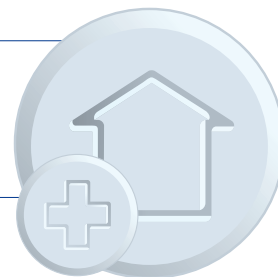


Summa Health System

AKRON, OHIO

by T. Clifford Deveny, MD, Vice President for Physician Alignment, Summa Health System and President, Summa Physicians, Inc.



Summa Health System, based in Akron, Ohio, includes six hospitals with more than 1,000 beds and a pluralistic physician alignment strategy encompassing employed physicians in system-owned and leased practices, as well as other arrangements with a thousand independent physicians on its medical staffs.

Summa launched its current alignment model with just seven employed physicians in 2005. Today, Summa employs 200 doctors who account for more than 30 percent of admissions, and it plans to grow to 300 employed physicians in one-and-a-half years. We believe it represents the future for many, but not necessarily all, doctors.

Summa offers doctors two employment options through Summa Physicians Inc. (SPI). The system will directly employ physicians and own their practices. Physicians who are not prepared to give up ownership can lease their practices to SPI and sign multiyear employment contracts with SPI. Today, Summa employs 50 percent of physicians directly and 50 percent through SPI.

In addition, Summa has a joint venture orthopedic specialty hospital focused on being branded as the highest quality with 30 independent orthopedists. It has another joint venture with 120-130 independent physicians to build a new suburban hospital in a growth market (pending regulatory approval), and a collaboration with 240 independent physicians who participate in an electronic medical records grant program to exchange information, coordinate care, and enter into risk contracts.

A MODEL WITH MULTIPLE OPTIONS FOR EMPLOYED AND INDEPENDENT PHYSICIANS

How did we get where we are today, and where are we headed?

TRUST: Trust was everything in attracting physicians to join Summa Health System as employees. The adoption of the Physician Enterprise Model was critical to earn the trust of private practitioners who wanted the advantages of employment but weren't prepared to make a career commitment (at least not yet) to sell their practices.

Peter A. Pavarini, an attorney with Schottenstein, Zox, and Dunn, Co., LLP, Columbus, Ohio, helped Summa's leaders create its Physician Enterprise Model and explains it in simple terms. The hospital or health system employs physicians through a separate but affiliated legal entity (the "physician enterprise") which is a "group practice" for Stark and other purposes. The physicians are employees and sign employment contracts of usually two or three years. Physicians are paid fair market value compensation for their clinical activities and additionally for administrative duties. Physicians retain ownership of their practices. SPI leases the practices which provide nonphysician support staff, office space, equipment, furnishings, and access to patient records. SPI provides a turnkey package of administrative services such as managed care contracting, billing, and collections, essentially serving as a management services organization.

As owners of their practices, the physicians still own the tangible and intangible assets of their practices and are under no compulsion to sell out. However, many of these arrangements give the hospital an option or right of first refusal should the physician eventually decide to sell.

→ *continued from page 1*

At the same time, the system doesn't assume any debt or receivables and can purchase practice assets at a depreciated value if needed. All the leased practices have business operating plans, so the system can make an informed economic valuation before hiring them.

"Physicians still have good reason to manage their practices as efficiently and profitably as they did when they were self-employed," says Pavarini, because they still own them. "The preferred compensation model rewards physicians for performing as they would in a totally private practice."

It was one thing to design the model and another to earn the trust of physicians to join SPI. Summa Health System had to be able to sit across the table, say the board was behind the physician enterprise model, and explain that the model is here to stay. Having SPI be physician-led (by the author and a physician-majority board) was important. The commitment of the system CEO also built confidence, and SPI gained credibility when it attracted respected leaders of the hospital's clinical departments. They became like salespersons for the model.

Every day, SPI acts in various ways to keep nurturing trust. We are transparent with information and business plans. We are developing a portal for physicians to look at reports on the budget, quality, and patient satisfaction.

Physicians are suspicious of hospitals, and so the compensation plan is transparent, with no favoritism. Everyone is hired under same deal. Physicians' compensation is not linked to payer mix, and they are not held accountable for things they can't control. We use independent third parties to establish lease pricing and to provide a practice valuation when physicians want to sell their practices. It's all how you do this that builds trust.

Is it working? In a time of physician shortage, physicians interested in employment are calling all the time, and residents are sending in resumes from outside the region. So we think the model is sustainable.

Every day, SPI acts in various ways to keep nurturing trust.

SHARED VISION AND STRATEGIC PLANNING: The fact that creating our physician alignment model was about mission, not just money, was an important element of the shared vision and values on which we've built physician partnerships. Physician leaders are traditionally involved in all strategic planning at Summa Health System. When recruitment and retention of physicians became a crisis for the community, board members and physician leaders worked together to develop a sustainable physician alignment strategy.

PHYSICIAN EMPOWERMENT AND ENGAGEMENT IN GOVERNANCE: Summa Health System (SHS) is governed by a 24-member system board (now being downsized) that includes approximately 40 percent physicians.

Summa Physicians, Inc., is a subsidiary board with authority, subject to the SHS board's reserved power, over virtually everything involving employed physicians. The SPI Board has 10 members: seven physicians and three executives. It meets every other month and its members are appointed by the system governance committee to serve three-year terms. The SPI Board has one committee for information technology. Budgets, strategic plans, new hires, policies and procedures, quality, and so on, go through the SPI board. The only exception is compensation, which is established by the SHS board through a compensation committee composed of independent directors. The compensation committee also carefully monitors physicians who "hit the caps" of their compensation range.

(As this is written, change is in the wind. The system board has said there will be complete system and clinical integration in three years, and we are currently engaged in a governance reorganization involving all levels of corporate and SPI governance.)

SPI also engages physicians in decision-making in other ways:

- 🏠 A Practice Operations Group meets weekly and includes lead practice administrators and physician services team members. All aspects of operations and financial performance are monitored and managed to provide the highest quality at the lowest possible expense.
- 🏠 All physicians are invited to a luncheon meeting every other month to hear and comment on strategic

→ *continued from page 2*

planning updates, educational topics, and a review of financial performance information for SHS and SPI.

🏠 The system CEO has an open meeting with physicians three evenings a year.

🏠 As SPI's president, I try to meet with each physician twice a year, but that's growing harder as SPI grows. However, hospital "physician sales representatives" and the operations directors meet with physicians regularly and SPI gets feedback from them.

🏠 SHS has created system-wide services lines with administrative and physician codirectors; the physicians are employed by the system SPI. Current service lines with codirectors include cardiovascular, senior, women's, orthopedic, oncology, surgery, and behavioral health services.

🏠 A Cardiovascular Institute is transforming care management. The cardiologists are employed, a Cardiovascular Executive Committee of physicians and managers discusses everything from office practices to hospital outcomes, and common metrics drive clinical care and operations. We're seeing significant improvements, hitting some dramatic quality and cost-per-case numbers in cardiovascular care. As a result, we are able to commit significant capital dollars to those areas. It's a form of gain-sharing.

OPERATIONS: All SPI practices are moved to a common IT platform for practice management on day one. Managed care contracting and backroom operations are operated by SPI for all practices.

All practices follow SPI's specific policy and procedures developed by our board. Plans are being developed to move all SPI practices to a common Electronic Medical Record (EMR) that communicates with all the hospital entities.

We don't say we "subsidize" employed physicians—we call it an investment.

COMPENSATION: Hospitals have traditionally lost money owning physician practices, and on paper, our practices lose about \$65,000 per physician, with variances based on specialty. However, the physicians are contributing to the system's patient volumes and ancillary services revenues, so we don't say we "subsidize" employed physicians—we call it an investment. And it's been a good one.

A key part of maintaining physicians' trust and entrepreneurial engagement is having the right compensation package. As noted earlier, physician compensation is not linked to payer mix, and physicians are not held accountable for things they can't control, such as charity care.

SPI uses a productivity-based compensation model. All physicians have a base salary that is earned by performing a target number of work related value units (wRVUs). Physicians earn additional income for excess wRVUs performed over the target wRVUs.

CONCLUSION: WHAT'S NEXT?

Is physician employment by systems, including the Physician Enterprise Model, a sustainable model or the latest in a long line of fads?

We feel the whole payment system for healthcare will change. Once the next phase of legislation and provider consolidation occurs, there likely will be more bundled pricing, risk contracts, and—we hope—pay for performance or at least recognition of quality. In a time of transparency, we have to be willing to put quality on the front page. Employers are unwilling to pay more so the pie is not going to grow. We are positioning SPI to take full risk as part of the system.

We think the employment model is an end game because it's the best way to get information to physicians about quality and costs and to instill shared accountability for patient care results. Departmental meetings don't work when care has to be coordinated. Leadership can't be left to volunteers worried about losing practice income.

→ *continued from page 3*

Once you solve physicians' financial situation with the security of an employment arrangement, and there's a governance and management model physicians can have faith in, they can look up and pay attention to quality, efficiency, and the continuum of care.

Physicians are by nature competitive—they respond to information saying they're different, and they look for ways to align their behavior with best practices. They get interested in hospital systems that help produce better outcomes and greater efficiency. We're seeing innovation and collaboration from our employed and other aligned physicians.

This is not an exercise because otherwise physicians would become or join competitors. We are in a transition period in American medicine from hospitals and doctors working side by side to working in true partnership because the public demands it. The old model of delivering care is not sustainable.

“Physicians still have good reason to manage their practices as efficiently and profitably as they did when they were self-employed.”

— Peter Pavarini

CONTACT INFORMATION: T. Clifford Deveny, MD | 330-375-3864 | devenyc@summa-health.org
Peter Pavarini | 614-462-5016 | peter.pavarini@szd.com

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.

For further information on our professional services and publications, go to www.GreatBoards.org, call 301-340-0903 or e-mail Barry Bader at bbader@GreatBoards.org.

© 2009 Bader & Associates. This case study may be used by individual organizations for their own board education and development, but may not otherwise be published or reproduced for distribution without the permission of Bader & Associates.