HAND IN HAND

VHA's physician leadership builds a bridge between 'suits' and 'coats'

By Neil Versel

For more than a decade, VHA, the national hospital purchasing cooperative, has been sold on the idea that effective physician leadership can improve staff morale, clinical performance and, ultimately, a healthcare provider's bottom line.

"We've bet the ranch on medical leadership," says Ken Smithson, M.D., VHA vice president for integration services.

Today, for example, the VHA National Physician Leadership Council boasts about 150 members drawn from the co-op's network of 2,200 affiliates nationwide. The council, open to any CMO in the network, meets three times a year. Its members work on skill-building, catch up on national issues and take part in "lots of networking," says Stuart Baker, M.D., VHA executive vice president for clinical affairs.

But the emphasis on physician leadership goes back as least as far as 1991, when C. Thomas Smith became president and CEO of Irving, Texas-based VHA. (He retired at the end of last month.)

Glenn Bingle, M.D., senior vice president for medical and academic affairs at Community Hospitals, a VHA affiliate with five acute care facilities and 1,800 physicians on the east side of Indianapolis, recalls writing to Smith and suggesting that physicians needed to be more involved in leadership.

"He did act on that," Bingle says.

Soon after, VHA formed the council, starting with about 25 CMOs and vice presidents of medical affairs. The co-op then reached out to other hospitals to educate physicians about it, according to Baker, who was among the first wave of physician executives hired at VHA headquarters in 1994.

"Physician executives at the time had neither the peers they could turn to nor a group other than the nonclinical leadership," Baker recalls.

Taking its cue from the council, Winston-Salem, N.C.-based affiliate Novant Health in 1994 initiated a "joint practice team" for performance improvement. Each medical staff—such as specialty departments and nursing—has a representative on the team. The system also has a multidisciplinary team for each condition treated.

"It's far more nimble than having 40 doctors meet," says James Lederer, M.D., medical director for performance improvement for the six-hospital Novant system.

The teams make decisions, then go back to the staff with suggestions, or the staff can suggest changes to the teams. The decision ultimately lies with the medical staff leadership.

VHA officials in suburban Dallas have taken note of programs like this. Given the decentralized structure of the purchasing cooperative, leadership ideas mostly come from member organizations.

"Ultimately, VHA doesn't set the agenda for its members. It's the other way around," Smithson explains.

Still disconnected

VHA has "recognized that there is something fundamentally flawed with how we manage the healthcare system," according to Martin Merry, M.D., of Exeter, N.H., a longtime consultant in the areas of clinical quality improvement and medical staff leadership. "The administrative side of the house has recognized that they needed to have a dialogue with clinicians."

Nevertheless, VHA still faces an uphill battle for effective physician influence at many of its affiliates. In a major study of CMOs and rank-and-file physicians on hospital staffs last year, the co-op found there was a profound disconnect between medical staffs and administrative leaders, including physician executives.

"Physicians on the voluntary medical staff see both the healthcare organizations' and their own leaders as mediocre at best," says the report, pointedly titled "Medical Staff Organizations: The Forgotten Covenant."

The survey of 87 CMOs and vice presidents of medical affairs and 418 staff physicians at VHA-affiliated hospitals showed that 52% of the organizations either had recently restructured their medical staff organizations or planned to do so soon. Of those that did make changes, 92% reduced the size of their physician executive committees, 84% reduced the number of departments and 76% shifted responsibility for performance improvement to the CMO and hospital.

Stuart Baker, M.D., VHA executive vice president for clinical affairs (left); and Ken Smithson, M.D., VHA vice president for integration services

Photo by Bob Kramer

VHA also found a "significant drop-off in support for decisions made by the physician executive committee," the study says.

"It would appear that no single segment of the healthcare sector has effectively positioned itself as an effective advocate for the physician's business needs," VHA reported.

VHA concluded in its survey report that performance improvement efforts must be integrated with other operational functions, and that it takes physician executives to make that happen. But that state of grace is still not the norm, according to physician executive John Anderson, M.D., senior vice president for clinical integration at VHA affiliate Baylor Health Care System in Dallas.


Anderson

"The organizational infrastructure of hospitals traditionally does not function this way," says Anderson.

Administrations and medical staffs still tend to butt heads, "a very old and suicidal model," he adds.

Grateful for physicians

Lederer, who leads 2,000 physicians at Novant, says he is grateful for the "value of the leadership that comes from physicians."

"Our organization has always felt that the value of medical staff leadership is incalculable," Lederer says. "Our performance-improvement structure has always been physician-directed."

The same holds true for Bingle: "I work for the administration, but I also work for the medical staff." Doctors, he says, "have to feel empowered to do things. If you aren't working for them, they may think you are working against them."

The medical teams at Novant Health are in the early stages of working on a long-range clinical vision, according to Lederer. He says they hope to find answers to questions such as: "What will we look like in 2007?" and "What will we need (from the medical staff) to help us get there?"

Lederer says top administrators "recognize that our fates are tied hand-in-hand," more so for the physicians with a heavy in-hospital practice. "It will always be that core group that leads the charge."

Says Lederer: "Whither our physicians go, so go we." ■

Staying connected

Traditionally, American healthcare has had a "two-silo culture," with administrators kept separate from physicians, says Martin Merry, M.D., of Exeter, N.H.

Merry, a medical staff leadership consultant, says leaders—no matter what the industry—commonly make the mistake of understanding what they need from others without understanding what others need from them.

In the context of health systems, hospital executives "tend to be not comfortable around physicians . . . and physicians tend to be suspicious of administrators," Merry says. "They need to open communication lines."

Many leaders of the 2,200 hospitals aligned with the VHA follow its doctrine of promoting healthy relationships between those who wear dark suits and those who wear white coats.

"You need to keep docs engaged," says James Lederer, M.D., medical director for performance improvement at Novant Health, a VHA member in Winston-Salem, N.C. "Docs tend to be disengaged, and the administration doesn't do enough to bring them back. There's a disconnect. When there is no engagement, there is a lack of trust."

In February, Indianapolis-based Community Hospitals, a VHA affiliate, opened the much-publicized Indiana Heart Hospital. The "all-digital" specialty hospital came to fruition because administrators listened to a group of cardiologists who saw the benefits of electronic medical records, according to Glenn Bingle, M.D., senior vice president for medical and academic affairs at Community.

With both medical and administrative leadership sold on the idea, other physicians on staff bought in as well.

"It would be impossible to do it without" medical leadership, Bingle says. "The administration is not affected by this technology, but the physicians are."

Physicians, of course, have a longstanding reputation for being technophobic, but VHA is helping on that front with HEALTHvision, a company it spun off three years ago.

In addition to being the technology behind the LaurusHealth consumer health content that is integrated into the Web sites of more than 800 hospitals. HEALTHvision provides physicians with a purchasing portal and a reference tool for clinical care.

"We have this out there for hospitals to use to get their physicians using technology. It becomes a very easy way for them to get their doctors online," says Jonathan Teich, M.D., CMO of HEALTHvision and an attending emergency physician and medical informaticist at Brigham and Women's Hospital in Boston.

"We care also about how we can improve clinical quality. We want to make sure doctors have the right information and access, (both) in the hospital and remotely," Teich says.

-N.V.

VHA leadership campaigns for quality

By Neil Versel

Since the late 1990s, with a base of physician leaders firmly in place among its member hospitals, VHA has proselytized for clinical quality improvement initiatives.

"Three or four years ago, we would have gotten blank stares" when mentioning the need for quality improvement, says Stuart Baker, M.D., executive vice president at VHA. "Now there is uniform acceptance. I've seen this sea change myself in just a few years, and that's encouraging."

Today, about 97% of the 471 shareholder and partner organizations that make up VHA participate in the Irving, Texas-based cooperative's clinical quality programs.

David Nash, M.D., director of the health policy office at the Jefferson Medical College of Thomas Jefferson University in Philadelphia, says the American College of Physician Executives, of which he is a member, "owns" the concept of physician business leadership.

But "VHA has adopted and implemented this strategy," Nash says.

"To be successful at the national level, an organization needs to promote physician leadership and support it appropriately," Nash says. "VHA, to their credit, has done that. VHA knows that good hospital-physician relationships are linked to better quality."

Relieving patient distrust

VHA supports its members' clinical improvement efforts with the Center for Research and Innovation, its in-house research arm that identifies and analyzes issues of concern for its member hospitals.

Their latest research points to an increase in patients' distrust of healthcare providers.

"This is a trend we've been seeing for the last four or five years" as the population has aged, says Ken Smithson, M.D., vice president for integration services at VHA. "Baby boomers are demanding more and want to be part of the decision process."

He says a VHA focus group found that 96% of those born between 1946 and 1964 are "very much aware of the medical error issue."

According to Baker, the healthcare system is disjointed. He says there needs to be more linkage between hospitals, physicians and consumers—a group that includes patients and their families.

Marc Edelman, Clinic Effectiveness Award winner (left), with Stuart Baker, M.D.

Photo by Bob Kramer

One way VHA seeks to bring these disparate pieces together is through two technology ventures, LaurusHealth and HEALTHvision.

LaurusHealth is a consumer healthcare information Web portal as well as the publisher of consumer-centric content for the Web sites of 820 hospitals. HEALTHvision provides much of the technological infrastructure supporting LaurusHealth, including the operation of VHA hospital Web sites and online portals used by more than 15,000 physicians.

"Our strategic niche is to bring the clinical piece, the business side and consumer needs to kind of that 'sweet spot,'" Baker says. "It's about the best care for the patient every day."

Bingle

A little more than three years ago, VHA formally brought top hospital management in on quality improvement by forming the CEO Workgroup for Clinical Excellence—actually a number of workgroups, each concentrating on a specific clinical area, and open to others besides CEOs.

"These are collaborative groups that work over a period of three or four years," Smithson says.

Membership is controlled at around a dozen hospital executives per group "to maintain intimacy," Baker says. After the meetings, the leaders return to their own hospitals and team up with physician executives to implement the ideas they've discussed.

"Every time we work on one of these programs, we assemble an expert clinical panel that's primarily physician-driven," says Marc Edelman, vice president of the four-hospital Crozer-Keystone Health System, Upland, Pa., and a member of a CEO workgroup.

Crozer took home a national award for clinical effectiveness at the annual VHA Leadership Conference in Boston last month for its 2-year-old program in evidence-based medicine.

Current CEO workgroups are looking at adverse medical events, medical error prevention and infection reduction, areas now being emphasized by CMS and the Joint Commission on Accreditation of Healthcare Organizations.

"Why not be good at the things that you are going to have to report?" Baker says.

One part of a yearlong program of the CEO initiative on transforming intensive care units was pain management. The CEOs sought out data on clinical performance to communicate to physician leaders their desire to concentrate on this area.

"We found that many hospitals weren't even recording pain scores," says Smithson. "Starting to pay attention alone led to dramatic improvement in just a week."

VHA determined that following this and other protocols on treating patients in intensive care potentially can save 47 lives and $3.1 million per 1,000 ICU admissions at the hospitals it studied, Baker says.

"Two secrets (to a successful clinical improvement plan) are involving physicians and involving leaders," Baker says.

> **"We collaborate with other institutions around the country. The docs get to talk with other docs whom they are not competing with."**

Tracking tech

Even though the CEOs have ended their ICU focus, VHA leaders continue to monitor healthcare information technology and report their observations to members.

"We follow the vendors very closely to watch the efficacy of their products in our hospitals," Baker says.

For example, Smithson says physician leaders in the national office outside Dallas are tracking installations at VHA member hospitals of bar-coding technology for medication administration from Bridge Medical and the eICU virtual intensivist program offered by Baltimore-based vendor Visicu.

Community Hospitals, a five-hospital system in Indianapolis, worked with the CEO Workgroup for Clinical Excellence on the ICU program, but it also has taken advantage of its affiliation with VHA to network with other healthcare provider organizations it might not otherwise contact.

"We collaborate with other institutions around the country," says Glenn Bingle, M.D., Community Hospitals' senior vice president for medical affairs. "The docs get to talk with other docs whom they are not competing with."

When Community's physician leaders share strategies and stories with their counterparts in other markets, Community's staff performs better, Bingle says.

Involving physicians in quality planning has paid tangible dividends for the system, improving the care of diabetics and post-operative open-heart patients, two areas of disease management VHA has stressed, according to Bingle.

Community Hospitals also uses clinical quality data to develop standardized protocols to aid decisionmaking at the point of care, he says.

These programs, as well as current efforts at Community to adopt computerized physician order entry, bar coding and other technology to automate the clinical process, have firm roots in the VHA philosophy of empowering physicians to lead, Bingle says.

For Community, this empowerment goes back nearly 15 years, when the medical staff had a voluntary leadership that rotated annually and, thus, was ill-equipped to tackle long-term projects. One of them was a program to address "some surprises in the quality arena . . . issues of malpractice," recalls Bingle.

The Indianapolis system adopted a VHA model and gave Bingle more authority to act. He initiated a systematic review of each physician's claims history and incorporated it as part of the credentialing process. "Those initial (quality) problems resolved themselves over a couple of years," Bingle says.

According to Smithson, this demonstrates that healthcare organizations can indeed overcome the incentives not to provide quality—such as payments based on visits and procedures, not outcomes—that pollute the system today.

"Even in the face of this toxic environment, you can deliver quality care," Smithson says. "Times like these call for leadership." ■

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