

## FEATURE STORY

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healthcare financial management association www.hfma.org

## physician acquisition what to avoid after the deal is complete

The challenges of acquiring a physician practice do not end when the agreement is signed. Hospitals also need to take steps to ensure the transaction leads to successful integration.

### AT A GLANCE

After a hospital acquires a physician practice, relations can become strained between the parties in any of four areas:

- > Governance and decision making
- > Technology
- > Payment structures
- > Emotional factors related to the acquisition

For a hospital or health system, negotiating the acquisition of a physician practice can take months of painstaking work, as both sides work out details on terms such as price and compensation. When the final line has been signed, it's no wonder the natural inclination is for everyone to breathe a collective sigh of relief. The deal is done.

Except that now, the real work begins.

Successfully integrating a hospital and a physician practice group requires operational and financial due diligence before completing the deal—but only so much can be accomplished before the closing date. Sometimes, in the flurry of preacquisition negotiations, the details regarding actually managing the practice become lost. That is why a hospital's actions in those first several months after acquiring a physician practice are critical to the long-term success of this partnership. If issues arise after a physician practice has been integrated with the organization, and if these issues are not addressed, the resulting tensions could lead to major bumps in the relationship—or could derail the partnership altogether.

Even hospitals and physician practices that share an excellent relationship prior to an acquisition could face strategic, operational, financial, or even cultural challenges after integration, when the differences between the organizations become even more apparent. Such differences can negatively affect not only each “business,” but also each physician within the practice.

What's more, just because negotiators have come to a successful agreement does not ensure that the two parties will successfully integrate. The key to a successful integration is recognizing the four areas where problems are most likely to arise after the transaction is complete—and taking preventive steps to avoid cracks in the relationship.

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### **Problem Area No. 1: Governance and Decision Making**

A physician practice's decision-making process is fundamentally different from that of a hospital or health system. Although the multilayered governance structure of a hospital allows for better monitoring of resources, it also consumes more time. Capital investments are generally part of a hospital's annual expenditure budget; requests that are not budgeted must undergo an approval process. The need to run such decisions through a chain of hospital administrators and committees can tax the patience of physicians in a practice group that has just been acquired. In physician practices, a small group of key physicians often is responsible for making decisions regarding long- and short-term strategy, capital investments, and compensation. This compact structure means decisions are made relatively quickly and are not subject to the compliance oversight and regulatory approval under which hospitals operate.

**Case example.** A physician submits a request for a nuclear camera at the beginning of the month and expects to receive a decision by the end of the month. That request, however, has to pass through several committees, from materials management to finance, before it goes before the hospital board for a final decision—a process that could take several months. When the physician does not receive what he perceives to be a timely response, he becomes frustrated, making it more challenging for the hospital to obtain physician buy-in down the road and prompting the physician to consider leaving the practice.

**Suggested solutions.** Immediately following the acquisition, the practice physicians should receive a full explanation of the hospital's process for including capital requests in annual budgets. For unbudgeted items, a governance system should be set up to oversee such requests. For example, a steering committee composed of hospital administrators and practice physicians could be created to govern the practice group. A request for a nuclear camera would go first to the steering committee for approval, and then to the hospital's materials management and finance committees. The hospital board would make the final decision. This process could still take two to three months, but it involves the physicians in decision making, which is key to gaining their understanding and compliance with the governing process.

### **Problem Area No. 2: Technology**

In general, hospitals have adapted to the use of electronic health records (EHR) faster than physician practice groups. Hospital-based EHR systems tend to be more sophisticated—and more complicated to use—than EHRs used in practice groups. Some physicians still may be using paper charts for documentation. One reason is cost, but another is time. It often takes a physician longer to complete documentation using an EHR system because there may be a number of screens to link through before a desired file can be accessed. The physicians are likely to prefer EHRs that focus on ease of workflow in terms of documentation, scheduling patients, and organizing day-to-day operations.

**Case example.** As a matter of convenience and expedience, a hospital implements its EHR system within its newly acquired practice. A physician who works 11-hour days and sees about 30 patients each day finds it challenging to carve out additional time to learn a new computer system. To accommodate this learning curve, he begins to see fewer patients, causing volumes to decline.

**Suggested solutions.** During the time when physicians are learning the new EHR system (generally, 60 to 90 days), the hospital should reduce the number of patients that physicians are

seeing during normal practice hours. Patients not seen by the physicians during regular hours could be transferred to midlevel practitioners, such as nurse practitioners, or the physicians could elect to see these patients during added evening and weekend hours. To shorten the learning curve, the hospital can recruit a practicing physician to be a champion who focuses solely on helping physicians and other clinical staff learn the new system.

### Problem Area No. 3: Payment Structures

When it comes to payment structures, hospitals and practice groups differ widely—and such differences can have a direct impact on revenue. Alignment of economic interests between a hospital and an acquired physician practice does not happen automatically; for example, physicians will not instinctively alter work practices to become more cost-efficient for the organization as a whole. One reason is that payment mechanisms differ between hospitals and physician practices. Physicians are accustomed to being paid on a professional fee-for-service basis, while hospitals look more critically at utilization. Physicians also may be accustomed to using specific supplies and vendors that are higher in cost than the hospital would prefer.

**Case example.** An interventional cardiologist, practicing within a hospital-based setting, unknowingly increases costs by ordering redundant tests and using an expensive stent that provides no greater value than a less expensive stent of the same quality.

**Suggested solution.** The hospital should develop a meaningful alignment strategy for acquired physician practices, such as a comanagement structure that aligns the best interests of the hospital with the best interests of the physicians. In addition to providing a fixed fee, the hospital should offer financial incentives to physicians based on their ability to follow care protocols and meet agreed-upon metrics. For example, utilization protocols could be created that give physicians incentives to select from a choice of three stents, rather than six.

### Problem Area No. 4: Emotional Factors Related to Acquisition

No matter the industry, when two entities merge, employees always wonder, “What is going to happen to me?” Within a physician practice, clinical and administrative staff may fear losing authority, existing wages, or even their jobs.

For example, salaries of similar positions can vary widely from a hospital or health system to a physician practice group. A registered nurse with five years of experience at a practice may earn \$30 an hour. The salary range at the hospital for a

#### Warning Signs of Trouble in Hospital-Physician Group Relationships

Four metrics can help hospitals gauge how well its integration with a physician practice is proceeding.

**Is the number of new patients declining?** This may be a sign that physicians are not working as hard or the practice comprises too many follow-up and chronic care patients. Practices grow through new patients in need of diagnostics and procedures. These same patients may require other hospital services as well.

**Are patient access times increasing?** If a patient cannot make an appointment to see a physician within a reasonable time—say, three to five days for a cardiology practice—there may be inefficiencies in the patient scheduling process and problems with internal operations. Perhaps a physician isn’t responding to a scheduler’s request to see a patient in a timely manner. That practice risks losing the patient to a competitor.

**Are emergency department (ED) providers complaining?** This is a sign of poor customer service and even inadequate patient care. An ED physician doesn’t want to treat patients who should be seen by specialists. A cardiologist on call, for example, should not triage a patient with chest pains over the phone with the ED physician. The cardiologist should have the patient sent to cardiology for treatment. Otherwise, the ED may send patients to a competitor.

**Is the number of follow-up visits increasing?** If the practice has scheduled too many follow-up visits, there may not be enough time for physicians to see new patients and expand the practice. This could be the sign of an aging or inefficient practice. It might be time to move some of the follow-up visits to a nurse practitioner, physician’s assistant, or a younger physician in the practice.

position with the same qualifications, however, might not exceed \$25 an hour.

For hospitals, the challenge is retaining experienced staff and enabling employees to feel secure within a new working culture. A hospital that opts to reduce salaries of incoming practice staff may lose valuable expertise if employees decide to leave.

**Case example.** A registered nurse leaves a practice group after her salary is reduced by 20 percent when the practice is acquired by a hospital.

**Suggested solutions.** Grandfathering in the salaries of existing practice staff and setting a base salary while making up any gaps with bonuses are two possible solutions. For example, a practice group nurse who received \$30 an hour would earn a base salary of \$25 an hour at the hospital, plus a bonus that would be equivalent to the \$5 per hour gap between the practice and hospital salaries. Hourly wages for hospital nurses may also have to be adjusted to align with the salaries of the practice nurses.

### **Avoiding Pitfalls**

Preventing issues related to acquisition from escalating into serious problems requires communication—early and often, whether in group form or one on one. Physicians and staff should be educated and reminded about the changes resulting from the new business venture—especially those changes that have the greatest potential to affect their daily operations.

**Explain the transaction.** Negotiators for the hospital and practice group will know the terms of the transaction quite well, but that doesn't mean physicians, senior leaders, department managers, and hospital and practice staff will be as informed. After the closing date, hospital senior executives should take the time to review and explain the transaction to leaders and employees in both the hospital and physician practice—perhaps more than once—to ensure everyone understands how the changes will affect their work. Developing a decision matrix that explains who

can authorize expenditures and sign checks, who can make decisions regarding charity care, and who will oversee the benefits structure will help physicians and staff transition into a new working environment.

**Be up front.** Fears of change and layoffs are common upon news of any merger. The initial goal is to calm those fears by announcing that there are no planned layoffs—if this is true. But hospitals or practices should not make guarantees that cannot be kept. It should be made clear that hospitals have no control over market forces, such as reductions in payment that negatively affect revenue. Nor should either side claim to have all the answers when it comes to the many variables that can affect a business transaction. The hospital should provide as much information as possible, but not mislead.

**Understand who will be affected by the transition, and how.** Before implementing major changes, hospital leaders should seek to understand the needs of physicians and clinical and office staff who will be affected by those changes. For example, hospital and practice information systems may not be compatible. Any new system should meet the needs of both sides. A review of each party's IT systems may be necessary to determine which functions overlap and where potential issues may surface. It may be necessary to reallocate hospital IT staff during the first several months after a physician practice acquisition to focus on the IT issues related to the practice.

### **The Financials and Beyond**

A successful integration will create benefits for both sides, such as higher revenue, better compensation, increased benefits, reduced cost, and access to more specialized staff. Anticipating the potential pitfalls related to integration—and working proactively to limit their effect on either party—can help hospitals and practice groups optimize the expected financial benefits and minimize potential downsides.

When a hospital acquires a physician practice, there is more at stake than the hospital's and

practice's potential financial rewards of success or fallout from failure. A failed integration between a hospital and practice can have a significant impact on the community that both entities serve. If a neurosurgeon leaves a practice because of a mishap after integrating with a hospital, does that leave the community without a neurosurgeon? What services will a community be left without if an integration turns sour? Both sides should consider the potential impact if the integration does not go well.

Hospitals and physician practices spend a great deal of time going over the terms of an acquisition before the transaction takes place—and rightfully so. But even the best-planned weddings don't make for the best marriages. Often, much time is spent on planning the deal, but little thought is given to what comes into play after the transaction—how the relationship is going to

work from day to day. Knowing where the problems are most likely to arise and preparing for them can make for a smoother transition and increase chances of success—for everyone involved. ●

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