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New research and expert opinions in the area of hospital and health system governance.

## What's Inside



# A Problematic Repeating Pattern of Physician Beliefs in Community Hospitals and Health Systems

***By Daniel K. Zismer, Ph.D., Co-Founder and Managing Director, Greg Carlson, Ph.D., Senior Advisor, Greg Hagfors, M.B.A., Managing Director, and Elliot D. Zismer, M.S., Co-Founder and Managing Director, Castling Partners, LLC***

Most community hospitals and health systems in the U.S. are in a transition from independent physicians dominating the composition of medical staffs to employed physicians assuming this position. Depending upon where an organization is in this transition, the relative proportion of these two groups can create challenging dynamics for organizational success and stability. Governing boards, along with senior leadership teams, should understand how related dynamics and potential "situational disorders"[1] can affect organizational performance and culture.[2]

## An Undeniable Shift in the Physician Services Business Model

By the end of 2016, more than 40 percent of all physicians in the U.S reported being employed by some form of organized health systems (including academic health centers), an increase of more than 60 percent from mid-2012.[3] All regions of the U.S. report participation in this trend. Conversations with leaders of community hospitals and health systems demonstrate that virtually all are experiencing this transition with expectations that employment of physicians will continue to accelerate. A growing number of leaders report the proportion of employed physicians exceeding 50 percent and are on the way to higher levels. This trend crosses all clinical specialties, most notably those where the economics of independent practice have turned unfavorable.

Leaders of community hospitals and health systems should recognize the risk of reductions in the supply of independent physicians required to support key mission-driven and strategic programming for community hospitals. Two risks

1 Daniel K. Zismer, "The Social Psychology of Clinical Service Line Management; A Model and Method for Dyads to Understand and Manage the Inevitable 'Situational Disorders,'" Castling Partners, April 2017.
2 Daniel K. Zismer and Benjamin Utecht, "Culture Alignment, High-Performing Healthcare Organizations, and the Role of the Governing Board: Part Two: Setting a Culture of High Performance and the Responsibility of Governing Boards," The Governance Institute, E-Briefings, Vol. 15, No. 3, May 2018.
3 Physician Advocacy Institute, *Updated Physician Acquisition Study: National and Regional Changes in Physician Employment 2012–2016*, March 2018.

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are to be considered here. The first is that independent physicians are available to the community, but not the hospital; the local independent physicians become competitors of the hospital. Second, as the supply of independent physicians declines in a market (for whatever reason), the hospital does not position itself for timely responsiveness to the future threat (or potential); it waits too long and market and financial stability risk becomes irretrievable.

## Key Board Takeaways

Governing boards should work with senior leaders and physician leaders to understand:

- The status and expected direction of the ratio of employed to independent physicians, by specialty, over the next five years with related rationale presented by senior leaders.
- The organization's current and projected net operating margin and net operating cash flow productivity derived from the work of employed and independent physicians over the next five years.
- The "alignment" of key stakeholder groups on the whole of the variable set presented here to serve as a road map to the integrated culture that will be required to effectively meet mission and strategic goals in the face of increasingly complex health policy and related market dynamics.

## Understanding the Risks Inherent with the Independent-to-Employed Physician Organizational Transitions

As hospitals and health systems add to the ranks of the employed physicians, there is usually a reaction to be expected from independent physicians that is understandable in the context of social psychological theory. Data from the Stakeholder Alignment Survey demonstrates a need for a watchful eye, open communication, and a ready plan of response to the inherent risks.[4]

One sound, well-researched, and practiced social psychological theory applicable to organizations in transitions suggests that the behaviors of identified stakeholders (including their attitudes toward the organization) are influenced by expectancies for rewards they value. When these expectancies and valued rewards remain available, behavior patterns can be predictable. Disruptions in expected rewards and changes in perceived values of rewards can lead to behavior pattern change. Let's examine this theory in the practical.

Historically, independent physicians composed the more substantial proportion of a community hospital's medical staff. These physicians were the gatekeepers of patient utilization of the hospital, controlled the number and supply of physicians in community markets served, and controlled the acquisition of profitable office-based ancillary services with little concern for reprisal from the hospital. If there were competing hospitals in the market, they enjoyed the potential for leverage through "hospital admission redirection." With changes in the economics of the private medical practice coupled with related shifts in the political and regulatory environments, community hospitals and health systems entered the business of employing physicians. As hospitals grew their base of employed physicians the expectancy for the implied leverage positions began to shift for the independent physicians. The hospital is no longer the "workshop" of the private practitioner. Consequently, the hospital becomes more of a direct competitor, and the availability of the patient supply can be perceived by independent physicians as being at risk. Some or all of these dynamics are viewed by independent physicians as a tectonic shift in their expectancies for personal and professional control over their worlds, and they may perceive their livelihoods to be threatened.

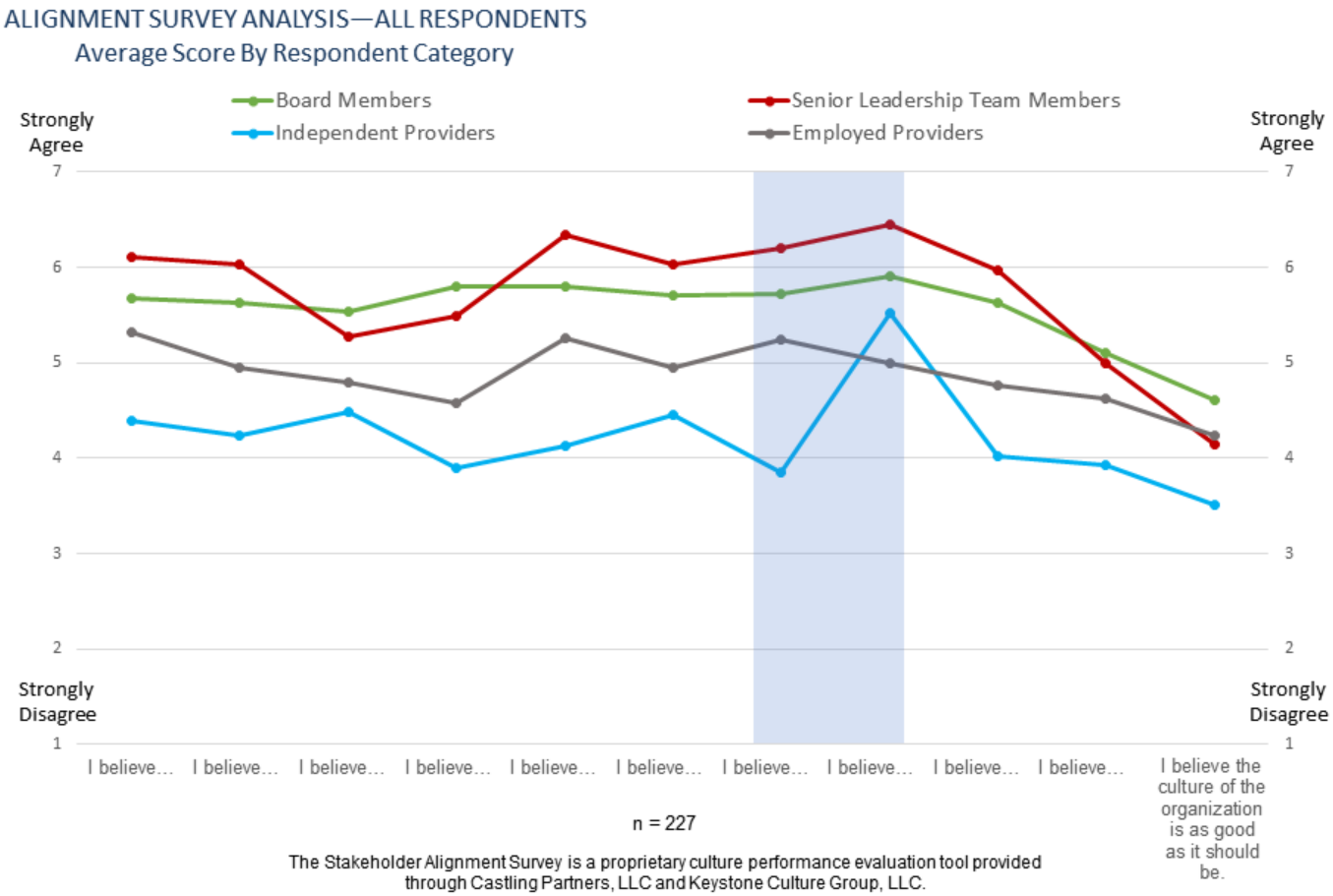
## What Does Our Data Tell Us?

The Stakeholder Survey evaluates stakeholder alignment on 11 factors in health systems (see **Exhibit 1**). Stakeholders of interest here are members of the governing board; members of the senior leadership team; a representative sample of employed physicians, including formal and informal leaders; and a representative sample of independent physicians who are members of the formal medical staff of the affiliated hospital(s). The survey presents respondents with 11 "belief statements"[5] representing a cohesive model that demonstrates alignment between stakeholder groups. A range of analytics is applied to demonstrate alignment congruities and incongruities between and among stakeholders.

4 The "Stakeholder Alignment Survey" is a proprietary organizational performance evaluation instrument developed, owned, and applied by Castling Partners, LLC (www.castlingpartners.com) and Keystone Culture Group, LLC (www.keystoneculturegroup.com).

5 Daniel K. Zismer and Benjamin J. Utecht, "Why a Belief System is Essential to the Success of Culture in Organizations: An Application to Healthcare," The Keystone Way, Vol. 1, Issue 1, June 2018.

## Exhibit 1: Stakeholder Alignment Survey—Average Score by Respondent Category




While the complete data set demonstrates an array of useful findings, the one of interest and import in this article is what is found to be a reliable and repeating pattern represented between items seven and eight in Exhibit 1. Here, stakeholders are asked about their "beliefs" as they relate to how "the organization values independent physicians" (item #7) and how "the organization values employed physicians" (item #8). Of the reporting stakeholder groups, members of the governing board, members of the senior leadership team, and members of the employed physician group will, reliably, assert that "they believe" the independent physicians are valued at levels far higher than the independent physicians self-report. Correspondingly, the independent physicians will affirm a belief that the employed physicians are valued at a level significantly higher than they. Additional examination of the Stakeholder Survey results supports the observation that this finding is strongly predictive of related beliefs worthy of leaders' attention (see sidebar on the next page).

### What Might These Findings Mean for Hospitals and Health Systems and What Are the Risks?

Let's return to our theoretical, social psychological framework for answers to this question. Remember what the theory asserts regarding the motivators of behavior change (and attitude is a behavior). Behavior change is a function of peoples' expectations for a reward that is valued. Within this framework, personal and professional control is considered to be an expectancy that is valued. Changes in either the expectancy or reward variables can affect behaviors. So, under certain organizational, environmental conditions, independent physicians may be motivated to modify their behaviors in a way that is not supportive of a hospital's/health system's mission or strategic path. Independent physicians have an extensive repertoire of behavioral

opportunities available to them when they don't feel they are adequately valued and believe their personal and professional freedoms are threatened. Examples include opportunities to shift hospital affiliations and related patient volumes, invite health system competitors to the community as partners, consolidate multiple independent practices to enhance "critical mass" and operating scale and add competing services, and sell their practices to regional competitors.

## How Should Boards and Senior Leadership Teams Think About This?

First, don't assume the collective leadership of the organization (including the board) knows how the employed and independent physicians perceive their value as it relates to each other or other stakeholders in the organization. The data supports a reliable pattern of misunderstanding. However, if you ask the related questions correctly, physicians will tell you. Second, and according to the social psychological theory presented, when high-achieving, well-educated, and trained professionals who are in demand believe they are "trapped" by situations where their freedoms and/or rewards availabilities (including psychological and emotional rewards) are constrained or threatened, they are likely to seek resolve by all options at their disposal.

Results from a number of administrations of the Stakeholder Alignment Survey demonstrates an undeniable "problematic repeating pattern" of beliefs that is worthy of understanding by hospital boards and senior leadership teams. The results showed that the extent to which independent physicians believe they are "less valued" than their hospital-employed peers can also affect:

- Their beliefs as they relate to mission effectiveness of the organization (i.e., the likelihood that independent physicians believe in how the board is directing the mission).
- Their beliefs as they relate to strategic plan effectiveness (i.e., the likelihood that independent physicians believe in the strategic direction of the organization).
- Their beliefs as they relate to resource availability (i.e., sufficient resources are made available to providers in the hospital to care for their patients).

What can be done if the pattern reflected in the Stakeholder Survey portends challenges for hospital and health system leaders? Related response patterns from the survey are helpful. Physicians' beliefs regarding the state of whether "the culture of the organization is as good as it should be" is strongly associated with perceptions of "being valued" as is the collective leadership's approach to "open and honest communication." Boards and board behaviors are implicated in the results as well, especially as they relate to holding those who serve the organization to "high levels of performance accountability," "how financial resources are controlled," and "providing resources sufficient to provide a high quality of care."

It is noteworthy that the state of stakeholder alignment is affected situationally. What is predictive of stakeholders' perceptions of how well the organization is governed and managed (at a point in time) is not static; it can and will shift over time based upon environmental conditions. As cited above, the state of the culture of an organization is susceptible to change based upon any number of leadership decisions and market conditions. Stakeholder alignment in community hospitals and health systems should be considered a priority for governing board evaluation and discussion at board meetings and strategic planning sessions. The topic of discussion presents in the form of a question: Do affiliated physicians (whether independent or employed) feel sufficiently "valued" by leadership, and if not, how might the organization be at risk?

*The Governance Institute thanks Daniel K. Zismer, Ph.D., Co-Founder and Managing Director, Greg Carlson, Ph.D., Senior Advisor, Greg Hagfors, M.B.A., Managing Director, and Elliot D. Zismer, M.S., Co-Founder and Managing Director, Castling Partners, LLC, for contributing this article.* *They can be reached at daniel.zismer@castlingpartners.com, gregcarlson2018@gmail.com, greg.hagfors@castlingpartners.com, and elliot.zismer@castlingpartners.com.*

# The Intersection of Mission and Margin

*By Alexandra Normington, Director of Communications, Juniper Advisory*

As healthcare has transformed from a nascent local patchwork of services to one of our country's leading industries, hospitals hold steadfast to their missions that have roots going back a century or more.

The precursors of many public and non-profit hospitals were almshouses or sanitariums created by municipalities or religious orders. These institutions treated the infirm and indigent and were funded largely by benevolent organizations, local public coffers, and personal donations. Patients paid whatever and however they could for care. In detailing their institution's history, hospitals fondly evoke early 20th-century fundraisers held by school children, women's auxiliary groups, and the like to purchase medical supplies and equipment.

Today, hospital care in the U.S. is a trillion-dollar industry. Mega-mergers among health systems are announced with increasing frequency. New access points are springing up outside the walls of hospitals. Municipal taxpayer funding for publicly sponsored systems and for non-profit tax exemptions is tenuous. Naming rights are negotiated with endowments for select organizations able to attract big donors. All of this falls against a backdrop of unstable government- and employer-based health coverage policies, declining reimbursement, and burdensome out-of-pocket costs for consumers.

So much has changed, but the main tenets of every hospital's mission have remained the same: ensure access to compassionate, quality care and advancement of community health.

Yet, as any CEO will tell you, a modern charitable bent may earn a tax exemption, but it does not ensure the revenues necessary to keep a hospital's doors open. No margin, no mission. Without a functional hospital, charitable endeavors are moot. The need to fulfill a hospital's historic altruistic mission must be reconciled with the need for that hospital to successfully operate as a business in a complex and competitive industry. These drivers are not diametrically opposed; they are the reality of the American healthcare system.

Hospital boards and senior leaders are charged with preserving their institution's mission by interpreting it with a contemporary lens and setting a course of action that will ensure the hospital's ability to serve its patients and stakeholders in the near- and long-term—from maximizing the deployment of resources to best serve the community and operate efficiently, to cultivating mission as a staff motivator, to proactively identifying and filling gaps as access to care and population health indicators fluctuate.

Either out of foresight or financial necessity, hospitals of all sizes are exploring partnership opportunities. A partnership can help a hospital advance care quality, shore up its administrative and clinical operations, and gain meaningful scale. Above all, the key area of alignment hospitals seek in a partner: mission.

Community board members often believe in principle that there can be value in a business combination with a larger, like-minded health system. Such organizations specialize in healthcare operations and are well positioned to ensure optimal stewardship of a hospital's mission and resources. What can cause stress, however, are concerns about dilution of local control or differences in ownership structure and implications for the mission.

In evaluating potential partnerships, the board must assess the feasibility of continuing as a standalone in an industry that increasingly rewards scale and systemization, as well as benefits and drawbacks of joining a larger organization, taking a hard look at which outcome truly aligns best with the hospital's mission.

The days of every neighborhood or small town having its own independent hospital have passed. It may no longer be financially

## Key Board Takeaways

To ensure the healthcare organization is fulfilling its mission and able to compete in today's complex industry, boards should:

- Regularly evaluate their hospital's mission to determine if it remains feasible for the hospital to achieve and relevant to its community.
- Discuss the questions posed in the article (around relevancy, fidelity, recognition, and sustainability) with a complete understanding of the hospital's performance, local and national dynamics impacting care delivery, and community health needs.
- Consider how a mutually beneficial partnership with a health system that has additional clinical and operational expertise, financial resources, and opportunities for scale could sustain the hospital's mission.

Above all, the key area of alignment hospitals seek in a partner: mission.

feasible nor clinically appropriate. It is incumbent on each hospital to forge its own future in the modern healthcare landscape on behalf of its community. The board and management team have a responsibility to routinely assess its mission and consider:

- **Relevancy:** Does the hospital's mission still reflect the needs of its community? What unique role does the hospital play in the regional health ecosystem?
- **Fidelity:** Is the hospital true to its mission? How is the hospital advancing its vision for its community? Is the organization prioritizing independence over mission?
- **Recognition:** Is mission top of mind for leaders and staff in their day-to-day work? Do patients and stakeholders perceive the hospital as a provider of mission-driven care?
- **Sustainability:** Does the hospital have the resources and expertise necessary to uphold its mission now and in the future? If not, what are possible alternatives to preserve the hospital's mission?

These questions should be discussed with full understanding of the hospital's financial and operational performance, competitive landscape (including looming market entrants), regulatory factors, and community health needs.

A hospital's primary purpose is to care for its community, protecting life and livelihood, regardless of its size, ownership, or geography. Boards must continually evaluate the underpinning of their mission, how it relates to their service to the community today, and take a mission-forward approach to strategic decision making to ensure long-lasting fiscal and philanthropic sustainability.

*The Governance Institute thanks Alexandra Normington, Director of Communications at Juniper Advisory, for contributing this article. She can be reached at anormington@juniperadvisory.com.*

# Aligning Physician Compensation in a Pay-for-Value Era

***By Jon Burroughs, M.D., M.B.A., FACHE, FAAPL, President and CEO, The Burroughs Healthcare Consulting Network, Inc.***

Many physicians are compensated today based upon work relative value units (wRVUs), a standardized formula that associates value with volume, intensity, and resources worked. The intent is to create a fair market value approach to linking physician compensation with work and effort in a volume-based industry. The assumption is that the more a physician does, the more a hospital or health system will earn, thus aligning the efforts of physicians with those of the organization.

This methodology has a number of significant flaws including:

- Physicians who perform procedures are valued at a much higher rate than physicians who perform cognitive tasks.
- The assumption is made that quality is constant and therefore should not be factored into either the rate nor the conversion factor.
- It is generally assumed that the faster a physician works, the more she/he should be compensated regardless of the potential impact on quality, safety, service, or cost.
- Aligning with volume will generally lead to improved financial performance.

Thus, the traditional methodology for physician compensation may paradoxically undermine quality, safety, service, and

financial performance. Healthcare organizations that utilize a robust cost accounting system have actually found that almost half of physicians inadvertently generate a negative margin due to their variable costs exceeding the fixed payments received.

Most agree that the traditional physician compensation methodology should be replaced by a method that aligns physician compensation with value and organizational/payer success and drives superior clinical and financial outcomes.

The following represents an approach that can align the efforts of clinicians with the organizations in which they work to achieve mutually agreed-upon goals and objectives.

## 1. Align with All Employed and Self-Employed Physicians

Partnerships with both employed and self-employed physicians is far more effective than hierarchy and supports both engagement (pride of ownership) and alignment of interests between physicians and the healthcare organization. This is accomplished through the creation of co-management relationships that reward physicians for both clinical and managerial performance in a way that meets fair market criteria for both. Some executives assume that fair market value is a constant value based upon clinical specialty. However, clinical work has a separate fair market value from management responsibilities; management fair market value can increase proportionally to the economic parameters involved such as operating or budgeted revenues. For instance, someone overseeing covered lives worth $5,000,000 can be paid at a significantly higher rate than someone overseeing covered lives worth $500,000 due to the increased level of volume and complexity required.

Such agreements bind physicians to management in a mutually beneficial way and enable both parties to work together to achieve outcomes that have an impact on both organizational performance and individual compensation.

## Key Board Takeaways

When working to align physician compensation with business and clinical outcomes, the board will need to oversee and hold management accountable for the following initiatives:

- Consider physicians as strategic business partners and not employees, FTEs, or individuals to be "managed."
- Ensure that co-management relationships have a calculable ROI for the organization.
- Hardwire "regulatory quality" and create business relationships around "strategic quality."
- Quality has a financial value so define it as both clinically and financially important.

## 2. Standardize Processes to Achieve Regulatory Quality Goals

Regulatory quality represents externally imposed quality metrics (e.g., value-based purchasing, HCAHPS, readmission rate, etc.) that impact potential payment by both public and private payers. Obviously, the goal for every organization is to achieve the highest possible compliance in all regulatory metrics to optimize reimbursement. This also has the impact of reflecting favorably with regards to publicly reported sites such as Hospital Compare, ProPublica, Leapfrog, and Healthgrades.

The best way to achieve consistently high performance is to standardize processes throughout the inpatient and outpatient clinical settings so that consistent performance around standardized metrics take place. For instance, many organizations utilize "hard stops" and "decision support" tools to ensure that patients receive the right care each and every time, monitoring exceptions to ensure compliance.

Obviously, this level of cooperation requires pre-existing alignment to ensure that both leadership groups are in agreement with how processes are to be standardized and are willing to sacrifice some autonomy to support consistently high performance. Physicians are unlikely to support standardizing processes until they have a "stake" in the outcome through some form of co-management relationship whether employed or self-employed.

## 3. Monetize All Key Performance Indicators throughout the Organization

Every quality metric has a monetized value to a healthcare organization and can be calculated and compared for significance. For instance, case mix index (CMI), top-box HCAHPS, length of stay, adjusted cost per case, total cost throughout the continuum of care for a defined episode of care (e.g., hip or knee replacement), market share, and readmission rate can all be calculated for a given organization based upon calculated values. This is an important first step in order to develop a compensation methodology for physicians that emphasizes quality, safety, and experience, and enables the implementation of steps four and five outlined below.

## 4. Prioritize Monetized Metrics through the Creation of a Pareto Chart

Once the financial values of all significant quality metrics are

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calculated, it is necessary to rank these metrics in order of significance. Like the Italian economist Vilfredo Pareto found in the 19th century, not every metric is equally significant and there are a disproportionally small number of metrics that make a significant impact upon the quality outcomes of an organization. Thus, a Pareto Chart helps organizations to prioritize which metrics to invest scarce resources into due to their predicted return on investment (ROI).

### 5. Create Co-management Arrangements Based upon Quality Metrics That Will Have the Greatest Impact on Clinical and Business Performance

Once the "vital few" strategic metrics are identified and the financial values calculated, co-management agreements can be formally established between physicians and management that will drive predicted clinical and business outcomes with calculable ROIs. I recommend that co-management agreements have at least an ROI of 2:1 so that for every $1 physicians earn, the organization doubles the value for itself. Thus, each agreement becomes a business unit with both a cost and profit center based upon performance.

The following represents a strategic co-management agreement created for an OBGYN in a for-profit healthcare system last year:

A. Above average wRVUs (FMV1 = $400,000)
B. Supervision of four APNs (allowed by Texas state law) (FMV2 = $200,000)
C. Leadership of Charity OBGYN Clinic (FMV3 = $300,000)
D. Leadership of OBGYN service line with negotiated clinical and business outcomes (all have calculated ROI for both clinician and management) (FMV4 = $400,000)

The value of this contract was $1.3 million for the OBGYN who essentially had four contracts, each with its own fair market value calculation. The value of this contract for his employer was $3.9 million and had an ROI of 3:1. Only contract A had a fair market value calculated based upon clinical work. The remaining contracts were based upon management services to hire and oversee advanced practice practitioners, lead a charity clinic to keep uninsured women out of the emergency department and inpatient units, and leadership of a service line that could generate monetized returns.

## Conclusion

As the healthcare industry moves from volume to value it is essential that physician compensation be aligned to both clinical and business outcomes that have strategic value for healthcare organizations. The traditional volume-based payments undermine the ability of physicians and management to work together towards shared objectives and is no longer sustainable. The sooner organizations transition to a physician compensation methodology aligned with value, the sooner they will optimize quality and financial outcomes with payers and their own strategic goals and objectives.

*The Governance Institute thanks Jon Burroughs, M.D., M.B.A., FACHE, FAAPL, President and CEO, The Burroughs Healthcare Consulting Network, Inc., for contributing this article. He can be reached at jburroughs@burroughshealthcare.com or (603) 733-8156.*