CHAPTER

Techniques to Foster Effective Working Relationships

NUMEROUS TECHNIQUES CAN foster productive and positive working relationships between hospital management and physicians on the medical staff. Using these techniques as a guide for everyday dealings with the medical staff, hospitals and systems can begin to forge a foundation of mutual trust with physicians and earn their loyalty. Such loyalty may create opportunities to transition physician relationships from independence and competition to more collaborative dealings and more active participation on medical staff organizations.

Not all of the techniques discussed in this chapter will apply to all situations, and most will need to be tailored to account for unique circumstances. According to Leo Brideau, FACHE, president and chief executive officer of the Columbia St. Mary's Health System in Milwaukee, Wisconsin, an important prerequisite to the consideration of any of these techniques is to recognize that the hospital environment and the physician practice environment are different (Brideau 2003). Applying this mindset will help hospital management and physicians appreciate and respect that each is

working with different cultural and educational backgrounds and viewing healthcare delivery and its environmental influences from very divergent perspectives.

Differences in Decision Making

Physicians work in predominantly entrepreneurial environments; hospital leaders usually work in environments that tend to be bureaucratic, garnering input from many constituents potentially affected by a decision. The bureaucratic hospital management setting often demands exhaustive analysis to reach consensus on issues, compared to the rapid, independent decision making in physician practices. The bureaucratic hospital environment is also viewed as more conservative and thorough in decision making. Boards of trustees today typically establish an environment for prudent and methodical decision making, a culture and attitude that can be viewed as onerous by the physician operating in an entrepreneurial environment.

According to Robert Pickoff, M.D., "to be fair, it is more than bureaucracy that leads to exhaustive analysis on the hospital side ...there are allocation of cost issues that aren't considered in a physician's office mostly because physicians are ignorant of many of these issues. Educating physicians about the issues a hospital or system considers important is another good technique" (Pickoff 2003).

Personal Investment

Often overlooked in physician-hospital dynamics is the issue of physicians' personal stake in business dealings. When economic relationships are on the table, healthcare executives have inherently lower stakes because they are negotiating the investment of organizational funds. Physicians on a medical staff who choose to participate in an

economic relationship with a hospital or system are contemplating the use of personal funds. For a physician, such initiatives may require them to draw down a personal bank account, take out a second mortgage, or borrow from a bank or venture capitalist. The capitalization of a joint venture may compete with the need for college funds for children or house-renovation money; hospital managers do not have to personally invest in these initiatives.

These differences in personal investment and decision making add up to enormous potential for misunderstanding on both sides. Clearly, the environments in which hospital leaders and physicians operate are quite different, and as a result, each party's perspective can be shaped differently. Nevertheless, the techniques in this chapter present some common ground for forging effective and mutually beneficial ties between physicians and the hospital that will strengthen medical staff organizations.

TECHNIQUE 1: DON'T FIGHT THE INEVITABLE OUTMIGRATION OF ANCILLARY SERVICES AND TECHNICAL FEES

Hospital and system leaders can be short sighted when considering how to respond to the increasingly prevalent provision of ambulatory services out of the hospital environment. Some leaders battle ferociously to retain all outpatient services in the hospital setting. But this movement of services out of the hospital setting is neither new nor unexpected and is becoming more common (see Figure 6.1 for more detail on this trend).

Several issues drive this trend, including the following:

- Physicians are motivated by stagnation, or in some cases reduction, in their professional fee schedules. Essentially, physicians are working harder for the same or less money, as shown in Figure 6.2.

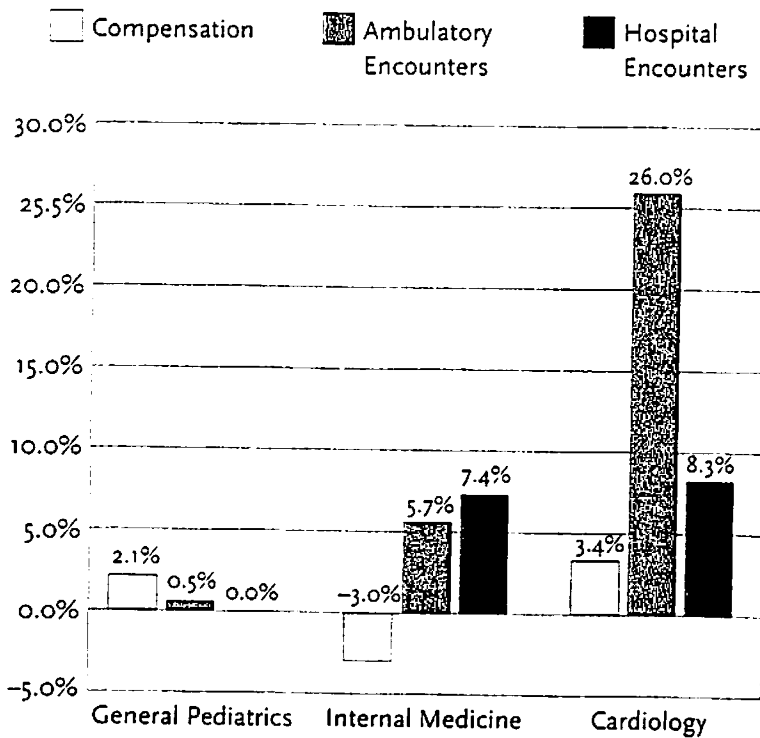
Figure 6.1. Outmigration of Ancillary Services

Outpatient Service Line	Site of Care	1994	2001
Gastroenterology	Freestanding	19	36
	Hospital based	81	64
Urology	Freestanding	16	30
	Hospital based	84	70
Neurology	Freestanding	11	24
	Hospital based	89	76
Ear, Nose, and Throat	Freestanding	17	27
	Hospital based	83	73
Dermatology	Freestanding	27	35
	Hospital based	73	65
Orthopedics	Freestanding	26	36
	Hospital based	74	64
Ophthalmology	Freestanding	56	68
	Hospital based	44	32

Source: Excerpted from Coile (2003).

- Physicians are also motivated by escalating practice costs. The combination of stagnant reimbursement and escalating expenses has a double effect, causing a deterioration of take-home compensation by physicians, as detailed in Figure 6.3.
- Technological advancements will continue to drive care into the outpatient setting. Technologies used for diagnosis and treatment will continue to evolve and become less invasive, smaller, more cost-effective, and generally more suitable for physician offices. Examples abound in surgery, chemotherapy, endoscopy, erdoscopy, and other routine outpatient diagnostic and treatment services.
- The elimination of state certificate-of-need regulations as a barrier to market entry is making it easier for physicians to provide services that were traditionally provided exclusively in hospitals. Approximately one-half of all states still maintain certificate-of-need regulations, which restrict open-market

Figure 6.2. Percent Change in Compensation Adjusted for Inflation Compared to Change in Utilization, 1996–2002



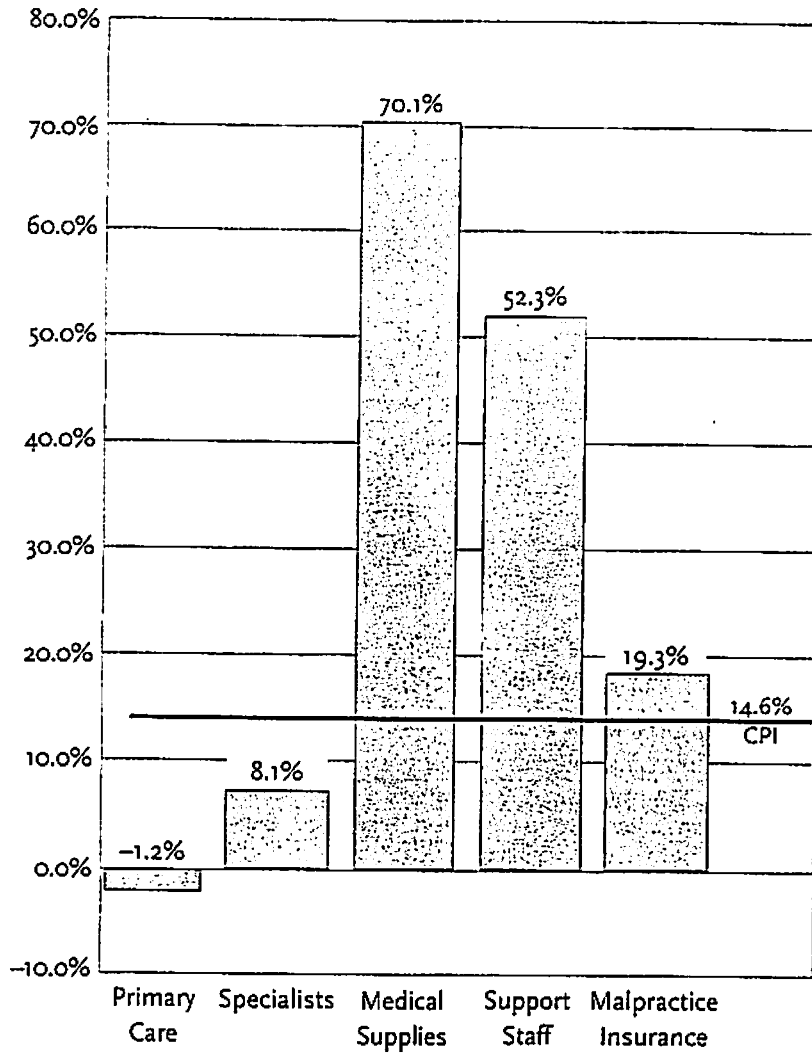
Note: Comparison year is 2002.

Sources: MGMA (1997, 2003). Used with permission from the Medical Group Management Association, 104 Inverness Terrace East, Englewood, CO, 80112-5306; 303/799-1111. www.mgma.com.

program and service development by establishing a process that attempts to rationalize community resources.

- For-profit partners are facilitating the outmigration of ancillary services. In ambulatory surgery, no less than 50 for-profit, publicly traded companies are interested in partnering with physicians to develop ambulatory surgery centers (Health Strategies & Solutions, Inc. 2003). Many companies cite operational efficiency, management expertise, contracting

Figure 6.3. Percent Change in Physician Compensation Compared to Percent Changes in Typical Practice Costs Adjusted for Inflation, 1996–2002



Note: Comparison year is 2002.

Sources: MGMA (1997, 2003); InflationData.com (2004). MGMA data are used with permission from the Medical Group Management Association, 104 Inverness Terrace East, Englewood, CO, 80112-5306; 303/799-1111. www.mgma.com.

capabilities, and most importantly, access to capital as reasons for a partnership with a for-profit company.

According to Robert Pickoff, M.D., "Rather than fighting this inevitable outmigration of services, one obvious alternative for hospitals to pursue is to partner with physicians to salvage a portion of ambulatory services. Physicians may welcome the deep investor pockets of the hospital in return for a piece of the action, even a 51 percent share" (Pickoff 2003).

The lesson of this issue is that in some cases, hospital management should focus energies on those healthcare services not likely to be moved out of the traditional hospital environment. In other cases, management will need to focus on services to backfill or replace those services that outmigrate. In yet other cases, hospitals will find it appropriate to partner or compete with physicians in the provision of redundant healthcare services. The course of action will depend on the specifics of the situation, including the healthcare service, the physician practice, and hospital capabilities. Getting started on this topic is reviewed in Chapter 7.

TECHNIQUE 2: DON'T UNDERESTIMATE PROCESS REQUIREMENTS

Creating a viable, strong, and effective medical staff organization requires a substantial expenditure of time, money, and effort. Hospitals have a long track record of failed collaboration efforts, which has generated animosity and even outright hostility among physicians. According to a vice president of a Mid-Atlantic health system, new and more effective dealings with physicians will take "ten times the effort you plan in your day planner." Physician practices are still typically small groups, and each will require interaction and explanation of initiatives underway or contemplated.

Delegating the day-to-day responsibility for negotiating arrangements with physicians entirely to middle managers is short sighted

and inappropriate; not only does this approach tend to delay the process because of the "I will get back to you with approval" mentality, but it demonstrates insufficient and insincere commitment to the importance of these relationships.

TECHNIQUE 3: IMPROVE HOSPITAL OPERATIONS EFFICIENCY

Improving hospital efficiency is an important technique for building effective relationships with physicians. High-priority operations and systems improvements and the demonstration of efficiency should address, at a minimum, the following:

- Ancillary procedure and test scheduling: access and convenience
- Patient information; results reporting: turnaround time, electronic 24/7 access, and accuracy
- Operating room performance: utilization, hours of operation, room turnaround time, and staffing
- Wait times for different patient cohorts (e.g., urgent, emergent, and nonurgent) and specialist coverage in the emergency department
- Provision of hospitalists for inpatient coverage
- Average length of stay
- Cost per case data
- Clinical outcomes measures and results

TECHNIQUE 4: DEVELOP A FORMAL PHYSICIAN RELATIONSHIP OR "OUTREACH" PROGRAM

Physician outreach programs were commonplace 25 years ago. However, with the Balanced Budget Act financial pressures and increased efforts by pharmaceutical sales representatives to maximize

personal visits to practices most of these programs have been severely curtailed or discontinued or are difficult to differentiate from the efforts of pharmaceutical representatives.

Seasoned managers, executives, and board members may question the value of physician relationship programs, especially at a time when budget items such as strategic planning and marketing are being scrutinized to demonstrate their worth as measured by a very short time frame. However, many hospitals and systems are realizing that they can substantially increase market share in target service lines and geographic areas as a direct result of activating an organized process for seeking physician input and then aggressively addressing physician concerns. For most hospitals and systems, the cost of operating a comprehensive physician outreach program may be far less than the expense of major defections from the medical staff. Further, the outreach efforts of competitive hospitals to physicians historically loyal to your medical staff can be easily but disastrously overlooked.

Successful outreach programs should do the following:

- Monitor physician activity levels at the hospital and its affiliated sites, using monthly (at a minimum) encounter data for admissions, procedures, and other encounters and referrals
- Target top-tier (e.g., the top five to ten percent of active or potentially active) physicians to be included in an outreach program
- Track substantial changes in activity levels (e.g., an increase or decrease of 20 percent) every month; reasons for changes in activity may be as simple as vacation time, but may also be a result of substantial dissatisfaction with emergency department coverage, staff coverage on inpatient units, or operating room procedures
- Establish a formal system for practice visits to ascertain impediments to high satisfaction levels with hospital services
- Address and monitor issues that are raised by physicians and report back to physicians promptly on actions to be undertaken

- Devote senior management time and energy to outreach rather than delegate the responsibility to sales representatives

One healthcare system in the Midwest devotes two to three full-time staff members to this effort: 2.5 FTEs. Three of five workdays are spent on the road meeting with physicians, averaging five appointments per day. This effort adds up to 40 physician visits per week or approximately 2,000 individual physician visits per year—visits that take place in the physician office, on their turf, listening to their issues. The remainder of dedicated staff time is spent addressing and remedying any unresolved physician issues. Three potential responses to physicians' concerns are communicated: "The issue is fixed, and this is how"; "The issue will be fixed by the following date, and in this manner"; or "Here is why we cannot fix the issue, but we will reexamine the issue by the following date."

TECHNIQUE 5: BALANCE CONSISTENCY WITH FLEXIBILITY

Overall guidelines and principles for collaboration are useful as are clear evaluation criteria to determine whether partnership or competitive relationships with members of a hospital's medical staff are more advantageous. Developing guidelines provides a context for each potential arrangement and helps hospital administrators avoid the perception that they make special and unique sweetheart deals with individual practices. Example guidelines and evaluation criteria are described in Chapter 7. Such guidelines help hospitals maintain a consistent, objective, and fair approach to collaborative relationships with physicians. However, hospitals and systems must avoid coming to the negotiating table with rigid expectations for physician relationships or "all or nothing" demands. The failed physician-hospital relationships of the 1990s are evidence that this "my way or the highway" or "one size fits all" mentality is not acceptable to physicians and fails to enable physicians to have

meaningful and valued input into key decisions about healthcare delivery.

TECHNIQUE 6: REPRESENT COLLABORATION BETWEEN HOSPITAL AND MEDICAL STAFF AS A BINDING AND LONG-TERM COMMITMENT

The early models of physician-hospital partnerships suffered from the mere fact that they were highly experimental. The partnerships also fell victim to unrealistic expectations about joining together such diverse groups and motivating physicians to buy into the value of and need for partnerships. Many physician-hospital relationships were initiated during the flurry of activity associated with the perceived need to develop tightly bound integrated delivery networks in the late 1980s and throughout the 1990s to assume full-risk capitation contracts. One physician leader in a New England hospital system accused hospitals of a "bullying, thug mentality" when observing regional hospitals' efforts to impose organization to hospital-physician partnerships.

To avoid committing similar mistakes in the future, physicians, hospitals, and systems need to adopt the perspective that "We're in this together, for the long haul." Storms will be weathered, and together we will find meaningful ways to collaborate that will be beneficial to ourselves and the community we serve.

Successful (and long-lasting) business relationships formally develop a business plan. Previously, in the absence of formal business plans, faulty assumptions characterized business relationships between hospitals and physicians, including misconceptions that:

- Physicians and hospitals could rationally divide up a shrinking reimbursement pool from physician-hospital organizations in the form of capitated or global fee payments.

- Physicians and hospitals could measure and monitor utilization of healthcare services to work successfully under capitation or other risk arrangements.
- Hospitals could employ physicians and instill the same entrepreneurial spirit and accountability as demonstrated by physicians who are in private practice.

TECHNIQUE 7: INVOLVE PHYSICIANS IN HOSPITAL LEADERSHIP

According to Michael Rovinsky (2002),

> The inability of IDSs to align physicians' interests with those of the organization has been due in large part to a failure to develop governance and strategic-planning structures that adequately incorporate physicians' perspectives. Physician input into the strategic development of these organizations often was limited to formal or informal "confidential stakeholder" interviews with key physician leaders identified by the hospital or health system administration. Occasionally, select physicians would be invited to participate in a strategic planning retreat, or results and recommendations from the strategic planning process would be presented to a "physician advisory group" that was formed to serve as a vehicle for physician input. But these tactics were insufficient to foster physician support of the organization's business strategy and goals.

Except in unusual circumstances, physician input into hospital and system management issues has been restricted to clinical care. As hospitals and physicians become more equal partners in the healthcare delivery system, physicians must participate more fully in crucial strategic and financial decision making so that all parties understand the potential risks and rewards of future actions. When physician-hospital relationships demonstrate a spirit of partnership, cooperation, and collaboration and a willingness to share control

and work together to face strategic issues, more successful outcomes are ensured for both physicians and hospitals.

Hospitals should strive to include physician leaders in both formal and informal capacities. Formal leadership positions, not figurehead slots, must be formed. Formal and informal forums for candid discussion and truth telling must be created.

For the Columbia St. Mary's Health System, Leo Brideau includes physicians in leadership, but also actively solicits physician input on major decisions made by the system. For example, more than 70 physicians provided input into a recent strategic planning initiative. Columbia St. Mary's also formed a physician advisory group to provide input into critical program and service developments, such as program planning for a new replacement hospital in downtown Milwaukee. In addition, in the Columbia St. Mary's cancer program planning initiative, every physician related in some fashion to oncology services was invited to participate in the process of determining the future direction of oncology services. Brideau's general philosophy is that physicians can opt out of program and service line planning (and other planning initiatives), but his goal is to not allow the physicians aligned with Columbia St. Mary's to feel left out of these important planning processes (Brideau 2003).

Including young physicians in leadership initiatives is critical. Competing responsibilities and priorities might get in the way, but solidify the involvement of physicians as early as possible. Compensate physicians for time spent in these planning and leadership roles if necessary; compensation may be a better option than leaving out this important constituency.

Particularly critical to gaining the trust and commitment of younger physicians is the understanding that most business dealings with physicians and hospital management should be conducted and resolved outside of the medical executive committee. Business is better conducted in settings that are comfortable for physicians, such as in the medical staff lounge or at the country club on weekends.

Some hospitals and systems elevate the lead administrative physician role on the management team by appointing a chief medical

officer. This role often includes managing information systems and quality and outcomes initiatives (in addition to fostering productive relationships with the medical staff), in contrast to the perceived less influential role of vice president of medical affairs. Many physician executives plan to pursue hospital chief medical officer roles in the future.

One way to maximize participation in leadership is to establish term limits for physician leaders. For example, allow a physician leader to serve an elected term for two or three years, after which the physician is ineligible to serve for a certain period of time.

The Bristol Group has established recommended targets for physician participation in hospital leadership: 30 percent of the hospital board of trustees and 50 percent of strategic planning committees are expected to be physicians. Whether or not these proportions are appropriate for a hospital or system depends on the particular situation; the goal is more physician involvement in hospital management (Sherer 1999).

TECHNIQUE 8: DEMONSTRATE THE VALUE OF ANY FORMAL COLLABORATION

The value of a physician-hospital relationship can be expressed as direct financial contribution or return on investment to each of the parties in the partnership, or as indirect value, measured, for example, by elimination of the "hassle factor" or by strategic importance. Other successful collaborative initiatives have demonstrated the value in seeking early gains in the pursuit of formal business relationships with physicians to gain momentum for other potential arrangements with physicians.

Past collaborations between physicians and hospitals failed to provide accurate and timely financial and utilization performance monitoring. Instead, financial forecasts and utilization projections were made, but ongoing monitoring was usually nonexistent. Today,

financial benefits to each party, including hospitals, physicians, and third party developers or investors, must be monitored and demonstrated. Examples of performance indicators that can be used to demonstrate financial performance are outcomes and other quality-of-care measures, patient satisfaction, return on investment, net income, profit, volume indicators, and market share.

Generally, efforts to collaborate with physicians focus on financial benefit, but hospitals can offer other meaningful benefits, such as operating room block scheduling and facilities located near physician offices.

TECHNIQUE 9: AVOID MEETING WITH PHYSICIANS IN THE EXECUTIVE SUITE

New management teams should make every effort to meet physicians on their own turf. The new chief executive officer of a Philadelphia health system put many miles on his car recently while employing this strategy, but, as one private practice physician put it, "at least he [was] out of the corporate palace." By visiting physicians in their offices, hospital managers and executives demonstrate their understanding of the value of a physician's time and show a willingness to become acquainted with physicians on a more personal level. This situation also applies to senior management assuming a greater role in practice outreach on an ongoing basis. In some cases an invitation to the ivory tower demonstrates respect for physician leadership, but more often the executive suite is too formal and intimidating for garnering frank input and fostering healthy dialog.

TECHNIQUE 10: OFFER PHYSICIANS A CHOICE

Many hospital leaders look at physicians as a homogeneous group when in fact physicians are a highly diverse group with wide-ranging

perspectives on the type of relationship they want to have with a hospital or system. A one-size-fits-all approach to physician-hospital relationships should be abandoned in favor of more personalized relationships that fit the interests and comfort levels of all categories of physicians: young and old, representatives of solo and group practices, primary care physicians and subspecialists, and community-based and hospital-based physicians.

TECHNIQUE 11: BUILD TRUST AND ENABLE EVOLUTION TO MORE SUBSTANTIAL COLLABORATION

A common theme in past collaboration mistakes was substantial and immediate physician-hospital integration. Many physicians will be more receptive to gradual or phased initiatives that allow trust to be built. If initial success is achieved, a platform of trust will be created, enabling further collaboration.

TECHNIQUE 12: AVOID EXCLUSIVITY AND MEDICAL STAFF SECTION CLOSURE

It is far better to let physicians opt in to potential partnership arrangements than to have the hospital select preferred partners. Hardball strategies may foster an anticompetitive environment and attract the interest of regulators. Fostering competition and choice will hopefully help hospitals avoid a lose-lose outcome—litigation.

TECHNIQUE 13: INVOLVE LEGAL COUNSEL TO AVOID LAND MINES

Systems, hospitals, and physicians must first conceptualize collaboration strategies, business objectives, and services that need to be

provided. The possible model or structure can then be constructed to meet the objectives. At this point, legal counsel should scrutinize the feasibility of the plan. By including legal counsel early, the participants can avoid investing significant time and energy in a project or structure that is not legally feasible at the present time or possibly in the future because of likely regulatory changes.

According to Lou Glaser, Esq. (2003), topics that participants should explore in creating arrangements between hospitals and medical staff members include:

- physician anti-self-referral laws (e.g., the "Stark law" and state equivalents)
- state and federal anti-kickback and fraud and abuse laws
- other compliance laws
- federal income tax rules
- tax-exempt bonds
- reasonableness (rather than excessive benefit to physicians)
- certificate-of-need and licensure laws
- corporate practice of medicine laws

TECHNIQUE 14: MONITOR AND COMMUNICATE PERFORMANCE AGAINST EXPECTATIONS

The importance of this technique is best illustrated by observing what happens when performance expectations are not communicated or monitored. Industry performance indicators for employed physicians demonstrate that hospitals and systems typically lose $50,000 to $100,000 per year per physician, yet the oft-stated goal for employed physicians is to operate as close to breakeven as possible.

"Dashboard indicators" of performance are often not developed or not communicated. These dashboard indicators could be developed for many initiatives:

- *Recruitment assistance*: Dashboard indicators include the number of physicians recruited, how many physicians remain in the community after five years, the viability of physician practices, and physician loyalty to a hospital and its specialists.
- *Purchased revenue stream*: Dashboard indicators are collections rate, payer mix, days in accounts receivable, expense levels by major category, and so forth.
- *Competitive situation*: Dashboard indicators include volume of admissions, referrals to specialists, and ancillary services salvaged; competitive recruitment success; financial performance of competitor; and financial performance of medical staff organization.

Performance measures should be developed and measured for both physicians and the hospital.

TECHNIQUE 15: HAVE AN EXIT STRATEGY

Federal and state regulations change almost daily, the reimbursement environment changes frequently, the competitive environment evolves quickly, and individual situations and positions change rapidly. The term or time frame of any major initiatives should allow sufficient time to achieve success, but not be so long as to lock either party into an unwise strategy should the regulatory, reimbursement, or competitive environment change. In addition, the term of any economic partnership should take into account the required capital investment and payback period for the respective venture. Given all the unknowns, agree with physician partners in advance to resyndicate or divest to cut losses if certain key indicators or milestones are not achieved.

CONCLUSION

The success of these techniques will depend heavily on how expertly and creatively they are tailored for the unique situations hospitals and systems face and the level of trust and confidence already present among physician and hospital leaders. Patience, perseverance, and careful planning and monitoring will be key to successfully employing these techniques in building effective working relationships between hospitals and physicians.

REFERENCES

Brideau, L. 2003. Personal interview, July 8.

Coile, R. C., Jr. 2003. *Futurescan 2003: A Forecast of Healthcare Trends: 2003–2007.* Chicago: Health Administration Press.

Glaser, L. 2003. Personal interview, August 13.

Health Strategies & Solutions, Inc. 2003. Company research.

InflationData.com. "Historical CIP." 2004. [Online data; retrieved 1/18/2004.] http://inflationdata.com/Inflation/Consumer_Price_Index/HistoricalCIP.aspx.

Medical Group Management Association. 2003. *Physician Compensation and Production Survey; 2003 Report Based on 2002 Data.* Englewood, CO: MGMA.

———. 2002. *Physician Compensation and Production Survey; 1997 Report Based on 1996 Data.* Englewood, CO: MGMA.

Pickoff, R. 2003. Personal interview, July 8.

Rovinsky, M. 2002. "Physician Input: A Critical Strategic Planning Tool." *Healthcare Financial Management* 56 (1): 36–38.

Sherer, J. L. 1999. "Engaging Physicians in True Strategic Partnership." *Healthcare Executive* 14 (3): 26.