Physician-Hospital Alignment Still Eludes Many Integrated Programs

The foundational attributes required for aligning a cardiovascular program.

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MedAxiom regularly polls top cardiovascular (CV) leaders from across the country to identify their "top-of-mind" priorities. Although health care change is moving at a rapid pace, the most pressing issues have remained somewhat stagnant for the last few years, with physician-hospital alignment models and strategies consistently ranking in the top three (Figure 1). This despite years of experience with the integrated model; already by 2012 more than half of CV physicians were employed or leased. Although the rate of integration from private practice has certainly slowed, the percentage of CV physicians integrated with a hospital or health system has now climbed past 80% (Figure 2).[1]

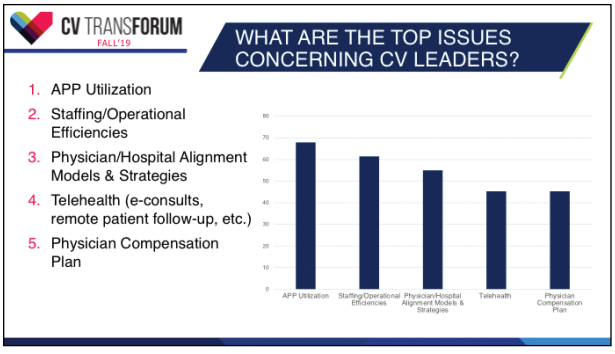

Figure 1. MedAxiom survey of CV program leaders 2019. APP, advanced practice professional (physician assistant or nurse practitioner).

How can we still struggle with this model when an overwhelming majority of CV physicians have now been partnered with a hospital or health system for nearly a decade? How is alignment still cracking the top three concerns of health care executives?

Let's start by defining *integration* and *alignment* to get a better understanding of these trends, because the differences are critical. Merriam-Webster defines *integration* as "the act or process of uniting different things." In contrast, *alignment* is defined as "the proper positioning or state of adjustment of parts in relation to each other; an arrangement of groups or forces in relation to one another."

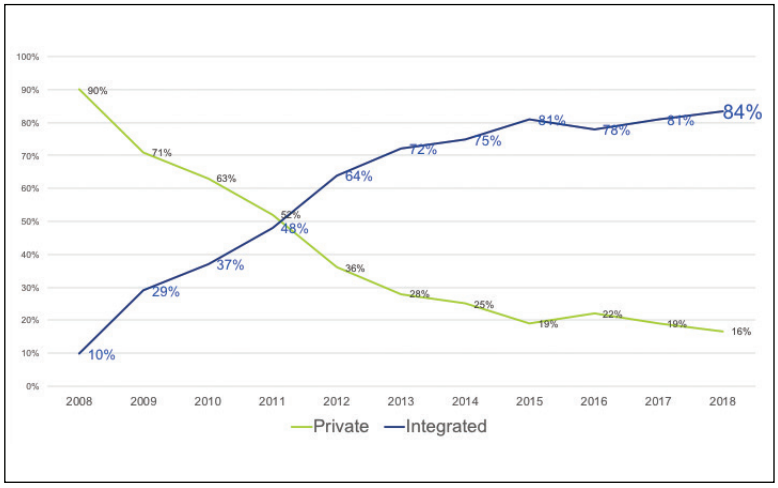

Figure 2. Integration rates for CV physicians. From MedAxiom. 2019 report: cardiovascular provider compensation & production survey. https://www.medaxiom.com/news/2019/08/27/news/2019-report-cardiovascular-provider-compensation-and-production-survey/. Accessed March 2, 2020.

HISTORY OF INTEGRATION PROBLEMS

When we bring these definitions into the CV physician's world, we see that

integration involves a transaction: acquiring groups and moving the physicians into either employment or, much less frequently, a professional services agreement (MedAxiom data shows that < 10% of integrated CV groups are in a professional services agreement).[2]

The transaction involves getting appraisals, creating contracts, and executing the transition plan, but those who have been through it may argue that it is not easy or straightforward. It's certainly a long and exhausting process. Typically the negotiation of financial terms that takes the most time and, of course, the operational and cultural transition after the documents are signed.

However, years after these transactions, the parties are still searching for that elusive "proper positioning" or "arrangement of forces in relation to one another." This lack of alignment can become painfully apparent when it's time to negotiate the contract renewal. One or both parties will treat the process like a game to be won and not as a valuable partnership to be protected. In our roles as consultants, we are often part of these processes and frequently hear "you" and "they" as opposed to "we" and "us."

In the most cases, the driving force behind integration is declining practice economics, not vision, mission, or strategy. We know this story all too well: draconian cuts to imaging and other procedure reimbursements, coupled with exponential growth in regulatory burdens, have driven the private CV physician group to near extinction. With a relationship primarily built on economics, it's little wonder why we're still struggling. Compounding the problem are some self-inflicted organizational structures that perpetuate, if not promote, separation and operational dysfunction.

First, most hospital/health systems employ (or lease) physicians through a separate physician entity. This entity not only has its own balance sheet and profit and loss (P&L) statement, which we'll discuss next, but it is also governed separately from the inpatient (hospital) resources.

This may make sense from a legal and contracting standpoint, but it certainly isn't how the patient experiences CV care. These governance silos can create some obscene operational scenarios where prudent decisions in one entity actually cause exponential harm in the other. We've seen these scenarios all too regularly in our travels, and they go both ways.

For instance, a practice with major communication challenges (eg, phone support, test results, scheduling) may be directed to reduce support staff. Not surprisingly, the next round of Clinician and Group Consumer Assessment of Healthcare Providers and Systems might show yet another drop in patient satisfaction scores. Or, the practice may unilaterally choose to reduce or drop an outreach site, logically focusing instead on coverage at the mother ship. Then, it may turn out that this site was strategically critical to the health system that was in affiliation negotiations with the local hospital.

Second, in two-thirds of integrated models, certain imaging services are moved out of the practice and over to the hospital as hospital outpatient departments.[1] Although this transition makes great economic sense and is not problematic in and of itself, the resulting impact to the practice P&L is quite devastating. As previously noted, physician services are contained in distinct legal units with their own financial statements. An outsider might read this and think, "So what? You can simply combine the P&Ls and manage as one." While this is quite logical, it is rarely the case in practice.

This financial scenario is reminiscent of the financial crisis that started in 2008. In large part, it was created by segregating and then packaging subprime (ie, junk) mortgages into different bulk investment vehicles. Once they were cordoned off from good mortgages, these junk investments were then stratified from top to bottom. In a fit of worldwide amnesia, investors forgot (disregarded?) that the entire lot was junk and began treating the top tier as if it were a grade A investment. Basically, they created financial silos and then started managing those silos as if they weren't really connected.

Does this sound familiar? It should. We're doing it in our health systems, which is putting these integrated relationships in a perilous position and hurting patient care in the process.

MOVING FROM TRANSACTIONAL TO TRANSFORMATIONAL INTEGRATION

Alignment means linking the disparate goals that reside in the governance silos we have created, moving from *transactional* integration to *transformational* integration. This requires hard work and collaboration. Achieving true collaboration takes time to develop and requires trusted relationships between leaders, transforming the "you" and "they" to "we" and "us"—or, simply, the CV service line (CVSL).

The following are some ways to move toward transformational integration.

Develop a Clearly Articulated Vision

The first step in moving toward integration with alignment for the CVSL is a clearly articulated vision. The CVSL vision establishes a road map for where the entire program wants to go and provides the framework for all strategic decision-making. For this reason, it cannot be developed in a vacuum. Key stakeholders and repre-

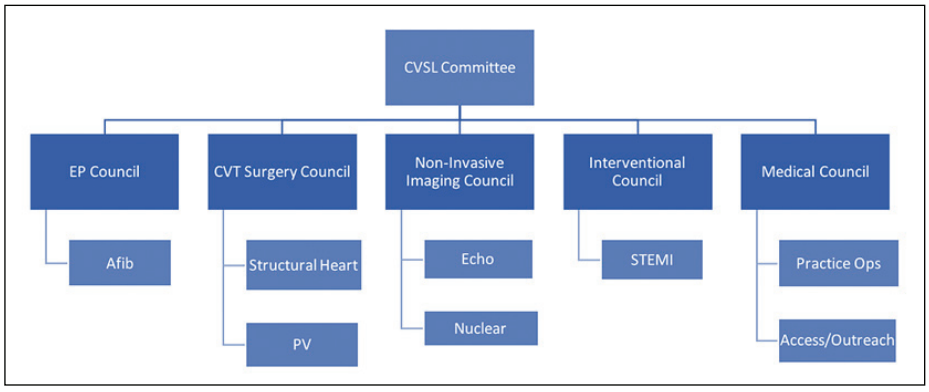

Figure 3. Example of a CVSL governance and leadership model. Afib, atrial fibrillation; CVT, cardiothoracic; EP, electrophysiology; PV, peripheral vascular; STEMI, ST-segment elevation myocardial infarction.

sentatives from clinical and administrative teams should collaborate to develop the CVSL vision. Ideally, it will answer the question, "Where do we want to be in 3 to 5 years?" It should be an aspirational yet realistic preview of the CVSL in the future—simply stated, memorable and meaningful to every level of the organization. That vision should focus on our patients at all times.

Establish an Effective Governance Structure

Once the vision is developed, it is equally important to put in place an effective governance structure to ensure sustained alignment and a high-performing CVSL. Without the foundation of a functioning leadership and governance structure, the vision will languish for lack of execution. To create effectiveness, CV physicians must have meaningful leadership roles in strategic planning and decision-making from the executive level down through frontline committees and work groups. Likewise, authority and accountability must be balanced.

A dyad leadership model is best practice for health care, pairing physician leaders with system, practice, and hospital operational administrators. MedAxiom believes so strongly in this that the structure has been embedded within its own organization. The dyad model allows service line leaders to act more nimbly and have a timely approach to operationalizing and managing strategic priorities.

An executive council of the CVSL, ideally composed of subspecialty council physician leaders and senior administrative leaders, may act effectively in the governance of the CVSL (Figure 3). Under the executive leadership, subspecialty dyad-led councils promote and support collaborative work throughout the service line and into the examination room or at the bedside.

These subspecialty councils are where the "heavy lifting" occurs: fleshing out burning priorities, developing a plan, and implementing strategic tactics for improvement.

Recognize the Team Versus the Individual

Based on surveys and our own consulting experiences, CVSL leaders across the country are overwhelmed by change and competing priorities. This state is only exacerbated in the absence of a common vision and effective governance structure for making decisions and getting things done. These deficiencies can lead to frustration and even a sense of hopelessness in the pursuit of high-quality, patient-centric care.

We often hear that the squeaky wheel (high personal urgency, low organizational importance) dominates in driving priorities. With a clearly articulated vision for the CVSL, dyad-led teams are better able to prioritize short- and long-term strategies and establish common goals to eliminate this dysfunction, manage change, and support the care team. With this alignment, the team is recognized over the individual, and the squeaky wheels can be channeled into productive dialogue.

Align Priorities and Goals

Synchronizing priorities across the CVSL is the next foundational step toward transformative alignment. When we work with programs in a predominantly production-based compensation model, it is not unusual to hear someone describe the culture as "a group of individuals sharing overhead." This is a quick tell about

the level of alignment, and it often reflects a culture in which partners are competing against each other. This type of isolation is certainly not limited to physicians. An improper organizational structure may allow or even encourage entire departments within the practice or hospital to isolate from the whole, competing for full-time equivalents or capital. In this culture, it is essentially impossible to work toward common goals.

Objective, measurable targets that are consistent with best practices should be set through the governance structure, and all goals should be aligned with achieving the CVSL's overarching vision. When mature, performance improvement objectives will bubble up from the subspecialty councils, still laser focused on the larger vision. Great sources for metrics come from the cardiac and cardiac surgery registries, Centers for Medicare & Medicaid Services value-based purchasing programs, and operational metrics that support best practices. The executive council should provide oversight of each council's performance and progress toward goals, offer course correction when needed (after establishing strategic tactics), and take a program-level balanced scorecard approach to measuring performance across the integrated CVSL.

This structure supports a framework for transitioning to purposeful standardization in operations and clinical work. It also creates the catalyst for recognizing the team over the individual and prepares the team to be highly engaged in achieving its goals.

Aligning Compensation With Vision

Only after the vision is established, along with the strategic tactics that will promote it, should provider compensation be tackled. All too often, the compensation plan is put in place before strategy, only to discover that it creates significant barriers to moving the organization toward its goals. For instance, an objective might be to move to a more team-based care delivery model, yet current physician compensation is derived 100% from individual production. Thus, ceding work to a team may be resisted because of potential negative impacts on income. As leaders, when physicians and team members respond to their economic incentives we need to consider such behavior not abhorrent but logical and appropriate. Thus we need to get the incentives right.

Although it may seem like a straightforward process to create appropriate economic alignment, history has proven that the journey is quite complex and takes significant time and effort. There are legal, fair market, internal cultural, and myriad other dynamics that must be considered. Additionally, there are unintended consequences of nearly every remuneration system, so devoting ample time to the process is critical. The model development will be helped tremendously if the leadership and governance structure has been carefully and thoughtfully constructed.

A few critical things to consider when approaching provider compensation include organizational mission and strategic objectives; quality, outcomes, and service; advanced practice professional utilization and deployment; the team relative to the individual; and participation in alternative payment models (ie, "risk").

TRANSFORMATION THROUGH ALIGNMENT

If alignment is eluding your program, take an inventory of the foundational attributes we've described. Each attribute relies on the successful implementation of the one preceding it. Keep in mind, the work starts with a unified vision and then a functional leadership structure, which inherently requires trust. Don't skip these steps; they're just too important.

The level of transformation your program will achieve is directly related to the amount of effort the team puts into it. And trust us, this takes a lot of intentional hard work! The good news is that all this sweat equity is worth it, both for your program and, more importantly, for your patients. ■

1. MedAxiom. 2019 report: cardiovascular provider compensation & production survey. https://www.medaxiom.com/news/2019/08/27/news/2019-report-cardiovascular-provider-compensation-and-production-survey. Accessed March 2, 2020.
2. Data on file at MedAxiom.

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