EXECUTIVE REPORT

MAKING HOSPITAL-OWNED PHYSICIAN ORGANIZATIONS WORK

In the early and mid '90s, many health systems eagerly purchased physician practices to secure referrals, grow market share and prepare for capitated contracts. At the same time, physician groups were seeking partners to invest in infrastructure, provide additional management capabilities, assume risk and capitalize on partner equity. These arrangements seemed mutually advantageous, and met with the approval of hospital CEOs, board members and physicians.

A few years later, some portion of anticipated benefits has been realized, but new challenges loom large. Most compelling among the problems is disappointing financial performance. This executive report addresses how hospitals can engage physicians in returning these owned practices to financial viability with the added benefit of a more positive working relationship.

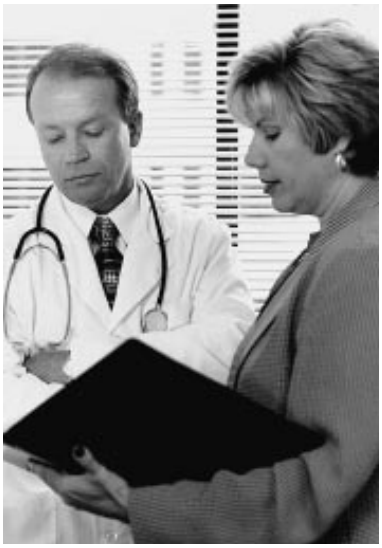
"The world we have made as a result of the level of thinking we have done thus far creates problems we cannot solve at the same level we created them." – **Albert Einstein**

According to many published surveys, hospital-owned practices generate an average annual operating loss of $46,000 to $54,000 per physician, with losses in excess of $100,000 per physician not unusual. Even allowing for incremental downstream revenue, such losses are difficult to justify and sustain, especially when health systems are being scrutinized for potential Stark violations.

Further stifling progress is the fact that physicians often develop serious misgivings about new arrangements with their hospital-owner. Pressure to improve physician productivity and financial performance often results in physicians feeling a loss of control and power. Too often, individual incentives are poorly aligned, providing few rewards for increased productivity. CEOs and administrators are caught in the middle between boards demanding improvement and physicians verbalizing disenchantment.

A wise observer once remarked, "When alligators are nipping at your heels, it's difficult to remember the initial objective was to drain the swamp." Faced with new challenges, beleaguered executives and physicians often start questioning:

Should we stay together or part ways? Are these temporary growing pains or early manifestations of eroding trust and goodwill? Are the differences too great to allow for full realization of the potential benefits of integration?



Following close examination, health systems and physician groups are likely to reaffirm the legitimate basis for their coming together, provided progress can be made on new problems created by integration.

Einstein's axiom noted previously suggests the need for creative approaches and new possibilities, rather than retreat and dissolution.

To be effective, a new approach for managing hospital-owned practices needs to address fundamental concerns of both physicians and administrators. Some of these include:

- Physicians' desire and need to play a central role in managing day-to-day operations. The practice should be physician-led.
- Physicians and administrators must commit to common objectives based on a realistic assessment of markets, competitors and enlightened self-interest. Leadership must coalesce around a shared purpose and articulated plan.
- Practice leaders require effective tracking tools to support informed decision-making. These tools should capture objective, quantifiable data, portrayed with a private practice mentality, while reflecting differences by specialty.
- Open-book financial management should be used to educate and train physicians and practice leaders, building trust throughout the organization.
- Real accountability needs to be operational, holding practice leaders and physicians responsible for meeting financial, quality and service targets.
- Compensation should be linked to performance, though this need not be strictly formulaic.

When pursued as part of a comprehensive change-management process, this new model of practice management can transform organizational performance. Two recent examples demonstrate the potential for dramatic improvement.

CASE STUDY A

Situation

In the early '90s, Charter-North Shore Health Systems of southern Massachusetts acquired more than 80 physician practices. Geographically dispersed across its service area, these practices are part of a cohesive strategy to dominate local healthcare markets along a continuum of services. Despite numerous efforts at improving financial performance, deficits in these physician practices continued

to mount, approaching $10M per year, or about $117,000 per provider. Senior leadership was divided as to how to proceed, though all agreed the situation was economically unsustainable. At the same time, physicians and their leaders were frustrated by failures of the health system's infrastructure to keep pace with new acquisitions and address longstanding operating problems. Given a lack of progress and significant provider discontent, divestiture of the practices was under serious consideration. However, this option involved serious risks to Charter-North Shore. Competitors were on a "shopping spree" for physicians and would likely acquire divested practices, threatening Charter's market position and impeding its ability to compete for contracts with payors.

Impact

Following a physician-led redesign effort, practice leaders submitted a first-year budget projecting a deficit of $4.9M, about one-half that of the previous year. The fiscal year ended with the physician organization exceeding its budget by $200,000, and the deficit was completely eliminated the following year. Now operating at breakeven, Charter-North Shore's group practices compare favorably to "best practice" standards. Physician productivity improvement ranged from 15% to 50%, depending upon specialty. Physician leaders have assumed enhanced roles in the health system, functioning as key decision-makers and full partners. In 1998, Charter-North Shore modified its incentive plans, providing additional compensation to reward productivity, both as individual practitioners and as a group practice. Today, the health system is actively recruiting additional physicians to join the practice.

CASE STUDY B

Situation

Throughout the '90s, a large western U.S. health system acquired more than 170 physician practices. As part of its commitment to building an integrated network of services spanning the continuum of care, this system took the approach of physician practice ownership. However, as practice deficits grew in excess of $16M per year, or $96,000 per physician, senior leadership was questioning whether the strategy could be sustained. At the same time, physician relations were on a downward spiral, and divestiture of physician operations in the system's Southern region was deemed inevitable with the Northern region close behind.

Following close examination, health systems and physician groups are likely to reaffirm the legitimate basis for their coming together, provided progress can be made on new problems created by integration.

Whatever the outcome, a comprehensive change management program results in physicians who are more sophisticated and better informed having directed and participated in their own turnaround initiative.

Before agreeing to part ways, system leadership presented a 55-physician group in their Northern region with an opportunity to redesign the practice and significantly reduce their $8M loss. Faced with stark options—divest or turn around the practice—physicians elected a new board of directors for the medical group. After considering partnering opportunities in the surrounding market, physicians agreed that redesigning the practices represented the best opportunity to influence change and increase control of their professional destinies. Physician leaders from the 18 practice sites were selected to participate in three design teams whose mandates included:

- Create guiding principles critical for managing a successful group practice.
- Develop an in-depth understanding of the physician organization's economics and the flow of funds between the practices and the health system.
- Complete comparative productivity and compensation benchmarking for physician practices.
- Create an "integrated leadership model" providing peer accountability for financial and productivity performance while maintaining collegiality.

Impact

After completing its financial and productivity assessment, physicians agreed to reduce current year operating losses by about one-half, or $52,000 per provider. In the first year, the group reduced the per-provider loss to about $62,000. While the turnaround continued, with the group on track to further reduce losses, the health system's parent company experienced both significant deterioration in their financial situation and key leadership changes at the head of the organization.

As a result, the health system and its physicians are once again revisiting key strategic questions and are grappling with whether to continue the turnaround or begin a divestiture process. Leadership members are continuing to ask themselves five key questions surrounding their primary care physician practice strategy[2]:

- Do we have the talent and resources for continued turnaround initiatives?
- Do we have enough time?
- Can we afford to continue suffering losses while we forge ahead with the turnaround?
- Can we afford the "distraction" of continuing in the physician practice management business?

- Do we have a compelling vision to be in primary care practice ownership?

The answers to these questions will ultimately determine the system's on-going physician strategy in this market. Whatever the outcome, the physicians are more sophisticated and better informed having directed and participated in their own turn-around initiative. If divestiture is chosen, physician leaders are better prepared for what independence and private practice means to them. For some, it would be a return to what they knew before being acquired. For others, independence is uncharted territory. Both physicians and the health system are committed to a smooth transition and continued alignment with each other in their respective market areas, should divestiture occur.

A CLOSER LOOK AT REDESIGNING PRACTICES

Both of these health systems called upon CSC's Healthcare Group to facilitate redesign of their owned practices. While work plans were customized to each situation, a number of common elements emerged as key factors in both processes:

- Redesign was achieved using a three-phase approach (see Figure 1).
- Prior to formal commencement of the project, health system leadership and physicians committed to a set of operating principles to guide the work. Typical examples include:

Establish a leadership group of physicians and administrators to develop recommendations and prepare materials for discussion with the whole physician organization.

Train and develop physician leaders to understand the financial underpinnings of the health system and physician practices and have them present their findings to their physician colleagues.

Use quantitative data and rigorous analysis, where possible, to support informed decision making.

Develop specific operating policies for a successful group practice.

Share all information openly and be completely forthcoming in all exchanges.

Revisit leadership structure, roles, responsibilities and appointments in order to empower physicians to manage the practice.

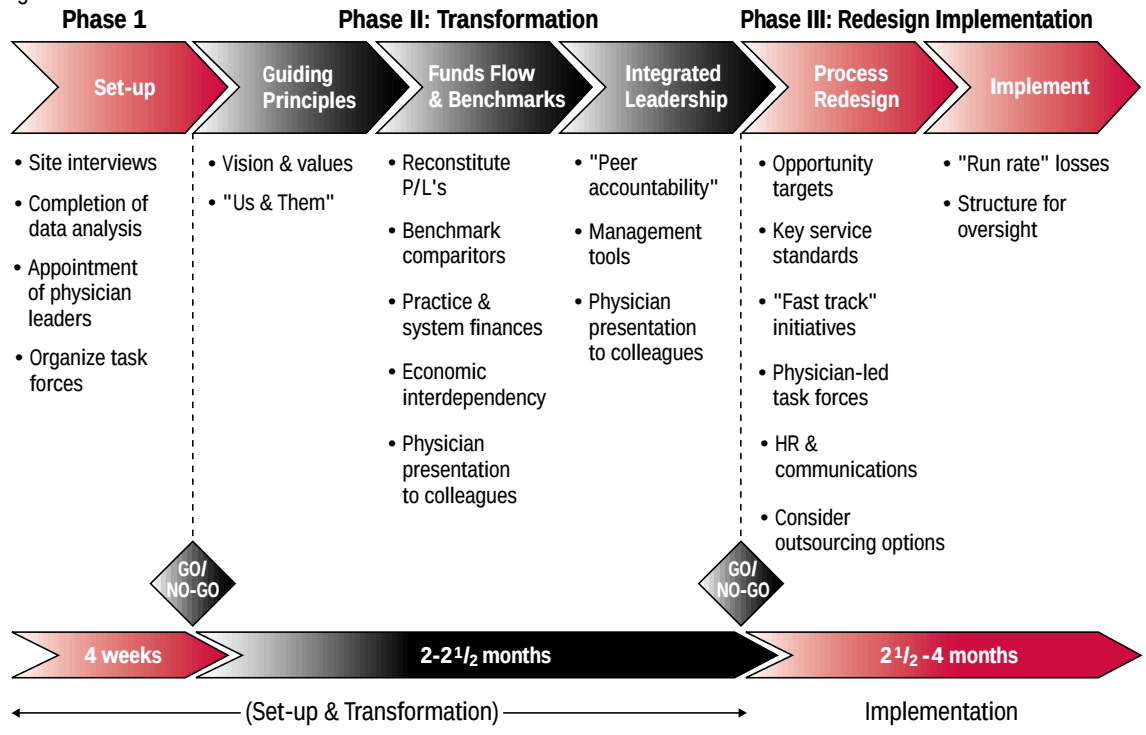
Explore other options, including divestiture, as deemed appropriate by the leadership group.

Honor past agreements, but do not allow the future to be determined by them.

- At the end of each phase of the process, health system leadership and physicians evaluated their progress and level of commitment, and then made an informed decision about whether to move forward. A retreat was organized at which physician leaders presented design team recommendations to rank-and-file physicians. After communicating progress and implications to their colleagues, the physicians took a formal vote on whether to move forward or pursue other options. These were watershed events where commitment to future direction was forged.
- Following an affirmative vote by membership, recommendations were implemented. These included revising budgets, instituting peer accountability, convening design teams to determine methods for achieving goals, and implementing "quick hits."

Three Phase Overview

Figure 1



KEY SUCCESS FACTORS

While all work steps in the redesign process are important, four factors have proven most crucial in achieving successful outcomes. When executed effectively, these steps produce a framework for managing hospital-owned practices in a manner that is consistent with the shared goals of both the health system and practices and which provides physicians with degrees of autonomy and self-governance. Key success factors include:

- ***Coalescing health system and physician leadership*** around a shared vision of the future and the need to manage the practice to achieve shared goals.
- ***Establishing a peer-review accountability process*** with authority for recommending corrective measures to bring operating units in compliance with the stated goals and policies of the practice.
- ***Providing timely, accurate information*** that details the financial performance of each operating unit within the practice and the productivity of each physician within operating units.
- ***Revising compensation systems*** to link a portion of physician and leadership compensation to individual and group productivity, respectively.

Together, these key success factors lay a foundation for successfully managing physician practices. Each factor is examined in more detail below.

Coalesce Leadership

The most important step in the transition to effective management of owned practices is the establishment of shared goals for the health system and the physician organization in a context of market and financial realities. This requires significant education about the emerging environment and its implications, current financial trends and projections, recent performance measures, variances across and within the practices and timing considerations.

The most important step in the transition to effective management of owned practices is the establishment of shared goals for the health system and the physician organization in a context of market and financial realities.

New leadership and accountability processes must be established for balancing individual interests with those of the practice as a whole. Physician leaders need to be rewarded for addressing politically sensitive issues in order to advance the interests of the entire system. This requires a transformation of culture and a transfer of loyalties that will only be possible when a broad base of physician leadership is engaged in constructive dialogue aimed at managing resources, increasing productivity and improving performance.

An advisory committee of practice leaders broadens the role of physician leadership in managing fiscal affairs and productivity for the overall physician organization.

As noted previously, this transformation can be initiated during a leadership retreat of health system and physician leaders. During the retreat, leadership defines new processes for managing the practice which will achieve clearly defined goals. A compelling "case for change," prepared with the active involvement of physicians, is presented and discussed in open, lively exchanges. Proposals are put forth for organizing an advisory committee of medical leadership to develop policies, practices and accountability processes for managing the practice to achieve its goals (see "Establish Peer-Review Accountability" segment to follow). A structure for accountability, performance measurement and alignment of interests is defined and embraced by leadership. Participants agree to a timeline for implementing changes and reviewing progress. The cornerstones of successful physician practice management begin to move into place during this retreat.

Establish Peer-Review Accountability

Command-and-control accountability, so prevalent in health systems, is largely foreign to the culture of physician practices. On the other hand, peer-review processes are proving effective in motivating change and modifying behavior. Building on this insight, an advisory committee, comprised of eight to 10 practice leaders and supported by health system staff, can review the performance of all aspects of the entire physician organization and prepare recommendations for each of the individual physician practice leaders. The mandates of this advisory committee are to:

- Access and review all necessary financial and productivity information.
- Advise health system and practice leaders on fiscal affairs and physician productivity.
- Develop operating policies to specify financial and productivity goals, rank practice funding priorities and manage faculty compensation/incentives, etc.
- Recommend productivity targets for individual physicians and practices.
- Develop plans to eliminate any negative budget variances.
- Hold physician practice leaders accountable for achieving performance goals.
- Manage turnaround situations, as necessary.
- Serve as a "budget hearing" committee for practice leaders.

- Develop strategies for funding investments in practice priorities.

This advisory committee broadens the role of physician leadership in managing fiscal affairs and productivity for the overall physician organization. At bi-weekly meetings, the advisory committee works through issues and prepares specific recommendations for the CEO. After review and any necessary modification, recommendations of the advisory committee are presented to rank-and-file physicians in the practice.

Once approved, policies and performance goals become binding on all levels of the practice. The advisory committee reviews actual performance to ensure compliance with established policies and achievement of performance goals. Matters that come before the advisory committee are resolved quickly and collaboratively. The CEO retains ultimate authority for managing the physician organization while involving a broad base of peers to ensure accountability for meeting overall goals.

Providing Timely, Accurate Information

Once constituted, the advisory committee is highly dependent on timely, accurate information to fulfill its mandate. It is essential that the committee agree on performance measures and develop productivity and fiscal performance tracking tools in support of an effective peer-review accountability process. In some practices, these tools may already exist;

Ultimately, the ability of the physician organization to effect improvement in performance will depend on leadership communicating its commitment to change.

Figure 2

Performance Indicators

- Physicians per session
- RVU's per provider (normalized)
- Clinic visits per session
- Visits per physician per session
- Support staff costs per visit
- Support staff per physician
- Skill mix
- Staffing to demand
- Facility costs per visit
- Visits per square foot per year
- Non-labor costs per visits
- Residents per medical student rotations*

*for practices affiliated with teaching hospitals

A new compensation system is most likely to succeed when it allows time to increase productivity; provides specific information about individual performance; and encourages leadership to work actively with physicians on improving productivity.

for others they may need to be created. Working closely with the CEO and the advisory committee, appropriate measures of performance can be established (see Figure 2).

Performance indicators should be formatted into user-friendly reports for use by leadership in monitoring performance and identifying opportunities for improvement.

Revise Compensation Systems

Ultimately, the ability of the physician organization to effect improvement in performance will depend on leadership communicating its commitment to change. The most effective method for getting the organization's attention is to link performance to compensation and leadership opportunities. This can be a highly sensitive undertaking, especially if historical arrangements have not tied compensation to individual, practice or group productivity. A new compensation system is most likely to succeed when it allows time to increase productivity; provides specific information about individual performance; and encourages leadership to work actively with physicians on improving productivity.

Physicians can be very receptive when information regarding personal performance, peer standing and site economics is shared in candid, personal discussions. This gives them valuable feedback while encouraging them to manage their own performance. Working with human resources and legal counsel for the health system, options should be developed to modify compensation systems to be consistent with the goals of rewarding practice and individual contributions.

CONCLUSION

The precepts which brought physician groups and health systems together earlier this decade are often still valid and there is hope for an on-going positive relationship and improved financial picture in many cases.

With these major components of a comprehensive change management process in place, a foundation is laid for managing owned practices more effectively as a means of improving financial performance and increasing physician satisfaction.

[1] Health Care Advisory Board, Physician Defection, Physician Retention and Long-Term Physician Partnerships, 1998

[2] Health Care Advisory Board's 1999 National Membership Meeting

About the Authors:
David Hefner and Dwight Monson are co-directors of CSC's Healthcare Group physician services practice.

For more information, call 1.800.CSC.4799.

About the Healthcare Group
CSC's Healthcare Group is the country's largest full-service consulting and information technology (I/T) services company committed exclusively to healthcare. Our end-to-end solution sets are built around best-of-breed capabilities tailored to the unique business requirements of each sector of the healthcare industry—payors, providers, and life sciences organizations. An operating unit of Computer Sciences Corporation (CSC), a world leader in the use of information technology, CSC's Healthcare Group is committed to being the best and most comprehensive service organization in healthcare.

Computer Sciences Corporation

Healthcare Group
1325 Avenue of the Americas, 6th Floor
New York, New York 10019
+1.212.401.6000

Worldwide CSC Headquarters

The Americas
2100 East Grand Avenue
El Segundo, California 90245
United States
+1.310.615.0311

Europe, Middle East, Africa
279 Farnborough Road
Farnborough
Hampshire GU14 7LS
United Kingdom
+44(0)1252.363000

Australia/New Zealand
460 Pacific Highway
St. Leonards NSW 2065
Australia
+61(0).2.9901.1111

Asia
139 Cecil Street
#08-00 Cecil House
Singapore 069539
Republic of Singapore
+65.221.9095

About CSC

Serving industry and government for 40 years, CSC is a global, multibillion dollar company recognized as a world leader in the strategic use of information technology to achieve business results. No other company offers the range of professional services at the level of quality we provide in e-business strategies and technologies, management consulting, information systems consulting and integration, application software and I/T and business process outsourcing.

www.csc.com
1.800.CSC.4799

Printed in USA 9/99 990260