Ensuring Satisfaction and Quality Vascular Care as Hospitals Consolidate

Several years ago, Gary M. Ansel, MD, moved from a high-volume private practice into hospital employment, and more recently, when his hospital system began to expand, he took on the role of overseeing the entire system's vascular division. In this interview, Dr. Ansel describes physician compensation models, job satisfaction, and efforts toward establishing high-quality care, regardless of which door a patient passes through.

Gary M. Ansel, MD, is System Medical Chief: Vascular for OhioHealth Health System and practices at Riverside Methodist Hospital in Columbus, Ohio; and Assistant Clinical Professor of Medicine, Department of Internal Medicine, University of Toledo Medical Center in Toledo, Ohio. Dr. Ansel may be reached at gary.ansel@ohiohealth.com.

FROM PRIVATE PRACTICE TO HOSPITAL EMPLOYMENT

How would you describe your ability to maintain quality care across a wide spectrum of vascular disease patients while you were part of a high-volume, private-practice interventional cardiology group?

Dr. Ansel: In our private practice, we were able to keep our quality high because we were already very introspective. The group measured outcomes and published frequently; we participated in a lot of clinical trials, and thus regularly had our work evaluated by core labs. We had a fairly sophisticated group, and as we joined the hospital, they wanted to expand that insight and expertise to the rest of the health care system.

What originally led you to leave the private practice model for hospital employment?

Dr. Ansel: We did it for several reasons. First, we always had a good relationship with our health care system. As the pressures of staying in private practice were increasing, hospitals were able to hire more physicians, and we saw a chance to team up with our health care system and hospital. We had a hard time marketing and working together as private practices because of Stark laws and other factors, and we believed that this type of employment would offer us a better opportunity to really approach the marketplace as a team.

Another reason was to gain stability from a financial standpoint, as the overhead costs and requirements were getting higher and higher. Take electronic medical records, for example. We spent over a million dollars on the system, and there was also an increase in ongoing support services overhead. We were unable to maintain a reasonable overhead.

Combined with the partnership with the health care system, it just seemed like the right time.

What were the potential cons you were weighing these benefits against?

Dr. Ansel: When you have a successful, high-volume private practice, that kind of success usually comes because you have a group of entrepreneurs who are really working hard. So, one concern was that we didn't want to get bogged down in the hospital bureaucracy or lose our self-determination and control. We also really worried about our employees and wanted to make sure that they were secure in their futures. There were certainly some concerns as we moved down that pathway.

Were you able to maintain your employees in the transition?

Dr. Ansel: Yes, I think the employee transition went well overall. If you were to ask, "What was the longest negotiation?" it was to make sure that we maintained the stability

of our employee pool. Many of them had been loyal and with us for a long time, and we wanted to make sure that loyalty was rewarded. It paid off in the end, as we were able to avoid wholesale turnover in our staff. The health care system did a really good job in maintaining our group.

How would you compare your ability to maintain the level of quality in the private practice setting to that of hospital employment?

Dr. Ansel: I think we've been focused on putting processes in place that will improve the overall system's quality for the treatment of vascular disease. We have a team for whom that is a primary focus. We still do a lot of clinical research—our research foundation was absorbed by the health care institution as well—and that is a driver of sustained quality.

My personal role changed because they wanted me to help manage and guide the health care system to bring the quality that was being achieved at the tertiary care centers to the community and smaller hospitals. There is always a challenge in that, in part because of the variable patient demographics and distances involved. We've had to work hard on that, but we're making really good progress. We created a multispecialty, multihospital vascular institute, and this is increasing resources available to all campuses for the treatment of vascular disease.

What were the differences in how physicians were compensated in the private practice versus in the hospital?

Dr. Ansel: In private practice, you're driven by your own view of the world. In our own group, there wasn't a huge focus on relative value units (RVUs), but there was a focus on being busy and making sure that we were bringing the latest and greatest to our referral base. When we first joined the hospital, it was an RVU-based system. Before we even finished our first contract, however, they hired a new physician administrator to help run the heart and vascular service line for the entire health care system. Under this guidance, we've gone away from an RVU-based system—it is now quality-directed, and instead of a flat salary, there are financial incentives for quality and patient satisfaction. Not only are physician managers making sure that you are doing your job, but you're getting graded on it from multiple quadrants.

It's really interesting to watch how our health care system has focused on quality outcomes and patient satisfaction and walked away from the true RVU system. It's been a breath of fresh air. It allows for a lot more camaraderie among the specialties because you really do focus more on working as a health care team to the benefit of the patient.

In what ways did hospital employment fall short?

Dr. Ansel: We are not as fluid in our decision making as we were as a private group. There certainly are reasons for that. The hospital system is very large and well run from a business standpoint. Universally, I think private practitioners value being able to rapidly change with the environment and meet new challenges rapidly. As a part to a larger entity with a "matrix management" style, decisions are vetted down several avenues before a change, as there are more stakeholders. Certainly, this can be frustrating.

EMPLOYMENT IN A LARGER HOSPITAL GROUP

What was your initial reaction when you were presented with the opportunity for your latest job, in which your oversight would extend far across the larger OhioHealth landscape?

Dr. Ansel: It was a really big decision. My boss said, "Go talk to your wife about this," and I think she understood how much it would change my life even more than I did. I was a very singular-hospital-focused guy. I am at Riverside Hospital, one of the top tertiary care centers in the United States, and when I was asked to help manage the broader OhioHealth care system, which meant that in the next 5 years I would go from 0% to 50% administrative; it was an eye-opening moment. My wife and I took a whole weekend to discuss that, and it came down to: If we're successful—and I really think we are going to be—I'll be able to affect a lot more patients than I could ever see and treat individually. Although I've been able to maintain a pretty vigorous clinical and procedural practice, there are a lot of evenings and many days when I'm doing administrative duties. I'm a very competitive guy, so I told my wife, "If we're going to do this, we're going to really go after it." Instead of aspiring to be a top local system, we want to be one of the nation's top health care systems, and I think we are moving rapidly in that direction. I am very fortunate in that OhioHealth provides many resources to help you become successful. I am also fortunate that the critical decisions for the Vascular Institute are made by a multispecialty executive team. This executive team meets monthly and has high-quality physicians with vision as well.

How did the compensation structure for physicians differ from that of a private practice or a single hospital?

Dr. Ansel: As I mentioned before, we originally had an RVU-based system, but before the contract was halfway finished, our health care system came to us with an idea to be non-RVU based. As doctors, at first, we were very suspicious and questioned the motive. I think this is prob-

ably a natural inclination; it sounded too good to be true. It took a lot of conversation before we were convinced that this quality focus was real, and it has been. It has totally changed the focus from one of RVU to quality outcome and patient experience based. This has changed some of the day-to-day interactions of the physicians.

For example, one of our surgeons who performs endovascular interventions said at one point, "We don't have drug-eluting stents in surgery yet, but I have a patient I feel would benefit from treatment with one." I told him to come over to the cath lab, and I'd do it with him—but that he would bill. The case could potentially get into one of the drug-elution trials, so it gives us another research patient, and the surgeon could become more familiar with the cath lab. It's increased cooperation among the specialties, because we're less worried about fighting for turf between the specialties.

The only place that the structure rubs a little differently is that now you have employed physicians and unemployed physicians, and you have to be thoughtful regarding ethic and compliance regulations.

In what ways can different compensation models affect patient care?

Dr. Ansel: I think our current model drives appropriate care to the appropriate place, because we are driven for quality outcomes and patient satisfaction even to the point that we keep a scorecard in this area. Again, physician managers are now really trying to facilitate colleagues to attain goals. We also survey patients frequently to evaluate their thoughts on their care. The entire health care system is very introspective from that standpoint, so those are the kinds of things that we look at and try to drive the doctors toward.

It's like the Ritz Carlton—they don't have to run a special. You have a different experience when you go to that hotel, and that's what we want to create here. When patients come here, not only do they get great care, but they also feel like it's an environment that is very patient friendly and everybody is looking out for the patients' best interest.

How can they affect physician satisfaction?

Dr. Ansel: Physician satisfaction is actually very high. We just did a survey, and the physician satisfaction was the highest it's ever been at the institution and we lead the nation in physician satisfaction.

How do quality scorecards and associated bonuses work?

Dr. Ansel: Our balance scorecard has four equally weighted quadrants: quality, finance, service, and work life. At the beginning of each fiscal year, the medical chiefs of each of the divisions within the Heart & Vascular service line work on developing the metrics that year for each quadrant. The quality quadrant may focus on targets related to mortality, readmission rates, or episode of care projects. The medical chiefs make sure that they are providing feedback on a quarterly basis to the physician within their division. A good example is our vascular access complication rate. It was not bad before, but it wasn't perfect by any stretch of the imagination. It became a quality improvement project that we focused on as an institute. In this system, our vascular complication rate dropped from approximately 3% to 0.2%–0.4% within 6 months.

We're also participating in additional databases, such as the SVS VQI, to make sure the physicians can have access to quality benchmarks and feedback. Our work to improve quality is not punitive but rather provides venues for the physicians to improve quality outcomes in a supportive environment with access to mentors. We have an intranet where the doctors can communicate with each other, and presentations from national conferences can be accessed. It is in the early stages of development, but I can really see where that's going, and I think it will be an educational resource for the doctors, especially those in the outlying hospitals. Physicians in more rural and outreach communities can sometimes feel like they are on an island; we want to create opportunities for their engagement, participation in meetings, quality initiatives, and educational opportunities. If they are faced with a complicated case, the members of the Vascular Institute are available for input and consultation at any time, and in some cases, may travel to the outlying hospital to provide support and mentoring.

APPLYING QUALITY STANDARDS AND TREATMENT ALGORITHMS

Please discuss the philosophy behind establishing and installing treatment algorithms across a 12-hospital system. To what degree are turf wars a challenge in this setting?

Dr. Ansel: As I noted, we have created a vascular institute without walls as a quality initiative. When we initiated our journey to developing a vascular institute, our physicians and senior administration visited the Massachusetts General Heart, Stroke and Vascular Institute to better understand their model. Dr. Michael Jaff and his colleagues have developed a multidisciplinary model of quality care delivery for the vascular patient. Our goal was to adapt their model for our 12-hospital system, creating a new culture of partnership working across disciplines, hospitals, and regions with quality as the focus.

The vascular institute is changing the paradigm that many PCPs and specialists have experienced when refer-

ring their patient to a tertiary care center, where it can be like a black hole, never seeing that patient again in the referring practice. For patients cared for through the vascular institute model, there are service expectations: communication with the referring doctor, care plans, follow-up, and testing performed in the patient's community whenever possible. The patient receives care where he or she should be getting it, which is locally if possible.

Another fundamental change in our new model is the quality review process. A multispecialty, system-based physician committee reviews cases referred from the individual campus peer-review committees.

Although I am the administrative lead, there is a system multispecialty executive team. This team is accountable for approving treatment guidelines, participation criteria, and decision making regarding policy and procedures.

An example of how the vascular institute can be of benefit to our patients is the recently established system-wide algorithm for treating pulmonary embolism (PE). It details indications for transfer of patients from community to tertiary hospitals, provides guidelines for low-risk submassive PE versus higher-risk submassive PE, and it is not directed at any one technology. The algorithm has approval of the critical care, emergency department, and heart and vascular clinical guidance counsels. The result of the work is consistent treatment for PE across the entire region. The standardized treatment guidelines and data collection will allow the vascular institute to improve quality outcomes and also to engage in continual improvement of processes to optimize patient care.

Even with an algorithmic approach, to what degree must the more challenging cases still be directed toward the most experienced and skilled teams in the group?

Dr. Ansel: The algorithm provides the data to support directing the patient to the level of care that is indicated clinically with the goal of providing the right care by the most appropriate physician and/or hospital. It is an approach not seen within other hospital systems. One example is the endovascular treatment of chronic total occlusions (CTOs), whether in the iliac, superficial femoral, or tibial artery. Trying to get through these long total occlusions with good outcomes is often what makes or breaks successful endovascular PAD treatment. We have created a "CTO Outcome Criteria" that requires physicians who treat CTOs to have an 80% or higher success rate. That seems like it should be inherent, but that's really not done anywhere else that I am aware. Insurance providers and referring physicians are more likely to support programs where this type of quality outcome is delivered. The vascular institute is setting performance expectations, collecting data on clinical outcomes, offering mentoring opportunities, providing education seminars, and reporting individual quality outcomes to the Vascular Institute members.

During our formative discussions, one physician said, "I don't think I can achieve an 80% success rate in 30-cm total occlusions," to which the answer was, "You don't have to. You have to cross 80% of the occlusions you try." That's the difference—they have to be successful at the cases they choose to perform. If we can treat patients with complex disease in a very timely, cost-effective manner and achieve quality outcomes, then we'll really see a change in how we deliver health care across the entire system.

When a single airline has the only routes between two cities, prices can rise dramatically. When a single company is the only one providing a service to a city, the rates can be high and the service indifferent. Might patients face similar pressures if one hospital chain were to dominate a city or region?

Dr. Ansel: Our approach is based on the Value Equation: outstanding service to patients and families, demonstrated quality outcomes, provided in the most efficient manner across the system. Our patients are expecting no less from our system.

I expect eventually, there will probably be 10 to 20 health care systems in the United States, with those institutions maintaining an efficient administrative model, purchasing power, and data-driven clinical pathways resulting in improved outcomes. From my perspective, I don't want to copy the European model, where they lean toward what is most cost effective just at the time of the procedure but not looking at long-term outcomes. Our vascular institute is focusing on the entire episode of care including the 1- and 3-year outcomes. Repeat procedures and rehospitalizations have significant impact on health care cost. We want to know and therefore will be monitoring as one of our metrics, the most effective care plan longitudinally.

What is the next step in your quality assurance effort?

Dr. Ansel: There are many projects in front of us, some examples include the following: We will continue to develop and implement standardized clinical care algorithms. The evolution of our databases into a user-friendly format so it is efficient for the clinicians to utilize.

The goal of integration of the interventional radiology and cardiovascular departments is to improve cost efficiency in terms of the number of labs and staffing, as well as to enhance cooperation between the specialties. Those are some of the major changes that we are piloting with an effort to be the best-valued system around. ■