HealthLeaders Media | Intelligence

FREE REPORT

September 2013

Physician Alignment in the New Shared Risk Environment

An independent HealthLeaders Media Survey supported by

MEDSYNERGIES®
Your mission. Your partner.

Powered by

HEALTHLEADERS MEDIA Council
Access. Insight. Analysis.

Physician Alignment in the New Shared Risk Environment

This report reveals the staffing models gaining traction as healthcare leaders seek new ways to achieve and strengthen physician alignment.

- Learn why independent physicians are still expected to be in the majority (56%) compared to employed physicians in three years
- Find out the six key lessons Catholic Health Initiatives gleaned from launching a clinical integration network across multiple markets
- Discover why more than half (51%) of respondents expect to be pursuing population health within three years
- Deep-dive into over 400 charts with segmented peer data
- Get analysis, takeaways, and actionable recommendations

Perspective

THE EMPLOYED PHYSICIAN: MOVING FROM EMPLOYMENT TO ENGAGEMENT

With the changing pressures brought on by the Patient Protection and Affordable Care Act and the inevitable reimbursement reductions, it comes as no surprise that health systems continue to maximize efforts to grow physician networks to preserve their patient base.

The 2013 HealthLeaders Media *Physician-Hospital Alignment Survey* results unveil that a staggering 87% of respondents anticipate an increase in their organization's employed physician base within the next 36 months. This is a significant 16-point rise compared to last year's survey. At the same time, 70% of respondents anticipate their organization's number of independent physicians to decrease over the next three years.

While looming financial pressures are forcing physicians to employment, the rewards of focusing on quality measures are reconfirming the decision. More than three-quarters of hospitals and health systems (78%) are paying employed physicians for nonproductivity performance such as patient satisfaction, clinical quality, and citizenship. This figure is expected to rise to 94% in the next three years, but approximately 64% of independent physicians are missing this compensation altogether.

What we have learned in our business is that finding the right compensation model is important to building strong physician relationships, but it's only a starting point. True alignment requires an enhanced focus on engaging physicians. This year's survey clearly shows that the No. 1 motivator behind creating these strategic relationships is to get physician buy-in to quality and safety initiatives.

We believe that the most important step in achieving this goal is to work with physicians to create a unity of purpose. It's only through an effective process of collaboration, communication, and governance that physicians get a say in these infinitives and feel tied to the big picture.

It's no surprise that in this year's survey, physician engagement ranked highest as the most difficult aspect of managing physicians. Many health systems align with physicians and operate as though physicians can maintain the same autonomy they once enjoyed. We feel it's time to embrace interdependence and come to an agreement on what that means for both parties. It's certainly possible, and the health systems that can achieve this will stand above the rest. But more importantly, their patients win.

J.R. Thomas
CEO
MedSynergies
Irving, Texas

About the Premium and Buying Power Editions

This is a summary of the Premium edition of the September 2013 HealthLeaders Media Intelligence Report, **Physician Alignment in the New Shared Risk Environment.** In the full report, you'll find a wealth of additional information, including the results of all the survey questions. 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), 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 T. Clifford Deveny, MD, Senior Vice President for Physician Services and Clinical Integration for Catholic Health Initiatives in Englewood, Colo., and the Lead Advisor for this Intelligence Report
- Three Case Studies featuring initiatives by Lee Memorial Health System in Fort Myers, Fla.; Methodist Health System in Dallas; and Catholic Health Initiatives in Englewood, Colo.
- A list of Recommendations drawing on the data, insights, and analysis from this report
- A Meeting Guide featuring questions to ask your team

Foreword

THE MATURING RELATIONSHIP WITH PHYSICIANS—EMPLOYED AND INDEPENDENT

In the past three years, the entire landscape of healthcare has changed dramatically due to a couple of key factors, not the least of which, of course, is the Patient Protection and Affordable Care Act and its clear-cut push for a change in the way medical care is paid for in this country. The inexorable shift from fee-for-service to pay for performance—or from volume to value—represents a true transformation in a national healthcare system fraught with fragmentation and dysfunction.

Nowhere has this change in the healthcare industry been more dramatic—unsettling to some, a breath of fresh air to others—than in the often-conflicted relationship between physicians and hospitals. As we look ahead to the next few years, into a period where the only certainty will be lower reimbursements, an overriding strategy for success appears to be a harmonious and mutually beneficial relationship between two entities whose vested interests typically were at odds in the past.

Almost three-quarters of the respondents to the HealthLeaders Media *Physician-Hospital Alignment Survey* (73%) included "physician buy-in to quality and safety initiatives" among their top three objectives, followed by two other more traditional hospital strategies: maximizing the patient population served (47%) and ensuring coverage of strategic service lines (43%). Oddly, despite the focus on physician alignment, only 32% of the respondents called "physician retention" a top objective. Despite that low percentage, it's clear across the industry that hospitals and health systems are moving quickly to add to their ranks of employed physicians. This is due not only to market considerations and the expected rapid growth in the number of insured as a result of health reform, but also to lifestyle considerations on the part of newly graduated doctors. These new physicians, concerned about declining reimbursements and the high costs of private practice, are seeking stable hours and a steady income. That change is reflected in the responses to the survey, as 62% of hospital and health system leaders report that physicians are motivated by stable compensation as a factor in seeking employment; another 43% are driven by escalating private practice costs.

Respondents also were clear in another area of physician employment: Nearly nine in 10 (87%) said they expect the number of employed physicians to increase over the next three years. Only 2% expect that number to decrease, and just 11% said that the numbers would remain the same.

At Catholic Health Initiatives, which ranks as the third largest faith-based health system in the nation with 86 hospitals in 18 states, a strategic goal since I arrived about two years ago has been building the employed physician enterprise. In fact, CHI has more than doubled the number of employed physicians to more than 2,000 across the system. Those physicians are supported by approximately 900 advanced practice clinicians.

Foreword (continued)

Still, despite this rush by hospitals and health systems to hire physicians, the survey results show fairly modest overall growth in the total number of employed physicians over the next three years: The average number of employed physicians reported by hospitals and health systems now stands at 246 and is expected to increase to 301, an increase of about 22% over three years.

The fact is that independent physician models are not moribund, contrary to what many people think. Indeed, while respondents indicate the average number of independent physicians is expected to drop in the next three years by about 16%, from 693 to 579, that segment still will outnumber the employed doctors.

But regardless of numbers or trends, we all recognize that we are dealing with a far more organized and sophisticated group of independent physicians. So, whether we are looking at employed or independent physicians, we are encountering a maturing relationship with these vital partners that includes mutual accountability, collaboration, and precise decision-making based on data rather than emotion. And that is good for the entire system—and especially for our patients.

T. Clifford Deveny, MD
Senior Vice President for Physician Services and Clinical Integration
Catholic Health Initiatives
Englewood, Colo.
Lead Advisor for this Intelligence Report

Table of Contents

Methodology

The *Physician-Hospital 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 2013, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 302 completed surveys are included in the analysis. The margin of error for a sample size of 302 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.

ADVISORS FOR THIS INTELLIGENCE REPORT

The following healthcare leaders graciously provided guidance and insight in the creation of this report.

T. Clifford Deveny, MD
Senior Vice President for Physician Services and Clinical Integration
Catholic Health Initiatives
Englewood, Colo.

Pamela Stoyanoff
Executive Vice President and Chief Operating Officer
Methodist Health System
Dallas

Scott Nygaard, MD
Chief Medical Officer for Physician Services
Lee Memorial Health System
Fort Myers, Fla.

Upcoming Intelligence Report Topics

October: ***Population Health***

November: ***Executive Compensation***

December: ***Cost Containment***

ABOUT THE HEALTHLEADERS MEDIA INTELLIGENCE UNIT

The HealthLeaders Media Intelligence Unit, a division of HealthLeaders Media, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, print publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

HealthLeaders Media
A Division of HCPro

Intelligence Report Research Analyst
MICHAEL ZEIS
mzeis@healthleadersmedia.com

Publisher
EVILEE EBB
eebb@healthleadersmedia.com

Editorial Director
EDWARD PREWITT
eprewitt@healthleadersmedia.com

Managing Editor
BOB WERTZ
bwertz@healthleadersmedia.com

Intelligence Unit Director
ANN MACKAY
amackay@healthleadersmedia.com

Media Sales Operations Manager
ALEX MULLEN
amullen@healthleadersmedia.com

Intelligence Report Contributing Editor
PHILIP BETBEZE
pbetbeze@healthleadersmedia.com

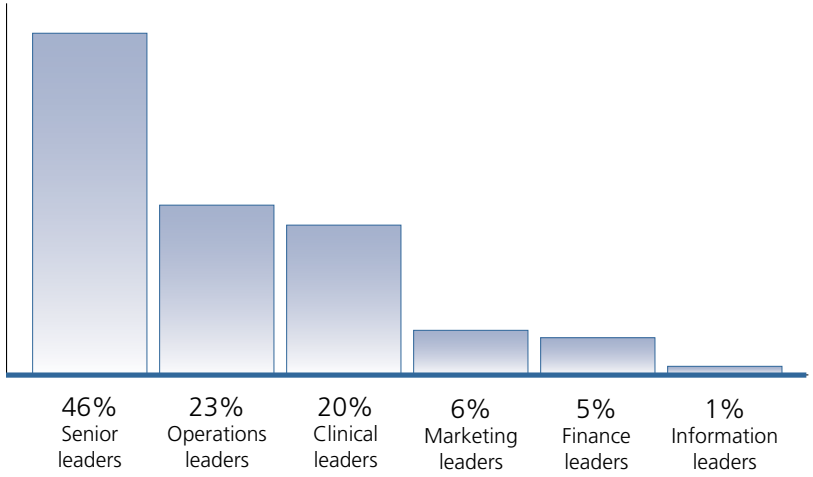
Intelligence Report Design and Layout
STEVE DINIS
sdinis@hcpro.com

Respondent Profile

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

Title

Base = 308



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 Orthopedics, Chief of Radiology, Chief Nursing Officer, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency 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)

Operations leaders | Chief Compliance Officer, Asst. Administrator, Dir. of Patient Safety, 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

Finance leaders | VP/Dir. Finance, HIM Director, Director of Case Management, Director of Revenue Cycle

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

Type of organization

Base = 308

Hospital	59%
Health system	41%

Number of beds

Base = 179 (Hospitals)

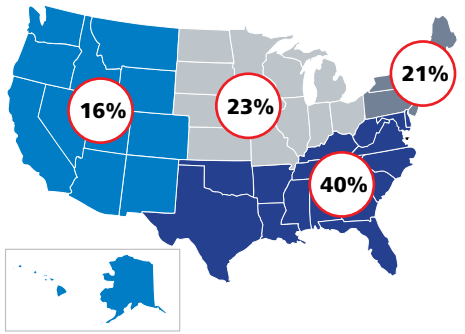
1–199	45%
200–499	37%
500+	18%

Number of sites

Base = 123 (Health systems)

1–5	22%
6–20	35%
21+	43%

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, DC, Maryland, Delaware

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

ANALYSIS

Priorities Are Recast as the Industry Reforms

MICHAEL ZEIS

The *2013 Physician-Hospital Alignment Survey* demonstrates that healthcare organizations are recasting their priorities to meet the expected requirements of industry reform. And, as the annual survey reveals, not only are there changes in emphasis regarding employment models, but also there is increased pursuit of collaborative relationships and at-risk payment models. Leaders are showing increasing interest in undertaking initiatives in population health and accountable care models.

Looking at population served. Maximizing admissions has been a long-standing top objective of hospital-physician alignment efforts. As the healthcare industry shifts away from fee-for-service, more treatment will take place in outpatient and ambulatory environments and the patient mix will change in those settings as well as at acute care hospitals. Leaders at hospitals and health systems will probably rely more on their specialists, which will make it important to offer a targeted set of specialty services and to have a primary care network with sufficient coverage to provide the necessary referrals.

Pamela Stoyanoff, executive vice president and chief operating officer for Methodist Health System, which operates five hospitals and 1,161 licensed beds in the Dallas area, summarizes the classic approach to

WHAT HEALTHCARE LEADERS ARE SAYING

"We are targeting primary care physicians in order to build a larger base for medical home models and population health. You need volume in order to enter into risk-based agreements."

—Chief financial officer for a medium hospital

"We are aligning internal incentives to improve care processes, quality outcomes, patient safety, and efficiency. The result will be valued by population health managers. Those managers are expected to include top-performing medical groups in our market and the major health plans serving this market."

—CEO for a medium hospital

"We are launching a commercial ACO with a goal of having 50% of system revenues in population care contracts by 2015."

—Service line director for a large health system

"We're moving from inpatient management to more strategies with case managers in physician practices. By having an integrated model, we can better coordinate and collaborate in this environment. The moves will decrease our readmissions and reduce the overall cost of care."

—Chief operations officer for a small health system

Analysis (continued)

building referrals: "You have to shore up referrals, and physicians in your primary care network are the ones who are giving specialists their referrals. I think that's one reason so many health systems are buying big physician primary care practices."

Motivating physicians to participate in quality and safety initiatives is included among the top three physician alignment objectives by 73%, more than any other objective. But nearly half of respondents (47%) say one of the top three objectives behind their physician alignment strategy is to maximize the patient population served, which doesn't necessarily mean maximizing admissions.

"We've done a lot of things to try to improve access to care, which gets patients the right care at the right place at the right time," says Scott Nygaard, MD, chief medical officer for physician services at Lee Memorial Health System in Fort Myers, Fla., which serves Lee County through four acute care hospitals. "We're trying to create a better delivery system."

Is fee-for-service sustainable? Alignment discussions are taking on a flavor of collaboration or mutual accountability, fostered by doubts on the part of many in acute care settings about whether the fee-for-service business model is sustainable. "Physicians are trying to understand how they go from being just a commodity and become a value-added partner," says T. Clifford Deveny, MD, senior vice president for physician services and clinical integration for Catholic Health Initiatives, an Englewood, Colo.–based not-for-profit health system that operates 86 hospitals in 18 states. When the very financial foundation of the industry is on the table, a different discussion can take place. Deveny, lead advisor for this report, says, "One issue is: How do you transform the physicians into accountable leaders, leaders who will help devise the models, or drive the models, or create financial sustainability? Physicians can't be passive."

> "Physicians are trying to understand how they go from being just a commodity and become a value-added partner."
>
> —T. Clifford Deveny, MD, Senior Vice President for Physician Services and Clinical Integration, Catholic Health Initiatives, Englewood, Colo.

Even though it is more common, still, for both parties to approach the alignment topic with income preservation in mind, larger groups with financial stability may provide an early view of what is to come in a more competitive environment. "There's been a lot of discussion around income preservation and keeping physicians happy," Deveny observes, "but mature physicians are saying, 'We're financially sustainable. We know where we're going. We're looking for a partner, a hospital system partner.' That tends to be a better discussion, but I would say that's the rare

Analysis (continued)

instance where you're seeing that type of a discussion."

An emerging competitive environment. When large groups with financial stability and access to a patient population of sufficient size come to the bargaining table, it is not necessarily the hospital's bargaining table. Deveny says, "Along the front range of Colorado and in California, I've seen large organized primary care physician practices that are taking a large amount of risk directly from insurance companies, typically through the Medicare Advantage plans." Command over the referral base will increase the competitive stature of such large groups. Deveny continues, "Because they're organized and they're controlling a large amount of dollars, in a sense they have created almost a commodity situation with specialists and with hospital systems. And because their patients are loyal to them and [reduced] payments are motivating the private care doctors to send people to the highest-quality, lowest-cost venue, they're using data to move patients to different venues of care."

Deveny calls this the *advocate model* of primary care, in which acute care facilities are "beholden to the new requirements and the new expectations of the primary care physicians." At this stage, he does not know how extensible the model is. "Will they develop in other markets, or will the lack of capital or the lack of physician leadership to create the necessary culture keep it from happening?"

Stoyanoff, an advisor for this report, says that even though only 32% of respondents place physician retention among their top three physician alignment objectives (sixth highest of eight response options), retention is a top mission for her. "In most of the markets I'm in, physician retention is a big reason behind our physician alignment strategy. We need to create effective models."

> "Physicians are not going to want to be part of every ACO on the planet. They'll start to pick and choose, and you want them to pick you."
>
> —Pamela Stoyanoff, Executive Vice President and Chief Operating Officer, Methodist Health System, Dallas

Deveny expects that the new dynamic will improve outcomes and lower costs. "Where the physicians become organized and are using data, they're in a position of strength. They've got a choice on health systems, and they can move populations overnight, based on cost and quality. I think it's going to be a healthier environment for everybody—we should have healthier communities and at least some flattening of the cost curve."

Which model? All of the above. Near-term shifts in organization models indicate that hospitals and health systems will place more emphasis on collaboration. One-fifth of respondents (22%) include clinical integration among their top three staffing models now, but three years out,

Analysis (continued)

twice as many, or 46%, expect to be involved in clinical integration.

"We're going to be doing more partnering with physicians rather than employing or just underwriting them," Deveny says. "It will be a shared-risk or pay-for-performance structure. We're going to come together, share data, and present ourselves as a network. Collectively, we will either all succeed or fail." On-staff physicians will have to be more collaborative as well. Clinical comanagement agreements stand at 15% now, and respondents say that will increase to 30% in the three-year time frame.

As clinical integration and clinical comanagement gain more support in the coming years, medical staff appointments, hospitalists, and paid directorships are finding fewer proponents. Overall, the result of these shifts is a broadening of support for a variety of models. Says Deveny, "The bottom line is that people do see physician engagement as being important. And they don't see employment as a be-all, end-all. Survey results confirm that there is still a lot of diversity of thought, and not everybody's betting the farm on one model."

Nygaard of Lee Memorial, a report advisor, keeps the mission in mind as alignment choices are examined. "If we can prove that we're providing pretty good access, whether through employment or partnerships, I'm not really wedded to a given model per se," he says. "How do we know when we've succeeded? When we've fulfilled our mission, which is to meet the healthcare needs and improve the health status of the people of southwest Florida. I'm open to a lot of those staffing models, but we have to achieve the goal."

"Healthcare reform provides a huge impetus for looking at other models," Stoyanoff says. "When you're implementing population health management or an ACO, you have to have physicians working with you. Physicians are not going to want to be part of every ACO on the planet. They'll start to pick and choose, and you want them to pick you."

> "If we can prove that we're providing pretty good access, whether through employment or partnerships, I'm not really wedded to a given model per se."
>
> —Scott Nygaard, MD, Chief Medical Officer for Physician Services, Lee Memorial Health System, Fort Myers, Fla.

Independents remain viable. Although much has been made of a physician hiring frenzy, survey responses show that independent physicians have critical mass and do not appear to be threatened in the near term. "A lot of the physicians still prefer not to be employed," Stoyanoff says. "Even though the numbers of physicians we're all employing are growing, there are still a lot of entrepreneurial physicians out there."

As Stoyanoff suggests, survey results do show expected increases in employed physicians and decreases in independents. The average percent

Analysis (continued)

increase in employed physicians in the three-year time frame is 40%. Over the same time period, the average percent decrease in independent physicians is expected to be 29%. But with the average number of employed physicians standing at 246 per respondent compared to 693 per respondent for independents, the latter will be in the majority three years hence, despite the expected decrease. "I've doubled the number of employed physicians," Stoyanoff says, "but that's still only 10% of what we have. There still are a lot of independent physicians out there."

A learning process. When respondents talk about current and near-term initiatives, the talk is about collaboration and risk-sharing. Today, 41% of respondents are involved in an ACO, up from 26% in last year's survey. Within three years, 55% will be pursuing or involved in an ACO. Stoyanoff acknowledges that, for Methodist Health Systems, learning is an important benefit to be derived from making such steps.

"A lot of healthcare institutions are wondering about learning to manage patients along the continuum of care," she says. "We are focusing primarily on the development of our ACO, which started a year ago. And we are in a Medicare Shared Savings Program, so we're learning how to manage lives from a global perspective."

Other collaborative care models are gaining traction, according to survey respondents. More than half of respondents (52%) are now undertaking initiatives related to a patient-centered medical home, up from 39% a year ago, and 58% expect to be there within three years. Similar growth is seen for the population health model, which was a current initiative of just 25% last year, now stands at 33% of respondents, and will reach 51% within three years.

Hospitals and health systems also are learning about at-risk payments. Higher percentages of employed physicians are being compensated for clinical quality and patient satisfaction metrics, and the level of incentive is increasing, too. Now, 17% of respondents report that compensation for clinical quality and patient safety for employed physicians is in excess of 10%. That percentage will increase to 44% in the three-year time frame.

> "Where the physicians become organized and are using data, they're in a position of strength. They've got a choice on health systems, and they can move populations overnight, based on cost and quality."
>
> —T. Clifford Deveny, MD, Senior Vice President for Physician Services and Clinical Integration, Catholic Health Initiatives, Englewood, Colo.

"That's something that we're all going to be emphasizing over the years to come," says Stoyanoff. "Employing physicians is still an expensive endeavor, so even in an employment model, we like to have a portion of their salaries at risk for performance targets." Again, Stoyanoff recognizes

Analysis (continued)

learning opportunities when establishing at-risk incentive programs: "It's making a lot of organizations struggle because we don't necessarily know how to go about establishing those metrics, or have experience tracking them, or even know which ones we should choose, but it is something that we're all going to concentrate on."

Maturing relationships. Deveny notes that early steps are being made with physicians, steps that include accountability and data-based decisions. As relationships mature, he says, "We all have the obligation to show our value to our communities and to the people who are going to be purchasing healthcare."

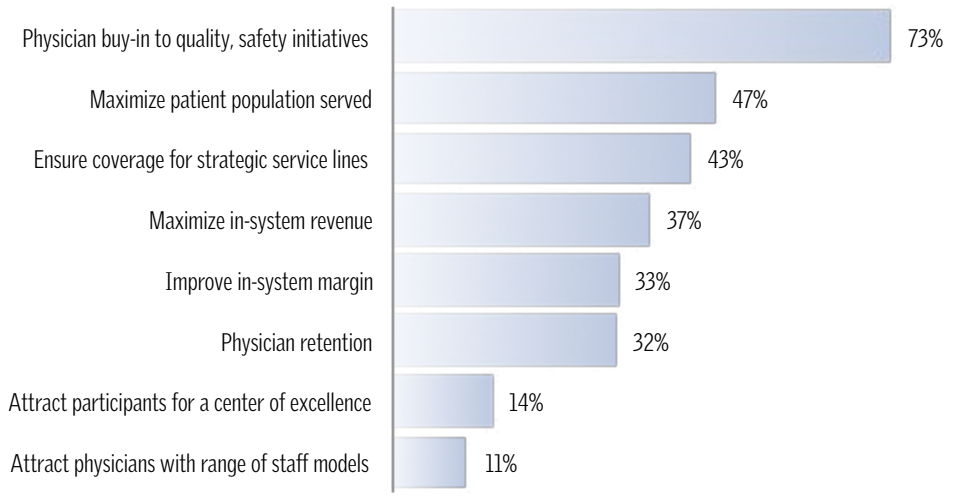
Deveny anticipates a patient-as-consumer focus. "Medicare Advantage is a good example," he says. "One by one, you've got to convince every one of those enrollees that they want to give up Medicare and move to your Medicare Advantage plan, and you're going to have to have strong reasons for them to move. That's why I say physicians can't be passive. We won't be in the income preservation business anymore. We've got to require more out of both parties, but then the health systems have got to be just as accountable to the physicians on performance."

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

FIGURE 1 | Physician Alignment Strategy Objectives

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

Total responses



Base = 302, Multi-Response

TAKEAWAYS

- Nearly three-quarters of respondents (73%) say that buy-in to quality and safety initiatives is among their top three objectives behind physician alignment strategies. Physician buy-in is the most frequently selected motivation and shows little variation by setting or size of organization.
- Maximizing the patient population served is included in the top three motivations by 47%, up from 33% in response to a similar question last year. Higher percentages of respondents from large organizations than small include a focus on expanded patient populations among their physician-alignment strategies: 58% of respondents from health systems with 21 or more sites do so, compared to only 30% from health systems with five or fewer sites.

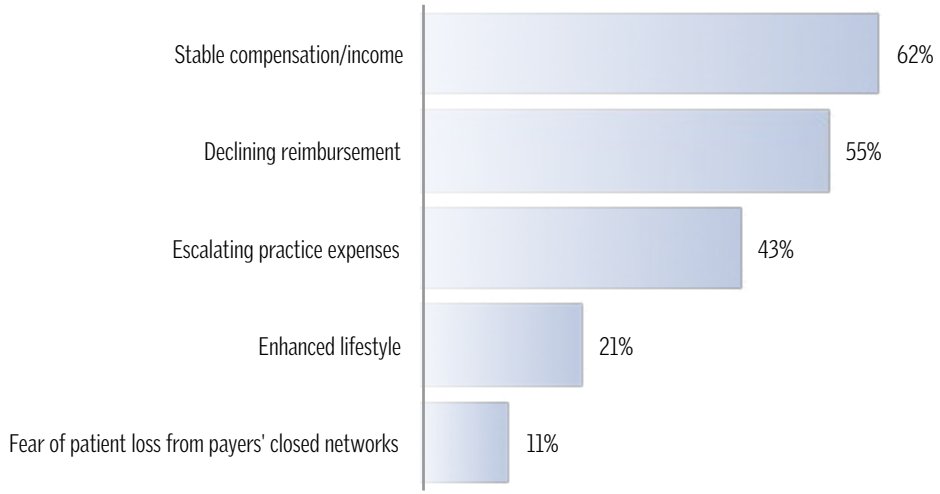
WHAT DOES IT MEAN?

Medium and large health systems have the largest investment in facilities, which may be behind their relatively high interest in maximizing the patient population served. In addition, investments in population health management are more common among larger organizations, providing another rationale for maximizing the patient population served.

FIGURE 2 | Motivators for Physicians to Seek/Accept Employment

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

Total responses



Base = 302, Multi-Response

TAKEAWAYS

- The desire for stable income is the top motivator for physicians seeking employment, according to 62% of respondents.
- A related issue, declining reimbursements, is identified by by 53% of hospital and 58% of health system leaders as a top motivator for physicians seeking employment.
- Those same two factors were the top-mentioned items in last year's survey as well, although last year declining reimbursement (62%) edged out stable compensation (52%).

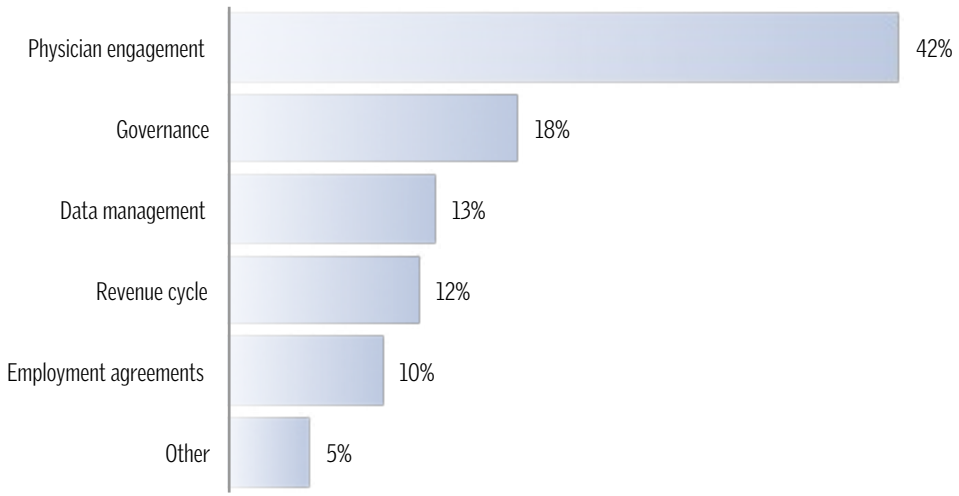
WHAT DOES IT MEAN?

Although the switch from fee-for-service to value-based purchasing affects all in healthcare, independent physicians may, indeed, see fewer options than hospitals or health systems, which may be behind their desire for the stability that employment offers. Also, as reimbursements decline, it becomes more and more difficult for physicians to maintain an independent practice.

FIGURE 3 | 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



TAKEAWAYS

- Overall, 42% of respondents have difficulty with physician engagement, more than any other factor. The response varies little by setting.
- Governance, the second most frequently mentioned difficulty, is a problem for a higher percentage of health systems (25%) than hospitals (13%). However, within the hospital setting, a smaller percentage of small hospitals (8%) than medium (18%) or large (19%) say that governance is the aspect of managing physicians that causes the most difficulty.

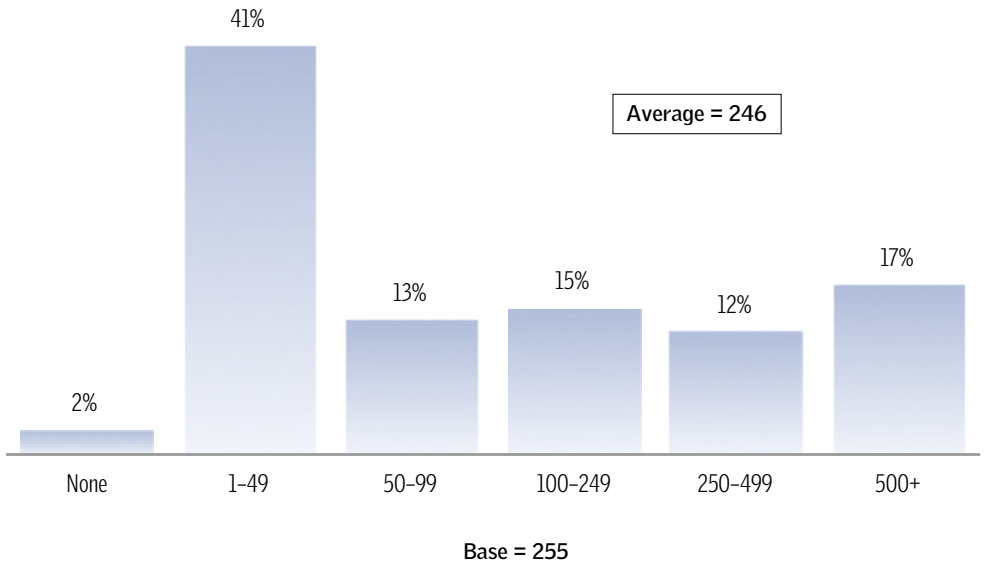
WHAT DOES IT MEAN?

In Figure 1 we noted that physician buy-in to quality and safety initiatives is included most often among the top three physician alignment objectives, and here we see that physician engagement tops the list of most difficult aspects of managing physicians. So we see that healthcare leaders are experiencing the most difficulty with the objective that is most important.

FIGURE 4 | Number of Employed Physicians

Q | How many employed physicians are part of your hospital or health system now?
Among those reporting

Total responses



TAKEAWAYS

- While very few organizations (2%) have no employed physicians, most do and look to increase that number. The average number reported by respondents is 246, but that does vary, as expected, by organization size and setting: hospitals average 89 employed physicians and health systems 475.
- Health systems dominate at the high end of the employed physican scale, as one might expect: 36% of systems report employing 500 or more physicians, while just 4% of hospitals report such large numbers.

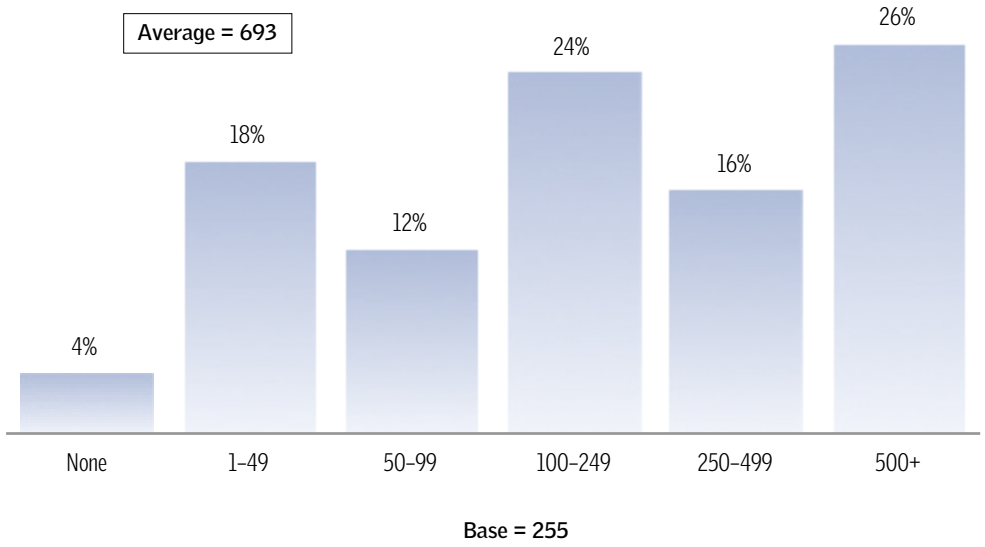
WHAT DOES IT MEAN?

With their larger size, health systems dominate the physician employment picture. More than half of health systems (54%) employ 250 or more physicians, and of the largest systems (21 or more sites), employment of 250 or more physicians reaches two-thirds (67%).

FIGURE 5 | Number of Independent Physicians

Q | How many independent physicians are part of your hospital or health system now?
Among those reporting

Total responses



TAKEAWAYS

- The distribution of independent physicians leans more to the high end of the scale than the distribution of employed physicians. More than one-quarter (26%) report 500 or more independent physicians as part of their organizations, which includes 15% of hospitals and 42% of health systems.
- At the other end of the scale, 27% of hospitals report relationships with 49 or fewer independent physicians, compared to 5% of health systems.

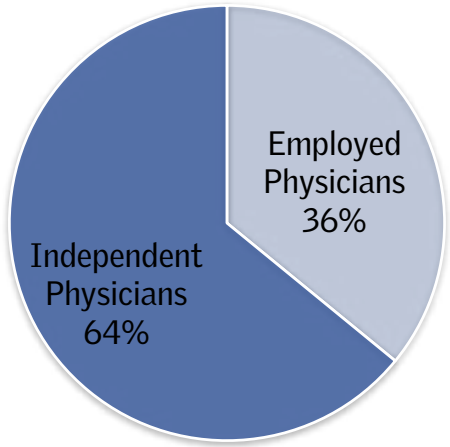
WHAT DOES IT MEAN?

The comparison of counts of employed to independent physicians underscores the common practice of utilizing independent physicians in greater numbers than employed doctors. The average number of employed physicians is 246, while the average number of independents stands at 693.

FIGURE 6 | Employed Physicians/Independent Physicians Percentages Now

> | Average of Employed Physicians/Independent Physicians Percentages Now
Among those reporting

Total responses



Base = 255

TAKEAWAYS

- This chart demonstrates the large percentage of independent physicians compared to employed physicians. Overall, the average ratio of independent to employed is 64% to 36%.
- Hospitals have a slightly higher average percentage of independent physicians (67%) than health systems (60%).

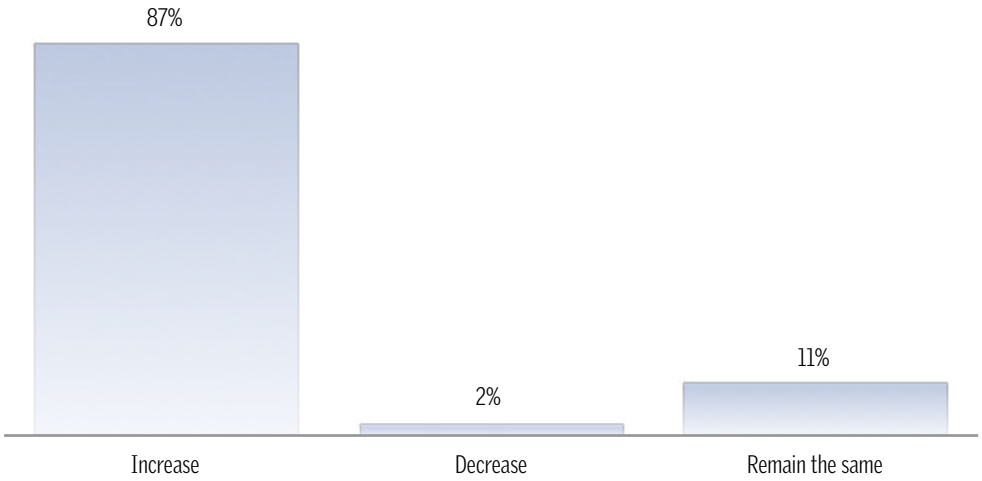
WHAT DOES IT MEAN?

While hospitals have a slightly higher average ratio of employed physicians than health systems (67% vs. 60%), the health systems employ about four times as many physicians on average (1,236 vs. 319). On average, healthcare facilities have working relationships with twice as many independent physicians as employed physicians.

FIGURE 7 | Anticipated Change in Number of Employed Physicians

Q | In three years, do you expect the number of employed physicians will increase, decrease, or remain the same?
Among those reporting

Total responses



TAKEAWAYS

- Survey respondents confirm the industry trend toward employment, with 87% reporting that they expect the number of physicians employed by their organizations to increase over the next three years.
- Overall, 11% expect the number of physicians employed by their organizations will stay the same. The percentages by setting are just about the same: 10% for hospitals and 12% for health systems. However, within the health system setting, a higher percentage of small health systems (19%) than medium (15%) or large (8%) expect that their employed physician count will remain unchanged over the next three years.

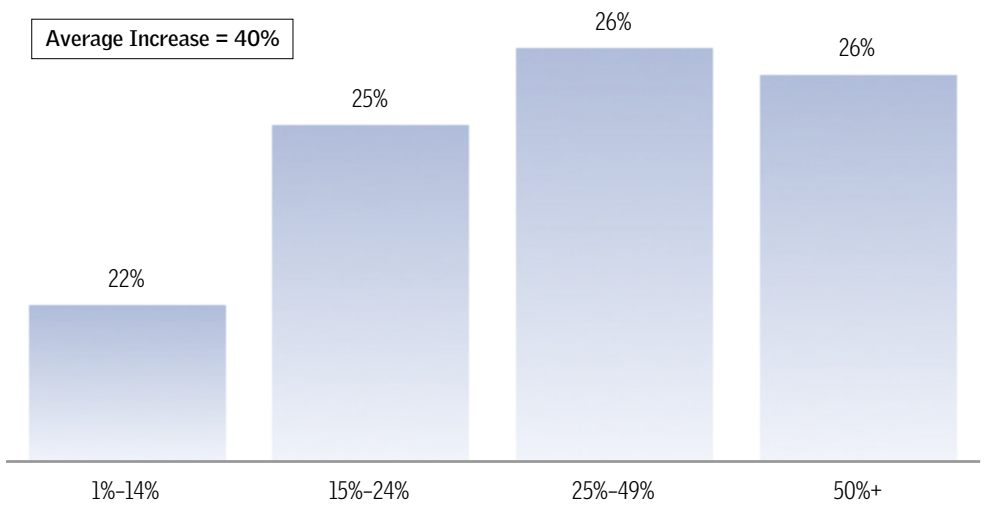
WHAT DOES IT MEAN?

Industry wisdom indicates that employed physicians offer more support to the organization's initiatives. With the switch away from fee-for-service, initiatives such as clinical quality and patient experience become more important. Another reason for increased physician employment may be the need for closer collaboration, especially in the outpatient environment.

FIGURE 8 | Percentage Increase in Employed Physicians in Three Years

Q | By what percentage will the number of employed physicians increase?
Among those reporting an increase

Total responses



TAKEAWAYS

- The average projected increase in employed physicians at responding organizations is 40% over the next three years.
- Small hospitals report more aggressive employment growth expectations (47%) compared to medium (38%) and large (33%) hospitals.

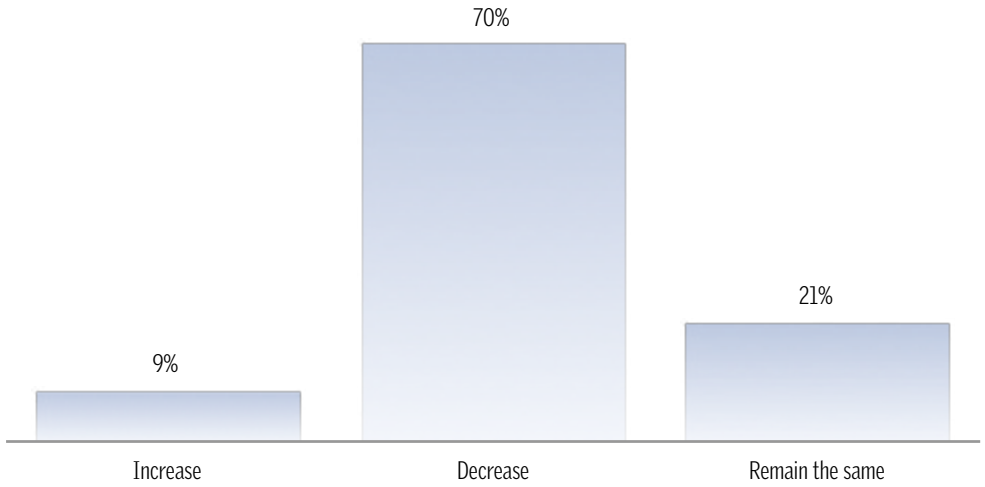
WHAT DOES IT MEAN?

The growth of the employed physician model is not nearly at an end. While there is fairly even division among the ranges of percent increase expected in the coming years (1%–14%, 15%–24%, 25%–49%, 50%+), growth is relatively consistent regardless of size or setting. Small hospitals may have more aggressive plans for employed physician growth as they position themselves for the tighter alignment that healthcare reform is likely to require.

FIGURE 9 | Anticipated Change in Number of Independent Physicians

Q | In three years, do you expect the number of independent physicians will increase, decrease, or remain the same?
Among those reporting

Total responses



TAKEAWAYS

- At the same time that the industry is adding employed physicians, it is moving away from independent physicians. Nearly three-quarters (70%) expect their count of independent physicians will decrease over the next three years.
- Just over two-thirds of those in the hospital setting (68%) expect the count of independent physicians to go down, with little variation by organization size.
- A slightly higher percentage of those in health systems expect a decrease (73%), including 81% of respondents from health systems with five or fewer sites.

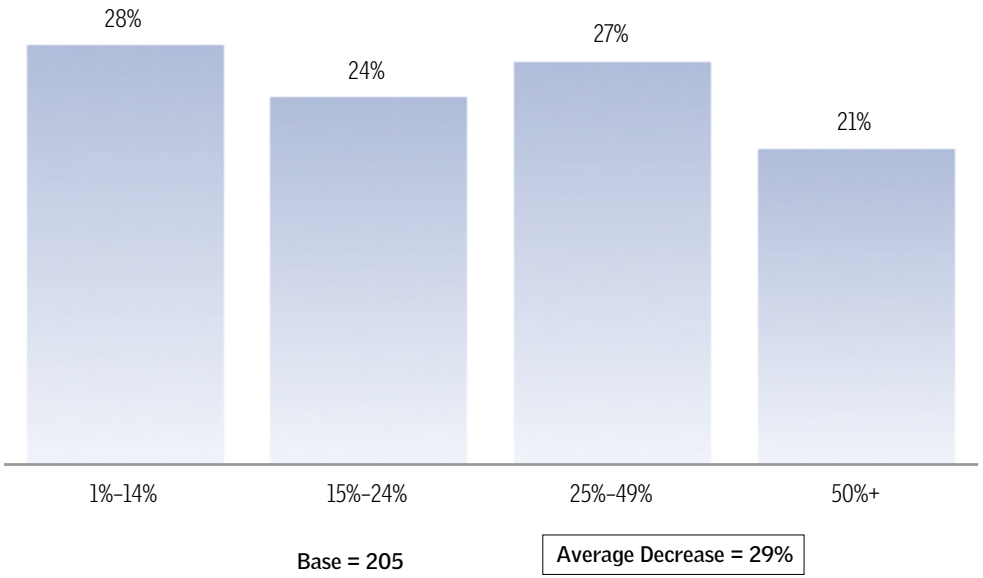
WHAT DOES IT MEAN?

The base of independents is not threatened near-term because it is so large relative to employed physicians (roughly two independents for every one employed). Also, one-fifth (21%) expect their count of independents to remain the same and 9% project increases.

FIGURE 10 | Percentage Decrease in Independent Physicians in Three Years

Q | By what percentage will the number of independent physicians decrease?
Among those reporting a decrease

Total responses



TAKEAWAYS

- Expected percent decreases in independent physicians are distributed fairly evenly, with 28% of respondents expecting decreases of 14% or less, and 21% expecting decreases of 50% or more.
- There is little variability between settings: 20% of hospitals expect to reduce their count of independent physicians by 50% or more, compared to 22% of health systems.

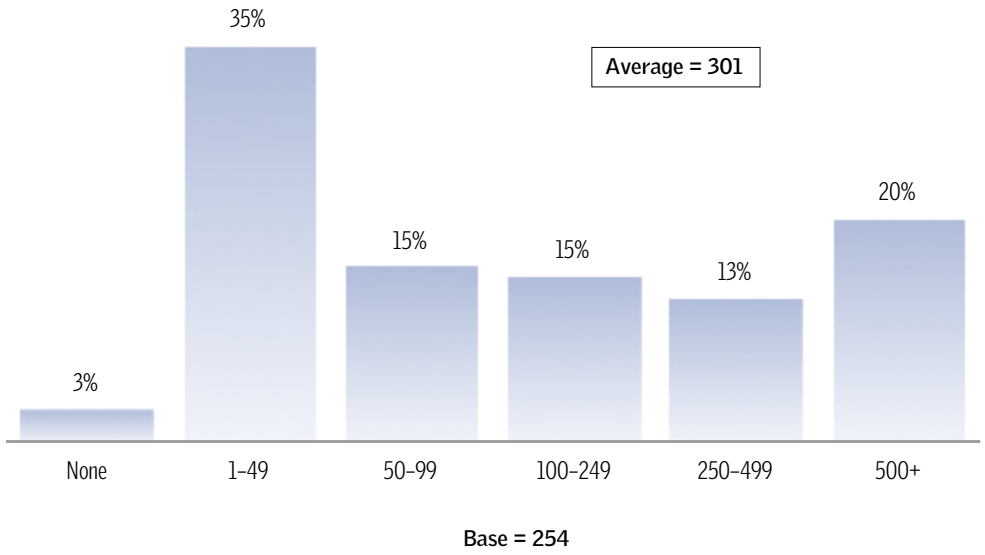
WHAT DOES IT MEAN?

The average expected percent decrease in independent physicians is 29%. Although the average percent increase in employed physicians is higher (40%), the smaller average percent decrease in independents works against a significantly larger base, so the level of decrease in independents is larger than the level of increase in employed physicians.

FIGURE 11 | Employed Physicians in Three Years

> | Number of Employed Physicians in Three Years
Among those reporting

Total responses



TAKEAWAYS

- Overall, 35% of respondents expect that they will employ 1–49 physicians in the three-year time frame, a decrease from the 41% who employ 1–49 physicians now (Figure 4).
- The 500+ category sees the biggest increase. Figure 4 shows that 17% employ 500 or more physicians. In three years, 20% expect they will employ over 500 physicians.

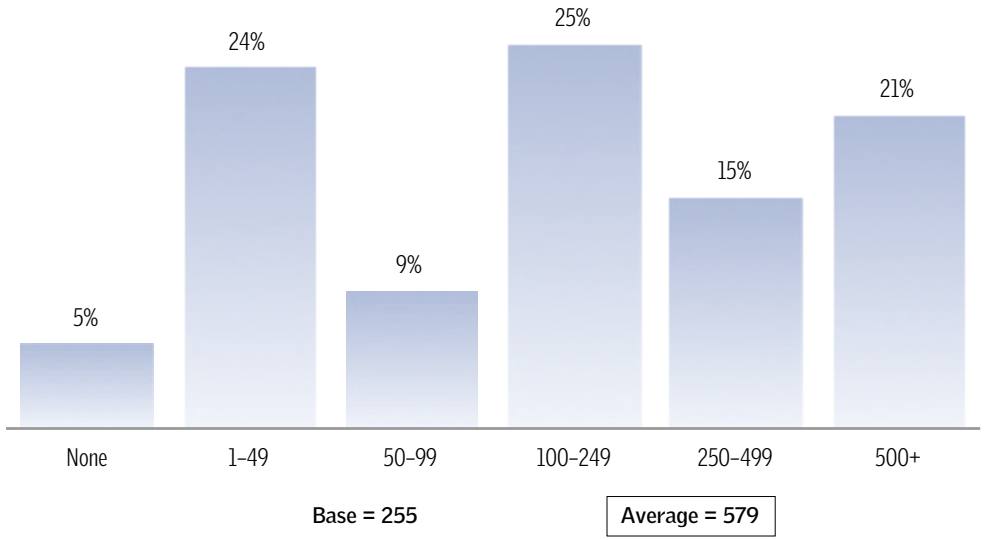
WHAT DOES IT MEAN?

Reflecting the trend toward employing physicians, the average number of employed physicians is expected to increase to 301 in three years, compared to 246 now (Figure 4).

FIGURE 12 | Independent Physicians in Three Years

> | Number of Independent Physicians in Three Years
Among those reporting

Total responses



TAKEAWAYS

- Over the next three years, the percent of respondents with working relationships with 500 or more independent physicians is expected to decrease from 26% (Figure 5) to 21%.
- There will be a corresponding increase in the percentage of respondents who have working relationships with 1–49 independents. The reading stands at 18% now (Figure 5) and will increase to 24%.

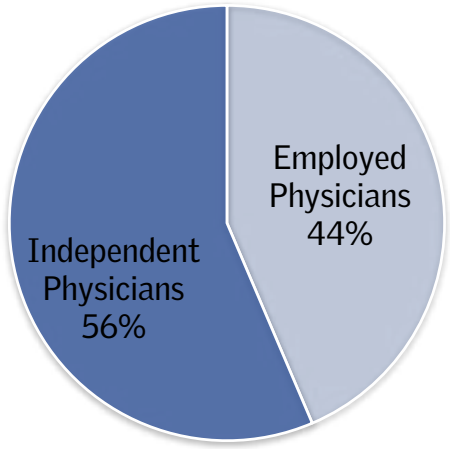
WHAT DOES IT MEAN?

Reflecting the trend away from working with independent physicians, the average number of independent physicians is expected to decrease to 579 in three years, compared to 693 now (Figure 5).

FIGURE 13 | Employed Physicians/Independent Physicians Percentages in Three Years

> | Average of Employed Physicians/Independent Physicians Percentages in Three Years
Among those reporting

Total responses



Base = 255

TAKEAWAYS

- This chart demonstrates the shifting percentage of independent physicians as a result of the industry trend toward employing physicians. Overall, the average ratio of independent to employed physicians is expected to be 56% to 44% in the three-year time frame, compared to 64% to 36% now (Figure 6).
- Hospitals expect to have a slightly higher average percentage of independent physicians (60%) than health systems (52%).

WHAT DOES IT MEAN?

In spite of attention to working with employed physicians, independents will remain an important element in care delivery.

FIGURE 13 *(continued)* | Employed Physicians/Independent Physicians Percentages in Three Years

> | Average of Employed Physicians/Independent Physicians Percentages in Three Years

Among those reporting

Click on these icons to dig deeper

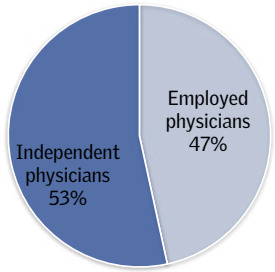
VIEW BY PRODUCTS/SERVICES
Indicates the type of goods or services the respondent is involved in purchasing

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

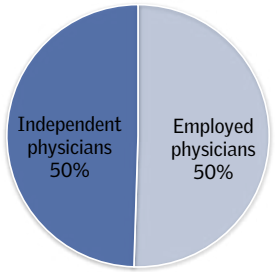
PRODUCTS/SERVICES

Clinical products



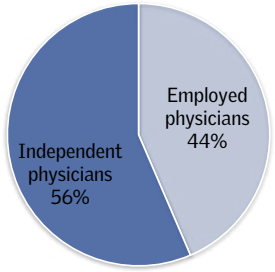
Base = 144, Among those reporting

Financial services



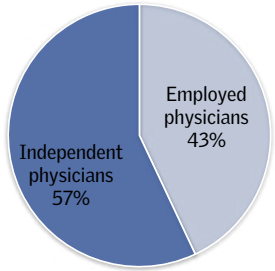
Base = 87, Among those reporting

Executive search



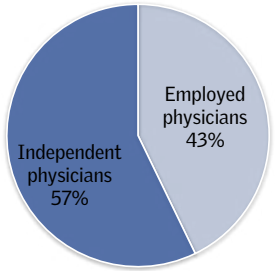
Base = 99, Among those reporting

Consulting services



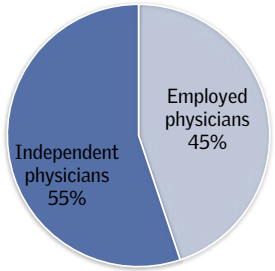
Base = 142, Among those reporting

Outsourcing services



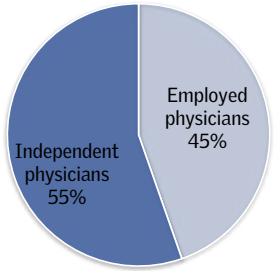
Base = 99, Among those reporting

Legal services



Base = 72, Among those reporting

Information technology



Base = 153, Among those reporting

FIGURE 14 | Current Physician Organizational Model

Q | Please select the top three physician organizational models that best represent your current physician alignment strategy.

Total responses

Hospitalist	67%
Medical staff	55%
Paid directorship	31%
Contracted	31%
Professional service agreement	28%
Clinical integration	22%
Academic/faculty	17%
Clinical comanagement	15%
Joint venture	12%
Medical services organization	9%
Foundation (California hospitals)	4%

Base = 302, Multi-Response

TAKEAWAYS

- Two-thirds of respondents (67%) include hospitalists among their top three current staffing models.
- Medical staff assignments (55%) are nearly as common. With both hospitalists and medical staff assignments, there is little variation between settings (hospitals and health systems) and little variation by size within settings.
- Overall, clinical integration is included among the top three physician organizational models by 22%, the sixth most frequently mentioned item. That said, 29% of respondents from health systems include clinical integration among their top three, compared to only 17% of respondents from hospitals.

WHAT DOES IT MEAN?

Several of the more "collaborative" organizational models—such as clinical integration, clinical comanagement, and joint ventures—are mentioned by relatively few respondents, although such models will become more important as the industry shifts from fee-for-service to value-based purchasing.

FIGURE 15 | Physician Organizational Model Expected in Three Years

Q | Please select the top three physician organizational models as you expect them to be in three years.

Total responses

Hospitalist	55%
Clinical integration	46%
Medical staff	34%
Clinical comanagement	30%
Professional service agreement	27%
Contracted	25%
Joint venture	20%
Medical services organization	17%
Academic/faculty	17%
Paid directorship	14%
Foundation (California hospitals)	4%

Base = 302, Multi-Response

TAKEAWAYS

- Despite a 12-point drop from 67% to 55%, hospitalists remain the most frequently mentioned staffing model in the three-year time frame.
- Clinical integration will receive more attention in the next three years and is included among the top three by 58% of health systems, twice the present percentage. Also, twice as many hospitals (37% compared to 17%) expect to engage physicians via clinical integration.
- Clinical comanagement, the eighth most frequently mentioned current staffing model, gains support by doubling from 15% to 30% among those including it in their top three future staffing models.

WHAT DOES IT MEAN?

The comparison of Figure 14 to Figure 15 shows a decrease in emphasis on hospitalists, medical staff, and paid directorships, and an increase in clinical integration, clinical comanagement, and joint ventures, pointing to a trend toward more emphasis on collaboration.

FIGURE 16 | Recruiting Targets Over Next Three Years

Q | Please select your top five physician recruiting targets over the next three years.

Total responses

Primary care	68%
Hospitalists	50%
General surgery	42%
Cardiology/cardiovascular	42%
Orthopedics	41%
Neuroscience/neurosurgery	31%
Emergency medicine	25%
Oncology	23%
Gastroenterology	20%
OB-GYN	20%
Pediatrics	17%
Pulmonary medicine	14%
Urology	13%

Base = 302, Multi-Response

TAKEAWAYS

- More than two-thirds of respondents (68%) include primary care physicians among their top five recruiting targets in the three-year time frame. A higher percentage of health systems (79%) than hospitals (60%) are targeting primary care physicians.
- Half of the respondents (50%) are pursuing hospitalists. As we saw with primary care, a higher percentage of health systems (54%) than hospitals (47%) include hospitalists among their top five recruiting targets.

WHAT DOES IT MEAN?

The emphasis by health systems on primary care and hospitalists is an indication that health systems are grappling with reform-related shifts in payments. These shifts will likely change the patient mix in acute care facilities, with more care (and more sophisticated care) taking place in outpatient and ambulatory environments.

FIGURE 17 | Current Initiatives

Q | Which of the following initiatives is your organization undertaking now?

Total responses

Integrated delivery system	53%
Collaborative care: Patient-centered medical home	52%
Collaborative care: ACO	41%
Population health model	33%
Physician-hospital shared savings agreements	29%
Payer-provider shared risk agreements	27%
Other collaborative care	21%
Employer-provider shared risk agreements	18%

Base = 302, Multi-Response

TAKEAWAYS

- The percentage of respondents involved in an ACO has increased from 26% in 2012 to 41% now.
- This year, 54% of health systems report they are involved in an ACO, up from just 31% last year.
- The year-over-year increase in patient-centered medical homes is nearly as large, moving from 39% in 2012 to 52% now.

WHAT DOES IT MEAN?

With a strategic shift toward the establishment of patient-centered medical homes and ACOs, healthcare providers must learn to incorporate a team-based approach to collaborative care.

FIGURE 18 | Initiatives Likely to Pursue Within Three Years

Q | Which of the following initiatives is your organization likely to be pursuing within three years?

Total responses

Collaborative care: Patient-centered medical home	58%
Collaborative care: ACO	55%
Integrated delivery system	53%
Population health model	51%
Payer-provider shared risk agreements	41%
Physician-hospital shared savings agreements	40%
Employer-provider shared risk agreements	29%
Other collaborative care	21%
Employer-payer shared risk agreements	20%

Base = 302, Multi-Response

TAKEAWAYS

- In the three-year time frame, 55% expect to be involved in an ACO, which represents a 14 percentage point increase from the 41% who say they are currently involved in an ACO initiative (Figure 17).
- The shift toward population health is even more pronounced: Figure 17 shows that 33% are now pursuing population health, while 51% say they expect to have a population health initiative within three years.
- Larger percentages will also be pursuing shared-risk agreements. For example, 27% are pursuing payer-provider shared risk now (Figure 17), while 41% expect to be doing so in three years.

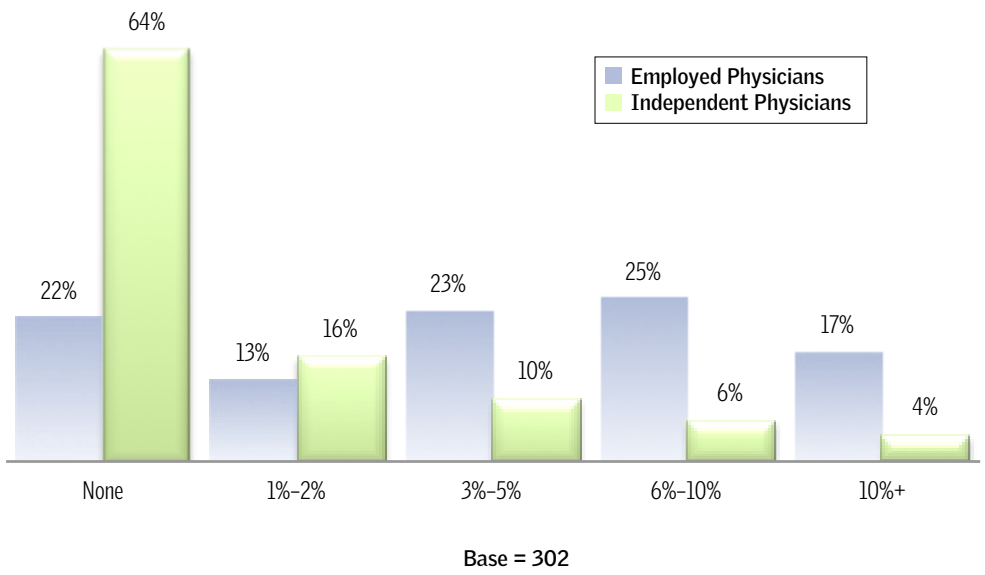
WHAT DOES IT MEAN?

With increased attention to initiatives involving collaboration, at-risk payments, and population health, hospitals and health systems are likely to be making significant alterations to the way physicians are compensated and otherwise incentivized in order to encourage the collaboration necessary to make these new care models successful.

FIGURE 19 | Percentage of Compensation for Nonproductivity Performance Now

Q | Approximately what percentage of total compensation for employed and independent physicians is for nonproductivity performance (such as patient satisfaction, clinical quality, and citizenship)?

Total responses



TAKEAWAYS

- Four-fifths of hospitals and health systems (78%) now compensate their employed physicians for nonproductivity performance. Incentives are slightly more common among health systems (86%) than in hospital settings (72%).
- Higher percentages of health systems pay their employed physicians top-end incentives: 56% of health systems pay performance incentives of 6% or more, compared to 33% of hospitals.
- Independent physicians are not included in incentives as often (included by only 36%), and their incentive payments are lower.

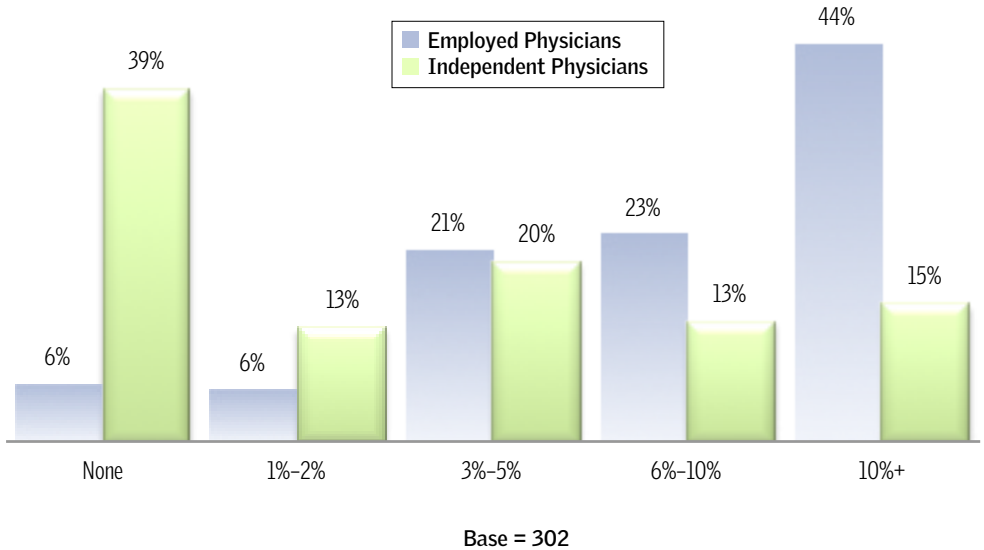
WHAT DOES IT MEAN?

Most hospitals and health systems offer their employed physicians an incentive payment for achieving performance targets in areas such as patient satisfaction and clinical quality. As the industry moves forward to value-based purchasing, such incentives may become virtually universal in acute care settings. Today, many independents are contractually excluded from such payments. As working relationships become more collaborative, we expect that some providers will look for ways to remove such contractual exclusions and include independents in performance-based compensation programs.

FIGURE 20 | Percentage of Compensation for Nonproductivity Performance in Three Years

Q | What percentage of total compensation do you anticipate for nonproductivity performance (such as patient satisfaction, clinical quality, and citizenship) in three years?

Total responses



TAKEAWAYS

- More physicians will be included in incentive programs in the three-year time frame, both independents (61% compared to 36% now) and employed (94% in three years, compared to 78% now).
- The level of payments will increase for employed physicians. Within three years, 67% of employed physicians will receive incentives of 6% or more, which is up considerably from the current 42% (Figure 19).
- The level of incentives for independents will increase also. In the next three years, 28% will be receiving incentives of 6% or more for nonproductivity performance, nearly three times the current 10% level (Figure 19).

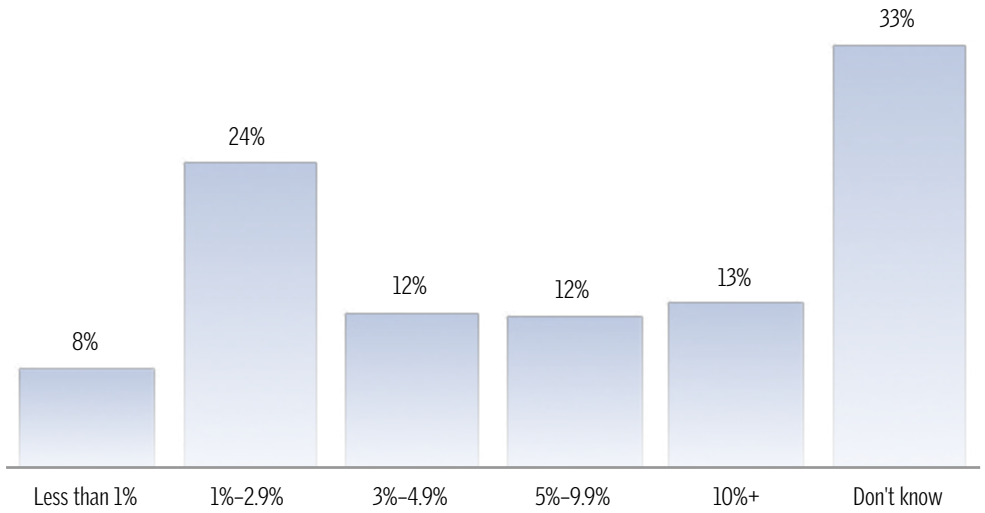
WHAT DOES IT MEAN?

The increase in the number of physicians who will receive nonproductivity performance compensation and the increase in the level of that pay indicates hospitals and health systems are prepared to hold caregivers responsible for more than volume. It also reflects that hospitals and health systems are limited by statute and contractual regulations with respect to nonproductivity incentives for independents.

FIGURE 21 | Percentage of Net Operating Revenue Committed to Physician-Hospital Alignment

Q | Please estimate the financial investment your organization is committing to physician-hospital alignment in the next three years in terms of percentage of net operating revenue.

Total responses



TAKEAWAYS

- One-fifth of hospitals (21%) and 29% of health systems are investing 5% or more of net operating revenue in physician alignment activities.
- There is variation based on the organization's net patient revenue. While 24% of small organizations and 19% of medium organizations will invest 5% or more of net operating revenue in physician alignment activities, 36% of large organizations are making such high-end commitments.
- One-third of the respondents (33%) could not provide an estimate of their organization's investment in physician alignment activities. This includes 35% of respondents from hospitals and 30% of respondents from health systems

WHAT DOES IT MEAN?

An organization's success in the post-fee-for-service healthcare industry may hinge on its success in fostering relationships along the care continuum. Establishing workable staff models and contracts for employed and independent physicians will require investments. Including physicians in nonproductivity performance incentives is a sign that the board and leadership acknowledge the need for investment. That one-third of respondents cannot estimate the overall level of physician alignment investments may be a sign that the importance of the program may not be widely understood or that investments in physician alignment may not be categorized as such on the balance sheet.

Access.
Insight.
Analysis.

Council

The nation's most exclusive
healthcare intelligence community

Be a voice
Gain insight from your peers
Shape the direction of the industry

Join today at *www.healthleadersmediacouncil.com*