Hospital-Physician Relationships: A Changing Dynamic in the Era of Accountable Care

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Presented by Todd Sagin, M.D., J.D.
Sagin Healthcare Consulting (www.SaginHealthcare.com)
Hospital Need for Physicians

Hospitals no longer just need physicians to fill hospital beds:

- In the era of accountable care ("at-risk" care) and with a move to population health management the health care world becomes ever less ‘hospital-centric’
- Doctors needed to step up and redesign care to be higher quality, safer, less expensive, and more patient oriented
- Doctors needed to coordinate care across the continuum and provide greater array of services in outpatient setting
- Doctors needed to step up into greater leadership roles
The Basis for Hospital Employment of Physicians

- Deteriorating financial position of private medical practices
- Preference of younger physicians for employment
- Desire of hospital to assure alignment with its physicians and to capture referrals
- Need of hospitals to assure an adequate complement of physicians for the present and the future
Not All Doctors Giving Up Private Practice

“To paraphrase Mark Twain, the reports of the death of private practice medicine have been greatly exaggerated.”

Dr. Ardis Dee Hoven

AMA Physician Practice Benchmark Survey:
- 53.2% doctors self-employed
- 41.8% employed by another entity
- 5% independent contractors
There are contrarians who see the trend of employment reversing …

• Advocates of private practice argue that physicians are becoming disillusioned with hospital employment and dissatisfaction will grow as it did following the employment trends of the 1990s.

• There is growth in efforts to find viable private practice models that can flourish and provide physician satisfaction under the evolving 21st century business model of healthcare.
Private practice fighting back with new approaches:

- Physician sponsored ACOs
- Strengthening of some large private group practices
- Concierge medicine (practice that accepts insurance and also requires an additional fee from patients)
"When I grow up, I want to go into medicine and help people who can pay out of pocket."
Private practice fighting back with new approaches:

- House call medicine (no overhead & doctor can take payments over smart phone)

- Direct physician reimbursement model (practice does not accept insurance)
Direct Primary Care

• Typically described as ‘membership-based primary care’ in contrast to ‘insurance-base primary care’

• Primary care practice serves as patient’s “primary care medical home” where they go for all routine primary, preventive, and chronic care management types of care.

• Patients pay one monthly fee (ranges from $49 to $100) directly to PCP. Works like health club membership – covers unlimited visits/access. No deductibles or co-pays. Patient maintains a ‘catastrophic’ insurance plan to cover emergencies and serious illness.
Employment of Physicians Done Right Delivers Tremendous Strengths

MAYO CLINIC

Cleveland Clinic

Ochsner Health System

GEISINGER HEALTH SYSTEM

Group Health Cooperative

Kaiser Permanente
Mistakes in the Employment of Physicians Are Common

• Physician employment done poorly can jeopardize the future viability of a stand-alone hospital

• Board, Management, and Physician leadership all have a role in making sure the implementation of this strategy goes right
Common mistakes in hospital employment of physicians:

Making Offers to the Wrong Physicians

Hospitals should consider withholding offers of employment to physicians with the following characteristics:

- Loudly critical of hospital management, opposed to change & not supportive of hospital’s long term goals;

- History of being a poor team player or disruptive behavior;
“True, he can be annoying, but let’s keep in mind that he’s our only source of income.”
Consequences of hiring the wrong players …those with behavior concerns:

- Consume leadership time that should be devoted elsewhere
- Undermine efforts to develop culture of collegiality, partnership, trust
- Alienate other workers and can impede recruitment and retention
- Can create legal problems

(If this list looks familiar, the problems are identical to those you see when you credential a disruptive physician or fail to remove one from the medical staff)
Common mistakes in hospital employment of physicians: Making Offers to the Wrong Physicians

Hospitals should consider withholding offers of employment to physicians with the following characteristics:

- Significant concerns about quality or competency;
- Clinicians who do not have the confidence of their colleagues;
- Those with history of questionable business practices.
“For me, crime pays for what Medicare doesn’t cover.”
Why these exclusionary criteria aren’t a “no-brainer”:

- Desperation is rising at many hospitals to secure physicians in primary care or for mission critical service lines;
- Growing numbers of physicians in the pool of potential recruits raise competency concerns;
Why these exclusionary criteria aren’t a “no-brainer”:

Demographics for physician recruitment are worsening.
A Growing Physician Shortage

• 18% of practicing physicians are planning to leave medicine in the next 5 years

• 36% of practicing physicians are planning to leave medicine in the next 10 years

• Approximately 1/3 of practicing physicians are 55 and older

• Approximately 40% of practicing physicians are 50 and older

• Only one in six general surgeons is younger than 40
Case Scenario

Mountain Hills Hospital has been trying for three years to recruit a general surgeon. It had three general surgeons until last year when one retired at age 72. Its remaining general surgeons provide continuous community coverage: one is 56 and the other is 62 and has several significant health problems. The medical staff development plan commissioned by the board calls for three general surgeons.

A recruitment firm has recently identified a possible candidate. The chief medical officer has reviewed the candidate’s file and has summarized several salient features of this candidate:
• Dr. Habboushe is an international medical graduate who did surgical residency training in NYC in the early 1990s. He is now 47 years of age and has practiced in five different communities since his residency.

• His file shows he has had seven malpractices suits with settlements or judgments ranging from $50,000 to $700,000.

• He has a NPDB report showing he had his license suspended for one year in Pennsylvania for improper prescribing of narcotic medications.

• He is currently doing locums work for a small hospital in West Virginia. He has been accused of having an inappropriate sexual liaison with a hospital employee and it has made it difficult for him to continue work in this small community even though the relationship was consensual.
Common mistakes in hospital employment of physicians: **Offering the Wrong Deal**

- Illegal payment beyond fair market value
- Paying at unsustainable rates near the top of fair market value
- Long-term contracts
- Use of an ineffective or counterproductive compensation model/guarantees
Consequences of ‘retrenching’ deals:

- Loss of trust (accusations of ‘bait and switch’)
- Legal confrontations
- Defections
- Long term morale problems
- Distraction from the work of care redesign
Common mistakes in hospital employment of physicians:

**Failure to set & communicate clear expectations of employed physicians & nature of the relationship.**

Examples include:

- The need of the institution to tie compensation to the fiscal realities of the organization (just like in private practice);
- The possible need to consolidate practices, change practice locations, modify practice personnel or staffing ratios, the transfer of business functions to a central office, etc.;
Additional examples include:

- The need to embrace new technology, including any EHR the institution adopts;

- The fluid nature of call obligations and office hour obligations to promote ‘open access’ and ready availability;

- Need to change referral patterns;

- Transfer of ancillary services to the hospital enterprise.
Common mistakes in hospital employment of physicians:

• Failing to have an appropriate administrative infrastructure to manage practices (i.e. repetition of a classic mistake from the 1990s).
Common mistakes in hospital employment of physicians: **Treating Physicians Like An ‘Employee’**

- Loss of autonomy is the biggest adjustment for experienced physicians to make when moving from private practice to employment.

- Physicians are frustrated when they have little or no say over personnel decisions regarding their support staff.

- A major complaint of employed physicians and significant source of diminished morale: Being “bossed around by less-educated administrators” who often manage their insecurities by bullying physicians and through passive aggressiveness.
A critical best practice:

• Provide physicians with the professional autonomy they expect as long as they demonstrate they will use it to help the organization meet its mission;

• Best done through moving hospital-employed physicians into a multispecialty group practice with a considerable degree of self-governance, responsibility, and of course, accountability.
Common mistakes in hospital employment of physicians:

• Making accommodation of private practice physicians on the medical staff a higher priority than addressing the concerns of hospital employed physicians;

• Believing it is necessary to ‘enfranchise’ private practice physicians by giving them significant leadership positions

• Allowing the employed physicians to take an apathetic attitude toward the activities of the ‘organized medical staff’.
Common mistakes in hospital employment of physicians:

Failure to adequately consider various compensation models and involve employed physicians (through representatives) in the ongoing study, design, and revision of the compensation model.

**Best practice:** Form a Physician Compensation Advisory Committee to recommend to management and the Board appropriate compensation model and ongoing adjustments as reimbursement approaches change. Include physicians, and some members of management and the board. (A sample charter for such a committee can be requested from TSagin@SaginHealthcare.com)
Common mistakes in hospital employment of physicians:

Underestimating the organization’s need to recruit and retain primary care physicians (especially smaller hospitals).
Common Mistakes of Hospitals Employing Physicians

Most hospitals have failed to put enough focus on retention of current physicians:

Increasingly hospitals and health systems are taking more steps to increase physician retention. This may take the form of bonuses, on-call pay and retirement funds, as well as strategies to avoid burnout. Some health systems have established work force committees to focus on physician satisfaction.

AMGA survey: Recruiting a new physician now averages $270,000. Replacing a physician averages $1.2 million.
Common mistakes in advancing physician leadership in hospitals and health systems...

• Inadequate efforts at leadership education, development, and succession planning;

• Allowing confusion to develop between the roles of traditional medical staff leaders and new physician leadership roles in the institution.

• Failing to streamline the leadership organization tree & exhausting the available appropriate physician leader candidate pool;

• Creating ‘input-only’ leadership roles.
Trials & Tribulations of Getting It Right
Sample Physician Leadership Structure

**Hospital/ System Board:**
- Physician Board Members

**Hospital or System CEO(s), who oversees:**
- CMO
- VPMA
- Chief Quality Officer
- Chief Informatics Officer
- Chief Innovation/Transformation Officer

**Organized Medical Staff:**
- MEC
- Medical Staff Officers
- Department Chairs/Vice Chairs
  (typically 2–15 dept. chairs)
- Med Staff Committee Chairs
  (often 5–20 committees)

**Hospital MD Leadership Roles:**
- Service Line Medical Directors
  (e.g., Oncology, Women’s Health, Neurosciences, Ambulatory Care, Vascular Institute, Cardiac Services)
- CEO’s Physician Advisory Council
  (key physician stakeholders)
- Clinical Project Champions
  (e.g., to promote practice protocols and patient safety initiatives)

**Employed Physician Group Board:**
- President or Chair
- 10-12 Board Members
- Leadership of Working Committees
  (e.g., Finance & Operations, Quality, Culture)
- Group Practice Medical Director
- Group Practice Division Leaders
  (e.g., Hospitalists, Intensivists, ED practice)
- Group Practice Site Leaders
  (physician leaders for geographic office practice locations)

**Additional Physician Leadership Roles:**
- Physician Leaders on Org Board*
- Medical Director
- Physician Leaders on Committees
  (e.g., Peer Review, Credentialing, Utilization, Best Practice Development)

* Accountable care organization, clinically integrated network, or physician–hospital organization
Primary Goal:

- To develop the leadership skills of physicians within Acme Hospital or Health System so that they can effectively participate in and contribute to the management of the health system in multiple roles and capacities.

Secondary Goals:

- Provide “bench strength” within the Acme physician community so that there are always future leaders with the skills and ability to step up to leadership roles.

- To promote physician retention and recruitment by providing educational and training opportunities for those physicians motivated to develop their leadership skills.
Traditional Onsite Physician Leadership “University” Approach- Questions:

- Tiered curriculum?
- Small bites or large bites (e.g. 1 hour grand rounds vs. full or half day programs)
- CME?
- Who can participate?
  - By invitation only?
  - By nomination?
  - Must you commit to the entire curriculum?
  - Mandatory give back of some kind?
  - Mandatory for entry into selected leadership roles?
  - Should non-physicians be participants- e.g. administrative leaders/nursing?
Logistical Questions

• Length of Sessions
• Timing of Sessions
• Frequency of Sessions & Overall Program Length
• Location of Sessions
Examples of Subject Matter

Education for Traditional Medical Staff Leadership Skills:

• Effective Credentialing and Privileging
• Best practices in peer review and collegial performance management
• Dealing with unprofessional conduct
• Undertaking Corrective Action properly
• Managing bylaws and related policies
• Understanding accreditation requirements
• Tackling unique medical staff challenges: ED call, effective communication, meeting attendance and management, etc.
• Meeting management
Examples of Subject Matter/Executive Skills for Physicians

• Understanding the Nature of Leadership & Leadership Styles
• Creating and Sustaining Vision
• Strategic Planning
• Principles of Governance
• Change Management and Leading Organizational Transformation
• Conflict Management/Negotiation/Mediation
• Performance Management (getting outstanding results) – adopting best practices from Toyota Lean Management to Six Sigma
• Fostering Collaboration & Teamwork in Healthcare Settings/Fundamentals of Team Building

• Understanding and Utilizing Emotional Intelligence

• Communication Skill Building (e.g. Crucial Conversations, Effective Listening, Providing Feedback, Building Consensus)

• Presentation Skills (effective public speaking: from powerpoint to keynotes)

• Ethics and Regulatory Compliance

• Legal Principles in Health Care

• Effective Delegation & Development of “Subordinates”

• Life Balance and Stress Management

• Problem Solving and Innovation
Operational/Managerial Skills for Physician Leaders

- Fundamentals of Financial Management (budgets, income statements, economic forecasting, pro-forma creation, ROI analysis, etc.)
- Project Management/Group Management
- Fundamental Time Management Techniques
- Spreadsheet and Databases: Transforming Data into Knowledge
- Marketing and Branding
- Human Resource Management/Modern Talent Management
- Understanding Management Styles
- Service Line Management
“Who the hell wants to hear actors talk?!”

- Quote by Harry Warner, Warner Brothers Pictures, 1927