

# ROUNDTABLE

## TIES THAT BIND: DEVELOPING HOSPITAL-PHYSICIAN ALIGNMENT

It's no secret that the business model between hospitals and physicians is in a state of flux. In fact, a recent HealthLeaders Media survey of hospital and medical group CEOs found that 36 percent of participants spend more than 26 percent of their time on physician relations. Hospitals are now developing complex arrangements to maintain the medical staff, including joint ventures, ED call-coverage payments, pay for performance, gainsharing and full employment. Now is not the time to wait for market changes to dictate strategy. *HealthLeaders* gathered a roundtable panel of experts to discuss how forward-thinking hospitals are continually assessing how they can develop physician alignment tactics that support doctors and the business.

### Panelist Profiles



**RICK JOHNSON**, senior editor, HealthLeaders Media, served as moderator



**WILLIAM C. THOMPSON, MD**, chief medical officer, Baptist Hospital, Nashville, TN



**JOHN PHILLIPS**, president, PivotHealth, Brentwood, TN



**AL STUBBLEFIELD**, president and chief executive officer, Baptist Health Care Corporation, Pensacola, FL



**JEFFRY JAMES**, chief financial officer/chief operating officer, Christie Clinic, Champaign, IL

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# Roundtable Highlights

## Understanding the gap

**RICK JOHNSON:** *What's the root cause of the gap between physicians and the hospital?*

**AL STUBBLEFIELD, Baptist Health Care Corporation, Pensacola, FL:** Today, physicians have new business opportunities put in front of them every time they go out of town to a meeting. We have a physician who came back from his national meeting, and he was really exasperated. He is a very loyal friend to the hospital, and he said the first meeting he went to was all about how to negotiate with your hospital to pay for emergency room coverage. The second meeting he went to was all about how to build your own surgery center. So the nature of the things that physicians are hearing and learning put them in more of a conflict relationship with the hospitals than has historically been the case in the past.

**JOHNSON:** *At the same time, more physicians are open to hospital employment opportunities than before. Bill, as someone who has set up a hospitalist program, could you talk about what's driving this?*

**WILLIAM THOMPSON, MD, Baptist Hospital, Nashville, TN:** There are several significant shifts that have occurred among physicians over the course of the past 20 to 30 years. And newer physicians typically are more interested in work-life balance than older physicians, who are more inclined to be comfortable working 60 to 80 hours a week. There is less entrepreneurial zeal in this more recent generation of physicians. They are more inclined to accept full employment opportunities. I have also seen plenty of younger physicians who are interested in a traditional model, so I don't think I would try to paint this whole new generation with one color. But there is clearly a shift, and many people have noticed a rise in the hospitalist movement. It just fits in perfectly with a desire for more shift-type work and a clear delineation between personal and professional life, which has probably not been the case so much in older, self-employed physicians who worked in a traditional, private practice model.

## Distinct differences

**JOHNSON:** *Jeff, does a hospital management team have anything to offer to your clinics and your management team?*

**JEFFRY JAMES, Christie Clinic:** The management teams are so different that they can't easily adapt. When you think about it, the nuances of what we do are so different. We do huge volume of low-dollar stuff—we are truly, on the physician side, looking for the nickels. The hospital does small vol-

ume, high-dollar stuff. They run a 24/7 shift. We run a 9 to 5. It seems that one of the big missteps that hospitals made in the past is that they tried to acquire and manage practices themselves, but they did not recognize the very real differences in managing, working with, and leading physicians compared to leading nursing staffs or other administrative staffs.

**STUBBLEFIELD:** Physician practice management is a different animal and takes a different skill set. Hospitals messed up lots of businesses through the '80s and '90s by putting hospital people in place to run nursing homes, physician practices and other attempts at horizontal integration.

**JOHNSON:** *And physician service organizations have been tried before. So how is the physician service company model going to be different than in the past?*

**JOHN PHILLIPS, PivotHealth:** There are a several things that are different today. First, 15 years ago, you didn't have reliable, fast, dependable, distributed, 100 percent backed-up Internet-based systems. Today, even within our small company network, we have more than 3,000 doctors using an ASP solution for practice management systems. They no longer have to worry about Medicare updates, HIPAA compliance issues, etc. Also, available and affordable EMR systems are out there today, again with ASP approaches that are very affordable with minimal upfront costs. Additionally, we now have the ability to offer financial management and employee benefit services that were not really available or affordable just 10 years ago. So, today, the hospital can offer an integrated solution not previously available to smaller physician offices that can also save the practice several percentage points off their expense line.

**AL STUBBLEFIELD**  
President and Chief  
Executive Officer  
Baptist Health Care  
Corporation

## Lessons learned

**JOHNSON:** *What services to medical groups should hospitals stay away from entirely?*

**STUBBLEFIELD:** Billing and collecting. I've got scars that I could show you from when we got into it—it's a no-win situation. If it ever goes bad, then the physicians think you have deep pockets and you should step up and make up for it.

**PHILLIPS:** On the other hand, if a hospital administration wants to get in that business and even consider providing a guaranteed collection percentage, then they can do something the doctors can't do for themselves. The hospital can benefit from outsourcing the management and the reputation risk of this area to the physician services company, a good buffer for the hospital if there are issues with the physicians in this sensitive area.

**JAMES:** As long as they hire somebody, not their business office, to do it.

**STUBBLEFIELD:** We recruited physicians in town and offered to do their billing, but we didn't do a good job with it. And then they looked to us to make up for the fact that a poor job was done. And, legally, we couldn't just write them a check.

**PHILLIPS:** That's why if you're going to offer physicians business solutions, you have to find people who are out there who are already doing a good job in already providing these services for physicians.

## Adding value to physicians

**JOHNSON:** *Al, you still have a lot of traditional relationships with your physicians, even though you have competition in Florida that has very different models. How are you sustaining your traditional relationships?*

**STUBBLEFIELD:** We are sustaining it by continuing to look for ways to bring

value to those doctors. There is a core of physicians out there who like the traditional model and who are repelled by the physician-employment model. Still, it's a shrinking core. We are trying to communicate, trying to stay close, trying to look for things that can bring value to them, but it is a continuing uphill challenge.

**JOHNSON:** *Is the traditional model sustainable?*

**STUBBLEFIELD:** I have doubts. I think that the models are going to change over the next 10 or 15 years, and you will not see as many unaffiliated physicians on staff. Every market will be different, but there is going to be more economic alignment with hospitals.

**THOMPSON:** They'll have to. The solo and small groups are just finding it such a tough slog that they're moving to more consolidation of physicians.

**JOHNSON:** *But Al spoke to his communication and outreach efforts—something every hospital should be doing. But what really sets those efforts apart?*

**THOMPSON:** It's always much more than physician communications. You have to think about what results you can achieve and then how to communicate that to the medical staff. For instance, what can we do from a quality perspective that sets us apart? Can we give them an electronic medical record package that is going to make their economics better? Can we make their lives better? We need to involve them on the front end and say, "What would make your life better? Help us figure out which one of these systems is the best for your office."

**JOHN PHILLIPS**  
President  
PivotHealth



**JOHNSON:** *I'm reminded of a hospital CEO who said that you have to have a rallying cry and engage the medical staff in answering that call to action.*

**JAMES:** I think it's critical. You have physician buy-in and develop a common culture. That will keep you from having to do the "deal of the day." But a large part of it is trust. Until you can get the physicians' trust, you're not going to be successful. And part of it comes to the issue of transparency. If you can get to the point where you have a trusting relationship with transparent data, then physicians and administration can focus on opportunities to pull in the same direction.

**PHILLIPS:** This is going beyond communication. It's much more than asking the doctors to tell you what's important to them. The rest of it is showing that you listened and doing something about it—and celebrating successes. It's not an easy piece. They're scattered all over the place. It takes staff and time and energy and investment in dollars or creating something to offer them that's not there.

**THOMPSON:** And that's not to underplay the importance of money, but I think you're still dealing with a professional group for whom service, quality and patient safety sells. That is really job one. If you cannot deliver the goods, they're not going to bring their patients to your facility. If their patients don't

get good care, and they don't trust the nurses, and they're not satisfied with the outcomes that are under the hospitals purview, then they're not going to come—I don't care how much money you dangle in front of them.

**JOHNSON:** *Al, tell me about what you're doing to "deliver the goods," as Bill said.*

**STUBBLEFIELD:** Another area hospital put \$300 million dollars into the physical plant, creating this incredible, beautiful facility that I am very lustful of. But, we managed to grow our market share in a not very good part of town. It happened because the physicians ultimately want their patients where they're going to be happy and where they're going to be taken care of, and the physicians felt the difference in the environment of the organization, so they brought their business to us. We've stayed at the 99th percentile for 10 years in patient satisfaction, and we've been in *Fortune* magazine's "Top 100 Companies to Work For." Now, when we started our service excellence program, early on physicians had very little involvement; they sat back and watched, feeling like this is another program of the year. But as they began to hear from their patients that there really is a difference, the physicians began to understand the culture we were creating.

## Time to step up

**JOHNSON:** *Jeff, what are you seeing in terms of successful physician engagement?*

**JAMES:** Hospital administration needs to decide whether they are going to be proactive or reactive. The reactive hospital can do more harm than just encouraging a physician down the path of adding services for themselves; that stance actually pushes physicians away. In our market right now, we have one hospital that is very proactive, and one hospital that is being very reactive. This is pushing our physicians toward a hospital that they typically did not practice at. By proactive, I mean that the admin-

istration is talking to us about marketing strategies, EMR, and generally about how we get on the same page. At the same time, the reactive hospital's administration is talking about curtailing our privileges, recruiting against us, and changing the way unassigned call is provided. I think the way these two hospitals are interacting with volunteer medical staff is going to change the landscape in our market. Physicians are loyal—even though hospitals don't believe that they are. No matter how painful it is, they prefer to practice where they're comfortable, and it really takes a lot of effort to get it to go in another direction. But once they get that comfort level in another direction, then they're loyalty shifts—once they figure out where to park at the other hospital and where their locker is, the dynamics change.

## How much to share

**JOHNSON:** *We've talked a little about transparency with the medical staff, but could you expand on how far you need to go with sharing of financial and quality data?*

**STUBBLEFIELD:** We've become much more open with our staff. We call it a no-secrets environment. A major part of the cultural transformation was to be more open about where we were, about what we're facing, about sharing our results and sharing our quality results.

**PHILLIPS:** That's a huge issue, and a refreshing change from what physicians have come to expect from their hospital partners.

**STUBBLEFIELD:** When the medical staff meet, we show them how we are performing under all of our pillars—our people, our service, our quality, our financial and our growth pillars.

**THOMPSON:** But it is a challenge for hospital administration to really open itself up to physicians—to have collaborative decision-making. That is a culture that is very difficult to build and to maintain, because the medical staff's interest doesn't always align economically with the hospital. And physicians are not historically as business savvy about a large complex organization like a hospital, and there's just a gulf there.

**JOHNSON:** We talked about the importance of transparency, but the downside of that is when the data isn't something you're comfortable sharing. Bill, how do you deal with that?

**THOMPSON:** This is an active debate within my institution and within my system. My system is very committed to transparency and quality. We regularly have a report card that we share with the physicians. We report our financial status regularly at medical exec committees. But that still doesn't necessarily reach out to our entire or full community, and there's always concern about sharing that information. We have recently done fairly well in HealthGrades ratings, and our hospital is trying to publicize that, but it really brought into focus the fact that the quality data that gets shared with the public frequently has a one-, two-year lag, and there's not really standardization yet. So what we're actively



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Chief Medical Officer  
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discussing is, do we put our raw results out on a Web site that is publicly available and report the most current information we've got in the most transparent fashion that we can? I think that's the right thing to do.

**PHILLIPS:** It's uncomfortable and worth the risk if you do it properly.

**THOMPSON:** It's very uncomfortable, and there is a lot of hesitancy.

**PHILLIPS:** But accountability breeds responsibility. And that's really a hard thing for hospitals. It's a hard thing for any of us. It's hard for me to say to the doctors, "We want every doctor in this group to know what every other doctor is producing." And doctors don't want that if they're in the lower-third or lower-fourth. But take Al's organization, for instance: He got rid of his lower-tier employees and replaced them with better employees over time. You incrementally average up and average up. That's what accountability does to you if you survive. It basically exposes your weaknesses and you have to deal with them.

**JAMES:** We're moving toward reporting physician individual patient satisfaction scores on our Web site. We haven't gotten there yet. We're telling our physicians it's coming and giving them a few months to adjust some of the behavior patterns. But we want to hold ourselves accountable.

## EMR assistance

**JOHNSON:** *Now that Stark rules have loosened, I'm beginning to hear of more hospitals attempting to assist with EMR purchase and implementation for practice groups. Bill, are you starting to get inquiries from doctors?*

**THOMPSON:** Across Ascension Health, we absolutely have seen this. And we have gone through an evaluation process on a national level to really come up with a list of recommended vendors that the organization feels will remain

in business tomorrow. And we're looking for vendors that will give some price break because of the business we can bring as a multistate hospital organization. But those are difficult relationships. It's very hard to come up with that list, because physicians have a wide variety of preferences, and they're not just sterling-clear market leaders. The best-of-breed EHR for the office is frequently not a clinical information system that works well in the hospital.

**JOHNSON:** *But when you're talking about physician alignment, offering electronic records and having a shared platform could be a big benefit, right?*

**STUBBLEFIELD:** There's a real upside to the EHR if it's done properly. Access to information and automated systems not only for billing and collecting, but also for reports from imaging centers that a hospital may have an interest in really resonates with physicians. And the prescribing piece is huge. But hospitals are struggling over whether we can afford to do this. IT is so expensive and there are not clear market leaders that have fully integrated solutions that work well in any environment.

**PHILLIPS:** Or the hospital delivers a practice management system. Before, they might have had to invest \$1 million or \$2 million into system hardware. Now, maybe Al can make a service company available to his physicians through an ASP solution. There are no upfront costs, and they pay a few hundred dollars a month. So this is an alignment opportunity based on hot buttons for the doctor—starting with economics, but also impacting positively on their lifestyle issues. This practice management system is ASP, so the medical group doesn't have to have

"techie" people out there. They just have to have a PC. If you can make the doctor's life better and economics better at the same time, then you've got a winning solution.

**THOMPSON:** The other advantage to the EHR and the integration with the institution is the competitive advantage that they offer a physician practice because of the access to the data and the ability to really compete for that pay-for-performance dollar, as well as to really drive up quality, which I think everybody understands is what's going to move the market. That's what's being demanded of all of us, and it is almost impossible to deliver that cost effectively in a paper environment. Physicians have got to get electronic medical records in their office, but it is such a steep climb for them financially.

**JOHNSON:** *We've talked a lot about hospital-physician alignment strategies, but what about the impact of the shortage of physicians and the dynamic of physician work-life balance.*

**JAMES:** The changing dynamics of physicians is only going to speed up. Pretty soon it's going to feel like they all want to work part-time, and that's going to be compounded by the fact that there is not as many of them. So expect competition for physicians to intensify. ■

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