The Imperative of Alignment

The changes in healthcare delivery that hospitals and health systems seek in today's market cannot be accomplished without the cooperation of physicians. Conversely, many physicians find that they need relationships with hospitals to guarantee patient volume and income. *Physician-hospital alignment* is the phrase used to describe the ideal state of physicians in lockstep with strategic goals. But achieving alignment is complex. The trend of employing physicians continues, yet employment does not necessarily lead to integration. Whether employed or independent, and regardless of specialty, physicians must see value in collaborating with acute care hospitals.

Executives and physician leaders need one another to counter declining reimbursements and the other challenges facing the industry. HealthLeaders Media recently joined with five executives for an in-depth, three-hour conversation on governance, compensation, culture change, and accountability.

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Roundtable Highlights

HEALTHLEADERS MEDIA: *One of the major findings from HealthLeaders Media's research is that nearly 90% of leaders say they expect to increase physician employment. What does this trend mean for alignment?*

CLIFFORD DEVENY, CATHOLIC HEALTH INITIATIVES: I think in the past, employment "version one" was more of a reactive strategy—a way to either maintain market share or to move market share. But what a lot of us didn't really think about were the implications from a cultural standpoint, from an integration standpoint, of employing providers but not setting clear expectations, not setting clear accountabilities ahead of time. It was much more of an appeasement type of a situation. What we found is we have lots of individual deals. We don't really have compacts that say, "This is what it means to be part of this health system and these are your obligations." So what we were doing was economically maintaining the private-practice model that was a referral source to the hospital. I think employment 2.0 will be much more proactive, much more prescriptive as to what the requirements are to be part of the health system. What are the accountabilities of the provider? What is the obligation to the whole health system?

And so we're actually going through that process now of changing all of our provider compensation, and getting away from productivity alone as we add other metrics. We will have compensation plans instead of individual comp deals. Last year, I think we had 1,800 individual contracts that had to be reviewed, so we're getting away from that paradigm. Then, more importantly, everybody will sign a physician compact, which will include provider work standards. It will have behavior standards. It will have community service standards. And in the future, rather than holding providers accountable just to productivity and giving them their bonus check, they will get monthly feedback on the different types of metrics.

MEGAN PERRY, SENTARA HEALTHCARE: A lot of health systems went out in the mid-'90s with what I refer to as "Bill and Hillary—Healthcare Reform Round 1." Healthcare systems around the country went out and bought primary care groups. ... We employed them, thinking that this was going to protect us from what was then going to be a national health plan, and having the primary care docs as the gatekeeper was going to be the key to our success. We didn't do that well. ... We brought them in and salaried them, which did not get the outcomes we had wanted. The physicians really did not want to be employed, they did not like being salaried, and we did not know how to really manage. And a lot of health systems divested after a few years of that and spun the doctors back out into private practice.

We, as a health system ... held on, and ... said, "No, we've made an investment. Let's sit down with these guys and figure out how we can make this work." We next tried what we referred to as a private practice model, which was back to more of an RVU compensation model, which was what they were accustomed to in private practice. I think we're now on our next version, the same way as Cliff, where we've now moved the doctors to a new comp plan where I'd say almost 25% or 30% of their pay is now based on metrics, quality performance, citizenship, being a member of the team.

JONATHAN SCHOLL, TEXAS HEALTH RESOURCES: In north Texas, our market is 6.5 million right now, and our aspiration is to manage a third or more of those lives. So how many primary care doctors do you need? You can easily get the numbers around a thousand, 1,200. We're not going to employ them all. ... So to build a system that is pluralistic, that offers the option for well-run employment, but also [considers] how an independent physician relates to the system in a way that provides them benefit and also marches toward the destination of accountable care, is critical.

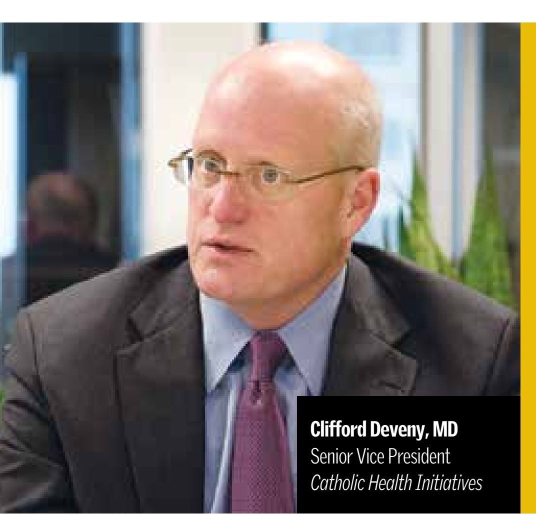
J.R. THOMAS, MEDSYNERGIES, INC.: Each market is different. If your competitor is acquiring doctor groups and you're not, you have to make a choice on what is your model. ... If you have 300 retail locations and primary care docs on the ground operating, you have to recognize that's a competitive advantage to some degree to the patients. The biggest challenge we see is that everybody thinks employment of docs is the end. ... Employment of docs is the process to get the patients. And whether they're independent or employed, the goal is not doc numbers; it's patient numbers in your market. ... The hard part is, how many of those heartbeats should you see? How many of those do you want to see? How many do you have to see? We believe over time that the lines will blur between an employed physician and an independent physician if it's done well.

SCHOLL: I've literally said to physician groups, "I don't really care where you get your paycheck from. What I really care about is whether or not we're operating as a system to improve the quality and the value of the patients that we serve, and if we can do that together better, that's a win for you, a win for us."

Megan Perry
Corporate Vice President
Sentara Healthcare

PERRY: We made that mistake of thinking the minute a physician starts to get a paycheck every two weeks like the rest of us, that they were automatically signed, sealed, and delivered and were our team. That just didn't happen. ... Doctors are raised to be independent, autonomous thinkers, and that's what we should really reward and applaud and not try to fight that. How do you embrace that and make that a good thing and not a bad thing? We tried to corral that, probably not appropriately in the past, and so we've learned a lot.

LINDA BUTLER, REX HEALTHCARE: Where we're trying to get [physicians] is to have team goals rather than individual goals. Because that's exactly how you're trained in medical school: You're the captain of the ship or the quarterback of the team. But when you think about it, physicians aren't the only ones taking care of patients. It really is a team. ... I've got to count on everybody doing their part given the tools to do it. We're trying to get the docs to the same place. We now have multiple employed groups, and the culture of every group is different. Some really get it. ... They say, "Don't just think of us as getting patients. We're your partners. We want to fight this fight together." And then we have others, even employees, who say, "Well, what's in it for me? I'm not going to document in the right place," or, "I don't really care if you get your meaningful use on the hospital side. I'll do it in my practice."


Clifford Deveny, MD
Senior Vice President
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HEALTHLEADERS MEDIA: *Alignment for what purpose? What is the purpose in your markets and for your organizations?*

THOMAS: This is a continuum of investment and alignment, exclusivity, independent docs, services, and managed care contracts. From our perspective, the question is how do you get strategy and tactics and alignment with physicians and ambulatory providers for a marketplace over a five-year continuum? Because most major care contracts are three. So it has to be more than that contract. This is a major shift.

BUTLER: At least in our hospital, we're all patients eventually. So I joke that, "I want to make this the best place so that when I'm a patient, I'm not going to worry about any of the care that I receive." ... Even looking at readmissions, the right thing to do for that patient is to make sure that they have a nice transition home or have home health or whatever so that they don't come back. Because people don't really enjoy being in the hospital. ... Let's do the right thing for the patient and the rest will follow.

SCHOLL: It's an issue of strategy, too, though. I've faced competitors where their alignment purpose is "Join me or you're against me. You're in my network or you're not in my network." The purpose needs to be for addressing the cost and value of care together. It's a local priority; it's a national priority.

HEALTHLEADERS: *Primary care versus specialty physicians versus hospitalists—alignment has different purposes for each.*

SCHOLL: It all is under the umbrella of value. How do you actually get alignment for the purpose of improving the value and quality of healthcare? They all have different roles. For the hospitalist it's about predictability; it's about throughput; it's about managing the patient well in the hospital setting. For the specialist, it's about low variation; it's about evidence-based practice. And for primary care, it's about access, practice transformation, and extending themselves

Linda Butler, MD
Vice President of
Medical Affairs, CMO, CMI
Rex Healthcare

to get more people in. So how we construct the governance models, the compensation models, really has to pay attention to the purpose of each of those categories and subcategories.

DEVENY: There are not enough doctors in the current fee-for-service world. But there are enough doctors to manage a team if we provide care in a different way. The next step is the specialist. Right now in the fee-for-service world, there are not enough specialists in regions—so we need to train them on the patient-centered medical home model and other team-based care models.

BUTLER: In Raleigh, we have a lot of subspecialists. I think they are a little worried that if the primary care docs really start managing referrals tightly, their volumes will be impacted.

THOMAS: When you look at the staff and physician groups, they have 35% turnover. Physician practices are a retail business just like anybody else. They have high turnover in the staff; meanwhile, customers are expecting higher levels of service.

HEALTHLEADERS MEDIA: *How should compensation change to drive the goal of physician-hospital alignment?*

DEVENY: We've been an organization where 50% of the physicians are paid on work RVUs and 50% are paid on

revenue minus expense. We spent about six months with physician leaders and executives around the system, and a couple things have come out of that. Eliminate the revenue-minus-expense, private-practice model because it impedes investment in some of the infrastructure that is going to be required going forward, such as getting a doctor to pay for EMR, getting him to pay for compliance—those types of things. Get rid of that disincentive, but start to reinforce the different metrics: creating compensation of at least 20% or more around citizenship, basic work expectations on timeliness, meetings, and those types of things.

Eventually, I think what we're going to see is we're going to set variable compensation that is aligned with the executive team, so everybody is running in the same direction. I think as we move to population health, we need to get away from the reinforcement of productivity for productivity's sake.

PERRY: I think compensation in healthcare in totality, not just for our physicians but for our extenders and our nurses on the units, has to change. ... We haven't really aligned the incentives even for our teams. There's no real incentive to do things in a productive way. We've tried; we have a bonus program for our staff called "Performance Plus" which rewards team members if as an organization we achieve certain quality and efficiency metrics. But I think we're still very young as an industry in creating meaningful recognition programs.

BUTLER: The physicians are always going to think we don't pay them enough, and the executive team will think that we pay them too much. Trying to get them to shift from RVUs is a challenge for some groups. We have people who are salaried and then get a bonus. We have people who are still paid by shift, so they may have the shift mentality.

THOMAS: Should physician comp be any different than another executive?

BUTLER: It shouldn't, but traditionally it has been.

THOMAS: The challenge that we see is that the average life of a compensation scheme for a doc is about two years ... and on a spreadsheet it's perfect. Well, all of a sudden the physician practice changes. ... There's no perfect model. The comp model is a fluid discussion of how the economics are outlined to the doc. We've done a lot of work for groups that say, "Just give us the answer. Give us the model." But there are some fundamental issues: Compensation is changing; base compensation is going to be radically different in terms of maybe doing less but doing the right things. ...

If the doctor is disconnected from the overall economics of their practice, and they didn't cover that loss, the compensation model does not work. Doctors and those who employ doctors have to have some exposure to overall practice economics. That physician, however they're paid, has to have some interest in the economic unit of their practice, because someone has to bear that economic loss or gain. So whether it's good or bad, we believe doctors should be financially engaged in their practice.

SCHOLL: You have to get alignment by type of physician to what the overall mission is of quality and value. We mentioned hospital specialists, primary care physicians, the hospitalist or hospital-based physicians on continuum management, patient experience, primary care for access, availability, teaming, and specialists for low-variation, evidence-based practices. All of that will get factored in to the future of compensation.

HEALTHLEADERS MEDIA: *Talk about physician leaders and bringing physicians into leadership—not necessarily at the CMO level, but to be part of the strategic planning process.*

BUTLER: We've had a couple different strategies. We actually have the medical director of our hospitalist team and one of our surgical leaders sit in the VP meetings. So they know. They're hearing all the same discussions that we're having, so it's very transparent there. We've also had some investments in leadership academies for key positions. We've tried to use more of the younger, up-and-coming docs. So they sit there with their directors and get to have healthcare finance 101 and get to really figure out how the hospital works, because most of them really have no clue. That helps them when we're doing performance improvement projects.

HEALTHLEADERS MEDIA: *Do they take that back to other physicians?*

BUTLER: They do. ... This was a voluntary thing. They gave up some of their time practicing. They weren't all our employees, these were some of the community docs. You just get the people who already have an interest, and then they go into it. So you don't have to go get an MBA; you don't have to get an MHA. You can learn how the hospital functions and then grow that relationship that way.

Jonathan Scholl
Chief Strategy Officer
Texas Health Resources

DEVENY: What I keep telling physicians is you can either choose to be a victim of everything that's going to go on, or you can be an architect. So we're using words like *opportunity*. ... I think it's critical that all our physicians can tell the bigger story and how they play a part in that and how they can influence it. The ones that haven't realized that and don't understand it tend to be the ones that become victims, and that's where your dissatisfaction and your patient satisfaction and productivity and all those things get negatively affected. But if they understand the bigger picture, it's critical that you involve them in strategic planning.

J.R. Thomas
CEO
MedSynergies, Inc.

We send out the financials to everybody. They should know the financials; they should know the quality outcomes. We should be very comfortable questioning why are we a one-star program in open-heart in this community, and sit and hear peers. It's amazing when you bring the people together, a community of cardiovascular leaders from around the country, how they challenge each other. All we did was we gave them the variation. We said, "Here are the outcomes," and they just went after each other. They all thanked us because they learned from each other. They want to get better. ... At the end of the day, people have that internal mission: They want to do the right thing.

THOMAS: The challenge we're seeing throughout the country is that communication with the docs is hard. ... We took a bell curve of physicians: There's 10% that were doing a great job before you, and through pride and effort initiatives are going to do a great job with you and are going to do wonderful things. You've also got the 10% on the other end who are the characteristics of discontent, non-engaged, losing economics. Then you have the group in the middle, which is kind of what you would call your break-even practice in terms of volume, engagement, etc. ... We practically stratify them: A, B, C, and D practices. Where you can move the needle—and that's what our program is called, Move the Needle—is in that group that is silent. It's the 80% of the docs that we are not traditionally touching.

PERRY: When I was listening to only my curmudgeons all day long, it really took my focus away from the real opportunities. I then decided I had to go listen to my positive guys just so I could try to determine how to best reach that middle 80%. I tried to have two good conversations and two bad ones, but at the end of the day I wanted it to be equal, which is where most physicians are.

HEALTHLEADERS MEDIA: *Can you set up a governance model that brings physicians into strategic planning?*

DEVENY: We actually went through a formal recommitment with our senior management, and now we're kind of doing that with physicians: "Do you really believe in this?"

PERRY: I laugh because I have this conversation with a lot of docs, particularly when I go into new markets, about a burial or some sort of ceremony to say, "That's done." I do not want to hear about what terrible things happened to you 10 years ago, five years ago, because right now it's really not relevant. I don't want to look out the rearview mirror. Let's look out the windshield and go forward. Every religion has redemption, so can we just move on? We weren't perfect in the past; we've made mistakes; you've probably made some, too. But can we all agree going forward we're going to start anew? You almost have to say that, because otherwise it seems we have this Groundhog Day thing that goes on in healthcare where they will talk about past issues forever.

SCHOLL: We talk a lot about giving the physicians more control, more transparency, and more data. I think all of that's important, but I also don't think we should back away from the professional management and the careers that good administrators have made. ... It's the couplet you've heard: physician-led, professionally managed. I really believe that that is an appropriate and best way to think about governance. ... We have dyads, and then in hospitals we have triads with the nurse and the CMO and the president. We've had good success with it. It's learning new muscles for sure for everybody in there.

HEALTHLEADERS MEDIA: *How do you move a culture that's been in existence for a while toward a new model of alignment? I hear all the time that culture is the hardest thing.*

THOMAS: Culturally, the biggest issue is this amount of change that we're asking on physician alignment. ... The pace of the cultural change will dictate the effectiveness of the change, how long it lasts, and how permanent the change will become. The economics can be delivered quickly, and you can change things around. But the strategy and the culture will dictate the effectiveness of the tactics. Say I need to cut my loss per doc about $50,000 this year. That can be done—not easily, but it can be done. The problem is you're going to leave bloody noses, some broken arms, and bruises. However, you have to build a long-term patient market share strategy through your physician alignment tactics and strategy.

What is the strategy? Are you really committed to it? Can you communicate it throughout the organization? The strategy, by and large, should be consistent, at least in the five-year view. The tactics are what's going to change, but the culture and the strategy will always trump the tactics. You can drive down losses and you can improve economics and make other changes, but if the doctors are not engaged with you they're not going to stay.

SCHOLL: Culture is the only sustainable, long-term advantage any company can have. So culture is part of a strategic intention. What culture do I want, and how do I get to that culture through time? It really is part of this alignment question. Do I want to have a physician alignment culture through fear, uncertainty, and doubt by exerting power, or do I want to have an alignment through mission, vision, values, and collaboration to improve care and quality?

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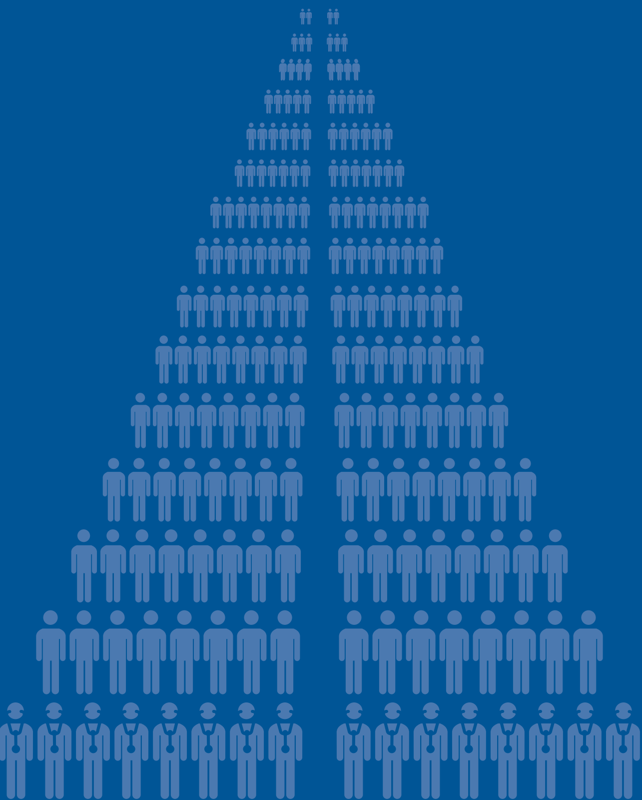

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