The Psychology of Organizational Structure in Integrated Health Systems

By Daniel K. Zismer, PhD

In this article...

Examine a social learning theory model as a framework to guide health system leaders as they consider the psychology of organizational design as it pertains to the successful integration.

....

Even though health care market dynamics, health care economics, policy and politics are likely to encourage provider-side consolidation leading to the formation of more fully integrated health systems[1] some independent physicians and community hospital leaders and managers resist integration for a variety of reasons, including those that can reasonably be categorized as psychological (and perhaps emotional).

Within the realm of the psychological, physicians, especially, have concerns for (and perhaps fears of):

- Loss or compromise of professional autonomy and related prerogatives of professional judgment

- Non-physician "managers" will control work-life decisions and professional productivity expectations, compensation-related rules and expectations

- And, in the extreme, employment termination and the right to practice medicine within the community

Such fears and concerns are not the province of physicians alone. Health system leaders and community hospitals operating from the more "traditional" clinical and business models may view "integration" as a path to physicians "taking over"; taking over control of not only clinical programs, but health system operations, strategy, mission and finance as well.

"If physicians take over leadership of the health system, why do they need me?" is a frequent comment from the non-physician health system leader who is concerned by the potential for expanding physician leadership.

Dilemma in a psychological framework

Julian Rotter, progenitor of one model of social learning theory.[2,3] believed that behavior is a function of a person's expectation for a reward of sufficient (and motivating) value, plus intervening situational and related psychological factors.

B f: Expectancy + Reward Value + Đ

Modify one or all factors sufficiently and behavior is changed. "Behavior," under this definition, is defined broadly to include related attitude.

At its most basic, social learning theory suggests that if an individual (or group) values a particular reward, but doesn't believe it's attainable, behavior will not be directed toward the goal.

Correspondingly, if a goal is perceived to be attainable, but is of insufficient value, behavior toward the goal is unlikely, as well. Further, the model is affected by (and disrupted by) situational and "psychological" factors that may override the other principal variables (expectancy for reward and reward value) under certain circumstances.

Let's set this in the general context of systems' behavior, and specifically health care systems behavior. A timely example is the new health reform law.

Health care professionals, administrators, physicians and others can believe health care reform to be inevitable, with impending change to affect all. Effects can be perceived as being imminent and profound.

The results will affect personal (or system) economics negatively, and within the near term, and the path to mitigate the negative effects may be known and achievable (say the integration of community hospital and independent physicians) and yet the path or pathways are not pursued.

Under such circumstances the social learning theory model would explain a lack of "rational behavior" toward a goal as being a product of situational or psychological factor

Physicians are a critical piece of the new puzzle; the integrated health care delivery model.

"override." In this case, "We (hospital leaders and physicians) fear a loss of control in the integrated model—a fear of loss of independence, professional autonomy, or fear of being taken advantage of or even exploited."

Rotter suggests that behavior change can be affected by sufficient change in one or all of the factors in the model—expectations, reward value and/or the related psychological and situational factors.

Environmental pressures

Presuming Rotters' social learning theory holds water in the context of reforming U.S. health care, and there is a chance of modifying the factors in the model, then to what extent do organizational and structural solutions apply to:

- Cause community hospitals and physicians to effect integration as

a rational response to health care market reform?

- Cause health care organizations that have achieved integration to fully exploit the model to its highest levels of function and performance?[4]

An initial assumption here is health care market dynamics and legislated "stimulus" will encourage the acceleration of provider-side consolidation, resulting in the formation of larger, more complex, community-based health care delivery systems.

Here structure refers to both organizational design and the application of that design to achieve required levels of function and performance within the mandates of a reforming health care organizations in a changing marketplace.

What must structural change achieve within the context of the social learning theory model foundation? It must, at least:

- Provide the expectation that the response (here the integrated organizational model change) is a rational response to the market dynamics at hand.

- Show that rewards to be achieved are sufficiently positive or, at least, sufficiently less negative.

- Prove that the psychological (or situational effects) must be sufficiently manageable within the design and its application.

The focus going forward here is on the psychological and situational factors within the model. If "the fear" is loss of personal (and professional)

Figure 1

Integrated Health System Organizational Design
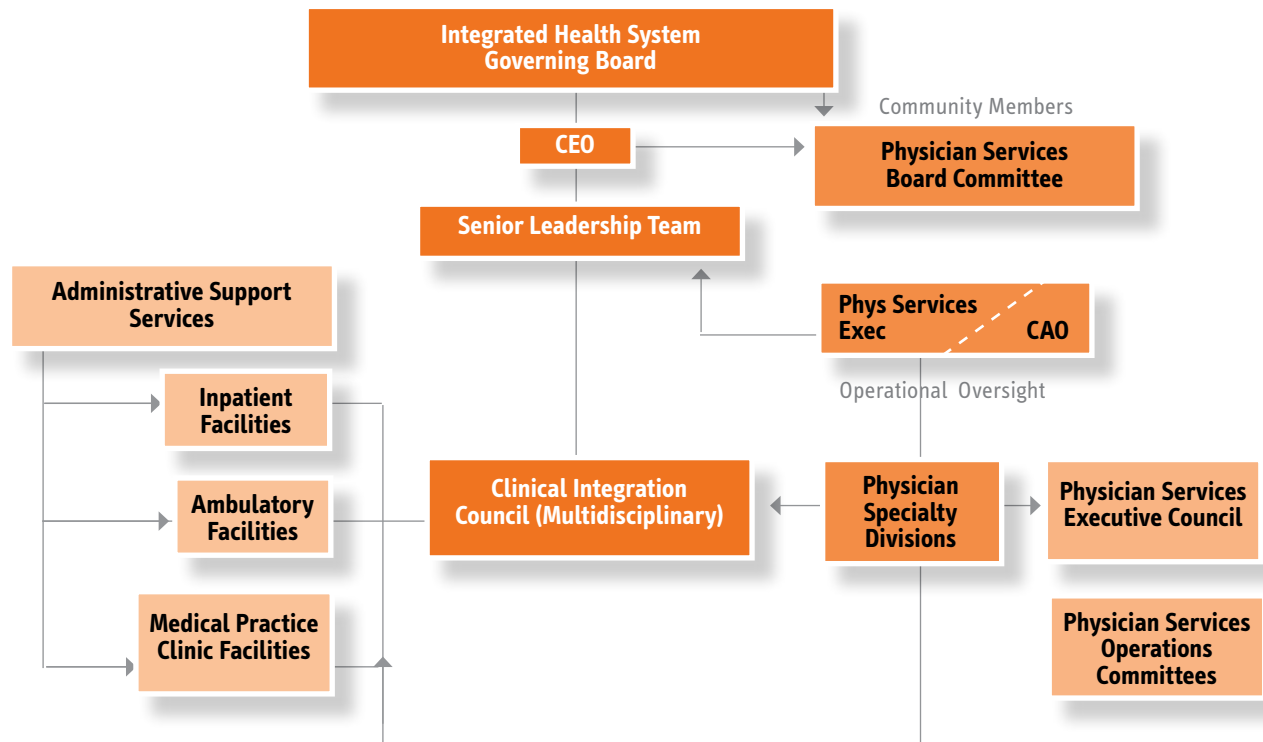**With a Single, Unified Multispecialty Group Practice**
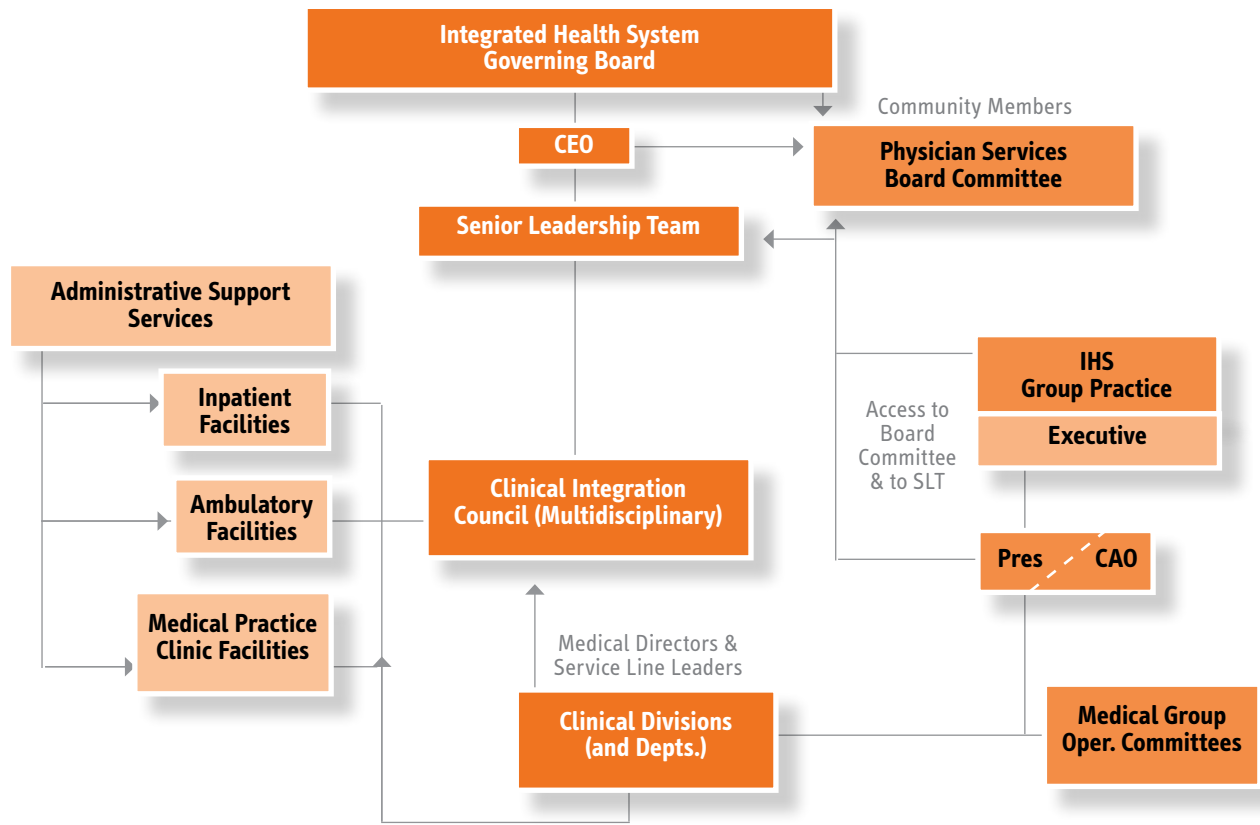
Note: The SYSTEM with a unified multispecialty group practice model relies upon an organized medical group leadership team to deliver all physician services throughout the SYSTEM structure. Physician leaders are responsible for the performance of the medical group practice and it's obligations to serve the health system.

control leading, in the extreme, to exploitation or, at least, professional and personal dissatisfaction, then organization structure, including its design and application, should play a role in affecting behaviors.

The success drivers of effective, integrated health system structural designs are important as a starter:

- Everyone must be engaged as vested "owners" in the enterprise (psychological owners at least).

- All must feel they have a valued stake in organizational decision making.

- New organizational behaviors are likely to make a difference, a connection between action and useful outcomes.

- Those with responsibility within the structure have accountability and are held accountable.

- The organization has a clear sense

of direction and a viable plan and that plan is known throughout.

- The structure (the organization) has a conscience, moral compass, an ethical foundation, a mission and value set that drives a respectful and functional culture.

- There is a clear path to a fair hearing by the ultimate authority, when organizational promises and covenants are perceived to be breached. (This as structural

Figure 2

Integrated Health System Organizational Design

With a Divisional Physician Services Structure

Integrated Health System Governing Board

Community Members

| CEO | → | Physician Services Board Committee |

| Senior Leadership Team |

| Administrative Support Services |

| Phys Services Exec | CAO |

Operational Oversight

| Inpatient Facilities |

| Ambulatory Facilities |

| Clinical Integration Council (Multidisciplinary) | ← | Physician Specialty Divisions | → | Physician Services Executive Council |

| Medical Practice Clinic Facilities |

| Physician Services Operations Committees |

Note: The Divisional model allows for some operating independence of integrated medical groups. All integrated specialty groups are required to collaborate as a "unified group practice" for issues such as patient quality, safety and service.

"trait" is, often, especially important to physicians who fear being trapped within a health system with no method for a fair hearing on concerns and disputes).

Integrated health systems gone wrong

When attempts at structural integration in health care have gone wrong, observers can often trace the root causes to structural flaws that frequently manifest as control (and ultimately behavioral) issues as described in our social learning theory model.

Structural design flaws (on the physician side):

- Physicians integrated with the organization are segregated and separated from organizational governance and real operational, strategic and financial decision making.

- Physician's professional value to the health system is relegated to being "production workers" and not co-leaders and co-managers of a new, integrated design.

- Financial incentives for physicians are not sufficiently tied to success of the enterprise.

- The operating structure favors clinical service, clinical specialty and programmatic "silos" for ease of cost accounting and budget

Figure 3

Principles of Physician Services Organization for a Fully Integrated Health System

	Principle
1	The SYSTEM will employ most, if not all, physicians required to meet mission, clinical service model, patient needs, strategies and financial requirements.
2	Integrated physicians serve in positions of leadership at key levels within the SYSTEM design: governance, senior leadership, the physician services organization and key clinical service lines. All physicians will have opportunities to serve in capacities that control or influence SYSTEM mission, strategic direction and operations.
3	Physician compensation will be at market rates (by clinical specialty) and related incentives will align physicians with SYSTEM goals and objectives.
4	Physicians will work in clinical teams with other physicians and clinicians for the benefit of patient care and service.
5	Physicians will work collaboratively to develop and/or adopt accepted, best practices based upon evidence-based clinical and managerial practical and applied research results.
6	To the greatest extent possible, physicians will endeavor to retain patient care within the SYSTEM except when required clinical services are unavailable from the SYSTEM or the best interests of patients cannot be served.
7	Physicians are accountable to peers and the SYSTEM for their professional behaviors and all agree to abide by organizational values and approved code of conduct.
8	The SYSTEM agrees to adopt a sufficiently encompassing definition of "provider productivity" recognizing the value provided by physicians beyond direct patient care. The SYSTEM agrees to compensate physicians fairly for such efforts and contributions.
9	The SYSTEM agrees to ensure that fair due process will be applied in the evaluation of physician performance and potential disciplinary actions; fair, due process including appropriate internal and external peer review.
10	Management of contracted obligations and covenants with physicians will provide for appropriate routine and necessary ad hoc review and fair hearing by SYSTEM governance.
11	The physician services organization within the SYSTEM is governed by a SYSTEM board that retains designated "reserved powers" over specified health system decisions.
12	Physicians will operate from a common employment agreement; terms and conditions consistent across individuals and clinical specialties.
13	Physicians are provided an employee benefits plan that is consistent with market conditions and legal and regulatory requirements as they relate to "qualified" plans.
14	Physicians clinical practices are governed by credentialing and privileging criteria, policies and procedures, as developed by the SYSTEM physician services organization with required approvals from SYSTEM governance and related controlled hospital licensing and accreditation rules and regulations.

management. It ignores how the customer (the patient) is actually served, or how the professional (the physician or other clinicians) actually cares for the patient; e.g., a longitudinal approach to care and care process as patients move through the health system over time.

- Physicians aren't required to be accountable for behaviors of peers.

This list begs a question, "Do structural design flaws disadvantage physicians only in the integrated design?"

The answer is no; however, when one essential group is disadvantaged the enterprise, as a whole, is disadvantaged. The focus here on structural design flaws and physicians stems from the more common experiences with integrated health systems, whether early in their development or fully matured. The structural model fails to sufficiently and productively engage physicians and their potential.

Flawed structural models suboptimize the potential of the integrated strategy; sub-par function and performance is often blamed on integration and not the real root causes, one of which is often structural design.

Easing psychological distress

Structure design matters for integrated health systems. Since the integrated health system is frequently formed from the integration of independent physician practices, psychological distress usually manifests among physicians and transfers throughout the organization, leading to performance-related problems.

Preventive measures for those contemplating integration, or therapeutic interventions for those that are integrated, but are "distressed,"include a structural assessment that can become the basis for a healthy rejuvenation of structural design moving forward.

Physician governance

With very few states in the U.S. as exceptions, integrated physicians (employed physicians) are permitted as members of not-for-profit, community health system boards.

While related not-for-profit tax codes will restrict the percentage of "insiders" represented on the board, integrated physician representation is essential, providing the physician board members recognize that, by their position, they are fiduciaries working in the best interest of the organization and are not board members representing constituencies.

As integrated community health systems approach a point where most physicians are required to meet mission, patient care, strategic and financial requirements, the role for independent physicians on the board is eliminated. Rationale?

Independent physicians can be competitors of a health system. Furthermore, integrated physicians will frequently object to independent physicians serving on a health system board on grounds that "we are completely committed to the system; they are not."

Some integrated health systems will form a standing committee of the board composed of community board members only, together with the health system CEO for the purpose of periodic review of physician-related issues brought to the board by way of a definitive process and designated committee of physician leaders.

This special committee provides physicians direct access to board review consideration of specific issues. (See figure 1)

This committee may also be viewed as a relief valve if the "physician body politic" believes it is being treated unfairly or otherwise is at-risk due to health system policies, strategies and behaviors of management.

Irrespective of whether the integrated system's CEO is a physician,

physicians should be represented on the senior leadership team. A common approach includes the chief physician officer of the physician services organization and often a chief medical officer who may play a role in health system quality and safety, or as an executive with other, designated hospital services responsibilities.

Theses positions are rarely blended. They're different and important in their own right. Physicians may fulfill more "traditional" senior management roles as well, depending upon qualifications and experience: e.g., chief operating officer, chief strategy officer, chief information officer.

Successful integrated systems organize physicians, generally, within one of two designs:

- The multispecialty group practice model

- The divisional model (See figure 2 for annotated examples.)

In certain cases, typically larger integrated health systems or more geographically diverse systems, both models are applied with success.

While the designs and their execution are critical to the success of any system, the psychology of the designs is important. This psychology translates well to "principles" of physician services organizational design and management (see Figure 3). These principles convey key messages.

- **Message #1:** Physicians are organized within the system according to accepted principles and common expectations and policies. The integrated health system is not a collection of individual arrangements and "deals" including multiple compensation plans.

- **Message #2:** Physicians are accountable to a structure with a mission. Physicians are leaders and managers within the system design.

- **Message #3:** The potential of the physician services component of the integrated health system design must be optimized in pursuit of the goals of the health system overall. Physicians are not independent practitioners working from self-stylized perspectives and expectations of professional practice; physicians are accountable members of an organized team.

- **Message #4:** Physicians as leaders and managers are valued assets of the system. The organization invests in them. Such positions are career paths and leadership carries decision-making authority and accountability.

- **Message #5:** Most physicians will have opportunities to play roles in care delivery design, organizational planning and operation through an array of standing and ad hoc committees. There are opportunities to participate and opportunities to be heard.

The design and function of the physician services component of the system speaks volumes and plays a key role in the psychology and psychological well-being of the integrated organization.

Managing clinical service lines

High-functioning systems recognize that patients are cared for acutely and longitudinally, and effective coordination of patient care services requires teams working together across care settings over time.

Physicians serve as members of clinical teams and are leaders and co-leaders of clinical teams. The responsibility and accountability is to the patient with the team delivering on a promise of a high-quality, safe and efficient experience. When the system fails patients, the team fails. The reverse is true as well.

Cultural attributes

In addition to the structural aspects of an effective design, there are cultural aspects worthy of mention.

- Physicians help shape mission direction and application of resources to mission.

- The system's financial and operational performance (and reporting) must be transparent.

- Physicians are responsible and accountable for the review and evaluation of peer performance, clinical care and productivity and, when required, disciplinary action is a process accountable to the organization, which is led by peers in positions of authority.

- If physicians are sued for professional activities, the organization is the first line of defense and support.

- Physicians can develop their careers "in place," meaning the organization supports the development of professionals as they mature in their careers.

- Physicians (as with other professionals) are viewed as knowledge workers and not production workers. The difference was well-described by Peter Drucker many years ago with the recognition that knowledge workers require the prerogatives of self-direction, self-management and professional judgment and cannot be subjected to a management structure or method that dictates routinization of judgment and behaviors. Knowledge workers must participate in the pursuit of organizational mission, strategy and performance at the highest levels.

Practical aspects

We began with the description of Rotter's social learning theory as one framework for the evaluation and management of the psychology of the integrated health system.

The rationales for the need to actually manage the psychology of the system, at least the psychology of the physician services component of the system, are:

- Market dynamics are likely to encourage consolidation of the provider-side of the health care industry, resulting in the formation of integrated health systems at an accelerating rate. Physicians in private practice today may have no choice but to integrate.[5, 6]

- Physicians who integrate with more traditional, not-for-profit, community hospitals are leaving a world they're familiar with for one where, by definition, no one may be experienced with the organizational design required.

- Even for the more mature systems, market dynamics will sometimes cause physicians to question the viability of their organization as well as leadership.

- Organizations in psychological distress rarely perform at their best. Consequently, assets and potential are wasted. In industries that rely primarily on human capital for value production, which is the case for health care, a day of lost potential is not recoverable. There is no "inventory" held over on the shelf for sale another day.

So let's return to the social learning theory to explain the psychology of the integrated health system with special attention paid to physician services.

A central thesis here is that organizational structure (the structure of the system) will affect the factors of importance for physicians within the social learning theory model:

- Expectations of control over internal and external factors that affect professional practice.

- What is the perceived value of rewards made available from behavior change (including compensation and security)?

- Also consider the psychological factors; specifically, factors that affect the psychological state of the organization at a specific point in time.

The central thesis here is the psychology of the physician component of integrated health systems counts in the successes or failures of the model, especially in a pressured health care market place.

The picture should be clear. Physicians are a critical piece of the new puzzle, the integrated health care delivery model. Their sense of "well-being" affects organizational productivity and the psychological state of the organization overall.

The central thesis is, the organizational design of the system matters; it matters as a determinant of the psychological and cultural well-being of the organization and, ultimately performance. And while "structure" isn't the answer to all organizational and cultural performance problems, structure is often among the factors that affect problem identification and resolution.

Daniel K. Zismer, PhD, is associate professor at the University of Minnesota School of Public Health and director of the Executive Studies Program and managing principal of Essentia Health Consulting.

zisme006@umn.edu

Note: The SYSTEM with a unified multispecialty group practice model relies upon an organized medical group leadership team to deliver all physician services throughout the SYSTEM structure. Physician leaders are responsible for the performance of the medical group practice and it's obligations t serve the health system.

Note: The Divisional model allows for some operating independence of integrated medical groups. All integrated specialty groups are required to collaborate as a "unified group practice" for issues such as patient quality, safety and service.

References

1. "Building a Successful Employed Medical Group", *The Edge*, 2009, Sg2, Chicago Illinois

2. Rotter, J.B., Chance, J.E., Phares, E. J.; *Applications of a Social Learning Theroy of Personality.* New York; Holt, Rinehart and Winston, Inc. 1972.

3. Rotter, J.B., Generalized Expectancies for Internal Versus External Control of Reinforcement. *Psychological Monographs*, 80(1):1-28, 1966.

4. Zismer, D. K., Person, P.E., Aggarwal, R.; "Finding the Economic Leverage in the Fully Integrated Health System Model"; *Group Practice Journal*, May 2009.

5. Zismer, D. K., Person, P.E., "What Does the Future Hold for the Larger, Independent, Multispecialty Medical Group? Is a "Tipping Point" on the Model's Horizon?" *Group Practice Journal*, April, 2007.

6. Zismer, D. K., Person, P.E.; "Are Community-Based, Not-for-Profit Health systems a Threat?" *Group Practice Journal,* February 2008.

7. Rotter, J.B., Some Problems and Misconceptions, Related t the Construct of Internal vs. External Control of Reinforcement. *Journal of Consulting and Clinical Psychology*, 1975, 43 1, 56-57.