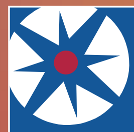
Exploring Hospital–Physician Business Relationships: What Trustees Need to Know



CENTER FOR HEALTHCARE GOVERNANCE™

Monograph Series

About the Author

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The Center for Healthcare Governance is a community of board members, executives and thought leaders dedicated to advancing excellence, innovation and accountability in health care governance. The Center offers new and seasoned board members, executive staff and clinical leaders a host of resources designed to progressively build knowledge, skills and competencies tailored to specific leadership roles, environments and needs. In partnership with the American Hospital Association.

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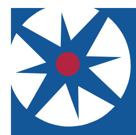

CENTER FOR HEALTHCARE GOVERNANCE™

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Overview

Effective and productive hospital/physician relationships are essential to continuing to improve patient care quality, service and clinical outcomes. While hospitals and physicians are employing a variety of strategies to redefine and strengthen how they work together to achieve these goals, (see "The Hospital-Physician Relationship: Redefining the Rules of Engagement", *Trustee Workbook,* February 2005) the business and economic ties between both parties remain a crucial part of the relationship. Understanding how to successfully engage in market-based collaboration is a critical cornerstone of effective hospital/physician relationships and can lead to productive relations on quality, safety and care of patients. Building an environment for successful collaboration in all these areas starts with the board.

This publication briefly reviews the history of how hospitals and physicians have worked together and the key events leading to the need for greater collaboration in today's resource constrained and increasingly competitive health care environment. It discusses the key role of the health care organization governing board in working with physicians to frame the value exchange between both parties in the context of the organization's mission, goals and market position. It also encourages boards to guide their organizations in moving beyond transactional relationships, engaging physicians across a spectrum of collaborations and building an infrastructure to enable such collaborations. This publication also reviews several specific opportunities for hospital/physician collaboration and outlines the enabling infrastructure necessary to accomplish them.

Boards, health care organization executives and clinician leaders can use this publication in a variety of ways, for example, as a background resource for board meeting educational sessions or as advance reading for a board retreat. It also can be used as a reference to help guide board or board committee discussion on setting overall hospital policy regarding hospital/physician collaborations or in evaluating proposals for specific collaboration opportunities.

As author John H. (Hank) Duffy concludes, while it is difficult to make predictions in a tumultuous environment, "It is, however, safe to say that…the more hospitals and physicians are able to successfully collaborate, the greater the probability that they will be more successful on a good day and suffer less pain on a bad one."

Background

The health care landscape is changing. The ability of hospitals and hospital systems to move from managing physician relations to engaging in entrepreneurial collaborations may well make the difference in who they may be competing against in the future. Building a collaborative environment starts with the board.

The relationship between physicians and hospitals has been complex, but it started simply enough in 1752. It was in that year that the Pennsylvania legislature granted a charter for Benjamin Franklin and Dr. Thomas Bond to establish the Pennsylvania Hospital, the nation's first hospital. Over the ensuing 250 years, the simplicity disappeared due to several key events including:

- The great clinics (Mayo, Lovelace, Carle, and others) were founded in the late 1800s and early 1900s as a new way for physicians to practice medicine. This model was built on the idea that multi-specialty care encourages a continual search for better ways of diagnosis and treatment, and as a result fashioned a style and quality of medical practice that dramatically changed health care.

- The earliest form of a health maintenance organization (HMO) became available in 1910 in the form of a plan offered by the Western Clinic in Tacoma, Washington to lumber mill owners and their workers as a prepaid health plan. This type of prepaid plan burgeoned during the Great Depression as a method for providers to ensure a constant and steady stream of revenue.

- In 1945, President Harry Truman sent a message to Congress asking for legislation to establish a national health insurance plan. After two decades of debate, Medicare and its companion program Medicaid were signed into law by President Lyndon Johnson as part of his "Great Society".

- In the early 1970s, Paul Ellwood, often called the "Father of the HMO", was instrumental in the enactment of the Health Maintenance Organization Act of 1973, which laid the foundation for the current health system, and the need for physicians and hospitals to look at the health care market differently.

As HMOs became a factor and the nation moved away from a pure indemnity fee-for-service model, physicians were put into a position where they would no longer be paid based on what was considered "customary and reasonable" for each specific encounter, and had to proactively find ways to negotiate contracts with payers. In this regard, they were candidates to become victims of the process if they did not have the scale or sophistication to negotiate favorable contracts. As a result, contracting vehicles such as Physician Hospital Organizations (PHOs) and Independent Physician Associations (IPAs) were created. Both vehicles, to varying extents, facilitated the ability of physicians and hospitals to negotiate more successfully as a group with payers. Under the PHO model, local hospitals and a combination of employed or affiliated physicians jointly marketed their services to managed care or other insurers. Under the IPA model, physicians sought to preserve traditional practice autonomy while introducing the advantages of a business organization for contracting purposes. Both of these solutions had modest and short-lived success.

In the early 1990s the market moved toward increased "delivery system cost control". As a result, the health financing system created a cost structure and reimbursement levels that many physicians criticized as being seriously unrelated to the delivery of quality and cost-effective care. At about this time physician–hospital conflicts emerged. As reimbursement pressure increased on physicians, there was a corollary increase in physician entrepreneurialism, particularly through the introduction of freestanding physician-owned surgery centers, which became an early and tangible focus of conflict between the interests of hospitals and physicians.

The situation then escalated as physicians began building their own hospitals. Physicians contend that specialty hospitals are formed so that they can gain greater control over how the hospital is run, to increase their productivity, and to provide greater satisfaction to both the physician and the patient. However, hospitals will counter that because physician owners can refer patients to their own hospitals they

compete unfairly and that such hospitals concentrate on only the most profitable procedures, leaving community hospitals to take care of the poorest, sickest patients, and provide services that are less profitable. The response of some hospital/system governing boards rapidly became defensive if not aggressive in seeking to stop this type of physician entrepreneurialism.

The following example illustrates where failure to set a collaborative tone in hospital–physician working relationships, resulted in a competitive situation, where in the end both the hospital and physicians became losers in a situation where both could have been winners.

Several physicians associated with a 200-bed community hospital were seeking a solution to insufficient office space, and concluded that they would build a Professional Office Building (POB) near the hospital. As their thinking evolved, they decided to include a small surgery center to support procedures. At this point, the physicians approached the hospital about joint venturing the POB/Surgery Center. The hospital decided not to entertain the joint venture. In response to the initial position of the hospital, the physicians became more entrepreneurially creative.

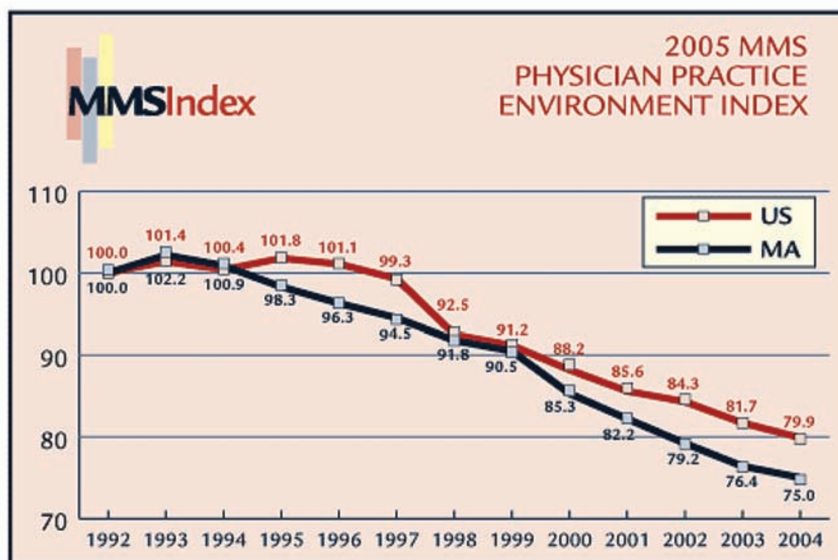
As the physicians found themselves on their own, their vision grew. Within six months they developed a plan for a short-stay specialty hospital directly across the street from the community hospital. This facility managed to beat the Medicare Prescription Drug, Improvement and Modernization Act of 2003 which imposed an 18-month moratorium on specialty hospitals. Within a year the specialty hospital was operational, and in addition to the original physicians, a significant number of surgeons and procedure-oriented physicians also chose to practice there.

In the short term, the physician specialty hospital attracted a large number of the most lucrative procedures from the hospital, and as a result came out a winner at the expense of the community hospital. The hospital subsequently developed its own surgery center, effectively increasing the local competition. Had both parties been able to collaborate early on, they both would have been long-term winners, not only in the marketplace, but also in terms of their setting a foundation for future joint ventures.

Since 2000, the history of hospital-physician collaboration has been increasingly checkered. The market landscape is continuing to change rapidly, with increasing entrepreneurship by physicians, which should only be expected to make the situation more acute. Physicians are feeling under constant siege, with their practice environment on the decline for a number of reasons including:

- Continued decreases in reimbursements from payers—with some specialties such as OB/GYN, cardiac surgery, and others seeing dramatic declines.
- Increases in the cost of being in practice through higher malpractice insurance premiums, increasingly complex administrative costs, and the cost of technology.
- A sense of helplessness as the market changes, which further aggravates a perception of declining professional status.

This decline in how physicians perceive their practice environment was best captured in a Physician Practice Environment Index developed by the Massachusetts Medical Society and published in 2005. The index measures the impact of nine



Source: The Massachusetts Medical Society Physician Practice Environment Index Report: March 2005

indicators representing three major factors that influence the practice environment for physicians:

- **Supply of Physicians,** including the number of applications to Massachusetts medical schools, the percentage of physicians over age 55, and the number of employment ads in the *New England Journal of Medicine*;

- **Practice Financial Conditions,** including New England median physician income, ratio of housing prices to median physician income, and professional liability costs;

- **Physician's Work Environment,** including physician cost of maintaining a practice, mean hours per week spent in patient care, annual number of visits per emergency department.

The index established the physician practice environment base at "100" using the results from the 1992 survey, and then tracked the same indicators year over year. While this index was specific to Massachusetts, it captured the sentiment of physicians nationally. In this regard, the national trends which are having an impact on physician perceptions of their practice environment include:

- Unsustainable health care cost growth due to structural issues in the system, an aging population, and failure of the managed care paradigm—possibly or probably leading to a serious provider cost crunch in 4 to 6 years.
- Continued rapid, and costly, technological advances on the medical device and drug delivery side, particularly in interventional surgery and radiology.
- Continued, unrelenting growth of administrative complexity, due to HIPAA and other compliance requirements.
- A large and growing uninsured and underinsured population.
- An unremitting nursing shortage.
- Information technology solutions, particularly for transaction-based services, beginning to take hold and requiring significant outlays of capital.

- Aggressive growth of Medicare HMO programs and "consumer-directed" health care insurance programs.
- Changing reimbursement patterns, including new payer strategies, indigent care, and Centers for Medicare and Medicaid Services (CMS) and other pay-for-performance initiatives.
- Provider fee schedules and other medical cost information becoming more transparent.
- Increasing innovative specialty hospitals and outpatient centers.

To a large segment of the physician community, the health care market has turned on them, and they are responding, to some degree, with defiant entrepreneurialism. They are combining into larger group practices in the belief that size counts; they are shifting patients and services into outpatient-based settings; they are developing new fee-for-service businesses; and they are increasingly seeking ways to own or share in the technical and facility fee, which have traditionally been in the domain of the hospital. It is this last factor, fee sharing, which is the most immediate source of conflict and potential collaboration between hospitals and physicians.

The reality that should not escape hospital and hospital system trustees is this: effective hospital–physician relationships are key to hospital and system success. In this regard, the physician has the lead role in determining the quality and cost of the care experience each patient receives. Physicians are the chief determinant of clinical outcome, the clinical team leader, the manager of clinical cost performance across the spectrum of care, the source of clinical innovation and technology, and increasingly important and involved as administrators and board members.

Historically, the traditional types of hospital–physician cooperation have included participation in committees and medical directorships; informal agreements such as scheduling of labs or operating rooms; co-marketing of featured physicians/services; physician recruiting; service agreements, such as radiology, anesthesia, and emergency department; affiliation with physician networks/medical groups for global risk, and facility joint ventures. However, the more tangible collaborations involving outpatient facilities and services have a checkered history. Hospitals have employed

a number of strategies when working with physicians which have not achieved the expected results. These include:

- Deferring or delaying, responses to physicians who are seeking to develop new revenue sources.
- Seeking to segment the physician community to prevent them from initiating new facilities.
- Developing outpatient facilities without physician partners in the belief that the first facility in place will garner the patients.
- Deciding not to work with physicians and building competing facilities.

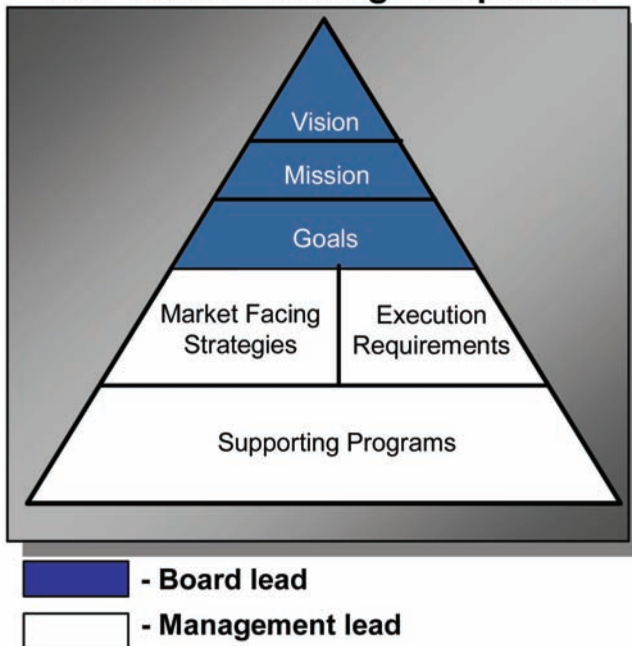
On the other hand, many physicians have competitively freelanced in a manner which undermines a hospital's market position. They have built specialty hospitals and surgery centers across the street from hospitals, and they have diverted high-margin work from inpatient settings by developing, endoscopic centers, imaging centers, and other freestanding facilities.

These strategies, more often than not, have predictable results. There are short-term winners, either the physicians or the hospital, but no long-term winner. As a result, the stage now is set for greater effort toward hospital–physician collaboration.

The Trustee Perspective

For this situation to change, hospital governing boards will need to take the lead in moving their organizations beyond only seeking excellent relationships with physicians to creating an environment of ongoing market-based collaboration. While proven models and emerging opportunities for these types of collaborations exist, the impetus for them needs to start with the board. Governing boards are charged with advising and consenting on the hospital's mission, vision, and goals; overseeing the development of a market-responsive strategy; evaluating the results of operations; and setting the "tone" for the clinical enterprise. As depicted in the accompanying diagram, management then needs to take the lead on execution.

It is in the context of mission, goals, and market positioning that the board needs to take responsibility for framing the hospital–physician value exchange, recognizing that:



- Physicians are the architect of the patient's care experience, the major factor in patient attraction and retention, the manager of cost-per-covered-life performance, and the primary source of clinical innovation and technology.

- The hospital provides physicians with an increased ability to focus on clinical/academic activities, the ability to network with high-quality colleagues, the capital to take on high-impact initiatives, the availability of more sophisticated infrastructure, and the prospect of increased income and security.

Boards by necessity will need to shape the value exchange appropriate to their specific hospital or system in conjunction with physicians. Physicians alone will not be sufficiently organized and process-oriented to take the lead. In this context, the board will need to look into the future, rather than seeking to refine historical strategies. This means that the board will need to:

- Move beyond transactional relationships into more interwoven physician-centric collaborations for:
  - system-wide services and capacity mix based on consumer/patient/market segmentation.
  - governance, accountability and incentives integrated with market requirements and delivery system objectives.
  - continuity of care/care improvement through information technology.

- Establish an environment which fosters entrepreneurially engaging physicians across a continuing spectrum of collaborations focusing on:
  - market development,
  - demonstrable clinical quality,
  - consumer-responsive service,
  - internal hassle reduction,
  - speed to market/agility, and
  - risk and reward.

- Build an entrepreneurial infrastructure to enable a range of collaborations including:
  - development funds able to disperse seed money and investment capital.
  - establishing a "portfolio strategy", or an approach to diversifying investment and risk while increasing the value of collaborations, for investing across the physician community.
  - incubator capabilities to develop new services or ventures including business planning, management infrastructure, intellectual property protection, and mentoring.
  - publishing results.

A significant range of opportunities for collaboration exists and the number and types of opportunities are growing. Specific examples include:

- promoting specific collaborative approaches to facility joint ventures such as specialty hospitals, surgery centers, endoscopy centers, and imaging centers.
- building joint infrastructure capabilities, such as electronic medical records.
- selectively recruiting physicians as employees or purchasing physician groups.
- providing MSO (management service organization), contracting, and related services to community physicians.
- developing research capabilities, such as conducting joint clinical trials programs or investing in physician-initiated development of innovative medical equipment.

- co-branding services in consumer-intense programs such as cardiology, orthopedics, geriatrics, cancer, wellness, and women's health.
- establishing joint incentive programs to support cost reduction (gainsharing), "pay-for-performance", and market development.
- developing opportunities for "participating bond transactions" which allow a hospital to provide high yield to physicians and gain significantly more influence over the governance and management of facilities such as ambulatory surgery centers, endoscopy centers, and cardiac catheterization labs.

A number of essential conditions need to be present to make these collaborations successful. Obvious attributes and capabilities include a joint planning process; availability, accuracy and transparency of data; agreement on assumptions/projections; and a sense of mutual trust. While these attributes are relatively straightforward, hospitals that have had more success in developing collaborative models with physicians have been the ones that focused less on controlling physicians and more on a set of guiding principles. These principles need to be established by the board and be flexible to the situation. Examples include developing ventures which:

- clearly address demonstrated community need and/or improve the health of the community.
- are financially and operationally feasible for both parties.
- support all patients with a common standard for clinical care and service.
- allow for shared governance, risk, and reward.
- identify conditions for exiting or dissolving the venture.
- enhance long-term relationships.

Finally, it is important for everyone involved to recognize that different factors make different ventures successful. It therefore is incumbent on all parties, hospital management and the participating physicians, to identify the main factors that need to be managed for a specific venture, and assure that they are fully addressed. The table below provides sample ventures with the primary success factor for each.

MSO Agreement	Practice Acquisition	Clinical Collaboration	Facility Joint Venture
Agreement where physicians sell hard assets to MSO owned by others, then sign a services agreement.	Physician sells entire practice to hospital and signs an employment contract.	Physician group and hospital jointly develop disease management programs, gainsharing programs, Electronic Medical Records, or other clinically focused collaboration	Hospital and physicians create an outpatient facility such as a Surgery Center, Endo Center, Cath Lab, Imaging Center, Specialty Hospital, or other and share in returns.
Primary attributes of success are: - Quality of service - Pricing schedule	Primary attributes of success are: - Approach to profit center accounting - Physician compensation methodology - Culture integration	Primary attributes of success are: - Clinical outcomes - Patient service	Primary attributes of success are: - Market response - Return on Investment

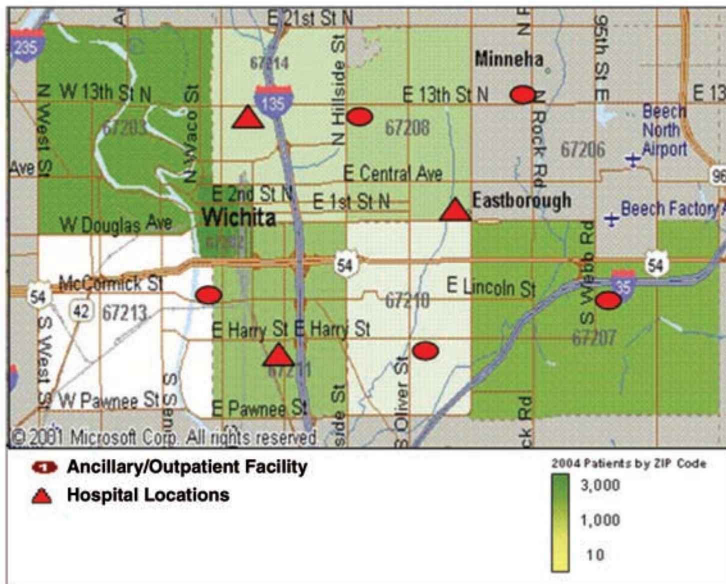
Specific Collaborations

The specific opportunities for hospital–physician collaboration are numerous, and will continue to grow. The laws that govern economic collaboration do provide for joint ventures that work. A few examples of collaborations are described below.

Facility Joint Ventures are becoming more common as hospitals try to minimize lost business and keep physicians "bonded" to the hospital system. These facility ventures can take a number of different forms, including free-standing facilities, hospital-based facilities with joint ownership, a hospital satellite with a joint venture management company, an office-based center with a management company, or others.

In June 2005, an 18-month moratorium on specialty hospitals imposed by the Medicare Modernization Act ended, potentially re-opening the door for physician-sponsored specialty hospitals. However CMS has stated that it "will undertake a series of steps to reform Medicare payments that may provide specialty hospitals with an unfair advantage over other types of providers, such as community hospitals and ambulatory surgical centers." While it is probable that CMS will modify reimbursement to moderate the growth of specialty hospitals, the growth of outpatient facilities, including specialty hospitals, will continue.

Market Coverage/Patient Zip Code



Given this background, the starting point for any facility venture must by necessity be a common and in-depth understanding of the market, consumer/ patient patterns, where physicians practice, and the availability of competing facilities.

With the market picture in focus, the aspirations of physicians need to be blended into a common strategy that is centered on the hospital's larger market strategy. This includes understanding the market in terms of the target market, available alternatives, and the map. Consumers are increasingly responding to convenience, and from their point of view, the map counts.

Lastly, the finances of the venture then must be made to work, retaining margin while increasing physician participation.

Hospital Sponsored Management Service Organizations (MSOs) are beginning to go through a renaissance. A number of years ago, hospitals offered services, such as billing and collection, to physicians through MSOs. The concept often worked, but the value proposition to the physicians was not broad enough to create a positive bonding with the hospital. In part because of the large capital requirements for technology such as electronic medical records, we are seeing a resurgence of hospitals providing MSO services to physicians.

A joint MSO arrangement can plant the seed for broader collaborations without immediate financial alignment. The operating environment has become so complex that a well-managed MSO can provide a broader range of services

to the physician, increasingly integrating clinical operations and dependencies. Services can be provided on a competitive-fee basis, often on an "a-la-carte" basis, and can be marketed to include any one or all of the services listed in the chart below.

Over time, as MSO services prove effective, the integrating effect can encourage a more united front between hospitals and physicians to the marketplace; a platform for additional joint ventures; and a critical mass/mix of physicians to support the hospital.

Information technology is an area where most physicians are playing catch-up, which becomes an opening for a number of prospectively advantageous collaborations. Frequently, physicians have weak practice management information systems and either no Electronic Health Record (EHR) or an EHR which has been only partially implemented. They are however increasingly recognizing that it is only a question of when and how they make a commitment to EHR technology, which more often than not pulls through a new practice management system.

Physicians are facing three significant hurdles which make it difficult to move forward with investments in technology, particularly an EHR. These hurdles include:

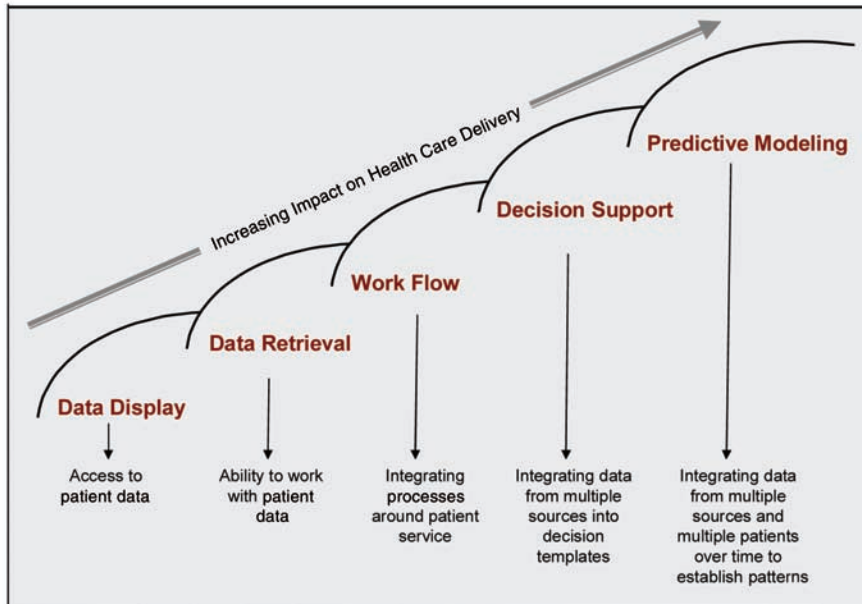
Targeted Services		
- Scheduling	- Integrated Electronic Medical Record / Practice Management System	- Clinical Protocols
- Charge Capture	- Pay-For-Performance Support	- Quality Management and Reporting
- E-Prescribing	- Malpractice Procurement	- Practice Consulting and Development
- Coding Audit/Training	- Physician Recruiting	
- Billing and Collection	- Clinical Decision Support	
- Contract Maintenance and Compliance	- Operations Improvement Support	
- Credentialing	- Medicare Compliance Programs	
- Accounting and Reporting	- HR support - Payroll and Benefits	
- Cash and Treasury Services		
- Information Technology Support		
- Dictation and Transcription		
- Group Purchasing		

- The amount of capital required—EHRs can cost $25,000 to $50,000 per physician when purchased individually.
- The talent to implement and integrate the EHR into their clinic operation—vendors will provide the initial installation assistance, but making an EHR really work on an ongoing basis can be problematic for a physician practice.
- Lack of an upfront understanding that an EHR will be a transition headache for six months (physician productivity drops during this period, only to rebound as the system takes hold), will change how physicians practice medicine, and will positively impact their revenues if effectively used.

However, there is tremendous potential value to both the hospital and physicians from an integrated EHR including:

- Near-term improvements in care coordination between a hospital and its physicians, for example, the availability of laboratory/imaging results and record access regardless of location.
- the opportunity to manage cost downward because of fewer tests, fewer medical errors, and more streamlined work flows.
- the longer-term clinical quality, safety and economic impact of fewer medical errors.
- the market and consumer perception of coordinated and proactively managed care. An EHR allows the provider to reach out to patients who need to change any aspect of their care.

A hospital–physician integrated EHR sets the foundation for an increasing value curve to both parties. There is a clear initial value from the efficiency of being able to immediately display clinical data, and being able to retrieve and work with patient data. In addition, as the EHR and its uses are better understood, work flow for clinical and patient flow purposes will begin to improve. Data also will be increasingly available for decision support, and possibly in the future, the ability will exist to jointly develop predictive population and disease models. This adaptation process results in an increasing "Health Care Value Curve" as illustrated in the accompanying diagram.



Gainsharing has become fashionable again with the release of six advisory opinions in February 2005 from the Department of Health and Human Services Office of the Inspector General. The opinions make it possible, though not easy, for hospitals to reward physicians financially when they collaborate in achieving cost reductions.

Very clear criteria have been developed for these gainsharing programs, including the use of baseline thresholds under which no savings will be shared with physicians and caps on potential savings from Medicare and Medicaid patients. Within these criteria, any gainsharing program will require extensive data on cost, utilization, and quality.

The savings can be significant, though, and can come from standardizing devices, substituting less costly items, opening prepackaged items less often, and performing tests, such as blood cross matching, only when necessary.

Employing physicians and acquiring physician practices has historically been an approach used by hospitals to protect or develop their market positions. In the mid-1990s, a number of hospitals and systems purchased physician practices, both multi- and single-specialty, toward the goal of a fully integrated health care delivery

model. During this period, a number of mistakes were made which turned the initiative into a costly program and resulted in many cases in physician practices being "spun back out" during the early 2000s. These mistakes included:

- Practices were initially overvalued.
- No joint plan was developed to achieve specific market and coordination-of-care integration goals.
- The revenues normally included in a physician practice (selected ancillaries and labs) were pooled into the hospital's financial results under traditional hospital accounting treatment.
- The integration challenges of cultural differences were not fully considered.
- Physicians remained on a "lump and divide" compensation methodology, whereby regardless of the productivity or effectiveness of a physician, that physician earns as much as the other physicians in the group.

While this acquisition/employment experience was a dark period for many hospitals and systems, it remains a viable approach to increasing clinical integration. However, the central keys to successful physician employment are common goals and culture and a compensation methodology which creates incentives for both hospitals and physicians. Compensation needs to be linked to productivity and cost control, while recognizing administrative effort (such as time spent in committee work) and the

Incentive Based Compensation Model

TOTAL PHYSICIAN COMPENSATION

Physician Base	$214,000
Bonus (Actual)	40,000
Risk Pool Allocation	7,000
Other Compensation	500
Physician Total	$261,500

BONUS CONTINGENCIES

Contingency	Maximum % of Bonus
Productivity	45%
Admin. Costs	20%
Patient Satisfaction	20%
Admin. Responsibilities	15%
	100%

PRODUCTIVITY

- Measured by RVUs
- Adjusted by specialty

Range of RVUs:

Lower	Upper	Bonus (% of pool)
Less than	10,750	0%
10,750	11,000	20%
11,001	11,500	25%
11,501	12,000	30%
12,001	12,500	35%
12,501	13,000	40%
Greater than	13,001	45%

ADMINISTRATIVE COSTS

- Measured on group rather than individual basis

Variable administrative cost (% of total collections):

	Percent of Collections	Bonus (% of pool)
Greater than:	38%	0%
Less than:	38%	2%
	35%	7%
	31%	15%
	28%	20%

PATIENT SATISFACTION

- Satisfaction surveys

Range of Rating Score:

Lower	Upper	Bonus (% of pool)
Less than	85%	0%
86%	87%	4%
88%	91%	10%
92%	94%	15%
Greater than	95%	20%

ADMINISTRATIVE DUTIES

- Additional hours devoted to administrative duties

Range of administrative hours worked per year:

	Hours (at least)	Bonus (% of pool)
Less than:	40	0%
Greater than:	40	0%
	50	4%
	60	6%
	70	8%
	80	10%

reaction of patients. As clinical data become available on a reliable basis, clinical quality measures can be added, even at a basic level, such as using HEDIS (Health Plan Employer Data and Information Set) compliance factors.

The table on page 18 summarizes the different types of considerations that should be part of developing a compensation methodology that provides appropriate incentives.

Compensation systems that do not include heavy incentive/accountability elements could potentially be "showstoppers" for new hospital-physician ventures or collaborations.

The Enabling Infrastructure

Too many hospital boards look at hospital–physician collaboration as an event rather than a series of actions which require their own enabling and supporting infrastructure. If the mechanisms are not put into place which facilitate, control, fund, and monitor an organized hospital–physician collaboration process, the best result will be an occasional win, and the worse result will be a series of setbacks, frustrating future collaborations.

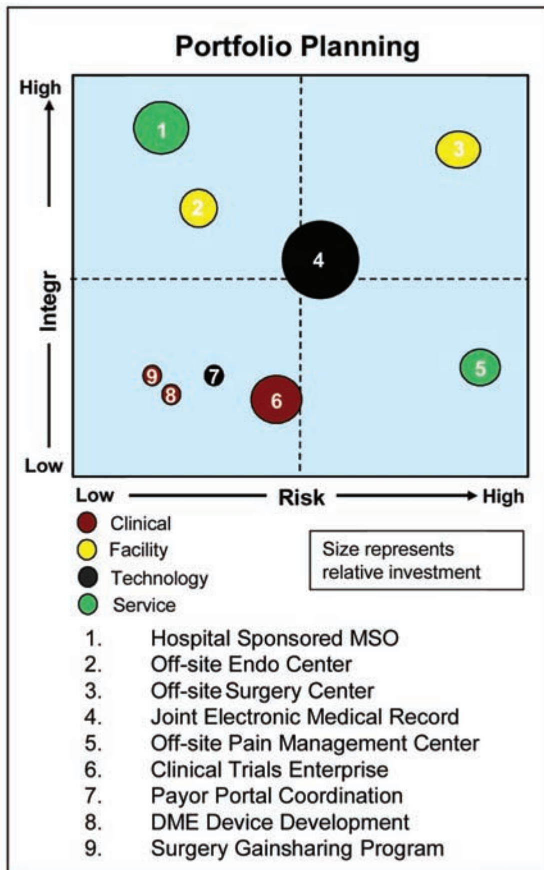
The key components of an enabling infrastructure that need to be approved at the board level appear below.

- **The Plan:** A documented set of goals which dovetail into the strategy of the hospital/hospital system and the interests of the physicians, a set of supporting guidelines, and clear responsibility for execution.

- **The Process:** A clearly communicated process for identifying, vetting, and selecting collaboration opportunities.

- **The Money:** Regularly setting aside capital for use as seed money or capital investments to fund collaborations.

- **Support:** Providing the necessary incubator support including space, management, intellectual property protection, and mentoring.



- **Communications:** Making all physicians aware of the hospital's commitment to collaboration and publishing reinforcing results.

At the board level, the collaboration program needs to be routinely reviewed as an investment portfolio. The board needs to take oversight responsibility to assure the appropriate balance of investments (see portfolio planning diagram) between risk and integration, and the nature of individual investments (facility, technology, service, and clinical).

Over a period of time, sustained collaborative success based on shared goals and real financial results will create a bond difficult to unravel.

Closing Thoughts

To quote the American icon Yogi Berra, "It is difficult to make predictions, especially about the future." It is, however, safe to say that the future of health care in the United States will be subject to continued turmoil; and the more hospitals and physicians are able to successfully collaborate, the greater the probability that they will be more successful on a good day and suffer less pain on a bad one.
It is essential that the board starts the process and keeps in mind that:

- Moving the hospital enterprise from managing physician relationships to engaging in real collaborations will set the stage for the much elusive "win–win" experience.
- In addition to the commitment to specific collaborations, a collaborative infrastructure is required to put legs on the intent.

- The rules can be complex. Seek good legal advice.
- Flexibility with actual collaboration structures and economic terms will get more deals done. As more successful deals are completed, the number of new deal ideas will increase.
- Once you have worked with one physician, you have worked with one physician. There is a wide range of physician personalities, motivations, and capabilities, necessitating that collaborations be broadly developed and individually applied.

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