

# Modern Hospital Management Trends: Hospital-Physician Relationships

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# Presentation Outline

- Hospitals vs. Physicians
- Historical Overview
- Voluntary Medical Staff Model
- Two Tracks of Hospital-Physician Relationships
- Summary
- Questions & Answers

# Hospitals vs. Physicians

## HOSPITALS

- Big
- Community/External Focus
- Long-Range Perspective
- Management Control
- Bureaucratic
- Delegated Decision Making
- Organizational Funds
- Conflict and Risk Addressed

## PHYSICIANS/GROUPS

- Small
- Internal Focus/Survival
- Short-Term Perspective
- Owner Control/Entrepreneurial
- Anarchistic
- Consensus-Based
- Personal Funds
- Conflict and Risk Avoided

# Hospitals vs. Physicians

## ● HOSPITALS

- Often Not-for-profit
- Mission Driven
- Proactive – Strategic Planning
- Focused on Program Growth
- Capital intensive  
(high fixed expenses)
- Medicine from a business perspective (MBA)
- Owns the “house”
- Physician as “tenant”
- Bundled payment per case
- Incentive to shorten LOS and efficiency

## ● PHYSICIANS

- For-profit entrepreneurs
- Self Driven
- Reactive – Minimal Planning
- Focused on Individual Patient
- Thinly capitalized (minimized fixed expenses)
- Medicine as science/profession (MD/DO)
- Owns the “patient”
- Hospital as “landlord”
- Fee-for-service payment
- Risk averse which may extend care

Despite their differences,  
“They can work it out!”

# Early 1990s

- “Voluntary Medical Staff Model”
  - Foundation of Hospital-Physician Relations
  - Community hospitals serving as the “physician’s workshop”
- Supported by State licensure, conditions for participation in Medicare and JCAHO

# Voluntary Medical Staff Model

- Not a typical market relationship
- Use of facilities and equipment in exchange for overseeing quality (serving on hospital committees) and taking ED calls
- One can call this as “Marriage of Necessity”
- As a hospital CEO put it: “Voluntary call system...reflected the abundance of the past, and being a good citizen and taking call as part of your obligation to the community.”

# Reasons for Reluctance to take ED Call

- Risk of malpractice
- Lack of reimbursement of uninsured
- Take away time from the scheduled office
- Break from the hospital's mission



# Fee-For-Service Era

- Fee for service
- Increase in volume (procedures, tests, etc.)
- Cost control was not a concern
- No attention to the quality of services

# Tight Managed Care Era

- HMO capitation, case + per diem rates
- Gatekeeper & preapproval requirements
- Competition for physician-hospital affiliation increases
- Development of new models (Physician-Hospital Organizations-PHOs and Individual Practice Associations-IPAs)

# Individual Practice Associations (IPAs)

- IPA is a legal entity, the members of which are independent physicians who contract with the IPA for the sole purpose of having the IPA contact with one or more managed care plans (HMOs)
- The IPA negotiates with HMO for a capitation rate inclusive of all physician services
- The IPA and its member physicians assume financial risk under capitation
- The hospital usually has no role in a traditional IPA

# Advantages of an IPA

- Has more ability to share risk and obtain HMO contracts than PHOs
- Not a complicated model and easily accepted by many managed care executives
- Provides convenient geographic access to enrollees
- IPAs require less capital to start up and operate

# Disadvantages of an IPA

- Little commonality among a large number of independent physicians
- May not be able to achieve economies of scale and modify physician behavior to the greatest degree possible
- Accepting a high degree of risk for medical costs may require a status change (i.e., to be a licensed health plan)
- Surplus of specialists is a problem

# Physician-Hospital Organization (PHOs)

- The PHO is an entity that, at a minimum, allows a hospital and its physicians to negotiate with third party payers
- Generally considered the first step on the evolutionary ladder in vertical integration with respect to practitioners and facilities
- Also viewed as a vehicle to provide some integration while preserving the independence and autonomy of the physician

# Physician-Hospital Organization (PHOs)

- The PHO is usually a separate business entity, such as a for-profit corporation striving toward equal partnership between the physician and the hospital
- PHOs fall into two broad categories: Open and closed

# Open PHOs

- The open PHO is one that is open to virtually any member of the medical staff of the hospital
- There are some minimum credentialing requirements
- Almost universally specialty dominated
- It is quite difficult to control or manage physician behavior



# Closed PHOs

- The closed PHO is one that limits physician membership in the PHO by specialty type and by practice profiling
- Limitation by specialty type are most common and most easily done: # of specialists vs. # of PCPs
- Practice profiling is more difficult to conduct: data availability, time-frame, and case severity issues

# Advantages of a PHO

- Ability to negotiate on behalf of a large group of physicians allied with a hospital
- Ability to track and use existing data for utilization management and quality improvement purposes
- It represents the first step to greater integration between a hospital and its medical staff

# Disadvantages of a PHO

- Little improvement in contracting ability. Even worse, an managed care organization may perceive the PHO as little more than a vehicle for providers to keep their reimbursement high
- Open PHO may be at a significant disadvantage if the MCO does not want all the physicians in the PHO to be participating with the health plan
- MCOs may view the PHO as a barrier to effective communication with the physicians and a hindrance to fully effective UM
- Limited ability to influence the provider behavior

# Late 1990s and Today: Key Hospital Challenges

- Weakening financial reimbursement, particularly from the government payors
- Staff shortages
- Keeping up with technology
- Greater consumer expectations
- Capacity constraints
- Competition for niche providers

# Late 1990s and Today Physician Challenges

- Maintain clinical autonomy
- Maintain reasonable income
- Need for capital
- Increase consumer expectations
- Staff shortages
- Higher business overhead
- Balancing professional and personal time

# First Track: Physician Employment By Hospitals

- Employment of PCPs
  - Response to capitation from managed care
  - Most hospitals divested them because they were losing money
- Employment of Specialists
  - Appears to be more common today
  - Most common: Obstetrician-gynecologists (OB-GYNs) and surgeons

# Hospitals' Motivations for Employment Relations

- Expand into a new market
- New profitable service lines (branding the service)
- Need to cover ED calls
- Fill a shortage or compete with MDs who are uncooperative with hospital initiatives
- Preempt competition from specialty owned ASCs, specialty hospitals, or imaging facilities
- Gain cooperation with quality improvement efforts

# Another CEO Perspective On This Matter

“With the increased emphasis on quality, public reporting, transparency, and having technology in place for evidence-based medicine, having closely aligned physicians is critical.”



# Physicians' Motivations for Employment Relations

- Gain more regular work hours
- Less frequent call responsibility
- Seek shelter from an increasingly complex and unstable market
- Assistance with malpractice premiums
- “...Physicians don't always want to align, but from a business point of view we have to do it.”

# Role of Market Consolidation

- Physician employment is more common and appears to be increasing in **highly consolidated** hospital markets
- Nobody wants to be left out!

# Second Track: Separation From and Competition With The Hospital

- Rapid increase in physicians' ownership of
  - Ambulatory Surgery Centers (ASCs)
  - Specialty Hospitals
  - Imaging Centers (PET, CT, MRI)
- Additional sources of income for physicians
- Competition with hospitals
- Less common in highly consolidated hospital markets

# Other Forms of Hospital-Physician Alignment

- Joint Ventures
  - Joint venture ASCs are common
  - For physicians: access to capital, management expertise, access to broader pool of patients
  - For hospitals: maintain revenue, more referrals
- Specialty Service Lines
  - Heart, cancer, and orthopedic/spine centers
- Physician-Hospital Organizations
  - No longer popular

# Potential Impact of Hospital Employment of Physicians

- A decline in physician autonomy
- An increase in coordinated hospital-physician efforts to improve quality and control costs
- Increased leverage in negotiating with health plans
- Increased availability of physicians to care for uninsured
- Antagonizing independent physicians

# Potential Impact of Physician Separation

- Increased difficulty in obtaining specialist call coverage
- Lack of leadership for medical staff activities
- Decreased opportunities for physician-hospital efforts to jointly improve quality and control costs
- Hospitals' loss of patients and revenue to physician-owned facilities
- Higher overall health care costs if physician-owned facilities provide services of questionable clinical necessity

# Recognition of Dual Cultures

## PHYSICIANS

- Autonomy
- Independence
- Patient advocate
- Doers
- Immediate gratification
- Deciders

## MANAGERS

- Collaborators
- Participative
- Organization advocate
- Planners
- Deferred gratification
- Delegators

# Physician Engagement

- Discover a common purpose
- Understand the culture
- Understand the legal opportunities and barriers
- Reframe values and beliefs
- Make physicians partners
- Promote system and individual responsibility

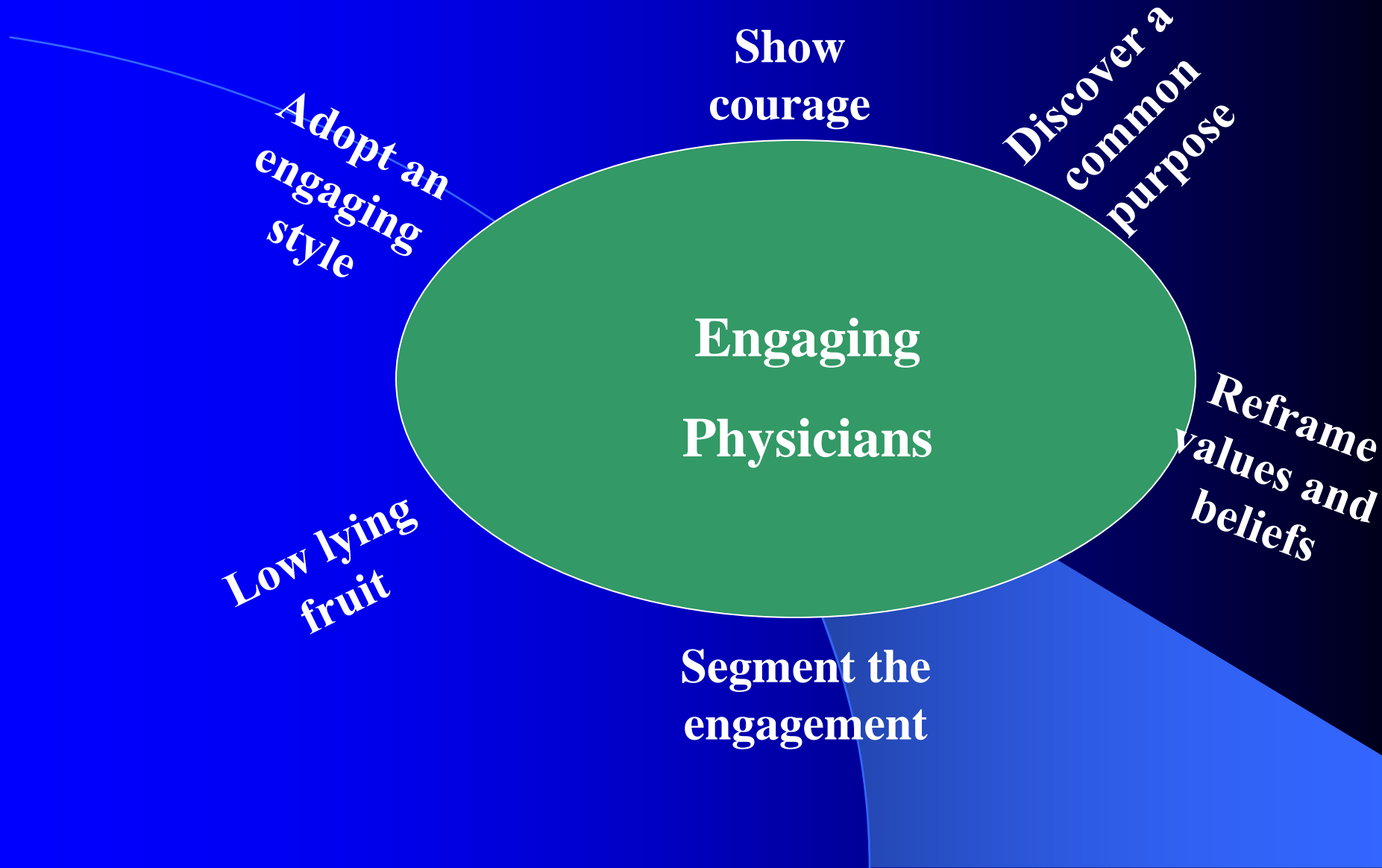


# Physician Engagement (Cont.)

- Adopt an engaging style
- Involve physicians from the beginning
- Work with real leaders
- Choose messages and messengers carefully
- Make physician involvement visible
- Build trust
- Communicate candidly and often
- Value physicians' time with your time

# Physician Engagement (Cont.)

- Segment the plan
- Play to the strengths
- Show courage



**Show  
courage**

**Discover a  
common  
purpose**

**Reframe  
values and  
beliefs**

**Segment the  
engagement**

**Low lying  
fruit**

**Adopt an  
engaging  
style**

**Engaging  
Physicians**

# Summary

- No one is self sufficient
- Physicians need hospitals
- Hospitals need physicians

Patients need hospitals and physicians to work together!

# Questions & Answers

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Thank You!

# Follow-up

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