From courtship to marriage
A two part series on physician-hospital alignment

Part I: Why health reform is driving physicians and hospitals closer together

Part II: How physicians and hospitals are creating sustainable relationships
Introduction

This document combines two reports published by PwC Health Research Institute between December 2010 and April 2011 on physician-hospital alignment. Part I of the series examines how health reform is pushing physicians and hospitals closer together, and profiles physicians’ interest in alignment. We explore the hurdles that must be overcome for alignment to be successful and discuss how hospital leaders need to be more transparent about everyone’s roles and responsibilities when partnering with physicians. Part II of the series looks at how physicians and hospitals are creating sustainable relationships to make alignment work for both sides. Our research focuses on three interlocking issues that support successful physician-hospital alignment: shared governance, aligned compensation, and changing physician practice patterns. We conclude our research by synthesizing key elements of successful alignment strategies and identifying a step-by-step method for aligning health systems with physicians.
From courtship to marriage
Part I: Why health reform is driving physicians and hospitals closer together
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The heart of the matter

Nearly three-fourths of physicians surveyed by PwC are already in financial relationships with hospitals, and more than half said they want to move closer financially.

Executive summary

An in-depth discussion

Under reform, hospitals and physicians may need to lay aside their trust issues so they can instead focus on new approaches to care delivery, care coordination, and payment.

Alignment may help hospitals cut costs as Medicare payments lag medical inflation

Physicians seek financial security from hospitals

What this means for your business

Closer collaboration among physicians and hospitals is critical if providers want to succeed in a post-reform market.
Nearly three-fourths of physicians surveyed by PwC are already in financial relationships with hospitals, and more than half said they want to move closer financially.
As US health reform attempts to alter the way health services are paid for and delivered, hospitals and physicians are quickly moving to align more closely. “At the end of the day, the one thing that must exist in order to survive health reform is the creation of strong relationships between physicians and hospitals,” said Craig Sammitt, MD, president and CEO of Dean Health Systems, a Madison, Wis.-based network of more than 50 clinics, hospitals, and a health insurance plan.

Physicians and hospitals often have had caustic relationships, brimming with competing interests and skepticisms. In the 1990s, hospitals bought and then sold hundreds of physician practices, an integration strategy still remembered as a largely failed experiment. That was followed by years in which physicians in turn opened competing outpatient surgery and imaging centers as well as specialty hospitals. Trust—never a natural instinct between physicians and hospitals—eroded. Now, health and payment reforms have all but put an end to those formerly lucrative options for independent physicians and group practices. Further, hospitals have new reasons to bond with physicians so as to transform how care is delivered, consistent with health reform and market demands.

Does health reform provide enough aligned incentives to overcome physician-hospital trust issues? Can enough money overcome lack of trust? Nearly three-fourths of physicians surveyed by PwC are already in financial relationships with hospitals, and more than half said they want to move closer financially. So, the courtships are already under way, but will they result in marriage? “Physicians and hospitals are ill prepared for the relationships they will be entering,” said Dan Wolfson, executive vice president and chief operating officer of the ABIM Foundation. “There will need to be a lot of cultural change and aligned incentives for this to happen. Physicians have been renters in hospital facilities, not owners.”

Hospitals that want to successfully partner with physicians can take nothing for granted; they must approach the physician population in the way candidates approach an election: some will be for them, some will be against them, and a vast majority will need convincing.
Executive summary

The notion of independent physicians may be a myth because so-called independent physicians are becoming increasingly financially tethered to hospitals. The new health reform law focuses on population health and adopts a Medicare compensation model that penalizes poor quality and rewards cost savings and electronic information sharing. Some commercial payers are already pushing that business model. “Hospitals are recognizing that they need to partner with physicians to improve the delivery system and increase healthcare value—to better serve patients across the continuum of care,” said John Combes, MD, senior vice president of the American Hospital Association.

This report is the first in a two-part series on physician-hospital alignment. In Part I, PwC Health Research Institute describes how health reform is driving physicians and hospitals closer together, and it profiles physicians in terms of their current alignment patterns and future alignment interests. Part II will describe the alignment strategies that benefit hospitals by addressing the key components of trust, governance and compensation, as well as today’s changing physician practice patterns. For an in-depth discussion of the information technology (IT) infrastructure required for better physician-hospital alignment, see PwC’s companion report Designing a health IT backbone for ACOs.

The key research findings of the current report are as follows.

Health reform is accelerating the physician and hospital courtship

• Decreasing payments create the need for cost reduction. With Medicare fee-for-service and Prospective Payment System reimbursement being squeezed, the biggest potential income stream for both hospitals and physicians may reside in sharing savings from payers. To do that, hospitals and physicians must manage care together. Two-thirds of physicians surveyed by PwC indicated that hospitals need physicians to reduce inpatient costs, thereby signifying a need for better collaboration and care management.

• Better quality will finally pay off for hospitals, but they need physicians to deliver it. An average-size community hospital could lose more than $1.4 million annually starting in 2013 due to poor quality scores. Hospital leaders interviewed for this report said they need physicians to improve clinical outcomes and to protect them from or minimize penalties, which implies a need for new approaches to better care coordination.

• Hospitals need physicians to participate in the new payment systems. Hospital executives we interviewed were bullish on the need to partner with physicians as a means of participating in accountable care organizations (ACOs) and other new payment arrangements. Physicians
corroborated that view, with more than 50% citing bundled payments as a motivator for hospital alignment and more than 54% saying that because of ACOs, hospitals and physicians will become more closely aligned over the next five years.

**Physicians want financial security from their hospital relationships**

- Nearly three-fourths of physicians surveyed said they’re already aligned financially in some way with hospitals. Such relationships include directorships, employment, and joint ventures. In addition, 24% said that they already work primarily in hospital practice settings.
- Fifty-six percent of physicians surveyed want to more closely align with a hospital in order to increase their income. Another 40% want to align in order to ensure a more consistent income stream. In-depth interviews with physicians for this report revealed that many physicians fear income loss, citing recent Centers for Medicare & Medicaid Services (CMS) reductions in cardiology payments as a precursor for other specialties.
- Cardiology specialists want hospital paychecks. Two-thirds of cardiology specialists surveyed for this report said they're interested in being employed by hospitals. The cardiology specialty—which is among the most lucrative of all physician specialties—has experienced deep cuts in Medicare payments.
- Physicians are finding that competing with hospitals pays less than aligning with them. Forty-seven percent of physicians surveyed said there are now better opportunities to align incentives than there were during the integration efforts of the 1990s. Hospital executives we interviewed also said they see market changes related to decreasing reimbursement and falling patient volumes resulting in more physician-owned enterprises being sold. The health reform bill is now accelerating that trend by capping the sizes and numbers of physician-owned hospitals and facilities.
- Physicians are more burdened with higher overhead costs than in the past. More than one-third of physicians surveyed said hospital alignment would decrease administrative burdens such as health information technology requirements; 63% said alignment could lead to better work-life balance.

**Moving on to marriage will require new methods of courtship**

- Lack of trust is a barrier to alignment. When asked whether they trust hospitals, 20% of physicians surveyed said no, and 57% said sometimes. Trust was never a strong foundation in the relationship between the suitors, and rebuilding it could take time because as hospital systems snap up physician practices, past legal battles and power struggles could get in the way.
- Physicians view payer negotiations as a key motivator for hospitals wanting to align. Sixty-eight percent of physicians surveyed identified such consolidation of market power as the primary motivator for hospitals’ desire to align with them.
- Desire to align varies widely among physician segments. For example, two-thirds of cardiologists want to be employed by hospitals, but only one-fourth of orthopedists do. Physicians who practice in large groups are two to three times more interested in hospital alignment than sole practitioners are. Physicians who already have financial connections to hospitals (discussed later) are most interested in alignment. Therefore, a hospital’s first strategy might be to create relationships via less-intense models—such as co-management agreements—before moving to employment.
An in-depth discussion

Under reform, hospitals and physicians may need to lay aside their trust issues so they can instead focus on new approaches to care delivery, care coordination, and payment.
The Patient Protection and Affordable Care Act (PPACA), known colloquially as health reform, provides dozens of new incentives—both positive and negative—for hospitals and physicians to work together. But where is the trust? Twenty percent of physicians surveyed by PwC said they don’t trust hospitals, and more than half only sometimes trust them. The reasons physicians said they don’t trust hospitals run the gamut from competing goals and misaligned incentives to lack of representation in the governance of a hospital’s operations. (See Figure 1.)

Under reform, hospitals and physicians may need to lay aside their trust issues so they can instead focus on new approaches to care delivery, care coordination, and payment. The PPACA specifies such changes as reduction of inflation increases for hospitals under Medicare, establishment of a system of penalties for hospitals that have high readmission rates and that are of poor quality, and creation of a commission that would make recommendations for the reduction of healthcare costs.

It is not clear whether the physicians surveyed really believe that the PPACA itself is the source of most of the changes or whether the act is just a catalyst that will inevitably lead to major system changes. “Is healthcare reform accelerating the desire for alignment? It seems so,” said Brian Burmeister, senior vice president of physician services at ThedaCare, Inc., an Appleton, Wis.-based health system. “There is more activity now than I remember for a long time. There is a lot of discussion around reform, ACOs, and bundled payments, but no one is certain how this will stick.”

Some observers may assume that a PPACA “part II” will have to be implemented to fix the high costs that were not dealt with in the initial legislation. In some sense, this is what Massachusetts is focusing on now. But will health reform’s movement to new payment standards and new business models actually reduce costs and improve quality? “The only way to reduce costs is to empty out more hospital beds and provide less specialty care,” said Peggy O’Kane, president of the National Committee for Quality Assurance, a not-for-profit organization working to improve healthcare quality. “And to improve quality, hospitals will need more capabilities like measurement, analysis, and clinical management. There are a lot of people wondering whether hospitals can really do this.”

The belief that health reform changes will reduce payments is coupled with the recession. The number of elective procedures is down, and the numbers of uninsured and Medicaid patients are increasing faster than before the recession. This bolsters the general feeling that major system reform could ratchet down every provider’s income.

No one really knows what the final details of health reform will look like in five or 10 years. However, our survey of physicians and our interviews of hospital leaders show that both groups are of the mind-set that physicians and hospitals will have to work together regardless of what happens in Washington.

**Figure 1:** Top five reasons physicians do not trust hospitals as partners

Please select which of the following statements best describes why you do not generally trust hospitals as partners. Select all that apply.

- Competing goals
- Not enough physician leadership and/or representation on the board
- Lack of transparency
- Lack of communication among physicians and hospital administrators
- Incentives are not aligned

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Competing goals</td>
<td>60%</td>
</tr>
<tr>
<td>Not enough physician leadership and/or representation on the board</td>
<td>56%</td>
</tr>
<tr>
<td>Lack of transparency</td>
<td>56%</td>
</tr>
<tr>
<td>Lack of communication among physicians and hospital administrators</td>
<td>50%</td>
</tr>
<tr>
<td>Incentives are not aligned</td>
<td>50%</td>
</tr>
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</table>

Source: PwC Health Research Institute
Physician-hospital alignment is a formal financial agreement between physicians and hospitals. Such relationships can range from directorships whereby physicians are paid for management and oversight duties to joint ventures, full employment, and accountable care organizations. (See Figure 2.) Although the ACO is a frequently discussed model for alignment, health leaders should explore all alignment options in order to develop a broad strategy that can be successful in any environment. Based on our physician survey, physicians seem to be extremely interested in pursuing alignment over the next two years. The level of interest seems to be at the opposite ends of the alignment spectrum. The largest pools of physicians either are employed or have low or no integration. It appears that for most physicians, alignment has largely been either all or nothing.

**Figure 2: Alignment models**

<table>
<thead>
<tr>
<th>Integration model</th>
<th>Description</th>
<th>Percent of physicians currently aligned via the corresponding model*</th>
<th>Percent of physicians most interested in pursuing the corresponding model over the next 2 years*</th>
<th>Level of alignment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Physicians are employed for medical services. In return, either a full-time or a part-time salary is paid by a hospital, medical foundation, provider-based clinic, faculty practice plan, or group practice.</td>
<td>44%</td>
<td>46%</td>
<td>High</td>
</tr>
<tr>
<td>Joint venture</td>
<td>In a joint venture between physicians and multiple service lines, such as ambulatory surgery and imaging and laboratory centers, the venture owns the service lines and bills third-party payers for patient services.</td>
<td>8%</td>
<td>38%</td>
<td>Medium</td>
</tr>
<tr>
<td>Co-management company</td>
<td>Either by direct contract or through a new-entity joint venture management company, the hospital contracts with physicians to manage a service line. The hospitals and physicians share in the management contract based on their ownership shares.</td>
<td>8%</td>
<td>34%</td>
<td>Medium</td>
</tr>
<tr>
<td>Leasing</td>
<td>A hospital, a physician, or a hospital-and-physician joint venture leases space, equipment, or staff for a predetermined time period.</td>
<td>9%</td>
<td>21%</td>
<td>Medium</td>
</tr>
<tr>
<td>Directorships, stipends, and</td>
<td>Services are driven contractually, including leadership and administrative oversight provided by a clinician leader. Some of the responsibilities are certification/education of medical staff and liaising with the medical staff.</td>
<td>24%</td>
<td>51%</td>
<td>Low</td>
</tr>
<tr>
<td>management contracts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No integration</td>
<td>A physician has no financial ties to a hospital, practicing either independently; or at an insurer; or in a group practice, a consulting firm, a government agency, a biotech/pharmaceutical company, or some other organization.</td>
<td>29%</td>
<td>N/A</td>
<td>None</td>
</tr>
</tbody>
</table>

* Respondents were allowed to choose more than one option. Therefore, the sum of the column is not 100%.

Source: PwC Health Research Institute
Decreasing payments to hospitals are forcing hospitals to reduce costs, and hospitals say physicians can help them do that. The biggest impact stems from Medicare, which is trying to reduce both the prices and volumes of services to hospitals.

**Mandated discounts:** The health reform law mandates new discounting of the prices that Medicare pays for each inpatient hospital stay. The discounts will apply to what is commonly known as the inflation factor, which calculates projected increases in the costs of hospital wages and supplies. For the past seven years, Medicare has increased payments to keep pace with this inflation factor; in other words, as the costs of hospital wages and supplies increased, so did the prices paid by Medicare for inpatient stays. However, beginning in fiscal year 2012, Medicare payments for each hospital stay will be reduced 1.2% to 1.9%.

PwC calculated the difference in what the expected increase in hospital wages and supplies would be from 2011 to 2020, and then applied the discounting mandated by the health reform law. As shown in Figure 3, the gap between the expected cost (market basket) and expected pricing (Prospective Payment System update) would widen with each passing year. Even though the mandated discount each year is relatively small, the cumulative discounts add up. (See Figure 3.) For example, if hospitals had been paid under the former methodology—in which prices rose with inflation—their Medicare rates from 2011 to 2020 would have increased 27.5% from 2011 to 2020, according to the Congressional Budget Office. Under the health reform law, their payments are expected to increase by 11.9% over that period.1

Alignment may help hospitals cut costs as Medicare payments lag medical inflation

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Mandated coding reductions:
Totally unrelated to the health reform law, Medicare switched to an expanded coding system, which added more complex and expensive codes for hospitals to use in billing. The coding system was designed to be revenue neutral, but hospitals gravitated toward using the higher, more expensive codes, which drove up spending. To get back to revenue neutrality, Medicare is further discounting prices on each inpatient stay by 2.9% over the next two years and 3.1% in 2012. For hospitals, this will represent a real cut in Medicare pricing—something they haven’t experienced in seven years.

“Hospitals are incredibly nervous about the reimbursement cuts,” said David R. Maizel, MD, president of Sentara Medical Group, a 380-physician multispecialty group owned by Sentara Healthcare in Virginia. They know that the costs of providing care must be reduced to avoid operating losses.

Richard Sheridan, corporate senior vice president and general counsel at San Diego’s Scripps Health, said commercial insurers will adopt the same payment reductions as Medicare, noting “we are having difficulty negotiating the higher rates we think we deserve.”

Lower payments for poor quality scores: The PPACA also contains a number of provisions that penalize hospitals for poor quality of care. This daunts hospital leaders because such penalties could cut their Medicare inpatient net revenue by millions of dollars on top of expected reimbursement reductions. For example, PwC analysis has shown that a 300-bed community hospital with $50 million in annual Medicare revenue could lose more than $1.4 million annually starting in 2015 if it has high readmission rates, a low value-based-purchasing score, and large numbers of hospital-acquired infections. In 2012, the Medicare value-based purchasing program will begin to measure hospitals on efficacy, patient satisfaction, and quality of care. Hospitals scoring in the bottom quartile will see reductions in Medicare payments.

This means hospitals will have to fight to stay in the top quartiles of quality performance, and according to Betsy Aderholdt, president of Michigan’s Genesys Regional Medical Center, the answer to how to stay at the top resides in the physician relationship. “Given the reimbursement changes, we can’t be in the top deciles unless we work closely with our physicians,” she said.

Genesys’s chief clinical officer James Bonnette, MD, added that “hospitals are recognizing the urgency in starting to work differently with their hospital staffs in order to achieve the quality improvement that will help their bottom lines.” Our physician survey corroborates that: 64% of surveyed physicians said hospitals are motivated to align with them in order to improve patient outcomes.

The penalties and cuts may be reduced by ensuring appropriate levels of care, skill mix, and the efficacy of expensive tests or procedures. Physicians are seen as the keys to cutting costs because only they can admit and discharge patients and make major treatment decisions during inpatient stays. Significantly reducing hospital costs without physician cooperation may be impossible. Physicians agree that they are major factors in efficiency improvements. Our survey revealed that 66% of physicians said hospitals are dependent on them to reduce costs and improve efficiency.

To reduce costs, hospitals will have to work with doctors to successfully implement standard practice guidelines. “You have to bring physicians into your inner circle. Provide them with performance data they trust and can readily digest. Encourage them to develop performance criteria they believe to be relevant. Then foster physician-manned oversight processes to ensure that those performance requirements get met. Few will consent to be governed under processes and standards that are perceived as coming from an external source. You may need to occasionally remind physicians to respect their own processes, but without active physician participation in governance, you aren’t going to gain the full benefits of integration,” said William Roberts, senior vice president of Baylor Health Care System.
Incentives to reduce the volume of Medicare inpatient services: Medicare has a number of demonstration and pilot projects—such as ACOs and bundled payments—that are designed to reduce expensive hospital admissions and to then share the savings with physicians and hospitals. As Medicare squeezes fee-for-service and inpatient prices, the biggest potential income stream may reside in sharing savings from payers. The new payment models require physicians to manage care with other health providers, including hospitals, and then share in the savings if they find a more cost-efficient way to care for patients. A Medicare bundled-payment pilot will begin in 2013 and will include one payment for episodes of care that include the inpatient stay as well as three days prior to admission and 30 days postdischarge. According to the PwC survey, more than 50% of physicians said hospitals are motivated to align with physicians in preparation for bundled payments, and physicians and hospitals will be more closely aligned through ACOs in the next five years.

One of the most significant challenges will involve the distribution of savings among the partners under the new reimbursement models within both Medicare and certain commercial contracts. Compensation models will have to incentivize providers to work toward the goals of cost-effectiveness and quality outcomes. Compensation can’t be structured in ways whereby incentives are not significant enough to motivate changes in behavior. Developing new physician compensation models and influencing physician practice patterns will be addressed in the forthcoming Part II of this report as we further address the question of whether the newly aligned incentives will be enough to overcome physician-hospital mistrust.
What is an ACO?

Accountable care organization (ACO) is now a ubiquitous term in the healthcare landscape. Nearly every health organization wants to be one, or claims it already is one, or says it’s working to become one. But little agreement exists on what exactly an ACO is. In some ways, ACO is a metaphor for how the health system is changing from an individual output-based system to a population-risk-based system that rewards quality and efficiency instead of volume.

The definition of ACO is derived by the type of organization describing the model:

According to the federal government: Under the health reform law, an ACO is a network of providers and/or organizations that are accountable for the health of a discrete group of Medicare beneficiaries. Starting in 2012, providers can organize themselves into ACOs if they have sufficient primary physician participation, if they implement evidenced-based medicine guidelines, and if they report on cost and quality. If an ACO succeeds in delivering high-quality, low-cost care, it will share Medicare money and share in that savings. Details around the concept are not complete because CMS is still developing them. They are expected to be published by the end of December 2010.

According to commercial health insurers: Several private payers, such as Anthem Blue Cross and Blue Shield as well as Blue Cross and Blue Shield of Massachusetts, have developed accountable care programs that pay providers either capitation or global payments instead of traditional fee-for-service payments. Some of these payment models include a quality incentive. Without a quality component, it’s simply a cost reduction and risk-shifting strategy.

According to providers: Many providers in integrated delivery networks (IDNs) consider their organizations the equivalent of ACOs or, at least, positioned to quickly become ACOs. An IDN’s physicians, hospital, and health plan are responsible for a patient population; they share risk; and they’re ultimately capable of proactive population health management. IDNs with active insurance licenses and histories of disease management are well poised to become ACOs.

Non-IDN providers consider the development of infrastructure that will allow for shared savings among providers and payers to represent a first step in becoming an ACO. That infrastructure can include health IT, evidence-based guidelines, and quality measures.

Types of ACO

<table>
<thead>
<tr>
<th>Type of ACO</th>
<th>Infrastructure ACO</th>
<th>Pre-ACO</th>
<th>Commercial ACO</th>
<th>CMS shared-savings program ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Providers build a provider network and an infrastructure to prepare for an accountable care environment such as health IT, physician practice guidelines, and data analytics.</td>
<td>An IDN with infrastructure to manage patient populations and the ability to manage risk.</td>
<td>A commercial payer contract with some level of risk sharing and quality requirements.</td>
<td>An organization of healthcare providers accountable for the quality and cost of care for a group of Medicare beneficiaries.</td>
</tr>
<tr>
<td>Relationship/designation</td>
<td>No formal designation. Strengthens relationships and alignment between hospitals, physicians, and payers.</td>
<td>No formal designation. Includes an insurance license, provider-owned health plan, hospital(s), and physicians.</td>
<td>Contractual relationship between provider and payer negotiated on an individual basis.</td>
<td>A CMS designation for the Medicare shared-savings program or pediatric demonstration project as described in the PPACA.</td>
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</table>
Physicians seek financial security from hospitals

Hospitals aren’t the only ones trying to protect their incomes. Physicians, too, are looking down the barrel of future Medicare cuts. Medicare has already cut cardiology and imaging payments and could implement certain long-planned physician fee cuts under what’s known as the sustainable growth rate (SGR) formula. The new health reform law also limits physicians’ ownership interests in hospitals and related health entities. “For the doctors there is a good deal of anxiety about possible reductions in income given the decreasing reimbursement. Specialists observe that the group at risk shifts from time to time, so most—not knowing what the future holds—feel some level of vulnerability,” said Jack Silversin, president of Amicus, Inc., a physician change management firm in Cambridge, Mass.

SGR cuts loom

Figure 4 shows the proposed SGR cuts compared with physician practice costs as measured by the Medicare Economic Index. In 2009, before the PPACA became law, the Congressional Budget Office estimated that the SGR would cause fees to fall by 21.2% in 2010 and then 6% over each of the following three years, for a cumulative effect of 40% by 2014. By 2020, the SGR will have caused rates to fall approximately 28%; without the SGR cuts, rates would increase 18% by 2020. Few believe the SGR cuts will come to fruition, because such cuts would devastate physician income and result in too many physicians’ dropping Medicare patients. However, to eliminate the cuts, Congress must fund them through other means. Coming up with that funding has been difficult, so Congress continually delays the cuts, thereby creating much uncertainty for physicians.


Figure 4: Changes in proposed SGR compared to expected Medical Economic Index

Source: Congressional Budget Office, October 2010

Physician Medical Economic Index (MEI)

SGR
For several decades, physicians invested in freestanding outpatient centers that cut into hospitals' rapidly growing outpatient business. Increasingly, many physicians are finding that they cannot sustain these ventures, and cardiology has been frequently cited during the research as an example of the changes. “Cardiologists, in particular, invested in outpatient diagnostics, but now they are concerned and are approaching hospitals to help them out,” said Palmer Evans, MD, chief medical officer at Tucson Medical Center.

“Until 24 months ago, single-specialty cardiology groups were very prevalent, but now cardiologists are finding things hard financially, and such groups are therefore being acquired by hospitals and multispecialty groups,” said Dean Health Systems' Sammitt.

It’s not surprising then that 63% of all of the cardiologists PwC surveyed said they’re interested in hospital employment, compared with only 48% of primary care physicians (PCPs) and 45% of all specialties combined. (See Figure 5.) It appears that cardiology specialists understand their vulnerable state and are therefore increasingly more attracted to the idea of partnering with hospitals.

Hospital Medicare and commercial outpatient reimbursement rates are typically higher than physician outpatient rates, possibly because hospitals have more clout with insurance companies. Physicians are realizing that they can make more at hospital rates (under a proposed rule this may be equalized) and that they have neither the capital nor the expertise for managing their practices in today’s complex regulatory environment.

The albatross of administrative costs

Physicians are also finding it challenging to spread increasingly high administrative costs across their small practices. According to Bob Margolis, MD, managing partner at Healthcare Partners Medical Group, a Los Angeles–based multispecialty group practice of more than 350 physicians, “it is so darn hard to run a small or midsize physician practice anymore—with the unfunded mandates, the regulations, the collections, the fee reductions, the claims denials, the push for reporting on outcomes, and the capital needed for IT investment.” A physician used to be able to function in a small practice with a receptionist, a nurse or two, and a few administrative staff. The equipment for many physicians’ professions also was minimal. In recent decades, though, multiple payers with electronic systems have increased the complexity of billing. Sophisticated equipment has added to the overhead costs of many specialties. And recent legislation has significantly burdened overhead costs with requirements for electronic medical records and compliance with dozens of new regulations.

The usual solution for high overhead costs is to spread them over a larger organization such as a much larger physician practice or a hospital. Nearly three-fourths (74%) of physicians surveyed said their professions will become more integrated with hospitals in the next five years, and 82% agree that more and more physicians will become integrated with medical groups. Large hospitals, in particular, have entire departments separately devoted to IT, billing, and compliance. Hospitals also have access to capital markets and, in the case of nonprofit community hospitals, tax-exempt financing bonds. Given such advantages, a hospital may be able to use the gains from lower overhead costs to pay physicians more than physicians would earn in independent practices and still have enough money left over to make the exercise profitable for the hospital.

**Figure 5: Interest in hospital employment**

<table>
<thead>
<tr>
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<th>Percentage</th>
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<tbody>
<tr>
<td>Cardiologists</td>
<td>63%</td>
</tr>
<tr>
<td>PCPs</td>
<td>48%</td>
</tr>
<tr>
<td>All Specialists</td>
<td>45%</td>
</tr>
</tbody>
</table>

Source: PwC Health Research Institute Physician Survey, 2010
Moving to marriage will require new methods of courtship

According to the PwC survey, the courtship has already begun: 71% of physicians are currently aligned with hospitals on some level—from directorships to employment. Only 29% of physicians reported they are not integrated at all with hospitals. (See Figure 6.)

When asked to indicate their level of interest in more closely aligning with hospitals, 58% of physicians surveyed said they were interested in closer alignment, including physicians who said they already had some level of alignment with hospitals. This means that some physicians who have directorships or are involved in joint ventures may still be interested in additional relationships, including employment. The survey also showed that physicians are interested in merging with medical groups. (See Figure 7.) Of all of the physicians surveyed, PCPs—compared with specialists—tend to be more interested in alignment whether it be with hospitals or medical groups.

Figure 6: Type of physician alignment with hospitals

Please select which of the following ways best describes how you are currently integrated with a hospital. Select all that apply.

- Employment: 44%
- No integration: 29%
- Directorships, stipends, and management contracts: 24%
- Leasing: 9%
- Joint venture of services: 9%
- Co-management: 8%
- Other: 4%

Source: PwC Health Research Institute Physician Survey, 2010

Figure 7: Percent of physicians interested in aligning with hospitals or medical groups

What is your level of interest in more closely integrating with a hospital?
(very interested and interested)

<table>
<thead>
<tr>
<th>PCPs</th>
<th>Specialists</th>
<th>All Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>66%</td>
<td>54%</td>
<td>58%</td>
</tr>
</tbody>
</table>

What is your level of interest in merging your practice with another practice or joining a medical group, as opposed to more closely integrating with a hospital?
(very interested and interested)

<table>
<thead>
<tr>
<th>PCPs</th>
<th>Specialists</th>
<th>All Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>47%</td>
<td>44%</td>
<td>45%</td>
</tr>
</tbody>
</table>

Source: PwC Health Research Institute Physician Survey, 2010
Of those who identified interest in closer alignment, our study findings showed that PCPs, who are in larger practice settings such as hospitals or large multispecialty medical groups, have a higher probability of favoring alignment with hospitals, whereas specialists, who are younger and have less experience and are in a single specialty with no current alignments, tend to have a lower probability of being interested in hospital alignment. (See Figure 8.)

Of the same 58% of physicians who showed interest in more closely aligning with hospitals, 51% said they are interested in directorships, stipends, and management contracts; and 46% said they are interested in employment. (See Figure 9.) This means that physicians are most interested in alignment strategies at the two ends of the integration spectrum, with directorships at the low end of integration, and employment at the high end of integration.

Further analysis of these segments revealed the distinct specialties that are interested in employment. (See Figure 10.) Cardiology, among the most lucrative specialties but also the one enduring the deepest Medicare cuts, appears to have the most specialists interested in employment. The least interested specialty is orthopedics, with only 25% of orthopedic specialists saying they are interested or very interested in employment. These findings indicate

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**Figure 8: Physician segments with a high and low probability of interest in alignment**

- PCP
- Practicing in hospital or large multispecialty group
- Somewhat already aligned

- Specialist
- Age 35–44
- Practicing less than 15 years
- In a single-specialty practice
- Not currently integrated

* Greater than 90% probability that the specified physician profile would be interested in hospital alignment.
** Equals 22% probability that the specified physician profile would be interested in hospital alignment.

Source: PwC Health Research Institute Physician Survey, 2010

**Figure 9: Probability of interest in alignment by model**

Please indicate your level of interest in more closely integrating with a hospital.

- 58% Interested in closer hospital alignment
- 42% Uninterested

Please rate the models you are most interested in pursuing in the next 2 years.

- Directorships, stipends, and contracts: 51%
- Employment: 46%
- Joint Venture of Services: 38%
- Co-Management: 34%
- Leasing: 21%

Source: PwC Health Research Institute Physician Survey, 2010
strong interest in physician employment as the new method for alignment. Hospital executives we interviewed said the threat of further reimbursement cuts and the overall financial insecurity faced by physicians are causing physicians to seek employment with hospitals and large group medical practices. According to the American Hospital Association’s Combes, “we are seeing more physicians approaching hospitals for employment—not the other way around.”

Yet medical specialty is only one indicator of desire to align. PwC performed a multivariate analysis of the physician segments. We found that the significance lies much more in the desire to align and less in the type of alignment model proposed. (See Figure 11.) For example, nearly all of the alignment models showed interest on the parts of physicians who have existing formal relationships with hospitals.

### Figure 10: Percent of specialties interested in hospital employment

<table>
<thead>
<tr>
<th>Specialty*</th>
<th>Percent interested in employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most interested in employment</td>
<td>Cardiology</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>61%</td>
</tr>
<tr>
<td>Surgery</td>
<td>53%</td>
</tr>
<tr>
<td>Ob-gyn</td>
<td>50%</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>50%</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>50%</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>49%</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>48%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>48%</td>
</tr>
</tbody>
</table>

| Interested in employment | Anesthesiology | 48% |
| Family medicine | 46% |
| Dermatology | 45% |
| Pulmonology | 43% |
| Endocrinology | 39% |
| Oncology | 39% |
| Allergy | 38% |
| Ophthalmology | 38% |

| Least interested in employment | Neurology | 31% |
| Radiology | 31% |
| Nephrology | 30% |
| Gastroenterology | 27% |
| Urology | 25% |
| Orthopedics | 25% |

* Specialties with fewer than 10 respondents were excluded from the list.

Source: PwC Health Research Institute Physician Survey, 2010

### Figure 11: Profiles of physicians interested in selected alignment strategies

<table>
<thead>
<tr>
<th>Demographic segments of physicians with a HIGH probability of interest in different alignment strategies</th>
<th>Employment</th>
<th>Directorships</th>
<th>Joint ventures</th>
<th>Leasing</th>
<th>Co-management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care physician</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Currently involved in at least one type of alignment strategy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Currently practicing in a hospital or multispecialty practice</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practicing in a setting with more than 31 full-time equivalents</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: PwC Health Research Institute Physician Survey, 2010
Physicians want something in return for aligning with hospitals. And surveyed physicians said they think they know what hospitals want in return. (See Figure 12.)

**Physicians said they think hospitals want to consolidate market power.** The number one reason physicians may think hospitals want to align with them is to consolidate market power for payer negotiations. Health reform, especially in the form of ACOs, is creating a race to partner and consolidate. Sixty-eight percent of physicians surveyed said this is the primary motivator for hospitals wanting to align with them. But this may cause a backlash if new reimbursement models like ACOs result in too much market consolidation and drive up costs. Market consolidation and resulting cost effects are issues with which the commonwealth of Massachusetts is very concerned. “We see one of our key roles to be the development of health insurance products that help guide our members to what we describe as high-value providers: providers who deliver high-quality care at a lower cost. These products feature co-pay differentials and tiered networks that incentivize members to seek their care in these high-value settings,” said John Fallon, MD, senior vice president and chief medical officer of Blue Cross Blue Shield of Massachusetts.

**Physicians said they think money is the motivator for everyone involved.** Physicians expect that alignment with hospitals will favorably impact their bottom lines by ensuring higher income levels, but they also said they think hospitals will benefit from the relationships by reducing costs and increasing revenues. Those findings corroborate what we found from the hospital executive interviews: aligning financial incentives is one of the strongest attractors for physicians and hospitals to work together.

**Physicians said they think hospitals have more to gain from quality than they do.** When it comes to better patient outcomes, physicians ranked it sixth in order of importance, with 48% of physicians stating that providing better care influences their decisions to align. But physicians said they think hospitals have more to gain from better patient outcomes and coordination of care, with 64% and 56% of physicians, respectively, stating that hospitals are motivated to align to improve patient outcomes (ranked fourth) and enhance quality (ranked fifth).

**Physicians said they think hospitals see them as the key to accessing ACOs.** Only 17% of physicians stated that better clinical integration motivates them to align with hospitals; meanwhile, 30% said hospitals want to align with them to be better prepared to form ACOs. Based on our interviews, hospital administrators agreed that in order to form ACOs, physicians and hospitals must align more closely.

These findings indicate that physicians want their relationships with hospitals to improve their work situations and increase their incomes, while physicians think hospitals are interested in aligning with them to increase market power and profitability. The keys will be the functionality of the newly emerging payment models and whether hospitals and physicians will be able to reconcile higher physician incomes and cost savings simultaneously. “We are paying too much for healthcare, and so there’s pressure for integrating the system of care,” said Mary Jane Kornacki, a partner with Amicus, Inc., the physician change management firm in Cambridge, Mass. “The challenge is figuring out how to enhance quality and add value while reducing cost at the same time.”
Figure 12: Top five reasons physicians want hospital alignment compared with top five reasons they think hospitals want them

Why physicians want hospitals

- 63% said work-life balance
- 57% said competitive benefits and retirement package
- 57% said job satisfaction
- 56% said increased annual income
- 40% said consistent income

Why physicians think hospitals want them

- 68% said consolidate market power for payer negotiations
- 65% said increase outpatient and ancillary revenues
- 65% said improve patient outcomes
- 64% said improve patient outcomes
- 56% said enhance coordination of care across the continuum

Source: PwC Health Research Institute Physician Survey, 2010
**What this means for your business**

Closer collaboration among physicians and hospitals is critical if providers want to succeed in a post-reform market.
Closer collaboration among physicians and hospitals is critical if providers want to succeed in a post-reform market. The introduction of ACOs, bundled payments, regulatory requirements to implement health IT, reduction in Medicare rates, and quality-based payments are forcing hospitals and physicians to collaborate more closely. The following recommendations pave a pathway for closer physician-hospital alignment.

**Assess the post-health reform landscape, and model the effects on your system.** Closer alignment with physicians is not a foregone conclusion. It is a serious undertaking that when done correctly will forever change health systems. Understanding how health reform, state regulations, and current market forces will affect your health system is a good first step to making a go/no-go decision for closer alignment. Modeling the effects of reimbursement changes, potential quality penalties, and new payment models for your organization will clarify the opportunities and costs associated with selecting a physician alignment strategy.

**Resist ACO fever.** Make sure your physician alignment efforts aren’t knee-jerk reactions to a perceived need to create an ACO. Nearly every organization says it’s already an ACO or will become an ACO in the near future. Although the ACO is a promising new tool for delivering better, more-efficient care while allowing providers to share in any realized cost savings, still it represents only one model. ACOs represent a significant transformation for both hospitals and physicians, with requirements that may not represent the strengths of many at this time. Providers are therefore encouraged to try “dating” through physician alignment, before they “truly commit” through an ACO.

Other physician alignment strategies such as directorships, co-management models, and employment can also deliver better, more-efficient care, although these may not result in the same level of shared savings as through an ACO. Regardless of the model chosen, physician alignment should advance your organizational mission and vision and address such key questions as, Will your community needs and benefits requirements be met? Will the alignment enhance your quality goals and improve your financial health? Will your service line capabilities and geographic presence expand?

**Give physicians reasons to trust your organization and its leaders through shared governance, information, and infrastructure.** Twenty percent of physicians PwC surveyed don’t trust hospitals, and more than half only sometimes trust hospitals. Closer relationships must be fostered. Developing trust by means of sharing information, working together on infrastructure, and collaborating in governance are good first steps for any physician alignment strategy.

**Identify and segment the physicians who are most likely to want to partner with you.** The scattershot approach to relationships can sometimes be dangerous and, ultimately, short-lived. Focusing efforts by understanding the physician populations in your community gives you a foundation for long-term business relationships. The notion that younger doctors want to work for hospitals doesn’t always hold true. Deeper and more accurate segmentation based on multiple demographic and preference factors is an important part of alignment strategy.

Our research has shown that physician integration is necessary but not sufficient to prosper in a post-health reform world. Alignment and the financial and quality incentives that can be included in these models are what’s needed for long-term sustainability. Furthermore, one cannot divorce physician alignment and the larger strategic plan of a hospital anymore—they are one and the same.
From courtship to marriage
Part II: How physicians and hospitals are creating sustainable relationships
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Part II: How physicians and hospitals are creating sustainable relationships

The heart of the matter

Like a real marriage, hospital and physician alignment is based on sharing power, sharing resources, and, ultimately, sharing the outcomes

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Physician and hospital alignment is about reaching new agreements on money and control

Physicians want to lead

Employed physicians expect higher incomes

Nonmonetary incentives can influence practice patterns

What this means for your business

Successful alignment will require hospitals to make significant investments in people and processes
The heart of the matter

Like a real marriage, hospital and physician alignment is based on sharing power, sharing resources, and, ultimately, sharing the outcomes.
Hospitals and physicians have been to the altar before, but many of those marriages ended in divorce. Like a real marriage, hospital and physician alignment is based on sharing power, sharing resources, and, ultimately, sharing the outcomes. That’s not easy, because traditional financial incentives have worked against those aims. But health reform changes all that. The government is making it financially attractive for physicians and hospitals to integrate and collaborate.

It’s difficult, though, for providers to digest these changes as they build new foundations of trust in one another. Doctors want something real and tangible from their relationships with hospitals. For example, 83% of physicians we surveyed want to maintain or increase their income in return for hospital employment, and nearly all physicians want more say in the governance and management of hospitals. Hospital leaders told us they aren’t ready to hand over the keys just yet. Many said they won’t pay physicians more unless physicians help them reduce supply and infrastructure costs. And no hospital leaders we spoke with were ready to go back to the days of paying salaries without physician productivity measures and quality incentives.

So, now the tough work begins. Hospitals and physicians must decide how to share leadership, how physician practices can reduce costs, how to build physician compensation models, and how to work together. If they can do all of those things, they will be rewarded with higher quality, lower costs, and better patient care.
**Executive summary and key findings**

In the first part of the From Courtship to Marriage series, PwC’s Health Research Institute examined how health reform is pushing physicians and hospitals closer together, and it profiled physicians’ interest in alignment. Part I explored the hurdles that must be overcome for alignment to be successful—most notably, the issue of trust, which practically disintegrated after the failed integration strategies of the 1990s. In that report, we talked about how hospital leaders need to be more transparent about everyone’s roles and responsibilities when they seek to partner with physicians.

This second report examines how hospitals and physicians can make alignment work for both sides. Our research focused on three interlocking issues that support successful physician-hospital alignment: shared governance, aligned compensation, and changing physician practice patterns.

**Shared governance**

- More than 90% of physicians surveyed said they should be involved in hospital governance activities such as serving on boards, being in management, and taking part in performance improvement. Hospital leaders we interviewed want physicians more involved in administrative decisions to create buy-in for new quality programs and cost reduction initiatives.

- Nearly two-thirds of physicians said they can devote time to leadership and management activities. To make sure physicians have time to fulfill administrative obligations, more providers are paying them for serving on committees and participating in administrative activities. Others are implementing alignment models that compensate physicians for their time and participation.

- Hospital leaders said most physicians lack needed leadership and business skills to participate in these activities. Physicians must be given the training and incentives they need to effectively lead. Hospital execs say physicians didn’t get that type of education in medical school, and so some health systems are providing continuing education now.
Aligned compensation

- Physicians said half their compensation should be fixed salary, and the remainder, incentive based. This shows that physicians realize the health system is changing to track and reward performance and that they can influence the quality and cost of care delivery at the institutional level.

- More than 80% of physicians who are considering hospital employment said they expect to be paid the same as or more than they are now. When asked how much more, the average increase was 2.4%. The average range of expected compensation increase spanned from 1% to 4.7%. Less than one in five physicians surveyed said they would accept a pay cut to work for a hospital.

- Hospital leaders are developing compensation models that benefit their overall system. Physicians will be the key drivers in improving and sustaining clinical quality, and providing them with the right mix of compensation based on productivity and incentives will aid in hospitals’ being able to avoid financial penalties.

Changing physician practice patterns

- Physicians, who have traditionally been paid to generate volume, may have to adjust practice patterns that emphasize overall system quality and efficiency. Aligned models emphasize effectiveness of the whole system, not its parts. Elements of health reform such as accountable care organizations, bundled payments, and medical homes are designed to redesign the care delivery model with the patient at the center, but they could reduce utilization.

- Hospitals should lean on accepted guidelines as they move forward. Sixty-two percent of physicians surveyed said nationally accepted physician practice guidelines have the most potential to change current physician practice patterns; only 30% preferred locally developed guidelines. Multiple hospitals interviewed as a part of this report detailed partnering with state and national organizations to establish clinical guidelines.
An in-depth discussion

Physician and hospital alignment is about reaching new agreements on money and control
Hospital leaders and physicians may have to cede on money and control issues if they want to succeed in the future. “A lot of the health reform initiatives around quality and accountable care can be more successful if physicians are brought into the early strategic discussion with hospital leaders. This physician involvement should stretch all the way to the board level,” said William Roberts, senior vice president and chief strategic development officer of Dallas-based Baylor Health Care System.

Shared governance depends on whether physicians are willing and able to perform.

Are they willing? Yes.

Physicians surveyed almost unanimously said that they should be involved in leadership roles and activities of hospitals. (See Figure 1.)

Are they able? Maybe.

The ability of physicians to follow through on sharing governance centers on two issues: time and skills. “We need to involve physicians in the strategic planning process so that they are involved in the front end, and we must determine how to do this in a time-efficient way because their time is so valuable,” said Mary Starmann-Harrison, former president/CEO of SSM Health Care of Wisconsin (SSMHC/WI).

Figure 1: Physicians say they should be involved in leadership roles and activities of hospitals

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance improvement initiatives</td>
<td>97%</td>
</tr>
<tr>
<td>Hospital executive leadership</td>
<td>95%</td>
</tr>
<tr>
<td>Board of directors/trustees</td>
<td>93%</td>
</tr>
</tbody>
</table>

Source: PwC Health Research Institute Physician Survey, 2010
Over two-thirds of physicians surveyed said they believe they have time, according to the PwC survey. (See Figure 2.)

To make sure they make time, Franciscan St. Francis Health, a three-hospital, Indianapolis-based system, compensates physicians who participate on committees and in leadership roles. “We added a citizenship component to our physician compensation model,” said Christopher Doehring, MD, vice president of medical affairs. “The citizenship score is based on credits received from participating in hospital and medical group committees. Doctors are incentivized to participate.” The citizenship score along with components related to quality of care and patient satisfaction makes up the incentive portion of each employed physician’s total compensation.

On the issue of skills, those interviewed for this report said most physicians need to develop better leadership skills. “Most physicians are not trained to be leaders or executives, nor is it something that medical schools select for. That is an omission that urgently needs to be corrected,” said Peggy O’Kane, president of the National Committee for Quality Assurance, a not-for-profit organization that accredits and certifies a wide range of healthcare organizations.

From undergraduate studies through medical school and into residency and fellowship programs, physicians focus almost exclusively on the science of medicine. “Medical schools are busy enough teaching medicine. They are beginning to develop more course work around ethics and patient safety but still must focus mostly on the sciences. The residency is where physicians get more exposure to practice management and the economics of practicing medicine,” said Donald Kerner, MD, past interim president of St. Francis Medical Group, the employed physician group of St. Francis Hospital.

The Health Research Institute’s review of the required curricula of the 10 largest US medical schools by total active enrollment revealed that no time is formally allocated directly to business-related training. However, several universities are offering joint MD/MBA programs. In fact, 53 medical school–affiliated universities are recognized by the Association of American Medical Colleges for offering such dual-degree programs. This reflects the medical and academic communities’ awareness of and response to the need to address medical students’ changing educational needs.

Yet these programs are too late for today’s doctors, making on-the-job training a necessity. Hospital leaders we spoke to indicated they often rely

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2 Association of American Medical Colleges list of institutions offering combined MD and MBA programs 2010: http://services.aamc.org/30/mededportal/servlet/downloadableBinary/138628/Combined%20MD%20and%20MBA.pdf.
From courtship to marriage: An in-depth discussion on external associations, such as the American College of Physician Executives (ACPE). ACPE offers educational programs, continuing medical education courses, and a leadership development program.\(^3\)

Other hospitals develop their own physician education programs. Baylor Health Care System developed Accelerating Best Care at Baylor (ABC Baylor), which teaches theory and techniques related to quality improvement, outcomes management, and staff development. “We invest heavily in physician leadership. We give physicians the data, hold them accountable to meet their quality metrics, and allow them to lead initiatives,” said Roberts. “We have armed our physician leaders with the information they need to bring the message home to their peers.”

**Aligned compensation means shifting more spending to physicians, enhancing revenue from services.**

Physicians surveyed by PwC who are considering hospital employment expected to receive an increase in income of 2.4% on average. That expectation varied by specialty, with those in pediatrics—typically one of the lowest-paid groups—having the highest expectation: an increase of 4.7%. (See Figure 3.)

Hospital leaders interviewed for this report said that if they paid physicians higher salaries, they’d have to fund those salaries through improvements in the care delivery model, translating into cost reductions elsewhere. Plus, physicians would be expected to generate additional revenue. However, hospitals benefit from a type of Medicare pricing arbitrage. For example, Medicare pays 35% less for certain services provided by independent practices than when the services are performed in hospital-based settings. When a physician formally aligns with a hospital, reimbursement goes up, offsetting part of the cost of purchasing the practice.

Not all physicians expect to make more money. Seventeen percent of physicians surveyed said they would accept a decrease in overall compensation when considering employment.

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An additional 38% said they would accept the same amount. This shows that over half of physicians are willing to take the same amount of pay and in some cases, accept a decrease in return for the security of hospital employment. For hospital executives, the key lies in determining the right compensation package to offer to the right physician. (See Figures 4 and 5.)

To align with new reimbursement methods set forth by health reform, physicians and hospitals will need to develop physician compensation models that share risk and promote better outcomes both clinically and financially.

For years, Scripps Health, a nonprofit healthcare system with five hospital campuses based in San Diego, used a compensation model based on relative value units (RVUs), a measure of physician productivity. The healthcare delivery network set a target payment per RVU based on certain metrics and paid physicians accordingly. “We determined that compensating our physicians based on RVUs was inadequate because volume is the only thing being incentivized. Now, we are looking at a hybrid compensation model with a large component being a fixed payment and then three or four payments/bonuses that relate to quality metrics,” said Richard Sheridan, Scripps Health corporate senior vice president and general counsel.

**Physicians say half their compensation should be fixed salary, and the remainder, incentive based.**

Responses to the PwC survey were almost uniform across practice settings with regard to which components should be incorporated into physician compensation. Each group indicated that fixed salary should be roughly half of total compensation. The other half should be a combination of productivity, quality, patient satisfaction, and cost of care. (See Figure 5.) This represents a radical change in the ways physicians have been compensated in the past. The survey results may illustrate that physicians recognize that their earning potential might be limited by fixed salaries and that they should be compensated for influencing changes in quality and efficiency. Clearly, it underlines a broad industry swing toward performance-based compensation.
This type of compensation structure lets hospitals align physicians with system goals—for example, in technology adoption. Within a year of setting such a bonus structure, nearly 90% of Massachusetts General Physicians Organization (MGPO)—a multispecialty group serving Massachusetts General Hospital—had begun using electronic medical records, and 96% were using the electronic radiology order entry system. In addition, MGPO also met all of its department-specific clinical performance goals, with at least 70% of participating physicians having reached individual targets.4

Physician compensation based purely on volume will be less and less effective under future reimbursement models that value quality and efficiency. In addition, a volume-based compensation model already doesn’t fit well for many of today’s physicians. “New physicians want to balance lifestyle more than previous generations did. They want a more predictable work schedule and adequate free time for their families and personal lifestyles,” said Starmann-Harrison, formerly of SSMHC/WI.

As mentioned in Part I of this report, deeper and more-accurate segmentation of physician groups based on multiple demographic and preference factors is an important part of any alignment strategy. The hospital leaders we spoke to for this report agreed that generational differences affect practice preferences. Overall, hospital leaders recognize that one size does not fit all.

Health reform has established quality of care as a focal point of reimbursement for the future. As mentioned in Part I, a hospital with poor quality scores could lose more than $1.4 million annually beginning in 2013. Physicians will be the key drivers in improving and sustaining high performance clinically, and providing them with the right mix of compensation based on productivity and incentives will aid in hospitals’ being able to avoid financial penalty. Beyond compensation, the conversation moves toward nonfinancial methods that can influence physician practice patterns to enhance quality and improve clinical efficiencies.

Figure 5: Ideal physician compensation model by practice setting

Please assign percentages to any of the following components you think should be incorporated in a physician compensation model. Please assign 0% to any component you think should NOT be included in the compensation model. Sum must add to 100%.

<table>
<thead>
<tr>
<th>Component</th>
<th>Solo Practice</th>
<th>Single Specialty Practice</th>
<th>Multispecialty Practice</th>
<th>Hospital</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salary</td>
<td>47%</td>
<td>46%</td>
<td>47%</td>
<td>50%</td>
<td>56%</td>
</tr>
<tr>
<td>Productivity (volume-based)</td>
<td>13%</td>
<td>16%</td>
<td>16%</td>
<td>12%</td>
<td>10%</td>
</tr>
<tr>
<td>Clinical quality as measured by standards of quality care for your specialty</td>
<td>13%</td>
<td>13%</td>
<td>12%</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td>Patient satisfaction scores</td>
<td>10%</td>
<td>9%</td>
<td>10%</td>
<td>11%</td>
<td>9%</td>
</tr>
<tr>
<td>Cost of care in your offices</td>
<td>10%</td>
<td>8%</td>
<td>9%</td>
<td>7%</td>
<td>5%</td>
</tr>
<tr>
<td>Total cost of care delivered for the patients</td>
<td>7%</td>
<td>6%</td>
<td>7%</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Percents do not always total 100 because of rounding.
Source: PwC Health Research Institute Physician Survey, 2010

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Changing physician practice patterns benefit from changes in governance and compensation.

While hospitals may have to give up some control in governance, physicians may have to do the same in the ways they practice. As Medicare moves to outcomes-based payments, hospitals will want the physicians on their teams to enhance their clinical and cost effectiveness. Additionally, physicians will be challenged to practice as a part of a multidisciplinary team post reform—one that makes the most of the scope of practice of a wide range of health professionals. This, too, will require physicians to change their practice patterns because they must begin allowing other health professionals to do what they have traditionally held for themselves.

One of the ways of convincing physicians to change is by asking them to adopt national clinical guidelines, most of which have been developed by physician peers. In the PwC survey, 62% of physicians said nationally accepted guidelines would have the most potential to change practice patterns; only 30% said locally developed guidelines would have the most potential. (See Figure 6.)

This result challenges the historical preference for medicine to be practiced according to local needs and preferences. Many of the hospital executives we interviewed for this study indicated that “medicine is local,” and clinical guidelines may need to reflect local biases. But they also said that they often lack sufficient resources to develop localized guidelines and that they’re looking to state or national guidelines as starting points.

“We initially developed our clinical guidelines locally but quickly realized it was an unsustainable task because there was too much work and too many resources being devoted to the process given the rapid change and expansion of guidelines,” said Theodore Praxel, MD, medical director, Institute for Quality, Innovation and Patient Safety at the Marshfield Clinic.

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Table: Figure 6: Non-financial methods that physicians said can enhance clinical and cost effectiveness

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nationally accepted guidelines</td>
<td>62%</td>
</tr>
<tr>
<td>Clinical protocols for clinical conditions</td>
<td>53%</td>
</tr>
<tr>
<td>Standardized order sets for clinical conditions</td>
<td>46%</td>
</tr>
<tr>
<td>Requirement for board certification</td>
<td>40%</td>
</tr>
<tr>
<td>Transparent distribution of blinded physician performance data (i.e. each physician can view their own performance data and the anonymous data points of their peers)</td>
<td>35%</td>
</tr>
<tr>
<td>The credentialing, recredentialing and privileging process</td>
<td>33%</td>
</tr>
<tr>
<td>Locally developed and accepted guidelines</td>
<td>31%</td>
</tr>
<tr>
<td>Joint Commission requirements such as focused and ongoing professional practice evaluations</td>
<td>30%</td>
</tr>
<tr>
<td>Continuing medical education requirements</td>
<td>29%</td>
</tr>
<tr>
<td>Transparent distribution of physician performance data (i.e. each physician’s performance data is made available for all to see and identifies the physician)</td>
<td>28%</td>
</tr>
<tr>
<td>Hospital- or facility-related administrative requirements</td>
<td>19%</td>
</tr>
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</table>

Source: PwC Health Research Institute Physician Survey, 2010
multispecialty clinic consisting of 775 physicians with locations throughout northern, central and western Wisconsin. Given the daunting nature of developing their own guidelines, Marshfield Clinic became a member of the Minnesota-based Institute of Clinical Systems Improvement (ICSI), which comprises 60 medical groups representing 9,000 physicians. Marshfield uses ICSI’s guidelines as a platform and then in a consensus building process consults with its own experts, receives suggestions from the clinic’s physicians, and refines the final guidelines to be evidence based and specific for the Marshfield Clinic practice.

Having physician buy-in and ownership in the development and implementation of clinical guidelines presents the greatest opportunity to influence practice patterns. “In the past, physicians were frustrated because they weren’t seeing any change. Now, they are involved and are helping to initiate change within our organization,” said Betsy Aderholdt, president of Michigan-based Genesys Regional Medical Center. “We have doctors reading about leadership development processes and ways to improve our change efforts. They now realize it’s more than just barking orders and influencing staff. Physicians are beginning to understand what it takes to lead the change process, requiring them to work in an interdisciplinary team and flattening hierarchies.”
What this means for your business

Successful alignment will require hospitals to make significant investments in people and processes.
In hospital boardrooms around the country, discussions are taking place on how to better work with physicians. Some organizations are preparing for accountable care; others are purchasing physician practices and extending health information technology to outlying physician offices. All of the goals are the same, but the journeys can be quite different.

In the following case studies, our research focused on three organizations of different sizes, geographies, and levels of alignment to show how the process can work and what resources and mechanisms were used to increase alignment.

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**Indianapolis-based Franciscan St. Francis Health, a not-for-profit, faith-based network of providers, is moving toward becoming an accountable care organization (ACO). Its strategy for developing itself as an ACO is the same for a successful physician-hospital alliance. Franciscan St. Francis Health’s integrated network of providers includes hospitals, physician groups, ambulatory surgery centers, home health agencies, post-acute and long-term care facilities, and both system-owned and independent health plans.**

Given the integrated nature of its operating capabilities, Franciscan St. Francis Health has been able to concentrate more efforts on chronic disease management and population health, one of the key elements of the accountable care model. “The vision of the ACO model is to seek out those members in our market that have a chronic disease and appropriately manage their care,” said Jay Brehm, executive vice president and regional chief financial officer of the system. “To find success in the future, leaders will focus on quality and the patient experience, eliminating infections and putting resources into chronic care.” The system has developed a number of programs to engage its patients and address their underlying conditions with such programs as health risk assessment profiling, lifestyle and wellness initiatives, motivational interviewing, and member incentives.

Aligning with physicians through employment or other partnership arrangements is an ongoing effort at Franciscan St. Francis Health. “At this point, it’s what we do. We are focusing on primary care to expand the market and are talking to many independent PC groups,” added Brehm.
**Shared governance**
Physician involvement and physician leadership in the development of care coordination strategies around accountable care have been important for Franciscan St. Francis Health. “Our medical group has a robust governance system in place. It is truly a physician-led enterprise. The board is balanced between physicians and executives. Committees are chaired and led by physicians, and they drive the agendas,” said Doehring, vice president of medical affairs.

Franciscan St. Francis owns a managed care plan called St. Francis Health Network (SFHN), which coordinates patient care between the system’s hospitals, physicians, and ancillary health service providers. The governance structure of SFHN is governed by a board of directors consisting of hospital executives, network physicians, medical directors, and community representatives. The board guides the direction of SFHN, with two physician-led committees (Professional Services and Finance and Operations) and a regional executive director reporting to the system’s board. This physician-led structure is ultimately responsible for improving patient care and satisfaction.

**Aligned compensation**
Franciscan St. Francis Health does not have a standard compensation model. Rather, the system negotiates with prospective physicians and group practices on an individual-case basis. The system references the targeted practice’s financial statements as well as compensation databases and surveys to benchmark where physicians should be when they are recruited to the hospital. “The most useful information we receive is the physician’s current financial performance in the existing practice. We can’t simply look at compensation surveys and just say, ‘Here’s your compensation to be employed,’” said Brehm. “You really have to go through full due diligence when considering purchasing an existing practice.”

For incoming practices, Franciscan St. Francis Health guarantees the physician salaries for up to two years. Past that, compensation is based primarily on productivity and some incentives for quality of care, patient satisfaction and committee involvement. In the next year, the system is undertaking a project to better define its compensation structure for employed physicians as preparation for their move to a potentially risk-based ACO model.

**Changing physician practice patterns**
Physician involvement in the development process of initiatives has been a catalyst to the ability of Franciscan St. Francis Health to successfully institute change within the organization. Franciscan St. Francis Health partnered with Zynx Health, a clinical decision support solutions company, to develop evidence-based order sets for physician practices. Physicians themselves have been involved in the process, with compliance reaching 50% across practice settings and with some departments already reaching their 100% compliance targets.
Huntsville Memorial Hospital

A comanagement model designed to improve quality and efficiency

Huntsville Memorial Hospital, a 123-bed, Huntsville, Texas, community hospital affiliated with Memorial Hermann Healthcare System, adopted a shared governance model that allows for joint management of its clinical services. HMH Clinical Management, LLC, a company formed by 35 community physicians, currently comanages a number of clinical services of the hospital, with plans to add more in the future. The agreement originated with the comanagement of outpatient surgery and imaging services that the hospital purchased previously from community physicians, but has since expanded to include several inpatient service lines.

“The administration’s vision is for the management company to be involved in all clinical aspects of the hospital. The goal is to be totally integrated,” said Larry Boyle, MD, comanagement medical director of HMH Clinical Management, LLC.

Added Tripp Montalbo, chief operating officer of the hospital: “The hospital doesn’t necessarily make any moves without first talking with the management company. It’s all about sharing power. It would be ridiculous not to seek advice from our physicians.”

One overarching challenge experienced has been the time and effort required to see the process through. Boyle and Montalbo warn that the amount of energy expended in the process of dotting all i’s and crossing all t’s can be overwhelming initially and will hinder progress; that negative weight can bog down the momentum. They suggest organizations pursuing closer alignment start with setting the framework and then work out the details. “The details will make it never happen. The idea is most important - having hospitals and physicians work closer together to provide better care to patients,” said Boyle. “Having people on board with the concept and moving toward making it a reality is a long, but accomplishable task.”

A handful of physicians initially agreed that a comanagement arrangement was needed between the hospital and medical practices. Then, they influenced the rest of the medical staff toward consensus around the comanagement model. Boyle added: “The hospital has to take the initiative to educate the medical staff on the benefits of closer alignment. Doctors are always skeptical of what hospitals are trying to do. It can be a hard sell because they are leery early on in the process. Once you have buy-in from key physician leaders, the others fall into place.”

From courtship to marriage

What this means for your business
Shared governance
The comanagement contract is overseen by an eight-member joint operating committee on which the hospital and physicians have equal representation. “The joint operating committee is the engine that really drives the agreement,” said Montalbo. The committee engages in activities ranging from strategic planning and budgeting to marketing and patient outreach. The committee members meet at least once a month and set the direction for the comanagement agreement.

Aligned compensation
In addition to getting paid for seeing patients, HMH’s physician-owners are paid for administrative duties such as active participation in the joint operating committee, committee involvement and meeting attendance. In addition, they’re eligible for bonuses based on performance on quality and safety measures. The company’s medical director is responsible for ensuring effective communication and coordination between the company, the joint operating committee, the medical staff and other departments of the hospital.

Changing physician practice patterns
System leaders say they now have a more stable and collaborative working environment. “This has been a huge bonanza with the nursing and support staff at the hospital. In the past, it was a real Catch-22 for the nurses. They worked for the hospital but also have to satisfy the request of physicians who don’t work for the hospital, which put them in a difficult situation,” said Boyle. “Now, there is unbelievable camaraderie between the nursing staff, physicians and executives. We are all working together and improving patient care.”

SSM Health Care and Dean Health Systems
A provider-owned health plan positions for the post reform environment

In Wisconsin, SSM Health Care of Wisconsin (SSMHC/WI), a health system of eight owned and affiliated hospitals, and Dean Health System, a 450-member physician multispecialty group, are increasingly aligning their organizations—operationally and financially. They jointly own two businesses: St. Mary’s Dean Ventures, a primary care network of approximately 150 providers, and Dean Health Plan, a 228,000 member HMO. In addition, SSM holds a small minority interest in Dean.

The Dean Health Plan is the glue that holds the two organizations together as more than 50% of Dean and SSMHC/WI’s patients come from the health plan. Additionally, the organizations are able to better control costs through effective management of their network. “Provider-owned health plans’ costs are lower to employers. Savings come from aligned incentives where physicians work on supply costs and length of stay,” said Starmann-Harrison, former president and CEO of SSMHC/WI.

The system has experience in dealing with bundled payments, a key feature of health reform that is meant to drive shared savings, as a result of delivering higher-value healthcare. “It really gives us a head start toward reform as we’ve lived in the bundled payment world for years. We’ve gotten quite good at delivering better care at lower costs,” added Craig Samitt, MD, president and CEO of Dean Health System. That said, he feels that those systems that have not had experience in shared risk/shared
gain will see challenges in terms of unbundling payments to physicians and the hospital.” Unbundling payments is complex - how do we take a capitated service and distribute the savings among physicians and hospitals? The challenge is developing a methodology for unbundling payments that fairly rewards better care at reduced costs for both the hospital and the doctors. We’ve developed that methodology at Dean and SSMHC/WI.”

Shared governance
Dean owns 53% of the health plan, and SSM Health Care owns 47%. They share in both management responsibilities and risk related to the network. The organizations continue to refine the agreement to ensure both parties drive efficiencies within the health plan. “We are currently renewing our service agreement, e.g. our unbundling formula to define how we share risk and to ensure that each side’s incentives are aligned,” said Starmann-Harrison.

Aligned compensation
Dean pays its physicians predominantly on a fee-for-service basis. “We still pay our physicians mostly for volume as opposed to value; this is not a sustainable model,” said Samitt. With that in mind, Dean has begun to shift toward rewarding physicians for quality of care and cost containment. “Aligning incentives appropriately is a delicate balance. You don’t want to move to zero production in your compensation model. It is important that systems be able to have balanced incentives to ensure that we reward the right care, in the right place at the right time, while also attracting more patients,” said Starmann-Harrison.

Though the health plan has been key for operational success, the future advantages—given changes related to health reform, are uncertain. “In the future it will be unclear how things are going to play out, i.e. health exchanges, ACOs with managing the Medicare population with an open access model,” said Starmann-Harrison. “A health plan that assumes all the risk is very similar to an ACO but the difference is that an ACO may still allow open access. If that becomes the case, you are managing a population but can’t control the network; this is a fundamental flaw. How can you assume risk for something when you have no control over the utilization and costs?”
**Changing physician practice patterns**

One of the greatest advantages to owning their own health plan is the ability to aggregate accurate and timely hospital and physician data. “Our integration enables us to gather good information about utilization, cost and even quality.” said Starmann-Harrison.

Samitt believes that other organizations will be able to do the same in the future as regional health information exchanges become operational. “Through the exchanges, eventually everyone will have information about themselves that will allow them to improve their care. For now though, because of our integrated network and in-house information systems, we are at least 10 years ahead of everyone else.”

Dean plans to concentrate its technology efforts on a number of internally developed competencies. “In terms of technology, we are working on additional enhancements that are aimed at ensuring that we are one of the nation’s highest performing accountable care organizations,” said Samitt. “Currently, we are looking to develop medical business intelligence expertise. Organizations need an analytical platform to benchmark where they are straying from the norm and other groups and to see where they are inefficient. We have the foundation for this. We have the clinical and claims data from the health plan but still need the analytical component.”
## Summary of case studies

<table>
<thead>
<tr>
<th>Reason for alignment</th>
<th>St. Francis</th>
<th>Huntsville</th>
<th>SSM/Dean</th>
</tr>
</thead>
<tbody>
<tr>
<td>To prepare to become an accountable care organization</td>
<td>To remain competitive given current operating market</td>
<td>To improve efficiencies and reduce costs</td>
<td></td>
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<table>
<thead>
<tr>
<th>Type of alignment</th>
<th>Integrated delivery model</th>
<th>Comanagement agreement</th>
<th>Provider-owned health plan</th>
</tr>
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</table>

<table>
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<tr>
<th>Developing ACO</th>
<th>Yes</th>
<th>No</th>
<th>No</th>
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<table>
<thead>
<tr>
<th>Provider-owned health plan</th>
<th>Yes</th>
<th>No</th>
<th>Yes</th>
</tr>
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<tr>
<th>Governance</th>
<th>Medical group board is made up of physicians and executives, committees chaired/led by physicians</th>
<th>Eight-member joint operating committee with equal representation between physicians and hospital leaders</th>
<th>Joint-ownership of health plan- 55% Dean and 45% SSM; the two organizations share in management responsibilities and risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Francis Health Network (SFHN) board includes hospital executives, physicians, medical directors, and community representatives; two physician-led committees (Professional Services and Finance and Operations) and a regional executive director reporting to the system’s board</td>
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<tr>
<th>Compensation</th>
<th>Income guarantee up to two years for employed physicians. Primarily productivity based, with incentives for quality, patient satisfaction, and committee involvement</th>
<th>Hourly rate for administrative duties. Additional pay for directorship/positions on JOC; physicians qualify for bonuses based on performance on quality and patient satisfaction measures</th>
<th>Fee-for-service. Have begun the process of moving towards rewarding physicians for quality and cost containment</th>
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</table>

<table>
<thead>
<tr>
<th>Physician practice patterns</th>
<th>Partnered with Zynx Health to develop evidence-based order sets for physician practices</th>
<th>Have observed a trickledown effect from improved relationship between physicians and the hospital. Nursing and support staff are no longer subject to competing interests and all stakeholders are working collaboratively</th>
<th>Currently developing analytical platform to benchmark performance and guide improvements in clinical operations</th>
</tr>
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</table>
Although each of these organizations is taking a different approach to alignment by employing physicians, developing comanagement models, or capitalizing on a provider-owned health plan, the goals and desired outcomes are the same. The process of aligning is usually also similar. During the research for this report, the Health Research Institute synthesized the key elements of successful alignment strategies. Following is a step-by-step method for aligning health systems with physicians.

**Making alignment work: Key elements of successful alignment strategies**

**Step One: Executive commitment/direction**

Ask yourself: **Is more alignment needed, and are we ready to make the commitment to drive change?**

The process of more closely aligning health systems with physicians is both time and resource intensive. Executives must realize this early in the discussion and recognize that they must be 100% committed to the idea. If executive team members cannot answer yes to the question, they must reconsider taking further action. If they aren’t on board, how can they expect others to be?

**Barriers:** Resistance to change, inadequate information for decision making, lack of financial means, time commitment

**Considerations:** Does our organization need closer alignment? Are we committed to seeing it through? What type of alignment meets our needs? Do we have the resources to invest in the process?

**Step Two: Physician leadership involvement/buy-in**

Ask yourself: **Are physician leaders in place to be involved in the process and have influence on decision making?**

Having effective physician leaders is important to success. If none exist, recruit ones with experience or train existing physicians to take on these roles. The earlier these leaders are on board, the easier it will be to make progress. Without them, any attempt at influencing physicians will likely fall flat. If executives recognize that physician leaders have not been put in a position to influence change in the organization, they must create such opportunities for physician leaders if they wish to more closely align.
Step Three: Physician participation

Ask yourself: Have practicing physicians been engaged, and are they participating in the effort?

Many organizations get stifled by distrust and fear of change. Physician education can be effective for increasing physicians’ level of comfort with the idea of better alignment and should be considered. Give physicians the opportunity to understand the ramifications of their actions on the hospital’s reimbursement and how both parties benefit from the relationship. Let them know how they are performing to give them an opportunity to improve.

Barriers: Lack of trust, feared loss of autonomy, lack of physician training and education, misaligned incentives, resistance to change.

Considerations: Are we placing physicians in a position to influence change? Are they on board with the idea? Do we have the physician leaders in place to partner with? Can we educate physicians to become leaders? How do we motivate them to be involved? Should we look outside our organization for talent?

Step Four: Infrastructure, to support alignment

Ask yourself: Do we have the people, technology, and processes to support alignment?

Once hospital leaders and physicians agree that closer alignment is desired, considerations must be given to the infrastructure needs that would give the relationship the greatest opportunity to succeed. This might include creating an organizational structure that prompts change and improves communication and coordination of care. Or it might include implementing care protocols, pathways, and guidelines that improve quality, lower costs, and reduce duplicative tests and unnecessary hospital admissions. Recognize the infrastructure needs of your organization, and take action to address them within your current operations. Doing so is a necessary step to successful alignment.

Barriers: Significant investment in time and resources.

Considerations: Do we have the right people in place to support alignment and spark change? What additional technologies are required to bring about closer alignment and more-efficient care delivery? Do we have processes that need redesign given our alignment efforts?
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This report is the second in a two-part series on physician-hospital alignment and discusses guidelines for the development of a model of alignment that meets the needs of a provider’s specific physician population. The first report describes why hospitals and physicians want to align. To inform these reports, PwC Health Research Institute conducted 28 in-depth interviews with thought leaders and executives representing healthcare providers, payers, and professional associations. PwC Health Research Institute in the summer of 2010 also commissioned an online survey of more than 1000 physicians balanced by age, gender, practice type, and specialty.

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