Changing Demographics, Competencies and Physician Leadership

Peter B. Angood MD
Chief Executive Officer
American College of Physician Executives
“The acute care hospital is the most complex organization to lead and manage.”

Peter Drucker

**But Health Care Is Not Just Hospitals:**

- Highly Complex Processes
- Unique Problems & Patient Variability
- Loosely Knit Team System
- Multiple Outcomes Measures
- Incomplete Evidence Base
- Variable Layers of Responsibility
- Unpredictable Workloads & Case Mix
- Work Hours, Fatigue & Variable Employee Support Systems
FSMB Updated Stats

- Nearly 900,000 licensed physicians in the US (280 MDs/100,000 population)
- Avg. age = 51yrs & just over 76% certified by an American Board
- 2/3 of physicians are still male but...
- Female physicians with an active license increased in past 2 years by 8% - compared with only 2% of male physicians
- And 34% of female physicians are less than 39 years compared with only 18% of male physicians.
- Actively licensed physician population grew at faster rate in the older population compared with younger groups
  - 11% increase for those >60 years vs. 1% increase for those <49 years
- 26% of physicians are now over age 60 years, a demonstrable actuarial need for an increased supply of physicians in order to avert a physician manpower shortage in the near future.

Surge With Physician Employment

• Nearly 75% increase in the number of active physicians employed by hospitals since 2000, and recent hospital announcements suggest this trend is accelerating.

• September 2010 survey revealed that 74% of hospital leaders planned to increase physician employment within the next 12 to 36 months.

MGMA Survey
Surge With Physician Employment

• Share of physician searches that were for positions with hospitals hit 51% for the 12 months ended in March, up from 45% a year earlier and 19% five years ago.

• The number of searches for physician groups and partnerships has dropped.

Merritt Hawkins
And Yet....

• ACA will rapidly expand the coverage by an additional 32 million in the next few years

• HRSA, distribution of physicians to rural underserved areas remains problematic
  – 52 million people currently live in so-called Primary Care Health Professional Shortage Areas (HPSAs)

• AAMC states that physician shortage numbers will increase overall to almost 130,000 during the next 10 years
53 Global Health Care CEO’s

Challenges for Future:
• Managing Change
• Funding Care
• Define/Measure Quality
• Managing Regulation

Leadership Characteristics:
• Innovative
• Insightful on Patients
• Insightful on Providers
• Collaborative
• Data Analytics
• Humility

R. Herzlinger – Harvard University
Organizational Challenges in Managing and Nurturing Talent - Biggest Area of Difference - Implications:

- CEOs differ from academia: to them, academia does not produce the specific skills we need

- CEOs want business driven knowledge more than public health

- CEOs more ready to rehire than retrain than academia
Success Factors for Early and Mid-level Entrants - Implications:

- Academia values big picture vs. health care specifics more than CEOs

- CEOs think that ability to manage change is more important than knowing health policy, regulations

- They need flexible, adaptable people

- They need problem solvers with generic managerial skills more than those who can speak the health care language

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Role of Academia in Future Health Care:

- Present a Global View
- Teach End-to-End Portrait of Health Care
- Enable Critical Business Thinking
- Use of Field-Based & Case-Based Learning
- Mentoring Strategies
- Facilitate Interactions with Real World Peers
- Acceptance of *Health Care Paradox*

R. Herzlinger – Harvard University
MD Demographics: What is Happening In Your Organization
American College of Physician Executives

Vision Statement:
ACPE is the world's premier organization for lifelong growth and support of physician leaders.

Mission Statement:
To help ensure that physicians continually grow as individuals and become successful health care leaders, ACPE develops and provides the necessary programs, products and services.

Strategic Goals:
1. ACPE is recognized as the premier organization for physician leadership education.
2. ACPE provides lifelong development and support of physician leaders.
3. ACPE is the collaborative community of choice for physician leaders.
4. ACPE is the preferred organization through which to engage and interact with physician leaders on issues of healthcare policy, management and delivery.
ACPE is the nation’s oldest and largest educational organization for physician leaders.

Nearly **11,000** physician members of ACPE representing **45** countries

**65** expert faculty across dozens of disciplines

More than **50** physician leadership courses

**4** Master’s degree programs with **1,000** graduates

More than **2,000** physicians with ACPE board certification (Certified Physician Executives)

**150** in-house leadership courses taught each year at hospitals and health systems

**4** major educational conferences per year

More than **3,100** online courses sold annually

More than **20,000** physicians have completed the popular Physician in Management Seminar

**ACPE has educated nearly 100,000 physicians**
Largest categories of positional titles

- **VPMA, CMO**
- **Administrator, CEO, President, Commander (full-time administrative roles)**
- **Medical Director**
- **Department Chair**
- **Regional Chief, Practicing Physician, Academic, Vice President, Chief Operating Officer, Owner or Founder, Chief of Staff, Medical Staff Officer, Board Member, Student/Resident**
- **Other**
### Largest categories of specialty types

<table>
<thead>
<tr>
<th>Specialty Type</th>
<th>Color</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>Navy</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>Green</td>
</tr>
<tr>
<td>Surgery</td>
<td>Orange</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Light Green</td>
</tr>
<tr>
<td>Other</td>
<td>Red</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>Light Blue</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>Light Orange</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Light Yellow</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>Light Pink</td>
</tr>
</tbody>
</table>

![Pie chart showing the distribution of specialty types](chart.png)

- **Internal Medicine**
- **Family Medicine**
- **Surgery**
- **Pediatrics**
- **Other**
- **Emergency Medicine**
- **OB/GYN**
- **Psychiatry**
- **Anesthesiology**
Largest categories of organization types

- Hospitals
- Group practices
- Health Systems
- Academic Medical Centers
- Managed Care
- Ambulatory Care Center, Government, Military, Physician/Hospital Organization, Insurance, Pharmaceutical, Industry, Consulting, Contracting, Review
- Other

Pie chart showing proportions of different categories of organizations.
9 key elements that ACPE views as pivotal to patient-centered care:

1. Quality-centered
2. Safe for all
3. Streamlined and efficient
4. Measurement-based
5. Evidence-based
6. Value-driven
7. Innovative
8. Fair and equitable
9. Physician-led
So What Are We Hearing Out There??
Physician Leadership & Integration

The 5 Vowels for HCOs Are:
1. Acceptance of MDs in Local Culture is Variable
2. Engagement is Complex
3. Integration is Pivotal
4. Opportunity for MDs to Facilitate HCOs’ Learning
5. Uncertainty by MDs on Future of Health Care

The 5 A’s for MDs Are:
1. Awareness of Leadership Interests
2. Assessment of Potential and Charting a Course
3. Acquire Knowledge and Early Experiences
4. Adjust Course/Approach
5. Accentuate Leadership
### Three ways to lead

Research suggests that at least three distinct types of clinical leaders exist.

<table>
<thead>
<tr>
<th>Few</th>
<th>Institutional leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Clinician executive acting as steward of whole organization</td>
<td></td>
</tr>
<tr>
<td>• Little direct contact with patients</td>
<td></td>
</tr>
<tr>
<td>Sources of power</td>
<td></td>
</tr>
<tr>
<td>• Highly credible to colleagues as clinician and leader; able to communicate vision</td>
<td></td>
</tr>
<tr>
<td>Selected leadership skills and knowledge required</td>
<td></td>
</tr>
<tr>
<td>• Corporate-level strategic thinking, talent management, succession planning</td>
<td></td>
</tr>
<tr>
<td>• Political savvy; strong skills in negotiation and influence</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service leader</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Passionate advocate for own service, feels responsible for clinical and financial performance</td>
</tr>
<tr>
<td>• Moderate level of direct contact with patients</td>
</tr>
<tr>
<td>Sources of power</td>
</tr>
<tr>
<td>• Highly credible to colleagues, primarily as clinician; well connected, can tap into centers of excellence</td>
</tr>
<tr>
<td>• Innovative, willing to take risks</td>
</tr>
<tr>
<td>Selected leadership skills and knowledge required</td>
</tr>
<tr>
<td>• Fluent service-management skills—eg, strategy/people development, budgeting</td>
</tr>
<tr>
<td>• Detailed knowledge of evidence-based medicine in own clinical area</td>
</tr>
</tbody>
</table>

| Many | Frontline leader |
|---------------------------------------------|
| • Great frontline clinician who focuses on delivering and improving excellent patient care |
| • High level of direct contact with patients |
| Sources of power |
| • Passionate about clinical work, credible to colleagues |
| • Close to patients and frontline realities; can see opportunities for improvement |
| Selected leadership skills and knowledge required |
| • Understanding of systems- and quality-improvement techniques—eg, process mapping, operational improvement |
| • Self-starter, able to work well in teams |

*Health International 2009 Number 9*
Changing Skill Requirements

- **High**
  - Personal leadership skills
  - Management skills
  - Technical skills

- **Low**
  - Professional/Individual
  - Manager
  - Leadership

Relative Skill Importance
Competencies:
Healthcare Leadership Alliance (HLA)
16 Critical Competencies for Healthcare Leaders

**Cornerstone 1:**
Well-Cultivated Self-Awareness
Living By Personal Conviction
Possessing Emotional Intelligence

**Cornerstone 2:**
Compelling Vision
Being Visionary
Communicating Vision
Earning Loyalty and Trust

**Cornerstone 3:**
Real Way With People
Developing Teams

**Cornerstone 4:**
Masterful Style of Execution
Building Consensus
Cultivating Adaptability
Driving Results
Generating Informal Power
Making Decisions
Stimulating Creativity

Source: *Exceptional Leadership: 16 Competencies for Healthcare Leaders* (Health Administration Press, 2006).
# Medicine vs. Leadership

<table>
<thead>
<tr>
<th>THE NATURE OF MEDICINE</th>
<th>THE NATURE OF LEADERSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribe and expect compliance</td>
<td>Lead, influence and collaborate</td>
</tr>
<tr>
<td>Immediate and short-term focus and results</td>
<td>Short-, medium- and long-term focus and results</td>
</tr>
<tr>
<td>Procedures/episodes</td>
<td>Complex processes over time</td>
</tr>
<tr>
<td>Relatively well-defined problems</td>
<td>Ill-defined, messy problems</td>
</tr>
<tr>
<td>Individual or small-team focus</td>
<td>Larger groups crossing many boundaries, integrated approach</td>
</tr>
<tr>
<td>Being the expert and carrying the responsibility</td>
<td>Being one of many experts and sharing the responsibility</td>
</tr>
<tr>
<td>Receiving lots of thanks</td>
<td>Encountering lots of resistance</td>
</tr>
<tr>
<td>Respect and trust of colleagues</td>
<td>Suspicion of being a “suit”</td>
</tr>
</tbody>
</table>

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Competencies: Which Are Valued – In Your Organization
## Physicians as Hospital Leaders

<table>
<thead>
<tr>
<th>Rank</th>
<th>Organization</th>
<th>State</th>
<th>Name of CEO/President</th>
<th>Physician?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Johns Hopkins Hospital</td>
<td>MD</td>
<td>Paul B. Rothman</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Massachusetts General Hospital</td>
<td>MA</td>
<td>Peter Slavin</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Mayo Clinic</td>
<td>MN</td>
<td>John H. Noseworthy</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Cleveland Clinic</td>
<td>OH</td>
<td>Delos M. Cosgrove</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>UCLA Medical Center</td>
<td>CA</td>
<td>David T. Feinberg</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>Northwestern Memorial Hospital</td>
<td>IL</td>
<td>Dean M. Harrison</td>
<td>No</td>
</tr>
<tr>
<td>7</td>
<td>New York-Presbyterian University Hospital of Columbia and Cornell</td>
<td>NY</td>
<td>Steven J. Corwin</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>UCSF Medical Center</td>
<td>CA</td>
<td>Mark R. Laret</td>
<td>No</td>
</tr>
<tr>
<td>9</td>
<td>Brigham and Women's Hospital</td>
<td>MA</td>
<td>Elizabeth G. Nabel</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>UPMC-University of Pittsburgh Medical Center</td>
<td>PA</td>
<td>Jeffrey A. Romoff</td>
<td>No</td>
</tr>
<tr>
<td>11</td>
<td>Hospital of the University of Pennsylvania</td>
<td>PA</td>
<td>Ralph W. Muller</td>
<td>No</td>
</tr>
<tr>
<td>12</td>
<td>Duke University Medical Center</td>
<td>NC</td>
<td>Victor J. Dzau</td>
<td>Yes</td>
</tr>
<tr>
<td>13</td>
<td>Cedars-Sinai Medical Center</td>
<td>CA</td>
<td>Thomas M. Priselac</td>
<td>No</td>
</tr>
<tr>
<td>14</td>
<td>NYU Langone Medical Center</td>
<td>NY</td>
<td>Robert I. Grossman</td>
<td>Yes</td>
</tr>
<tr>
<td>15</td>
<td>Barnes-Jewish Hospital/Washington University</td>
<td>MI</td>
<td>Richard Liekweg</td>
<td>No</td>
</tr>
<tr>
<td>16</td>
<td>IU Health Academic Center</td>
<td>IN</td>
<td>Dan Evans</td>
<td>No</td>
</tr>
<tr>
<td>17</td>
<td>Thomas Jefferson University Hospital</td>
<td>PA</td>
<td>Stephen K. Klasko</td>
<td>Yes</td>
</tr>
<tr>
<td>18</td>
<td>University Hospitals Case Medical Center</td>
<td>OH</td>
<td>Thomas F. Zenty III</td>
<td>No</td>
</tr>
</tbody>
</table>
Physicians as Hospital Leaders

How are hospitals and health systems different when run by physicians?

- Better understanding on nature of challenges & common knowledge base
- Improved understanding of patient operational issues
- Unwilling to compromise quality/safety/labor for profit
- Finance as a means not an end
- Aligning differing values (RNs, MDs, support staff etc.) & improved interactions
- Greater value on physician leadership, compensate appropriately
- Anticipate change within health care industry and selectively embrace new technologies/methods, e.g., new trends, governmental regulation
- Better coordination with referral sources (private offices/clinics)
- Less duplication of similar services within region, more collaboration among local hospitals
- Greater insight into clinical/patient care activity on local and regional level

(Kearns et al - Physician Executive Journal, Jan/Feb 2009)
Physicians as Hospital Leaders

• Among the nearly 6,500 hospitals in the United States, only 235 are run by physicians
  (2009 - Academic Medicine)

• Overall hospital quality scores 25% higher when doctors ran the hospital, compared with other hospitals.

• For cancer care, doctor-run hospitals posted scores 33% higher scores
  Physician-Leaders and Hospital Performance: Is There an Association?
  (Goodall July 2011 - Social Science and Medicine)
Table 1.

Construction of the Dependent Variable - Index of Hospital Quality (IHQ)*

<table>
<thead>
<tr>
<th>Structure 30% Weight</th>
<th>Outcomes 35% Weight</th>
<th>Process 35% Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Availability of key technologies (15 technologies linked to specialty fields).</td>
<td>✓ Mortality rates 30 days after admission for all IHQ-driven specialties. It is calculated using a risk-adjusted method which includes: Volume of cases; Severity of illness; and a specialty-specific risk-adjusted mortality calculation.</td>
<td>Reflects physicians’ decisions made in the hospital setting, such as:</td>
</tr>
<tr>
<td>✓ Volume index (number of medical and surgical discharges).</td>
<td>✓ Patient-safety index includes: “freedom from accidental injury”, the practice of modern medical procedures and safety. This accounts for 5% of total score and is tied to both Outcomes and Process.</td>
<td>✓ Choices about admission</td>
</tr>
<tr>
<td>✓ Nurse staffing – intensity of outpatient and inpatient, and level of excellence.</td>
<td>✓</td>
<td>✓ Diagnostic tests</td>
</tr>
<tr>
<td>✓ Presence of a trauma centre.</td>
<td>✓</td>
<td>✓ Course of treatment</td>
</tr>
<tr>
<td>✓ Patient services index (e.g. presence of an Alzheimer’s centre, fertility clinic, etc.).</td>
<td>✓</td>
<td>✓ Choice of medication</td>
</tr>
<tr>
<td>✓ Have at least one specialist in critical-care medicine.</td>
<td>✓</td>
<td>✓ Length of stay.</td>
</tr>
</tbody>
</table>

This information is acquired through a survey of randomly selected board-certified specialist physicians in each specialty field.
Figure 1.

Mean Index of Hospital Quality (IHQ) Score of Hospitals Led by Physician CEOs and Manager CEOs in Three Specialty Fields
Kaiser Health News Article

• KHN - physician-owned hospitals continue to emerge as among the biggest winners under two programs in the health law.
  – rewards or penalizes hospitals based on how well they score on quality measures.
  – penalizes hospitals where too many patients are readmitted after discharge.

• More than 260 hospitals owned by physicians; scattered in 33 states (prevalent in Texas, Louisiana, Oklahoma, California and Kansas)

Physician Hospitals of America
• Of 161 physician-owned hospitals participating in the health law's quality programs,
  – 122 are getting extra money and 39 are losing funds

• In contrast, other hospitals have 74 percent penalized.

• Medicare is paying the average physician-owned hospital bonuses of 0.21 percent more for each patient during the fiscal year that runs through September

• Meanwhile, the average hospital not run by doctors is losing 0.30 percent per Medicare patient.
Kaiser Health News Article

• Past research: physician-owned hospitals score high in following basic clinical guidelines and patient satisfaction... the same factors that Medicare is using to determine bonuses and penalties in its VBP program.

• Successes are arguably made easier by the fact many patients come for elective surgeries rather than emergencies, allowing for more orderly preparations than at a typical acute-care hospital.
Physician Leadership: Is It Valued – In Your Organization
V = \frac{Q}{C} + A + E

1. Academic Medical Centers
2. Aligned Integrated Systems
3. Multi-Hospital Systems
4. Rural Hospitals
5. Stand-Alone Hospitals
STEPPING STONES TO DEVELOPING A CLINICAL INTEGRATION MODEL

**Legal and Successful**
- "Valuable" provider for, and viable competitor of, health plans
- Willing and able to directly compete for and manage self-funded employer contracts
- Consistently outperforms the market (providers and health plans) in terms of quality of care
- Consistently outperforms the market (providers and health plans) in terms of cost of care

**Legal**
- A network of physicians committed to improving the value of care has been established.
- A set of quality, cost and utilization initiatives/metrics has been developed to promote value creation by all participating physicians.
- A system has been put in place to track and monitor physician performance (IT infrastructure).
- A process for addressing performance issues has been established.

**Per-Se Illegal**
- A group of independent physicians promotes itself as "clinically integrated," but has made no real effort to integrate (i.e., modified messenger model).
About This Survey. The 2012 HealthLeaders Media Physician Alignment Survey was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a series of monthly Thought Leadership Studies. In June 2012, an online survey was sent to the HealthLeaders Media Council and select members of the HealthLeaders Media audience. A total of 279 completed surveys are included in the analysis. The margin of error for a sample size of 279 is +/-5.9% at the 95% confidence interval. A detailed report and analysis can be found online after September 11 at www.healthleadersmedia.com/intelligence/.
### Please select your top five physician recruiting targets over the next three years.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care</td>
<td>69%</td>
</tr>
<tr>
<td>Hospitalists</td>
<td>37%</td>
</tr>
<tr>
<td>Cardiology/Cardiovascular</td>
<td>46%</td>
</tr>
<tr>
<td>General surgery</td>
<td>43%</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>42%</td>
</tr>
<tr>
<td>Neuroscience/Neurosurgery</td>
<td>37%</td>
</tr>
<tr>
<td>OB-GYN</td>
<td>20%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>20%</td>
</tr>
<tr>
<td>Oncology</td>
<td>19%</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>16%</td>
</tr>
<tr>
<td>Pulmonary medicine</td>
<td>16%</td>
</tr>
<tr>
<td>Urology</td>
<td>14%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>10%</td>
</tr>
<tr>
<td>Multiresponse</td>
<td></td>
</tr>
</tbody>
</table>

### What are the top two motivators that are driving physicians to seek/accept employment with your hospital or health system?

<table>
<thead>
<tr>
<th>Motivator</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declining reimbursement</td>
<td>62%</td>
</tr>
<tr>
<td>Stable compensation/income</td>
<td>32%</td>
</tr>
<tr>
<td>Escalating practice expenses</td>
<td>42%</td>
</tr>
<tr>
<td>Enhanced lifestyle</td>
<td>21%</td>
</tr>
<tr>
<td>Fear of patient loss due to payers assembling closed networks</td>
<td>9%</td>
</tr>
<tr>
<td>Multiresponse</td>
<td></td>
</tr>
</tbody>
</table>
**PLEASE SELECT THE TOP THREE THREATS TO YOUR HOSPITAL-PHYSICIAN ALIGNMENT STRATEGY.**

<table>
<thead>
<tr>
<th>Threat</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician shortage in key specialties</td>
<td>61%</td>
</tr>
<tr>
<td>Expected reductions in reimbursement</td>
<td>53%</td>
</tr>
<tr>
<td>Difficulty getting physicians to participate as leaders</td>
<td>34%</td>
</tr>
<tr>
<td>Loss of medical staff to competitor hospitals</td>
<td>33%</td>
</tr>
<tr>
<td>Demands for paid call coverage</td>
<td>30%</td>
</tr>
<tr>
<td>Regulatory burdens</td>
<td>27%</td>
</tr>
<tr>
<td>Competition from physician-owned outpatient organizations</td>
<td>24%</td>
</tr>
<tr>
<td>Out-of-system referrals</td>
<td>19%</td>
</tr>
<tr>
<td>Physicians' requests for nonmonetary remuneration</td>
<td>5%</td>
</tr>
</tbody>
</table>

**PLEASE IDENTIFY THE TOP THREE OBJECTIVES OR MOTIVATIONS BEHIND YOUR ALIGNMENT STRATEGY FOR EMPLOYED PHYSICIANS.**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create coordinated physician buy-in to quality and safety initiatives</td>
<td>64%</td>
</tr>
<tr>
<td>Ensure coverage for strategic service lines</td>
<td>49%</td>
</tr>
<tr>
<td>Physician retention</td>
<td>42%</td>
</tr>
<tr>
<td>Maximize in-system revenue</td>
<td>41%</td>
</tr>
<tr>
<td>Maximize patient population served</td>
<td>33%</td>
</tr>
<tr>
<td>Improve in-system margin</td>
<td>23%</td>
</tr>
<tr>
<td>Attract participants for a center of excellence</td>
<td>23%</td>
</tr>
<tr>
<td>Attract physicians by offering a broad range of staff models</td>
<td>13%</td>
</tr>
</tbody>
</table>
Before embarking on a physician-integration strategy, hospitals and health systems should perform a detailed analysis of the following four critical areas to ensure that the strategy is competitive and sustainable:

- Strategic objectives
- Financial resources
- Requisite experience and functional capabilities
- Organizational structure, culture, and commitment

**Typical Elements of a Practice Acquisition Package**

A typical practice acquisition package will include the following:

- A three- to five-year term for the initial employment agreement
- An asset purchase agreement, specifically outlining assets to be purchased and those that will remain with the practice
- A custodial agreement between the practice and the health system for access and use of patient medical records post transaction
- A two- to three-year fixed compensation plan with productivity based on work relative-value units at the group or individual level and indexed to recalculate
- Employment of practice support staff under the hospital or health system’s wage and benefit plans
- Establishment of a practice advisory committee ("operating board") that gives physicians a voice in operations and strategy development
- Malpractice insurance provided by the health system with funding of tail coverage commonly provided as well
- Noncompete restrictions

*Source: Kaufman, Hall & Associates, Inc.*
<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>Typical Cost per Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property, plant and equipment, workforce in place, medical records, etc.*</td>
<td>$80,000 to $100,000</td>
</tr>
<tr>
<td>Funding networking capital</td>
<td>$40,000 to $60,000</td>
</tr>
<tr>
<td>Transaction costs</td>
<td>$20,000 to $40,000</td>
</tr>
<tr>
<td>Facility and technology upgrades</td>
<td>$20,000 to $40,000</td>
</tr>
<tr>
<td>Capitalization of leases as debt†</td>
<td>$100,000 to $250,000</td>
</tr>
<tr>
<td>Capitalization of operating losses</td>
<td>Significant</td>
</tr>
</tbody>
</table>

* Workforce in place and medical records are two intangible assets that are booked as long-term assets on the balance sheet.
† According to the new GAAP requirements, operating leases need to be considered as debt.

Source: Summary of recent observed transactions by Kaufman, Hall & Associates, Inc.
System Integration & MD Engagement:

- Stage 1: Create Physician Buy-In
- Stage 2: Create & Communicate System Vision & Common Goals
- Stage 3: Build MD Confidence & Trust
- Stage 4: Create Performance Leadership Structure
- Stage 5: Use Measurement to Assess & Report MD Performance
- Stage 6: Develop & Train MDs
- Stage 7: Create a Physician Code of Conduct

S. Beeson
For System Integration to Work:

• MDs must support and engage in a collaborative organizational culture
• MD behavior must be consistent with the vision and values of the organization
• MD and Administrative leadership must be tightly coupled moving in a unified direction

S. Beeson
Early Results on Integration?

ACPE recently surveyed its 11,000 physician leaders about what happens to health care costs when a group or practice is bought by a hospital or health system. Nearly 500 responded:

- Costs go up 32%
- Stay mostly the same 15.9%
- Costs go down 4.9%
- Not sure 12.5%
- Not applicable 34.7%

ACPE press release generated > 410 hits.

CNBC article... Dan Mangan (http://www.cnbc.com/id/100911258)
4 pitfalls to clinical integration

> Assuming that EHR adoption is the cornerstone of successful integration

> Believing that knowledge of clinical integration initiatives will passively diffuse through the ranks

> Delaying the development of ambulatory services that support clinical integration

> Attaching too much weight to Federal Trade Commission/Department of Justice approval of a clinical integration model
Issues/Approaches for Sustainability

• Capital Requirements
• Impact on Financial Performance (aggregate/within practice/across enterprise)
• Implementation Risk
• Impact on Current Operations
• Impact on Clinical Delivery
• Staffing Requirements
• Contracting Obligations
• Ability to Cover Geographic Needs
• Ease of Replication
Mayo Clinic Survey: Is It Accurate – In Your Organization
The extent to which participating physicians and administrative support staff understand the impact of clinical integration on their day-to-day activities is a strong predictor of the long-term success of the program.
Physician Integration Works – And Is Essential

Thank You For The Attention

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