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FREE REPORT

SEPTEMBER 2014

Physician Alignment

New Leadership Models for Integration

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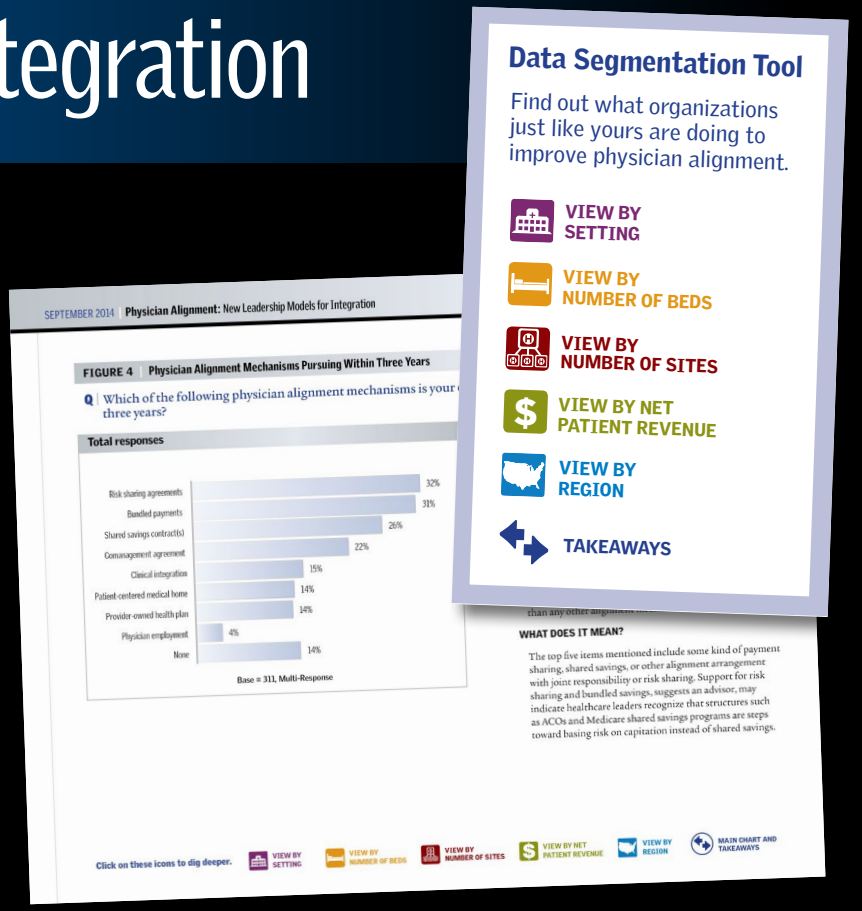
Physician Alignment:

New Leadership Models for Integration

This report reveals how a new focus on physician leadership, care transformation, and efficiency can propel the goal of physician alignment. Get answers to key strategic questions, such as:

- How is UnityPoint Health successfully developing physician leadership skills by utilizing a Physician Leadership Academy?
- How are savvy organizations preparing for closer relationships with payers by modifying their goals and performance objectives, giving special attention to protocols that ensure efficient and predictable care?
- How has Providence Health & Services strengthened alignment by expanding its hospitalist program to address the acute care needs of primary care physicians and providing tools such as integrated care management solutions?
- How did Covenant Health drive alignment by creating a series of service lines, each of which takes into account physician engagement and needs assessment, business and clinical analytics, financial and clinical quality performance, evidence-based practice, and employed physician performance and compensation?



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PERSPECTIVE

The Importance of Communication and Coordination for a Positive Patient Experience

Thank you to all the physicians and healthcare system leaders who participated in the HealthLeaders Media *2014 Physician Alignment Survey*. This national study, with insights from more than 300 healthcare leaders, displays the overarching need for collaboration among traditional antagonists to achieve their mutual objective of improving the nation's healthcare system.

One of the leading findings of the HealthLeaders Media study is that 55% of respondents say they will move toward or emphasize clinical integration with primary care physicians over the next year. This is a significant and ongoing task in aligning healthcare systems across the entire care continuum at the market level. Clinical integration and alignment requires an initial high-level strategy based on a foundation of collaboration between hospitals, physicians, and all caregivers to improve the quality of care, patient experience, and patient access—all while lowering the cost of care.

Clinical integration includes a myriad of organizational initiatives, from physician employment to the formation of managed care entities to technological initiatives. All of these tasks require a foundation of best-in-class workflow streams combined with technology that not only tracks patient care but also ensures the clinical and financial outcomes for that care delivery. The most difficult aspect of all this, however, is cultural change. Old habits are hard to change even in the dynamic healthcare world.

Additionally, 37% of the healthcare leaders surveyed are currently undertaking risk-sharing agreements as part of their physician alignment efforts, and 32% of those not doing so now plan to implement such agreements within the next three years. The Patient Protection and Affordable Care Act requires hospitals and physicians to share risk related to care outcomes and savings. Such agreements entail a tremendous amount of collaboration in their own right, as historically disparate groups must work together in all aspects of the healthcare delivery system. Needless to say, these risk-sharing relationships will take significant investments in technology, workflow, and care management systems as well as governance among independent groups and systems.

Finally, such alignment/integration objectives and initiatives require a commitment to physician engagement at all levels throughout the organization—from clinical pathways to financial case management.

Perspective (continued)

When healthcare leaders cite their top patient care or physician engagement objectives, they look to address quality initiatives, care redesign and standardization, and value-based compensation while also improving clinical and financial performance. The success or failure of these key objectives will depend on the quality, frequency, and success of provider involvement in all of these aspects of our new healthcare model.

New care models will continue to evolve in every variety, including payment systems, local market consolidation activities, and approaches to risk. The cultural change necessary for hospital-physician alignment is much more difficult to achieve than for a single managed care contract or direct employment, yet a true compact of trust must evolve between these historically disparate groups. Common objectives centered on patient market share create the basis for a symbiotic relationship among a physician, a healthcare system, and a payer within a market. Effective communication starts at the leadership level of these organizations, with honest, frequent, consistent discussion of how these objectives will be met and, more importantly, why these objectives will improve overall patient care.

The ultimate indicator of successful alignment between hospitals and physicians occurs when the conversation moves from individual financial concerns to how to provide better, more effective care for the patients we are privileged to serve in our markets. Clinical integration and physician alignment are reached through collaboration fueled by a trust compact with a keen focus on patients and their care.

John R. Thomas
CEO
MedSynergies
Irving, Texas

About the Premium and Buying Power Editions

This is a summary of the Premium edition of the report. In the full report, you'll find a wealth of additional information. For each question, the Premium edition includes overall response information, as well as a breakdown of responses by various factors: setting (e.g., hospital, health system, physician organization), number of beds (hospitals), number of sites (health systems), net patient revenue, and region.

Available separately from HealthLeaders Media is the Buying Power edition, which includes additional data segmentation based on purchase involvement, dollar amount influenced, and types of products or services purchased.

In addition to this valuable survey data, you'll also get the tools you need to turn the data into decisions:

- A Foreword by Alan S. Kaplan, MD, MMM, FACPE, FACHE, Senior Vice President and Chief Clinical Officer for UnityPoint Health and President and CEO for UnityPoint Clinic in West Des Moines, Iowa, and Lead Advisor for this Intelligence Report
- Three Case Studies featuring initiatives by Covenant Health in Knoxville, Tennessee; Providence Washington in Spokane, Washington; and UnityPoint Health in West Des Moines, Iowa.
- A list of Recommendations drawing on the data, insights, and analysis from this report
- A Meeting Guide featuring questions to ask your team

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Methodology

The *2014 Physician Alignment Survey* was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In June 2014, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience from hospitals, health systems, and physician organizations. A total of 311 completed surveys are included in the analysis. The bases for the individual questions range from 134 to 311 depending on whether respondents had the knowledge to provide an answer to a given question. The margin of error for a sample size of 311 is +/-5.6% at the 95% confidence interval.

Each figure presented in the report contains the following segmentation data: setting, number of beds (hospitals), number of sites (health systems), net patient revenue, region, purchase involvement, dollar amount influenced, and types of products/services purchased. Please note cell sizes with a base size of fewer than 25 responses should be used with caution due to data instability.

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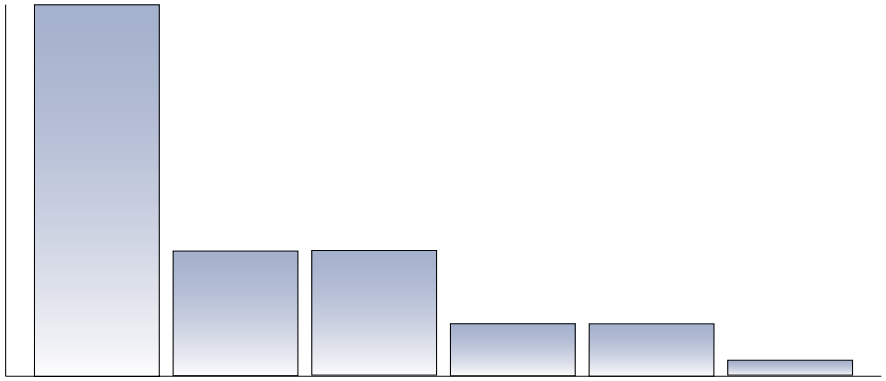
Respondent Profile

Respondents represent titles from across the various functions at hospitals, health systems, and physician organizations.

Title

Base = 311



Senior leaders | CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer

Clinical leaders | Chief of Cardiology, Chief of Neurology, Chief of Oncology, Chief of Orthopedics, Chief of Radiology, Chief Nursing Officer, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Inpatient Services, Dir. of Intensive Care Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director, VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MD), VP Nursing

Operations leaders | Chief Compliance Officer, Chief Purchasing Officer, Asst. Administrator, Chief Counsel, Dir. of Patient Safety, Dir. of Purchasing, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/ Administration, Other VP

Information leaders | Chief Medical Information Officer, Chief Technology Officer, VP/Dir. Technology/MIS/IT

Financial leaders | VP/Dir. Finance, HIM Director, Director of Case Management, Director of Patient Financial Services, Director of RAC, Director of Reimbursement, Director of Revenue Cycle

Marketing leaders | VP/Dir. Marketing/Sales, VP/Dir. Media Relations

Information leaders | Chief Medical Information Officer, Chief Technology Officer, VP/Dir. Technology/MIS/IT

Type of organization

Base = 311

Hospital	47%
Health system	36%
Physician organization	17%

Number of beds

Base = 147 (Hospitals)

1–199	50%
200–499	31%
500+	19%

Number of sites

Base = 112 (Health systems)

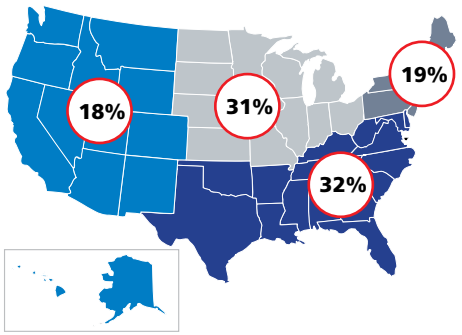
1–5	23%
6–20	29%
21+	48%

Number of physicians

Base = 52 (Physician organizations)

1–9	17%
10–49	21%
50+	62%

Region



WEST: Washington, Oregon, California, Alaska, Hawaii, Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming

MIDWEST: North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, Minnesota, Illinois, Indiana, Michigan, Ohio, Wisconsin

SOUTH: Texas, Oklahoma, Arkansas, Louisiana, Mississippi, Alabama, Tennessee, Kentucky, Florida, Georgia, South Carolina, North Carolina, Virginia, West Virginia, D.C., Maryland, Delaware

NORTHEAST: Pennsylvania, New York, New Jersey, Connecticut, Vermont, Rhode Island, Massachusetts, New Hampshire, Maine

ANALYSIS

Physician Alignment: Modifying Relationships to Meet Value Requirements

MICHAEL ZEIS

More and more, alignment decisions are pivotal strategy decisions. Although many dynamics are at work, the core concept is that emerging changes to the financial underpinnings of the healthcare industry will reward organizations that provide care more efficiently and deliver value.

The changes required go well beyond optimizing the cost components of the efficiency equation. Although shared objectives are commonly part of physician-hospital alignment mechanisms, performance objectives and compensation have been largely based on revenue and production. Now, with efficiency in mind, many aspects of reimbursement for care are in transition or queued up for change. In turn, that prompts an examination of the conventional role of healthcare administration in setting policy and managing the enterprise, with the result that many leaders are pursuing ways to incorporate physicians and other members of the clinical team in decision-making that hinges not on the number of procedures or office visits or patients seen, but on keeping a population healthy.

In addition, previous concepts about physician autonomy are being examined. New approaches to physician alignment must acknowledge the role of physicians as partners in care transition, as supportive participants in efficiency measures, and as leaders in their organizations.

WHAT HEALTHCARE LEADERS ARE SAYING

"We build alignment around clinical outcomes and the achievement of improved outcomes year over year. This is then tied through process improvement to cost-efficiency and effectiveness and used as a method of rate leverage."

—Vice president of planning for a large health system

"We have contractual requirements with specialists and hospitalists that have minimal VBP components as part of organizational goals, and leadership roles with stated objectives and LLC profit sharing."

—Chief nursing officer for a medium hospital

"For employed physicians, we are tying a portion of compensation to work productivity, quality metrics, and patient satisfaction scores. For independent physicians, we are offering an IPA to include EHR at reduced rate, participation in an employee healthcare product at defined rates, and inclusion in bundled payment gainsharing."

—Vice president of finance for a large health system

"We do so through a bottom-up execution process whereby our physician organizational structures drive decision-making. We set goals top-down and execute them bottom-up."

—Vice president of finance for a large health system

"We are using shared savings agreements for some specialists and using a short list of incentive targets (LOS, patient satisfaction, readmissions rates, etc.) for primary care."

—CEO for a medium hospital

Analysis (continued)

The business side of efficiency. Although improving efficiency by changing the way care is delivered is an objective, healthcare organizations must retain solid financial footings as they do so and, on the face of it, business priorities of the past are business priorities of the present. Nearly two-thirds of healthcare leaders (63%) say that system margin is among the top three business-related goals behind their physician alignment strategies. Half say that maximizing system revenue is a top goal.

Jim VanderSteeg, and advisor for this report, is executive vice president for hospital operations and chief operating officer for Covenant Health of Knoxville, Tennessee, a health system with nine acute care hospitals, a psychiatric hospital, rehabilitation centers, homecare, and other facilities serving East Tennessee. He notes how strong the link is between finances and the delivery of care. "Covenant's goal is not primarily to have the biggest margins. Our goal is to serve our community. We know that we cannot serve our community if we don't have strong financials. You can't separate the financials from the healthcare. They are one and the same, and they enable each other."

Clinical coverage challenges. Ensuring sufficient staff, especially in specialties, is another classic business objective and is among the top goals for 50% of respondents. Jeff Collins, MD, an advisor for this report, is chief physician executive for Providence Washington in Spokane, which is part of Providence Health & Services and encompasses nine acute care hospitals as well as clinics, in-home services, and assisted living and nursing homes.

> "We know that we cannot serve our community if we don't have strong financials. You can't separate the financials from the healthcare."
>
> —Jim VanderSteeg

He explains that the age-old challenge of ensuring coverage in the acute care environment is persistent. He describes arranging for call coverage for Providence Health & Services' emergency departments. "To cover a busy ED 24/7, you really need to have at least four or five people in a given specialty."

Contracting with a surgery group may not provide a complete answer, considering specialties and subspecialties. "Even within a sizeable group, for example, there may be only one or two who do vascular surgery." In addition, the competitive landscape has to be taken into account if one approaches the problem of ED coverage by employing specialists. First, as Collins points out, one must hire several specialists to provide adequate coverage. Second, there is a good chance that the added employed specialists will compete with existing specialty groups and weaken their finances, which could have undesirable side effects.

Analysis (continued)

In the case of Providence Health & Services, the need to cover unassigned patients in the ED led to the establishment of a hospitalist program, and the organization now is using the hospitalist model in other areas, as well. "In the 1990s," Collins says, "our hospitalist program was implemented to take care of the unassigned patients in the ED. But it has grown to take care of the hospital portion of primary care doctors' practices." Thus, an approach that was taken to resolve ED coverage can be extended to respond to a newer need to cover the acute care needs of patients whose primary care physicians want to minimize the time they spend in hospitals.

The industry trend of providing more services in outpatient settings has created acute care shortages, especially in specialties. Says VanderSteeg, "Over the past two to three years, we have been employing more physicians who are spending the lion's share of their time in the hospital. This includes employed cardiologists, cardiovascular surgeons, neurosurgeons, and neuro-hospitalists." He says the shift to the outpatient setting on the part of neurologists has created a nationwide shortage.

"Especially as hospitals become higher in the tertiary care hierarchy, they need neurologists in the hospital. We've had to develop a neuro-hospitalist model in order to get neurologists in our hospitals to take care of patients," VanderSteeg says.

The need to share risk. Alan S. Kaplan, MD, MMM, FACPE, FACHE, is senior vice president and chief clinical officer at UnityPoint Health in West Des Moines, Iowa, a 17-hospital integrated health system that includes UnityPoint Clinic with 280 locations, all serving Iowa, Illinois, and Wisconsin. Kaplan also serves as president and CEO of UnityPoint Clinic.

> "If you believe we're going to get paid for value—quality over cost—then you need to have physicians aligned. Because if they're not aligned, nothing good happens."
>
> —Alan S. Kaplan, MD, MMM

He says previous views about physician relations were hospital-centric. "Historically it was about volume. Hospitals would ask themselves, 'How do we become the most physician friendly?' Hospitals would look at who has been loyal, and which physicians are splitters." Now, Kaplan says, "The old ways we did things—appoint medical directors, enter into comanagement agreements or joint ventures—now they're just small pieces of the big picture of creating value. They may still exist, but they're inefficient."

Physician relations today are colored by the pending need to share risk. Says Kaplan, lead advisor for this report, "We're moving toward shared

Analysis (continued)

savings with no risk and then shared savings with risk. I suspect most of us will then move toward some sort of partial or full capitation. When that happens, alignment with physicians will have gone from being physician friendly and maximizing referrals to being an absolute strategic imperative. If you believe we're going to get paid for value—quality over cost—then you need to have physicians aligned. Because if they're not aligned, nothing good happens."

VanderSteeg speaks with force about the importance of alignment strategies in a risk-sharing environment. "You can only do bundled payments if you have alignment with your physicians and you can trust your performance. If you can't trust your performance, in a bundled payment arrangement you can lose tremendous amounts of money."

Care redesign as an alignment objective. VanderSteeg and Covenant look very closely at payers when determining their alignment strategies, with a view that underscores the strategic importance of alignment.

"Payers want quality outcomes at a fixed or reduced cost to them," he says. "Of course they want high satisfaction scores. But they also want outcomes that are very much associated with the cost part of the equation. So when we look at our dashboards, they focus heavily on financial outcomes. And they focus on clinical outcomes, too, because we believe that good quality costs less." And here is the crux of it. "If what you bring to a payer is quality outcomes at a guaranteed or reduced cost, they're going to be very interested."

With payers providing a financial incentive based on efficiency, organizations recognize new or enhanced roles for physicians in establishing strategies for care enhancement and in directing modifications to care delivery systems. Both are aided by alignment mechanisms that enhance physician engagement.

> "In our work, I ask, 'How do we make the right things or the best things the natural or the easy things that happen in care?' You do that by designing systems that make the right thing the default."
>
> —Jeff Collins, MD

Looking at alignment objectives related to patient care and physician engagement, nearly half of the respondents (45%) include the need to engage physicians in care redesign among their top goals. Even higher percentages were recorded by those in health systems (57%) and those from organizations with net patient revenue above $1 billion (62%).

Collins offers some insight into why care redesign might be a big-organization phenomenon at present. "In our work, I ask, 'How do we make the right things or the best things the natural or the easy things

Analysis (continued)

that happen in care?' You do that by designing systems that make the right thing the default. That kind of system design just doesn't happen until groups get some critical mass." Although survey results indicate the higher percentages of large healthcare organizations include care redesign as a top objective, Collins says that smaller organizations are working at care redesign, too. "I'm not saying they don't pay attention to it, I just think it's probably not one of their top three objectives."

Care standardization can help avoid the financial pitfalls that Kaplan warns about and can help make one's organization attractive to payers, as VanderSteeg expects to do. Collins adds his perspective: "Most of us who work in systems believe that in order to make our healthcare delivery system better, there has to be increasing systemization. You have to have standardization and eliminate or minimize the unnecessary or unrequired and reduce variation. In order to traverse the kinds of changes coming and to be effective with the change management structures we have, you have to get a critical mass of physicians on the bus."

Physicians' role in management. Collins suggests that the industry's focus on value-based purchasing is prompting new perspectives on physician engagement. "Practice management was very focused on doing what you got paid for, and now we sort of have to undo that. Now what's important is how patients do over time, what the outcome measures are, and what the total cost of care for a group of patients over a period of time is. So we've spent a lot of time and energy doing that educational piece. At the same time, we are putting into place a structure where physicians really have significant, not ceremonial, management roles."

> "Especially as hospitals become higher in the tertiary care hierarchy, they need neurologists in the hospital. We've had to develop a neuro-hospitalist model in order to get neurologists in our hospitals to take care of patients."
>
> —Jim VanderSteeg

Can there be a more significant management role than a seat on the board? That is one of the keys to alignment for the UnityPoint Clinic, which has 280 locations and 1,100 primary care and specialty physicians. Says Kaplan, UnityPoint Clinic is one of 10 senior affiliates, "which means the medical group is now on par with our hospitals, with delegates to the parent board. With that representation, we see a physician-driven organization come to life, not only culturally but structurally."

Of course, even though not all physicians will be called to serve in management or be able to guide the organization's strategic direction, they all probably will be asked to participate in the new direction of healthcare, so leaders emphasize that communicating to physicians

Analysis (continued)

(55%) and seeking physician input on strategic decisions (44%) are actions that are essential to engage physicians in strategic planning.

"The docs need to understand that they're going to have to add value," Collins notes, "and they're going to have to demonstrate the value that they add in order to get any sort of money over and above what they're going to collect from their practice. That's kind of the hard message that some don't want to hear. You have to explain the underpinnings of all this and provide them with the tools to get there. If we do that, I think that we can make the transition."

Although physician engagement is important in all organizations, survey results indicate that large organizations approach engagement differently. For instance, in response to a question that asked respondents to pick only the top two actions that are most important in engaging physicians in strategic planning, a smaller percentage of healthcare leaders from organizations with high net patient revenue (43%) than those from small (62%) or medium (50%) levels of net patient revenue include communicating goals to physicians. That is not to say that large organizations don't value communication. Rather, larger organizations may be more inclusive and therefore may depend less on top-down communication. Indeed, more than half of the large organizations (55%) designate physician leaders for participation in strategic planning, such a step is less common at small (43%) and medium (41%) organizations.

VanderSteeg's description of a likely scenario helps us understand that more top-down communication is called for when there is less physician involvement in developing and leading alignment structures. "Larger healthcare systems tend to have resources," he says. "They tend to be more advanced in some of their strategic planning and their responses to market dynamics. As a result, we see that they have more involvement with clinical integration models, for instance. Well, with clinical integration models, not only do you need communication with physicians, but also you need physician leadership."

> "I think you have to be sensitive to the fact that being a physician in private practice now is like hell. You've got meaningful use, you've got ICD-10, you've got all kinds of requirements from the CMS, you've got concerns about liability."
>
> —Jeff Collins, MD

Indeed, higher percentages of organizations with high net patient revenue (18%) than small or medium (10% each) include leadership and fiscal training for physicians among their top two actions to engage physicians. "If you have a truly risk-sharing clinical integration model and your physicians are less involved in really developing the model, then what you

Analysis (continued)

need is common communication. But if physicians are actually helping to drive clinical integration in your organization, physicians not only need to be communicated with, they need to lead," VanderSteeg says.

He observes that the difference in approach is particularly evident when staffing for service lines. "Years ago ... you had to have the right physicians, the right specialists. While that is still important, now we've got to have physician leadership. Physicians have to co-lead the service line with us for us to get performance to the level it has to be in order to attract payers."

About the money. Although 20% say that physician engagement is the aspect of managing physicians that presents them the most difficulty, a higher percentage (27%) say that dealing with compensation expectations is their top problem. Because the lever that drives healthcare reform forward ultimately is compensation-based (largely through reimbursements to healthcare organizations and incentives or risk-sharing for physicians), and because the transition from fee-for-service to value-based purchasing has barely begun, we can expect physician compensation to remain a top problem. Indeed, the challenge is multi-faceted and one that consumes a great deal of attention and energy. "It's the most laborious patience-challenging thing you'll do," says VanderSteeg. "But at the end of the day, you'll get to a good spot."

As we see variety in alignment models in use, we also see variety in compensation models. Straight production (work RVU) is still in use by 25%, but advisors say this model is in decline. More than half of respondents (58%) use work RVUs plus incentive, especially in organizations with medium (72%) and high (78%) levels of net patient revenue. "We definitely have to modify the way their compensation looks," Collins states. "Everybody is working on that in one way or another."

> "The old ways we did things—appoint medical directors, enter into comanagement agreements or joint ventures—now they're just small pieces of the big picture of creating value. They may still exist, but they're inefficient."
>
> —Alan S. Kaplan, MD, MMM

Kaplan reminds us that different compensation models apply in different circumstances. "Within a medical group, you may have some specialties that work well on work RVUs and some that work well on salary. For instance, we have hospitalists that couldn't possibly pay for themselves on work RVUs, so they are on salary with quality incentives. Then we have primary care physicians that are busy enough to support themselves, and they are on work RVUs."

Most observers expect that compensation will remain a combination

Analysis (continued)

of production plus incentive. As the industry makes the transition to value-based purchasing, the nature of both production and incentive will likely change, though. Kaplan envisions that panel size might replace production as a metric in the future. "Instead of saying we're going to add work RVUs to your production targets," he says, "we might say we're going to pay based on your panel size. The new production metric might be to manage 5,000 patients and get their cost of care down and the quality up."

While many recognize that such a shift is likely, many also recognize that such a change has been slow to start. "It's still a production incentive," says Kaplan. "Until payers start saying, 'We're going to pay you for managing a population,' it won't switch. It's a very hard transition—it's not just the providers who aren't ready; we're learning that the payers don't know how to do this either. So we may be in this in-between world for quite a while yet." Those who have the resources, skills, and market position can move now, though.

"A lot of larger integrated delivery systems are looking at buying provider-owned health plans," Kaplan says. "Then you own the premium. Then you're at risk. Therefore, you can pay your doctors on panel size and lowering costs because you have captured the total revenue."

Employment and clinical integration. Physician employment is the most common alignment mechanism, used by nearly equal percentages of hospitals (82%) and health systems (80%). Although there appears to be parity on employment, we see higher percentages of health systems than hospitals using most of the other alignment mechanisms. For instance, 65% of health systems are involved in patient-centered medical homes, compared to only 44% of hospitals. Says Kaplan, "Health systems have scale and scope, and they're just a little more forward and ready. But the single hospital that's not prepared for this may be left out."

> "In order to traverse the kinds of changes coming and to be effective with the change management structures we have, you have to get a critical mass of physicians on the bus."
>
> —Jeff Collins, MD

The key difference is that the long-term pursuit of models such as clinical integration has given UnityPoint and others who have gone down that path experience and intellectual capital that positions them to proceed as sharing risk becomes a requirement. The experience helps not only internally, with physician relations, but externally, in negotiating with payers. "They'll actually talk to us," Kaplan adds. Stand-alone hospitals whose main focus has been to maintain excellent financials will be ill-prepared to proceed in a risk-sharing healthcare industry.

Analysis (continued)

VanderSteeg underscores the importance of central direction in pursuing more complex alignment models, such as those with risk-sharing elements. "The health system brings talent and skills to help focus resources. The hospitals in the system may play important roles, but a lot of the leadership and direction is actually coming from the system. An individual hospital may not have the same amount of talent, or be able to spread that talent. When it comes to risk-taking and being on the cutting edge, you're going to see a lot more of that behavior in a health system than you are going to see in a stand-alone hospital."

Compensation or revenue-related issues top the list of items that respondents say motivate physicians to seek or accept employment. Nearly half (46%) say that the increasing costs of running a practice causes physicians to seek employment. Forty percent say that physicians are motivated by declining reimbursements, while 39% say that physicians seek the security of a stable income, a related idea.

Collins sympathizes. "I think you have to be sensitive to the fact that being a physician in private practice now is like hell," Collins says. "You've got meaningful use, you've got ICD-10, you've got all kinds of requirements from the CMS, you've got concerns about liability." And small practices can be challenged by the looming requirement to contract with insurers. "A fairly small orthopedic group with maybe 10 doctors may want to participate in an orthopedic surgery plan with their Blue Cross carrier," he says. "The payer may say, 'Tell us what your prices are for your knee bundle, your hip bundle, and simple one level spine surgery.' A small group practice won't have the resources to do all that. I mean, it's a killer. If you're physician-friendly enough, a system like ours can offer a refuge from some of the storm."

Clinical integration (55%) and patient-centered medical homes (45%) are selected as a new direction for primary care alignment or to receive additional attention by higher percentages of respondents than other alignment mechanisms. At the same time, organizations expect that contracting with physicians for care services will decline, for both primary care physicians (26% expect to de-emphasize) and specialty care physicians (21% expect to de-emphasize).

"What contracted services are not, clinical integration is," says VanderSteeg. "People are saying that a contract is not enough. They have to have a much more well-defined partnership, with leadership assumptions. It takes some kind of clinical integration strategy with physicians in order to live in this new world. Contracted services are going to continue, but I think you're going to see more of the time, energy, resources, and talent move toward more sophisticated models of alignment, models that feature integration with physicians."

The percentages of respondents who expect to emphasize employment over the next year with primary care physicians (35%) and specialty physicians (30%) are nearly equal. But 15% say they expect to de-emphasize

Analysis (continued)

employment with specialty physicians in the next year, while just 6% expect to de-emphasize employment with primary care physicians. Although the percentages in decline are modest, VanderSteeg suggests that some hospitals and health systems may have been expecting too much from the medical staff's status as employed physicians.

"If all you do is employ a doctor," he says, "that doesn't create alignment or integration. Healthcare systems and hospitals may have employed physicians thinking that there was magic in that and the reality is, they found out it wasn't."

Getting ready for risk. Four-fifths of healthcare organizations (79%) have at least some portion of compensation at risk for their employed physician staff. That percentage will increase to 90% within three years. For 32%, the entire employed physician staff has a portion of compensation at risk, a percentage that is expected to increase to 54% within three years. The larger the organization, the higher the percentage of employed staff has at-risk compensation: 100% of the organizations with net patient revenue of $1 billion or more use at-risk compensation for their employed physicians, compared to 71% of those with low net patient revenue and 81% of those with medium net patient revenue.

Although today's incentives may be relatively simple compared to what may evolve as a result of healthcare reform, VanderSteeg notes that organizations are laying an important foundation. He says, "In a lot of cases the incentives probably are not tremendously sophisticated—maybe quality metrics or efficiency metrics. Regardless, it puts us in a much better position to do risk-based contracting with physicians, because they understand that we're on the same team. What we are doing is helping to get our physicians in a mind-set of performance."

> "You can only do bundled payments if you have alignment with your physicians and you can trust your performance. If you can't trust your performance, in a bundled payment arrangement you can lose tremendous amounts of money."
>
> —Jim VanderSteeg

For VanderSteeg, the increase from 79% involved to 90% involved over three years reinforces the connection between alignment and compensation. "That tells us very clearly that executives understand that in order to have real alignment in outcomes, one of the pieces has to be financial alignment. If you don't have financial alignment, you do not have alignment."

As one would expect, smaller percentages of independent physicians than employed physicians have at-risk compensation (46% vs. 79%). However, with independents as with employed physicians, healthcare leaders expect that more will have compensation at risk over time, to

Analysis (continued)

74% in the case of independents. According to Collins, "Increasingly, that's the way that we do it. Almost all of our contracts now are going to have some component of risk. That's really evolved though over the past two or three years." However, it's more than a matter of making an administrative decision. "It's a challenge to come up with meaningful metrics that will pass legal muster," he says.

Linking care and compensation. With physician alignment, the relationship between delivery of care and compensation for care seems always on the forefront. The healthcare industry is attempting to increase efficiency and to improve health while reducing the overall cost of care.

Alignment methods will be in flux as organizations approach modifications to both care delivery systems and the cost of care. It boils down to needing physician leadership and physician support for care transformation activities, and compensation needs to change to reflect new financial realities. The underlying modification to compensation will be risk-sharing, one way or another.

Despite what may eventually be radical departures from traditional alignment mechanisms, though, we see a degree of momentum in the survey results: The majority of respondents plans no near-term changes in alignment mechanism emphasis. That may be because many of the contracts and, more important, many of the working relationships, have been in place for a long time.

But survey results indicate that change is coming: Risk-sharing is to get more emphasis, physicians will be called upon to take on leadership roles, clinical integration is receiving broad support as a mechanism that allows both employed and independent physicians to participate in risk-sharing, and the trend toward employment remains a means of ensuring care coverage.

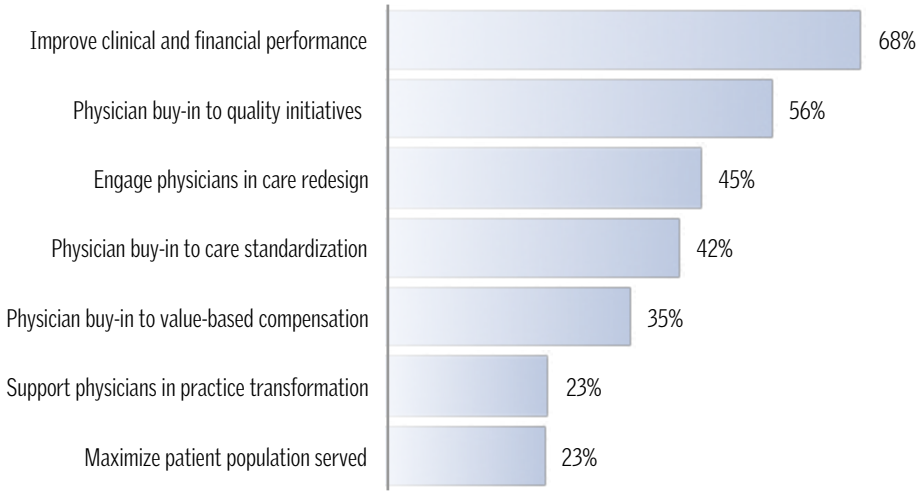
Still, there is no favorite alignment mechanism for the future. Particularly with specialty care, results show strong and nearly equal emphasis on a wide range of models. "We operate in an environment of ambiguity," says Kaplan, "and we're heading toward more ambiguity. People are looking at all the tools available to them and they're pursuing multiple avenues. Are you going to clinically integrate? Are you going to do bundled payments? Are you going to do shared savings or an ACO? What about employed physicians? Clinical comanagement? Are you going to do patient-centered medical homes? My answer would be yes, yes, yes, yes, yes, and yes because we have to do all of that."

Michael Zeis is senior research analyst for HealthLeaders Media. He may be contacted at *mzeis@healthleadersmedia.com*.

FIGURE 1 | Top Patient Care or Physician Engagement Objectives

Q | Please identify the top three patient care or physician engagement objectives or motivations behind your physician alignment strategy.

Total responses



Base = 311, Multi-Response

TAKEAWAYS

- The desire to improve clinical and financial performance was selected as a top motivation by 68%. This item was included by nearly equal percentages from all three settings: hospitals, health systems, and physician organizations.
- While two-thirds (67%) of respondents from hospitals include physician buy-in to quality initiatives among the top three objectives driving their patient care or physician engagement strategies, just 40% of health systems do.
- The objective of engaging physicians in care redesign is the second most cited motivation by health systems (57%), but only 41% of hospitals and 31% of physician organizations named it as a top alignment objective.
- Nearly two-thirds (62%) of respondents from organizations with high net patient revenue include care redesign among their top three alignment objectives, compared to 45% of those with a medium level of net patient revenue and 38% of those with low net patient revenue.

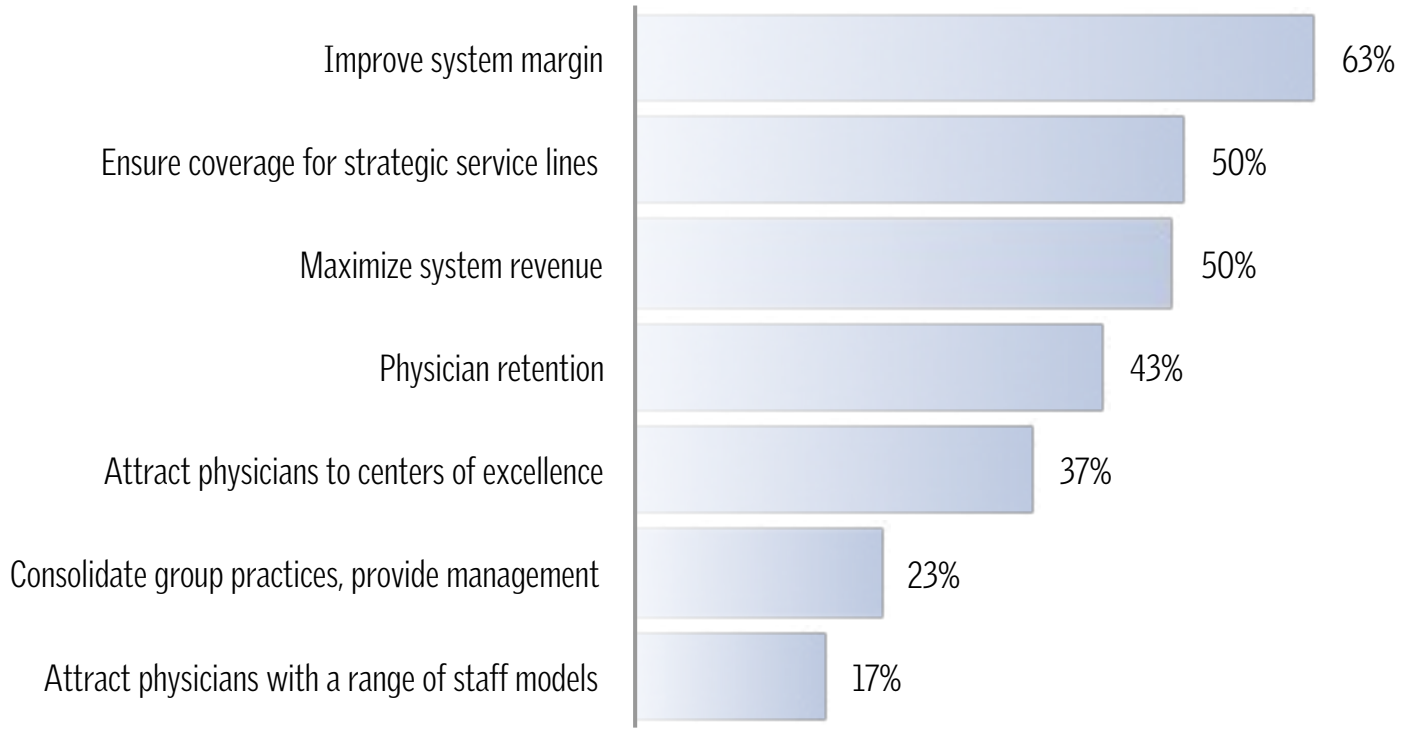
WHAT DOES IT MEAN?

Higher percentages of health systems and high-revenue organizations include care redesign among their top care-related or physician engagement alignment objectives, an indication of how health systems and high-revenue organizations tend to lead the industry in progress on resource-intensive healthcare-reform initiatives such as population health management.

FIGURE 2 | Top Business, Staffing, or Organizational Objectives

Q | Please identify the top three business, staffing, or organizational objectives or motivations behind your physician alignment strategy.

Total responses

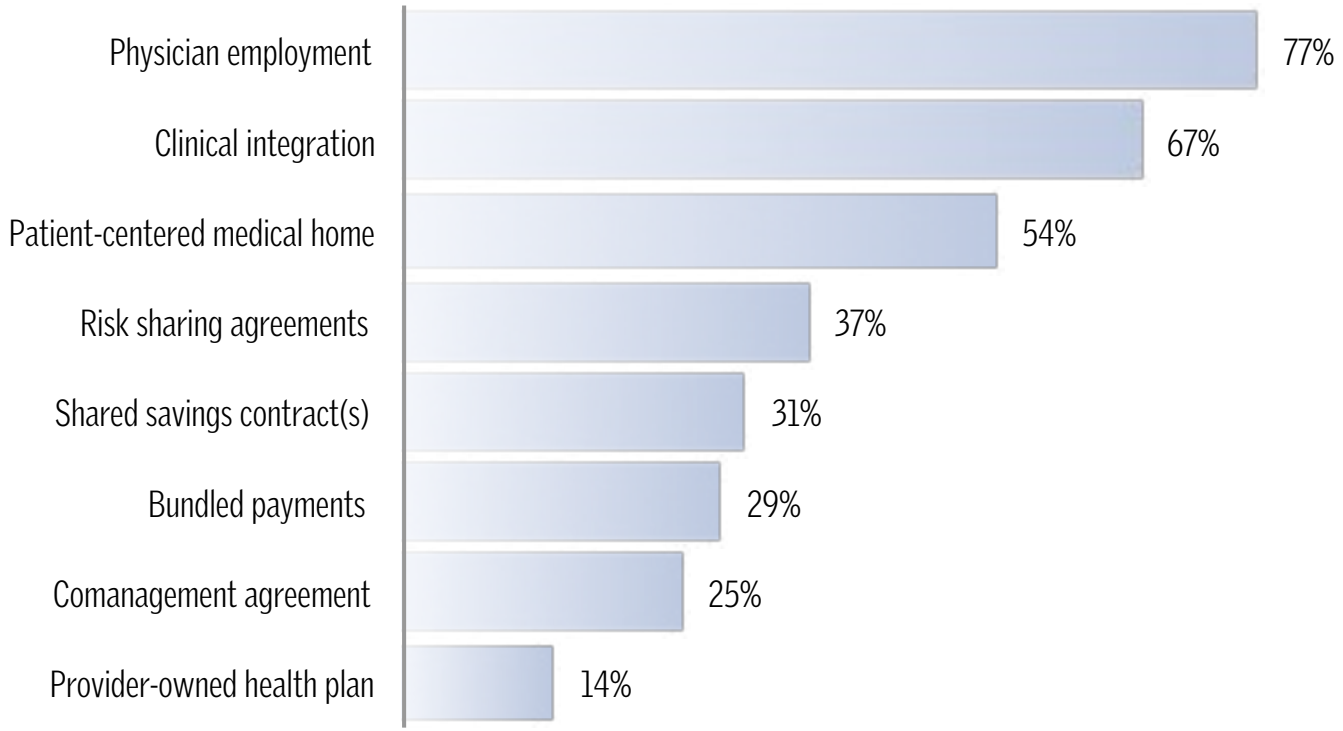


Base = 311, Multi-Response

FIGURE 3 | Physician Alignment Mechanisms Undertaking Now

Q | Which of the following physician alignment mechanisms is your organization undertaking now?

Total responses

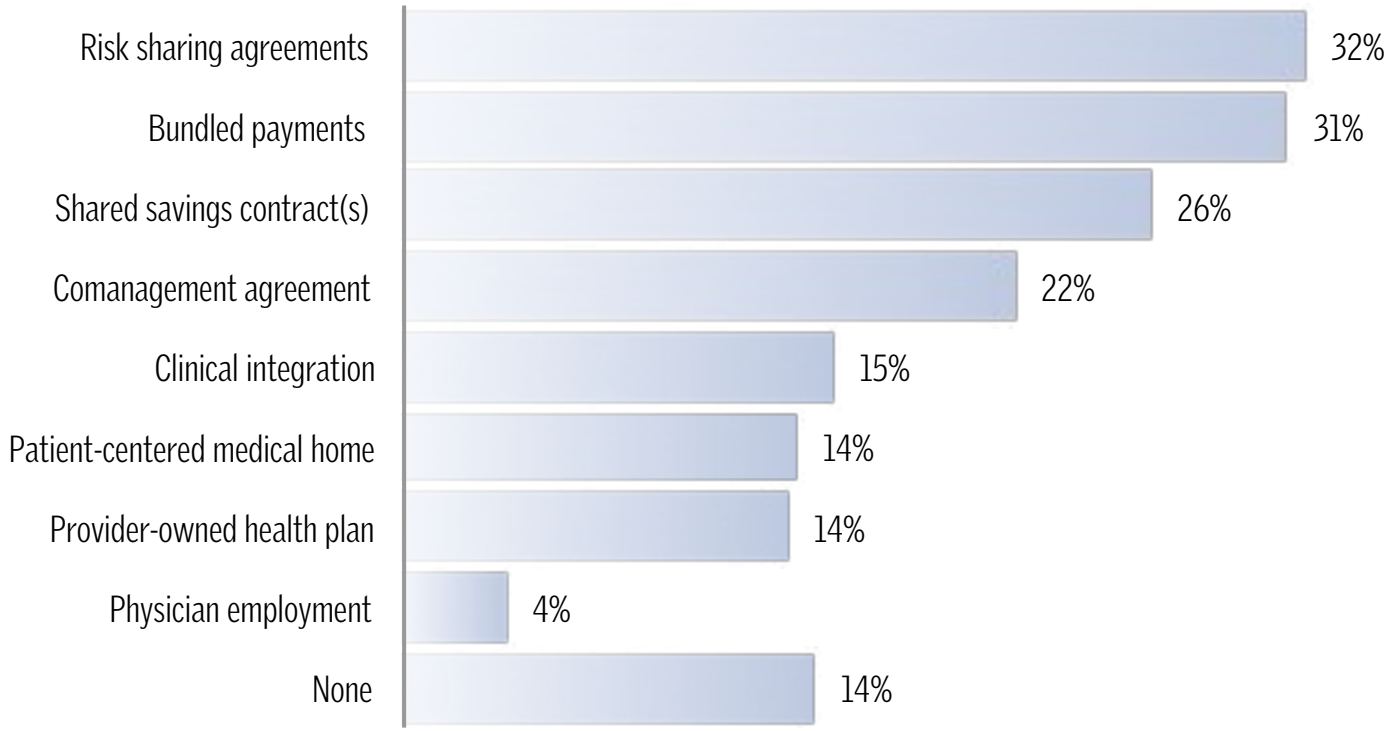


Base = 311, Multi-Response

FIGURE 4 | Physician Alignment Mechanisms Pursuing Within Three Years

Q | Which of the following physician alignment mechanisms is your organization likely to begin pursuing within three years?

Total responses

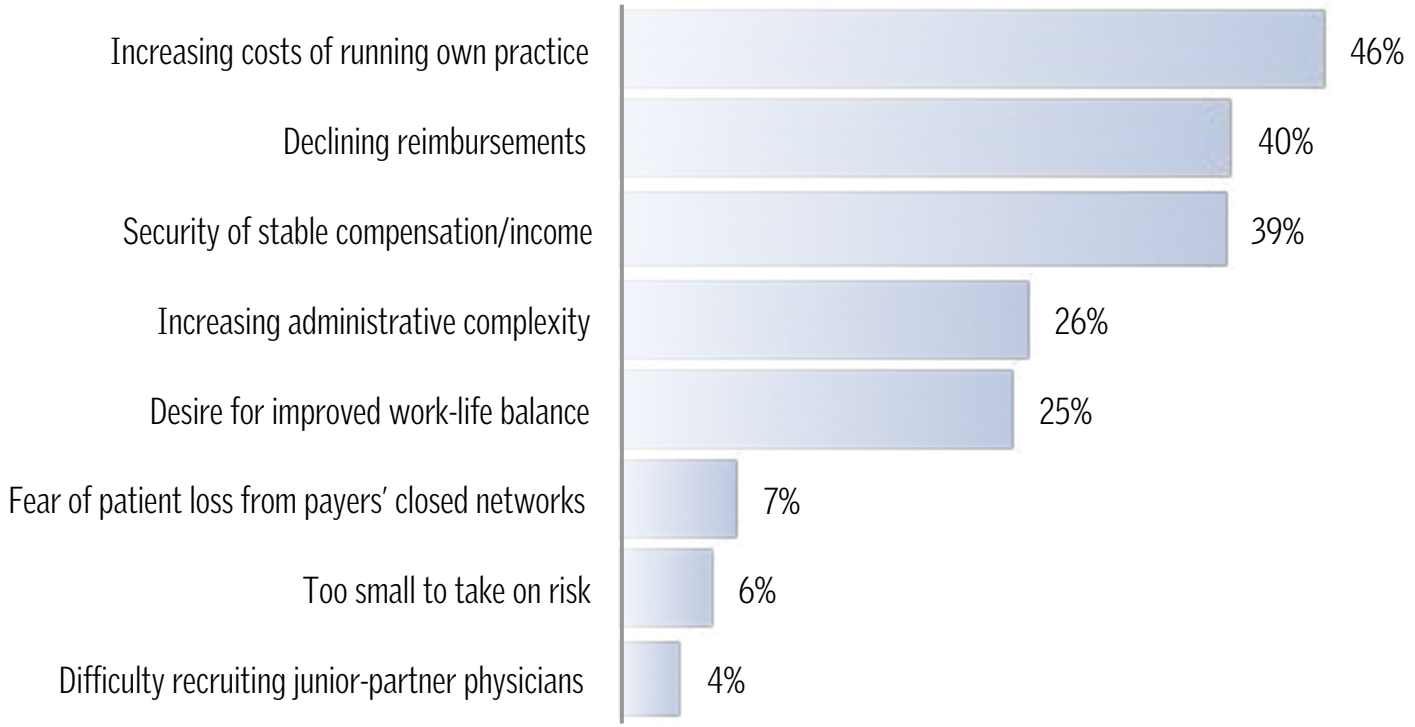


Base = 311, Multi-Response

FIGURE 5 | Top Motivators for Physicians Seeking Employment

Q | What are the top two motivators for physicians to seek/accept employment with your particular hospital or health system?

Total responses



Base = 295, Multi-Response

FIGURE 6 | Most Difficult Aspect of Managing Physicians

Q | What aspect of managing physicians has been the most difficult for your hospital or health system?

Total responses

Base = 311

TAKEAWAYS

- Dealing with physician compensation expectations was the management aspect selected most frequently overall, by 27%.
- Half of small health systems (50%) say physician compensation expectations present the most difficulty in terms of managing physicians, compared to 25% of medium health systems and 31% of large health systems.
- A higher percentage of health systems (34%) than hospitals (23%) say compensation expectations are their biggest problem.
- Nearly one-quarter (23%) say that finding physicians with the right leadership skills is the most problematic. This issue affects hospitals, health systems, and physician organizations more or less evenly.

WHAT DOES IT MEAN?

It is no surprise to see physician compensation on top of a list of problems encountered while managing physicians. Indeed, the principal reasons for independent physicians to seek employment in the first place are financial in nature (Figure 5).

FIGURE 6 *(continued)* | Most Difficult Aspect of Managing Physicians

Q | What aspect of managing physicians has been the most difficult for your hospital or health system?

DATA SEGMENTATION TOOL

Click these icons to dig deeper

Who controls the money? Click on the icons to learn how they think

VIEW BY PRODUCTS/SERVICES
Indicates the type of goods or services the respondent is involved in purchasing

VIEW BY INVOLVEMENT
Indicates the role of the respondent in making purchasing decisions

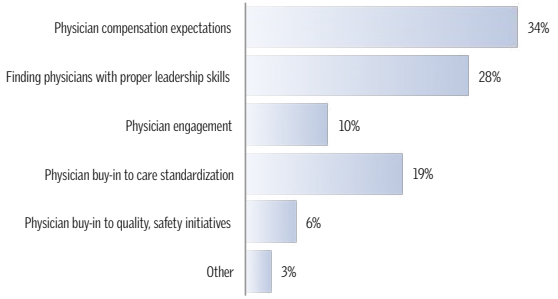
VIEW BY DOLLARS INFLUENCED
Indicates the total dollar amount the respondent influences

PRODUCTS/SERVICES

Clinical products

Base = 177

Financial services



Base = 98

Executive search

Base = 127

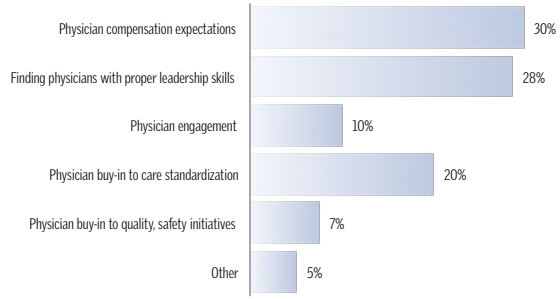
Consulting services

Base = 157

Outsourcing services

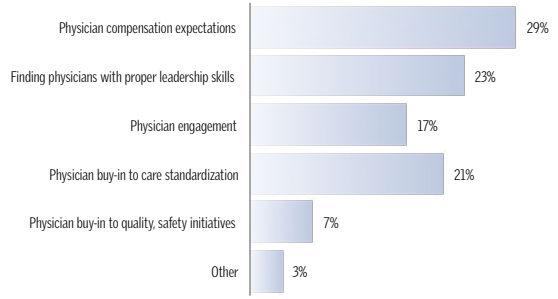
Base = 116

Legal services



Base = 81

Information technology

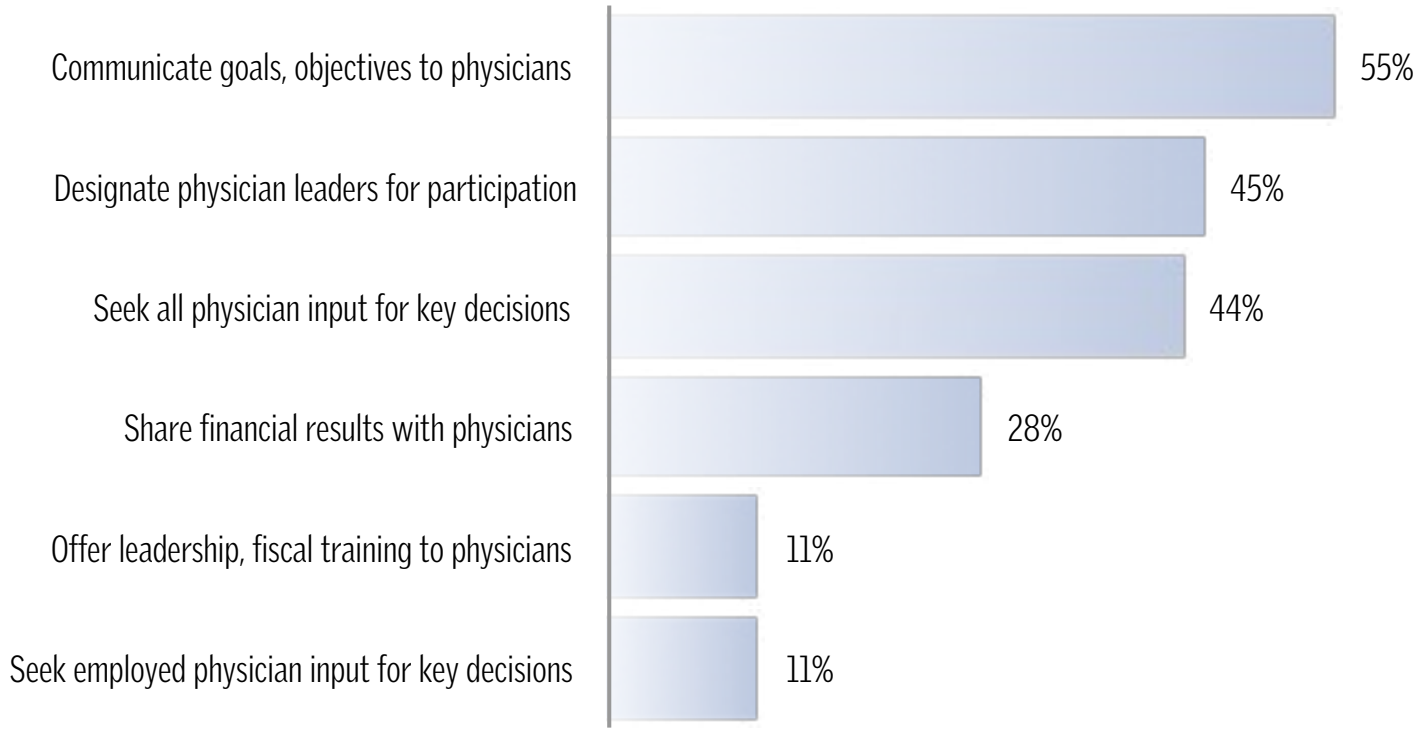


Base = 177

FIGURE 7 | Most Important Actions to Engage Physicians in Strategic Planning

Q | What two actions are most important to engage physicians in strategic planning?

Total responses

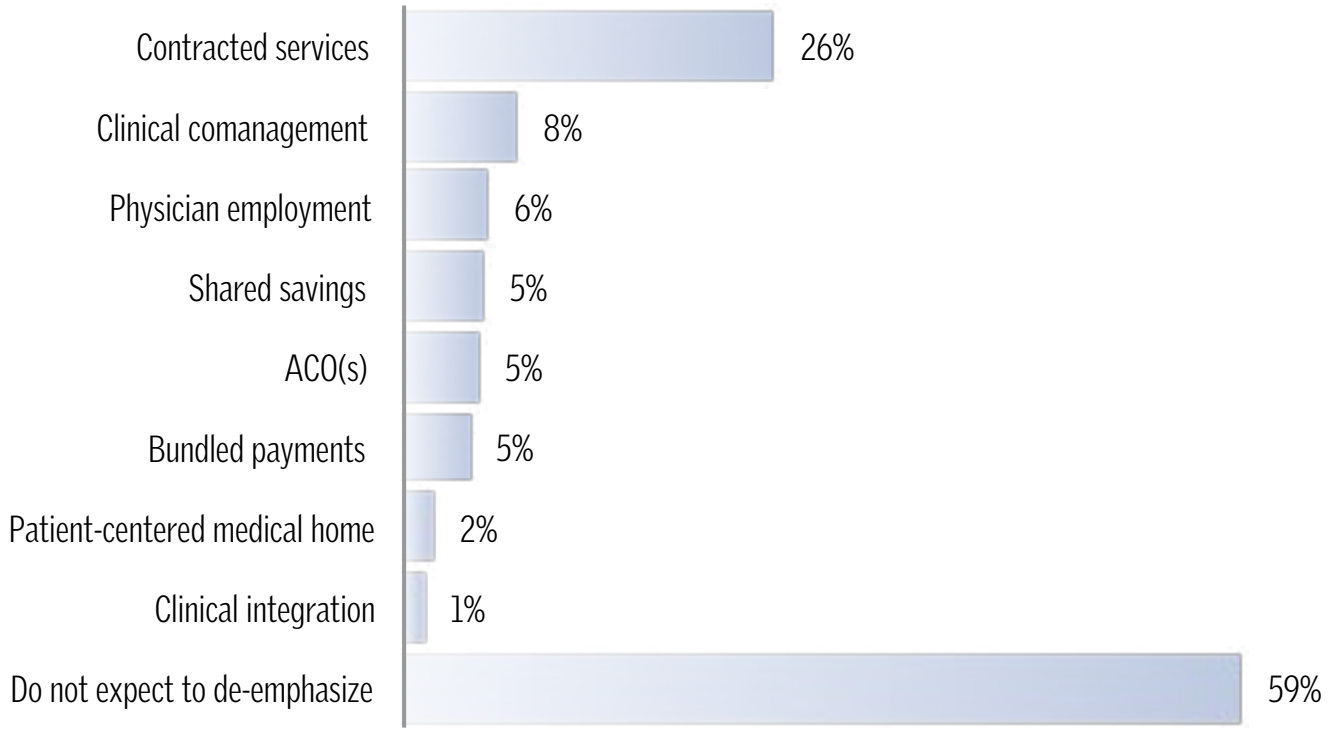


Base = 311, Multi-Response

FIGURE 8 | Primary Care Alignment Mechanisms to Be De-Emphasized Next Year

Q | Which of the following does your organization use now with primary care physicians but expect to move away from or de-emphasize over the next year?

Total responses

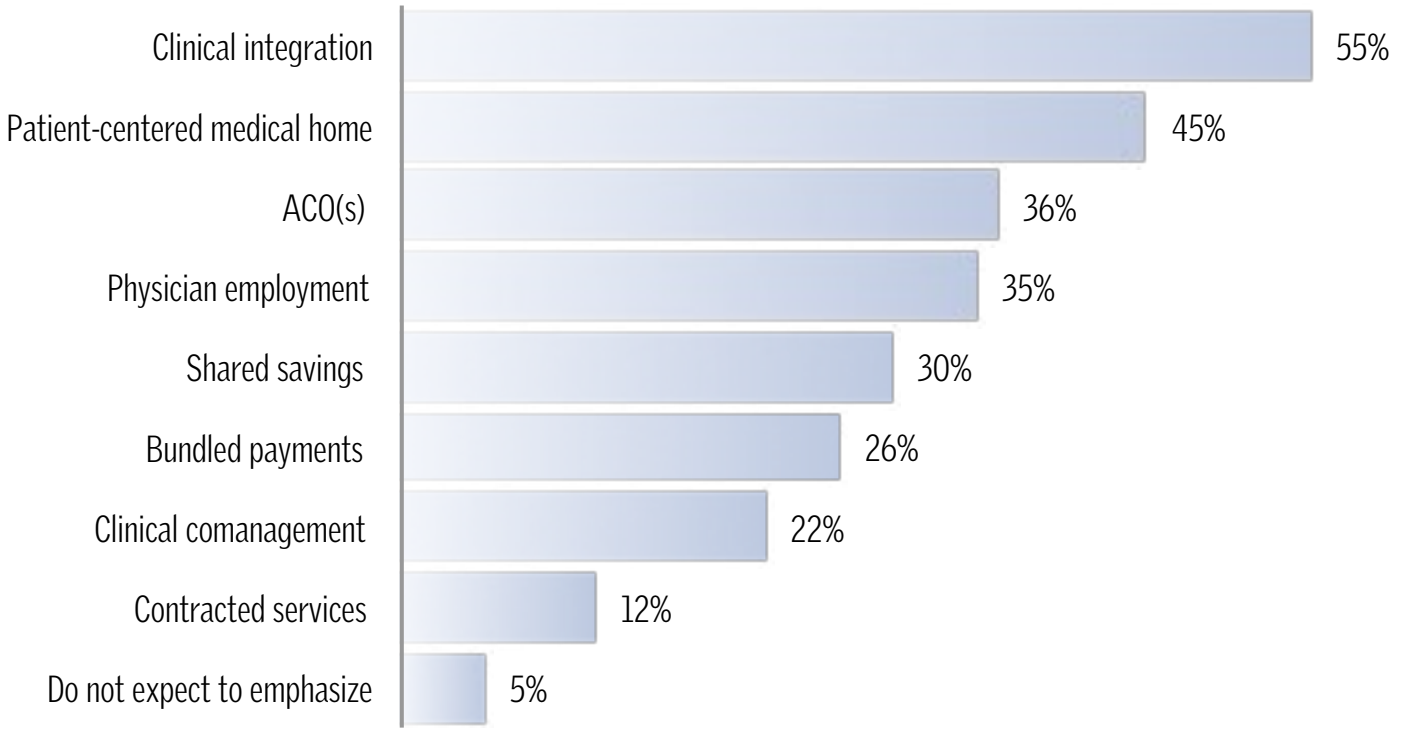


Base = 311, Multi-Response

FIGURE 9 | Primary Care Alignment Mechanisms to Be Emphasized Next Year

Q | Which of the following does your organization expect to move toward or emphasize more with primary care physicians over the next year?

Total responses

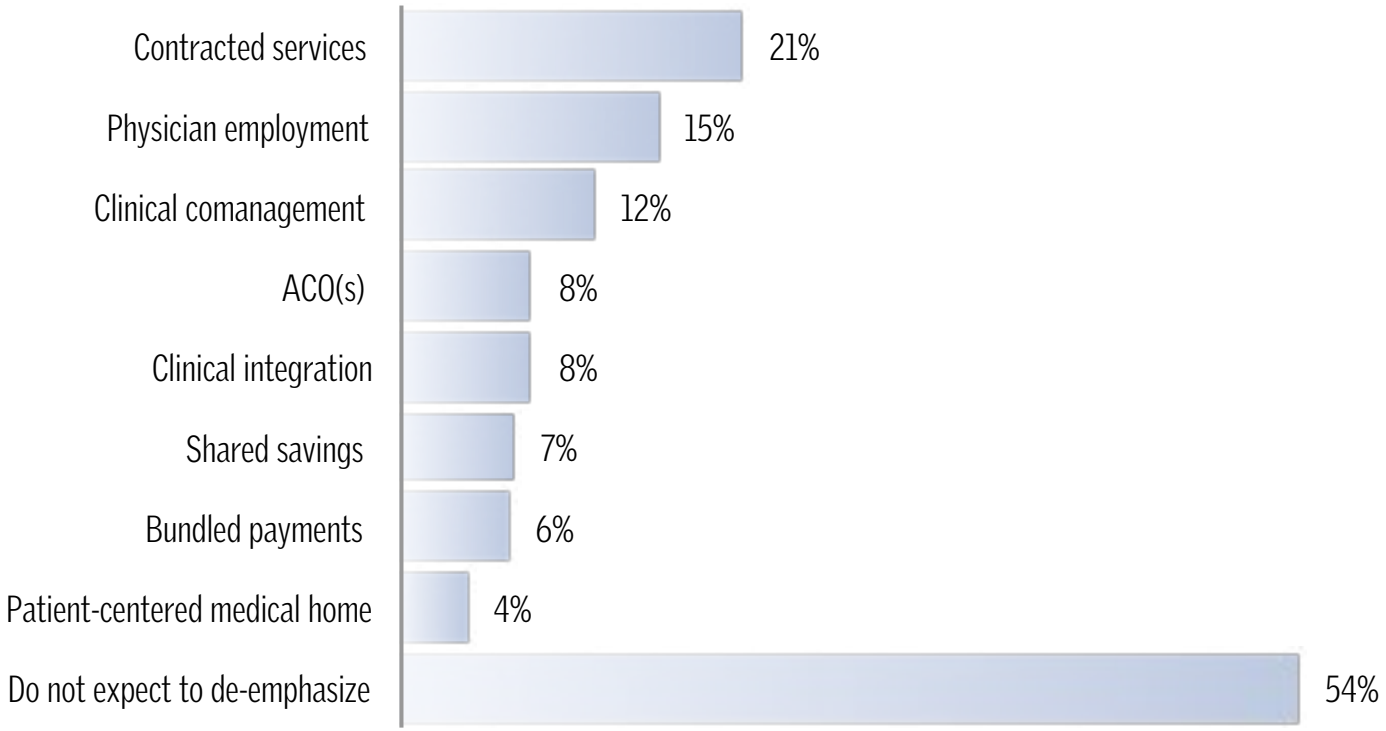


Base = 311, Multi-Response

FIGURE 10 | Specialty Care Alignment Mechanisms to Be De-Emphasized Next Year

Q | Which of the following does your organization use now with specialty care physicians but expect to move away from or de-emphasize over the next year?

Total responses

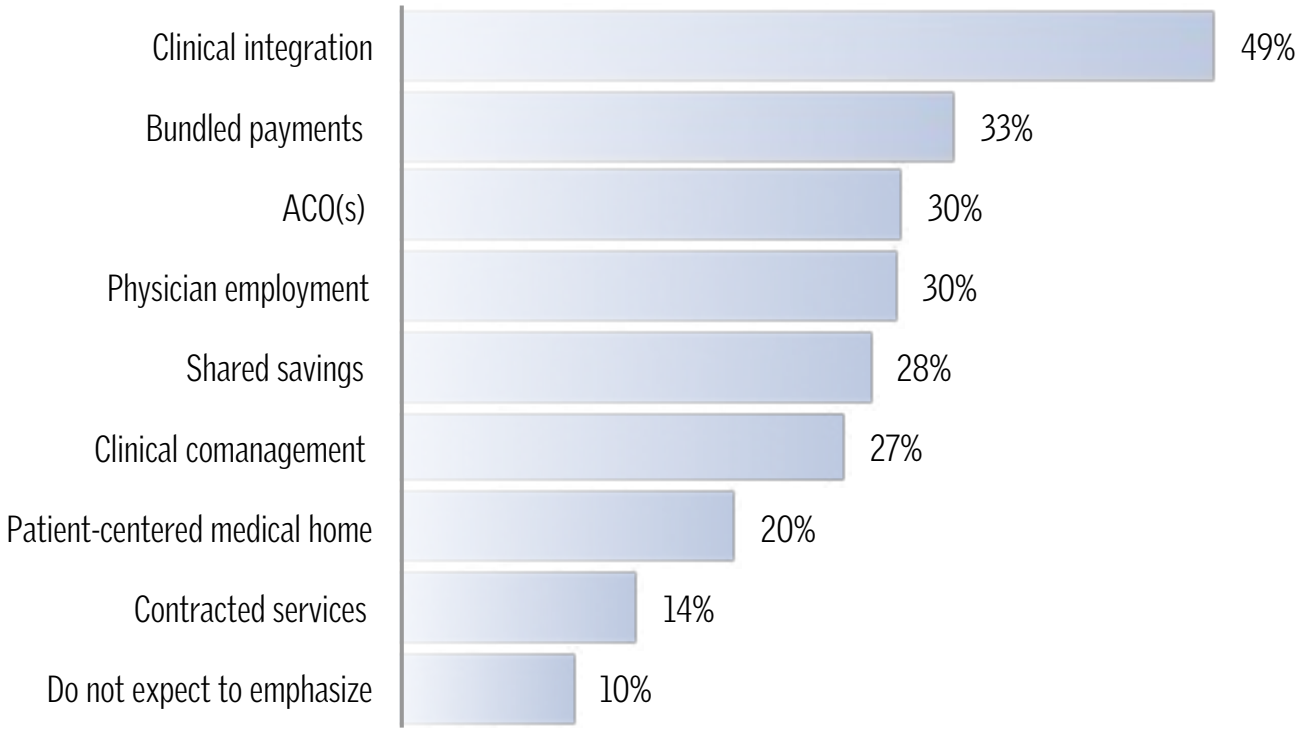


Base = 311, Multi-Response

FIGURE 11 | Specialty Care Alignment Mechanisms to Be Emphasized Next Year

Q | Which of the following does your physician alignment strategy call for you to move toward or emphasize with specialty care physicians over the next year?

Total responses

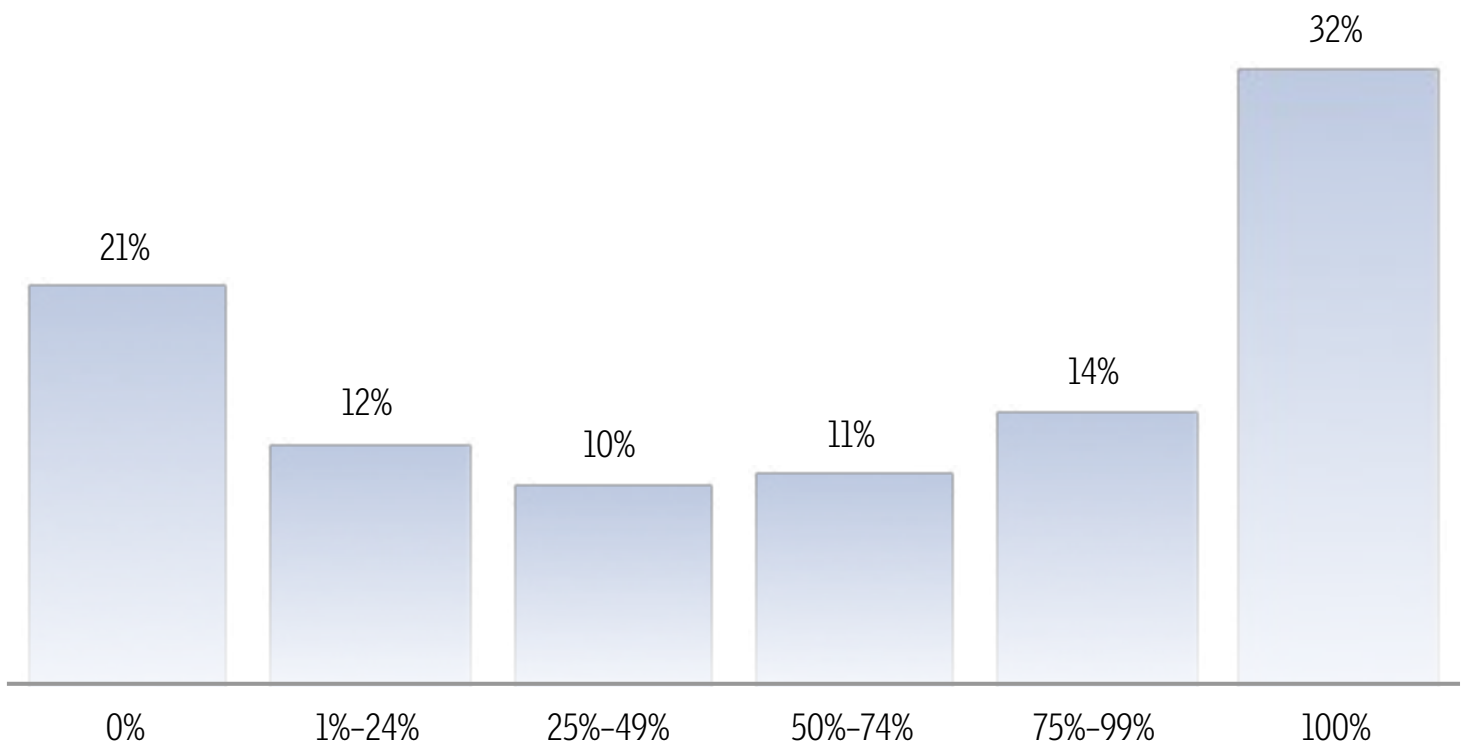


Base = 311, Multi-Response

FIGURE 12 | Percent Employed Physician Staff Compensation at Risk Now

Q | What percent of your employed physician staff now has at least some portion of their compensation at risk?

Total responses

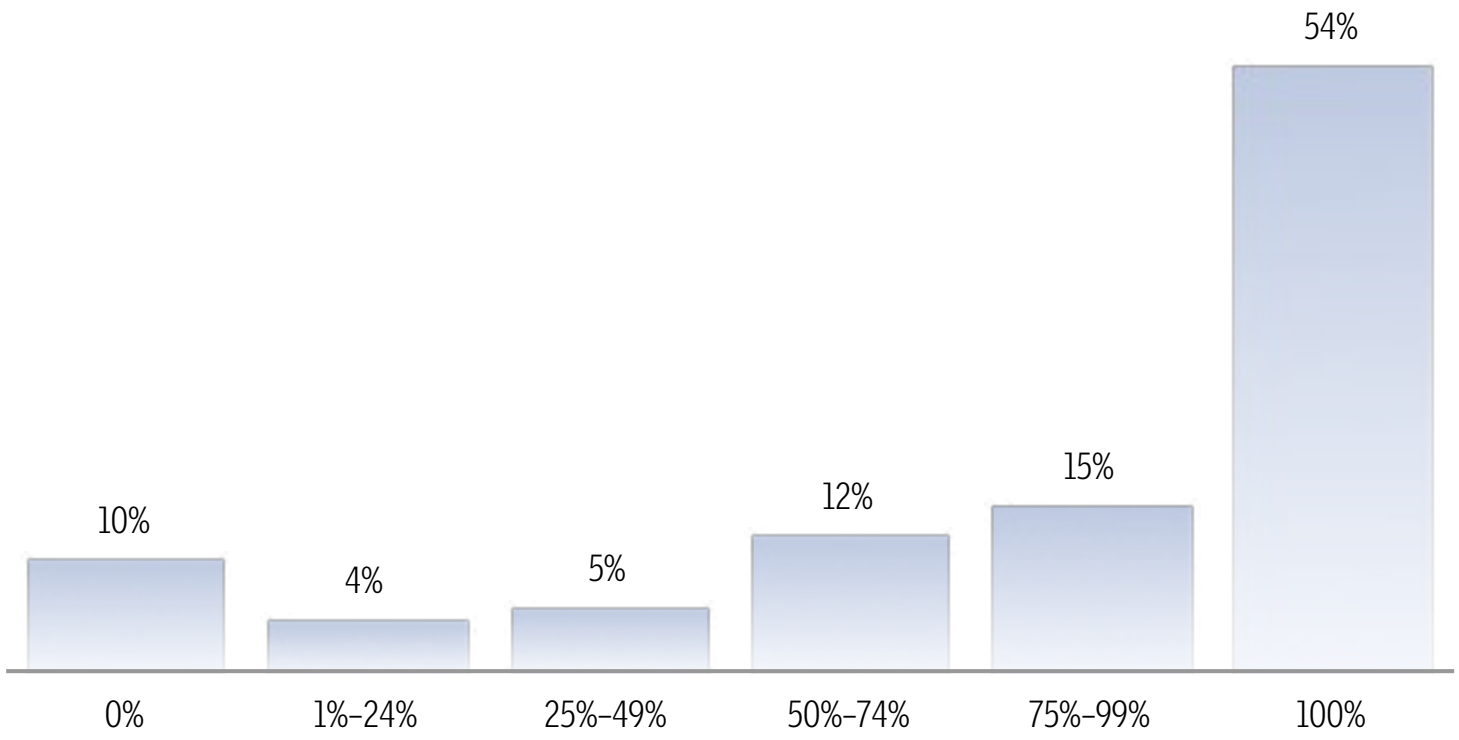


Base = 185

FIGURE 13 | Percent Employed Physician Staff Expected to Have At-Risk Compensation Within Three Years

Q | What percent of your employed physician staff is expected to have some at-risk compensation within three years?

Total responses

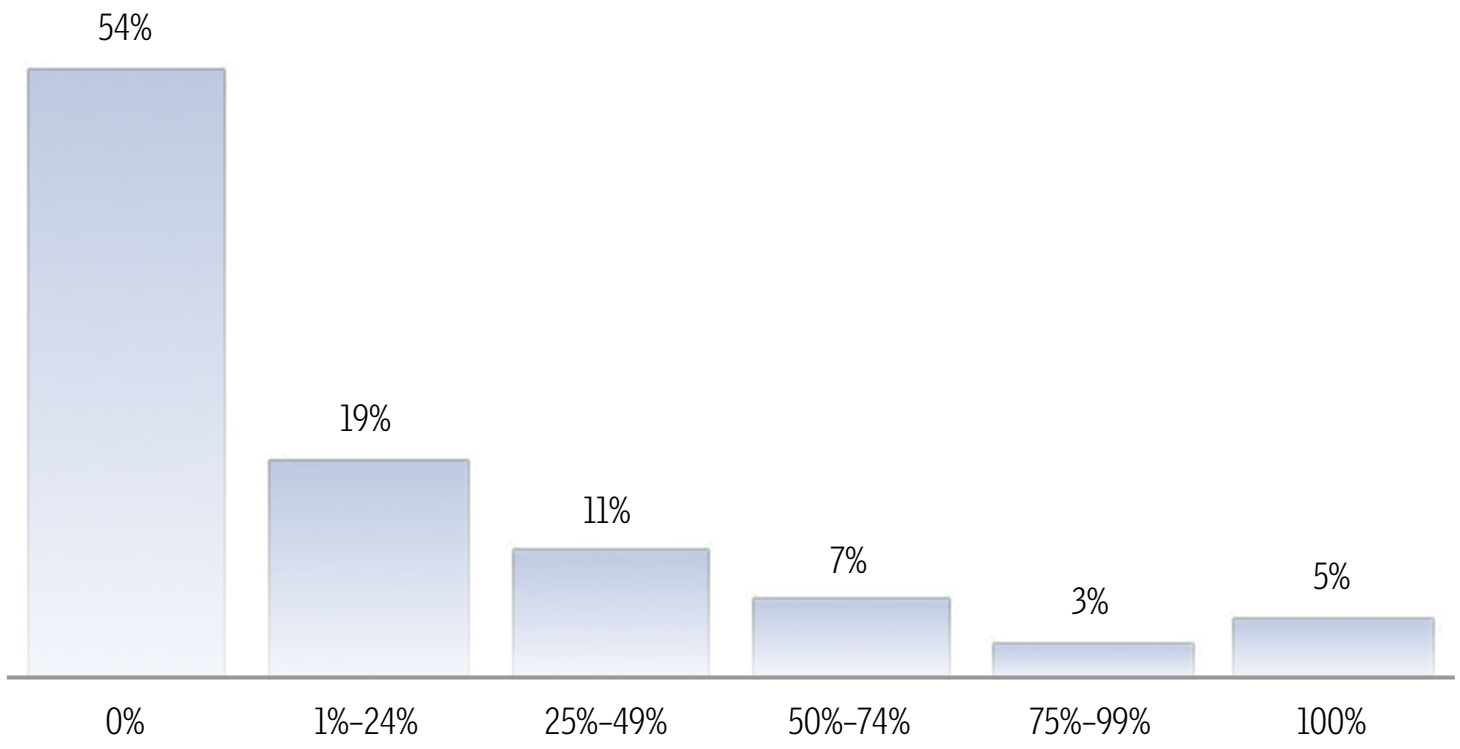


Base = 185

FIGURE 14 | Percent Independent Physician Staff With At-Risk Compensation Contracts Now

Q | What percent of your independent physician staff is now engaged with at-risk compensation contracts?

Total responses

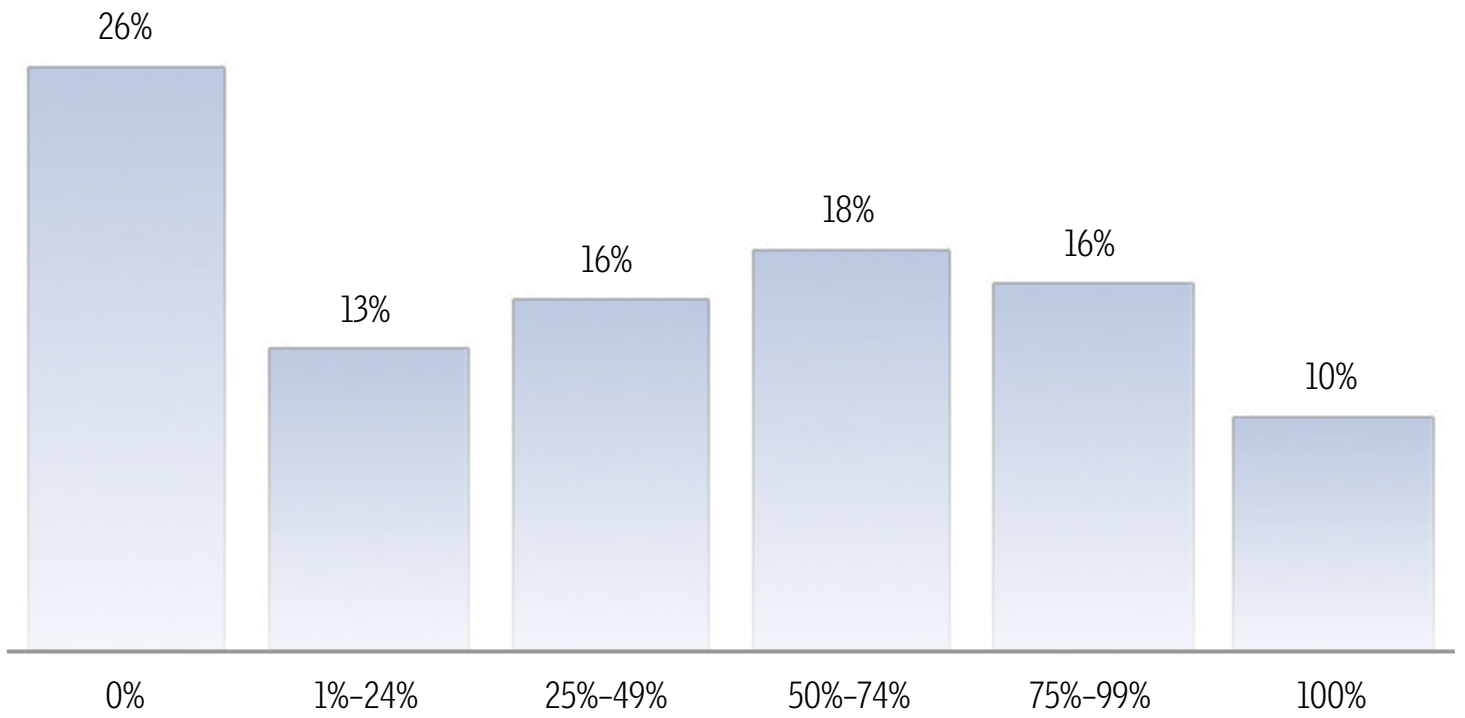


Base = 134

FIGURE 15 | Percent Independent Physician Staff Expected to Have At-Risk Compensation Within Three Years

Q | What percent of your independent physician staff is expected to be engaged with at-risk compensation contracts within three years?

Total responses

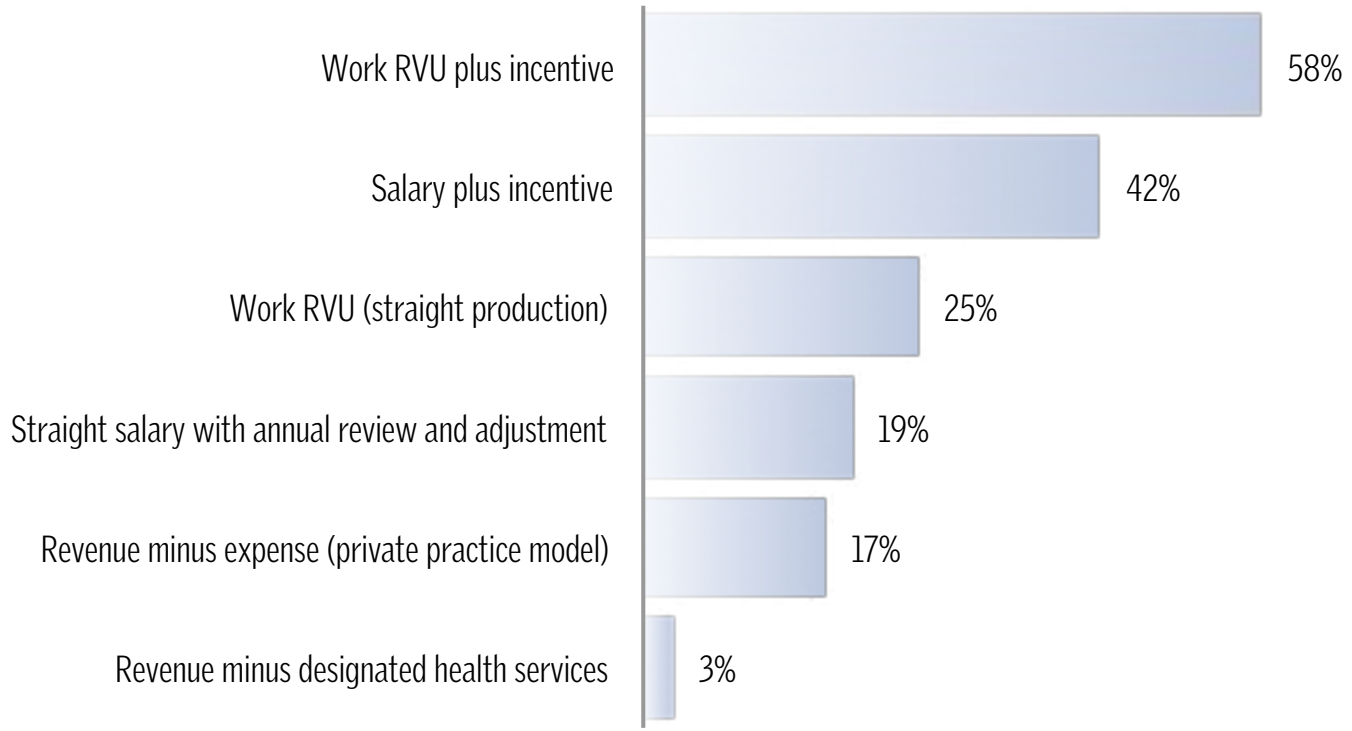


Base = 134

FIGURE 16 | Employed Physician Compensation Models

Q | Which of the following do you use now for employed physician compensation?

Total responses



Base = 311, Multi-Response

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