As chairman of the board at Renown Health in Reno, Nev., David Line is keenly aware that the Affordable Care Act requires a transformation in how his multihospital system operates. But traditional hospital leaders alone cannot drive the changes needed to create a model in which value takes precedence over volume. The effort requires a dramatic increase in the participation of physicians at executive and service delivery levels to help hospitals and systems work through the multitude of choices and make the best decisions.

“If we are going to impact the way things are being funded and reimbursed, we have to focus on the delivery of health care services,” Line says. “Doctors deliver health care and they can help us decide what our new best practices and processes should be.”

The need for greater medical expertise isn’t the only reason to bring more physicians into decision-making. “Any successful changes made within a health care system will have to be driven by doctors because physicians listen to other doctors,” Line notes.

Renown’s interim chief executive Donald Sibery agrees. “Hospitals and health systems cannot be successful unless they embrace physician leadership at all levels,” he says. “[Management’s] focus needs to change from traditional hospital-focused to physician-focused, with joint or shared responsibilities.”

**Docs in the C-Suite**

Until recently, the participation of physicians on hospital boards largely was limited to clinical operations. What’s changed is that hospitals and systems are now seeking ways to more directly engage medical practitioners in determining how the organization delivers health care under the ACA.

Many organizations have opted to recruit private practitioners directly into administrative positions where they can participate in decision-making. But the transition can be rocky due to differences in how doctors and executives work and the scale of managing a small office versus being part of a large hospital bureaucracy.

Many of the physicians who are migrating to the C-suite have been leaders in their own practices and are accustomed to independence. Along with having little experience working collaboratively, they may also lack some traditional management skills.

“You are transitioning from being the solo leader and problem solver in your practice to a group or shared decision-making process,” says Brian Callister, a physician and national medical director of the LifeCare Family of Hospitals, Plano, Texas. “Physicians expect quick action, not slow committee work. It is a shock to them to go from individual to team.”

Their challenge, he says, is learning to listen more and to manage people and processes, [instead of being] solo problem solvers.” To address this issue, some organizations have offered opportunities for coaching, training and mentoring programs to incoming physician leaders. But many physicians resist any implication by the existing leadership team that they are not fully prepared for the task.

Their mutual frustration hurts their prospects for working together, as well as an organization’s ability to retain doctors in management roles for more than a few years.

Compensation is another issue. Typically, physicians who join the C-suite have an expectation of higher compensation than other managers due to their medical education. When hospitals and health systems set physician-executive compensation above normal ranges, however, it can create a large gap in pay.

“I have seen physician compensation at the C-suite level exceed that of the CEO,” says Renown’s Sibery. He adds that Renown is addressing this situation by migrating to a more mar-
A market-based approach to pay, in which physician executives create their own market value, distinct from what they could earn in their clinical practices. Another approach involves the use of long-term incentives to span the gap between executives and physician executives and to drive the sustained efforts required to provide coordinated, effective care that is more affordable.

An Alternative Model
Given the challenges of turning clinicians into full-time managers, Renown recently launched an innovative, alternative approach to integrating physicians into decision-making at all levels of the organization: It established a physician collaboration committee of the board of directors. Line says the PCC’s goal is to serve as a vehicle for meaningful community collaboration, focused on initiatives from Renown’s board around patient care and community and population health issues.

“We did not want to duplicate other efforts that were mostly operational — we needed a think tank to help the board develop strategies for the next five to 10 years,” Line explains. “The committee provides us with input about what we need to do as a health system to move ahead with this new reimbursement model.”

Launched in 2013, the group is positioned as a standing committee under the board’s bylaws and charter, meeting monthly and reporting to the full board and its medical executive committee. It comprises 16 physicians, plus the board’s vice chairman and interim CEO Sibery, and is chaired by a physician board member. Line said the employed and independent physicians on the PCC were selected with an eye to having representation from as many medical disciplines as possible. Renown also assigned a dedicated staff person with a doctoral degree in nursing to help support the PCC’s work — an institutional commitment that Line considers essential to its success.

Renown’s leaders also believe it is critical to the committee’s credibility and effectiveness that its operations be perceived as transparent, open and collaborative. For instance, the PCC puts out a monthly newsletter about its work to help establish good lines of communication with the physician community. The PCC also will provide the board with at least one written report annually on its activities and recommendations. So many physicians responded to the invitation to participate in the PCC that a three-year term limit was established to ensure the broadest participation possible.

One of the committee’s first initiatives is addressing electronic health record integration. Renown has an EHR, but its facilities also are used by community physicians who may not use the same system. Line says sharing data has been difficult and the PCC is working on finding ways the different systems can communicate better.

“This is what we need in order to succeed, so we need the doctors working together,” he says.

Another key project is Renown’s pending accountable care organization application. “If we can be named an ACO, this committee will need to understand how an ACO will work, including what processes work and which don’t,” Line says. Once the PCC has full buy-in, “we can then take that input and use it as a platform to discuss it with other physicians.”

Renown’s board and the Nevada School of Medicine jointly have created a stand-alone strategic steering committee comprising physicians, trustees and executives from the university, medical school and the health system. The steering committee is responsible for identifying opportunities to enhance the delivery of health care services in Nevada.

Without the PCC in place, Line says, making progress on these efforts likely would have been much more difficult. “There would be distrust and lack of understanding from both sides,” he said. “People don’t like change, and none of us has any choice but to change in this new environment. The physician collaboration committee can help us to maneuver through this complex process.”

He sees the PCC as a foundation for the future success of Renown. “This is a new type of partnership — one that clearly advocates for community success,” says Line. T

Steven T. Sullivan (steven.sullivan@pearlmeyer.com) is vice president, Pearl Meyer & Partners LLC, Houston, and Joseph E. Jasmon (jjasmon@lasallegroup.com) is chief operating officer of the LaSalle Group Inc., Irving, Texas.