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To cite this article: Valinda Rowe Rutledge (1996) Hospital/Physician Alignment: A Model for Success, Oncology Issues, 11:6, 18-20, DOI: 10.1080/10463356.1996.11904645

To link to this article: https://doi.org/10.1080/10463356.1996.11904645

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Hospital/Physician Alignment: A Model for Success

Greater financial risk, declining resources, and increased external scrutiny by both the public and payers are changing the relationship between the hospital and its physicians. Today's competitive environment demands that physicians play a leadership role in balancing the issues of cost, quality, and access. Clearly, no hospital system will be successful unless it includes a solid partnership with its physicians.

Although physicians have always played an influential role within hospitals, their decisions were for the most part strictly confined to clinical issues, and rarely included the financial and strategic agenda. Administrators were quite reluctant to share financial information (especially financial data per physician related to the hospital's net operating income) with physicians. For example, within the last few years it has become common to find that two or three cardiovascular surgeons may contribute up to 40 percent of a hospital's bottom line. Administrators were fearful of the impact, influence, and power that sharing such knowledge with these physicians might confer.

Physicians also acted to inhibit the sharing of confidential, strategic information between themselves and the hospital. Many physicians were on several hospital staffs. They would frequently play one hospital against the other to obtain the equipment and technology needed for their program. That kind of behavior encouraged hospitals to mistrust physicians and not to treat them as partners.

Today 75 percent of all medical costs within hospitals are under the control of physicians. That fact alone underscores the need of aligning physicians within the integral structure of the decision making and strategic processes of the organization.

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THE CHANGING ADMINISTRATIVE STRUCTURE

Integration of the physician within the administrative structure has traditionally followed three phases: 1) the medical director, 2) the vice president of medical affairs, and 3) councils. Many organizations have stopped at phase one, and most have not moved beyond phase two.

The *medical director* is usually assigned a specific unit, often the ICU, oncology, or radiation therapy. He or she focuses on quality and is ex-officio rather than an integral member of the team. The medical director position is limited in scope and concentrates mainly on defining policy and procedures.

The next phase is *vice president of medical affairs (VPMA)*, or the chief medical officer (CMO). Today some organizations may have just four key executives: the chief executive officer, the CMO, the chief nursing officer, and the chief financial officer. The CMO blends administrative and clinical accountability within a single individual. The role and scope of the CMO as they relate to the chief of staff are unclear, as the duties and responsibilities of these positions often overlap or are blended. CMOs are at high personal risk. They recognize they must remain clinically competent if they are to have an influence on their peers. Yet the time constraints and extensive administrative responsibilities tend to force them to leave their practices and the clinical world. Additionally, they are often viewed by their peers as *hospital* administrators, and as such they do not represent the medical staff. In a rapidly changing health care environment, CMOs are not sure if this position will remain, or if they even want it to remain.

Phase three is a *clinical leadership council*, a structure that includes a multitude of different individuals. Such councils are found in just a few highly mature systems around the United States. Councils usually include a physician organization CEO, chief of staff, physician administrative executive (the CMO or VPMA), the primary care medical leader, and vice president of patient care services. This group is ultimately responsible for the quality and cost of all clinical operations and reengineering of the entire vertically integrated system. The system does not begin and end at the acute care hospital. It encompasses the entire spectrum of patient services, including ambulatory, home, and follow-up care.

Councils are charged with a variety of tasks, including:

- assessing outcomes of the system's initiatives on participants in their health care plan as well as the entire local community
- fostering collaborative relationships among council members and with the medical staff
- assuming a leadership role in the development and implementation of hospital information systems across the organization.

To accomplish their tasks, council members must be provided with educational opportunities that include general business courses as well as an understanding of health care economics. In many councils, physician members have returned to school to earn their MBA degrees.

THE UK MODEL

Under the United Kingdom's national health system (NHS), each region of the country is given an allocated amount of money each year for services provided, similar to a global capitated budget. In the 1980s the NHS found that administration allocated and selected resources independently of practitioners. The result: money ran out and services stopped. Clinical providers were forced into assuming a role of protecting patients from the NHS.

To enhance the value of health care services, the UK attempted to more fully integrate physicians into the NHS by developing a collaborative partnership of physicians and administrators. A clinical director position, similar to our service line director, was set up to manage a small scope of service organized around specialties within the larger system. The physician clinical director shares with a nurse manager day-to-day operational responsibilities that involve fiscal and quality issues, such as:

- overseeing medical, nursing, and administrative staff
- authorizing budgets
- assuring quality of service
- meeting contract obligations
- negotiating contracts with purchasing agencies.

Clinical directors are not compensated for their additional administrative responsibilities; however, most still carry their full clinical loads. A major weakness of the new model is that the clinical director position is usually focused on the acute care hospital, and does not examine the entire continuum of care.

The NHS found several issues in physician/hospital relations that are also salient within the U.S. First, many physicians were more comfortable with autonomous, isolated decision making than with facilitating a team decision-making process. Instead of looking at the system as a whole, some physicians had a narrow vision and focused only on obtaining resources they needed for their own specialty. There were considerable management and financial knowledge deficits. Obviously, physicians had come from the medical model and were not well versed in cost accounting or calculating their net operating income.

The clinical director model in the UK is on its way to making the traditional medical staff structure obsolete. The overall evaluation is that the model is extremely valuable. The NHS is in the process of involving the directors in widespread, strategic planning of the entire health care system.

THE ST. JOSEPH MERCY EXPERIENCE

In 1995 senior staff at St. Joseph Mercy Hospital in Ann Arbor, Mich., decided to put clinical leadership councils and the clinical director process and structure into place within the institution. The goal was to have efficient movement of patients through the system with a balance of quality and cost. Patient care would remain the number one priority. The new structure would:

- hold the patient care leader (a senior nurse administrator) and the medical co-leader accountable as clinical leaders for both financial and quality outcomes
- give authority to groups of physicians and nurses
- support the transition to a managed care environment
- continue a multidisciplinary approach
- feature a decision-making process that is data driven
- support a service line philosophy.

For the new structure to be considered successful, quality of care would have to remain unchanged, as would patient, nursing, and physician satisfaction. The goal was to decrease length of stay, cost per case, cost per day, and ancillary costs.

The clinical leadership council is composed of twelve members, patient care leaders and medical co-leaders from each of six areas of focus: oncology, surgery, medicine, women and children, cardiothoracic, and emergency services. Each of these areas encompassed the entire continuum of services and was not just inpatient, acute-care focused. Women and children services, for example, included labor and delivery as well as the clinic associated with those services, and home care components. Medicine services included the geriatric clinic, associated inpatient units, MICU, rehabilitative program, and associated home care programs.

Within oncology, the patient care leader and medical co-leader are responsible for budget and strategic planning for all operations, including inpatient medical and surgical units, outpatient chemotherapy, radiation oncology, acute/chronic pain programs, oncology research, and oncology program components. Each of these oncology patient care areas has assembled a team of key medical staff and clinical leaders to discuss quality and financial issues, review data, and design systems to meet identified goals.

The clinical leadership council has been quite advantageous to patients and the organization. However, for the structure to work properly, both the CEO and chief financial officer had to defer financial decisions to the six patient care and six medical leaders, who are ultimately responsible for the total cost per case and for resource allocation. These leaders must decide, for example, how many nurse managers or clinical specialists they need. They are also the ones who

must prioritize how they will use the capital, not the CEO, CFO, or chief nursing officer.

To make hard financial decisions, the physician leaders have access to all of the hospital's management and financial data. The cost accounting system allows them to see cost per case/per diagnosis by physician and to figure out the impact of their decisions on the cost per case. The information is available via computer at each physician leader's desk. If these leaders are responsible for the bottom line, they must have fast information access. Some of those cardiovascular surgeons now know that they do make up a substantial percent of the bottom line, and so their negotiations and their interactions with the hospital have changed.

Conflicting interests and opinions make financial decisions difficult and highly sensitive. Some questions have no right answers. Some units will not obtain the resources they have requested, quite simply because all the required resources are no longer available. In the end the patient care and medical co-leaders must involve the team in discussion, resolve conflicts within their focus area, and come to a decision.

The model has enhanced the respect of the nursing role within the organization. The nurse (called a patient care director) is a co-clinical leader with the physician. Patient care directors are able to mentor the physicians on management skills, showing them how to read a balance sheet, for example. Nurses see that the hospital executives defer decisions to the patient care and physician leaders. Which units are we going to close? Which units should we consolidate? These leaders, in concert with their appropriate team, must now make such decisions. If a particular unit is to stay open, for example, team members must decide where the money will come from.

THE PHYSICIAN/HOSPITAL ORGANIZATION

In some hospitals the new joint decision structure has moved into a legal entity, called a physician/hospital organization (PHO). PHOs have allowed providers to obtain contracts and leverage with the payers and increase collaboration and quality of care. Unfortunately, most PHOs have not been as successful as most people would like. All too often, the hospital executives believe they have put a great deal of money into the PHO and, therefore, own them. Instead of a partnership, the hospital dominates decision making. At the same time, young PHOs are often led by a physician executive who is inexperienced in managed care contracting and administration. This rather impotent PHO has formed a partnership with a very dominant hospital that may not treat its physician partners with full respect. The result is that the physician organization may leave the PHO.

An incentive plan cannot benefit any individual, nor can it benefit a private practice. The safest strategy is to make sure any money goes back into the physician organization or the group.

PHOs also fail because of a deficit in information systems. One of the major advantages of a PHO will be in assessing outcomes. However, when physicians or administrators are deficient in knowledge of information systems, the road to financial ruin is assured. Hospitals cannot assume risk if they are unaware of total costs. Many times PHOs underestimate the deficit in information systems. They do not hire the individuals they need to build the appropriate data systems.

Many PHOs are limited by state regulations. However, over the long term PHOs will no doubt transform joint decision making for all aspects of governance. Although hospitals may end up with their own board of directors and a physician organization board, all financial and strategic decisions will be done through the PHO board.

GAIN SHARING WITH YOUR PHYSICIANS

If a hospital does not have enough capitated contracts to change physician behavior, it should develop incentive plans to help transition physicians to joint decision making.

A first step in establishing any incentive, or "gain sharing," model is to seek legal counsel. Because of increased scrutiny from IRS regarding antitrust, it is helpful and smart to begin conversations with your hospital's or physician organization's attorneys. An incentive plan cannot benefit any individual, nor can it benefit a private practice. The safest strategy is to make sure any money goes back into the physician organization or the group. At St. Joseph Mercy, for example, each patient care area receives 20 percent of what it has been able to save with its initiatives. That money can be used for four purposes: temporary personnel, educational opportunities for physicians and other team members, research projects, and valuable equipment, including computers.

Before any determination of gain sharing can be made, baseline data must be identified, so cost per case can be determined. Quality of care must remain unchanged. It is important to subdivide baseline patient data into under age 65 and over 65 as resource utilization varies significantly between the Medicare and non-Medicare populations.

The overall hospital must achieve the net operating income. It would not make for a viable institution if the entire hospital went into the red, for example, and its physicians were to receive 20 or 30 percent back. We need to understand that the system as a whole must be healthy for each of its individual subspecialties to survive.

In conclusion, physician involvement in administrative decisions will enhance your hospital's performance. Research studies have proven that hospitals with high physician integration in the decision-making process have much lower cost and higher net operating income than those that do not have physician integration. Senior administration and physician leaders can dramatically impact a hospital's bottom line—if hospitals develop enhanced respect, honesty, and trust with their physicians as well as a mutual vision.