True Partners

Geri Aston

Hospitals can turn independent docs into allies by giving them a voice in governance, management and strategic planning

Without the cooperation of the medical staff, hospitals won't be able to make the quality gains needed to survive payment reform.

The stakes are high. For example, a 300-bed community hospital with $50 million in annual Medicare revenue stands to lose more than $1.4 million a year beginning in 2015 if it has high readmission rates, a low value-based purchasing score, and a large number of health care-acquired infections, according to a 2010 Pricewaterhouse Coopers LLC analysis. The health care landscape is leading to a much higher degree of dependency between hospitals and doctors to maximize reimbursement that's based on quality, says Warren Skea, a director in PricewaterhouseCoopers' Health Enterprise Growth Practice.

But how can a hospital or health system get physicians who don't want to go the employment route onboard with the organization's quality and efficiency goals?

The first step is building relationships with independent, nonemployed doctors, says Pamela R. Knecht, president of ACCORD Limited, a Chicago-based consulting firm. "In the rush to align hospitals and physicians, there are a lot of organizations that are helping to create deals between hospitals and physicians. It's more helpful to elevate the conversation above the business deals and concentrate on the true hallmarks of a positive relationship."

Paramount to a good hospital-physician relationship is trust. In many facilities, however, physicians don't have much faith. When asked whether they trust hospitals, 20 percent of physicians said "no" and 57 percent said "sometimes" in a 2010 Pricewaterhouse Coopers LLC survey of more than 1,000 doctors.

When trust is a problem, a hospital needs to engage in what amounts to "Relationships 101," Knecht says. "The way you build trust among groups—whether they're employed or independent physicians—is in relatively simple, but carefully thought-through ways of interacting."

An initial step can be to hold meetings or educational sessions with attendance carefully balanced among physicians, administration officials and board members, she says. Often the best place to start a discussion is patient care. "It is a lot easier to talk openly and honestly and in a productive fashion when you have a shared goal," she says. "Focus building these positive relationships on the ultimate end game: improving patient care."

From this foundation, independent physicians, administrators and board members can continue to build trust by working together on specific projects. For example, representatives from these three realms, as well as other pertinent staff, could form a task force aimed at developing or expanding a service line.

Strategic Planning Input

It's also critical to involve independent physicians in strategic planning at the earliest stages of the process and at every level, experts say. Before anything is even written down, a hospital or health system could hold multiple meetings in which physicians share what they think the critical strategic issues are for the next five years. Then the organization can give them feedback on how their input was used.

Consultants advise including physicians on the board's strategic planning committee, as well as the work group that develops the strategic plan. These doctors should reflect the physician community in terms of specialty and employment status.

St. Joseph's Hospital Health Center in Syracuse, N.Y., embraced the concept of physician participation when it created its five-year strategic plan. An ad hoc coordinating council, consisting of 10 physicians—both employed and nonemployed—and five hospital administrators, drove the process, says Kathryn Howe Ruscitto, president and CEO. "People said physicians won't put in that much time, or physicians aren't going to be that interested. Wrong and wrong."

The group met every three weeks for a year. At meetings, administrators made presentations to the physicians as if they were board members and asked them for input. The committee created five task forces: primary care strategy of the future, hospital throughput, the physician enterprise, quality and the emergency department. Each task force had about 10 physicians. Then the task forces sought the input of the rest of the medical staff via department-by-department advisory meetings. About 150 doctors participated. Their input was fed back up to the ad hoc coordinating council, which then developed the strategic plan.

The night the plan was presented to the board of trustees, both the medical executive committee and the ad hoc council were in the room, Ruscitto points out. "We knew at the end of the process we heard the voice of the medical staff," she says.

A Voice in Governance

Beyond strategic planning, hospitals should involve doctors in governance and leadership, say hospital leaders and consultants. "Governance is a significant issue," Skea says. "This is something [that] I think has been undervalued by hospital leadership in the past."

At Munson Healthcare in Michigan, physicians are co-equal participants in the governance process, says Dan Wolf, chair of the board of directors. About 95 percent of the health system's physicians are independent. Six of the system's 22 board members are active physicians, he notes.

"Our medical staff is our partner in delivering optimal patient care and driving value in health care," Wolf says. "We can't be casual about understanding the world of independent practice, like they can't be casual about understanding the challenge of running a hospital and ambulatory care centers. There is a two-way street here."
The trend toward hospital employment of physicians makes involving independent physicians in leadership especially important, Knecht says. "Independent physicians can feel as though their views are not being well represented," she says. "They often believe the employed physicians are going to get more of everything—more leadership positions, more patients, more business opportunities."

Reform is expected to accelerate the employment trend. To avoid losing the doctors who choose to remain independent, experts advise engaging a mix of nonemployed and employed physicians at all levels of the organization, including positions at the top of the administration and on the board.

Before a hospital or health system undertakes this effort, its leaders should

decide what criteria, if any, will be placed on independent physicians serving in management or governance positions, Knecht says. One consideration is whether the physician serves in a leadership capacity at a competing institution. For example, if the doctor is on the medical executive committee of a competitor, is it appropriate for that physician to serve on your medical executive committee? A hospital may decide a physician who is part owner of a competing facility can't serve as a paid medical director, or be on the board or the strategic planning committee.

Another consideration is whether the independent physician is clinically aligned with the hospital. Hospitals may want to establish a definition, determine which physicians are aligned, and decide whether only aligned physicians have the opportunity to serve in leadership roles.

The key in both cases is for the board, administration and physicians to discuss and determine what is appropriate and fair, and what supports the organization's mission, experts say. The criteria for leadership then must be communicated clearly to the medical staff.

Knecht recommends hospitals have a physician leadership development program, approved by the board and created by physicians with the administration's help. These programs teach the basics of leadership, from facilitating a meeting to leading a group. Part of the curriculum should be teaching doctors appropriate roles in governance.

"Too often we allow or ask physicians to serve on boards and their committees without ever having really explained to them what their fiduciary duties are when they sit in those roles," she notes.

This education is especially important for independent physicians, Knecht says. "You can start down a very negative, spiraling path if you bring a nonemployed physician onto the board without ever having articulated what the role of a board member is and what the fiduciary duties are," she says. "They may believe that if they're serving on the board, they're representing their specialty. The fiduciary duty of a board member is loyalty to the mission of the organization, not to the group that elected you, your specialty or your business colleagues."

When it comes to governance, some hospitals and health systems not only are opting to have physicians on their parent board, but creating a physician advisory council of the board. Experts recommend that this group include both employed and independent physicians. They provide advice to the top board on such topics as strategy, market development, clinical integration, and physician relations, as well as act as a sounding board.

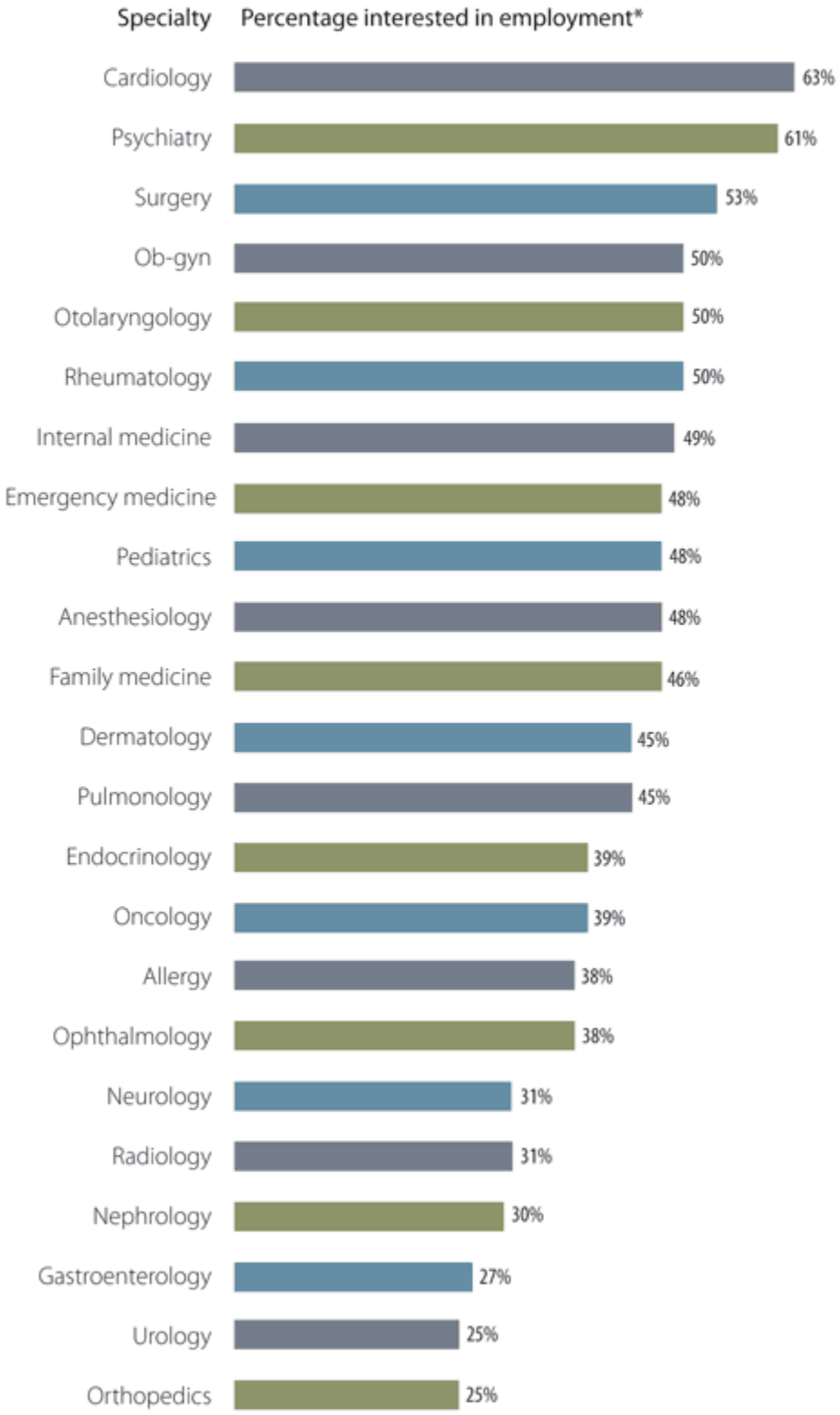
This type of council is a way to maintain positive relationships with independent physicians as hospitals employ more doctors, Knecht says. "Independent physicians look at the governance structure and say, 'There's a corporation with a board for the employed physicians. Where is our board?'" she says. "The answer is there is a physician advisory council at the system-level board, physicians are serving on the health system board, and they're serving on all the board committees they can. One has to outline clearly all the opportunities for engagement and be very intentional about communicating that."

The Dyad Approach

On the management side, there is a movement toward administrators and doctors serving as co-directors of clinical services and facilities. This approach, sometimes called dyad management, can lead to a more integrated approach to care. At the same time, it helps to strengthen relationships with physicians.

Who Wants to Work for You?

Physicians' interest in hospital employment varies widely by specialty, a survey of more than 1,000 doctors shows.



*Specialties with fewer than 10 respondents were excluded from the list.
Source: PricewaterhouseCoopers Health Research Institute Physician Survey, 2010

Another model being tested is service line co-management, Skea notes. Under

co-management, the hospital contracts with physicians who are given greater input and authority over quality and operational improvement. In some cases, the hospital and physicians share ownership of a management company for that service line. Hospitals pay the physicians for their leadership and management services, as well as incentive payments for meeting quality and efficiency goals. Both must reflect fair market value. (See Trustee Workbook 2, for more guidance on physician compensation.)

Co-management builds trust between the hospital and nonemployed physicians as they work together on unified goals, Skea says. "It's a gateway to a higher level of integration because it's a fairly low-risk way to align and build that trust."

In Gastonia, N.C., CaroMont Health has given more power to its physicians as it changes its delivery system to adapt to health care's changing landscape, says President and CEO Valinda Rutledge. A year ago, the health system created six physician-led service line councils, three of which are directed by independent physicians and one of which is co-led by an independent physician and an employed physician. The councils look at the community and the hospital and then develop strategic plans on care delivery that they report to the trustees, explains Sheila Reilly, vice chair of CaroMont Health's board.

For example, the cancer council is developing a strategy to integrate inpatient and outpatient oncology care to make it more efficient and improve quality, says Steven W. Yates, M.D., the cancer council's chair and a nonemployed physician.

Before the councils, "rightly or wrongly, it was felt that the hospital had an agenda and the physicians had an agenda, and they weren't always parallel," says Clay Thomason, M.D., who leads the orthopedic council and who is an independent physician. "Now the nonemployed and employed physicians alike are all on the same page and are working together with the hospital."

The working relationship the councils have fostered between the hospital and physicians helps position the system for the future, be it bundled payment or another reimbursement scheme, Thomason says. "You're going to get paid potentially as groups, and you may get paid more or less based on what your quality outcomes are," he says. "Ten years ago, everybody got paid separately and in a sense you could do your own thing and you probably were going to be just fine. Now, without working together, nobody will survive."

The hospital is exploring the concept of becoming an accountable care organization, Rutledge says. Regardless of how that program shakes out,CaroMont is focused on shifting from a hospital-centric organization to a community-centric one, she says.

"You need all the physicians at the table to help you do it. The physicians are the ones who are in charge of the clinical care. They must be the leaders that help us redesign that delivery system." Reflecting the community focus, the councils include nonhospital members, including representatives from the local business and provider communities.

"We want to do things that show that we're doing the right thing by patients so that they don't have to come to the hospital when it's not necessary or they don't bounce back right after they've been discharged," Yates says. "The only way that is going to happen is if physicians, the hospital system and the other outpatient players—home health and all of our other ancillary providers, rehab and others—are on the same page."

Geri Aston *is a freelance writer in Chicago*

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