

A B O V E B O A R D



PHYSICIANS

Ten Questions for Building a Physician Relations Strategy

By David Miller and John Hill

Few relationships are more central to the success of the hospital than the one between the board and physicians. This relationship is becoming more important as physicians are increasingly deciding to compete with the hospital for patients in an effort to maintain their incomes.

What issues must the board address to build a strong, mutually beneficial relationship with physicians? Following are the 10 most important questions that the board should ask to cement that vital bond:

1. Is there trust among the physicians, the CEO and the board?

This does not mean you must have a love fest, but rather, that there should be mutual respect and a solid commitment that all parties will be straightforward and truthful with the other. If trust does not exist, trustees should determine why and focus management's attention on improving it. Also, the board can help identify physician leaders who can bridge the areas of distrust and encourage others to improve these relationships.

2. Is there a shared focus on quality care?

Everyone in health care says they are concerned about quality, but based on our experience, few are addressing the issue seriously. In those organizations that are, this shared focus can create a tighter bond among management, the board and physicians. Quality discussions can lead to useful communication among physician leaders, hospital executives and trustees, covering everything from medical staff credentials to the need for new and/or updated technology, and from physicians' treatment protocols to communication and working relation-

ships among clinicians, pharmacists and technicians, including the speed and accuracy of hospital test reports.

In one organization, the hospital employs halftime physician executives to head six major clinical services. These physicians meet with management to set goals, create budgets, discuss quality improvement, and deal with medical staff politics. Their cooperation with management lays a foundation for trust.

3. How and why do physicians make referrals, and how is that process changing?

Physicians make referrals to other physicians based on reputation, patient request, personal relationships, or simply who will take the patient. In some cases (more than you would expect), clerks in the referring physician's office choose a specialist based on the ease of making the referral.

This dynamic is changing in many markets with the advent of hospitalists who frequently assume the role formerly filled by primary care physicians (PCPs)—providing in-hospital care and making decisions about specialists. Combine this trend with the fact that PCPs can make more money providing office care, and it is not surprising that, in discussions with many family practitioners and internists, we have heard them say more than once, "I no longer need the hospital."

The result of these changes is that PCPs do not bond with specialists as their predecessors did, by meeting in the doctor's lounge or sharing care of a patient. Based on our interactions with physicians, many young PCPs have no idea to whom they can refer patients and simply depend on senior partners to direct them.

Through focused efforts, your hospital and medical staff can capture more business by asking PCPs and others for their referrals, handling the referral process and resulting patient interactions efficiently, and providing timely feedback about patients to the referring physicians.

4. Is the supply of physicians appropriate to meet the community's needs?

Faced with a physician shortage in many areas of the country, especially in certain specialties such as obstetrics, trustees should re-examine their role in building physician supply. Some trustees believe that ensuring an adequate number of physicians in the community is a core part of the hospital's mission and gladly use hospital resources to help meet that need. We have even seen a board set a policy that requires management to recruit doctors to meet the community's needs (thereby insulating management from dealing with their own medical staff's pressure to recruit physicians).

Others see this issue as falling squarely in the medical staff's domain. In a tight market, boards that relinquish this role are taking a big risk—one that could negatively affect the community's access to care and the hospital's ability to provide profitable services.

The board should direct the development of a plan to address deficiencies in physician supply. Doing so is complicated, as the federal government heavily regulates recruitment to avoid abuse of the Medicare and Medicaid programs. Because of legal complications, many organizations rely on outside, neutral consultants to determine both hospital and community needs. Others use internal

resources and legal counsel, who can advise the board on the optimal approach for their organization, while ensuring compliance with various federal laws and regulations.

Either way, a thorough evaluation of the market and community needs will help the hospital through that minefield. And, planning far enough ahead will prevent the need to recruit physicians with questionable skills or capabilities.

5. Do you have a method for developing medical staff leaders?

This issue has never been tougher to address. As competition from specialists has grown, and PCPs increasingly abandon hospital practice, the interest in, and relevance of hospital leadership has declined.

On the other hand, these roles have never been more important to the hospital. Physician leadership in improving clinical quality will become crucial as Medicare and other payers demand accountability and begin to determine payment based on outcomes. Their management of utilization will also be critical as all payers come under increasing pressure to manage costs.

Unfortunately, few hospitals are addressing physician leadership aggressively. Succession planning for physician leaders should be approached in the same way that it is done for executives.

When the board considers this issue, trustees should ask four key questions: "What is the advantage for the doctors of assuming needed roles?" "Do specific management roles need to be defined?" "What skills should physician leaders have and how can the board help them acquire those skills?" And finally, "How should the hospital compensate physician leaders?"

6. Should the hospital have economic relationships that help drive common goals and expectations between it and key physicians?

Employment and joint ventures are the two primary economic models for hospital and physician integration. Despite losses suffered in the 1990s as organizations pursued integration strategies, we are still seeing a growing trend in physician employment by hospitals.

What's behind this trend? The first motivating factor is the demand for specialists. Organizations perceive that

hiring them is the best way to ensure their availability in the community and in the emergency department as well.

The second integration model is the joint venture. An organization should first define under what, if any, circumstances should it consider such efforts—for all services, new services, services of strategic importance, or simply when the hospital is forced into it. The board must address the issue as part of the medical staff strategic planning processes.

7. Do you have attractive office space that will allow physicians to practice close to the hospital?

A physician's primary assets are knowledge and time. Convenient access, along with efficient use of his or her time, will increase both a physician's productivity and income. It is little wonder that close proximity to the hospital is a major determinant in where a physician practices.

8. Are physicians growing their own businesses aggressively, and how can the hospital help them?

In many cases, the hospital's business interests and those of its physicians complement each other, particularly if the physicians are loyal to the hospital. Growth in the doctor's practice will translate into more admissions and outpatient procedures. So helping physicians grow is a good investment for the hospital. If, for example, existing demand indicates that physicians clearly need help, the hospital could help recruit new associates for the practice. That situation is relatively straightforward.

However, if there is no demand for additional physicians, the hospital can still help physicians' practices increase their market share in a couple of ways: A physician "finder" or referral service will help match patients in need with physicians who do not have a full patient load. A physician liaison service may help increase referrals from PCPs to specialists. Featuring physicians in hospital advertisements may help grow both businesses. And, by helping those physicians, you will undoubtedly increase their loyalty to the organization.

9. Do you have information systems that enhance clinical practice and increase physician satisfaction?

Increasingly, information technology is changing the practice of medicine. Hospitals are reporting results on their Web sites, spearheading development of community-

wide medical records, allowing physicians to schedule hospital tests from their offices, and providing technology to help physicians make clinical decisions.

10. Do you have practice management resources that can be used to help key practices that are in crisis?

Some physician group practices are very well-managed, but others struggle with billing and collections, governance, staffing, financial reporting, compensation, and productivity. When such problems afflict a group practice critical to the hospital's long-term success, the hospital is at risk.

For hospitals, the consequences of failed physician practices include lost revenue from admissions, poor access to care for the community, limited growth because the practice is not attractive to new recruits, and significant hospital expenditures to rebuild and solidify the situation. That's why the hospital should help prevent these problems rather than simply fix them.

An effective approach to helping physician practices thrive is to have management resources to work with strategically important groups. Core capabilities would include expertise in billing and collections, strategic planning and compensation systems. We have seen this approach used to merge groups, improve group performance, and focus group members on common goals.

The downside for many organizations will be perceived favoritism, as some groups are helped and others are not. That process has to be managed well, with some sensitivity to the political realities in which management operates. In any case, the board should anticipate this issue as it considers helping physicians.

Other trends will likely change but not diminish the doctor's role. The focus on quality outcomes and cost efficiency will create new pressures on physicians, although those who can best deal with the underlying problems of cost and quality will be stronger. The result is that physician relationships and a strong medical community have never been more important, and the organization's effectiveness will be closely tied to theirs. **T**

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CHECKLIST FOR PHYSICIAN RELATIONS STRATEGY

This checklist is designed to help board members consider the organization's performance relative to physician relations and identify areas of potential concern. Not all issues are equally important to every organization, and issues requiring attention will vary by community and market. Setting priorities to improve that relationship is crucial if your executive team is to succeed in addressing deficiencies.

Check the items where you believe performance is appropriate. Items without checks represent poor performance. If you are not sure where the organization stands, use a question mark.

TRUST

- The CEO is trustworthy in dealing with physicians.
- Physician leaders are trustworthy in dealing with the board and management.

QUALITY

- The quality measurement and improvement program is very good.
- Physicians are adequately engaged in the quality process.
- Physicians and managers collaborate on quality initiatives.

REFERRALS

- Hospital executives and physician leaders understand the physician referral process.
- Hospital executives and physician leaders understand the organization's competitive stance regarding referrals.

PHYSICIAN SUPPLY

- An evaluation of the number of needed physicians has been completed in the last three years.
- The organization has a policy on physician recruitment.
- The organization is addressing the need for more physicians.

DEVELOPMENT OF MEDICAL STAFF LEADERSHIP

- There is a succession plan in place for medical staff leaders.
- Physicians' roles and required skills have been defined.
- An education program for physician leaders has been developed.

ECONOMIC RELATIONSHIPS

- The hospital has a policy on joint ventures.
- The hospital has a policy relative to physicians who compete with the hospital.

PHYSICIAN OFFICES

- The hospital has evaluated the need for physician office space in the last three years.
- Hospital executives understand how the organization rates compared with key competitors.

MARKETING AND GROWTH

- The hospital has considered building physician practice volume as part of its overall marketing plan.

INFORMATION SYSTEMS AND TECHNOLOGY

- The hospital has evaluated physicians' IT needs.
- The hospital understands its competitive position relative to other hospitals and niche providers.
- The information technology plan addresses the hospital's competitive position.

PRACTICE MANAGEMENT CAPABILITIES

- The hospital has considered developing resources to help strategically important groups who may be in crisis.

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