Health system and physician group alignment: The strategies that don’t work — and those that do

Hospitals and health systems continue to grow closer to the physician groups and networks in their market. Irrespective of system size and revenue, breadth of physician network and local market dynamics, organizations are likely to encounter some familiar challenges in their efforts to ensure patient access, invest in physician infrastructure, and include physicians in governance and other initiatives to drive alignment.

Here, George Whetsell, FACHE, Managing Partner with Chicago-based Prism Healthcare Partners and Timothy Ogonoski, Managing Director with Prism, discuss the alignment of health systems and physician groups, including common yet misguided strategies, shared concerns between system CEOs, CFOs and CMOs, and specific actions systems can take in the next six to 12 months to drive physician engagement.

1. Can you share a “state of the union” on where most health systems and physician groups find themselves today? Based on your work, what are health systems doing well in that relationship, what are they rarely doing well and what challenges are they up against?

George Whetsell: “Some health systems employ hundreds of physicians and a few employ thousands, so the ‘state of the union’ varies widely. Most health systems are doing reasonably well in building their physician network, recruiting physicians and other providers, and setting up the infrastructure — offices, IT, registration, scheduling and billing systems, etc. But most systems are still having problems with the overall economics — many systems find they need to subsidize the physician enterprise by $150,000 to $300,000 per physician. Many physician networks still struggle with access, throughput and overall patient volumes; too many and overlapping offices; and an inability to coordinate across the system with other physicians and hospital services."

Timothy Ogonoski: “Approximately 10 years ago, the majority of physicians became employed by either a hospital system or large physician group. That trend continues upward today for a variety of reasons, namely payer pressure, provider recruiting and operational support expense coverage, and escalating medical school debt. Health systems, especially high-functioning health systems, have done..."
a good job of integrating providers into their strategic plans to expand medical offerings/quality and market share as well as to leverage insurance plans for higher rates.

Yet few hospital systems include providers in their operating committees, hold providers accountable for their own P & Ls, or hold providers to acceptable patient access and quality standards. Systems are challenged by ever-increasing practice subsidies, incorporation of quality and access standards into provider compensation and transient government laws.

2. Say you sat down for dinner with the CEO, CFO and CMO of a health system affiliated with an 850-physician group. Based on your conversations with health systems, what are the likely pain points each person encounters as they try to drive alignment with the physician group?

GW: “At most health systems, all three will be concerned about the financial performance of their network, how big the subsidy is and whether it is growing. They may also be concerned that while they are losing money, they hear stories of patients unable to get an appointment on a timely basis. They may be concerned about the capital investments they’ve made and are continuing to make in offices, IT, EMRs, etc. They might be concerned about leakage — their employed physicians referring patients to physicians outside their network or to competing hospitals.

If they are more sophisticated, they might discuss approaches to aligning the employed network with the system’s overall strategies. For example, we’re beginning to see success stories on value-based/ACO models where the health system receives a large savings incentive reward, and that reward is shared with the physicians.”

TO: “The CEO, CFO and CMO will all be concerned about patient access, reducing or eliminating subsidies, and how they are going to cover the coming gap of providers as physicians age out of their current positions. They should work to incorporate providers into their long-term planning solutions and account for the transition from volume to value (or some form of that), provider burnout, improvement of flow and skill within their EMR systems, and most importantly, providing the right services at the right locations at the right time across the entire system, not every location.”

3. Can you each share a misguided strategy for health system-medical group alignment?

TO: “The mistake most systems have made in the past is recruiting or purchasing physician groups with no plan on how to integrate them into the system and, in many cases, a promise that ‘nothing will change once you come to work with us.’ This was done for a few reasons, mostly as a hedge against market share losses and expediency. Now, many hospitals have experienced reduced provider production due to no requirement from the system that providers maintain access and productivity goals while they continue to be paid at pre-ownership salaries. Systems also then increase overhead with new EMRs, management (with little provider management expertise), locations, equipment, etc.”
GW: “It’s a misguided strategy to pay for production with no guidelines or constraints. Essentially the more patients the physicians see, the more they are paid — but if the patients have no insurance or are on Medicaid, the network may not be paid or may be paid less than the cost.”

4. What are 1-3 pieces of advice you’d share with a health system’s leadership team so they can have more productive conversations with their medical group?

TO: “Have very clear conversations about patient access, productivity, support staff, operational expectations and market strategy prior to making any hires. Tie recruitment to market strategy and capabilities, not a wish list. Make sure you understand what an FTE is for each provider, and hold them accountable to both specific individual and system goals, e.g. profit and loss, quality targets, patient access goals, patient panel sizes. Have operational and strategic plans for each group of goals with an abundance of input from each provider. Also align employment and remuneration with those goals.”

GW: “Check on ease of access — if a patient calls, how soon can he or she get an appointment? Check the individual physician scheduling templates and remove all unreasonable blocks or constraints. Set a target for available patient-facing hours by physician — this should be in the zone of 37 hours per week. Make sure the IT and EMR are physician-friendly and easy to use. Don’t be afraid to share performance and financial data/info with the physicians. Don’t be afraid to not renew contracts with underperformers.”

5. All things being neutral, what should executive teams prioritize, consider or execute in the next six to 12 months to drive physician engagement, reduce burnout, increase the return on investment, improve operational efficiency and/or reduce waste?

TO: “Give providers support that minimizes non-value added distractions, letting them focus on delivering the best care and improving patient throughput and quality. Include providers (those who are interested in administration and who are good at it, not the squeakiest wheels) in all operational and strategic planning. Develop and provide reports that include at a minimum patient access, productivity, profit and loss and quality reporting to each provider every month. Unblind that data to providers for both transparency and competition or sharing of operational excellence within the group.”

GW: “If executive teams are implementing value-based payment models that include an incentive/at-risk feature and they earn an incentive, sharing a portion of the incentive with the physicians will help align them with the strategy and offset the subsidy on the network. If not, then involving the physicians in the management of the network via a shared governance model will promote ownership and alignment. This does not necessarily mean sharing profits (or losses), since there likely are not any profits. But we find that physicians want to participate in decision-making, especially in areas that directly affect them. If done right, the physicians will deal with poor performers themselves — especially if it impacts their wallet.”