all doctors can make the adjustment, and in these cases, the CEO’s role is to make that

**COMMON PITFALLS**

Despite physician employment’s benefits, the model also presents some potential hazards, according to C.B. Rebsamen, MD, FACHE, senior vice president, Navvis & Company, based in St. Louis. “These potential pitfalls are avoidable with a properly constructed compensation package for the physicians, so they are not reasons to be averse to employment; rather, they are hazards to proactively avoid,” he says. These can include:

- **Adverse selection**—some of the physicians most likely to be attracted to the hospital’s offer may be the ones with the most financial trouble
- **Productivity decline, as physicians begin to enjoy their employed status**
- **Decrease in on-site emphasis on collections**—with less physician involvement, day-to-day emphasis on billing, insurance filing and payment may become less important to the office staff
- **Growth in expenses**—physicians have less incentive to control costs at their practice sites; as a result, expenses may increase
- **Coding changes**—with no reimbursement for coding correctly, a lower level of coding may tend to become the norm. Revenue generated per encounter may slide below the historical rate
clear. Two physicians of 80 were lost during the transition at PHI. “Sometimes in order to be true to your mission you’ve got to call it the way you see it,” Stack says.

As HealthTexas’ Winter puts it, “Not every great soloist can play in a symphony, and not every great physician can work in a group practice. In our organization, majority rules, and if you can’t live with that, you might be better off in a different environment. I have that discussion a couple of times a year, but not with the same physician twice. Most physicians say they will become a team player, because the alternative is becoming bleaker and bleaker.”

The Healthcare Executive’s Role
According to Borgess Health’s Dyson, corporate leadership’s involvement is also necessary to build critical relationships with physician leaders who have the combination of administrative skill and clinical knowledge needed to engage the medical staff and achieve consensus with them on goals around culture, strategy and performance. “It’s becoming more and more of a partnership,” he says. “When you begin using physician brain matter to make strategic and performance decisions, you are putting their time and energy where it matters most.”

BEYOND PRIMARY CARE
The current wave of physician employment has expanded beyond the first wave’s emphasis on primary care to include medical specialties.

“Primary care physicians are not being ignored in round two, but what really makes this wave interesting is that hospitals are doing something they wouldn’t have done a decade ago, which is to employ a significant number of specialists,” says Rebsamen. HealthTexas, Borgess Health and PHI exemplify this trend. Baylor, an early adopter in the physician employment arena, now employs specialists in transplant medicine, neurology, pulmonology, dermatology, urology, gastroenterology, endocrinology, rheumatology, breast surgery and many other disciplines. Although Piedmont Healthcare has employed primary care physicians since 1995 and transplant surgeons since 1999, PHI’s creation has added 85 employed cardiologists, cardiac surgeons and vascular specialists to the medical staff.

According to PHI’s Battey, the integration made possible with employment has facilitated a level of multispecialty collaboration and patient-centered care that would not have been possible if the physicians had remained in competing silos. “Clinical integration positions us to drive improvement and reduce the variation that leads to differences in outcomes,” he says. “If the hospital does well, then we do well, so we have some additional incentives to improve quality, lower costs and reduce length of stay. We could never have achieved the same degree of focus on cooperation and doing what is best for the patient if we had remained in separate practices.” This cohesiveness has helped the group reach quality benchmarks. For example, there have been no heart valve–related mortalities since February 2009 and just one heart bypass mortality has occurred in the past 12 months, he reports.

In specialties and primary care, “We’re seeing exponential growth in physicians seeking employment,” says Kaufman. For that reason alone, no hospital or health system will remain untouched by the trend. As he plainly puts it: “Do you want to have doctors in your market? You won’t get the next generation without employment. Every organization that isn’t already doing so will have to look at this. It’s going to be a necessity.”

Susan Birk is a freelance writer based in Wheaton, Ill.
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