

## FEATURE STORY

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## creating a sustainable physician strategy

Hospital-physician relations are changing. Will your hospital keep pace? Get prepared with these six must-do actions.

### AT A GLANCE

To improve relations with physicians, hospitals should:

- > Include physicians in decisions related to operational issues and strategic direction
- > Explore options for engagement, which often can change with shifts in the regulatory and legal environment
- > Develop a formal process for sustaining relationships with physicians, particularly those in primary care

The next five years will be one of the most transformative periods for physician-hospital relationships in recent history. Will your organization be prepared?

Savvy hospital leaders recognize that organizational strategies must not only adapt—but also anticipate—needed actions to address the key forces with potential to alter the nature of today's physician relations. Notable forces include:

- > The increasing shortage of physicians
- > Soaring medical practice risk and costs
- > Continued emergence of high-impact, high-cost technologies
- > Shifting competition in profitable service lines
- > Major changes on the regulatory front

Organizations that take a proactive approach in light of such factors will be better positioned to achieve competitive strength and the related benefits, including the ability to recruit top-ranked physicians, maintain and enhance revenue and market share in both inpatient and outpatient arenas, and gain and maintain physician loyalties.

### A Changing Relationship

Recent trends are creating an environment where hospitals and physicians have great need for one another. Several situations in particular are changing the dynamics of this relationship.

The hospital-physician pendulum now appears to be swinging back to a point of relative equilibrium after nearly a decade of gains by physicians. Physician ambulatory strategies that eroded hospital outpatient volume in recent times are no longer yielding hoped-for results in some instances. Most notably, physician-owned imaging facilities are experiencing substantially reduced margins since the Deficit Reduction Act of 2005 took effect in January 2007. Physician-owned ambulatory surgery centers, which have been achieving significant success at the expense of hospital offerings in many areas of the country, will experience the first blows of reduced CMS payments this month; over the next four years, their payments are expected to fall to an average of 65 percent of the rate paid to hospitals under the CMS Outpatient Prospective Payment System.

Also affecting hospital physician relations, physicians' inflation-adjusted incomes have been falling considerably. Average net income declined 10 percent for primary care physicians and 2 percent for specialists during the past

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decade (*Losing Ground: Physician Income, 1995-2003*, Center for Studying Health System Change, June 2006). As physicians work harder to maintain their incomes, they are making choices that are likely to have a great impact on hospital operations, such as consolidating hospital privileges, declining on-call coverage, and/or requiring sizeable pay-for-call arrangements. Such strategies and retirements in the aging physician population are exacerbating the effects of physician shortages for hospitals in numerous areas nationwide. Estimated to be 50,000 today and projected by some to rise to 125,000 by 2015, the shortage is making it difficult for hospitals in many areas of the country to recruit physicians in high-demand specialties, particularly critical care, trauma, and emergency medicine. National studies cite severe forthcoming shortages in geriatric medicine, neurosurgery, oncology, primary care, and rheumatology, among others.

Physicians and hospitals need each other now more than ever, but unfortunately, the final Stark III rules, which became effective Dec. 4, 2007, are likely to reduce the number of viable ways to achieve alignment, especially through economic arrangements. Because the new rules do not contain relevant grandfather clauses, some current hospital-physician joint ventures may, in fact, be at risk for rule violation and need to be “un-done.”

### Six Must-Dos for 2008

Given such changes to the physician-hospital relationship, the following six strategies are non-negotiable “must-do” actions for 2008.

**Engage physicians in strategic decision making.** This strategy sounds obvious, but numerous hospitals lack formal or even informal means to gain physician input and perspective about organizational direction. Without this input, strategic plans are much less likely to be on target or achievable.

Communication must extend beyond operational issues to strategic topics, such as new opportunities and potential competition. Physicians often

can provide early information about competitive issues, such as breakthrough procedures/technologies or for-profit companies interested in establishing local ambulatory facilities. By proactively engaging physicians in strategic decision making, hospital leadership helps ensure the broadest possible radar sweep for competitive threats and allows for development of growth opportunities most likely to align hospital and physician interests.

Physicians look to hospitals with which they’re affiliated to develop, gain buy in, communicate, and implement a long-term vision for physician-hospital collaboration. They also expect the hospital to collaboratively develop a formal, market-driven strategy for each service line and communicate the strategy to relevant physician stakeholders. Physicians will not drive this process; the hospital must do so.

Creating a physician advisory council provides an excellent means for hospital leaders to involve physicians in strategic decision making. It also

## DOCTORS IN DEMAND

In a 2007 survey of 400 hospital CEOs, 86 percent stated they were currently recruiting physicians. Of those recruiting, 80 percent were seeking primary care physicians and 74 percent were seeking specialists, according to the Council on Physician and Nurse Supply survey.

### ANATOMY OF A PHYSICIAN ADVISORY COUNCIL

#### Charter

- > Begin with a formal charter to develop and improve care in your service area.
- > The council provides physicians with a venue for regular communication with the hospital and with other physicians.

#### Members

- > Co-chairs (the most critical decision) choose the remaining members.
- > Physician leaders should be drawn from a cross-section of specialties.
- > Include only one administrative representative (unless specific agenda items dictate additional administrative presence).

#### Operations

- > Conduct monthly meetings, more often at the beginning if possible.
- > Pay physicians for attendance.
- > Ensure administration follow up on action items between meetings and report on the follow up at each meeting.

#### Topics

- > Consider topics such as
  - Physician-hospital collaboration
  - Growth opportunities
  - Technology investments, facility planning, and long-term quality initiatives

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**PHYSICIAN-HOSPITAL ENGAGEMENT STRATEGIES**

Strategies	Alignment Strength	Advantages	Disadvantages
Physician input through boards and committees	Historically low, but increasing	Low cost; low risk	Longer-term benefits; no or little economic alignment
Medical directorships	Low	Flexible; can include as many physicians as necessary	Can create political conflicts; requires physician time commitment
Income guarantees or forgivable loans	Low	Flexible as long as there is demonstrated need	Short-lived; no guarantees of loyalty or collaboration
Physician/hospital organization or physician network	Medium	Some economic alignment	Loyalty is to the contracts, not the other party
Centers of excellence	Medium	Ties physicians to program; improves service offering	Little economic alignment unless combined with another strategy
IT connection	Medium	Easy to “touch” many physicians	No economic alignment; costly
Management services organization	Medium	Ties hospital to physicians’ business success	Costly; can hurt more than help if not done well
Gain sharing	Medium	Provides economic benefits for hospital and physicians	Short-lived; takes time to implement
Per-click arrangements	Medium	Some economic alignment	Represents small piece of overall physician income; recent legal challenges to the approach
Real estate investment	Medium/high	Opportunity to include primary care physicians	Limited strategic alignment unless building investment tied to strategy
Participating bond transactions	High	Strong economic alignment	More difficult to sell/implement
Leasing/co-management of facilities and/or service offerings	High	Strong economic and strategic alignment, somewhat easier to unwind if necessary	Contracting potentially complex; requires strong combined vision and agreement on strategic goals and operating principles.
Joint ventures	High	Strong economic and strategic alignment	Costly; challenging to implement and govern; may increase operating costs
Physician employment	High	Strongest alignment; minimizes economic risk for physicians	Significant economic and political risk, especially if incentive compensation is not set up properly
Integrated delivery system/clinic model	High	Physician-driven organization means high collaboration	High hurdles for implementation; must have significant support from all physicians in a community.

Source: Kaufman, Hall & Associates, Inc. Used with permission.

provides a venue, beyond the formal, legal governance structure, for regular and coordinated communication between the hospital and other physicians.

The first steps toward establishing such a council are to identify council co-chairs to develop the council’s formal charter, which generally

addresses broad goals related to the improvement of care in the service area. The co-chairs are responsible for shaping and inviting the desired group of physicians from a cross-section of specialties. The council should also include one representative from hospital administration, who ensures administrative follow-up on action items between meetings and reports relevant activities

## Despite a tightening physician market, an increasing number of physicians may be seeking employment in the future.

to both the council and management. Transparency and follow-through are vital. No hospital is too small to have a dedicated physician relations staff member, or members, to assist in this regard.

Council agenda topics can address physician-hospital collaboration, growth opportunities, technology investments, facility planning, and long-term quality initiatives. The council should meet monthly or more often if possible at the beginning; the hospital should pay physicians a nominal amount for attendance.

### *Investigate physician-hospital engagement options.*

Education about options is critical; the entire hospital leadership team and board of directors should be on the same page in this regard. If hospital leaders are not already familiar with federal and state regulations and laws related to antikick-back, Stark/self-referral, and tax exemption, they need to be so educated soon. These regulations and laws are quite complex, but leaders at the least should be able to recognize when expert legal or tax counsel is needed. Given the rapidity of developments and adverse consequences of improperly structured arrangements, counsel generally is required early in the exploration process.

Options are numerous and complex and may offer very different advantages and disadvantages. Although in-depth description is beyond this article's scope, the exhibit on page 64 provides summary information about current and emerging strategies. Recent implementation of

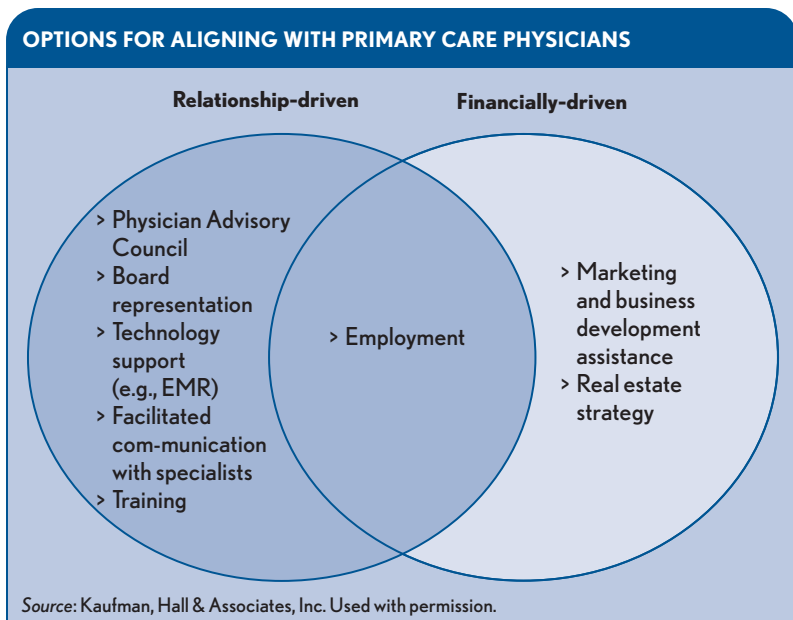
Stark III is casting additional regulatory scrutiny on the highlighted options, namely leasing/co-management of facilities and/or service offerings and per-click arrangements.

### *Carefully consider employing physicians, especially in high-demand, low-supply specialties.*

Many hospitals are recognizing physician employment as a proactive strategy to minimize risks, grow market share, and gain increased physician participation in quality improvement and care/cost management initiatives. As described earlier, numerous hospitals are experiencing shortages of physicians, making it difficult for them to ensure provision of needed services. Employment of physicians, particularly in high-demand, low-supply specialties, can mitigate such challenges. By employing physicians, hospitals are better able to direct the time of the physicians to activities that may have a substantial impact on cost-effective service delivery, clinical quality improvement, and financial performance.

Despite a tightening physician market, an increasing number of physicians may be seeking employment in the future. Employment may be a valued option for them to reduce risk, achieve a better work-life balance, and control expenses associated with malpractice coverage, leasing, and support staff. Also, as single and multispecialty physician groups grow and health plans require group affiliation for participation, independent physicians increasingly may consider employment as an alternative.

Hospitals not already employing physicians should be prepared to do so. Effective compensation plans will be critical to recruiting and retaining the best physicians. The best compensation plans—whether based on salary, salary plus bonus, productivity, or a combination thereof—consider issues including governance and leadership, teamwork, and performance monitoring and benchmarking. Laws in some states prohibit hospital employment of physicians for the provision of outpatient services, so again, legal counsel should be obtained early.



Given current trends, it's particularly important for hospitals to focus on relationships with PCPs. Baby boomers, who tend to understand wellness and preventive care, generally maintain strong relationships with their PCPs—and follow their referrals for outpatient services and admissions. As pay for performance takes hold, this PCP role in controlling patient care and referral is becoming increasingly important to hospitals.

Unfortunately, unlike opportunities with specialists, opportunities for hospitals to engage with PCPs are more limited. The exhibit at left shows eight strategies that warrant hospital consideration. Relationship-centered options include PCP participation on a physician advisory council and on hospital boards. These are imperative strategies for hospitals into the future.

***Develop age- and specialty-specific arrangements.***

There's no such thing as a one-size-fits-all physician strategy. First, age dichotomy is a reality. Older physicians most often focus on preserving historic income levels that are now under considerable pressure; younger physicians most often are focused on managing risk and maintaining lifestyle. Second, opportunities for collaboration vary by clinical specialty. For example, an equity joint venture strategy that offers high financial rewards is more likely to appeal to (and be offered to) established, high-income specialists, such as cardiologists and orthopedic surgeons who can assume proportionate partnership risk in an outpatient business related to their specialty area. Options for joint venturing with primary care physicians (PCPs) are limited, however, due to regulatory restrictions related to self-referral.

***Give priority attention to arrangements with PCPs.***

With abatement of the capitation frenzy of the 1990s, many hospitals took their eyes off PCPs and the vital importance of ensuring a formal primary care strategy. The increasing use of hospitalists who manage inpatient care instead of PCPs, while creating many benefits, also has generally decreased hospital communication with its PCP referral base.

Engagement with PCPs in the area of IT can yield significant mutual benefits related to quality of care and care outcomes and customer service. Although most physicians recognize the importance of an electronic health record system in reducing medication and other errors and enhancing care coordination, many PCPs are not able to implement such systems without financial and logistical support and incentives. In contrast, most hospitals have substantial IT resources, with the ability to support networks, servers, and various applications. Supporting physician practices

**HOW DO YOUR PHYSICIAN RELATIONS RATE?**

Agencies that rate hospital debt issues focus significantly on analyzing the state of a hospital's physician relations. Agencies examine how the economics of existing and proposed physician engagement activities are likely to influence the hospital's overall financial picture. A lack of appropriate physician economic alignment would be viewed as likely to negatively affect hospital volumes and net income.

Noted in a recent Standard and Poor's commentary, "As physicians will always be an integral part of healthcare operations, their relationships with healthcare organizations—whether positive or negative—will continue to have an affect on not-for-profit credit ratings for years to come."

### HOSPITAL-PHYSICIAN RELATIONS AT FRHG

Fremont-Rideout Health Group (FRHG), a three-hospital system 40 miles north of Sacramento, Calif., has committed to accomplishing the six must-do strategies described here.

In late 2006, the new leadership team of FRHG recognized that physician participation, engagement, and perception would be key to achievement of the organization's vision. That vision focuses on FRHG as a regional health system, including a medical center and integrated continuum of care, which provides comprehensive and advanced medical services to its market.

Some of the organization's affiliated physicians had partnered in recent years with a competitor that was building a short-stay hospital in the area. With this in mind, leadership has focused on building credibility, support, and positive communications with its physicians going forward.

Most notably, FRHG's leadership team is establishing a physician medical advisory panel. The panel will provide management and governance input related to growth opportunities, partnership opportunities, and facility needs.

To ensure provision of needed services, FRHG is considering a foundation model of alignment (California prohibits hospital employment of physicians for the provision of outpatient services, so this was not an option). Under the foundation model, the hospital would provide all services through a foundation, which would contract with physicians as independent contractors and with payers for the provision of medical services.

would seem to be an efficient and natural extension of hospital services, but the economic bounds of this activity are tightly controlled by the Stark and antikickback laws, as discussed in *Medical Practice Transformation with Information Technology*, by Charles M. Kilo, MD, and Mark Leavitt, MD, PhD.

CMS and Office of Inspector General rules effective in October 2006 provide that some donations of technology to support and promote physician adoption of e-prescribing and electronic health records will not violate Stark and anti-kickback laws. Hospitals can donate hardware, software, and training services to physicians if certain conditions are met, such as requirements related to cost-sharing and execution of a written agreement. Legal counsel is advised.

One way for hospitals to help align interests and enhance physician referrals is to consider ways to facilitate communication among specialists, PCPs, and the hospital. For example, Gundersen Lutheran Health System has developed an extensive regional referral network program. The organization's detailed provider database includes 1,500 physicians and other rural providers. An innovative "feedback loop" communication

system keeps the physicians that refer patients to the hospital informed about care that these patients receive while in the hospital.

Financially centered strategies typically include PCP employment, which all hospitals should anticipate and plan for; the provision of marketing and business development assistance; and jointly owned real estate. Many hospitals have been providing marketing and business development assistance to PCPs for years. Hospitals that have numerous affiliated solo or small-group physicians in private practice may wish to consider developing a primary care network that offers physician-to-physician and physician-to-hospital assistance with contracting, IT, and/or quality improvement initiatives. This may be an effective means to help support physicians in growing their practices.

Given concerns about self-referral regulations, primary care ownership of most hospital business ventures is not an option. However, a hospital that is investing in a new medical office building or other real estate often can offer PCPs a small percentage of ownership to encourage relationship development.

*Develop a formal engagement plan, commit capital to achieving the plan, and start purposefully implementing that plan.* Because both hospitals and physicians are more likely to succeed through collaboration than competition, hospitals must develop a formal physician-hospital alignment plan and revisit the plan on a regular (at least annual) basis.

The planning process begins with a physician workforce assessment that provides hospital leadership with a comprehensive understanding of physicians' perception of the hospital and general state of mind about future practice plans, opportunities, and challenges. Interviews with physicians conducted by neutral third parties offer a relatively easy way to gain physician perspectives on perceived quality and availability of care, areas for improvement related to physician relationships with the hospital, and recommendations for future engagement opportunities for physicians and the hospital. Analysis of data on affiliated physicians' age by specialty provides an indication of current and near-future recruitment needs.

In addition, education should be a key part of the planning process. Hospital leadership should continually learn about physician engagement options and how these might be affected by current and potential payment and regulatory changes. The physician advisory council should inform physicians about what hospitals can and cannot do as part of their relationship. Education will prepare all players for success.

Third, proper organization is vital to effective planning. Hospitals should develop a formal process for managing physician engagement initiatives and assign primary and supporting accountabilities to leadership—starting with the CEO—and staff.

Also, the overall physician strategic plan should include subplans for every major specialty. The development of a primary care strategy should be a top priority. The hospital's strategic planning and financial planning staffs should work together to address the strategic and financial impacts of engagement options. Requests for

capital related to selected options should be evaluated through the organizationwide capital allocation process. Once a strategy is approved, the organization must commit the capital needed to achieve success.

The development of a physician-hospital plan is only half the battle; it must be properly implemented, monitored, and achieved. Successful healthcare organizations determine indicators for success of strategies, measure performance against these indicators, and devise and implement plans to respond to less-than-anticipated performance.

### Aligning for Clinical and Financial Success

A high-quality, integrated strategic-financial plan should seek to maximize outcomes while reducing risk of failure and generating a profitable bottom line that is able to sustain an organization's competitive financial performance. Strategies to engage physicians are critical components to this plan, and thus integral to the hospital's clinical and financial success.

The strength of relationships with physicians influences the hospital's ability to recruit top physicians and staff, achieve quality initiatives, maintain strong credit ratings, and ultimately garner market share in both inpatient and outpatient arenas. Organizations that take a proactive approach to fostering these relations will be best positioned for long-term success. ●

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