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Workbook 2
APRIL

Physician-Hospital Alignment: Meeting on What Matters

The evolving U.S. health care system will demand more standardization, reduced variation in outcomes and lower costs, necessitating new care delivery methods. A variety of models may emerge but physicians are the one constant to any emerging care paradigm, making hospital-physician alignment imperative.

Frank Perez, retired chief executive officer of Kettering Health Network, Dayton, Ohio, had an early start in creating this alignment within his eight-hospital system, which began as a single institution. "When I came to Kettering Medical Center as CEO in 1994, there was considerable turbulence," Perez remembers. "The market was rapidly changing and Dayton was one of the fastest-growing managed care markets in the nation." A physician-owned and -operated health plan on which Kettering relied had "succumbed to market forces," he says, and was acquired by UnitedHealthcare. The medical center lost 13.5 percent of its revenue on the controversial deal. "Everyone felt very unsettled; we wondered if we would survive these headwinds," Perez says. "Our first objective was to reset the mission, vision and values of the organization and our chief priority was to not lose the support of the medical staff — engaging them in the turnaround was crucial."

Perez began by ensuring that the turnaround team predominantly had medical leader participation. He also shifted the board's composition to include one-third physician representation. "We identified physicians who were willing to collaborate, but who would also speak their minds," he says. "We wanted their first commitment to be advocating for patients and delivering quality care."

Eventually, Kettering formed a physician-hospital organization, with two-thirds physician board membership. Now, all eight hospitals may elect representation to the PHO board, which has laid significant groundwork for accountable care organizations, he adds.

THE ROAD TO PHYSICIAN ALIGNMENT

Kenneth Bradley's hospital is just beginning a similar journey. Bradley is CEO of Winter Park (Fla.) Memorial Hospital, one of eight campuses comprising the Florida Hospital system. "Strategically, I can't do anything as a CEO without physicians," Bradley says. "Physician alignment is the most important issue we face relative to health care reform — and it's what's missing in health care today."

The Florida Hospital system works with four categories of physicians: academic clinicians through its teaching hospitals; contracted specialists, such as intensivists and emergency department physicians; doctors in private practice, mostly primary care; and approximately 400 employed physicians among a total of 2,200 affiliated doctors. Winter Park is developing what it calls a hybrid medical staff model that will incorporate all four types of physician relationships, but with stronger strategic and legal hospital-physician alignment around cost-effectiveness, quality, safety and outcomes to qualify for reimbursement through ACOs and other emerging narrow network insurance models.

"The future of health care will include a per-member per-month, flat-fee payment model, and physician contracts will need to reflect this eventual standard," Bradley says. Florida Hospital has spent the better part of the last decade preparing for this evolving payment model. "To ultimately create a hybrid hospital-insurer-physician model, we have to bring doctors together in new ways," Bradley says. As an example, standardizing the types of implants a hospital buys can lower costs, which

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CENTER FOR HEALTHCARE GOVERNANCE

BY MARY K. TOTTEN

is what insurers are looking for, but surgeons should determine what the best "standard" devices are, as well as understand why standardization matters, he explains.

Questions for Discussion

1. What do our board and leadership believe the medical staff model of the future will be?
2. How is our organization preparing for care delivery under emerging health care payment models?
3. What education does our board need to understand how to govern effectively under these emerging care delivery and payment models?

SUPPORTING PHYSICIANS' SUCCESS

Last May, Winter Park advanced its efforts toward greater physician-hospital alignment by making it a strategic priority and establishing a work group comprising four physicians who represent each of the hospital's clinical affiliations, plus Bradley. His first task was to listen to the group share thoughts on Winter Park's strategy and operations and the future of health care.

"Listening can be the most difficult activity," he says. "I listened for hours to the concerns of physicians, how they feel they are losing control of the issues that matter most to them, like clinical quality and choice. It's a painful process, but necessary to ultimately establish the trust needed for the next level of integration."

The group is working not only on better integration, but better performance as well. The pilot project will examine how Winter Park's hospitalists and ED providers can improve admission and discharge processes by enhancing communication and clarifying responsibilities. Both groups are contracted providers: the ED group has had a 15-year agreement with the hospital, and the hospitalists are under a new contract that has been in effect for just a year. This area was chosen for the group's inaugural project both because it is a common source of provider frustration and because improved, mutually determined processes can establish an early win for the group that will build physician goodwill and hospitalwide support.

"It's all about listening to the physicians who are referring patients and those working in the ED, hearing about the goals and challenges that everyone has in common," Bradley says. "We've clarified the chain of command for admissions and discharges and how to communicate more effectively on care outcomes — everything from when to admit patients to ensuring that they get primary care follow-up; in other words, systemizing care handoffs, which many of our physicians identified as a major problem.

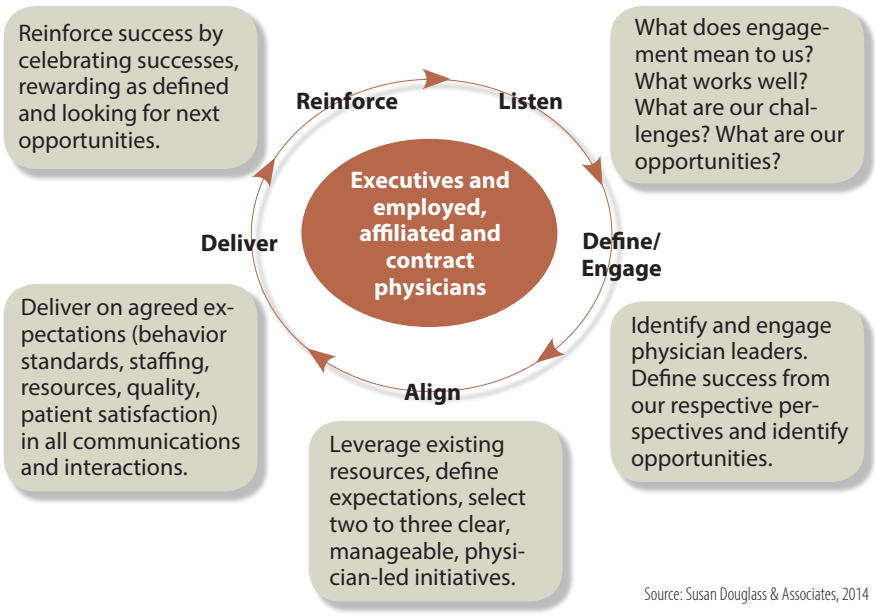
"Just talking about this has built new forms of trust and relationships," he continues. "We all assume no one has a better idea than anyone else — it levels the playing field." Even more important than representing Winter Park's various physician affiliations, the work group comprises physicians who want to make a difference and who are willing to make the time to do so, Bradley says. They are classic physician champions who command peer respect and, thus, have the capability to unite their colleagues.

Ultimately, "they are not complainers, they are problem-solvers," he adds. No one leads the group; rather, the discussion is informal and free-flowing, with each member's perspective taken into account — a task much easier to achieve in a smaller group. Bradley says a renewed appreciation for each physician's individual issues is developing and an improved set of admission and discharge process metrics, against which the group plans to measure performance, is emerging.

Physician-alignment group member Leonardo Cisneros, D.O., is a contracted ED physician at Winter Park, as well as a medical director and trustee on the Florida Emergency Physicians board. As such, he has a wide-ranging perspective on the challenges ED providers face and what might be done to address them. "I am glad to have the opportunity to have a real say in how my role will change going forward and on future care processes," Cisneros says. "I believe physicians need to be at the table to shape change."

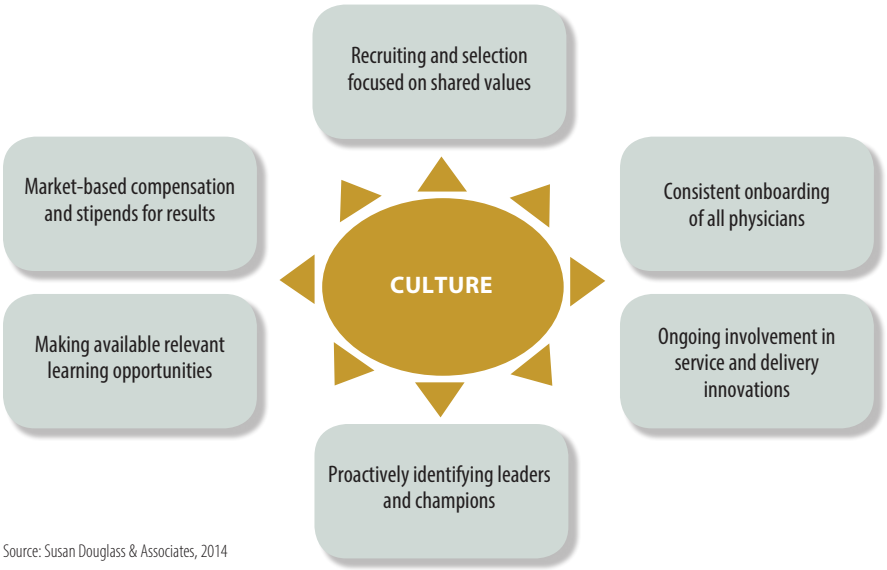
Susan Douglass, founder and president of Susan Douglass & Associates LLC, a physician-hospital alignment consulting firm, and Kenneth Cohn, M.D., CEO of Healthcare Collaboration, have assisted in guiding Winter Park's work toward hospital-physician alignment. The roadmap the hospital is following to create and work on group goals is below.

Winter Park Memorial Hospital's Journey



Source: Susan Douglass & Associates, 2014

Sustaining Physician-Hospital Alignment



Source: Susan Douglass & Associates, 2014

Questions for Discussion

1. What steps has our organization taken to foster closer alignment with physicians?

2. What common issues or goals have we identified as the foundation for building greater hospital-physician alignment?

3. How do our board and leadership define successful hospital-physician alignment?

FROM DOCTORS TO DATA

To move beyond the finger-pointing that can occur when responsibilities are unclear and patients are not efficiently admitted or discharged, the work group wants to shift its focus from doctors to data. "Managing with data is critical now," Bradley says. "Analyzing medical charts has always been standard, but population health data make charts anecdotal." Outcomes-related data are a powerful tool for measuring improvements in cost, length of stay and long-term health among larger groups of patients, he adds. "You see the [care] variations once you start measuring them and you see how physicians work, which helps to determine best practices," he says.

A data-driven approach is key to getting past siloed care provision, Perez says. For instance, rather than viewing surgery, orthopedics or any clinical area as a discrete discipline, providers instead should consider all the services comprising cardiac care, for example, and work as a team with all contributing care providers. Best practices result from the emerging team-based approach to care delivery that consistently achieves superior outcomes. "The old hierarchy still remains an obstacle, with a traditional 'protecting the trade' service-line approach," Perez says. "The task is to move into a big-picture, patient-centered approach to care."

Cisneros agrees. "Physicians look at health care one patient at a time, while the hospital looks at patients as more of a community. There is an underlying trust that needs to be there. Do doctors trust that everyone's best interests are kept in mind? We talk about physician-hospital alignment, but first we need to be honest physician-to-physician and be transparent with each other about what's important."

As a prime example, a patient waiting to be seen in the ED typically is viewed or labeled by hospital staff as an ED patient, but Cisneros disagrees — that individual is a hospital patient in the broader sense, simply because he or she is in the facility — and is every care provider's responsibility from that standpoint. "We tend to categorize responsibility for patients based on where they enter the system or what their condition suggests," he explains. "We need to treat patients more holistically. Everyone is trying to protect their piece of the pie, but a patient-centered culture sees patients as everyone's responsibility."

The priorities of reform need to be incorporated into the equation as well, Perez says. "Hospitals are beginning to get paid per case, but physicians are still paid on a per-unit basis," he says. "One key goal is to decrease length of stay, which translates into lower cost per admission. But, since most physicians are not employed, a shortened LOS will decrease their inpatient revenue. That's the misalignment. Physicians are paid for what they do and hospitals are increasingly getting paid for outcomes. But, by engaging doctors in quality projects early on, everyone can become aligned, because then we are all driven by quality, not cost-reductions," Perez explains. "We all become driven by the question, 'How do we improve care processes?' "

Kettering Health Network advanced this idea by seeking physician champions from each service line to drive best practices, with each champion leading a discrete service-line council. The impetus to participate came from telling physicians, "Out of these improved outcomes, we will make improvements in your service line, including funding for improvements to advance quality of care. In other words, each service line could directly benefit from improved access to capital to support their work," Perez explains.

"Physicians tend to look at the hospital [administration] and think all they care about is the bottom line," Cisneros says. "To change that, physicians need to be part of the conversation and understand how payments will be allocated. Everyone needs to understand bundled payment, so that both hospitals and doctors get their fair share. Reimbursement actually can be an equalizer."

Perez agrees. "Friction with doctors comes from their wanting better things for their patients and management's not listening to them," he

says. "What we have done could not have been achieved without physician champions committed to best practices in their own service lines, for their own patients. My capacity to affect 1,200 physicians was limited, but I could help establish two dozen leaders who did affect them."

With similar goals in mind, Cisneros has convened a second, separate physician group to talk even more candidly and privately about the challenges they face. These six physicians "can speak cathartically and say what they really feel," Cisneros says. "We don't talk about administration; we give each other healthy, non-accusatory feedback." This additional forum is needed, he believes. The group plans to augment its discussions with outcomes data to advance improvements nonjudgmentally.

'Medical staff loyalty has to be an at-risk element of executive compensation, however the board chooses to define it.'

"The best way the hospital can partner with us is to acknowledge our efforts and support us," Cisneros says. "If the administration responds with action, it will give what we do worth, since actions speak louder than words."

THE BOARD'S ROLE

Perez sees two fundamental board responsibilities for advancing hospital-physician alignment. First, the board itself should include numbers and types of physicians relative to national benchmarks and regulatory requirements; and second, executive incentive compensation should be tied both to meeting goals for physician participation in governance, as well as conducting an annual assessment of medical staff culture (employed and nonemployed) and provider engagement.

"Medical staff loyalty has to be an at-risk element of executive compensation, however the board chooses to define it," Perez says. "Boards should hold the C-suite accountable for physician engagement if it's important to the organization. You have to assess the attitudes of the medical staff and administration toward each other. Both verbal and nonverbal hospital-medical staff communication sets the tone for trust or mistrust. Doctors use both types of communication themselves, and they will pick up on both from leadership." That holds true for the board's attitude toward physicians as well. Bottom line, "You cannot have an adversarial medical staff relationship and expect success," Perez says.

He adds that, if the medical staff is asked whether the organization lives its values and more than 25 percent say, 'No,' "that's a red flag that physicians are not engaged, and the board and hospital leadership have to find out why." Focus groups can be a good way to begin. Ask medical staff what actions would do a better job of reflecting the hospital's vision and values. "You need partnerships and trust to transform health care and re-engineer care processes," he says. "Physicians live in a patient-centered world — you have to meet them there. And inclusion and transparency are the ways to gain their loyalty."

Adds Douglass, "Any successful physician-hospital relationship begins with common goals and shared purpose. Although both sides are committed to the patient, their respective roles in care processes and the patient experience are separate and distinct." When hospital leadership and physicians are working effectively together, she says, both are able to:

- partner to run the organization without competing;
- be enthusiastic champions of critical initiatives;
- be willing to consistently give their best effort;
- learn the competencies required to succeed;
- be proud of their organization and willing to actively recruit others [see Sustaining Physician-Hospital Alignment, Page 17, for how to reinforce those behaviors on a daily basis].

Cisneros understands that alignment cannot be achieved overnight. "There is no substitute [for accomplishing change] other than time," he says. "But ultimately, hospital-physician culture will change. It will happen to us all with bundled payment processes. You'll either be on the bus or not — change is coming and choices will have to be made. Money makes those changes very personal, and you can't deal effectively with personal changes in an impersonal way."

Questions for Discussion

1. What is our board's role in fostering greater hospital-physician alignment?
2. How does our board oversee our organization's alignment strategy and activities?
3. What joint efforts (such as establishing an ACO, participating in shared risk-reward contracts with insurers and others) are our hospital and physicians undertaking and trying to understand, so that they can work together successfully under new care delivery and payment models?

PHYSICIANS FIRST

Physician-hospital alignment begins with opening candid lines of communication among physicians, executive leadership and the board, establishing transparency and trust, and ensuring that everyone is on the same page to address the challenges new payment and delivery models demand. Rather than, "if you build it, they will come," the mantra to achieve true hospital-physician alignment should be, "if you want to build it, they need to come first." T

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