Case J
Where the Rubber Hits the Road: Physician–Phelps Hospital Relationships

Anthony R. Kovner

As professor of healthcare management at New York University/Wagner, I was invited by Phelps Memorial Hospital Center's CEO Keith Safian to visit the hospital in 2010 and review the impact of Medicare and potential health reforms on hospital–physician collaboration.

Competitive Position of the Hospital

Phelps is a community hospital of 235 beds, operating at 70 percent occupancy. Inpatient services include medicine, surgery, psychiatry, obstetrics, pediatrics, and physical rehabilitation. Two units of mentally ill chemical-abuse patients operate at 97 percent occupancy. Pediatrics operates at 20 to 30 percent occupancy. The emergency department had 25,000 visits in 2009.

Phelps is surrounded by other hospitals and by water. Patients do not come from the west side of the Hudson River. Phelps is part of the Stellaris alliances with Northern Westchester Hospital, Lawrence Hospital Center, and White Plains Hospital Center. The region is overbedded. Phelps collaborates *and* competes with these hospitals.

Half of Phelps' discharges are from its primary service area, and 9.5 percent are from its secondary service area. For both areas, Phelps has a 29.3 percent market share. An important nonhospital competitor is the Mt. Kisco Medical Group of 150 physicians, which is located across the street from Northern Westchester Hospital, about ten miles to the northeast.

Phelps Medical Staff

The medical staff includes 470 individuals, 445 of whom are physicians. About 100 physicians admit 80 percent of the patients. Two small medical groups are the largest—the North Star group, which includes 14 primary care physicians, and the seven-person orthopedic group. The hospital lacks enough physicians with thriving practices. The medical staff is aging—40 percent of the primary care physicians are older than age 55—and the hospital has the capacity to admit more patients. The hospital salaries three obstetricians and eight internists, a family practitioner,

a procedural gastroenterologist, a thoracic surgeon, and six hospitalists. Many of the directors of clinical services receive small hospital stipends; several are full-time employees.

I interviewed some key players to learn more about the situation and possibly to write a case study that would be useful for learning by physician leaders of tomorrow at Phelps Hospital.

Interview with Keith Safian, CEO

National health reform had just been passed by Congress. Mr. Safian estimates the impact on Phelps could be a negative $3.5 million each year for the next ten years. Presently, Medicare and Medicaid reimbursement to Phelps is at a rate lower than cost. Phelps operates at a 1.8 percent profit margin, while costs increased an average of 10.3 percent each year from 2007 to 2009. Phelps raises $2 to $3 million through philanthropy each year.

The hospital has physician issues. Specialists want to be paid to be on call for the ED. They want to be paid when they see indigent and Medicaid patients. They want to be paid for referring patients, although this is prohibited by law. Phelps is making some adaptations, and the CEO and the chief medical officer are considering the following options:

- The hospital has recently salaried two gastroenterologists. Voluntary cardiologists have approached the CEO about partnering to perform stress tests because reimbursement is better if these tests are done at the hospital.
- Phelps is thinking of discontinuing some outpatient mental health programs (which generate a total of 50,000 visits per year) if Medicaid cuts occur.
- The CEO does not approve of salary freezes. Phelps gave full-time employees an average 3.5 percent pay raise last year. Safian would rather cut some positions than decrease health insurance benefits.
- Phelps has started an educational program for younger physicians, the medical leaders of tomorrow. The program covers organizational and health system issues, hospital payment, and the nature of the competitive market.
- Phelps is considering building a new ambulatory surgery center on campus, although there is no pressure on operating room (OR) capacity as yet.
- Phelps has had difficulty collaborating with primary care physicians. The largest physician group has not been able to hire more primary care physicians, and they just added two specialists.

Interview with Dr. Robert Seebacher, Medical Director of Joint Replacement Services

Phelps is the only hospital where Dr. Seebacher practices. He is in a large orthopedic practice with seven partners. They now participate only in Medicare and workers' compensation. Medicare pays $1,200 for a knee operation, whereas commercial out-of-network insurance pays $22,000. Dr. Seebacher's malpractice premiums are $110,000 per year, and office overhead is 35 percent. He performs 240 joint replacements a year; he must do 100 to pay for his malpractice insurance.

Views on Medicare and Hospital Adaptation

Seebacher observes, "The United States is extremely wasteful of medical resources. For example, a 90-year-old person will find a surgeon who will do a knee or a hip replacement. So, in one year this expends more money than that person earned in her whole life. The elderly get wonderful care now, whereas 25 years ago they didn't live long enough to receive these operations. It's hard for the hospital to stop unnecessary knee replacements or take action when every gallbladder with a stone does not need to be removed."

He adds, "Many doctors do not wish to cooperate with hospital initiatives. The current payment system divides doctors from hospitals. The hospital should form partnerships with really good physicians, as they are doing, and take care of them. If the hospital is making a lot of money on a surgeon's patients and he's getting paid below his costs, the hospital should pay him a salary."

"A current problem," Seebacher observes, "is that Phelps can't get subspecialists to take call in the ED. Phelps should subsidize these physicians—for example, hand surgeons—to take call. The chief medical officer [CMO] should have more medical directors under him, and he should look for unnecessary surgery and overtreatment. Phelps should strengthen the hospitalist system, but hospitalists (and all primary care physicians) should not order 50 consults for their patients to cover themselves. There should be a more sensible focus on geriatric oversight."

Advice to the CEO

Seebacher urges that "the CEO should listen more to the CMO. The hospital should cut away from doctors whose practice patterns are poor or wasteful. Phelps should be innovative in forming relationships with physicians. Phelps should not look only at volume but also emphasize ethical and expert care. The CEO should value the high-quality physicians he has

rather than search for new people. There is too much emphasis on the patients Phelps is not getting. By definition, some of these patients won't come here anyway."

Seebacher observes: "Northern Westchester Medical Center—with its all-private rooms—appeals to patients who can pay. If Phelps shrinks, the hospital could have all private rooms. Phelps has three wards full of patients who can be frightening to other patients. Patient rooms are too small. The plant has been allowed to deteriorate. Patients see 'small, tight, dingy.' We don't have the money now to change this."

Interview with Dr. Richard Peress, Director of Surgery

Dr. Peress joined the Phelps staff in 1987 and specializes in the spine and scoliosis. He performs 50 operations a year. When he started, he brought a tertiary-level approach to Westchester County. He has recently become director of surgery.

Views on Medicare and Hospital Adaptation

Dr. Peress believes the sooner Medicare collapses the better. Attempts to prop it up "won't get us where we need to go. We do what is politically expedient." Medicare has become a two-tier system—those who can afford it and those who cannot. He believes that costs will be capped for all insurers, and charging patients more will be illegal. He observes that payments for kyphoplasty (a procedure to correct spinal fractures caused by osteoporosis) were $1,500 when he started; Medicare now pays $600. The procedure takes only 20 minutes, but the operation takes an hour of the surgeon's time, and he loses money on the procedure. A plumber charges $300 an hour to unclog a toilet. For epidural injections, Dr. Peress is paid only $69 an hour, and he is putting a needle into the patient's spine.

He asks, "When does gain-sharing under Medicare become fee-splitting?" The hospital makes a lot of money on certain procedures, while the surgeon loses money. This raises questions about how the money can be more fairly distributed.

He observes that the medical staff have to change their attitudes, too. Doctors have a long history of being loners. In today's economy, the bottom line is all that counts. This is changing things for physicians. "Now all we're doing is haggling about the price." But once the hospital makes a deal with a physician, the government can't just take it away. Dr. Peress says, "I can't continue without adequate compensation."

Advice to the CEO

Dr. Peress believes that whatever decisions are made by administration, they must be worked out so that physicians also benefit. For example, hospital online documentation that provides pay-for-performance rewards to the hospital should not be accomplished on the backs of physicians. The surge of "itinerant" physicians at Phelps pains the more loyal doctors.

Dr. Peress thinks Phelps should focus on physicians with unique talents that are not universally available at neighboring hospitals. The hospital's advertisements could tout these physicians so that patients leap over competitor hospitals in surrounding counties. His practice, for example, draws from other hospitals in Orange and Dutchess counties. Dr. Peress wants Phelps to be a true regional spine center.

Physicians should make their case for gain-sharing to a joint committee, Dr. Peress says. If a physician has the talents, she should let the committee know that. Providing high-quality care—and being personable and kind—count, too. The hospital should tell the public why physicians like Dr. Peress choose to work at Phelps. He gets better support at Phelps than elsewhere—for example, nursing support in the ICU and care for his patients from board-certified subspecialists in cardiology, pulmonary, nephrology, and infectious disease, among other areas.

Dr. Peress feels the problem Dr. Lawrence Faltz, the CMO, faces is to help with the implementation and enforcement of compliance. The Stellaris computer system is a handicap because "the computer system doesn't adapt to the physicians, so we have to adapt to it."

The CEO, Mr. Safian, did what was necessary 20 years ago to get rid of the $10 million annual deficit. But Phelps cannot make money anymore just by cutting expenses. The CEO has changed, too, but austerity is not the answer. As a new initiative, Dr. Peress is leading implementation of a pain clinic in the old ED. He wants people to say positively about this and other services: "Phelps? Yeah, Phelps!"

Interview with Dr. Arthur Fass, Chief of Cardiology

Dr. Fass has been on staff at Phelps for 25 years and has been chief of cardiology since the mid-1980s. His group has three cardiologists. The hospital has two cardiology groups and a smattering of individual practitioners.

Views on Medicare and Hospital Adaptation

Dr. Fass is very concerned that, as in his private practice, hospital reimbursement is down and costs are increasing. Physicians are now talking to Phelps

and other hospitals seeking to become employees. Then physicians can be guaranteed income, and physician employees become hospital employees with the hospital paying their health benefits.

Dr. Fass finds that what is important to payers is not quality or thoroughness but high volume, rushing through as many patients as possible. He observes that a financial incentive exists to refer patients not to the best physicians but according to what group they belong to.

Dr. Fass recommends that the CEO be sensitive to situations such as call in the ED. The CEO is asking physicians essentially to provide free service at 3:00 a.m.—while the hospital itself collects a fair amount of money. Physicians should be compensated in some way for this service that they are asked to provide.

Dr. Fass observes the Phelps staff includes about 100 dedicated physicians, and 20 of those are most active in providing clinical services. The hospital should only admit new physicians to their staff if they provide service primarily from a patient care rather than an economic perspective—for example, so that they can transfer patients to other hospitals for tertiary care.

Physicians should be fairly compensated for what they are asked to do, Dr. Fass believes. The CEO should sit down with neurologists, for example, and set one of them up with a good salary, office space, and staff. Not having the neurologist on call affects all doctors who then are in trouble "if their patient has an acute stroke and they can't get a neurologist."

Having a relationship with a teaching hospital would also be attractive for Phelps. This might help in attracting primary care physicians, some of whom may be tempted to set up practice in this community.

Interview with Dr. Lawrence Faltz, Chief Medical Officer

Dr. Faltz joined Phelps 15 years ago after serving as chairman of medicine and residency program director at New York/Queens for ten years. He specializes in rheumatology and internal medicine. Dr. Faltz is responsible for quality, credentialing, and physician discipline at Phelps. He is responsible for networks and academic affiliations. Dr. Faltz is active outside the hospital in the American College of Physicians, where he has held a leadership position.

Views on Medicare and Hospital Adaptation

Dr. Faltz observes that "the docs controlled the medical system up to 1980. After 1990, the payers have controlled the system." He notes that specialization raises costs. Before, the doctor waited to treat a hypertensive patient because of the risks of medications. Now there are treatments with far fewer side effects. When the patient has blood pressure of 120/80, the doctor starts

controlling for hypertension. For a pneumonia patient, the physician used to get a chest X-ray and make seven visits. Now the patient sees the primary care physician every day, plus the cardiology consultant, the pulmonary consultant, and the ID consultant; he gets a chest X-ray, a CT scan, and an echo from the cardiologist. The patient now uses 30 services when he used to get eight services. All of this adds to the cost of care.

Dr. Faltz believes that physicians need to understand their obligations as members of the hospital medical staff. Some of them see being asked to be on call as a personal attack. Doctors used to build their practice by taking call. Now there are too many specialists, so it's hard to build a practice. Physicians do not get paid sufficiently, if at all, for ED visits. Managed care companies do not give physicians a fair deal, and for many physicians just being in practice means tremendous liability issues.

Lifestyle is an issue for the younger physicians. They do not see the profession as an all-encompassing lifestyle as the older physicians might have, Dr. Faltz believes. The government has to spend money on sectors other than healthcare. There is not enough money. Phelps is run as efficiently as possible. The hospital is still run as a doctors' workshop. The hospital needs more integration of physicians and hospital by service. "We need trade-offs as to where the money is going. The hospital has to accept physician governance over some hospital issues," Dr. Faltz says. Many physician leaders at Phelps lack formal education about current health policy issues. Dr. Faltz recommends that Phelps and its physicians work together to make the newly salaried physicians productive. The present reimbursement system is not conducive to this. Phelps has to figure out how best to compete with growing medical groups, such as Mt. Kisco, that are recruiting additional physicians and taking away hospital ancillary service revenues.

Regarding call in the ED, Dr. Faltz points out that (1) subspecialists do not want call but they want to keep out the competition, (2) mature practices do not need the new patient flow from the ED, and (3) primary care medical staff are unprepared to say, "if you (specialists) won't take call, we won't refer patients to you." Phelps has to move the culture. The community does not understand that when no specialist is available after hours, patients have to be transported to another hospital. Patients view that as a hospital failure, not a medical staff failure. The medical staff does not understand that the hospital and its medical staff are viewed as a single entity by the outside world. The medical staff bylaws should be changed so that physicians still have to take call even if they are 55 years old and have worked at Phelps for 20 years, which currently are grounds for exemption from call, regardless of the availability of other members of a department.

Dr. Faltz concludes: "We must see that we can't get where we want to go without each other, and we can't turn the clock back to where it was before."

I didn't have an answer to the quandary in which the hospital and its physician leaders found themselves. On one hand, neither party seems to be netting sufficient revenue to meet revenue targets. On the other hand, neither side seems to be able to work out a satisfactory method of working closer together on some kind of combined production and billing process that would meet each side's targets.

Case Questions

1. What were the financial problems facing Phelps and its medical staff in 2010?
2. What are the options for hospital initiatives and what do the physicians recommend?
3. How should the CEO proceed? Give a rationale for your recommendations.
4. What are the unresolved questions in the situation facing the CEO and the board? What are the risks in adopting your recommended strategy?
5. What do you recommend that the CEO and the CMO do to improve the situation?
6. How do you approach this case from the point of view of a younger physician? What do you expect from the hospital, and what do you think the hospital should expect from you?