Hospital-Physician Alignment: Managing Change in the Shifting Health Care Environment

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These are times of great change in the American health care industry. The current level of health care spending in this country is unsustainable, so economic and legislative forces are demanding that health systems and physicians reduce costs while improving the quality of care they provide. Achieving those goals will require a fundamental shift in the hospital-physician relationship from somewhat adversarial to cooperative. Effective change management will be critical to getting health systems and physicians to work together across the continuum of care.

This white paper will explore what change management entails, particularly in the context of hospital-physician alignment. It will highlight some of the differences between health systems and physician practices that create tension, and it will outline best practices for managing the shift toward a more collaborative relationship between the two parties.

What is change management?

Change management is the function by which new processes, technologies, systems, structures and/or relationships are introduced into an existing environment. It focuses on the impact of what will change on those who will implement the changes. Effective change management will gain acceptance of the new paradigm from key stakeholders by minimizing the friction caused by the changes.

The elements of a successful change management strategy will be the same in any industry:

- Consensus on the outcome or goal
- Inclusion of stakeholders in decisions
- Redesigning roles, jobs and teams
- Open communication
- Detailed plan for execution
- Detailed plan for communication
- Detailed plan for development and delivery of training
- Agreed-upon metrics and key performance indicators to measure success.

Best practices for change management include the following:

- **Visible and active endorsement of the change from leadership**: Executives and other leaders must demonstrate that they have bought into the change, talk about it and generate excitement about it. A clear vision of the change should be produced and shared.

- **Repetition of messages from appropriate sources**: Employees like to hear messages from two sources: CEOs and their immediate supervisors. Furthermore, people need to hear a message 5-7 times before they internalize it. Communication themes and/or talking points should be developed before a change management project launches. The messages can be communicated by CEOs, supervisors, HR and other sources via any means available, including intranet, email, newsletters, bulletin boards, etc.

- **Two-way communication**: Messages must flow not only down the organization, but also up it. Employees will have questions about changes, and if answers are not provided, the information void will be filled with rumors and speculation. Something as simple as an email account for questions can facilitate the exchange of information and assure employees that their concerns are being heard.
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- **Empowerment of people**: A broad base of people must be empowered to take action by removing as many barriers to change implementation as possible.

- **Definition of success**: Everyone wants to win, and part of the challenge of change management is defining victory so every stakeholder feels he or she can participate in winning.

**How does change management apply to hospital-physician alignment?**

To understand why a cooperative relationship between hospitals and physicians can be difficult to foster, one first must understand the traditional sources of tension between the two parties.

Health systems or hospitals generally are large, bureaucratic organizations concerned primarily with the efficient use of their capital and facilities. Physician practices typically are small businesses concerned with getting patients in and out the door and getting paid quickly for their services. As a result of these differences, hospitals and the physicians who use them will disagree over the number of nurses, amount of technology and other resources necessary to effectively care for patients.

Furthermore, physicians frequently believe hospitals lack the experience and understanding to oversee the practice environment. They may have been a part of, or at least have heard about, hospital-physician alignment efforts from the 1990s that were unsuccessful because hospitals failed to provide sufficient practice-specific management services to their employed physicians. Practices need to be able to act quickly to remain profitable, and physicians often feel the hospital environment prevents them from making business decisions with the appropriate haste.

**Who will be resistant to change in hospital-physician alignment?**

People in every industry dislike change because they fear losing control. Therefore, change will be resisted wherever it is not managed. Here are some of the stakeholders who might be opposed to the changes that greater hospital-physician alignment entails:

- **Health system administrators**: They will fear losing control over the deployment of capital and the service-line management in their hospitals.

- **Physicians**: Fiercely independent by nature and largely accustomed to working for independent practices, physicians can be frustrated by the loss of autonomy inherent in hospital employment.

- **Hospital employees**: Think, for example, of a hospital’s technology department. They will have to provide a different level of service for employed physicians than they will for other hospital employees. This will force them to alter the way they operate.

- **Practice administrators**: They do not like ceding control of the front-desk and data-collection processes or the hiring and firing of practice employees, among other functions.

- **Practice employees**: They may be resistant to changes in benefits and to dealing with a health system’s bureaucracy.
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Who should manage change in a hospital-physician alignment initiative?

No individual can be solely responsible for managing change. The stakeholders involved in a hospital-physician alignment initiative must come together to gain consensus on expectations and goals in order to identify gaps and build a business plan to achieve their goals.

One way to help manage the competing agendas is to create a stakeholder matrix. In a stakeholder matrix, representatives from each constituency are interviewed, and their responses are compiled to baseline expectations and critical success factors. Next, a gap analysis is performed to identify and understand the roadblocks between where stakeholders are today and where they want to be. After the gap analysis is completed, an action plan should be developed to help navigate the gaps and set priorities and goals in the form of a business plan. Once the business plan has stakeholder buy-in, quarterly updates in the form of a scorecard should be provided. Stakeholder buy-in at all project stages is critical.

Again, open communication is key throughout the entire change management process. The concerns and needs of stakeholders will change over the course of the project. Questions and feedback should be solicited at all project stages to ensure that concerns are being addressed and that stakeholders are progressing toward goals. In a hospital-physician alignment initiative, monthly meetings of hospital and physician leadership may be appropriate venues for seeking input and providing progress reports.

Health systems undertaking a hospital-physician alignment initiative should also enlist the services of a project management organization (PMO). A PMO is an independent group that will oversee the execution of the change management plan. The PMO needs to be independent from all the stakeholders in the change so they can see that the process is transparent and impartial.

What changes must be made to facilitate hospital-physician alignment?

To create a successful hospital-physician alignment model, a partnership between the two parties must be formed. Traditionally the physician does not trust that the health system is concerned about the physician experience, and the health system does not trust the physician to use hospital facilities efficiently. Trust between the two parties can only be established if both feel they are valued and equal.

Health systems can show physicians they are valued by creating a governance structure in which the physician group is on par with member hospitals. The president of the physician group should be at the same table with hospital CEOs, helping to plan and direct resources within the system.

Additionally, health systems can do more to recognize the essentiality of physicians – and not just hospital facilities – to patient care. Systems then must compensate physicians for the value they bring to hospitals. Systems can do this in a number of ways, including the establishment of co-management structures for service lines and gain-sharing for cost reductions.

Health systems also need to recognize that their bureaucracies do not mesh well with physician practices; therefore, they should help create a management services organization (MSO) that is aligned well with the specific business needs of smaller, nimbler physician practices. A well-executed MSO will not only keep physicians happy by allowing them to focus on medicine instead of business, but it will also help to optimize revenues for their practices, reducing hospital subsidies.
Physician practices, for their part, must give up some autonomy with regard to business processes and become more efficient. For example, the collection of data has to be consistent across all physician practices within a health system so it can be used to make quality and cost decisions. Patient responsibility policies also must be common across the system, and charity care practices must be standardized. In other words, physicians must work within the overall governance model of the hospital to create an environment where patient care is improved while reducing costs.

Lastly, both hospitals and physicians must recognize the need to become more patient-centric. Their focus should shift from episodes and CPT codes, for which hospitals and physicians have been paid under the fee-for-service model, toward patient outcomes, for which they will increasingly be paid in the future under bundled payment models.

A hospital-physician alignment initiative requires substantial change for both parties, and if that change is managed poorly, then the initiative is likely to fail amid an environment of distrust and animosity among the various stakeholders. However, if the change is managed well – with good communication and consensus on goals, execution plans and metrics – then there will be an environment of accountability, greatly increasing the odds of the alignment initiative’s success.

About Frank Marshall

As chief operating officer, Frank Marshall oversees integrations, accounts receivable follow-up, payment posting, as well as information management and technology for MedSynergies, Inc. Mr. Marshall focuses on data and information to determine the right business process and measurement for the corporation.

Prior to joining MedSynergies, Mr. Marshall was the vice president of planning and control at The Associates Financial Services Company, Inc., and was responsible for financial analysis, financial reporting and accounting.

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