



Providence Regional Medical Center Everett

EVERETT, WASHINGTON



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Northwest Washington Service Area

At Providence Regional Medical Center Everett in Everett, Wash., employed physicians currently compose 80 members of a nearly 800-member medical staff, but they account for approximately 20 percent of system volume. Approximately 55 of the employed physicians are in primary care, filling a critical community need.

In addition, Providence has “one of everything” along the alignment continuum, including joint ventures with independent physicians, a risk-bearing Physician Hospital Organization (PHO), employed and contracted physician leaders serving as leaders of hospital clinical departments, and comanagement agreements for major clinical services, including a Regional Cancer Partnership.

However, with changing economic conditions, quality mandates, and regulatory limitations on economic arrangements between hospitals and nonemployed doctors, we think increasing numbers of physicians will be interested in direct employment.

Thus, growing the Providence Physician Group (ProvPG) has become a prime strategy. We plan to grow the group to about 100 members over the next three years because the market is under-doctored, leading to outmigration of patients. In addition, the delivery system is expanding as the county grows, adding subspecialists. We believe that employment is one of the most effective ways to bring new specialists in and to retain specialties that otherwise would have left the market.

“ONE OF EVERYTHING” ON THE ALIGNMENT CONTINUUM

TRUST: Effective relationships with any professional group must have a foundation of trust. Physicians are certainly no exception, and with the challenges of a relationship dynamic that many times includes collaboration while competing, trust is even more critical. Trust happens when the environment includes openness and honesty in dialogues, a fair playing field for all parties, an opportunity for input, and consistency in actions and behaviors that support the words stated. We continue to increase the amount of discussions in almost every aspect of our relationships, and we are open in sharing our needs and the ways we are willing to integrate.

We also have increased the “substantialness” of the involvement of physician leaders in our direction setting and decision making. For example, more than half of the members of the committee that establishes priorities for our capital plan are physician leaders. We have weekly meetings that include the four division chiefs (medicine, surgery, women’s and children’s, and ambulatory) along with senior leadership (and some board members) to coordinate major strategic and operational issues. Most major clinical functions have a dyad approach to leadership where an administrative leader is paired with a physician leader to manage day-to-day issues of the service, including patient care processes, patient and referrer satisfaction, budget management, and strategic direction.

PHYSICIAN EMPOWERMENT IN GOVERNANCE AND LEADERSHIP:

For our sponsored group, physicians are heavily engaged in governance through ProvPG. We use the dyad structure heavily. ProvPG is governed by the Providence Physician Group Oversight Committee, which reports to the Service Area Board. It includes approximately

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four community board members and four to five elected (by the group) physicians. They are responsible for the traditional roles of governance, including financial performance, strategic planning, and clinical and service quality, subject to their parent board's reserved powers. Various committees, such as the group's Quality Committee, are physician-driven but have shared administrative representation.

Our Service Area Board has approximately 22 members. In addition to community leaders, six physicians are represented. The ProvPG Oversight Committee presents a monthly report to the full board, and its quality report is reviewed quarterly at the board's Quality Committee.

Physician leaders sit on the board's Planning and Finance Committees, which process major strategic plans, and of course, on the full board which oversees the final process and product.

OPERATIONAL INTEGRATION: How are we integrating hospital and physician activities, and how are we running our medical group to achieve efficiency and quality?

Coordination and transparency, an integrated information system, and a strategic plan help align the hospital and physician enterprises. So do service lines and joint ventures, such as the regional cancer partnership, that have shared physician-administrative leadership.

The key to running an efficient medical group has been experienced management. The service area has upward of 20 years experience integrating a practice enterprise. The senior leadership of the group, including the group's physician leader and CEO, have decades of group practice experience and know-how to work within a delivery system. Within the group, we have the critical mass to dedicate people skilled in managing physician groups, not hospitals, in such areas as human resources, marketing, and finance.

At the hospital, to align physicians and hospital leadership, we have employed or contracted with physicians, full time or part time, as medical directors or division chiefs for medicine, surgery, women's and children's services, and ambulatory physicians. It's close to an academic model. These physicians are not presently members of ProvPG, they could be—just not now.

REGIONAL CANCER PARTNERSHIP WITH EMPLOYED AND INDEPENDENT PHYSICIANS

Among our other alignment strategies, the regional cancer partnership stands out. It is designed to meet community needs, provide a continuum of state-of-the-art cancer care, grow outpatient revenues and align financial incentives for four partners: Providence Regional Medical Center Everett (including our medical group); an independent radiation oncology group, and two independent multi-specialty medical groups, the Everett Clinic and the Western Washington Medical Group. Thus, the partnership is a collaboration of four major cancer providers joining forces to better serve the community's oncology needs. It is not a joint venture but rather a series of legal agreements (including comanagement, equipment leases for radiation oncology and imaging equipment, space leases, and joint strategic direction-setting.)

We are working to break down the silo mentality, beginning at the top level. A Cancer Executive Committee has nine members, including physicians paired with lay executives from each partner, plus the executive director. The committee monitors and makes recommendations on operating decisions, oversees a strategic work plan and outreach strategy, develops a physician recruitment and subspecialty staffing plan, and resolves problems in working relationships. The group looks at a balanced scorecard for quality, finances, physician and patient satisfaction, and community benefit monthly; we're a virtual governance group for the enterprise. The cancer center model still works under the new Stark rules, with some tweaking, by converting the equipment lease from "per click" arrangements (which reward volume and are now suspect) to fixed and market-based fee arrangements.

When you're in the cancer building, even though it is technically made up of four different legal enterprises, you wouldn't know you're not being treated by one organization. That's what hospital-physician alignment should mean.

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ALIGNED SYSTEM-PHYSICIAN COMPENSATION: The Providence Physician Group has required very little subsidy from the delivery system, averaging less than \$10,000 per primary care physician. That's with costs fully allocated and without ancillary services revenues. Financial results for specialties vary but are also good.

One reason for this is efficient operations, the other is the compensation model. Physician compensation is based on productivity. The culture is more like a group practice. There is a physician-driven compensation committee, with administrative representation, that develops recommendations for approval by the Executive Committee of the Service Area Board.

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CLOSING THOUGHTS: WHAT LESSONS HAVE WE LEARNED?

Key lessons include finding the right balance of professional autonomy and independence for the providers, along with meeting the strategic and community needs of the delivery system. It's an ever-evolving process. Another key is having leadership that is steeped in physician group experience but still knowledgeable and understanding of health/delivery system dynamics. Finally, allowing the physicians to manage and lead is critical—we have learned that the more you shelter the professional from the market and the community, the more they behave as if they are sheltered. Go figure, just like us administrators!

As we continue to integrate care processes to improve both the quality and efficiency of healthcare delivery in our community, employment must be one of the options for alignment of physicians. It can't be overused or underused. We must continue to make it as effective as possible, and then be willing to utilize it when the circumstances are correct. It is an important tool in the tool kit of physician alignment— just not the only one.

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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

This case study is provided by the *Great Boards* Web site and Bader & Associates, consultants in governance excellence and hospital-physician alignment.

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