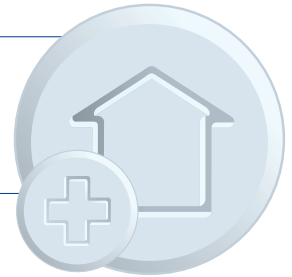


St. John's Health System

SPRINGFIELD, MISSOURI



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St. John's Health System (SJHS) is a not-for-profit organization that includes a 600-bed tertiary care hospital, five regional hospitals, a medical group—the St. John's Clinic—and a health plan. SJHS is sponsored by the Sisters of Mercy Health System, St. Louis, Mo.

The clinic makes up approximately 95 percent of the medical staffs of the SJHS hospitals and includes approximately 470 physicians, fairly evenly divided in thirds among primary care physicians, medical specialists, and surgeons. The clinic has 70 locations in 41 communities and records 1.4 million patient visits a year. It generates more than \$360 million in net revenues out of \$1 billion for the health system overall.

Most critical to restoring trust was the engagement of physicians in management and governance as equal partners.

"Physician-led, professionally managed" became the phrase that defined the desired new culture.

A FULLY INTEGRATED HOSPITAL SYSTEM AND MEDICAL GROUP—REBUILT ON TRUST

SYSTEM FORMATION AND TRUST: Like many other hospitals, St. John's acquired scores of physician practices in the 1990s. It employed physicians directly, but by 2000 both the system and the physicians were disappointed with financial performance, and working relationships were strained. As employees, formerly entrepreneurial physicians were paid a salary with little incentive to maintain productivity or collaborate with the hospital. The compensation model disengaged physicians from the business. Distrust, discontent, and misalignment of financial incentives were rampant, and the integrated system was in danger of being disassembled.

It was clear we had a trust issue, but rather than spend time on trust per se, we decided that if we fixed the business model, including compensation, then trust would follow. We believed we had to do the right thing and execute a good strategy and be transparent about it.

To restore trust, management and physician leaders agreed on a set of guiding principles to be embodied in a new model for integration. The guiding principles were designed to revive physician entrepreneurialism, break down hospital and clinic silos, and take advantage of potential operational synergies. They included:

- 1. Physician authority and accountability for medical practice.
- 2. Separate sister corporations for the hospital and clinic rather than physician employment by the system.
- 3. System provides some support services to physicians to take advantage of economies of scale.

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- ⦿ Joint contracting for health plan contracts to align financial incentives.
- ⦿ Transitional support for physicians during the change from a salary to productivity-based compensation.
- ⦿ Aligned hospital/physician incentives for meeting strategic, financial, and quality goals.

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FIGURE 1: St. John's Health System Organizational Chart

Executive Council

Meeting Frequency: Weekly
 Membership: SJHS CEO, SJC EVP, SJHS CFO, Chief of Staff, Chairman of the SJHS Board, Chairman of the SJHP Board, SJC Physician Presidents

Description/Charge

- System Strategic Direction
- Long-Term Planning
- High Level Decision Making

Operations Council

Meeting Frequency: Bi-monthly
 Membership: SJHS, SJC, SJHP Sr. Leadership and Physician Leadership

Description/Charge

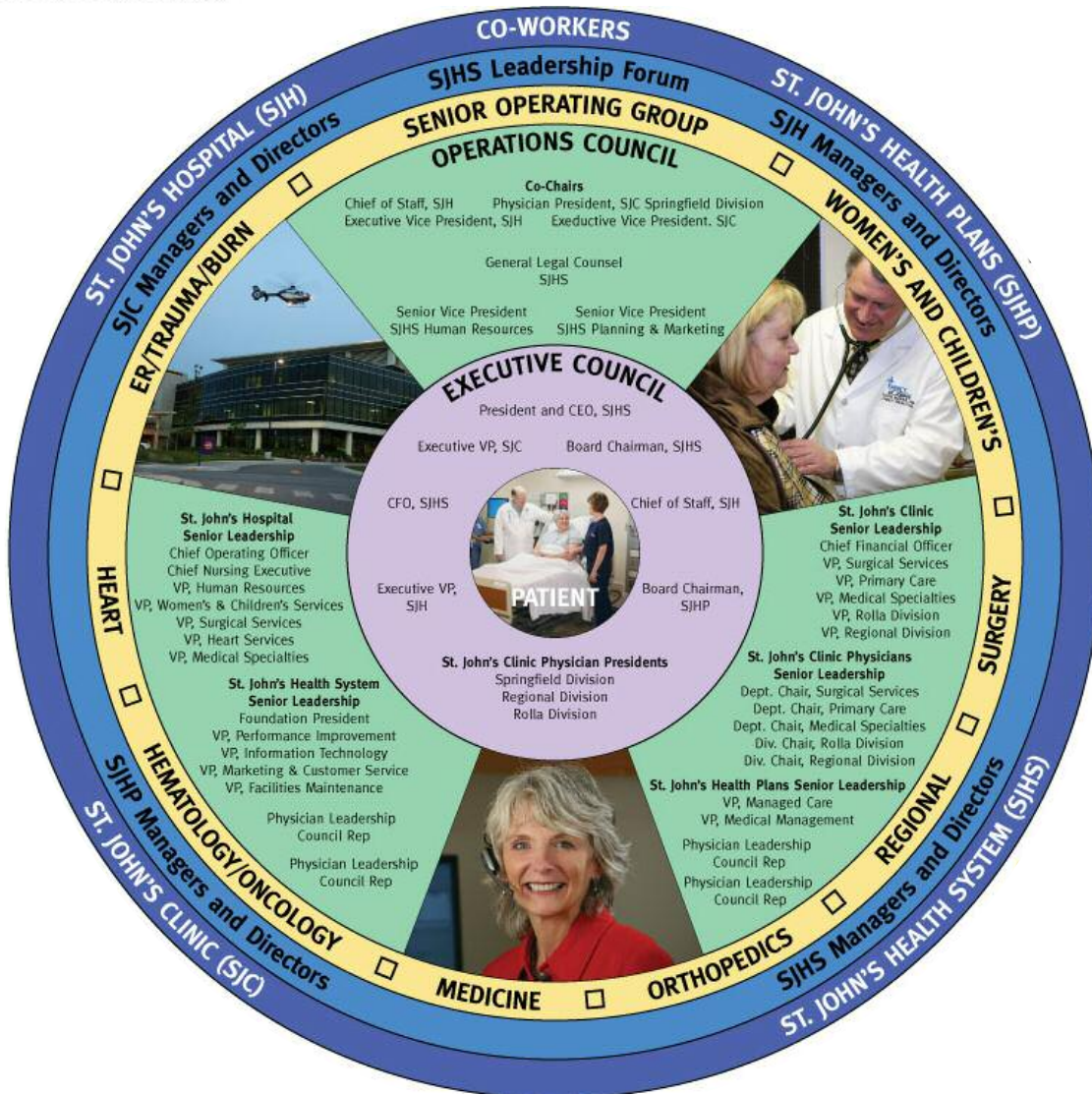
- SHO Coordination
- Strategic Plan Development
- Capital Allocations
- Operations

Operating Groups

Meeting Frequency: Weekly
 Membership: Physician Department Chairs, Physician Section Chairs, SJC & SJH VPs

Description/Charge

- Coordinated Decision Making
- Day-to-Day Operations
- Leadership and Direction



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SHARED VISION AND STRATEGIC PLANNING:

Based on these principles, we developed a shared vision centered on quality and a new approach to physician compensation to reward productivity and achievement of system and clinic goals.

The shared vision was and is a work in progress. Every other year, senior leadership brings in a large group of physician leaders to revise the overall plan. Because of the speed of changes in the current environment, especially in the economy, reimbursement, quality requirements, competition, and growth, we are finding the need to revisit and reset some elements of the plan quarterly. Consequently, the senior leaders and the Operations Council (discussed below) review the strategic plan quarterly. In some cases, there's no reset, sometimes there's a tweak, and occasionally there's a major change in the strategic plan.

PHYSICIAN EMPOWERMENT IN GOVERNANCE AND MANAGEMENT:

Physician empowerment begins at the top and extends organization-wide, consistent with the principle of "physician-led, professionally managed." Clinic physicians recognize that their practices need strong managerial competence, but physicians want responsibility for clinical matters and day-to-day practice operations. Therefore, physician-executive pairs exist at leadership levels throughout the organization, and these leaders are role models for trust and mutual accountability.

The SJHS organizational structure is shown in Figure 1. The 14-member health system parent board includes approximately one third physicians, one third lay community members, and one third religious or sponsor members, plus ex-officio executive leaders from the system and clinic. The system board approves a system-wide strategic plan, budgets, and measurable performance goals. The chairman of the health system board must be a physician, typically a clinic physician, but may not be a physician member of the senior management team.

The St. John's Clinic is also a not-for-profit organization. The system board is the corporate member of the clinic and retains reserved powers over the clinic's budget, strategic plans, compensation plan, and quality goals. Virtually all SJHS practicing physicians are employed through the St. John's Clinic, not the hospital.

St. John's Clinic is governed by a 17-member board, with 11 elected physicians and the clinic's physician presidents, clinic executive vice president, the health system CEO, and the executive vice president of St. John's Hospital, ex-officio. The clinic board meets six times a year to focus on operational policies, strategy and quality matters.

SJHS distinguishes between the system board's governance responsibilities for high-level policy and strategy, and the clinic board's engagement in governance and management of clinical care and physician practices.

Physicians are also engaged in the Physician Leadership Council, which is a broad-based group that includes the department chairs, section leaders, medical directors, and senior administrators. It meets monthly to discuss operational policy and issues and stay updated on clinic and system programs. To promote hospital-physician alignment, the clinic president appoints chairs for primary care, medicine, and surgery, and they hold the same positions on the hospital's medical staff. These are long-term management appointments, not elected, rotational positions.

A physician sense of ownership and investment in their practice sites is important to each site's success. To sustain physicians' entrepreneurship, decision-making is decentralized as much as possible, consistent with system-wide goals and policies. For example, the Clinic Executive Committee has established a policy requiring sites to provide convenient access for patients. Each site establishes its own schedule, but one site can't say, "We're closed Friday afternoons," without considering the impact on other system components and the policy of meeting patients' needs for access.

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RECENT CHANGES: Over the past year, however, SJHS leaders decided that partnerships weren't working as well as they could at either the leadership or operational levels. We needed deeper integration that would break down stubborn silos of the hospitals and medical group. There is a need to have separate board and management structures, because some things occur in and concern just the hospitals or the clinic, but we also needed more integration and coordination.

Consequently, three operations bodies have been instituted, each with approximately 50/50 management physician makeup, to carry integration right to the front lines (see Figure 1):

① The Executive Council is the senior decision-making body of SJHS. It meets weekly and includes the system CEO, physician chair of the SJHS board, the executive vice president of the clinic, the physician presidents of the clinic, the executive vice president of the hospital, the physician chief of staff in the hospital, the SVP and CFO of the hospital, and the physician chairman of the Health Plans Board.

② An Operations Council includes all members of the Executive Council plus all of the hospital and clinic vice presidents as well the physician department chairs and appointed Physician Leadership Council members. It meets every other week to coordinate strategic plan implementation and ongoing operations.

③ Eight Senior Operating Groups meet weekly to oversee day-to-day operations for medicine, surgery, cancer, ER/trauma/burn care, cardiac care, women's and children's services, orthopedics, and regional operations. "They run the place" consistent with system-wide direction and goals established by the board and Executive Council. Goals include the areas of physician engagement, growth, length of stay, clinical quality, patient satisfaction, and finances.

This model is really taking hold, and for the first time doctors are truly interested in things such as hospital length of stay and hospital operating income.

OPERATIONAL INTEGRATION: Integrating operating functions is critical to achieving efficiencies. All clinic locations use the same billing, scheduling, information technology, human resources, and other services policies and shared services. The hospitals and clinic have one electronic health record system, developed by Epic.

COMPENSATION: The compensation plan for physicians is approved by the clinic board and requires approval by the health system board. The clinic currently uses a "modified bottom line, or net revenues, compensation model." Each physician is compensated based on collected revenues minus expenses. The clinic rewards primary care physician production by providing a value payment incentive in addition to their baseline clinical compensation, which is distributed through a pool funded jointly by the hospital and the specialist physicians. Compensation is also provided for administrative responsibilities that take time away from practice. Physicians also have access to incentive compensation tied to achievement of core measures and other quality, safety, and financial indicators in the clinic and hospital settings. The compensation model isn't perfect, probably never will be, and is modified regularly.

SUCCESS FACTORS: Reflecting on the health system's evolution, our key success factors have been:

- ① A "physician-led, professionally-managed" structure and culture.
- ② Paired physician/administrator leadership at every level.
- ③ Shared mission and vision.
- ④ Aligned compensation and incentives.
- ⑤ Development of clinic or group practice culture.
- ⑥ Shared information system.
- ⑦ Communication, honesty, and integrity.

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LOOKING TO THE FUTURE: We believe providers in the future have to emphasize innovation around care models. The population is growing and aging, but the number of doctors available to practice remains flat in general and declining in certain specialties. In addition, many physicians want a better work-life balance, for example, by working part-time or practicing only in the office, not the hospital setting. So, we have to be innovative to recruit and retain doctors, and to deliver care with fewer physicians, especially in primary care and internal medicine. That includes increased use of allied health practitioners, telemedicine, and hospitalists; but these modalities alone

won't suffice. We also have to be smarter in taking care of populations, for example, using a team approach such as medical homes with a doctor in the lead, to deliver care, and promote wellness in more efficient ways.

We also have to be ready for policy changes in healthcare reform. We have to focus on patient quality and transparency. First, last, and always, we have to have fiscal responsibility with a net operating income. The best way to accomplish these things, we believe, is with a fully integrated system of aligned hospitals and physicians.

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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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