Operational Benefits and Barriers to Physician-Hospital Integration

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Operational Benefits and Barriers to Physician-Hospital Integration

Abstract
Physicians and hospital management and staff often work side by side but rarely together. There are many cost-saving and quality-improving benefits that could result from proper integration, but many economic and operational barriers stand in between the status quo and a fully-integrated healthcare system. These misalignments and practices contribute to wasted healthcare spending.

Keywords
physician hospital integration, operational barriers, hospital systems

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Operational Benefits and Barriers to Physician-Hospital Integration

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Acknowledgements: I would like to offer my sincere appreciation to the University of Pennsylvania and the Wharton School for allowing me to use its facilities for the course of this research project, to Dr. Joanne Levy, Dr. Utsav Schurmans, and everyone else in the Summer Program for Undergraduate Research for your organizing and funding this project, and to Dr. Lawton Burns for advising and offering guidance throughout this research project.

Abstract: Physicians and hospital management and staff often work side by side but rarely together. There are many cost-saving and quality-improving benefits that could result from proper integration, but many economic and operational barriers stand in between the status quo and a fully-integrated healthcare system. These misalignments and practices contribute to wasted healthcare spending.

Keywords: physician hospital integration, operational barriers, hospital systems
INTRODUCTION

In the status quo, payers and providers exist in fragmented, disjointed siloes. While the two principal agents of care delivery in the US – physicians and hospitals – often work side by side, they rarely work together. This inefficient and moderately frightening situation is the result of incentive misalignments, unwillingness among key stakeholders to cooperate, and wasteful spending practices. With the US spending more than $3.2 trillion on healthcare in 2015 (17.8% of its GDP, up from 17.4% in 2014), there is little doubt the US healthcare landscape needs some unification in order to stem the bleeding of valuable dollars into a poorly integrated system.

Figure 1: Healthcare Spending in the US, 1960-2010

Health care spending has grown much faster than the rest of the economy in recent decades.
METHODS

For this paper, we analyzed patient, physician, and hospital survey data and parsed through healthcare management and health economics literature to identify and examine the main economic and quality-improvement benefits that would result from better incentive alignment and cooperation between physicians and hospital management and staff and the barriers to prevent such integration.

OPERATIONAL BENEFITS TO PHYSICIAN-HOSPITAL INTEGRATION

Enhanced Coordination of Care and Patient Safety

Nowadays, very few significant medical conditions are diagnosed by only one physician. The healthcare landscape has evolved dramatically over the past six decades and has become increasingly intertwined. Patients are much more likely to be cared for and examined by a host of physicians than they were a few decades ago and a large variety of non-physician care providers (e.g. diagnostic technicians, clinical pharmacists, physical therapists) are becoming increasingly prevalent in the hospital. Having all players and stakeholder operate by the same playbook will help standardize and streamline operations within the hospital.

Encouraging collaboration between hospitals and physicians would also improve patient safety. Currently, patient safety procedures are administered by hospital medical staff rather than by physicians. Many of the errors that safety procedures seek to root out may only occur once in a physician’s lifetime and as such, physicians oftentimes do not see the value in trying to prevent a catastrophic event that has very little chances of happening. If physicians and hospital staff can be better integrated and if physicians take part in the safety checking process, then it would be
possible to reduce preventable errors during the medical procedures and potentially reduce professional and institutional medical liability costs.

**Improved Availability of Patient Information**

Integrating physicians and hospitals would also improve how patient care information is shared among various stakeholders in the healthcare system. Integrated electronic medical records would save time for both parties and improve quality of care because it would reduce the chances of in-hospital and post-discharge medication errors. There will also likely be a reduction in readmission rates, especially for patients with a history of chronic conditions, because physicians will have access to the full clinical story rather than the sliver of knowledge that current fragmented paper-based records offer. Fortunately, the technology for digitizing all medical records already exists and number of small to medium sized commercial vendors for electronic medical records platforms have increased dramatically over the last decade, which has helped lower the cost for transitioning to EMR platforms.

**Improved Length of Stay Management and Decreased Duplication of Diagnosis Tests**

In the status quo, Medicare diagnosis-related group (DRG) systems create conflicts of interests between physicians and hospitals. Hospitals usually charge patients a fixed fee for admissions and don’t gain financially from having a patient stay in the hospital for an extended period of time. Most physicians, on the other hand, are paid on a fee-for-service payment method and thus have a profitable incentive to keep patients in the hospital and order diagnosis tests even if those tests may be redundant. It was predicted that the US could have cut $25 billion in healthcare spending in 2004 if hospitals had avoided adverse events and duplicate tests.¹ Encouraging physicians and hospitals to work together would remove the profitable incentive that currently

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¹ [http://content.healthaffairs.org/content/28/5/1475.full](http://content.healthaffairs.org/content/28/5/1475.full)
exists in the sequence of events and will likely reduce the length of time that patients stay in the hospital and reduce the amount of money patients spend at the hospital.

**Figure 2: Types of Waste in US Healthcare Spending**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>DESCRIPTION</th>
<th>PERCENT OF HEALTH CARE SPENDING</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLINICAL WASTE</td>
<td>Spending that could be reduced with better prevention or higher-quality initial care; replacing services with less-resource-intensive alternatives; or improving processes by standardizing best practices</td>
<td>14%</td>
</tr>
<tr>
<td>ADMINISTRATIVE</td>
<td>Spending that could be eliminated with simpler, more-standardized processes for billing and collections, credentialing, compliance, and oversight</td>
<td>9%</td>
</tr>
<tr>
<td>COMPLEXITY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EXCESSIVE PRICES</td>
<td>Overspending resulting from paying high prices charged by inefficient suppliers (including providers), which could be eliminated by tying prices to efficiency, outcomes, and a fair profit</td>
<td>5%</td>
</tr>
<tr>
<td>FRAUD AND ABUSE</td>
<td>Spending associated with illicit schemes to extract payments for the illegitimate delivery of healthcare services</td>
<td>7%</td>
</tr>
</tbody>
</table>

**Economies of Scale in Purchase of Supplies and Equipment**

In many instances, physicians receive benefits from suppliers from using specific supplies, devices, or equipment produced by said companies. Because of physicians’ highly specific demand for certain products, hospitals often amass significant expenses to acquire these supplies. This conflict of interest costs the healthcare system and medical device/pharmaceutical companies billions of dollars every year in fines and added cost. In addition to stemming this issue through anti-kickback and whistleblower laws, physicians and hospitals ought to learn to work together. If physicians and hospitals agree to use the supplies from a single supplier,

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hospitals will have larger negotiating power and can save a lot from purchasing in bulk. A portion of the saved cost could be given as bonus to physicians to incentive and encourage their cooperation with the hospitals.

**Increased Utilization of Hospital Equipment and Floor Space**

Hospitals and physicians both lose money when hospital equipment and human capital do not achieve high utilization. The national average hospital bed occupancy rate in 2012 was 61 percent, yet many patients spend a long time queueing for hospital beds when they are admitted to hospitals. Under the fee-for-service payment model, physicians lose money whenever there are delays or scheduling conflicts for check-up rooms and other hospital equipment. If different physician groups work together and improve coordination with hospitals, it would be a win-win situation because hospitals can streamline the utilization of resources while giving physicians the opportunity to make more money.\(^3\)

**OPERATIONAL BARRIERS TO PHYSICIAN-HOSPITAL INTEGRATION**

**Operational and Financial Difficulties of Forming Multispecialty Groups**

Multispecialty groups comprise of physicians from a wide range of medical specialties all grouped within one organization. Multispecialty groups serve as one stop shops for patients and makes everything from scheduling appointments to transferring medical records more simple. They promote an environment that encourages and enhances communication, collaboration, and peer review that often leads to higher quality of care for their patients at a reduced cost. However, the difficulties associated with multispecialty groups are as abundant in their formation as in their day-to-day operations.

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\(^3\) [http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3950617/]
Income disparity among multispecialty physicians (MSP) is a large contributing factor to the difficulty in forming a multispecialty group. Family practitioners and pediatricians made on average $189,000 per year in 2012 while an orthopedic surgeon earned an average $519,000 during that same time. This large income disparity presents a dilemma. On one hand, if certain MSP were paid salaries that were significantly higher than other MSP in their group, this would almost certainly lead to a lot of clamor for more equitable pay. However, if the hospital system started to subsidize the wages of the lower salary MSP, then there will likely be a lot of unhappiness and disgruntlement among higher-paid physicians. Income disparity among multispecialty physicians and lack of payment methodologies that promote group function stands as an obvious and significant barrier to creating multispecialty groups and as such solving the salary problem is crucial.

Figure 3: Median Salary for Mid-Career Physicians in the US, 2014

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Multispecialty groups are also difficult to manage from an operational standpoint because most physicians possess an individualistic spirit by nature of their training and background from medical school and residency. As such, it may take time and training for physicians to embrace teamwork and integration. Additionally, in most instances, hospital administration makes the hiring decisions for nurses who will work with the multispecialty physicians in their organization. This may present issues if certain physicians cannot get along with certain nurses – a potentially conflict point that is virtually nonexistent in independent physician practices since physicians choose their own nurses and attending staff. Physicians can also pick their associates or partners based on their own skill level and personality fit, which lowers the chances that physicians will develop conflicts with other physicians over incompatible personalities and differences in training and experience.

**Physicians Disconnecting from Hospitals and Increased Competition Between Physicians and Hospital Groups**

Over the last several years, specialists and primary care physicians have started moving away from hospitals for many of the same reasons why it’s so difficult to integration physicians and hospitals, such as income disparity among physicians, different work cultures, and failure to share common vision in integrated delivery network. In fact, it is becoming more common for hospitals and private physician clinics to compete directly for profit rather than work together. Increasingly, physicians who have private practices are investing large sums of money to purchase equipment like MRI and X-ray machines to capture the technical fees from outpatient services and therapeutic procedures. The redundant purchases add cost to clinics and drive down profit margins for both hospitals and clinics.
**Different Work and Business Cultures**

Differences in work culture and business education also serve as barriers in proper physician-hospital integration. Prolonged decision-making processes in large hospital systems could be seen as overly bureaucratic and stand as a contradiction to private practice culture, which has much flatter hierarchical structure and less operational oversight and approval from administrators.

Furthermore, it is important to understand physicians and hospitals have fundamentally different training backgrounds. Although most hospital administrators have a background in hospital management and a deep understanding of the healthcare landscape, few have medical training or spent time in the clinic. On the other hand, most physicians undergo rigorous medical training throughout their four years of medical school and three to five years of residency but lack formal business training. Physicians are likely to mistakenly associate business lingo with unnecessary corporate bureaucracy, which makes communication and integration more difficult to implement.

In addition, physicians typically have a natural sense of self direction and feel entitled to a certain level of income and standard of living because of their heavy investment in their education.

**Protracted External Quality-Reporting Process and Lack of Consistent Quality Performance Measures**

Hospitals and physicians are required by payers and government regulators to undergo auditing and accreditation every year to ensure they meet standards of care. However, the accreditation process is usually independent for physicians and hospitals and does not have metrics that measure how well the two parties work together. Another drawback of having independent
accreditation is that the process is usually drawn-out and not as streamlined as if both hospitals and physicians were accredited together.

A potential solution to the lack of consistent quality performance measures is to establish metrics that measure collaboration between physicians and hospitals, such as conflict between physicians and medical staff and the number of important decisions that involved both hospital administrator and physicians. Doing so would encourage integration and greater degrees of collaboration because both physicians and hospitals will have an incentive to receive higher grades in the accreditation process.

**Lack of Electronic Health Records System Implementation and Standardization**

According to Hillestad, only 20 to 25 percent of all hospitals in the United States have adopted electronic health record (EHR) systems. One main reason is the high cost of implementation. Hospitals and healthcare professionals are weary about the high start-up and maintenance cost and the general lack of funding for a transition from paper medical records to electronic health records. Another cause of concern is the functionality and ease-of-use of the EHR system. Paper medical records have existed for a long time and many physicians and hospital medical staff lack the knowledge and operational skills to use EHRs. Training the physicians and staff will require extra time and money – resources that most hospitals do not have an abundance of – such that many hospitals don’t see the immediate value of switching to electronic medical records. Even if all hospitals switched to electronic health records, it is quite unlikely that all physicians will use the same EHR system since most parties do whatever is easiest to satisfy parochial requirements rather than which would offer the most benefits to other physicians and hospitals. This would present problems when hospitals and private clinics that use different EHR systems are exchanging patient records and would significantly diminish the convenience factor compared to
paper records. All of these issues are further compounded by the privacy and security concerns that often arise from keeping large quantities of sensitive data in a single database to the point where many just cannot justify the value over the risk of switching to EHRs.

**Failure to Share Common Long-Term Vision for Value in Integration**

Most importantly, one of the firmest barriers to physician-hospital integration is physicians’ failure to perceive the long-term value of integration. The majority of physicians believe that if they’re providing high quality medical care and service in the present, they are fulfilling their duties as physicians. Physicians are trained to be risk averse in their medical practices and that risk aversion carries over in their dislike of change in protocol. Rather than seeing the long-term value of integration, they instead see integration as a burden since it requires working outside with “the other party”. While many physicians know of integrated delivery networks (IDNs) such as Mayo Clinic, Kaiser Permanente, and Cleveland Clinic, very few physicians have experience working in such environments or know of anyone who have worked there because there are so few successful IDNs. Finally, from a psychological standpoint, most physicians are successful independent people who tend to perceive change as a negative rather than a bonus. This may further contribute to their distaste for change since they are comfortable with their status quo.

**Operational Changes to Encourage Integration**

Physicians and hospitals are more likely to integrate if they can share a common vision and have equal stakes in managing the system. It is important to realize that proper physician-hospital integration will rely on more than just physicians and hospitals – hospital administrators, payers, and technology systems all need to evolve and coordinate in order to promote better integration. In terms of management, physicians and hospital managers should engage in a collaborative
governance model to ensure that all stakeholders can voice their opinions in the decision making process and that all suggestions receive consideration before a final consensus is reached. Finally, physicians and hospitals are more likely to integrate if they share a common vision and dream for a more integrated and collaborative healthcare system in the future.

**CONCLUSION**

The benefits of integration range from enhanced coordination of care and improved safety for the patients to increased utilization of hospital equipment and buying supplies in bulk at discounted prices. However, given the complicated nature of the US healthcare system and the conflicting dynamics between physicians and hospitals, full integration between the two parties is a lofty goal that may take decades to complete. If all stakeholders in the healthcare delivery supply chain can fully understand the operational benefits of integration and work together to remove barriers, it is optimistic that integration will occur slowly but surely in the future and that doctors and hospitals will form a more perfect union in the coming years.
References


