



PHYSICIAN STRATEGY NEWS®

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Developing Physician Leaders

Special thanks to Terrance McWilliams, M.D., VPMA of Newport Hospital, Newport, RI; **Jeffrey Morris, M.D., M.B.A.**, VPMA of Wadsworth-Rittman Hospital, Wadsworth, OH; and **Daniel Varga, M.D.** of SSM Healthcare-St. Louis for their observations and input.

Strong physician leadership has rarely been more important. And the need for outstanding leaders will only escalate as hospitals continue to work to improve quality and utilization and address the challenges of pay for performance.

But physician leadership has never been harder to develop. The interests of physicians and their hospitals are diverging. Economics and advancing technologies are bringing physicians into competition with hospitals. Other trends, such as hospitalists, are changing practice patterns and eroding historical relationships.

How are hospitals dealing with these issues? We talked with three physician executives to gain their perspective and observations.

What are the biggest challenges in developing physician leaders?

Getting physician leaders to see the **big picture** and move beyond their parochial concerns is a major challenge. Many physicians struggle to separate their personal agenda from their role as a leader, exacerbating the problem.

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that focus on “and” rather than “or”, basically the ability to see **win/win solutions**. For example, how can we improve quality and improve **win-win** solutions. That perspective is critical, as many issues as being in competition.

How you start physicians on the path to leadership is important. Giving them **small but important projects**, will test and grow their capabilities. It is essential that physician executives help younger physicians gain experience. And matching potential leaders to those problems is a challenge.

Selecting leaders who can **work effectively in teams** is crucial. Team decision making is frustrating because of the pace of decisions, and physicians are hardwired to make decisions quickly. Physician leaders must overcome that bias as they take on leadership roles.

Two other issues were mentioned as **deal with disruptive peers**, of **physician/hospital interdependence**.

What are the attributes of the best elected leaders you have worked with?

One key attribute is **clinical skills**. All agreed that great practitioners tended to have the credibility to be good leaders (although not all great **clinical skills** a .220 hitter cannot be the leader on a

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Developing Physician Leaders

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baseball team, clinical mediocrity is a barrier to success.

Institutional loyalty is also an important attribute. Shrinking active staffs mean fewer physicians in the hospitals. And as physicians compete with hospitals, the economic interests of the two diverge. These factors make it harder to develop leaders with this important attribute.

Personality is crucial. Physician leaders need to be even-tempered, non-dogmatic, good listeners, and deliberative decision makers. Self **WbUXYbW** |g`Ubch`Yf`W|h`W`fU|h`Ug` it is easy for physicians to "blow with the wind", bowing to political pressure from peers and non-clinical executives U|`Y`7cbUXYbW`YdgU`YUXYf`HJ`YU stand and stick to it.

Two types of **conceptual ability** k`Y`Ya`Yb|h`cb`YX` : |f`g`zh`YUM`|hm` to **create consensus** through win/

win decisions, as mentioned above. Seeing the opportunities for consensus building is invaluable. Second, the ability to **see several steps beyond the issue at hand** is important. Foreseeing unintended consequences, opportunities for compromise, and potential long-term advantages is a very helpful skill.

What steps need to be taken to develop these leaders?

One executive argued that physicians are well trained to be good leaders. They diagnose problems, treat, call in consultants when needed, and make judgments without complete data. And, increasingly, they are working in teams, something required to be a good leader, as mentioned above.

Giving young potential leaders something important to do is a key part of their development. **Service**

line leadership is a good place to start. Senior physician leaders need to nurture and evaluate developing leaders, helping them to learn and apply these skills outside, their own service/area of expertise. This requires some level of accountability. One physician noted that this is easiest if the position is paid.

Focus on young, potential leaders and involve them in **education programs.** Key programs mentioned |b`W`XY`Wb`U|W`f`Y`g`c`i`h`cb`z`YU`h`W`f`Y economics, and strategic planning. Part of the goal is to have them mix with physicians from other locations.

Mixing with other physicians is important, but **interaction with the board** is important as well. Exposing young physicians to these leaders, with their differing processes and perspectives, is useful in developing the young physician leaders.

Interim Practice Management

As hospitals employ physicians or acquire practices, management of the new entity is frequently a challenge. The issues in a practice differ from the hospital and the scale of the operations is much smaller. That means that a |g`H`Y`g`U`f`Y`a`U`|b`|U`Y`Z`e`|W`m` showing up on the practice bottom line.

The result is often an underperforming practice. This is always a problem, but a bigger one if the Board is focused on and concerned about the performance. <cgd|H`U`g`c`Z`M`U`b`X`h`U`h`b`h`f`|a` management arrangements are useful in such an environment.

One advantage is that your organization can increase the talent and experience level of the staff focusing on the problem. Another is that an outsider can be a more effective change agent, better able to implement needed change and make the necessary restructuring decisions.

Such turnaround projects take 3-4 months at a minimum. However, in situations with major problems, we

have stayed engaged for up to three years. Those engagements have represented turnarounds of up to \$10 million, something that required a longer term commitment.

What should an interim management Úfa`Xc`|b`h`U`h`|a`Y3`H`Y`U`f`g`h`g`h`d` is to assess the situation, comparing the practice to relevant benchmarks, understanding the contractual relationships, and understanding the factors that are leading to poor performance. That process will help the interim manager identify the leverage points that will make a difference in the practice results. It k`|`U`g`c`Y`d`h`Y`d`f`U`m`W`h`c`X`Y`U`b`Y` targets, essentially the results it wants to achieve.

The second thing the interim manager should do is to develop action plans that will guide implementation of the improvement plan. Based on h`Y`U`b`X`|b`|g`c`Z`h`Y`U`g`Y`g`a`Y`b`z`h`c`g`Y` action plans can address a number of issues, and are likely to include many c`Z`h`Y`Z`c`k`|b`|`.

- Review of contractual relationships with the providers and ... |X`Y`b`|U`W`h`|c`b`c`Z`|g`g`Y`g`h`U`h`g`c`i`X` ... W`a`c`X`U`Y`X` ...
- 'j`8`Y`U`b`|b`|`j`c`i`a`Y`Y`d`W`U`h`|c`b`g`U`b`X` other standards for each physician.
- Improvements to the revenue cycle management processes.
- Changes in personnel or personnel ... |f`U`|b`|b`|`h`c`U`X`f`Y`g`g`X`Y`U`m`b`W`g`|b` skills.
- Changes in personnel policies.
- Management structure changes.
- Recruitment plan for a permanent group manager.
- 'j`8`Y`U`b`|h`c`b`c`Z`h`Y`g`f`U`h`|`|W`X`f`Y`W`|c`b` of the group, along with senior management.
- Financial modeling of the proposed changes and development of a budget.

Most importantly, the interim manager can begin implementation. In the 3-4 month timeframe, results can be produced and the practice dynamics changed. That creates an environment in which the new manager can be successful.

Quantifying Anesthesia Subsidies

Anesthesia groups are increasingly asking for subsidies as a result of a number of factors, including poor Medicare reimbursement and a tight supply of practitioners.

Faced with this request, how can a hospital executive team formulate a rational decision regarding the appropriateness of a subsidy? We have utilized four different methods to evaluate the need for subsidy, and at times have used multiple methods to verify the need.

Method One. One approach is to develop a proforma projection of the group's performance, based on past performance and industry standard. This method evaluates the group's revenue shortfall based on reasonable salaries, overhead expenses, and collections. As with all subsidy approaches it is intended to increase revenue so that salaries can be competitive.

Method Two. The second method looks at the competitiveness of pay exclusively. This approach entails a review of W-2s, and contrasts compensation with MGMA standards or gaswork.com job postings. When reviewing those job postings, it is important to compare compensation to similar jobs, ones with similar call demands and similar clinical complexity. Day jobs in outpatient centers pay less than jobs in tertiary centers with heart call, and gaswork.com will help you develop comparisons among similar jobs

Method Three. Operating suites that are well utilized will result in better utilization. As a rule of thumb, if your OR has a day shift utilization rate of 70% or below that level, you have built in a need to compensate for those hours. An estimate of the impact of that can

be calculated with the group by looking at their revenue per percent utilization of the OR and multiplying that dollar amount by the percentage below 70%.

Method Four. Many hospitals have built in standby time in their schedules. This relates to potential needs of non-operating room anesthesia sites, and requirements for full time OB coverage. Calculating the costs of this unproductive time potential subsidy.

Other techniques for addressing this issue likely exist, but these should answer to the request for subsidy.

Is Gainsharing in Your Hospital's Future?

As the landscape of healthcare continues to evolve, hospitals and physicians are looking to better align incentives. Alignment could help with management of resources in the face of rising costs and with quality in the face of growing consumer and payor expectations.

Hospital executives have long lamented the fact that physicians do not give their full focus to hospital quality and cost management issues. Gainsharing allows physicians to be rewarded for improvements in overcoming that long-standing problem.

To date, gainsharing efforts have been slowed because of concerns about the anti-kickback provision in Stark. But CMS has developed a demonstration project that sets those concerns aside, and they are currently studying the methodologies and innovative partnerships hospitals and physicians

create while under legal protection of the CMS demonstration.

The most critical requirement for successful gainsharing collaboration between hospitals and physicians will be the availability of accurate clinical information and its associated cost data. The data must track the clinical outcomes, costs associated with providing care, and the utilization of services incurred providing that effect of treatment.

"Implied in this is joint management of clinical services, with physicians and executives working together..."

Ultimately, the data are used to correlate practice patterns with which serve as best demonstrated practices. Once a standard of care is determined, the medical/surgical

equipment and services typically required to provide the appropriate patient care are determined and standardized.

Implied in this is joint management of clinical services, with physicians and executives working together to produce best practices required to produce good outcomes. Based on agreed to quality, physicians may be reimbursed for their efforts to improve care, although the level of those payments may be limited by regulatory bodies.

At this point, gainsharing is an interesting theory. As CMS learns more from its demonstration projects, there will be more tangible information available. However, it is a reasonable supposition that, by working together, physicians and hospitals will improve true, an avalanche of gainsharing opportunities may be in our future.

