# Is Physician Employment by Health Systems an Answer?

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The mad dash by hospitals and health systems to employ physicians has been noted by many observers. Many of these arrangements provide physicians with higher salaries than they were earning in their practices and, in some instances, with 10-year contract terms. In fact, there are a host of delusional predicates underlying this phenomenon, which has been demonstrated to be a money-losing proposition for hospitals.[1] Oncology is part of this trend.

Burdened by lowered reimbursement rates and higher office expenses, oncologists, like many physicians, often believe they will be able to continue to practice as the free-range chickens they were before their new employment. They believe they will have financial security with at least the same compensation they are getting today. They believe the contracts they have signed will protect them. The parallel delusions on the hospital side are that if the hospital pays the physicians on a W-2, it will control them, and that by employing physicians, it will have heft in its negotiations with payers.

These parallel fantasies ignore the fact that the future of Medicare and payment from all payers will entail less money to hospitals—money from which hospitals are today subsidizing these lucrative arrangements for physicians. The Medicare value-based purchasing program began by cutting Medicare payments to all hospitals and giving some back to those that performed better. The initial winners and losers have been announced. More hospitals are beginning to understand that the flames of their burning platform are stoked by reductions in payment for avoidable readmissions and hospital-acquired conditions. Furthermore, in a quality-driven, performance-measured setting, where the community-based health care system works as it should, hospitals will simply not see the same admissions, in terms of volume or type, that they do today. This has already been demonstrated in oncology.[2,3]

The challenges for oncologists, as for all physicians, stem in part from the transitional schizophrenia of payment models that are beginning to move to payment for value but are predominately mired in fee-for-service fee schedules. Several key factors will be relevant to the oncologist's assessment of the status quo, what it will take to change behavior to move toward meeting developing demands, and what the hospital employment context really offers, besides money.

Many of the relevant factors turn on an examination of the so-called four Fs of the options[4]:

- Form: the structure of the practice setting
- Function: the clarity of its mission and consistency of its operations
- Finance: the business, payment, and compensation models
- Feeling: the cultural markers of the practice setting

This article offers some questions oncologists should ask regarding potential hospital employment opportunities and references a self-assessment tool that can be used to determine the extent of clinical integration in either setting. However, whatever the necessary changes in the status quo, in the last analysis, everything that will matter will be oriented toward improved value: better quality at lower cost with an improved patient experience of care.

## Whether to Become a Servant[5]

The common law definition of employment is a master-servant relationship. Ironically, few hospital systems with newly employed physicians are doing much to control them, and the value they are producing together is questionable.[6] The most critical challenge to making the decision to become a health system employee turns on questions to which it is difficult to get answers: What is the primary reason for the new employment model? Is it based on responding to physician anxiety or competitive offers by other institutions? Is the primary goal market share and size, or can you deduce far better answers? Those are the first F questions.

Good answers include that the physicians who are already employed can tell you that they believe they are working in a better-quality, safer place for their patients—the second F. Something positive is being built if everyone involved can report—both from the physician side of the street and that of the administration—that they see one another as valued partners who are collaborating to make real change. When the physicians are involved, actively, in the development of both payment and compensation models, the third F will be positioned better in a dynamic environment. If the organization recognizes physicians as its true leaders—the fourth F—the likelihood of achieving real change will be improved.

Do we have evidence that such a statement is supported in the real world? Indeed we do. At a meeting convened by the Commonwealth Fund and Academy Health in September 2010, when health reform seemed imminent, leaders of significant integrated medical groups, like the Marshfield Clinic (Marshfield, WI), Scott and White (Temple, TX), and Billings Clinic (Billings, MT), came together to try to elucidate those salient characteristics that made them high-value, high-quality health systems—characteristics that might be replicated in a nonemployment model. To a clinic, they reported that it was their physician-driven culture that distinguished them from

most US health systems.[7] They also reported that sustaining that culture depended on the appropriate selection of participants. When hospitals passively take on high-volume admitters, high-priced specialists, and random physicians to garner their referrals, the potential for achieving this kind of culture is at risk.

The key questions that mark the hospital employment context are also relevant as oncologists confront their existing practice environments. The real demand for changed behavior in the developing arena requires that physicians clinically integrate with one another, even in their own groups.

## Clinical Integration

Clinical integration as addressed here is best described as: "Physicians working together *systematically*, with or without other organizations and professionals, to improve their *collective* ability to deliver high quality, safe, and valued care to their patients and communities."[4p30]

This is not about quality projects or utilization audits. It is about regularized, purposeful physician interactions that benefit all participants, most of all the patients. Regardless of the architecture within which health care is delivered—whether in a single medical practice group or among physicians whom hospitals now employ—to succeed, physicians must integrate clinically with one another to effect real change: improved quality and value.

There are at least 17 attributes of clinical integration that address common issues across physician entities, regardless of their form. They also can be categorized in relation to the four Fs to help to define the relative difficulty of achieving a truly integrated context. Regardless of physician practice setting, it is important to engage in critical analysis of the starting point and desired end points associated with these factors. There is a tool to do so: the Clinical Integration Self-Assessment Tool (version 2.0; CISAT).[8] Oncologists in their current practice settings would be well advised to engage in such internal review and make a commitment to change what needs to be changed to arrive at a more clinically integrated practice environment.

Purposeful choice of the organizational structure is relevant to issues that will entail governance and leadership design and operation, including how decisions are communicated and how accountable the leadership is to those being led. These are first F issues.

The function of the integration enterprise—the second F—is how it accomplishes change. Here, standardization is the leading theme. The extent to which all participants are expected to use and adhere to clinical practice guidelines and protocols will matter. Oncology has a head start with the availability of good, well-established clinical practice guidelines from the National Comprehensive Cancer Network and others. But standardization should go further. Standardization of to whom referrals are made based on clinical performance of those providers rather than who is merely in network is often overlooked in these activities. Of increasing importance will be from whom referrals are accepted and whether that is standardized. Standardized use of nonphysician personnel can be vital to success. Basic expectations of standardized documentation are fundamental. Standardized documentation facilitates measurement. Ongoing measurement of many things and transparency about everything are also critical benchmarks of clinically integrated environments.

The finance components of clinical integration—the third F—are also multifactorial. How is the work of the physicians reimbursed by outside payers? Developing forms of value-based payment such as bundled payments[9] and bundled budgets incentivize integration. How the physicians are compensated within the integrating entity should increasingly reflect and support outside models of payment as they change.[10]

Among the cultural markers of the integrating program—the fourth F—will be the extent to which value will be considered an explicit value in the operations. This means that participants will have to directly confront capacity control and efficiency, both in administrative and clinical terms. Using mechanisms that truly support a culture of teamwork and saving physicians for their highest and best use, while deploying nonphysicians to their highest and best use, can contribute to improved results.

## What to Do

The mere employment of physicians by hospitals guarantees nothing about the results that will ensue. Better motivations for employment include a new approach to true collaboration to deliver better, safer care for patients. Using the employment platform as a vehicle to seriously improve the delivery of quality and value is key. In considering which practice setting will be most effective to help oncologists produce value, the real issue is in which setting their clinical integration will be optimized.

Oncologists considering the master-servant relationship should ask the questions surrounding the four Fs. Those already employed should move toward clinically integrating themselves and should seek help from their employers to do so. Those considering remaining independent should recognize that clinical integration offers the best chance to produce value. All should use the CISAT, or something similar, to begin to develop a real plan to move from the status quo to a new vision.

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