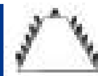

# Guthrie Health

SAYRE, PENNSYLVANIA

By Joseph A. Scopelliti, MD, President and CEO, Guthrie Clinic and Co-CEO, Medical Affairs, Guthrie Health

**Guthrie Health, located in Sayre, Penn., was formed in 2001 by the merger of the Guthrie Healthcare System with the Guthrie Clinic. Today Guthrie Clinic includes approximately 235 physicians, approximately 45 percent of them in primary care, and 55 percent in medical and surgical subspecialties. The clinic also employs 110 mid-level providers, of whom approximately 80 percent are in primary care practices.**

**Guthrie Healthcare System (GHS) is comprised of three hospitals, including its flagship facility, Robert Packer Hospital, a 258-bed tertiary care teaching hospital. Virtually all practicing physicians at this hospital are employed by the clinic, except for certain special situations, such as psychiatrists who work only at the hospital. The Guthrie Clinic had acquired practices in nearby Corning, N.Y., and we later acquired Corning Hospital, a 99-bed community hospital. Guthrie Healthcare System also includes Troy Community Hospital.**

Nothing embodies Guthrie's commitment to shared leadership more than its co-CEOs model. Guthrie uses this unusual structure (which seldom works in business) to model the leadership style it wants throughout the organization.

## A FULLY INTEGRATED CLINIC AND HOSPITAL WITH CO-CEOS

**HISTORY AND TRUST:** Robert Packer Hospital was founded in the 1880s and the clinic in 1910; they have shared side-by-side buildings for 98 years. In 1988, the clinic converted from a partnership structure to a not-for-profit professional corporation. It joined with the hospital briefly, then split apart amid conflict between the hospital and clinic executives. In 2001, we came together again with new boards and new CEOs who built a foundation of renewed trust and shared values. The process was a deliberate and open one, which included time for discussion and understanding. Considerable time was spent outlining the goals, objectives, and advantages of the new model. The original values that Dr. Guthrie brought to Sayre were reestablished as a means to align thinking, together with fundamental discussion of our mission. This time integration took, marking the birth of Guthrie Health.

**SHARED VISION AND STRATEGIC PLANNING:** Why did the hospital and Guthrie Clinic join? Kevin Carey, the prior clinic president, and Mark Stensager, GHS president, were the architects. The hospital and clinic had worked together well for years, aside from the bump in the road caused by conflict in the 1990s. In 2001, coming together meant the hospital and clinic gained the proactive ability to plan for healthcare regionally. We could pursue joint goals around strategic planning, quality, access to services, service to our patients, and growth. This also met the clinic's need for a capital partner, and met both our needs to recruit new physicians to the area. The affiliation was driven by a vision and core principles and values of teamwork, quality, patient centeredness, and a physician-administrative partnership at every level, from co-CEOs to departments to clinics.

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In the 1980s, as part of its strategic plan, Guthrie Clinic acquired and grew a physician group in Corning. The group has grown to 35-40 physicians and is a large presence in town. Consequently, when Corning Hospital faced serious economic challenges and put out a request for acquisition or network proposals in 1999, Guthrie was selected in large part because of the clinic's existing physician presence.

## CORPORATE AND GOVERNANCE STRUCTURE:

Physicians are embedded in governance and leadership positions at all levels and generally paired with executive leaders. However, we stress the difference between governance—which means setting high-level policy and making large decisions at the system level—and management, which involves operational policies, planning, decision making, and implementation of operations and clinical care.

**Parent Board.** Guthrie Health is the not-for-profit parent organization of hospitals, clinics, and other enterprises. It has a 14-member board, six of whom are physicians from the Guthrie Clinic and six of whom are public members from GHS. It also includes the co-CEOs for Administrative and Medical Affairs, respectively. There are no term limits.

The parent board has reserved powers over:

- Guthrie Healthcare System (GHS), which includes the two hospitals and several nursing homes.
- Guthrie Clinic, Ltd., which is organized as a 501c3 for IRS purposes and as a professional corporation under New York and Pennsylvania law, so that physician "shareholders" pay a nominal $2 to join.

**Co-CEOs Model.** Nothing embodies Guthrie's commitment to shared leadership more than its co-CEOs model. The system's two senior executives are co-CEOs for medical and administrative affairs, respectively. Guthrie uses this unusual structure (which seldom works in business) to model the leadership style it wants throughout the organization. Together, the co-CEOs (and other physician-administrator pairs in the organization) demonstrate the values of mutual respect and collaboration. There is due deference to our respective areas of expertise, to the administrative co-CEO on business matters, and to his medical affairs counterpart (myself) on clinical and quality matters. However, the real emphasis is on assembling the right facts and making decisions in an inclusive and transparent manner. As co-CEOs, we spend a lot of time together and work out differences before board or executive staff meetings. We can have passionate disagreements, usually on priorities, but it's behind closed doors. The co-CEOs model could have the potential for catastrophe with different people, but it works for us.

**Other Boards and Governance Entities.** Physician engagement is also present in other governance entities:

- Guthrie Healthcare System (GHS) is our operating board. It has 12 members, including three physicians. It meets monthly to address system issues that are pertinent to all the participants.
- Guthrie Clinic has a board of nine physician members elected by clinic physicians, plus the president of clinic, ex-officio, nonvoting. Members serve a maximum of three consecutive two-year terms to provide broader opportunity for clinic physicians to serve as leaders. To run, a physician must be board-certified and have worked for the clinic for two years. An informal nominating committee identifies and invites possible candidates to run, and usually there are more candidates than seats available. At least two directors must be from outside Sayre, that is, from Guthrie's regional network. Informally, the board seeks a diversity of PCPs and specialists. The clinic board is responsible for clinical quality, access, service to patients, clinic operating policies and strategic initiatives, and determining physician compensation consistent with a compensation philosophy approved by Guthrie Health.
- A seven-member Operational Leadership Group includes clinic and hospital management leaders and makes high-level decisions or recommendations on shared services and programs, including budgeting and financial management, human resources, compensation, and information technology, including the common electronic medical records system. This group is working on standardizing policies across the organization.
- The clinic has a traditional departmental structure with a full range of medical and surgery departments and also has regional medical directors.

**Clinic and Hospital Medical Staff Integration.** At Robert Packer Hospital, the medical staff is almost entirely from the Guthrie Clinic, so clinical department chairs in the clinic and the hospital are the same. They are first appointed by the clinic board, with vetting from hospital leadership, followed by formal approval by the hospital. There's been little turnover of department chairs.

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Corning Hospital has an open staff model and approximately 25 percent of staff are non-Guthrie physicians. However, the clinic has been wary of using its majority to have only clinic physicians as department chairs. Instead, it tries to promote selection of the best person to lead, whether Guthrie-employed or not. Our goal is not control, but rather, having the same level of care wherever a patient touches the Guthrie system. It's easier in Sayre, but we don't have the same control at Corning, so we're seeking collaboration through education and agreement with independent physicians on common goals. In the long run, it seems likely that in the future all physicians will work for the clinic since physician recruitment is so difficult for independent physician practices.

**OPERATIONAL INTEGRATION:** Paired physician-administrative teams use balanced scorecards to monitor achievement of system-wide goals for finances, quality, and patient satisfaction, thus keeping the clinic accountable in making operational decisions about scheduling and staffing. Guthrie is moving toward having a single income statement for the combined hospital and clinic at each of its campuses.

A common structure for goal-setting was critical to get everyone on the same page. This took a few years, but once we agreed on the categories and then the targets, it really got everyone aligned.

**COMPENSATION:** Most physicians are on a "net contribution compensation model" which, although complex, is designed to consider each physician's productivity (based on relative units compared to national norms); stipends and other compensation for leadership, supervision and medical education; contributions to practice site profitability; and efficiency. Each physician's compensation is calculated based on the total compensation pool established by the budget, and then it's reviewed for fairness and competitiveness compared to market surveys. Floors and ceilings may be applied to meet guarantees for new physicians and IRS requirements, respectively. This model rewards productivity and departmental efficiency. However, there's a disincentive for providing uncompensated care, which is being addressed.

We have multiple models for compensation because no one model works for everyone in a multispecialty group. Some physicians, such as emergency physicians and anesthesiologists, lack much control over their productivity, as do some hard-to-recruit specialties such as trauma surgeons, so they receive a fixed salary. Some specialties operate on a straight profit and loss or net revenues model.

At the leadership level we have common goals and incentives for our combined physician administrative partners.

## FUTURE

We believe that we are positioned well for the changes that are coming to healthcare in the U.S. We see payment for quality and cost controls being advantaged in integrated systems of care such as ours. Our electronic healthcare record pulls all of this together and will serve the integrated model very well.

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**FOR MORE INFORMATION:**
**"The Right Ways to Employ Physicians,"** *Great Boards,* Spring 2009
**"Developing a Hospital-Physician Alignment Strategy,"** *Great Boards,* Winter 2008
**"Aligning Hospitals and Physicians: White Paper from The Governance Institute,"** Fall 2008

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