Avoiding Costly Mistakes

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Physicians and hospital executives around the country are finding a need to come together in response to trends that are changing healthcare industry fundamentals.

Continued federal and state government downward pressure on reimbursement, increased industry regulation, scrutiny and enforcement, increased patient demand for services, changing physician psychographics, and more have healthcare providers (and payers) scrambling to adapt. The need to "circle the wagons" has been accelerated by current healthcare reform initiatives, and the resulting adaptation in most markets usually includes one or more forms or structures for physician–hospital integration. Unfortunately, many *structural integration* initiatives fail to ever achieve their potential—wasting political, human, and financial capital.

Structural Challenges

Structural integration takes a variety of forms, ranging from the least integrated traditional medical staff to the most structurally integrated physician employment model. Co-management arrangements, clinically integrated organizations, joint ventures, professional services arrangements, and others fall somewhere in between. Over the years, we have witnessed a variety of challenges associated with these models, including the more common structural integration mistakes listed below:

- **Bad deals:** We define a "bad deal" as any arrangement that is unsustainable for either party. Simply shifting money from a hospital to physicians is not a sustainable deal. A venture, including physician employment, that is not financially or operationally sustainable hurts both parties. Win/lose deals leave both parties fighting until the contract is over, and breaking up when it finally ends.
- **Inadequate market share:** When there are not enough patients (covered lives) to sustain the integrated structure, it is difficult to focus on the important issues like clinical quality and service delivery because the integrated structure is hemorrhaging cash.
- **Lack of engagement:** Physicians and other professionals are what Peter Drucker termed "knowledge workers."[1] They cannot be "bossed" in the traditional sense. We might purchase their knowledge and skilled hands, but winning their hearts and minds requires engagement in a shared vision that is *compelling* enough to capture their individual wills, regardless of their employment status.

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- **Over a barrel:** Sometimes hospital executives or physicians feel forced to enter into a bad deal in order to maintain a seat at the competitive table. Being held hostage is not the way to start a sustainable relationship. Hostage situations often result when a hospital is dependent on one subspecialty group, but does not have the primary care market share to keep negotiations on the level.
- **Inadequate incentives:** Incentives include personal satisfaction that stems from the work, maintaining employment, acknowledgement of performance, financial rewards, and more. As human beings, we are all motivated by such incentives. Many incentives are focused on outcomes rather than on the behaviors (personal accountability) that lead to the results we seek. Other incentives are so far removed from the targeted behaviors that they become meaningless (e.g., reward January behavior in April as part of a quarterly bonus).
- **Inadequate volume:** With all the recent attention to value, discussions about volume have lost their luster. In fact, talking about volume is almost taboo in some settings. The reality, of course, is that without volume there is no access, no productivity, no efficiency, no process improvement—no value. Many integrated organizations have failed to set adequate volume expectations even when the market share is available. Employed physician productivity chronically runs well below private practice productivity—even for some employed physicians who used to be entrepreneurs.
- **Limited accountability:** Many organizations fail to hold their members accountable for personal performance or team performance. Personal and joint accountability require clear expectations, personal commitment, transparent performance measurement, process improvement, and consequences for those who will not or cannot meet the expectations.
- **Structural integration alone:** A number of structurally integrated organizations do not *function* like they are integrated at all. There is little communication, no common vision or direction, no performance expectations, and no accountability for behavior or results. Referrals still leave the integrated delivery network allowing competing delivery systems to benefit. Physicians and hospital departments still view themselves as separate silos merely *coordinating* care in order to achieve their private agendas, payrolls, and budgets. Patients feel like they are starting over with every referral to someplace new. Service quality for patients and their referring providers is inconsistent, at best. These organizations never move beyond structural to *functional* integration—for the benefit of referring physicians and their patients.[2]

Time-Tested Solutions

Given current industry trends and challenges, avoiding mistakes that drain precious political, human, and financial capital is becoming increasingly imperative. There is little time and far less margin for error in adapting to new industry fundamentals. The following time-tested solutions are

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1 Peter F. Drucker, *Peter Drucker on the Profession of Management,* Boston: Harvard Business School Publishing, 1998, pp. 122–125.

2 Marc D. Halley, "Integration: From Structural to Functional," *Healthcare Financial Management,* June 2012, pp. 74–77.

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still proving relevant as integrated systems move from structural to *functional integration* and beyond:

- **Primary care market share:** A market share strategy for primary care is an essential part of any sustainable integration effort. Since most primary care patients still prefer a physician close to home and schools, having adequate numbers of affiliated primary care physicians (PCPs) and other providers in the right "neighborhoods" is a business imperative. PCPs may be located in traditional settings, in urgent care or convenient care settings, and even in occupational health settings. They may be employed or independent, but must be affiliated or integrated. An integrated delivery system with adequate market share will always have a seat at the competitive table. Adequate market share precludes most hostage situations because subspecialists cannot afford to walk away from 20–30 percent or more of their referrals.
- **Choice initiatives:** Many structurally integrated organizations anticipate that payer relationships (e.g., ACO, narrow network) will be adequate to manage the referral path, which leads from the PCP to more invasive diagnostic and therapeutic services and back to the PCP. Such relationships alone may work to manage population *risk*, but they will not position the integrated organization for functional integration or clinical integration—and certainly not for population *health* management. Being the preferred subspecialists based on access, communication, and patient experience is essential. Being the preferred hospital based on ease of referral, service quality, responsive hospital-based physicians, etc., is essential. Clinical quality tends to be assumed unless proven otherwise. Being the "specialist of choice" and the "hospital of choice" are essential to functional integration.[3]
- **Sustainable deals:** Sustainable deals derive from several factors, including (not surprisingly) a successful primary care strategy to ensure adequate volume that drives value. Their foundation is an integrated vision that is compelling enough to attract the interest of PCPs and subspecialists. Sustainable deals are based on careful *evaluation* as well as valuation. They are "investor grade" and could attract outside capital. If they involve acquisition and employment, it is the acquisition that represents the accumulated wealth of the seller rather than subsequent inflated compensation. Pro forma budgets are based on historical realities and performance-based compensation.
- **Engaging physicians as partners:** Integration, by definition, is a partnership that requires the best thinking of clinical and business experts. It is not physician led. It is not driven by administration. It is *partnership led*—partnerships of physician leaders and executives that counsel together to establish vision, strategy, performance expectations, and a culture of accountability. Functional integration and clinical integration require "the wisdom of crowds" to select or test best practices from among various clinical alternatives, processes, and support systems.[4] Partnerships (what we call *operational governance*) at the practice level, the medical practice network level, and the service line level are each essential to functional and clinical integration.
- **Establishing performance expectations:** Integrated partnerships must establish, rigorously measure, and continuously improve processes and behaviors that lead to the targeted outcomes in clinical quality, service quality, productivity, and financial viability. These four pillars must be carefully balanced to ensure both functional and clinical integration.
- **Effective implementers:** Again, the most successful organizations have the best leaders who partner to govern operations. The most successful partnerships then find and employ the best *managers as implementers* of their approved strategies, tactics, policies, and procedures in support of the four pillars: outstanding clinical quality, service quality, productivity, and financial viability. The best integrated organizations never confuse or mix operational governance (where partnership is essential) and management. They avoid physician/management dyads that tend to create confusion in reporting and accountability.
- **Building a culture of accountability:** A culture of accountability includes three components. First is the *organizational will* to establish performance expectations and to insist on compliance with those expectations as a condition of membership (e.g., employment, contract, or affiliation) for everyone who wants to be part of the compelling vision. Second is *personal accountability* for individual contribution and commitment to achieving the desired results. Third is *joint accountability*—the teamwork required to establish and achieve functional performance commitments and clinical integration objectives. Such accountability is integral to effective performance and to individual and group incentives.

Summary

While legal and organizational structures are essential as forums for integration, they do not guarantee and often don't result in functional integration—wasting precious political, human, and financial capital. Capturing market share in primary care practices, attracting appropriate volume along the referral path to "specialists of choice" and to a "hospital of choice," and providing the most effective and efficient care requires integrated organizations that set and achieve their performance commitments. Partnership-led structures in each practice, across a practice network, and within each integrated service line, provide direction to manager/implementers in achieving clinical quality, service quality, high productivity, and financial viability as organizations move from structural integration to functional integration and beyond.

The Governance Institute thanks Marc D. Halley, M.B.A., president and CEO of The Halley Consulting Group, Inc., for contributing this article. He can be reached at mhalley@halleyconsulting.com.

3 Marc D. Halley, *Owning Medical Practices: Best Practices for Sustainable Results,* Chicago, IL: AHA Press, 2011, pp. 225–229.

4 James Surowiecki, *The Wisdom of Crowds,* New York: Doubleday, 2004.