

COMMENTARY

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making physician integration work

It's happening again: Physicians and health systems are pursuing strategic, economic, and financial integration.

AT A GLANCE

- > Today, it is widely acknowledged that there is no single, universal model that should be used to achieve greater integration of care between physicians and hospitals.
- > The push toward such integration is being driven by many factors, such as greater physician receptivity to employment, physicians' desire for greater financial security, physician shortages, economic conditions, and health systems' need for competitive positioning.
- > In today's economic environment, the goals of physician-hospital integration are more attractive than ever.

With the current economic climate, there's good reason for today's trend toward physician integration to continue. Greater integration between hospitals and physicians has long held the promise of being a strategy that can ultimately lead to lower healthcare costs, and there has never been a greater need for pursuing such strategies than now, given the severe financial constraints facing U.S. healthcare providers. There also is greater promise that integration efforts will succeed this time. That said, hospitals and health systems should forge ahead with their efforts to establish closely integrated relationships with physicians.

One of several reasons the last movement toward integration succeeded in some cases and yet failed in so many others was the assumption that there was a single, universal model. This time, there is an understanding that every healthcare community has different characteristics and needs and no single physician-health system combination exists that can serve all of those needs. Multiple options are being developed.

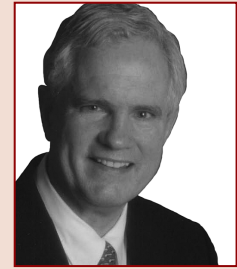
What Is Different This Time?

In the 1990s, most health systems embarked on a path of physician integration to prepare themselves to perform well under capitated contracts (contracts where the system agreed to provide all care for a given group of health plan members for a fixed fee). This time, physician integration is being driven by other factors.

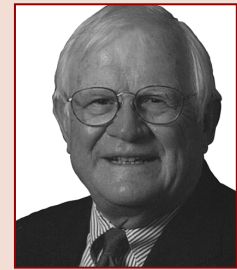
Greater physician receptivity to employment. Many physicians emerging from medical school are more interested in employment than in joining private practices. Meanwhile, many private practices are going through transition pains as the leadership generation that formed them approaches retirement.

Physician need for greater financial security. Concerns about declining payment are leading some private practice physicians to seek organizational arrangements where they can access new sources of revenues and capital, and guarantee their incomes.

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Among the books that Moore and Coddington have coauthored are *Strategies for the New Health Care Marketplace: Managing the Convergence of Consumerism and Technology*, with McManis colleague Elizabeth Fischer, and *Beyond Managed Care: How Consumers and Technology Are Changing the Future of Health Care*, with Elizabeth Fischer and HFMA’s president and CEO Richard L. Clarke.

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Renewed industry interest in clinical integration. The concept of coordination of care is back in favor, and the need for an electronic medical record linking medical practices and hospitals is a key ingredient.

Physician shortages. The cost of hiring new physicians is rising just as the economics of existing practices are feeling the pinch. The failure of many communities to add needed primary care physicians has caught the attention of specialists and health systems that rely on primary care physicians for referrals.

Use of integration as a tool for competitive positioning. For many health systems, integrating with key physicians is a way to head off the loss of profitable ancillary services. It also can be a way to secure the services of key specialists, reduce the overall costs of care, improve patient service, and/or organize more effective ambulatory services and outreach.

What Approaches Are Being Used?

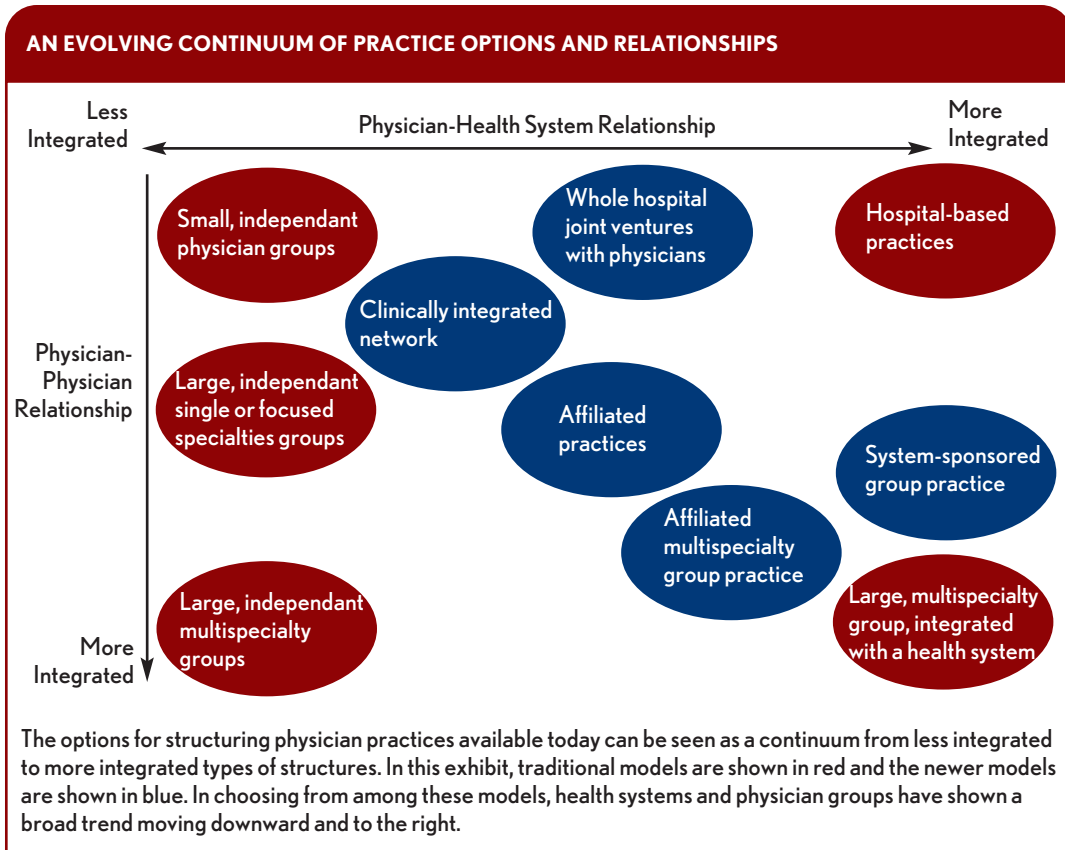
There is as much to learn from the failures of the physician integration initiatives of the 1990s as

from the successes. The failures were often marked by huge cultural clashes within the newly integrated organizations. Health systems often approached relationships with their new physician members with a heavy hand.

A “reverse Darwinism” developed. Weaker physician practices joined systems; compensation models did not encourage productivity and efficiency; the systems (not the physicians) made the key management decisions; and the practices became awash with red ink.

Physician leaders—sometimes blinded by the size of the buy-out of their independent practices—ignored their own needs for self-direction, put themselves and their colleagues in practice models that did not meet their operating styles, and then chafed under them.

Thus far, the current movement toward physician integration seems more realistic. Rather than one or two models, there is a range of approaches. As the exhibit on page III suggests, these options can be thought of as a continuum that fills in the gaps



between the standard practice models that most physicians began with (solo practices, single specialty group practices, hospital-based practices, multispecialty groups, and fully integrated systems).

Examples of the new models include:

- > Clinically integrated networks, where physicians remain in private practices but develop common patient quality and service initiatives and contract with payers as a single entity
- > Whole hospital joint ventures, where physician groups and systems jointly develop specialty hospitals and services
- > Affiliated practices, where practices actually become part of the health system but each still operates on its own bottom line, with a high degree of autonomy
- > Affiliated multispecialty group practice, where the previously cited affiliated practices come together as a multispecialty group
- > System-formed multispecialty practices, where groups of physicians employed within a health system begin to act as a coordinated practice

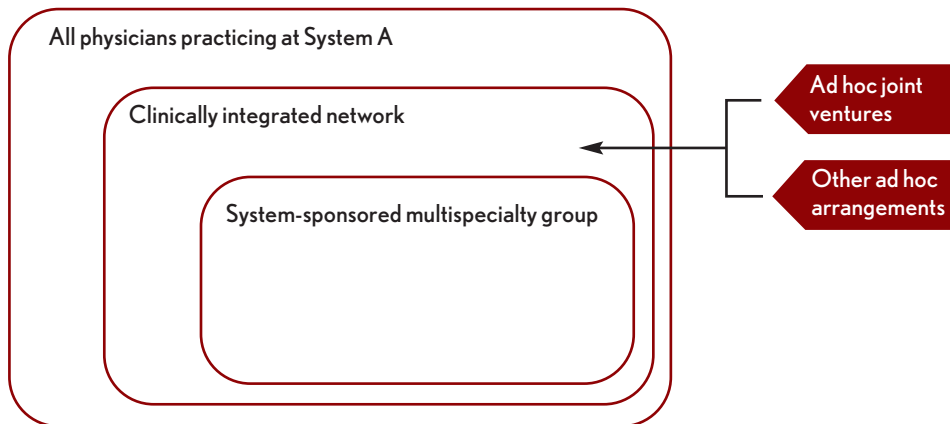
The new continuum reflects increasing physician-physician integration as well as physician-health system integration. Much of the value-added of these arrangements comes from physicians working still closer with one another on common systemwide agendas—in areas such as ambulatory services planning and outreach—within structures where incentives are more closely aligned and there are fewer antitrust and other legal constraints.

The pace of change varies from market to market, but the overall direction of change is clear. Health systems and physician groups are moving toward greater physician-physician and physician-health system integration.

Why the Need for Multiple Options?

The short answer to this question is, “Because one size does not fit all.” And this answer certainly applies to both physicians and healthcare markets. We recently studied high-performing health systems and found that they were

EXAMPLE OF HOW TWO PHYSICIAN RELATIONS MODELS COULD BE USED IN TANDEM



In this example, System A has a system-sponsored multispecialty group practice. These physicians are tightly integrated with each other and with the system in every respect. System A is also co-owner and developer of a clinically integrated network, which includes numerous small independent primary care groups (operating across a wide geographic area) and the system's key private practice specialty groups. The affiliated multispecialty group practice physicians participate in the clinically integrated network alongside key private practice physicians. System A also enters joint ventures and other arrangements, as appropriate, with selected specialists in its clinically integrated network. This combination of approaches allows System A to appeal both to the physician who fits well in a fully integrated system and the physician who places a high value on autonomy.

approaching many endeavors—including quality improvement, geographic expansion, financial planning, and identification of best practices—in a similar manner. But there were wide differences in how physician relations were being approached—both between and within these systems. Local differences require tailored approaches.

In a growing number of cases, we find that it is helpful for a health system to employ more than one physician relationship model, and to coordinate them, as is illustrated in the exhibit above.

What Can We Do to “Get It Right” This Time?

We need to tailor the organization to the specific circumstances. One key is to begin with the question, not with the answer. The basic steps in developing durable relationships—relationships that adjust to changing circumstances over time—are to listen, then to dialogue, then to model possible options, and then to listen and dialogue

again. It's usually a warning sign if only one option is discussed. It's usually an even bigger warning sign if only legal structures and financial flows are discussed.

A second key is to begin with strength. In our experience, choosing which physicians to engage in the first dialogues is a critical decision. These “organizing physicians” have to be respected by their peers. They have to be seen as clinically strong, as good strategic and financial thinkers, and as capable of rising above self-interest.

The good news is that most physician practice and health system leaders are aware of the failures of the past, and particularly given the profound need today to control healthcare costs, they also are aware of the value of achieving greater integration. Most important, this time, we won't see as much “one size fits all” or as much “just follow the money.” There is more realism, and more cause for hope. ●

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