



Health system sponsored physician employment: keys to success

Part 3: Organizational structure, governance and management

Organizational structure, governance and management of the physician employment enterprise

In the health system sponsored physician enterprise, clinical and financial improvements cannot take place without successful and sustainable collaboration between hospitals and physicians. Organizational structure, governance and management design are foundational elements of success. This paper explores the considerations and leading practices in the structural design, governance and management of health system sponsored physician employment.

Overarching theme: physician led and professionally managed

Hospitals that first employed physicians in the mid 1990s learned the hard way that physician practices underperform when structured as a department of the hospital. Separating the employed physician from a sense of ownership in the practice and failure to align hospital and physician incentives for successful practice performance is a prescription for significant annual financial operating losses and poor physician, staff and patient satisfaction. In short, such arrangements have proven by hard experience to be unsustainable.

A key lesson learned from failed physician employment ventures is that strong physician leadership is vital to success. The philosopher Plato said:

“Those who refuse to take part in the affairs of government are destined to live under the government of unwise men.”

In the context of health system sponsored physician employment, it is imperative that physicians be involved and engaged in the day-to-day management of their practices as well as in key strategic decisions impacting the practice. The best hospital or practice administrator is no substitute for this level of physician engagement.

Those who take the risk will be the managers

A corollary to this theme is that governance, management oversight and financial risk are intertwined. In systems where physicians are compensated based on a guaranteed salary model, and the hospital is charged with management of the practice, the physicians petition the governing body or management for resources. With no incentive to be concerned with any negative impact on financial or internal practice operations, the physicians ask without accountability. In this model, it is the physician's role to “ask” and management's role to say “no.” This is not a good model for physician/hospital alignment.

Health systems that consider physician employment as a legally sound vehicle for aligning hospitals, and physicians in systems that work, demonstrate leading practice. Specifically, the definition of successful physician employment is the ability of the hospital to satisfy community need and to fulfill its mission through appropriate investment in an employed physician strategy. The definition does not extend to total health system control of governance or management of that physician enterprise. This successful approach is characterized by appropriate organizational structure and governance and effectively aligned incentives – both of which are supported by information technology and dedicated talented physician practice management. The organization is professionally managed, but physician led.

In these successful models, physicians bear the brunt of financial risk associated with the operational practice decisions they make. Management's role is consultative, informing physician led decisions based on analysis of comparable data and pro forma illustrations of the impact of proposed decisions on the individual physician and the practice as a whole.

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John Deane is founder and CEO of Southwind Health Partners, a physician practice management and consulting firm serving not-for-profit, tax exempt hospitals, health systems and academic medical centers.

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Corporate structure

Success in physician employment can only be achieved under structures that facilitate joint decision making and that recognize that the physician practice enterprise is a different business than hospital administration. In most situations it is best for the physician employment enterprise to be configured as a separate corporate entity from the hospital. There are many reasons why this is preferable.

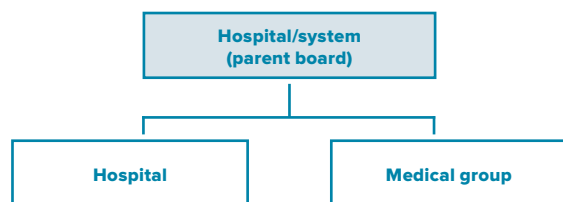
- **Joint Commission accreditation** As a separate entity from the hospital, the physician practices need not be accredited by the Joint Commission. While Joint Commission accreditation is generally accepted as a differentiating factor in hospitals, it is not yet widely recognized as such in the physician practice environment. Moreover, Joint Commission requirements on outpatient clinic operations result in a significantly higher cost structure.
- **Separate tax ID number** It is advisable to arrange for billing physician services under a separate federal tax identification number from the hospital. This avoids the significant accounting effort to separate co-mingled funds between physician and hospital billing and to adjudicate payments and credits appropriately. In addition, billing hospital and physician services under the same tax ID number hampers the ability to produce consistent, reliable, accurate, timely and relevant financial reporting for the physician enterprise at the practice site and for individual physicians.
- **Accountability** Having a separate corporate entity for the physician enterprise facilitates the laserlike focus on practice performance required for success, including physician, management and board accountability. Importantly, a separate entity allows for more formalized governance structures that elevate the role of physician leadership through participation in the decision making powers of boards and committees.
- **Staff compensation and benefits** It is desirable to be able to differentiate support staff compensation and benefits from the hospital. As a unique business enterprise separate from the hospital, physician practices require altogether different job classifications. With regard to employee benefits, it may not be appropriate or necessary for the physician employment enterprise to support employee benefits that are required for hospital-based employees.
- **The 72 hour rule** Since Medicare DRG reimbursement includes a provision that incorporates all outpatient ancillary services provided by the hospital within 72 hours of patient admission, it may be advantageous for physician clinic operations to be separately structured from the hospital in order to avoid such ancillary charges that emanate from the physician enterprise from being subsumed into the DRG payment.

Sister corporation or wholly owned subsidiary of the hospital

When the decision is made to operate the physician enterprise as a separate corporate entity from the hospital for the reasons stated above, then a determination must be made regarding ownership of the enterprise. The two options include incorporating the physician enterprise as a sister corporation of other health system-owned entities including the hospital, or as a wholly owned subsidiary of the hospital itself.

In most cases where the hospital is part of a health system and the health system is able to serve as a parent of both the hospital and the physician entity, this structure is preferable.

Table 1: Sister corporation structure



There may, however, be good reasons for some or all of the employed physicians to be employed within a hospital subsidiary. Most significant among these is the potential benefit of optimizing reimbursement through split billing arrangements whereby patients and payors are billed both a professional and technical

charge for outpatient clinic services. Large, more complex structures may involve some physicians directly employed by the hospital, others employed by a sister corporation as illustrated above, and still others employed by a wholly owned subsidiary of a hospital.

It is important to consult qualified legal counsel – combined with sound analysis of the financial implications – to achieve the best understanding of the advantages and disadvantages of the structural options outlined above.

Physician led and professionally managed regardless of corporate structure

Regardless of the structure adopted, it is imperative that the physician enterprise be governed by a separate board or boardlike body with representation from both hospital executives and physicians. Moreover, whether the physicians are employed directly by the hospital or under the auspices of a hospital-related but separate entity, it is imperative that the enterprise be under the management of a single, dedicated physician practice management infrastructure. The management structure should include a single practice management and physician leadership team, a common information technology platform and other necessary systems, policies and procedures required for consistent and optimum physician practice performance.

Governance: the joint policy board

Recognizing that governance and the alignment of financial incentives are intertwined, and that leading practices place substantial financial risk for physician practice performance on the employed physician, the most effective governance of the physician employment enterprise is through a joint policy board (JPB).

The JPB is typically structured with six or eight members and includes an equal number of hospital or health system executives and employed physician members.⁷ With this membership model, the JPB is positioned to address the vast majority of business issues that will arise within the enterprise. Typical functions of the JPB include:

- Articulate the organization's mission, vision, values
- Represent the interests of the physician enterprise as a whole
- Set policies that reflect vision and values
- Govern, not manage
- Hire, fire, oversee, monitor and guide chief physician and non-physician executives
- Oversee key financial decisions including:
 - Develop, finalize and recommend annual budget
 - Prioritize capital budget
 - Monitor financial and operational performance
- Develop and recommend operating goals and objectives
- Approve physician enterprise policies and procedures
- Prioritize capital expenditures among competing initiatives, including the number and type of physicians required as well as the number and location of practice site facilities

- Oversee clinical performance
- Monitor financial performance through a clinic-specific "Dashboard of Key Indicators":
 - Financial and operating performance
 - Hold management accountable for corrective action if problems are detected
- Verify that financial statements fairly and fully reflect the organization's financial status and that appropriate internal controls are in place

Selection and term of JPB members

Initially, JPB members may be appointed by the parent company (health system or hospital) board of trustees. In more mature organizations the parent company appoints the hospital or health system representatives pursuant to the recommendation of the health system or hospital CEO. Often the physician representatives will be nominated by the physician advisory committee as described in more detail below.

While employed physicians may have the power to nominate physicians to serve on the JPB, nominations are subject to the parent company's approval. In this way, the sponsoring institution retains a "silver bullet" to veto any nomination deemed to be a poor candidate to provide the leadership necessary for a successful physician enterprise.

JPB members are typically appointed in staggered terms of three years so that a minority of members rotates off each year. Longer terms insulate JPB physician members from being voted out annually based on a single controversial decision that may have been made in the best interest of the enterprise but not in the immediate, short term interest of certain physicians.

Reserve powers of the parent board

The parent company board should reserve the following powers and rights which are typically ratified pursuant to the recommendation of the JPB:

- Approval of annual budget
- Approval of capital budget
- Approval of strategic plan
- Approval of physician compensation plan

Employed physicians are prohibited by federal regulations from having the authority to approve their own physician compensation plan. For this reason, the parent board or an appointed committee of disinterested persons is charged with approving the physician compensation plan or any changes over time. However, the physician advisory committee and JPB typically play a vital role in recommending changes to the physician compensation plan.

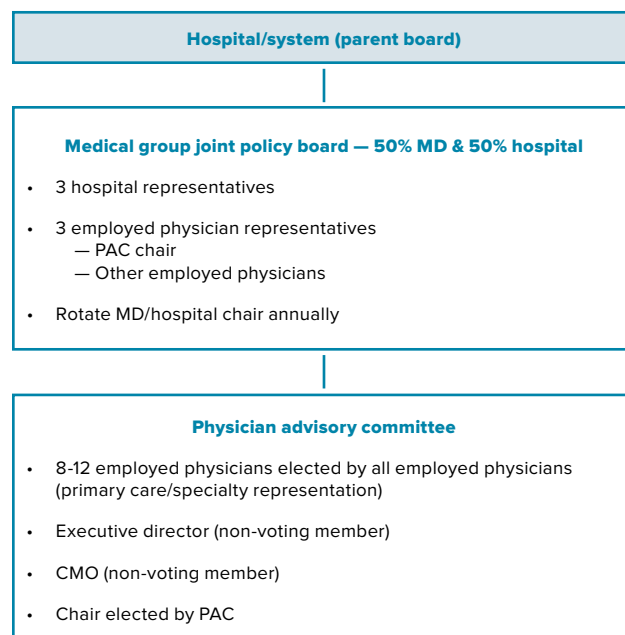
The physician advisory committee

In addition to the JPB, an essential element of governance in the physician employment enterprise is the physician advisory committee. The PAC is typically comprised of eight-to-twelve employed physicians representing the various specialties and practice sites. It is charged with making decisions related to the clinical practice of medicine and with serving as an advisory body to the JPB on business issues.

Key functions of the PAC include, but are not limited to:

- Develop and recommend physician enterprise policies and procedures
- Monitor clinical, quality and physician performance
- Provide input into organizational goals and objectives
- Assist with physician recruitment, and identify and promote physician retention strategies
- Deliberate specific issues at the request of the joint policy board's request (e.g. call coverage, streamlining appointment scheduling processes, clinical "turf" issues between physician specialties, etc.)

Table 2: Joint policy board, physician advisory committee and parent board relationships



Differentiating the role of medical group governance vs. medical staff governance

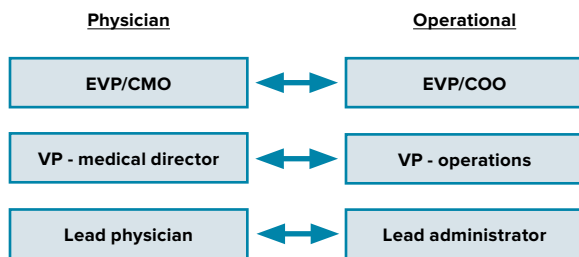
It is important to clearly differentiate the roles and responsibilities of governance for the employed physician enterprise from the traditional medical staff organization. Although the physician employment enterprise is health system sponsored, it should be treated no differently than other private practice groups from the perspective of the hospital's medical staff organization. In particular, physician discipline issues should be addressed by the appropriate governance authority (medical staff-related issues addressed by the hospital medical staff organization and physician practice-related issues addressed by the physician employment enterprise governance structure).²

Management of the physician employment enterprise

Leading health system sponsored physician practices structure the management team of the enterprise as a “management dyad.” A physician leader is paired with a lay administrator at each level in the organization. Depending on the complexity of the position, the physician leader may serve part time in performing administrative responsibilities, thus enabling him or her to also practice medicine.

The physician/administrator dyads are jointly accountable for their specific areas of responsibility. These pairings starts at the top of the organization and may continue down to management of the practice site level with a practice site manager being paired with a practicing physician designated as the “local” physician leader.

Table 3: The physician/administrator dyad

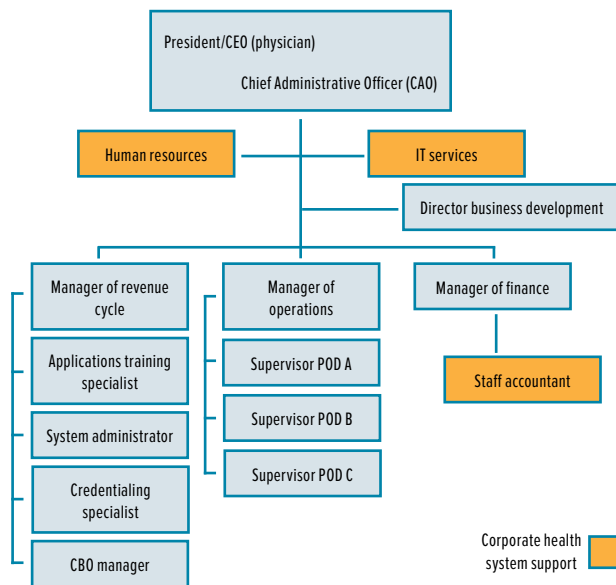


Dedicated management infrastructure

It is essential that the health system recognize that the physician employment enterprise represents a unique business that requires a dedicated management team. Fundamental elements of the employed physician enterprise include the executive director (chief administrative officer or equivalent), finance officer (CFO, finance director or equivalent) and revenue cycle officer (director, manager or equivalent).

Each of these key positions benefits from having an assigned physician leader to form the management dyad.³

Table 4: 30 physician medical group (150 employees)



For organizations supporting a larger number of physicians, additional management talent will be required. This can take the form of a chief operating officer and/or one or more directors of operations. Figures 4 and 5 depict the typical organization charts for a small and large health system sponsored physician enterprise respectively.⁴

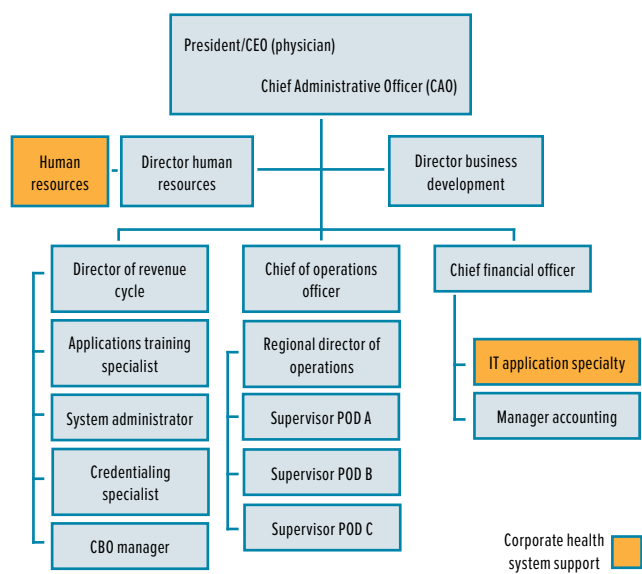
Corporate health system support

The leading practice in structuring the management infrastructure to support physician employment is to resist the temptation to rely on existing health system

or hospital infrastructure. It may be appropriate however to carefully structure some reliance upon corporate resources to support the enterprise, particularly in the areas of information technology and human resources.

Structure carefully any reliance on corporate resources to ensure that the dedicated physician enterprise management team and physician leadership are empowered to operate with a high degree of freedom. Resist the temptation to subject routine operational decisions to hospital administration oversight as this tends to slow down decision making and disempower physicians who are, after all, at risk for practice performance through the physician compensation plan.

Table 5: 150 physician medical group (750 employees)



Of course, to ensure the financial integrity of the physician enterprise and to facilitate the roll-up of financial information to the corporate level, the dedicated finance officer working within the physician employment enterprise will often have a dual reporting relationship to the hospital or health system CFO. However, trouble emerges in cases where members of the dedicated finance team become distracted by corporate priorities that take their focus off of the physician enterprise.

Conclusion

The structure, governance and management of the employed physician enterprise should be designed to facilitate physician leadership supported by professional management. Health system and hospital executives have a role to play in decisions that impact capital and investment, but as much as possible, decisions affecting practice operations and finances should be made at the practice site level. Decisions that impact multiple practice sites should be made by the joint policy board with significant input from the physician advisory committee. Hospital or health system members of the JPB should understand their organization's key governance roles and limitations related to the physician enterprise.

The health system sponsored physician employment enterprise requires a dedicated management infrastructure with individuals qualified and trained to operate a physician practice of significant size. In the same manner that governance is organized to be physician led, the management team should incorporate key physician leaders and professional administrators in management dyads. This approach to governance and management ensures that the enterprise is both professionally managed and physician led.

Health system sponsored physician employment: keys to success

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- Part 5 Metrics and reporting for the physician enterprise
- Part 6 Getting started: building the enterprise through acquisition and recruitment
- Part 7 Putting it all together

Case Study

Organizational structure, governance and management of the physician employment enterprise

**Virtua Health
Virtua Medical Group**

Dr. DiRenzo and Mr. Zuino discuss the rapid growth of the Virtua Medical Group to better serve community need and the dyad leadership model. The two of them share Virtua Medical Group leadership authority and accountability and will also discuss the roles of the VMG Physician Action Committee and the Joint Operating Committee .



Bob DiRenzo, M.D.
Vice President/Medical Director
Virtua Medical Group



Matt Zuino
Vice President, Operations
Virtua Medical Group

About Virtua Health and Virtua Medical Group

Virtua Health is a multihospital system with over 1,000 beds in four acute care hospitals, three ambulatory surgery centers, two rehab and long-term care centers, home care service and a mobile intensive care unit. Virtua is building a 250,000 square foot ambulatory center, a new replacement hospital and a new campus focusing on women care and pediatrics in two new service areas.

There are approximately 2,000 independent members of the medical staff, about 5% are employed in the Virtua Medical Group (VMG). This group has 115 physicians across 25 locations in southern New Jersey. Sixty physicians in the group are in primary care in 16 locations, and more than 55 various medical and surgical specialists practice in nine locations. The group has partnerships with independent groups in orthopedics and spine. The medical group includes Virtua Health hospitalists and neonatologists. VMG began in late 2007/early 2008 with 36 physicians, and in 18 months reached its current size of 115. VMG is expected to grow to 150 or 200 physicians by 2011.

Why such rapid growth in employment?

This rapid growth has been driven by a physician manpower assessment that showed significant shortage five years from now in primary care and specialty care gaps for patients in the communities served by the Virtua system. Southern New Jersey's communities are growing and the age group from 45 years to 64 years old and 65+ is growing. The assessment showed a future shortage of more than 200 primary care physicians and shortages in the specialties of general surgery, obstetrics and pediatrics.

Unlike the physician employment model of the 1990s, the group's growth is motivated by community need and facility and programmatic growth, and its governance model recognizes the value of the group as "physician led, professionally managed." Physician alignment is also seen as critical to deliver necessary care to patients.

VMG mantra: dyad leadership

VMG's leadership model is a partnership between the physician leader and the operational leader. This management dyad must have the responsibility, authority and accountability to effectively manage the physician enterprise and reach specific goals.

This dyad leadership model is mirrored not only in the Virtual Health system but also in VMG down to practice site leadership consisting of a lead physician and lead administrator. At each level, the physician and operations leader share one set of goals and rewards.

VMG physician action committee

Both Dr. DiRenzo and Mr. Zuino see the VMG physician action committee as key to the alignment strategy. The PAC is made up of four primary care physicians, three specialty physicians, and Mr. Zuino and Dr. DiRenzo who co-chair the committee. Virtua Health's assistant vice presidents of operations and finance sit on the committee as ad hoc members. The physician members of the PAC are very engaged in this committee which meets monthly for up to three hours. When the medical group was formed, these physician members were chosen by the system's senior management and by Dr. DiRenzo and Mr. Zuino. Eventually, these positions will be filled through election. The individuals reflect various specialties, primary care and practice locations. Beginning in 2010, the chairs will rotate and individuals will move off and new individuals onto the PAC.

The purpose of the PAC is to develop the policy and procedures of the medical group that are submitted for approval to the joint operating committee described below. The PAC monitors the operational and clinical performance of the Virtua Medical Group. The PAC approves VMG's strategic goals and objectives and takes action to drive necessary change. Subcommittee functions and members are assigned by the PAC.

Examples of policies and procedures developed by the PAC include:

- VMG charity care policy
- Requirement for physician board certification
- Patient no-show response policy
- Patient co-pay policy (pending)
- Patient dismissal policy (pending)

With rapid growth and pressing need to orient many practices into alignment with the Virtua culture, VMG's policies and procedures implemented group-wide are very important.

Several key subcommittees of the PAC include quality and information technology. The quality subcommittee designs and recommends annual clinical performance measurements for each specialty. These clinical performance measurements are reported quarterly to the organization and senior management and then reviewed individually with each physician by the practice site leadership dyad. This subcommittee assesses each of the integrated former practice groups and works with VMG's medical director and clinical nursing director on clinical and operational standardization so patients can experience Virtua's high quality care and commitment. The group also monitors Joint Commission preparedness.

The IT subcommittee, along with the Virtua Health CIO, is selecting a VMG electronic health record to be implemented in early 2010. This subcommittee is accountable for workflow engineering of the groupwide, phased implementation. This EHR also will be the link to independents and specialists to provide seamless care for Virtua patients.

VMG joint operating committee

The joint operating committee is Virtual Health leadership's venue from which to provide oversight of VMG policies and procedures as developed by the PAC. The JOC monitors the operational and financial performance and approves VMG's goals and objectives. In this group Virtua's CMO and COO interface with VMG's dyad management as well as

two members who are primary care physicians and two members who are specialty physician members. Mr. Zuino and Dr. DiRenzo believe senior involvement is key because physician performance and concerns can be seen by system administrative leadership at the highest level.

Structure, compensation, goals and rewards

Virtua Medical Group is a wholly owned subsidiary of Virtua Health with the same tax ID number.

Existing VMG physicians had been on fixed salaries and are moving to production-based compensation. Newly acquired members are placed in fixed compensation for one year based on historic production and then also moved to the production-based system.

The goals and objectives of each management team reward approved PAC goals. The physicians on the PAC and JOC receive a stipend for committee service.

The administrative time compensation for physician leaders reflects the physicians' clinical earning potential as if measured by relative value units (RVUs) but is valued at a greater rate if goals and objectives are achieved. So the upside opportunity is that successful attainment of the goals could exceed what the individuals could earn doing clinical work.

Virtua Health, the VMG and payers

This is the first year that the VMG and Virtua Health are negotiating together on managed health care contracts. A set of criteria was developed by the physicians before any new contract is accepted. This has been an effective engagement tool. Each proposal is reviewed by both the PAC and JOC. It is critical that these contracts have great transparency to both the hospital and medical group so there is no suspicion that the "doctors have been sold out" in terms of the contract for the benefit of the hospital.

VMG has a standardized tool to measure referrals, clinical quality and patient satisfaction performance. VMG does not send out mandates to "refer in the group". In fact, sending mandates harms the credibility of the group's specialists to whom patients are being referred. The groups specialists earn their colleagues referrals by their quality and responsiveness. It is critical that specialists within the group are held to a very high performance standard.

VMG does not have any supplemental retirement plan beyond the 401K.

Virtua Health sees physician employment as one of the menu choices in partnering with physician practices. The VMG leadership team is also responsible for all strategic support to the partnered independent practices.

Lessons learned

The two biggest keys to successful health system and medical group alignment is the willingness of the hospital leadership to really embrace the joint operating model of hospital and physician led medical group and the creation of the appropriate structure that operationalizes that alignment. If the large organization is just paying lip service to physician empowerment, physicians become disengaged. The key is empowering physicians to make decisions and be accountable.

Leadership development and succession planning for physician leaders is a necessity and is done not only in an informal way but also with development plans and education for each individual future leader.

This case study is summarized from comments by Bob DiRenzo, MD, and Matt Zuino on June 9, 2009 as part of the 2009 VHA CEO Affinity Group teleconference series.

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End notes

1. It is not advisable to have non-employed, private practice physicians incorporated onto the JPB. The governance concept being applied here is “physician led” and “self-governed” means that physician leaders should be identified from among the ranks of employed physicians.
2. In certain situations, an egregious physician discipline issue may require action by both the hospital’s medical staff organization and the health system sponsored physician practice enterprise. The key here is to keep the lines clean in terms of limiting the medical staff organization to issues that pertain to its mission and bylaws while ensuring that the employed physician enterprise addresses issues that any medical group would address in the course of day-to-day business.
3. Even in the case of the medical group CFO or finance director, there is value in assigning a corresponding physician leader to work along side the finance officer. In many organizations, the lead physician on finance also serves as chair of the finance committee, for example, engaging a small group of physicians to review financial performance and reporting.
4. For simplicity, in these organizational chart illustrations, the physician leader/administrator dyad is illustrated only at the CEO/CAO level.