Session 51AB
Culture: The Silent Killer of Successful Physician-Hospital Integration

Presented by:
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Culture: The Silent Killer of Successful Physician-Hospital Integration

Disclosure of Relevant Financial Relationships

The following faculty of this continuing education activity has no relevant financial relationships with commercial interests to disclose:

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- Thomas Whalen
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• Thomas Whalen, M.D.

Learning Objectives

• Develop strategies to better onboard physicians into your organization and discover the nonfinancial factors to consider when integrating physicians into your organization.
• Discover the warning signs that a healthcare organization is having difficulty assimilating cultures and develop strategies to help better manage your culture.
Agenda

• Review failed mergers and acquisitions
• Diagnosing your culture
• Supporting your desired culture
• Onboarding physicians
• Physician leadership
• Case study – our experiences
Major Mergers Killed By Culture

AOL/Time Warner

In January of 2000, Time Warner stock sold for $71.88. By 2008 you could buy a share of Time Warner for less than $15. What happened to the media giant? A failed $350 billion merger with AOL. Culture clash was widely blamed for the failure of the joint venture. Said Richard Parsons, president of Time Warner: “I remember saying at a vital board meeting where we approved this, that life was going to be different going forward because they’re very different cultures, but I have to tell you, I underestimated how different... It was beyond certainly my abilities to figure out how to blend the old media and the new media culture.”

HP and Compaq

And finally, a story of hope. In 2001, struggling computing giant Hewlett Packard announced it would acquire similarly struggling competitor Compaq. The merger was ill-fated from the start, as critics pointed out how the HP engineering-driven culture was based on consensus and the sales-driven Compaq culture on rapid decision making. This poor cultural fit resulted in years of bitter infighting in the new company, and resulted in a loss of an estimated 13 billion dollars in market capitalization. Though the merger itself was widely regarded as a failure, the company has hung on, and has been able to make significant cultural and leadership changes that have resulted in long-term success.
Major Mergers Killed By Culture

Penn State and Geisinger

The cultures of the two merged systems were extremely different. While Graham Spanier, the president of Penn State had been quoted in news reports as saying, “The similarity of cultures between Penn State and Geisinger is another strength in the relationship we are proposing,” his optimism quickly dissipated. HMC’s style of collective governance by cooperating with independent and strong academic departments clashed with Geisinger’s style of managing full time, salaried physicians in a multispecialty group practice.

Current Behaviors

Belief Structure

Fundamental Organizational Assumptions
• What are your values and beliefs?
• Are they consistent with your operating procedures?
• Organizational stories | myths
• What do your patients experience?

Your Experiences

1. Can you think of one of your stated values/goals/patient promise that is **not** consistent with your actual patient experience?
Warning Signs: Obstacles to Change

1. Complacency
2. Ineffective communication strategy
3. Failure to involve and engage physicians - strategy
4. Failure to address change vampires
5. MMM | Middle Manager Meltdown
6. Lack of shared vision and values
7. Failure to hold accountable

Your Culture: Diagnosis

- Is your organizational culture different in the hospital compared to your physician enterprise?
  - Hospital Culture (decision making, communication, leadership)
  - Medical Group Culture
What is your culture?

Organizational Culture Template

FLEXIBLE
COLLABORATE
INTERNAL

FOCUSED
CONTROL

EXTERNAL
CREATE

COMPETE

Diagnose your culture

Clan
Flexible
Values cohesion, participation, communication, a personal place, like a family; mentoring, nurturing, tight social networks

Adhocracy
Stable
Dynamic, entrepreneurial; people take risks; values innovation, adaptability, growth, innovation, cutting-edge services or products

Hierarchy
Favors structure & control; coordination & efficiency; stability is important, efficiency, timeliness, smooth processes.

Market
Inward
Results-oriented, getting the job done; values competition & achievement, customer-driven, achievement

Focus
Outward

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Hospital vs. Medical Group Culture

Create the Dyad – physician/administrator teams

<table>
<thead>
<tr>
<th>Administrative/Operational</th>
<th>Physician</th>
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<tbody>
<tr>
<td>CFO/COO/VP</td>
<td>VPPE</td>
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<tr>
<td>Executive Director</td>
<td>Medical Director(s)</td>
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<tr>
<td>Practice Managers/Leads</td>
<td>Site Medical Leads</td>
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Organizational Structure Alternatives

**Hospital Focused**
- CEO
- COO
- Group Administrator

**Dyad: Hospital & Physician Directed Management**
- CEO
- COO
- Group Administrator
- VP Physician Enterprise

The dyad leadership model often helps to address issues of trust and serves as a bridge to stronger relationships while aligning culture, business and clinical aspects of integration.

Structure to Support Culture

- Hospital CEO
- VPPE
- Doctors in Medical Groups
- VPMA/CMO
Seven Signs your Culture is Sick

1. Isolation prevails. Leaders and employees work in silos (departmentalism).
2. CYA dominates. The first thing people think about when something goes wrong is how to cover their axxx. Translation: “Who can we blame?”
3. Gravy stays at the top. Leaders keep the good jobs for themselves and delegate the garbage to everyone else.
4. Gossip is endorsed. I’ll never forget a leader endorsing the practice of talking about people behind their back under the guise of confidentiality.
5. Secrets abound. Organizations that need secrets have too many inequities – nobody talks about what really happened.
6. Politicians prevail. When brown-nosers, butt kissers, and credit-stealers prevail, self-serving and mediocrity wins.
7. Developing people is an inconvenience.


Seven Signs your Culture is Healthy

1. Organizational success trumps personal success. Team members commit to do what’s best for their team and organization. It’s time to leave if what’s best for the organization isn’t also good for you.
2. Elephants dance. Healthy cultures discuss tough issues with optimism, toughness, and kindness.
3. Diversity abounds. Cross-functional teams, diverse age groups, and the presence of female participants is expected and normal.
4. Open minds win. Alternatives are invited, honored, and explored. Teams committed to one solution can’t adapt as they go.
5. Leaders lift others. The spotlight points to performance not position in healthy organizations.
6. People know and respect each other’s strengths. One of the best things you can do for your team is to publicly discuss results.

How do you Ensure Success?

1. Match your strategy and culture
2. Focus on a few critical shifts in organizational behavior
3. Build the culture with small wins/projects to work together (co-management models, dyads, committees, JVs, etc.)
4. Make sure your managers are onboard
5. Monitor and measure the cultural evolution
   - Performance  (Creative Quadrant – Mobile access to scheduling appts.)
   - Behaviors  (Collaborative Quadrant – shared decision making to develop a joint venture surgery center)
   - Celebrate Milestones
   - Underlying beliefs

The importance of onboarding physicians

- Models of integration
- Increasing employment
- Physician development and leadership
- Formal and informal training
- Understanding the big picture
- Physicians and costs – MACRA
TYPES OF PHYSICIAN MODELS IN COMMUNITY HOSPITALS

- Integrated salary model: 45%
- Open physician-hospital organization: 15%
- Management service organization: 11%
- Medical foundation: 6%
- Independent practice association: 12%
- Group practice without walls: 4%
- Equity model: 2%
- Closed physician-hospital organization: 5%

Statistics on hospital-physician alignment models, based on the 2015 edition of AHA Hospital Statistics. Note: Data are from 2012 and based on 4,999 community hospitals.

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U.S. Physician Practice Ownership (%)

- Physician-owned
- Hospital-owned

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The Millennial Physician

- Diverse
- Time off is valued
- Volunteerism decreasing
- Communication
- Team based care
Practicing Physician and Physician Leader

• Doctor ⇔ Patient
• Advocate for the Practice
• Captain of the Ship
• Independent

• Doctor ⇔ Many
• System orientation
• Delegator
• Participative
Leadership Programs Abound

LVHN & USF SELECT

- Scholarly excellence
- Leadership experiences
- Collaborative training
Physicians and Costs

- Clinical care variation
- Competing priorities
- MACRA
- Risk programs
- Population health

**Advanced Alternative Payment Model (APM) List:**
The following models meet the criteria to be Advanced APMs in the 2017 performance year:
1. Medicare Shared Savings Program Track 2 Accountable Care Organization (ACO)
2. Medicare Shared Savings Program Track 3 ACO
3. Next Generation ACO
4. Comprehensive End-Stage Renal Disease Care Model
5. Oncology Care Model (two-sided risk agreement)
6. Comprehensive Primary Care Plus

**Qualifying Advanced APM Participant (QP) Steps:**
Clinicians must meet the following criteria in order to be deemed a QP:
1. They must practice within an Advanced APM
2. They must be on the Participation List of the Advanced APM Entity by August 31 of the performance year
3. All clinicians, in aggregate, in the Advanced APM Entity must meet certain practice thresholds (in 2017, at least 25% of Medicare payments or 20% of Medicare patients through the Advanced APM)

**MIPS APM List:**
The following models meet the criteria to be "MIPS APMs" in the 2017 performance year, offering MIPS reporting and scoring benefits to participating clinicians:
1. Medicare Shared Savings Program Track 1 ACO
2. Medicare Shared Savings Program Track 2 ACO
3. Medicare Shared Savings Program Track 3 ACO
4. Next Generation ACO
5. Comprehensive End-Stage Renal Disease Care Model
6. Oncology Care Model (one or two-sided agreements)
7. Comprehensive Primary Care Plus

**MIPS Exclusions:**
Aside from participating in an Advanced APM, clinicians will only be excluded from MIPS if:
1. They fall below the low-volume threshold of $30,000 in Medicare Part B allowed charges or 100 Medicare Part B beneficiaries
2. They are in their first year of participating in Medicare Part B

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**MACRA Decision Tree for Clinicians**

**Subject to MIPS:**
- Am I in an APM?
- Am I excluded?
- Do I want to report?
- Am I a "QP"?
- Do I want to be in MIPS?
- Do I want to report complete or partial data?
- Am I in a MIPS APM?
- Is my MIPS score & larger payment adjustment likely?

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**MIPS Exclusions:**
- No MIPS payment adjustment & excluded from MIPS
- Better MIPS score & larger payment adjustment likely
- Complete or partial data
- No MIPS payment adjustment
- Complete or partial data
- No MIPS payment adjustment
- Complete or partial data

**MIPS APM List:**
The following models meet the criteria for "MIPS APMs" in the 2017 performance year, offering MIPS reporting and scoring benefits to participating clinicians:
1. Medicare Shared Savings Program Track 1 ACO
2. Medicare Shared Savings Program Track 2 ACO
3. Medicare Shared Savings Program Track 3 ACO
4. Next Generation ACO
5. Comprehensive End-Stage Renal Disease Care Model
6. Oncology Care Model (two-sided risk agreement)
7. Comprehensive Primary Care Plus
• 5 Campuses
• 1 Children’s Hospital
• 160 Physician Practices
• 17 Community Clinics
• 14 Health Centers
• 11 ExpressCARE Locations
• 81 Testing and Imaging Locations
• 14,361 Employees
• 1,496 Physicians
• 642 Advanced Practice Clinicians
• 3,140 Registered Nurses
• 57,801 Admissions
• 208,882 ED visits
• 1,236 Acute Care Beds
Lehigh Valley Health Network

- Onboarding
- LVPG Orientation
- Institute for Healthcare Leadership
- Advanced degree sponsorships
- Rigorous succession planning

Summary

- A strong, relevant culture is foundational to organizational sustainability
- Most of the work to be done is below the water line
- This is a full looped process
- Patience is a pre-requisite
Speaker Bio

Nick Fabrizio, Ph.D., FACMPE, FACHE, is a Principal with the Medical Group Management Association’s Consulting Group. Dr. Fabrizio has over 25 years of health system experience in medical group practices, for-profit and non-profit hospitals, academic medical centers, physician faculty practice plans, as well as ambulatory care networks. His primary expertise is helping align the interests of physicians and hospitals to optimize business and operational performance while achieving financial, quality, service, and market goals.

Dr. Fabrizio currently serves on the faculty at Cornell University in the Sloan Graduate Program in Health Administration where he teaches Management and Organizational Behavior and Human Resource Management. In addition, Dr. Fabrizio served on several Boards including the New York State Medical Group Management Association where he served as President, and was the Regent for the American College of Healthcare Executives serving the New York Empire Area. He is an author of numerous publications and frequent speaker at national conferences. He has published the books, Goals into Gold: Strategic Planning for Healthcare Professionals, Integrated Delivery Systems: Ensuring Successful Physician-Hospital Partnerships, and two chapters in the 2014 book, Strategies for Value-Based Physician Compensation, published by MGMA.

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Speaker Bio

Tom Whalen, MD, MMM, CPE, FACHE received his AB and MD degrees from Boston University. In 1999 he completed a Masters of Medical Management at the H. John Heinz III School of Public Policy and Management of Carnegie Mellon University. Doctor Whalen became Chairman of the Department of Surgery at Lehigh Valley Health Network in Allentown, PA in September of 2006 after 17 years on the faculty of Robert Wood Johnson Medical School. He assumed the Chief Medical Officer position at LVHN in April of 2011. He retired from the US Naval Reserve in February of 2001 after twenty-eight years as a commissioned officer in the medical corps of the Regular and Reserve Navy. He has certified and recertified in the disciplines of General Surgery and Pediatric Surgery.

Doctor Whalen is Past President of the Association of Program Directors in Surgery and was elected a Regent of the American College of Surgeons in 2003 serving three terms to 2012. In October of 2010 he was elected Vice-Chair of the Board of Regents. He served on the Board of Directors of the Political Action Committee of the American College of Surgeons Professional Association from its inception in 2003 through 2009, and became Chair of the Residency Review Committee for Surgery in July 2008 serving until 2011. He was a member of the Council of Medical Specialty Societies and also on the Board of Directors of the NRMP where he was President. Upon becoming CMO in 2011 he joined the ACHE and recently became board certified in management as a Fellow of the ACHE. Doctor Whalen and his wife Elaine have three sons and two grandsons.

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Bibliography/References