Investing in a Different Relationship with Your Medical Staff

Robert A. Vento, Senior Vice President
QHR Operations

Setting the Table

<table>
<thead>
<tr>
<th>Healthcare Reform</th>
<th>Integration</th>
<th>Big Bang!</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment Reform</td>
<td>Economic</td>
<td>Integrate professionals into bureaucracies</td>
</tr>
<tr>
<td>Delivery Reform</td>
<td>Clinical</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cultural</td>
<td></td>
</tr>
</tbody>
</table>
### Setting the Table (cont.)

#### Unclear Path – The Impact?

<table>
<thead>
<tr>
<th>Care experience</th>
<th>Cost</th>
<th>Quality</th>
</tr>
</thead>
</table>

#### Understand History

#### What to Do?

### Evolution of the Hospital-Physician Relationship

- **Physician Workshop**
  - **1930 - 1965**: Third Party Payments & Dual Hierarchies
  - **1965 - 1990**: Medicare & The Consolidation of Hospital Authority
  - **1990 - 2013**: Managed Care, Market Consolidation, ACA
  - **2014 & Beyond**: Physician Teamwork & Collegiality

- **Rise of Hospital Industry**: 1870 - 1930
The Rise of the Hospital Industry
1870 – 1930

- “Physician Workshop”
  - Technology evolves
  - Controlled economics
- Access to hospital staff
- Physician management
- Social compact
- Limited employment
- Expansion of medical staffs (open)
- Clinical affairs overseen by physicians
- Dual hierarchies of administration and medicine
- Bedrock and constraints on physician-hospital relationship

Third Party Payment and Dual Hierarchies
1930 – 1965

- Depression threatens incomes of both groups
- Patients had no money
- Hospital/doctors pushed for voluntary versus government solution to healthcare insurance coverage
- BC/BS plans emerged
- Financial complexity lead to “professional” hospital administrators
- Physicians delegate control of non-clinical functions
- The balance of power: Triumvirate
  - Physician
  - Trustee
  - Management
Third Party Payment and Dual Hierarchies
1930 – 1965 (cont.)

- 1957 – Bing v. Thunig
  - Hospital now responsible for physician actions within the hospital

- 1965 – Darling v. Charleston Community Memorial Hospital
  - Affirmed & extended hospital legal responsibility

- Hospital has responsibility for:
  - Supervising care
  - Quality assurance
  - Credentialing
  - Corrective action
  - Patient outcomes

Medicare and The Consolidation of Hospital Authority
1965 – 1990

- 1965 – Medicare increased access
- Medicare Part A & B (silos)
- 1973 – HMO Act
  - Hospital & medical groups bear risk
  - Kaiser expands
  - Geisinger Clinic
- Investor-owned hospital systems emerge
  - Capital through equity market rather than philanthropy
Medicare and The Consolidation of Hospital Authority
1965 – 1990 (cont.)

- New models to finance
- More complex regulation
- Shift power to management
- Administrators to CEOs
- Marketing and planning
- 1983 – Prospective Payment System (PPS)
  - Attempt to standardize treatment & care
  - Part A only
  - Clinical autonomy
  - Corporate medicine

Managed Care, Market Consolidation, & ACA
1990 – 2013

- Early 1990s – market consolidation
- HMO & capitation
- Risk sharing with Independent Practice Associations (IPAs)
- Clinton plan threatens
- Physician-Hospital Organizations (PHOs)
  - Collaboration
  - Threat of managed care
  - Contracting vehicles
  - Downsizing provider capacity
- Activity slows by end of 1990s
- 1997 - Balanced Budget Act
Managed Care, Market Consolidation, & ACA
1990 – 2013 (cont.)

- Physician Practice Management (PPM) Companies
  - Rollup strategies
  - Not cost or quality
  - Managed care leverage
  - Consumed large amounts of capital
  - MedPartners/PhyCor
    - Two-year collapse
    - $12B in equity lost
- Changed physician employment
  - Practice buy-outs
  - Income guarantees
  - Productivity

Managed Care, Market Consolidation, & ACA
1990 – 2013 (cont.)

- Surgical specialists
  - Ophthalmologists
  - Urologists
  - Gastroenterologists
- Primary care shifting to ambulatory solutions
- Hospitalists/Intensivists
- Segmentation of profitable services
  - MedCath, Cardiology, Orthopedics
  - ASC
  - Physician-owned JV hospitals
Managed Care, Market Consolidation, & ACA 1990 – 2013 (cont.)

- Department of Justice, Federal Trade Commission, Stark
  - Ongoing “reform”
- Affordable Care Act (ACA)
- Continued division of hospitals & physicians

Physician Teamwork and Collegiality 2014 and Beyond

- Physician autonomy from hospitals lost??
- Physicians not well organized
  - Inhibited by antitrust laws
- Hospitals responsible to organize/collaborate/LEAD
Hospital-Physician Alignment
Structural Models

HOW TO MOVE TOWARD BETTER HOSPITAL-PHYSICIAN ALIGNMENT
To Develop Trust – DO’s

- Be transparent
- Fix the “small things” so focus shifts to strategic
- Treat physicians with fairness and respect
- Eliminate physicians’ obstacles and frustrations
- Engage physicians “on the front lines”
- Rally around a common goal: providing the best care for patients
- Show genuine interest in their interests

To Develop Trust – DON’T’s

- Ask for leadership but not provide support to help leaders succeed
- Be close-minded
- Over-promise and under-deliver
- Be inconsistent
- Trivialize physician leadership
What QHR Client Hospitals Have to Say About the Importance of Trust

Trust is Hard to Earn and Easy to Lose

“Trust is a critical, yet fragile commodity. To build and sustain it, healthcare leaders and boards must be willing to do what they say they are going to do, not change their minds without explaining why, and apologize when they make mistakes.”

William F. Jesse, FACMPE

Source: “Organizational Culture, Clinician Engagement and Physician Integration: Keys to Success” by William F. Jesse, MD, FACMPE and David D. Rowle, PhD and referenced in “Achieving Stronger Physician Engagement” (Oct 2013), John R. Combs, & Mary K. Totten, p.2
What QHR Client Hospitals Have to Say About Trust Being Fragile

Engagement versus Alignment

- Starts with Leadership versus Management
  - **Management** is the ability to ensure steady, reliable, consistent performance.
  - **Leadership** is the ability to successfully bring about a particular, big change, either culturally or operationally

Source: “Engagement and Alignment are Two Different Things”, Thomas J. Lee, February 16, 2011
What is Leadership?

“What leadership entails envisioning, articulating, inspiring, and supporting change or a breakthrough performance, typically requiring the discretionary and self-sacrificing efforts of people, and often in an environment of uncertainty and risk to oneself.”

Thomas J. Lee

Source: “Engagement and Alignment are Two Different Things”, Thomas J. Lee, February 16, 2011

Engagement versus Alignment

- Alignment is …
  - the product of good management
  - critical to meeting the needs of the present
- Engagement is…
  - the product of good leadership
  - Critical to meeting the needs of the future
What is Engagement?

When parties “care about the future of the organization and are willing to contribute their discretionary time to that end”

Matthew J. Lambert III, MD, FACHE

Nine Steps to Achieve a Culture of Physician Engagement and Improve Performance

1. • Assess organizational culture
2. • Measure engagement of employees, physicians, and volunteers
3. • Deploy clinical integration tools
4. • Recruit for cultural fit
5. • Actively manage culture conflicts
6. • Set clear expectations
7. • Provide performance feedback
8. • Don’t tolerate misfits or poor performers
9. • Align compensation and performance measures

Source: “Organizational Culture, Clinician Engagement and Physician Integration: Keys to Success” by William F. Jesse, MD, FACMPE and David D. Rowe, PhD and referenced in “Achieving Stronger Physician Engagement” (Oct 2013), John R. Combs, & Mary K. Totten, p.2
Characteristics of Hospitals Whose Physicians are Engaged

- Fewer formal meetings between physicians and management
- Leaders who are visible with physicians and employees
- An “excess” of communication with and from leaders
- Shift from minutiae to big-picture strategy and direction
- Consistent views among physicians

Source: “Organizational Culture, Clinician Engagement and Physician Integration: Keys to Success” by William F. Jesse, MD, FACMPE and David D. Rowe, PhD and referenced in “Achieving Stronger Physician Engagement” (Oct 2013), John R. Combs, & Mary K. Totten, p. 2

What QHR Client Hospitals Have to Say About Involving Physicians in Hospital Strategy

Melinda McBride, Board Chairman
King’s Daughters Medical Center
How to Involve Physicians in Governance

1. "The Future of Physician Leadership" (Oct 2013) p. 4 (Gundersen Lutheran Health System, La Crosse, WI)
2. "Essential Strategies for Hospital-Physician Relations" (Feb 2014), p. 4 (Martha Jefferson Hospital, Charlottesville, VA)

Physician Advisory Boards

- **Quality Care Board**
  (majority are physicians) – develops and implements clinical integration program

- **Physician Board of Governors**
  (physician-led) – submits major recommendations to Board of Trust for approval

1. "The Future of Physician Leadership" (Oct 2013) p. 4
2. "Essential Strategies for Hospital-Physician Relations" (Feb 2014), p. 4
How to Involve Physicians in Governance

- Leadership dyads (service lines headed by physician-hospital administrator pair)
- Hospital quality initiative committees
- Hospital process improvement and cost reduction initiative committees
- Physician leadership groups – gather, discuss, and submit concerns/ideas from the medical staff

What QHR Client Hospitals Have to Say About How to Involve Physicians

Dr. Donald Nicolay, MD, Chief Medical Officer
Community Hospital of Grand Junction
Physician Alignment Governance Models

- Adopt a physician alignment philosophy
  - Formal Statement
  - Strategic approach to physician collaboration
    - Patient care and financial measures
    - Compliance
    - Management of conflicts

- Audit physician collaboration arrangements
  - Monitor scope
  - Comply with IRS, CMS, Stark, FTC
Physician Alignment Governance Models

- Assess physician arrangement compliance standards
  - Are objectives/performance standards being met?
  - Tactics/arrangements may be transitional
  - Movement from/to employment models
Key Trustee Takeaways

• Spend the time and effort to develop trust
• Thoughtfully pursue physician engagement
• Meaningfully involve physicians in hospital governance

Thanks for Attending!

Intended for internal guidance only, and not as recommendations for specific situations. Readers should consult a qualified attorney for specific legal guidance.
Robert A. Vento  
Senior Vice President  
QHR Operations  
(615) 371-4741  
Bob_Vento@qhr.com