

# All Physicians Wear Lab Coats and Nine Other Myths Healthcare Executives Need to Know

## Building Realistic Strategies to Drive Physician Engagement and Productivity

Two healthcare systems employ medical groups. One improves productivity and saves thousands of dollars. The other experiences losses of up to \$75,000 annually per full-time physician and hopes to make it up in referrals to the hospital. Are both of these situations plausible? Based on lessons hopefully learned from the '90s – when hospitals were acquiring medical groups – healthcare leaders who establish realistic expectations when first engaging with physicians have a far better opportunity to realize true collaboration in an era of payment reform.

As hospitals and physicians continue to evaluate and participate in different alignment models, 10 common misconceptions can help provide useful insight into achieving a sustainable financial model.

### **MYTH 1**

#### **Employing physicians leads to better integration**

In the past, integration was often seen as an “all or nothing” proposition that required the full employment of physicians by the hospital. But today’s integration models provide a continuum of cooperative opportunities that can be tailored to meet the unique requirements of both. Stipends, gain sharing, joint ventures and management services organizations are examples along the integration continuum. Healthcare executives and physicians can evaluate all options based on the market and future goals.

### **MYTH 2**

#### **Our doctors trust that we have their best interest in mind**

Regardless of the type and degree of integration pursued by hospitals and physician groups, transparency is important and starts with setting realistic goals and identifying physician leaders and champions. A high level of credibility will be important to producing the changes necessary to create a sustainable healthcare industry. It will be important that physician leaders are able to use data and integrate it into performance improvement strategies while possessing the “soft skills” necessary to successfully execute policy.

### **MYTH 3**

#### **Compensation is key to collaboration**

While few people might argue that compensation is not important, in many cases where true collaboration is present, compensation alone is not enough. A shared goal of physician-hospital collaboration should be to create value for patients, physicians and hospitals. Collaboration results in win-win

## Market Dynamics:

*A survey done by the American College of Healthcare*

*Executives found that 72% of members were looking to align more closely with physicians.<sup>1</sup> While many doctors still want to remain independent, there is a growing number who are considering other options, including hospital employment.*

*For example, in a report by physician recruiter Merritt Hawkins, 74% of physicians said they plan on retiring, working part time, closing their practice to new patients, becoming employed or seeking non-clinical employment.<sup>2</sup>*

*Health care reform and the complex nature of the business of medicine in general are key drivers influencing the group practice landscape.*

scenarios that enlarge the economic pie rather than divide a predetermined, insufficient pool of money. Both parties gain if physicians act as owners rather than clients, increasing revenue and collaborating on ways to improve processes and outcomes.<sup>3</sup> It is also helpful for each function or department that contributes toward attainment of goals to have specific, measurable targets.

### MYTH 4

#### **Quality metrics and physician compensation cannot be done on parallel tracks**

Consider what happened when hospitals began buying up practices and employing physicians in the 1990s. Like a lot of hospitals at the time, doctors were brought in under a flat salary and in some cases productivity dropped. Fast forward to today. Restructuring physician employment by linking clinical and financial goals at the salary level is a viable option, particularly in consideration of pay-for-performance and other quality care initiatives. Therefore, setting physician salaries isn't just a job for the finance department anymore. There are productivity incentives, quality thresholds and bonuses for patient satisfaction that need to be taken into consideration.

### MYTH 5

#### **Annual performance reviews are an effective mechanism for providing physicians with feedback**

Performance reviews are an effective mechanism for providing physicians with performance feedback, but all too often they occur only once a year and fail to provide physicians with any insight into their ongoing performance. The result is physicians can be surprised by the evaluation and unable to adjust practice patterns throughout the year to compensate for shortfalls. One opportunity for hospitals is to implement a quarterly review process. At the start of the year a series of targets are set for physicians spanning both productivity and organizational goals. Performance is tracked and reviewed every 90 days. With feedback provided more consistently, there are no surprises at the annual review, which serves to decrease tension that could have previously surrounded these discussions.

### MYTH 6

#### **Informed decision making comes from the top down**

Until non-provider healthcare executives can admit and discharge patients, doctors have a key role in the financial and operational viability of the organization. But how many times does a doctor see a quarterly financial

statement specific to his or her department or area? The development and sharing of credible data related to utilization, cost and quality will be essential to making informed decisions by physician and hospital leaders on system composition, processes and incentives.

#### **MYTH 7**

##### **Doctors don't like technology**

Human nature is pretty basic when it comes to change. If you don't have a voice in the change, you are most likely not going to understand or support it. For example, when a hospital tackles the adoption of electronic health records for their physicians, do they look to the end user – the physician – for input to make sure the technology is user-friendly and meets their needs? Does the hospital explain the purpose for using the technology and what it hopes to achieve? While sounding fundamental in nature, without some measure of physician buy-in, hospitals run a higher risk that the new software will be outdated before it is ever truly used. On the flip side, it is usually unrealistic to think that hospitals can gain 100% consensus. Therefore, it may come down to getting as much feedback and buy-in as possible and then having the facts to back up the purchasing decision.

#### **MYTH 8**

##### **The billing expertise needed for hospitals is the same for physicians**

The question whether to build or outsource provider-based billing and collections is an important part of the relationship between a hospital and an employed medical group. With anticipated changes in ICD-10 coding and growing regulatory audits, provider-based billing has intensified. As a result, the need for specialized expertise to ensure the group's financial viability over the long term has become more important. When evaluating billing for medical groups, hospitals need to take into account the additional overhead, processes and technology required for optimal performance.

#### **MYTH 9**

##### **Potential culture clashes don't last long**

Culture is sometimes the overlooked factor when acquiring a medical group practice. It is important for hospitals to create a strong brand identity for the organization with a goal that every member of the organization can grasp and support. System-wide goals should be consistently applied across all areas

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of the organization — both clinical and non-clinical. In addition, leaders should encourage a close partnership between members of the executive team, with all members embracing the shared goals of the organization.

#### **MYTH 10**

##### **Collaboration develops over time**

While collaboration usually develops over time, the alignment of physicians and hospitals is usually achieved based on the actions both take to establish a joint structure, process, metrics and accountability. Consequently, it is this early collaboration that moves the organization forward.

##### **Summary**

Healthcare executives who strive to achieve improved physician alignment will need to build an integration model that best suits the needs of the community, the providers and the institution. While such an alignment may be a daunting task, it can be accomplished. Paying close attention to the achievement of agreed upon goals, establishing a collaborative culture, and identifying and reporting on key metrics from a financial and clinical perspective are all a part of a sustainable alignment model.

##### Sources:

- <sup>1</sup> *Physicians have leverage with hospitals in getting optimal practice set-ups*, *amednews.com*, American Medical News, November 15, 2010.
- <sup>2</sup> *Recruiters: Health reform may end independent private practice*, 11/22; Health Leaders Media, Merrit Hawkins report, 11/22.
- <sup>3</sup> *Mending the Gap between Physicians and Hospital Executives*, The Business of Healthcare, 611-394-V2-002.indd, 2007.

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