

When Strategy Informs Structure: Successful Board Oversight of Physician Integration at Mercy Health

by Mary K. Totten

The road to integration of hospitals and physicians has been a rocky one for many health care organizations. Failed attempts to integrate in the 1990s resulted from the realization that operating physician practices was very different from operating hospitals, leaving many health care providers wary of heading down the same road again.

Today, delivering greater value in health care demands close working relationships among hospitals and physicians. Realizing that “working solo” is becoming an outmoded option, hospitals and physicians that walked away from earlier integration missteps are now testing a number of new models for collaboration while trying to avoid the mistakes of the past.

Mercy Health, a regional health system based in Chesterfield, MO, began its journey toward integration some 25 years ago as a hospital organization “loosely affiliated” with its physicians around specific activities, such as joint purchasing of supplies and equipment.

“In the early 1990s, we began to employ physicians and encountered the same issues and problems other systems did,” said Mike McCurry, executive vice president and chief operating officer. However, instead of abandoning integration, Mercy stepped back to analyze not only what went wrong, but also what went right about earlier initiatives. This evaluation led to developing a new model for hospital-physician integration at Mercy.

Believing that hospitals and physicians would need to work closely together in an environment where cost and quality would become significant national health care concerns, Mercy decided to focus on building a regional structure where a large physician clinic and a hospital would be operated as sister corporations that were co-dependent and equal. Development of the model began with an “integration arrangement” between Mercy and the Smith-Glynn-Callaway Clinic in Springfield, MO. Over more than a decade, Mercy and its clinic physicians refined this model.

In 2008, Mercy’s board of directors and senior leadership decided to implement the model systemwide whenever physicians in a regional market were ready to pursue integration. Adopting this strategy spearheaded Mercy’s evolution from a “hospital company” to a hospital-clinic organization, a shift that not only changed the organization, but also the structure of the board.

“Our board chair and Finance Committee chair were intensely interested in integration, which dominated the board agenda as our strategy developed,” said Fred Ford, senior vice president, ambulatory care.

“Because our growth was organic and local and emerged from a hospital-centric point of view, we lacked a single, standardized approach at the outset,” McCurry added. “We determined that we needed one consistent approach and a clear line of sight on performance from the board to front line staff.”

“We knew we would need board input and approval for our regional clinic transactions and oversight for issues such as physician compensation,” Ford said. “Because it was important that this multi-million-dollar strategy was developed and implemented correctly, it became clear that we needed a board committee to discuss issues related to our emerging strategy and then bring the committee’s perspectives and recommendations to the board.”

In 2009, the board added a Physician Engagement Committee to advise the Mercy board on issues related to Mercy’s integrated groups and strategy to pursue integration in all of its markets. The committee’s primary areas of oversight are scope and development of regional integration efforts and leadership development and compensation for physicians. The committee also was designed as a forum for Mercy executive and physician leaders to share insights, discuss challenges and opportunities and learn more about each other’s perspectives.

Committee members include the board chair, Finance Committee chair, Mercy Health's president and CEO, a representative of Mercy's sponsoring religious order, and two outside experts—the president and CEO of Mission Health System in Asheville, NC, who also is a physician, and the president and CEO of Tufts-New England Medical Center. According to Mercy President and CEO Lynn Britton, committee members brought specific expertise from markets that had experience with the shift toward delivering greater value in health care. They understood and could provide Mercy leadership with informed perspectives on issues such as hospital-medical group relationships, managed care contracting and physician compensation and could challenge and refine the organization's strategy and implementation activities.

"The members of the board's Physician Engagement Committee were the first to grasp the integration issues important to physicians and help Mercy move from a hospital-centric to a broader view," says Fred McQueary, MD, president, Mercy Clinic North Central Communities. "They engaged physicians in discussions with Mercy leaders about sharing control with physicians

and involving them in upper levels of the organization's leadership. Committee members then took feedback from these discussions to the full board. Having board members, physicians and Mercy leadership involved in developing and implementing the integration strategy together added new points of view and brought credibility to the process, which was essential to successfully implementing the tightly integrated structure that Mercy has pursued."

"We needed to talk deeply about the benefits and risks associated with our systemwide integration strategy, and

the board needed to go on that journey with us," says Britton. "The board had seen our integration model developing successfully in Springfield and north-west Arkansas and believed it was the right approach. While the board realized that we could not take another decade to pursue integration across the system, they did not want Mercy to proceed too far or too fast. Our board engaged in a thoughtful review of foundational questions such as how to deal with the massive changes that would occur as we rolled out our integration model across the system and the risks to our long-term revenue picture of the increased costs associated with our strategy. Most importantly, the board carefully considered the structures, people and culture we would need to successfully achieve our goal."



Mercy engaged 150 physicians across five committees to work through the issues associated with large-scale integration. Their work was reported back to the board's Physician Engagement Committee, which gave board members confidence that the process involved transparency and trust and was not being driven solely from the top down. Development of a single model for physician compensation systemwide also was vetted through the committee so board members could understand the factors that would make the model work.

"Having deep conversations with the small group of experts that comprise the board committee has been affirming for management," says Cynthia Mercer, senior vice president of human resources. "Dealing with the complexity of large-scale change management is not everyone's strength or expertise," she says. "So management felt comfortable first talking through obstacles and gaps in the strategy with a subset of expert board members. Vetting issues with the committee makes everyone feel confident when it comes time to present recommendations to the full board for approval."

Thoughtful and inclusive planning and preparation are paying off for Mercy in being able to execute integration initiatives with increasing speed. Ford estimates that the more than 10 years

Mercy spent upfront to understand the critical success factors for its integration model has enabled the organization to gain buy-in and set up the operating structure for a clinic-hospital organization in a new market in about 12 months today.

Mercy currently has about 1,800 integrated physicians working in clinic-hospital organizations throughout the system and some 150

physicians participating in the Mercy management structure.

While independent practice physicians also deliver care at Mercy, the organization's integration efforts have achieved sustainable scale (some 40 to 60 percent of Mercy physicians are integrated systemwide) and have helped the organization identify a clear path toward its desired culture. According to McQueary, over the past two or three years more and more physicians who are not integrated are indicating they want to participate. He expects that Mercy and its physicians will be fully

integrated within the next five to 10 years.

“Like many other systems 25 years ago, Mercy’s ‘integration 0.0’ experience was an expensive, and at times painful experience; but it was worth it,” Ford says. “During ‘integration 1.0’ we learned how to do it. Our vision for ‘integration 2.0’ is to achieve clinical integration across Mercy delivering the same quality and service experience to patients across the system.”

As Mercy’s systemwide integration model and physician compensation system have become part of ongoing operations, the need for the board

Physician Engagement Committee is waning. Mercy leadership anticipates that committee responsibilities will be absorbed by other board standing committees, such as the board’s Compensation Committee and Culture and Service Committee.

“Some might say that disbanding the board’s Physician Engagement Committee indicates that we no longer think this issue is important,” McCurry says. “But we take the opposite view. We believe that physician integration is a critical strategy that has now become an operational pillar of our daily work. Therefore, the board’s oversight has moved from a strategic to an operation-

al focus. There’s no question that physician integration into Mercy Health was accomplished more quickly and successfully with the insight and involvement of our board.”

Editor’s Note: This article expands on a description of the Mercy Health board’s Physician Engagement Committee included in Governance in Large Nonprofit Health Systems: Current Profile and Emerging Patterns published in 2012 by the Commonwealth Center for Governance Studies, Lexington, Kentucky.

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