

Laying the Foundation for Successful Physician–Health System Partnerships

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This column is the first in a series that will explore the complex, evolving, and often elusive nature of physician–health system relationships. Affiliations between physicians and hospitals or health systems have experienced variable success throughout the last decade, as models with a wide range of goals and agendas have been tested. These columns will delve into some of the emerging models for integration of physicians and health systems and will review their effect and value for both hospitals and physicians.

For the first column, we will focus on a crucial aspect of physician–health system affiliations that is frequently overlooked. The environment in which relationships are created lays the foundation for all physician–health system partnerships and ultimately determines their initial and long-term success and the level of integration achieved. No matter how innovative, equity-oriented, or financially beneficial the physician–health system relationships may be, they will fail in the absence of mutual trust and feelings of shared destiny that are engendered by the environment in which the relationships are forged.

As healthcare executives have sought to bring hospitals and physicians together into integrated delivery systems, these affiliations have suffered from the mere fact that they were highly experimental, but there have also been grossly unrealistic expectations about the ease with which these diverse parties could join together and meet each other's expectations for creating value and benefits. Physicians tend to be entrepreneurial and comfortable with fast-paced approaches to collecting information and rendering individual decisions. Hospital executives are polar opposites, working in an environment that is consensus oriented and much more laborious in its approach to decision making.

It is not surprising that the 1990s have spawned a generation of relationships among physicians, hospitals, and health systems (such as physician-hospital organizations [PHO] and acquisition/employment relationships) that have failed to produce any sustainable value—such as market leverage, improved operational efficiencies, and increased access to managed care contracts. In some instances, the affiliations have been financial disasters, with hospitals losing millions each year on flagging ventures that were grounded in the belief that integrating physician practices with hospitals and systems was necessary for full-risk or capitated contracting. Physicians have also suffered during this decade of partnership experimentation. They have lost ground financially and have watched their autonomy erode

as they have joined or been acquired by new and often fledgling entities that have shown little knowledge or understanding of the practice environment.

Despite the numerous shortcomings of these early models of physician-hospital integration, compelling reasons exist to seek more effective approaches for working together:

- Hospitals and physicians are in the same business, serving the same customers, in the same communities; ideally hospitals and physicians should be jointly accountable for the health status of the communities they serve.
- The skills, characteristics, and needs of physicians and hospitals are complementary. For example, hospitals can benefit from physicians' entrepreneurial spirit and efficacious decision making and physicians can benefit from hospitals' business savvy.
- Competition between hospitals and physicians wastes valuable community resources and gives communities the impression that healthcare providers are more interested in their own financial interests rather than in providing quality, cost-effective patient care.

If a new generation of physician–health system partnerships is going to have any chance of succeeding where previous models have failed, hospitals and health systems must focus on evaluating their environments and creating a culture that engenders trust and a joint commitment to ensuring the viability and strength of both hospitals and physicians through mutually beneficial relationships. Overcoming the adversarial posturing exhibited in previous affiliations will not be easy, as hospitals and physicians must overcome past mistakes, unbundle existing relationships, and attempt to rebuild trust. But if these environmental issues are not addressed before the parties head to the bargaining table, new partnerships are doomed before discussions begin.

Hospitals and health system leaders should begin by asking the following questions:

- Are there strong levels of trust between physician and hospital leaders? Have previous experiences been characterized by open communication and honest discussions and have promises been backed up with action?
- Are hospital and system leaders accessible to physician practices? Do they reach out to individual practices to gain full appreciation and understanding of practice needs or do they rely on perceived needs as identified by the medical director or chief of staff?
- How will competitor initiatives affect the types of affiliation pursued?
- How will payor influences affect the relationship from a contractual standpoint and in terms of the degree of risk assumption that can be achieved?

- How can the needs of primary care and subspecialist physicians be met? Are integration models favoring one category of physicians to the detriment, perceived or actual, of another?
- Can partnerships be structured to accommodate younger and older physicians who are more amenable to fully integrated relationships and also meet the needs of middle-age physicians who are more tolerant of speculative, creative ventures and risk assumption?

Physicians should consider these questions:

- Are the outcomes of the affiliation clearly articulated and in line with physician expectations?
- Will information be shared with physicians so they can monitor and measure the value of the partnership?
- In addition to economic benefits, does the relationship with a hospital or system help eliminate the administrative "hassle factors" of daily practice operations?

As the responses to the questions are candidly evaluated, hospital and health system leaders should consider six key strategies for creating an environment that is conducive to forming successfully integrated relationships and a culture that nurtures the relationships over the long term.

1. Offer physicians choice. Physicians are not a homogenous group, but represent a spectrum of individualistic professionals who view integration and their practice needs from a range of perspectives. Hospitals and health systems must offer physicians choice to accommodate varying expectations and goals as well as comfort levels as they relinquish autonomy and assume risk. In particular, options must be available for subspecialists who have been overlooked in previous partnership models, most notably the acquisition of primary care practices.

2. Allow integration to evolve, but aim for significant integration. Although research does not support the theory that physician-hospital relationships must pass through low levels of integration before evolving to more tightly aligned relationships, physicians will be receptive to having options to start out slowly and allow trust to be built, or to skip intermediate stages and move to more fully integrated partnerships. Significant integration will secure the provider community and reduce the vulnerability of the hospital and medical staff to external threats.

3. Ensure the quality and efficiency of hospital services and medical staff. Hospitals have tended to focus on incentives and marketing and contracting support with previous physician affiliation models, often overlooking issues related to hospital clinical quality and operational efficiencies. If hospitals and health systems want to attract physicians as partners, they must demonstrate their healthcare delivery expertise and prove their willingness to address operational and system

inefficiencies identified by practicing physicians. Building a high-quality medical staff will also serve as a magnet for integration of other physicians.

4. Pursue acquisition only in rare circumstances. Most hospitals and health systems have learned the hard way that trying to manage and control entrepreneurial physicians leads to huge financial losses. New models should draw upon the strengths of each partner and protect each from further financial losses.

5. Evaluate the short-term and long-term financial effect of integration models. The era of having surpluses from hospital operations subsidize losses incurred from underperforming physician partnerships is nearing an end as the Balanced Budget Act has reduced hospitals' and systems' ability to subsidize losses incurred from hospital-affiliated practices. In the future, physicians, hospitals, and health systems must focus on income enhancement and strengthening their economic viability if they intend to survive even tighter reimbursement restrictions.

6. Build partnerships that add value. One of the principal failures of the traditional PHO model is that most PHOs simply converted existing hospital and physician payor contracts to PHO contracts and then "taxed" physicians to pay for the PHO infrastructure and management. New affiliation models must demonstrate added value. For physicians, value means increased access to incremental contracts and hospitals assisting physicians with practice viability and efficiency. For hospitals, value boils down to not losing money, maintaining or improving market viability, and improving their managed care contracting positions.

Achieving integration will not come easily, as demonstrated by the paucity of viable and value-added physician–health system partnerships currently in place and the abundance of relationships that are now unbundling, such as employment relationships with primary care physicians. But the starting point for looking at a new generation of models that can be sustained into the next millennium is a thorough evaluation of the partnership environment and a willingness to create a culture where open and honest discussion can occur about the full range of benefits and consequences of physician–health system affiliations.

For more information on this article, please contact Craig Holm at: cholm@hss-inc.com. Mr. Holm is the author of the upcoming Health Administration Press book, *Physician–Health System Partnerships: Models for the Next Generation*, scheduled for publication in the late spring.