Physician integration into the hospital system began in the 1990s in response to various pressures presented by managed care contracting. Hospitals and physicians formed new organizations to increase their contracting power with the managed care organizations. Four different models came out of this:

- Physician-Hospital Organization (PHO)
- Management Services Organization (MSO)
- Integrated Health Organization (IHO)
- The Foundation Model

Health plans paid physicians and hospitals on a capitated basis. The theory was to reduce healthcare costs and improve quality. Unfortunately, this arrangement failed on two levels:

1. The network’s support of capitated products limited the number of physicians in a network. This did not appeal to patients, who demanded more choices. In response to consumers, insurers developed products that allowed for larger networks and received a traditional fee-for-service payment. The plans were cost effective because they paid the hospitals and physicians lower fees and enforced strict management controls.

2. Physicians were salaried. Unlike private practice, their pay was no longer tied to the number of patients they saw. One office manager commented that, due to this practice, their office was open from 9:00 a.m. to 4:30 p.m., and the physician locked the door promptly at 4:30 p.m. It didn’t matter if a patient showed up at 4:32 p.m.; the patient had to wait until the following day or seek help elsewhere.

Talk ensued between hospitals and physicians about what to do with the existing arrangements that no longer seemed relevant. A complete departure seemed risky on both parts: physicians appreciated the participation in managed care contracts, and hospitals weren’t willing to risk the potential loss of referrals. The outcome was conservative—most hospitals retained some type of hospital-physician arrangement.

In 2000, studies showed that integrated systems had changed due to market conditions. The studies identified three different approaches in response:

- Hospital-based systems divested completely from integrated delivery systems, such as primary care practice ownership.
- Existing integrated delivery systems with cost-cutting strategies and physician incentives.
- Relationships with specialists fostered through financial arrangements such as joint ventures.
Overwhelmingly, there was an urgency for hospitals to develop and build relationships with specialists, the way it was before managed care came into play. Specialists could attract patients needing high-cost services to hospitals, bringing in added revenue under fee-for-service arrangements. Hospitals worked to attract specialists through multiple strategies such as building new facilities and developing initiatives in specific profitable areas including cardiology, orthopedic, and oncology services. Scenarios also evolved in which hospitals and physicians held joint ownership in not only the services listed previously but also in ambulatory surgery and imaging. Hospital ownership of primary care physicians was still evident but remained a significant management issue given the fixed costs, overhead, and reduced patient loads.

Today there is talk of a renaissance of physician-hospital integration. The look is new and driven by a number of factors such as economic necessity, a defensive market strategy, or simply quality of life. New models employed as part of the resurgence of this approach include:

- The emergence of investor-owned hospitals and surgery centers:
  - These centers are wooing physicians by offering them investment opportunities for practicing in their facilities.

- Revitalized practice management groups:
  - These groups offer physicians the benefits of managed care contracting, group contracting, and reduced pricing on practice management systems or electronic medical records.

- The creation of health systems and hospital group practices:
  - Clinic models such as Mayo Clinic, Cleveland Clinic, and now Carilion Clinic: The mission is to deliver a broad range of clinical services that may include research and education. Physicians form the governing body and fill leadership positions.
  - Hospital-based group practice (HBGP) model: This model is created by consolidating many physicians into a multispecialty group practice owned or connected to the hospital.

The new models have shown to be stable for today’s business environment. In addition, contracts today are unlike those of the 1990s in which physicians were given a salary. Today’s business model is based upon physician productivity. At the end of the day, though, what helps these relationships flourish? They are bolstered by the following attributes:

- Hospital-physician collaboration and mutual respect.
- Hospitals making it easy for physicians to work within their system(s).
- Support of the local community.
- A comprehensive strategic plan for achieving mutual goals in clinical, academic, and business outcomes.

Today, hospitals are using a hybrid approach to hospital-physician relationships. Some have moved away from employed physicians completely, while some use a model that includes hospital group practices, joint ventures, and investor-owned centers. They have unanimously stated that the patient (consumer), rather than the physician, is driving more and more referrals. While some decisions are guided by insurance, more are driven by patient satisfaction or perception of the hospital or clinic. Some hospitals have responded to this by engaging Press Ganey to perform patient satisfaction surveys and establishing hospital-wide empowerment teams to review concerns and devise a strategy and plan for deployment. Hospital management is required to become active in community service. These activities are just the start of efforts to regain or increase consumers’ trust and thus the support of the local hospital and physicians.
Hospital-physician relationships have evolved and changed in response to the economy, market strategy, managed care, and the desire for a work-life balance. While the model today is moving away from hospital-owned physician practices, there is mutual agreement that some type of integration is necessary for the continuum of care and to secure the best clinical and business outcomes. Many believe that healthcare reform will accelerate the integration of hospital-physician relationships. The integration must incorporate the participation of the physician at every level—from creating the mission statement to operational procedures to management philosophies. Hospitals and physicians must extend the same dedication of integration to consumers, viewing them as partners. This requires establishing trust through open communication, community involvement, and making patient access to care a priority.

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