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The Right Ways to EMPLOY PHYSICIANS

by Barry S. Bader

Hospitals and health systems increasingly employ physicians to keep them in the community; achieve quality, efficiency, and growth objectives; and meet community needs for primary care doctors as well as on-call, emergency department coverage by specialists. In some cases, employment is the centerpiece of a hospital's physician alignment strategy, with the goal of eventually employing virtually the entire medical staff. In other cases, physician employment coexists alongside arrangements, including joint ventures and professional services contracts with independent physicians and groups.

Either way, hospitals find it's harder than it looks to maintain the entrepreneurial spirit and productivity of employed physicians, to run physician practices profitably, and to integrate hospital and physician service lines around common goals. For their part, formerly independent physicians who are used to running their own show and who join the hospital with mixed feelings may find the constraints they face as employees difficult to accept.

Hospitals and physician practices have different cultures. Hospitals make decisions through hierarchies in a deliberate manner. Managers think about the way financial and staffing decisions will affect the care of groups of patients and the overall bottom line. Hospitals value teamwork. Physicians tend to make

decisions as individuals, and they act quickly. They think first and foremost about the way their decisions will affect each individual patient's care. Hospital economics are a concern, but they are always secondary to quality, as physicians define it.

Intellectually, physicians understand they have an impact on a system's finances. They know their clinical decisions to order tests and drugs, hospitalize a patient an extra day, refer a patient to a nonsystem hospital or physician, or convince the hospital to purchase new medical technology will affect the hospital's budget. However, as *private practitioners*, they are *not personally financially* affected by the way their clinical decisions impacted hospital finances.

As system employees, it's a new game. Physicians are expected to be financially aware and work as part of a team to produce the best value for the system. To succeed, integrated systems must have a new, common culture that is patient-centered and rewards the achievement of both quality and financial goals. Agreement on what constitutes scientifically-grounded (evidence-based) best practice is crucial. To show results, the new culture must be embraced by employed and other aligned physicians, as well as directors, executives, managers, and everyone else in the organization.

Critical Success Factors in Five Integrated Delivery Systems

To see how health systems with a large number of employed physicians are working to build a common culture, *Great Boards* looked at five integrated systems.

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Two systems—Guthrie Health of Sayre, Pa., and St. John’s Health System of Springfield, Mo.—are highly integrated organizations that employ virtually all of their physicians through a medical group.

Three other systems—Aurora Healthcare, based in Milwaukee, Wis.; Summa Health System in Akron, Ohio; and Providence Regional Medical Center Everett in Everett, Wash.—employ a growing number of physicians and also seek to align with independent physicians.

Key elements of the systems are summarized in Table 1, and complete case studies are available on the *Great Boards* Web site.

Despite differences, these systems share a number of critical success factors worth consideration by other systems that choose to employ physicians. They are:

1. Trust.
2. A shared vision and strategic planning process.
3. Physician empowerment within the governance structure.
4. Professional practice management.
5. Transparent, equitable, and aligned compensation.

Table 1. Physician Employment Approaches in Five Selected Systems

Organization	System-Physician Alignment Model	Number of Employed Physicians/Percent of Medical Staff	Corporate Governance	Physician Leadership Engagement Mechanisms
St. John’s Health System, Springfield, Mo.	St. John’s Clinic, a multi-specialty group practice; SJHS is the corporate member.	More than 470 physicians and 200 midlevel and allied health practitioners. 95% of medical staffs.	St. John’s Health System Parent Board: <ul style="list-style-type: none"> • 14 members. • Approximately 1/3 community members, 1/3 physicians, and 1/3 religious sponsors. St. John’s Clinic Board: <ul style="list-style-type: none"> • 17 members. • 11 elected physicians. • Three president physicians. • Clinic and hospital EVP. • Health system CEO. 	Physician-executive pairs Executive Council Operations Council Senior Operating Groups Physician Leadership Council
Guthrie Health, Sayre, Pa.	Multi-specialty group practice; parent organization has reserved powers over Guthrie Clinic and Guthrie Health System (GHS), which includes two hospitals.	Approximately 230 physicians and 110 midlevel providers. Virtually all of medical staff.	Guthrie Health, 14 member parent board: Six appointed by health system board and six by clinic board, plus system and clinic co-CEOs.	Co-CEOs for administrative and clinical affairs, respectively. Guthrie Clinic Board, nine physician members plus clinic president, nonvoting. Operational Leadership Group Paired physician-administrator teams

Case Studies

on the *Great Boards* Web site

To read case studies written by leaders of the integrated systems profiled in this article, go to www.GreatBoards.org. Click on “Samples and More” and “Hot Topics.”

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1. Trust: Don't Assume Its Presence or Permanence.

Before embarking on a strategy of physician employment or after acquiring practices, hospitals need to ask themselves: “Have we established a foundation of trust with physicians so that the employment relationship will be a sustainable and synergistic partnership—not a shotgun marriage driven only by economics?”

St. John's Health System. St.

John's Health System (SJHS) in Springfield, Mo., learned the importance of trust the hard way when it first acquired practices and employed physicians directly in the 1990s. By 2000, both the system and physicians were disappointed with financial performance and strained working relationships. As employees, formerly entrepreneurial physicians now were paid a flat salary, with no incentive to maintain productivity or work with the hospital system, says Donn E. Sorensen, executive vice president, St. John's Clinic. The compensation model disengaged physicians from the business. Distrust, discontent, and misalignment of financial incentives were rampant, and the system was nearing break-up.

“It was clear we had a trust issue, but rather than spend time on trust per se, we decided that if we fixed the business model, including compensation, then trust would follow. We believed we had to do the right thing, execute a good strategy, and be transparent about it.”

Table 1. → continued from page 2

Organization	System-Physician Alignment Model	Number of Employed Physicians/Percent of Medical Staff	Corporate Governance	Physician Leadership Engagement Mechanisms
Aurora Health Care, Milwaukee, Wis.	System-owned, multi-specialty group practices, subject to system's reserved powers.	1,200 employed physicians, including 850 physicians in the Aurora Medical Group, plus affiliations with other medical groups.	Aurora Healthcare board, 21 members, includes CEO and approximately five physicians.	Aurora Medical Group board of directors: 12 physicians plus AMG physician president, vice president/COO, and systems executive vice president/COO Physician Leadership Council: 37 physicians and administrative leaders Clinic Management Committees: five to seven physician members at practice sites
Summa Health System, Akron, Ohio	Summa Physicians Inc. (SPI), a physician enterprise that employs physicians under contracts and leases their practices, integrates SPI-employed and system employed physicians, and provides practice management services.	200 employed physicians, 50 percent of whom lease their practices to Summa Physicians, and 50 percent whose practices are system-owned.	Summa Health System Board, currently 24 members, is approximately 40 percent physicians. • SPI is a not-for-profit subsidiary. Board is currently 10 members: seven physicians and three executives. • Summa also has joint ventures and other arrangements with independent physicians.	Physician leader of SPI Physician-majority SPI board Practice Operations Group System service lines have SPI physicians as codirectors Frequent open meetings between employed physicians and both system and SPI leaders

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Organization	System-Physician Alignment Model	Number of Employed Physicians/Percent of Medical Staff	Corporate Governance	Physician Leadership Engagement Mechanisms
Providence Regional Medical Center Everett, Wash.	System-owned Providence Physician Group, and arrangements with independent physicians.	80 employed physicians (55 PCPs) who account for 20 percent of system volume.	Everett Service Area board of directors with linkage to Providence Health & Services System Board. Service area board has formal Oversight Committee for Providence Physician Group with lay board reps and elected physician group reps. Committee reports to full board.	Formal physician leadership structure (division chiefs, chairs, and medical directors) with medical staff as well as hospital management roles; structure mirrors academic medical center model in private medical staff setting. Formal involvement in strategic planning and decision-making through dyad approach.

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To restore trust, leaders agreed on “guiding principles” for a new integration model. They developed a shared vision centered on quality, as well as a new approach to physician compensation designed to align system/physician financial incentives for meeting strategic, financial, and quality goals.

Most critical to restoring trust, says Sorensen, was the engagement of physicians in management and governance as equal partners. “‘Physician-led, professionally managed’ was the phrase that would define a new culture.”

“Aurora and AMG gained a reputation for honesty and integrity. The development of trust was evolutionary over the course of more than 20 years.”

— Eliot Huxley, MD,
Aurora Medical Group

Aurora Health Care. At Aurora Health Care (AHC), a system of 14 hospitals and more than 1,200 employed physicians in eastern Wisconsin, a commitment to physician leadership was a powerful factor in developing sufficient trust for physician groups to join the system. A well-known clinician in eastern Wisconsin, Eliot J. Huxley, MD, assumed leadership of the Aurora Medical Group from its inception with three employed doctors. Many physicians interested in working for a healthcare system wanted a physician at the helm of any medical group they joined, says Huxley. They wanted a system that shared their values, would pay equitable compensation, and would engage them in key decisions.

“Over the years, AHC and AMG lived up to the commitments they made to each other,” says Huxley. “The development of trust was evolutionary over the course of more than 20 years.”

Summa Health System. “Trust was everything” in attracting physicians to join Summa Health System, in Akron, Ohio, says T. Clifford Deveny, MD, the system’s vice president for Physician Alignment and the president of Summa Physicians, Inc. (SPI). Summa Physicians Inc., a not-for-profit corporation currently employs 200 physicians, 50 percent directly and 50 percent through a practice lease model. SPI is a “physician enterprise” designed to appeal to private practitioners who want the advantages of employment

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but aren't prepared to make a career commitment to sell their practices. (See page 12, "The Physician Enterprise Model.") Summa plans to reach 300 employed physicians in approximately 18 months.

"We had to be able to sit across the table and say that the board was behind the physician enterprise model, and this model is here to stay," says Deveny. "Having SPI be physician-led was important." The commitment of the system CEO "built confidence," and SPI gained credibility when it attracted respected leaders of the hospital's clinical departments. "In effect, they became salespersons for the model."

SPI acts in various ways to keep nurturing trust, says Deveny. "We are transparent with information and business plans. Physicians are suspicious (of hospitals), and so the productivity-based compensation plan is transparent, with no favoritism. Everyone is hired under the same deal. Physicians' compensation is not linked to payer mix, and they are not held accountable for things they can't control. The way you deal with these issues is what builds physician trust."

"A physician who wants a richer contract doesn't get it, even when he goes to the CEO. Everyone gets the same deal, and every physician knows everyone else's base compensation."

— T. Clifford Deveny, MD,
Summa Health System

2. Develop a Shared Vision and Strategic Plan with Physicians at the Table as Full Partners

Shared values and vision are powerful forces for building trust and shaping culture.

Aurora Health Care. The architect of Aurora Health Care's system-wide vision, retired CEO G. Edwin Howe, preached a basic mantra: "Integrated care is a better way to provide healthcare." Beginning with its 1991 strategic plan, Aurora set out to become a regional, integrated health-care system.

In 1992, the well-respected, 70-physician Sheboygan Clinic became the first clinic to join Aurora Medical Group (AMG). "The clinic joined based purely on a shared vision—the benefit and potential of an integrated health care system," says Huxley.

Sheboygan's move gave AMG "instant credibility" so by 1995 more than 350 physicians had joined AMG. In 1997, the 40-plus-doctor Wilkinson Clinic joined AMG after exploring many options. "Wilkinson leadership had watched AHC and AMG for six years and came to the conclusion that Aurora had accomplished everything it said it planned to do," says Huxley.

Aurora's annual strategic plan updates continued to focus on integrated system development over the course of the next two decades. Both AMG physicians and other "closely aligned (but still independent) physicians" actively participated in the development of these plans. In addition, both AMG and "closely aligned physicians" sat on the Aurora Health Care board of directors over this time period. Individuals within the organization were held accountable for accomplishing the annual plan's organization-wide goals as well as individual goals.

Guthrie Health. A shared vision was also crucial in the formation of Guthrie Health in Sayre, Pa. The system was formed in 2001 by the merger of Robert Packer Hospital, a 258-bed, tertiary care teaching hospital, and the Guthrie Clinic, which today includes some 230 physicians, approximately 45 percent primary care and 55 percent specialists, plus 110 midlevel providers, of whom 80 percent are in primary care practices. Corning (N.Y.) Hospital subsequently joined Guthrie Health.

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The Physician Enterprise Model

“Independent physicians who want nothing to do with hospital employment or other institutional arrangements have warmed to the concept of a physician-centric affiliate of a nonprofit health system,” says Peter A. Pavarini, an attorney with Schottenstein, Zox, and Dunn, Co., LLP, Columbus, Ohio.

Pavarini assisted Summa in the creation of its “Physician Enterprise Model” and explains it in simple terms: “The hospital or health system employs physicians through a separate but affiliated legal entity (the “physician enterprise”) which is a “group practice” for Stark and other purposes. The physicians are employees and sign employment contracts of at least one year, usually two or three. Physicians are paid fair market value compensation for their clinical activities and additionally for administrative duties.”

Unlike the traditional hospital employment model, the hospital does not immediately buy and may never buy the physician’s practice, says Pavarini. Rather, the physician retains ownership of his or her practice. At Summa, SPI leases the practices that provide nonphysician support staff, office space, equipment, furnishings, and access to patient records. SPI provides a turnkey package of administrative services such as managed care contracting, billing, and collections, essentially serving as a management services organization.

As owners of their practices, the physicians still own the tangible and intangible assets of their practices and are under no compulsion to “sell out.” However, many of these arrangements give the hospital an option or right of first refusal should the physician eventually decide to sell. The system doesn’t assume any debt and does not buy the receivables. It may purchase practice assets at a depreciated value if needed. All the leased practices have business

operating plans, so the system can make an informed economic valuation before hiring the physicians.

“Physicians still have good reason to manage their practices as efficiently and profitably as they did when they were self-employed,” says Pavarini, because they still own them. “The preferred compensation model rewards physicians for performing as they would in a totally private practice.”

The health system is the sole member of the physician enterprise and retains certain reserved powers to keep it aligned with system goals. The physician enterprise has a board that maximizes physician participation.

“To patients, however, very little has changed,” says Pavarini. “The physician is still at the same location supported by the same staff; however, he or she is now a part of a larger enterprise that can provide patients with a broader spectrum of care.”

To the hospital, the physician enterprise model “takes a giant step toward a totally integrated system,” says Pavarini. “The parties can more readily share information technology and other equipment and facilities. The hospital can influence the physician’s activities through an affiliated medical group that is aligned with the hospital’s goals and objectives. “Managing care effectively becomes a shared goal, rather than something everyone pays lip service to.”

Summa’s Deveny agrees: “The key is how to take advantage of the efficiencies and culture of successful practices. We have strong practices that can’t bring in new partners. Employment provides a safe harbor to save these practices. We invest virtually no cash and lease the practices. It gets physicians at the table and involved, and we are working in a variety of ways to control costs and improve quality. Emergency department call, indigent care, and teaching issues have gone away. Employed physicians take calls and are blind to the payer mix.”

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Robert Packer Hospital and Guthrie Clinic are longtime cousins, sharing side-by-side buildings for 78 years. In 1988, clinic doctors converted from a partnership structure to a not-for-profit organization, and the clinic briefly joined with the hospital before mistrust led to an unhappy separation.

In 2001, with new boards and new CEOs, the hospital and clinic formed the tie that binds them today. Kevin Carey, the prior clinic president, was the architect. Joseph A. Scopelliti, MD, president and CEO of the Guthrie Clinic and co-CEO of Medical Affairs for Guthrie Health, says coming together in 2001 meant “the ability to plan for health care regionally, pursue joint quality goals, meet the clinic’s need for a capital partner, and meet the hospital’s need to recruit new physicians to the area.”

“The affiliation was driven by a vision and by core principles and values that revolved around teamwork, quality, patients, and a physician-administrative partnership at every level, from co-CEOs to departments to clinics,” he says. To manage in alignment with the vision, Guthrie uses balanced scorecards with system wide goals for finances, quality, and patient satisfaction.

Providence Regional Medical Center Everett. At Providence Regional Medical Center Everett in Everett, Wash., employed physicians compose just 80 members (including 55 PCPs) of a nearly 800 member medical staff, but they account for about 20 percent of system volume. In addition, Providence has “one of everything” along the alignment continuum with independent physicians, including joint ventures, a risk-bearing PHO, comanagement agreements such as a cancer center partnership, and numerous medical director and leadership arrangements.

However, with changing economic conditions and quality mandates, growing Providence Physician Group has become a prime strategy, says David Brooks, CEO, Providence Health & Services, Northwest Washington Service Area. “The plan is to grow the group to over 100 members over the next three years because the market is under-doc-tored, leading to outmigration of patients. In addition, the delivery system is expanding as the county grows, adding subspecialists. Employment is one of the “most effective way to bring new specialists in and to retain specialties that otherwise would have left the market,” says Brooks.

3. Empower Physicians within the Governance Structure

Hospitals are accustomed to persuading reluctant, independent doctors to participate in strategic planning and quality programs. Many limit physicians’ involvement in governance because some physicians have conflicts of interest. Once a system includes substantial numbers of employed doctors, this culture of separation must change.

Physician empowerment in governance, especially in decisions affecting patient care and practice operations, is at the heart of successful system integration. The most common vehicles for physician empowerment are:

- Paired executive-physician leaders at all levels.
- Physician executives.
- Physician members of the system’s governance structure.
- A medical group board with a physician majority.
- A distinction between the system’s responsibility for policy and strategy governance and the medical group’s responsibility for operational governance.
- Integrated system service lines with management and physician coleaders and operating groups.

St. John’s Health System. At St. John’s Health System, physician empowerment begins at the top and extends organization-wide, consistent with principle of “physician-led, professionally managed,” says Sorensen. “Physician-executive pairs

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exist at leadership levels throughout the organization, and these leaders are role models for trust and mutual accountability.”

One third of the 14-member system board is composed of physicians, and the chairman must be a physician.

Three operations bodies have been instituted, each with 50/50 management physician makeup, to carry integration right to the front lines, says Sorensen. “This model is really taking hold and for the first time doctors are becoming interested in things like hospital length of stay and hospital operating income.”

- An Executive Council is the senior decision-making body of SJHS. It includes top executives and physician leaders and meets weekly.
- An Operations Council includes members of the Executive Council plus all of the vice presidents in the hospital and clinic. It meets every other week to coordinate planning and operations.
- Eight Senior Operating Groups meet weekly to oversee day-to-day operations for medicine, surgery, cancer, ER/trauma/burn care, cardiac care, women’s and children’s services, orthopedics, and regional operations. “They run the place,” following system-wide direction and goals, says Sorensen.

The St. John’s Clinic Board has 17 members, including 11 elected physicians, three ex-officio physician presidents, and three ex-officio executive and physician leaders. It meets six times a year to focus on operating policies, finances, strategy, and quality matters. SJHS distinguishes between the system board’s responsibilities for overall policy and strategy, and the clinic board’s governance of clinical care and physician practices. The Physician Leadership Council is a broader-based group that includes department chairs, section leaders, medical directors, and senior administrators. It meets monthly to discuss operational policy and issues and stay updated on clinic and system programs.

To maintain physicians’ entrepreneurial interest in their practice sites, decision-making is decentralized as much as possible, consistent with system-wide goals and policies. For example, says Sorensen, “a policy requires sites to provide convenient access for patients. Each site establishes its own schedule, but one site can’t close Friday afternoons without considering the impact on other system components and the policy on access.”

To promote hospital-physician alignment, the clinic president appoints chairs for primary care, medicine, and surgery, and they hold the same positions on the hospital’s medical staff. These are long-term management appointments, not elected, rotational positions.

Aurora Health Care. At the Aurora Medical Group, Huxley says physician engagement in governance is organized at three levels, with successively more physicians involved:

- The AMG board of directors has global governance authority and is the policy-setting body for the medical group. It is comprised of 12 physician leaders, AMG’s president (a physician), AMG’s vice president/chief operating officer, and Aurora’s senior executive vice president and COO.
- The AMG Physician Leadership Council gathers broad-based input/communication from 37 AMG physician leaders plus AMG’s administrative leaders and medical directors, and then provides input to the AMG board.
- Clinic Management Committees of five to seven elected doctors at each site provide local physician leadership. The site administrator may be a nonvoting member. Committees oversee day-to-day operations, selection of new physicians for the clinic, physician discipline, and physician termination.

Starting with the partnership of the AMG president with the AMG vice president /chief operating officer, a physician-administrator dyad model flows throughout all levels of the organization and is a key factor in AMG’s success, says Huxley.

Guthrie Health. Similarly, at Guthrie Health, physicians are embedded in governance and leadership position-sat all levels. The system has co-CEOs,

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for medical and administrative affairs, respectively. This unusual structure seldom works in business, but at Guthrie it models the desired leadership style, says Scopelliti. Together, the co-CEOs and other physician-administrator pairs display mutual respect, with deference to the administrative co-CEO on business matters and to his medical affairs counterpart on clinical and quality matters.

The co-CEOs spend a lot of time together and work out differences before board or executive staff meetings, Scopelliti says. There's an emphasis on "assembling the right facts and making decisions in an inclusive and transparent manner," he adds. "We can have passionate disagreements, usually on priorities, but it's behind closed doors. This model has the potential for catastrophe with different people, but it works for us."

In terms of structure, Guthrie Health is the not-for-profit parent organization with 14 members on the board, including the co-CEOs for Medical and Administrative Affairs. The parent board has reserved powers for Guthrie Clinic and Guthrie Healthcare System, which includes three hospitals and one nursing home. The co-CEOs are the president of the Guthrie Clinic and the president of GHS, respectively.

Guthrie Health has a board of 14 members, six appointed by the GHS Board and six appointed by the clinic board, plus the president of GHS and president and CEO of the clinic ex-officio.

"We stress the difference between governance—setting policy and large decisions—and management, which is running operations."

— Joseph A. Scopelliti, MD,
Guthrie Clinic

Guthrie Healthcare System has a board of 12 members including three physicians all appointed through a bylaw outlined process.

Guthrie Clinic has a nine-member board, elected by clinic physicians, plus the president of clinic, ex-officio, nonvoting. Members serve a maximum of three consecutive two-year terms. At least two must be from Guthrie's regional network. The board is responsible for clinical quality and determining physician compensation within a system-approved compensation philosophy. Informally, the board seeks a diversity of PCPs and specialists.

A seven-member Operational Leadership Group includes clinic and hospital management leaders and makes high-level decisions on shared services including human resources, information technology and the electronic medical records system, and budgets and salary adjustments.

4. Implement Effective Practice Management

Systems also need to address the ways hospital and physician practices will be managed differently in order to achieve shared goals for revenue growth and profitability, quality and patient safety, patient satisfaction, efficiency and financial performance, and strategic growth to meet community needs.

St. John's Health System. At SJHS, integrating operating functions is critical to achieving efficiencies. All clinic locations use the same billing, scheduling, information technology, human resources, and other services policies and shared services. The hospitals and clinic have one electronic health record system.

Aurora Health Care. At Aurora Health Care, AMG wanted its employed physicians to work more as a single operating entity aligned with the medical group's and system's goals. To evolve to this group practice culture, Aurora approached cultural integration in three phases.

First, to achieve operational integration/standardization, AMG added staff with practice management experience and focused on centralization and standardization to achieve benefits of size and scale. For example, the practices had 13 different IT systems and 140 different job descriptions for front desk jobs in various clinics. Standardization and a conversion to a single practice management system took two years, but brought "tremendous improvements."

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Next AMG went to work on developing a group culture, because physicians still acted as if their actions had no impact on other parts of AMG. The first effort engaged physicians in a customer-focused, service quality initiative. Then AMG asked physicians to focus on increasing physician productivity by improving processes so they could be more efficient and see more patients. These initiatives helped physicians see customer satisfaction, efficiency and enhanced productivity as part of their normal thinking processes. Patient access and patient satisfaction dramatically improved, says Huxley.

Now, AMG is focusing physicians on clinical preeminence and innovation, including population management, such as improved care for patients with high cholesterol. AMG has been recognized nationally for this work, and Aurora Health Care outperformed all other systems in the country in a recent CMS performance initiative.

Providence Regional Medical Center Everett.

At the Providence Physician Group, “the key to efficiency has been experience, more than 20 years experience running a practice,” says David Brooks. “The paired senior leaders of the group, including the physician CEO leader and the vice president of operations, have group practice experience and know how to work within a system. We have the critical mass to dedicate people skilled in managing physician groups, not hospitals, in such areas as

human resources, marketing and finance. The compensation model is based on productivity. The culture is more like a group practice than a hospital running physician practices.”

As a result, says Brooks, the physician group has been “very efficient,” requiring a subsidy of less than \$10,000 per PCP, with costs fully allocated and without counting ancillary revenues and specialties.

5. Transparent, Equitable, and Aligned Compensation

The compensation plan for employed physicians in a successful integrated delivery system must meet a number of requirements, including:

- Competitive, market-based pay to recruit and retain high-quality clinicians.
- Incentives for productivity.
- Incentives to reward physicians for achieving system goals for quality, patient satisfaction, and efficiency.
- Payment for leadership and administrative work.
- Transparency, so physicians know they are treated equitably.
- In some systems, supplemental payments for primary care physicians, when prevailing market rates undervalue their contribution to the overall system.
- Meeting “fair market value” tests and other government requirements.
- Approval of the compensation plan by independent directors.

St. John’s Health System. At St. John’s Health System, the clinic changed from a flat salary to a productivity-based compensation plan that rewards desired behavior. In order to rebuild trust, a transitional approach was adopted to ease the immediate impact. The compensation plan for physicians is approved by the clinic board, and also requires approval by the Health System board.

The clinic currently uses a “modified bottom line, or net revenues, compensation model.” Each physician is compensated based on his or her collected revenues minus expenses. The clinic rewards primary care physicians’ production by providing, in addition to their baseline clinical compensation, a value payment incentive which is distributed through a pool funded jointly by the hospital and the specialist physicians. Compensation is also provided for administrative responsibilities that take time away from practice. Physicians also have access to incentive compensation tied to achievement of core measures and other quality, safety, and financial indicators in the clinic and hospital settings.

Aurora Health Care. At Aurora, AMG’s compensation philosophy and plan are reviewed by the AMG board and the compensation plan must be approved by the Aurora Physician Compensation Committee. AMG is presently moving all its physicians to a productivity model based on relative value units (RVUs). This model

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has been in place throughout most of AMG for a number of years and has been well-accepted by the physicians.

In addition, physicians participate in an incentive compensation plan that rewards physician performance in such areas as care management, quality, patient satisfaction, and patient safety. This compensation model works hand in hand with a strategy to recruit and retain the “right doctors” who are aligned with AMG’s values. AMG communicates its expectations and philosophy of integrated, efficient, and high-quality care to all new recruits and makes it clear that these expectations apply to all physicians.

Preparing for the Future

The systems we examined believe that physician employment and hospital-physician alignment are critical to position their organizations for the future.

“We believe providers in the future have to emphasize innovation around care models,” says Sorsensen. “The population is growing and aging, but the number of doctors is flat and they don’t want to work as much. We have to be innovative, especially in primary care and internal medicine. That includes increased use of allied health practitioners, telemedicine, and hospitalists. We have to be smarter in taking care of populations, using a team approach, such as medical homes with a doctor in the lead, to deliver care and promote wellness in more efficient ways. The best way to accomplish these things, we believe, is with a fully integrated system of aligned hospitals and physicians.”

Deveny agrees. “The whole payment system for healthcare will change. Once the next phase of legislation and provider consolidation occurs, there likely will be more bundled pricing, risk contracts, and—we hope—pay for performance or at least recognition of quality. In a time of transparency, we have to be willing put quality on the front page.

Employers are unwilling to pay more and so the pie is not going to grow. We are positioning SPI to take full risk as part of the system.”

Physician employment, says Deveny, “is an end game, not just an exercise. Otherwise, physicians would become scarce and potentially competitors. We are in a transitional period from working side-by-side to working in partnership, because the public demands it. The old model of delivering care is not sustainable.”

— *Barry S. Bader, publisher of Great Boards, is the president of Bader & Associates, a Maryland-based governance consulting firm. To contact him e-mail bbader@greatboards.org or call 301-340-0903.*

FOR MORE INFORMATION:

- Eliot Huxley, MD: 239-389-2709; ehuxley@aol.com
- Donn Sorensen: 417-820-2849; donn.sorensen@mercy.net
- Joseph A. Scopelliti, MD: 570-882-300; scopelliti.joseph@guthrie.org
- T. Clifford Deveny, MD: 330-375-864; devenyc@summa-health.org
- David Brooks: 425-261-4064; dave.brooks@providence.org
- Peter Pavarini: 614-462-5016; peter.pavarini@szd.com