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## Is **QUALITY** the **Common** **Language to** **CONNECT** Hospitals & Physicians?

By Don Seymour

Like most segments of the U.S. economy, hospitals and physicians benefited from expanding prosperity after World War II. The Hill-Burton Act helped build hospitals, the Health Manpower Act authorized funds to train physicians, and Medicare and Medicaid ensured payment for at least some of those previously underserved. Federal and state governments in effect entered into a social contract with patients and providers to pay for much of the care providers could offer, and private employers offered comprehensive health coverage for employees.

The social contract that evolved after World War II, what we might call "Greatest Generation Healthcare," lasted roughly 50 years. Hospitals and physicians both prospered; physicians performed medical staff duties gratis in return for the use of the hospital as a workshop.

However, with unchecked demand, healthcare costs skyrocketed and are quickly becoming unsustainable. A newly emerging contract, what we might call "Boomer Healthcare," is supported by a different set of concepts, including demand-side economics based on payment constraints and transparent information to compare providers' quality, safety, customer satisfaction, and prices.

The concepts sustaining Boomer Healthcare substantially alter the mutually beneficial relationship that previously existed between hospitals and physicians. Hospitals face a conundrum: on one hand, they must compete with increasingly entrepreneurial physicians. On the other hand, they need physicians as partners to deliver care based on best practices,

participate in quality and patient safety programs, and help meet community needs, especially emergency department coverage. The key question facing hospital leaders today is how to align hospital and physician interests.

Redefining the hospital/physician relationship will be complex. Money is an important factor but business-based collaboration alone is insufficient. The idea that hospital employment of physicians will guarantee alignment is far too simplistic. Nothing short of a comprehensive approach to realignment will succeed, and then only if it is established on a foundation of quality.

Quality can and should be the common language that brings hospitals and physicians together because:

(1) Both parties truly believe in quality and know it can be improved.

(2) The case for improving quality makes increasing sense in business terms, and

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(3) Payers and consumers are entering an era in which they will choose providers based on demonstrated quality.

### 1. A common interest in better quality

Both hospitals and physicians know the healthcare system could perform much better than our current experience:

- The Dartmouth Atlas and other research studies have documented great variability in patient care — so much so that patients receive “optimal care” only 55% of the time.
- The Institute for Healthcare Improvement’s 5 Million Lives Campaign was developed on the premise that there will be at least that many opportunities to protect patients from “incidents of medical harm” over just two years.<sup>1</sup>
- The leading cause of preventable sentinel events is “communications breakdowns” involving physicians, hospital staff and information systems.<sup>2</sup>
- A recent Boston University study indicated that 40% of consumers think care is worse than it was five years ago.

Increasing evidence shows that when physicians and hospitals work together, they can improve quality and patient safety. For example the IHI’s 100,000 Lives Campaign<sup>3</sup> “reduced inpatient deaths by an estimated 122,000 in 18 months” and made “great headway in delivering reliable (best practice) care for acute myocardial infarctions, preventing adverse drug events, and preventing surgical site and central line infections,” as well as inspiring life-saving rapid response teams.

The 266 hospitals participating in the Medicare pay-for-performance (P4P) program managed by Premier Inc. have also steadily improved the quality of patient care.<sup>4</sup> Among other indicators of success, it is estimated that these hospitals “experience nearly 1,300 fewer deaths in treating heart attack patients.”

### 2. The business case for quality is growing stronger

Poor care is costly. It is sad to note that in the past, preventable infections, complications and errors often benefited hospitals financially, since remedial care increased patients’ bills. However, that perverse incentive is changing as Medicare and some private payers

reimburse by diagnosis, not per day or per service rendered. One study estimated that for patients with central line-associated bloodstream infections (a potentially fatal and often avoidable complication) hospitals incurred average expenses of more than \$91,000 per patient, but were paid less than \$65,000, for a loss of more than \$26,000 per patient.<sup>5</sup> What’s more, under Boomer Healthcare, slim reimbursements mean hospitals need to maximize efficiency by reducing excess capacity and running at or near full occupancy. Consequently, when patient lengths of stay are extended due to medical error or other glitches, new patients can’t be admitted promptly, and the hospital loses revenues. Physicians grow frustrated over delays and eventually may open their own outpatient facilities.

If hospitals and physicians can align their interests, both clinical and financial results can improve. A recent study on patient safety from HealthGrades estimated that “if all hospitals had performed at the same level as the top-rated hospitals, about 206,286 patient safety incidents and 34,393 Medicare patient deaths could have been avoided, resulting in \$1.74 billion in

savings.”<sup>6</sup> In addition, preventing sentinel events can reduce costly malpractice claims and liability insurance costs.

### 3. Consumer-driven purchasing comes of age with Boomer Healthcare

The most powerful aspect of the business case may well be the empowerment of consumers.

The much-hyped but long delayed era of consumers buying based on value (quality/price), while still in its infancy, appears to be gaining momentum, driven by increased transparency of information as well as financial incentives (e.g. consumer-directed health plans and P4P payment systems).

—1 [www.ihl.org/IHI/Programs/Campaign](http://www.ihl.org/IHI/Programs/Campaign)

— 2 [www.ihl.org](http://www.ihl.org), Status Quon’t, Why Healthcare Will Never Be The Same, 2007 Status Report, IHI

— 3 [www.ihl.org](http://www.ihl.org), IHI Launches National Campaign To Reduce Medical Harm In U.S. Hospitals, Building On Its Landmark 100,000 Lives Campaign

—4 Bonus Pay by Medicare Lifts Quality, [www.nytimes.com](http://www.nytimes.com), January 25, 2007

— 5 "Hospital Acquired Infection: Meeting the Challenge," supplement to American Journal of Medical Quality, Nov.-Dec. 2006

—6 U.S. Hospital Errors Continue to Rise, [www.washingtonpost.com](http://www.washingtonpost.com), April 2, 2007 (citing the Fourth Annual HealthGrades Patient Safety in American Hospital’s Study)

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Approximately 50 different organizations are currently publishing “quality and patient safety” information in various electronic and print formats. The reliability of this information may vary, but it is all available for public consumption. It includes assessments of not just hospitals but also individual physicians.<sup>7</sup>

No, healthcare providers won't become Procter & Gambles, and we won't see every “consumer” consulting Consumer Reports to choose a hospital or doctor. But there will be enough well-educated, aggressive baby boomers to make the pursuit of quality not just the right ethical thing to do, but the right financial pursuit as well. Given the role Medicare, Medicaid<sup>8</sup> and the AARP<sup>9</sup> appear to be assuming as brokers, over time other segments of the population will join in.

## Realignment Based on Quality

A new social contract can align hospitals and physicians around their common quality goals. This realignment has five key components:

### 1. Clinical Priority

**Setting.** It has always been unlikely if not impossible for one hospital to have the best quality outcomes in everything. Today, clinical technology, fellowship training availability and payment algorithms encourage

even greater sub-specialization. Clearly, choices have to be made and supported through resource allocation (e.g., facilities, technology and workforce). Hospitals need to engage physicians in a process to identify the clinical specialties they will mutually support at a level of excellence.

— 7 America's Top Doctors (www.castleconnolly.com)  
— 8 Pay-For-Performance In State Medicaid Programs, The Kuhmerker Consulting Group, The Commonwealth Fund, April 2007

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## Three Physician Leaders Speak Out:

**How our hospitals align with physicians to improve quality**

By Elaine Zablocki

**Can quality serve as a common interest linking hospitals and physicians? We asked three physician leaders:**

**sad to note that in the past** **Arthur V. McDowell, III, MD**, chief of cardiology at Middlesex Hospital in Middletown, CT, and chairman of the board of Middlesex Health System, a single-hospital system with several affiliated outpatient facilities.

**Loring S. Flint, Jr., MD**, senior vice president for medical affairs at Baystate Health, a three-hospital system in Springfield, MA, with about 400 employed physicians plus 1100 community-based physicians.

**Gary R. Yates, MD**, chief medical officer at Sentara Healthcare, a seven-hospital system in Norfolk, VA, with a 310-physician medical group and over 3000 community physicians.

“There’s no question” quality can be a unifier, says McDowell, “because hospitals are very interested in quality and physicians are equally interested. We are inundated with external organizations demanding not only that

we talk about quality, but that we demonstrate quality.”

Flint agrees, but adds a caveat: “Keeping physicians aligned, or engaged

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— Arthur V. McDowell, III, MD, Chairman of the Board Middlesex Health System, Middletown, CT

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## 2. Customer Support.

Time is a physician's most limited resource. Most hospitals could do a better job of assisting physicians as "customers" by operating efficiently (e.g., procedure rooms that run on time), having competent and sufficient nursing staff, and providing needed information in the chart at the right time. In the most recent Quality of Care Survey by the American College of Physician

Executives, 42% of physicians called "patient flow" a major problem, ahead of overuse or underuse of care (32%), unexplained variances in care (28%), and medical errors (13%).<sup>10</sup> Customer support includes offering physicians appropriate, accurate information regarding variations in patient care. Hospitals can earn physicians' confidence by asking their input on hospital processes and systems that need improvement.

## 3. Hospital Clinical

**Leadership.** In many hospitals the traditional medical staff structure, which relies on decreasingly available volunteer time, is irretrievably broken.

Hospitals and physicians need to develop more sustainable leadership models for the future, designed to meet today's (and tomorrow's) growing demands for proven quality outcomes. Increasingly, department chairmanships will become full time salaried positions,

with appropriate allocations of time between administrative duties and clinical practice.<sup>11</sup> Additionally, job descriptions for many Chief Medical Officers and department chairs need significant revisions, with increased emphasis on quality.

— 9 www.healthcareitnews.com, April 24, 2007

— 10 Doctors say many obstacles block paths to patient safety, Bill Steiger, *The Physician Executive*, May-June 2007, pp. 6-14.

— 11 It is likely hospitalists and employed physicians will be prime candidates for many of these positions.

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(that's the new buzz word) is certainly a key challenge for any healthcare system or hospital. But I don't think quality alone will be the glue that holds everything together. In addition, physicians want to be involved in key decisions, including annual operating and capital budgets, strategic planning and the development of clinical programs. Employed physicians want a say in their working environment and day-to-day operations."

"Physicians want to deliver the best possible care to their patients, and so does the system," Yates says. "We find common ground when we begin to look

beyond care delivered at the individual patient level and look at a comprehensive system of care. When both physicians and the health system can examine and work on processes of care, then significant improvement is possible,

and their interests are very much aligned."

**How they do it**  
**Shared leadership mechanisms.** Baystate Health shows its commitment to physicians by engaging them in important leader-

ship processes. The capital planning process begins by asking physicians what they need. Through a series of meetings, each service line sets its priorities; then, service line chairs meet jointly with hospital administrators to prioritize all capital improvements for clinical services, facilities, and information technology, for all three hospitals. "It's a very open process in which each participant has an equal voice," Flint says.

Middlesex Hospital has developed a physician-dominated Imperative Oversight Committee that reports regularly to the board and in essence

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— Loring S. Flint, Jr., MD, Senior Vice President for Medical Affairs, Baystate Health, Springfield, MA

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#### 4. Physician Recruitment and Employment.

There's an old saw that physicians quote about the importance of the Three A's: Ability (quality), Affability and Availability. Combine this with the fact that today's physicians, as they emerge from training, seek a balance between lifestyle and work. The era of the physician as an independent, tireless small businessman is just an artifact of Greatest Generation

Healthcare. Hospitals today need recruitment plans that offer what modern physicians want out of life. Even in a time of physician shortages, hospitals still must be discriminating, though, looking for physicians who subscribe to the organization's mission and values and bring both strong clinical abilities and interpersonal relationship skills. Applicant interviews should be rigorous, to find physicians who will be a good fit over the long run.

Hospitals need to develop sustainable structures to employ and retain excellent physicians. They should consider various models, including the benefits of establishing their own physician-governed, professionally managed, multi-specialty groups.

#### 5. Business

**Collaboration.** As important as hospital-physician business arrangements are, they are the least important of the five components. However,

hospitals should have a clear understanding of what's in the "toolkit" as they enter into risk/reward arrangements with members of their medical staff, such as joint ventures, gainsharing and other endeavors. Quality will improve when physicians are incented to build volume, increase market share and standardize care.

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serves as a board-level planning committee. The committee meets every two months, and it includes three physician members of the board, past president of the medical staff, and the current (elected) president, vice president, and secretary of the medical staff. In addition, two members are selected from departments that aren't already represented, and the three largest departments (medicine, surgery, and family medicine) are always represented. "This is how we get the most important leaders together in one room," McDowell says.

On occasion the Imperative Oversight Committee will set up a task force that includes all relevant stakeholders to examine major issues. For example, an emergency care task force included emergency physicians, psychiatrists, primary care doctors, other hospital staff, and community members. The end result: a plan to significantly expand the emergency department.

"Once there's a final decision, there is a formal presentation to the board and review by the board finance committee," McDowell says. "But we don't have a board planning committee separate from the administration and medical staff. It's all done in a collaborative way."

Our GI physicians helped take the lead in a national gastroenterology pilot project, and our system was able to play a supportive role to meet their needs.

— Gary R. Yates, MD, Chief Medical Officer  
Sentara Healthcare, Norfolk, VA

#### Meeting physicians' needs as customers.

Sentara has made considerable progress in addressing physicians' needs as customers. For example, the system helped its gastrointestinal physicians

develop the information technology infrastructure and databases needed to begin collecting data on endoscopy indicators that were developed by their

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## How Boards Can Help

Boards can do a great deal to support increasing alignment of the hospital and physicians around quality. They can:

- Understand what's driving and troubling physicians – and look for ways the hospital can help
- Pay attention to quality improvement efforts and results

- Engage with physician leaders and senior management in a retreat setting to develop a strategic approach to physician alignment, with initiatives for each of the five components
  - Articulate clear policies to support alignment, e.g., to guide the formation of joint ventures, and to address the challenges posed by physicians who directly compete with the hospital or don't accept the responsibilities of staff membership

- Be willing to take prudent risks; to consider new employment structures, joint ventures and gain-sharing mechanisms; and to learn from experience the best ways to partner with physicians.

Don Seymour is a principal with Don Seymour and Associates, Boston, Massachusetts. His consulting practice centers on strategic planning and hospital-physician relationships. To contact him:

don@donseymourassociates.com  
OR 617-462-4313.

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specialty societies. "Our GI physicians helped take the lead in a national gastroenterology pilot project, and our system was able to play a supportive role to meet their needs," Yates says.

Special surveys go out to Baystate's high operating room users asking them to evaluate OR equipment as well as support from the anesthesia and surgical teams. There's a quarterly face-to-face meeting with high users of lab and pathology services, and additional surveys and/or focus groups seek input from other groups of high-user physicians.

**Common information system.** Baystate also has implemented an ambulatory electronic medical record for all its employed physicians, and the EMR is also available for community doctors who choose to participate (until now at their own cost.) "Because they're part of a larger system, the cost is very competitive," Flint says. Baystate is creating an interface so lab results from various sources will be reported directly into the EMR, and the hospital information system is available to physicians through a secure connection from their homes and offices.

### Aligning compensation.

Since the early 1990s Middlesex has reimbursed physicians for time spent in committee work, at a rate that's comparable to other administrative functions – less than they would generate in their offices, but enough to compensate them for time spent away from patients.

At Sentara at least 40 percent of variable compensation for senior executives is based on quality and patient safety performance. The employees' gain-sharing program also includes variable dollars based on quality and safety. "That's one of the ways we align the system," Yates says.

Sentara also has incorporated specific quality and service goals into management contracts with several large community-based specialty groups in the community. This approach has been particularly successful with an area oncology group, Yates says. It led to the development of inpatient and outpatient quality indicators, clinical improvement in those areas, and ultimately a decision to seek accreditation for the cancer program.

"Incorporating quality and service goals in the contract affords an opportunity to get together around the table and focus on

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trying to improve care across the specialty,” Yates says. “In this case, the group has a presence at all our hospitals, and we can use our relationship with them to develop needed infrastructure. Then we invite other oncologists to participate as well.”

**Innovative board structure.** Board quality committees are often a sound, top-level approach to aligning organization and physician interests, but Middlesex is finding success going against the grain. About seven years ago, it merged the board quality committee and the hospital quality committee. In the past, medical and nursing staff reviewed quality data and

filtered information to the board. Today one high-level quality committee includes physicians, nursing staff, two administrators — and five board members. Two of the board members are physicians; three are lay board members. This means that out of a twelve-person board, five members attend every quality committee meeting. When quality problems arise, they are able to explain the root causes, and potential solutions, to the rest of the board.

**Employment.** “We find more and more physicians are interested in exploring alignment through employment, so we anticipate the number of physicians in our medical group will grow, especially in the spe-

cialty areas,” Yates says. “That will offer us the opportunity to align in an even stronger fashion as we go forward.”

As important as all these formal mechanisms are, relationships remain the key. “The most important thing,” McDowell says, “is to anticipate potential conflicts and try to defuse them ahead of time.”

**For more information:**

Arthur V. McDowell, III, MD  
Board Chair, Middlesex  
Health System  
Arthur\_mcdowell\_md@  
midhosp.org

Loring S. Flint, Jr., MD  
Senior Vice President  
for Medical Affairs,  
Baystate Health  
loring.flint@bhs.org

Gary R. Yates, MD  
Chief Medical Officer,  
Sentara Healthcare  
gryates@sentara.com

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*Elaine Zablocki, an Oregon-based freelance writer, is the editor of Great Boards.*