

# Physician Leaders Drive ACO Development, Patient-Centric Care

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The move toward Accountable Care Organizations (ACOs) is in full swing, with organizations driving to develop and staff their models in response to health care reform. The Centers for Medicare and Medicaid Services (CMS) will begin using ACOs in 2012, and private insurers are turning to them to improve care and slow rising costs.

Two leading physician executive CEOs — John B. Chessare, MD, President and CEO, Greater Baltimore Medical Center in Baltimore and S. Rockwell (Rocky) Fredrickson, MD, President and managing director of physician integration of Integris Physicians Services in Oklahoma City — recently provided insights on ACOs and physician leadership during an interview with Witt/Kieffer Senior Vice President, Christine Mackey-Ross.

**Q. Christine Mackey-Ross:**

One proposed solution to the unsustainable spending in health care has been this new entity called the ACO. Please describe your understanding of what an ACO will mean to your organization.

**A. Dr. Chessare:**

ACO members are going to share responsibility for the quality and cost of care provided to a population of patients. CMS administrator Dr. Donald Berwick recently said he didn't see the ACO as primarily a financing mechanism, and he listed five expectations for ACOs: reduce dependence on hospitals; use a proactive approach to help people stay healthy; use retrospective health care data which would require a systematic review of electronic health records; adopt an innovative approach and push the best advances and

care models; and execute plans around changes in the care delivery system.

My organization is hospital-centric. We also own a physician company of about 40 FTE primary care physicians, and we have about 200 primary care doctors at different levels of alignment with our hospital. One of our first steps will be to communicate with that group of doctors about our intent, and then figure out the best model to get them linked in.

**A. Dr. Fredrickson:**

We're moving toward ACOs faster than CMS is anticipating. I know of two organizations that have already cut contracts with commercial insurers.

Integris employed consultants a year ago to look into integration in general and ambulatory care as the way of the future.

They developed a role for a physician leader, reporting directly to the CEO, to be accountable for all positions in a hospital-centric system moving toward an ambulatory-centric system. Typical of most systems, Integris has employed specialists in an opportunistic way. When I came into the organization there wasn't a strategic plan for developing a multispecialty group. So my task is getting the physicians together to be an ACO.

**Q. Christine:**

How does this new approach to health care differ from capitation proposed in the early 90s?

**A. Dr. Chessare:**

The word capitation generates a visceral reaction from people, but this really is about capitation. The difference now is

that the federal government is lacking any alternative strategy which improves the health of the population. Whether we use the word or not, it is going to be payment-per-defined-population, which is essentially capitation.

### **Q. Christine:**

Is there a difference in terms of physician alignment and physician integration?

### **A. Dr. Chessare:**

It won't just be aligning physicians. It will be aligning chief financial officers, CEOs, physicians, everyone, because the transition from transaction-based medicine to ACO is really about integrating care. The transition is going to be really hard. The hospital is about to become a cost center. We have been very comfortable as hospital executives and now we have to flip that on its head.

Alignment of the physicians is the first step. Getting them to work together towards a unified goal of doing right by the patient — and doing well financially — will be the real trick. I'm saving the term "integration" for integrating care. Our only hope in making this new world

work is to keep calling out problems in the present system that every patient — especially those with chronic diseases — must navigate every day.

### **A. Dr. Fredrickson:**

That's another important distinction about ACOs: we are moving towards a patient-centric model of care. If we go towards this new world of patient-home models, we have to make a giant leap from one business model (transactional, volume-based system) to one of performance-based, patient-centric, bundled care. That's going to be a very schizophrenic move for most hospital-based systems.

### **Q. Christine:**

How will physicians that the hospital does not employ be included in the ACO model?

### **A. Dr. Fredrickson:**

The current model which is catching fire pretty quickly is called clinical integration, where the hospital-based system can more tightly integrate physicians with shared incentives. This is a new world with the Federal Trade Commission

now loosening their ties on gain-sharing between hospitals and physicians. Physicians can remain independent but they are tightly integrated with the hospital and the employed physician group. You can do joint contracting with insurance companies, which is very desirable to physicians these days.

### **Q. Christine:**

Where do you think the ACO designation may be best held?

### **A. Dr. Fredrickson**

If you look at the literature, people talk about the integrated delivery system as probably the best model. It has all the facets that would make for a good ACO. However, just because you're an integrated delivery system doesn't guarantee you will be a successful ACO because integrated delivery systems are not always integrated.

Physicians are an essential key to the ACO. They can contract the services; they can get the payment and coordinate care in an ambulatory setting. And if the patient needs to be hospitalized, they can do that through contractual means. This is no longer a hospital-centric world. This is going to be an ambulatory-centric world with the patient at the center of care.

**"Our only hope in making this new world work is to keep calling out problems in the present system that every patient must navigate every day." — John Chessare, MD**

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**A. Dr. Chessare:**

The Healthcare Advisory Board described hospitals that sit still and just wait as being part of a “race to the bottom.” The best people to handle this are very large integrated physician groups. If they do it right and partner with some kind of an insurance function, they will be playing hospitals against each other and buying patient care as they need it from hospitals that bid the prices down. Those hospital margins are going to shrink and that’s the race to the bottom.

**Q. Christine:**

There has been resurgence in hospital expansion and construction. Is that a mistake?

**A. Dr. Fredrickson:**

The smart system will not be investing in inpatient care. They’ll invest in human capital because we know there is a primary care shortage, and there will be shortages in other specialties. There’s a price war for physicians in the market as systems buy up primary care physicians.

**A. Dr. Chessare:**

Our health system trashed the facilities master plan to build a new tower, and instead we are spending our limited capital dollars on rolling out the electronic health record. We’ll be

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creating a facilities plan that includes many more primary care facilities.

**Q. Christine:**

What roles and skill sets will physician executives need as they work on alignment and integration?

**A. Dr. Fredrickson:**

When President Obama talks about the most coordinated, most efficient and highest performing health care systems, he tends to name physician group practices that happen to have hospitals. We’re talking about Kaiser, Mayo, places like Virginia Mason. It’s more of that model that we’re working toward, and that means a much higher degree of physician management skills. There’s a gap in education for physician executives. We are going to be more physician-led, and we need to be in the accountable care age.

**Q. Christine:**

In some organizations we see parallel structures: hospital executive leadership and, if they have a large number of

employed physicians, there’s a silo of leadership focused on physicians. Will these two leadership silos merge?

**A. Dr. Fredrickson:**

I see them effectively merging, and a good example is the organization I recently joined. The senior leadership team is only six individuals supporting a CEO and two of those individuals are physicians. We will continue to add physician executives who need to be well trained and have good management experience.

**A. Dr. Chessare:**

This is not really about generating a different kind of physician executive. I see bringing people together of varied capabilities and training. So you need a physician who understands care delivery; people who understand finance; people with rich operational knowledge; nurses who understand nursing at a granular level. It’s not that every individual has to have every skill, but every individual has to be able to collaborate. So my goal is not to send doctors off to learn finance. It will be to get great physician leaders who are great accountability drivers and

collaborators — and marry them to other great collaborators with different skill sets to generate results.

### Q. Christine:

Many physician executives still spend a portion of their time in clinical practice. Is there value in spending some time in the trenches?

### A. Dr. Chessare:

When I was CMO of Boston Medical Center, I practiced a half-day a week, and I got a lot of credit for that with my colleagues. If I had my druthers, I would still have doctors participating in care.

### A. Dr. Fredrickson:

I think it depends on what level you're at. If you are in a single-hospital system, practicing may mean something. But it doesn't mean anything if you are in a system because no one would know. Quite frankly, I think the physician executive job is so complex that practicing is a detractor as opposed to something that would be beneficial.

### Q. Christine:

Witt/Kieffer recently completed a survey among hospitals and CEOs about physician executives\*. There are gaps in what they perceive as the most valuable responsibilities and how well they

perform. One of those gaps is improving the bottom line. What are your thoughts?

### A. Dr. Fredrickson:

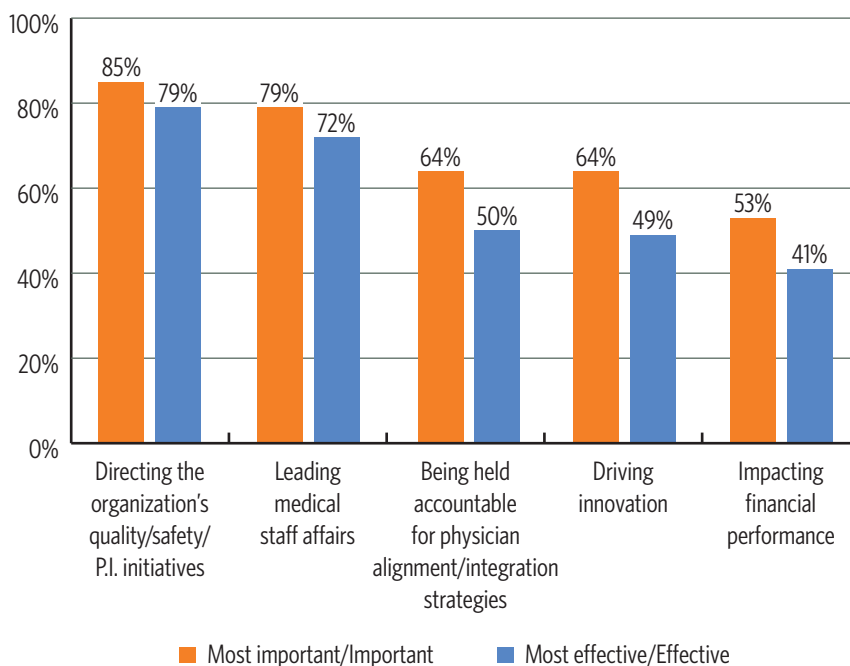
A physician executive in an ACO or a hospital system is always going to be on the line because of employed physicians. This has gone on for decades even though you can explain a thousand times that this is an investment for the long term. Downstream revenue is what you should be tracking, not short-term quarterly results and loss per physician. Hopefully, with the ACO, we will be able to do that.

### A. Dr. Chessare:

When I was at Boston Medical Center, my boss would have been happy if we made all our physicians productive as defined by how many patients seen per hour. But when we maximized that area, someone else would say: What are we doing about core measures? Then we would focus on that and eventually have a meeting when a board member would be upset with our patient satisfaction scores. We never believed the three domains were interconnected.

Organizations have been great at having doctors work on the conveyor belt.

\*Importance/Effectiveness of Physician Executive Responsibilities



Source: 2010 Witt/Kieffer Physician Executive Survey

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“There’s a tipping point with independent physicians, finally deciding that they are not going to make it in the new world and coming to us for answers.” — Rocky Fredrickson, MD

There’s been no reflection about whether the widgets were worth anything, but as long as we were selling them we were OK. Now we have a much more complicated task, but it’s going to be aligned and in the direction we should have been going all along. We should be able to drive out the waste and make clinical outcomes and satisfaction better.

**Q. Christine:**

Tell us what you are doing in your own organization about moving toward ACO status and incorporating physician leaders.

**A. Dr. Chessare:**

We are already involved in a transformation of our employed model, triggered initially by the board wondering why we were losing so much money per physician. We are transforming our primary care sites into places that should be better able to accept risk. We are rolling out electronic health records to physicians who are already employed, while we are strategizing on the structure provided to physicians who are not employed. We are walking through the

legislation and beginning to speak with partners who may help us do the parts where we have no internal capability. We’re getting ready to sign up to be a level one ACO by next spring and be ready to go by January 1, 2012.

**A. Dr. Fredrickson:**

A transformation is taking place in this market. There’s a tipping point with independent physicians, finally deciding that they are not going to make it in the new world and coming to us for answers. Our main competitor is offering an employee-only model, and we’re going to offer an independent model in a clinical integration system. Fortunately, the employed physicians I’m working with already have electronic health records, but we’re developing a model for providing electronic health records for independent physicians as part of the clinical integration strategy. The ACO — and its deadline — are in the back of our minds.

**Q. Christine:**

Given the importance of moving information between the components of

an ACO, are we going to see an era where physician practices migrate to one EHR system or will the bold and fast learn to use multiple systems?

**A. Dr. Fredrickson:**

You bring up an enormous problem. The proprietary companies that created these systems have done so with the purpose of becoming proprietary — and not open source — so they can make more money. Organizations are solving problems with health information exchanges, which work to a certain degree. There will be commercial products that act as interface between systems. It’s all a work in progress, and it’s not pretty.

**A. Dr. Chessare:**

As a practicing physician, when I went from paper to any electronic record there was a short-term price to pay, but I was much better off in the end. My hope is that the technology will be less about the venue and more about pressure in the market to make things more user-friendly for physicians. I’m not sure there is a perfect system. I think the real issue is to get it out there, get it in use and have a rich dialogue with clinicians about how we are using the new capabilities to integrate care for patients.

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“We’re developing a model for providing electronic health records for independent physicians as part of the clinical integration strategy.” — Rocky Fredrickson, MD

**Q. Christine:**

Any final thoughts on ACO integration and physician executives?

**A. Dr. Chessare:**

The conversations are not the same as they were 15 years ago. Now the primary care doctors are looking for solutions because they realize that groups of two or three aren’t going to make it. And even if they thought that it would work, young kids coming out of training want no part of it. They have too much debt and they don’t want the complexity of trying to run an office. They want to be employed. Leaders of health care organizations need to set an agenda

where everybody believes there is something in it for them.

**A. Dr. Fredrickson:**

I personally think this is the greatest time to be in health care in the last 30 years. The country cannot afford to go backwards because we have to bend the curve. This is a tremendous opportunity for physician executives in this environment, and I also think it’s going to be a lot of fun.

*Witt/Kieffer is grateful to Dr. Chessare and Dr. Fredrickson for their participation in this provocative discussion about the future of health care and its leadership. For more on physician leadership, visit [www.wittkieffer.com](http://www.wittkieffer.com).*



**John B. Chessare, MD, MPH, FACHE,**

began serving as President and Chief Executive Officer of Greater Baltimore Medical Center in June,

2010. Dr. Chessare has more than three decades of health care leadership experience and is a pediatrician by training. He holds fellowship status in the American College of Healthcare Executives and earned his medical degree from the University of Rome. Dr. Chessare completed his pediatric residency at the University of Massachusetts Medical Center and completed fellowship training in general academic pediatrics at Boston Children's Hospital/Harvard Medical School. Dr. Chessare completed his Masters of Public Health in Medical Care Organization from the University of Michigan School of Public Health.



**S. Rockwell (Rocky) Fredrickson, MD,**

joined Integris Physicians Services in Oklahoma City in July 2010 as managing director

for physician integration and president of the Integris Health Physician Organization. Dr. Fredrickson has more than 25 years of executive management experience in health care, the majority of which has been managing and leading physician group practices. He was a general internist in his medical practice and also served as an emergency room physician early in his career. Dr. Fredrickson graduated with distinction from Dartmouth College in New Hampshire, before earning his medical degree at the University of Michigan. He completed his residency at Virginia Mason Medical Center in Seattle.



**Christine Mackey-Ross, Witt/Kieffer**

senior vice president, was recently selected to lead the firm's new practice concentration

in physician integration and executive leadership. She has led successful searches for a wide variety of physician executive roles, as well as CEOs, COOs, CFOs and many other senior-level executives in all sectors of health care, including integrated delivery systems, academic medical centers and group practices. Christine's career, prior to joining the firm in 1995, included multiple roles in nursing administration and experience as an oncology clinical nurse specialist. She holds an MBA from Washington University, John M. Olin School of Business in St. Louis, MO, a BSN from St. Louis University and RN from Deaconess Hospital School of Nursing in St. Louis.

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