

THE COMPLETE GUIDE TO PHYSICIAN RELATIONSHIPS

STRATEGIES FOR
THE ACCOUNTABLE CARE ERA



KRISS BARLOW, RN, MBA

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About the Author

Kriss Barlow, RN, MBA

Kriss Barlow, RN, MBA, has spent her entire professional career in the healthcare industry. Even at an early age, she witnessed hospital–physician communications through the eyes of her father, who was a physician.

Barlow holds a bachelor’s degree in nursing from Augustana College and a master’s degree in business administration from the University of Nebraska, and she has spent the past 15 years sharing her extensive knowledge of clinical and business development with clients and helping them with physician strategy—including relations, retention, sales, and medical staff development. Today, she is principal of Barlow/McCarthy, a consulting group focused on hospital–physician solutions. She focuses on strategy, communications, relationship, and retention models.

Although her clinical background helps in her current role, strategy, program development, and business solutions are her real passions. She treasures the chance to work with so many healthcare professionals and the opportunity to help them achieve success.

A recognized expert, Barlow is a frequent speaker whose presentations are full of content collected through her vast experiences in the healthcare industry and made more lively by her many stories from the hospital trenches. She frequently presents at the Forum for Healthcare Strategists, the Society for Healthcare Strategy and Market Development of the American Hospital Association, The American Association of Physician Liaisons, and numerous state and local conferences. Barlow is a frequent speaker for HealthLeaders Media's webcasts. She is a faculty member for the American Academy of Medical Management's Physician Recruitment program and serves on the Board of Directors for the National Medical Staff Certification program. She is also a certified sales instructor.

Barlow is the author of the HealthLeaders Media book, *A Marketer's Guide to Physician Relations*, and coauthor of a previous book, *Physician Relations Today: A Model for Growth*.

When she isn't working, it is all about family. Her husband Doug is the steady force in her life and her biggest supporter. Together, they have three fabulous sons, two charming daughters-in-law, and a couple of adorable grandchildren. With one of her "boys" in the middle of an orthopedic residency, the cycle of medical staff relationships has taken on a personal feel.

Acknowledgments

The idea for this book was mine, but the interest and willpower to make it happen came from many fabulous people. It's because of them that I completed the physician surveys for this book and the content came together in a meaningful way.

To accomplish the surveys, I called on friends and colleagues in physician relations, marketing, and leadership roles across the country. Here's a huge shout-out and note of gratitude to all the physician relations reps who carried the survey to their practices and assisted in getting a strong survey response. It was a huge favor to ask, and I am grateful to each and every person who participated.

The topic of physician communication is front and center in the minds of our clients, and I tapped many of them to share a thought or offer insight. They are the innovators who consistently strive to enhance the experience for their doctors and their teams. It was an honor to work with such talented professionals.

The team at Barlow/McCarthy went above and beyond. I am proud to be associated with each of them. Allison McCarthy, Ann Maloley, and Michael Barber, MD, offered expertise and words of wisdom in those topic areas where they are experts; you'll see their content in the chapters. Ann did double duty, proofing the content

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to keep me on track. Dave Zirkle, PhD, lives in the world of analytics and survey work; he kept me on track with the data elements. I am proud of the team and the work they do to help each other and to make a difference for our clients.

On a personal note, the center of my ability to work passionately in this field is my husband, Doug, and our boys. From the bottom of my heart, I thank my family for their love and support. It enables me to freely grow in my profession.

Introduction

True confession: I love healthcare. I passionately believe in the commitment to healing and appreciate that every day the people in healthcare make a difference in the lives of others. I am proud to say this is my field of choice. I am surrounded by good people doing great work and, yet, communication within the healthcare ranks is not all it could or should be. That's what drives me and why I initiated this effort. I firmly believe that it's important to know how we can better understand the needs of our key stakeholder group: physicians.

Why This Topic?

I am frequently asked, “What do you find to be the most effective way to communicate with physicians?” And even though weekly conversations with doctors give me a sense of what works—and a better sense of what doesn't work—I always feel a little uncertain about being the expert opinion on this. We've all heard the advertising rule that messages need to be repeated up to seven times to be heard. But will doctors really tolerate that much repetition? There must be a way to communicate with physicians that is more efficient not only for the communicators but for the physicians as well.

In our message-filled lives, there is so much determination to get through and find innovative ways to ensure that our words are the ones that get heard through

all the clutter. Yet we often wonder about the keys to effective communication. Is it how the content is shared, the message itself, or the circumstances of our environment that impact our listening? It is probably a bit of each. But when it comes to connecting with physicians, seasoned healthcare professionals want to make the message meaningful and relevant. We don't get many chances, and it is often information that we need them to have, so we want to make the process efficient and desirable.

Healthcare organizations are looking for ways to align more closely with physicians, which means it is even more important to find out how physicians like messages to be delivered and what they believe to be most important. This book is the result of asking those types of questions—190 doctors shared their opinions in response to questions in four areas of interest. We asked what they want to hear from healthcare leaders, from marketing, from physician relations, and from their peers—especially as it relates to referral relationships. (Full details of the research respondents and methodology are in the appendix.)

The Content

Getting input straight from the source always raises awareness. We can no longer say, “That’s just Dr. Whiner, he always has something negative to say.” The result of research is that we see trends without names, which provides a less biased view of the issue. It also gives us a chance to revisit our personal perspectives on the topic.

- Common wisdom is that it’s always best to get answers “straight from the horse’s mouth.” So in order to understand the best method of

communication and most meaningful content for doctors, we asked physicians. If the responses varied based on demographic or specialty differences, we called those out in the text. Interestingly, there was a great deal of consistency in the top responses.

- While leadership teams will likely want to explore the implications of the survey findings alongside their strategy, we do offer tactical suggestions that can help jump start the implementation.
- In addition, perspectives and suggestions from market leaders are provided throughout the book. Our industry colleagues are always anxious to hear how others are approaching a topic. Market leaders have weighed in with opinions about the survey findings and their recommendations.

There's a lot of theory out there about communications, and much of it is fabulous reading. With all that we hope the book can be, however, it is not going to provide that. The intent of this book is to provide data to help us define our methods and messages to enhance success and push communication to drive measurable benefits as we work with our physician audience.

What Do Physicians Want to Hear From Leadership?

“The art of communication is the language of leadership.”

—James Humes

There are many references about the relationship between organizational leaders and physicians in healthcare publications, in webinars, and on the speaking circuit. We get it! There is a need for healthcare organizations and their leadership to be in sync with the medical staff. Leaders are acutely aware of the need to balance cost containment and care delivery. In the *2011 HealthLeaders Media Industry Survey*, cost reduction was the highest priority for leaders, with 35% selecting it as one of their top three priorities—quality/patient safety ran a close second, at 33%. Care delivery is at the center of our discussions, but collaboration to manage cost effectiveness is the driver. And although models and methods abound, at the heart of change is the ability to talk with each other—the need to appreciate the business and personal challenges of each party.

Physicians still have room for improvement with their ability to listen to other perspectives and give leaders who are trying a chance. But building that trust is

tough to do in the healthcare market. This survey is not about acknowledging trust issues or calling out what the physicians should do differently; rather, it is about providing leaders insight into what the physicians want to hear.

The data highlights priorities for the future success of leaders and the physicians they work with and also provides perceptions about organizational cultures and perspectives. As we anticipate closer working relationships between physicians and healthcare organizations, it is key to understand where doctors believe the organization does an excellent job and where healthcare organizations do not perform as well. The survey was designed to understand how well physicians believe their organization does in several key areas. Other survey questions centered on physicians' views of where leaders need to focus their attention for the medical staff and, more specifically, what aspect of the new hospital–physician relationship is most important to them. Not surprisingly, the desire for involvement—control—of one's own destiny is apparent in the survey results.

Remember that the survey was implemented to expose communications, so as we discuss operational challenges or business structures, the intent is not to build out the method, only to define and then detail what they want to hear—with a little bit of when and how.

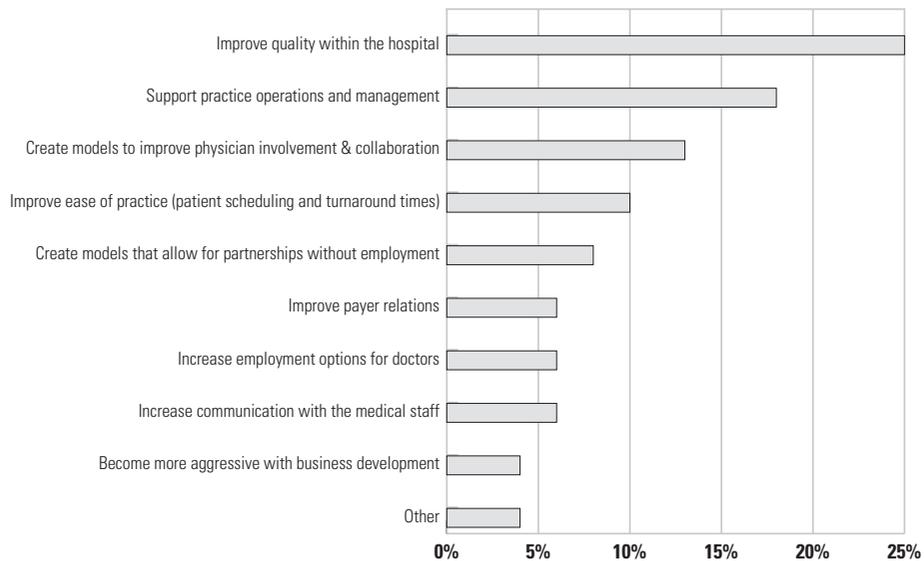
Where the Medical Staff Wants Support From Hospital Leaders

The survey respondents can be grouped almost equally into two categories (see Figure 1.1):

- Those who want healthcare leaders focused on care delivery
- Those who desire attention on the business relationships

FIGURE 1.1

WHERE THE MEDICAL STAFF WANTS SUPPORT FROM HOSPITAL LEADERS



Source: Barlow/McCarthy.

Twenty-five percent of respondents say quality is the most important obligation of leadership over the next three years. This would indicate that doctors are listening to health reform messages on the topic of quality and collaboration, as well as having a strong desire to provide good care to their patients. An additional 13% felt that the leaders' most important role was to improve physician involvement and collaboration. Another category that emerged as a priority under the umbrella of hospital operations was the need to make it easier to practice at the facility, which scored 10%. In total, 48% responded that the focus should be on the care delivery side of the equation.

None of the collaborative business/practice strategies scored very high as a standalone, but when grouped together, 36% of the respondents say these strategies are their single choice for hospital leadership's support of the medical staff. It included a small number (6%) who want increased employment, almost 18% of physicians who want practice support, 8% who desire partnerships without employment, and 4% who cited more aggressive business development.

In the "other" category, respondents most frequently mentioned physician recruitment. (You will see this topic called out later in the survey as well.)

For most of the survey questions, there was more unity around the answers than for this one. The differences may be due to the level of in-hospital involvement, so we evaluated the data by primary care physicians (PCP) vs. specialists:

- Improving quality is the most important element to both PCPs and specialists; however, is it emphasized more by specialists
- PCPs are more likely to identify practice management/support than specialists

When survey respondents were asked to select one answer, 5% chose multiple answers—which may say something about their perception that one priority is not enough.

Priorities and agendas

Today's leaders have a lot going on. As they evaluate medical staff relationships with clinical, business, and peer groups, multiple obligations are in play. The physicians responding in this survey are almost equally divided on their perceptions of the leader's priority to support the medical staff. At face value, it leaves strong leadership teams challenged to determine what to tackle first. And this is only the medical staff's agenda—there are others, of course.

Getting the local pulse

There are national trends and then local realities. With regard to the priorities and expectations of your local medical staff, it's imperative to dig deeper into their needs, the pulse of the local market, and the priorities. Starting with data, the decision support team can assist the leadership in understanding which physicians fall into that “can't afford to lose” category. Use the data to first project their three-year practice plan. You can use data like age, admissions patterns, and tenure with the organization, as well as qualitative details like recent discussions regarding employment or group merger to get a sense of their ability to remain in this category.

Next, carve out those physicians that you perceive to be future leaders. You may find some in the “can't afford to lose” category, whereas others may be active in practice building and may be splitting current referrals. Focus on these two

categories first. Leaders should meet personally with these doctors—there will be a time for group discussion (primarily for action and implementation) later. If your organization has leaders who have been engaging with medical staff on a regular basis, use that group. If the physician relations team has a strong relationship with the doctors who have been selected, then ask them to facilitate the discussion with leadership.

The personal meeting has value at several levels. First, you are able to clearly discern the priorities of your vital medical staff members. Second, it sets the stage for shared development. And third, it is a proactive method of reaching in and framing a model for ongoing communication.

Even though some CEOs may say it is too time-consuming, if it is staged and well coordinated, it can actually be a time saver. Instead of fighting the rumor mill, create the message.

Quality

As it does in many conversations with physicians about priorities in today's healthcare environment, quality bubbled at the top in this study as well. The physicians' responses to having leaders focus on quality improvement likely leaves some leaders saying, "They have no idea about all the quality work we are doing." Physicians clearly want the hospital to exceed expectations in quality and to create a safer and better experience for themselves and their patients.

Whereas leaders recognize all of the efforts internally to enhance quality within the hospital, physicians recognize only those elements that impact them on a

personal level. The gap between these two areas may fall to directors and managers to regularly remind the doctors of the strides that have been made to work on quality and to share the information in a way that is patient care–centric. Data can be shared that graphically shows the impact of quality initiatives. Physicians can be asked to weigh in on quality initiatives that will impact them. Rather than creating a committee, consider a meeting or a task force that includes two sessions with very actionable agendas and outcomes. The beauty of their desire for quality is that everyone wants the same end result, and the language of data speaks for both parties.

Support at the practice level

Second to quality, getting the hospital's support in practice operations and management is on the minds of physicians, with almost 18% of survey respondents indicating so. This is great news for hospital leaders in that physician practices view the hospital as a resource for more support and are willing to ask for it. For those physicians who want more support, there is the challenge of practice management in a tough economic climate with more change to come. Organizations should define where are the opportunities to help physicians—for example, by evaluating the type of tools that could be offered and the fit of those tools with what the doctors in your market desire.

Best practice in this area would be to make sure that you only offer what you know you can deliver. And let doctors' needs be the driver of your actions. Resist the temptation to create practice support strategies that are more focused on what you need them to do to help you grow your business. If you stay focused on their practice development needs, you'll gain in the long run. Careful messaging for

your team around what can be done legally and what should be done politically will of course make for an appreciated value-add.

Beyond Doing, Communicating

Each week, I see organizations and leaders doing great things. There is a great deal of time, energy, and money spent on trying to enhance the physician experience, the communication flow, and providing a service that will add value for the physicians and their patients. But the sad reality is that many doctors really don't see it, feel it, or appreciate it.

Even as an outsider, that is frustrating; however, it is a problem that can be solved. Physicians will rarely initiate a strategic discussion. Communication with leaders is generally around tactical needs, personal agenda items, or issues that need to be resolved. Most leaders focus on strategy and prefer to be in the future tense rather than the daily issues. Proactive communication about strategy that has value for the physician must be leader-initiated. Sometimes this starts with involvement in the strategic plan; for other organizations, it can be around a physician partnership model; still others use national leadership conferences or local classes to immerse the right group of physicians in understanding of strategy.

By understanding strategy, communication about setting and reaching goals sets the stage for enhanced communication. Physicians rarely want to be told the final outcome; rather, give them the tools to experience how it was determined.

SPEAK MY LANGUAGE

Consider how physicians learn. Most physicians have undergraduate degrees in science; their advanced training was about deductive reasoning and ruling out conditions. And their practice success is based on an ability to determine what is wrong. Understanding the choices, the rationale, and the process is comfortable for them. When a solution is provided without an understanding of how it was derived, the result is often doctors questioning, second-guessing, and needing to work through the detail. Why not present the process and approach, then the outcome?

Getting the clinical house in order

Physicians who have practices with heavy hospital patient volume have increasingly called out the importance of quality. It is not a stretch to say that every hospital is working on quality initiatives; however, the level of physician engagement in the processes is variable. It is important to encourage early physician involvement. Hospitals struggle to enforce quality processes without physician buy-in, and buy-in will not occur without involvement. Shared quality goals need to be just that: nurses and doctors working together with leaders supporting the process to discern the obligations for every party. So, we are back to communication again.

As organizations work to do more with less, to better manage costs, and to improve quality, success will depend on tighter alignment and shared goals. Everyone in the system wants to do the right thing for the patient. In many decision points—including scheduling and operational processes—there is more than one way. Involve doctors, consider options, and be open to change about the process.

We have all heard the analogy of herding cats as we try to get physicians to align. As the clinical process is enhanced through physician involvement, the best communication to other physicians often comes from one of their own. Growing physician leaders is absolutely essential, and this is a great place to message from within the physician community.

INSIDER'S VIEW

SHIFTING MODELS OF CARE

Amy Dirks Stevens, regional vice president, strategy & business development/CSO at Provena Health, shared her thoughts on this portion of the survey data. In the old hospital–physician relationship model, she says to physicians, hospitals looked frustratingly similar to their noncompliant patients. “We asked for help, but didn’t consistently follow our physicians’ advice. We wanted to get a clear diagnosis, unless the treatment required change. It would probably take a crisis to motivate us to real action. We needed our doctor, far more than our doctor needed us.”

Now, there’s a shift, Stevens says. “Physicians and hospitals need the best shared continuum of quality to even remain on payer panels. With their larger scale, hospitals are becoming natural aggregators of ‘back office’ services to reduce the burden of practice management, whether the physician is employed or independent. And both hospitals and physicians are creating new business models that share the risk of income tied to outcomes.”

Today’s version of alignment isn’t about improving “poor medical staff communications.” In fact, if we’re honest, there will be many physicians and hospitals left behind who simply won’t meet the higher thresholds that will be expected of us. Alignment, this time, is about tangible business integration aimed at preserving financial viability while improving quality of care.

Business Models

Employment

National data tells us that organizations expect to grow the number of employed physicians. The September 2010 *HealthLeaders Media Intelligence Unit* report, “Physician Alignment in an Era of Change” concluded that at present, 16% of physicians are hospital employed, but 74% of hospitals are planning to employ more physicians in the next one to three years. Of interest is that 70% of hospitals report increased requests for employment by physicians, and half of physicians completing residencies are now hospital employed.

Employment is a viable business model. Primary care employment has been a key strategy in many markets for years. Specialty referrals are very common when smaller markets don’t have depth in specialists, and hospitals have used employment as a strategy to shore up a market and protect some ancillary income.

Organizations feel they have done a good job of communicating their employment strategy with their medical staff. Perhaps that is the reason they did not earn a higher score on this survey. The physicians are aware of the employment strategy, and those who wish to opt for employment are in conversations or have signed the contract.

The right type of partnerships

With so many options beyond employment, like management and comanagement agreements, joint ventures, gain sharing models, medical staff offices, or California’s Foundation models, leaders are striving to find the “best one” and to make certain

that their interests are represented. I asked Richard Keck, founder and president of StratEx, to address the topic of partnerships and whether there is a perfect—or near perfect—business partnership for hospitals and physicians at this time.

Keck says that structure follows strategy. Partnerships are formed to accomplish specific goals or tasks. Whether it is reducing infection rates or building a free-standing ambulatory care center, they are the legal and organizational structures that enable hospitals and physicians to work together to accomplish specific goals.

*“The most important aspect of partnerships
are the mutual goals of the respective parties.”*

—Richard Keck

The foundation for successful partnerships are agreed-upon measurable goals/outcomes and a plan to accomplish those goals that includes a financial projection. This helps ensure that the parties are clear about what they are trying to accomplish and the anticipated outcomes, thereby increasing chances for success. Plans are obsolete the moment they are published, but they do provide understanding of the implications of variations in revenue or expenses, so the parties can make the necessary adjustments to meet their mutual goals.

The regulations defining hospital–physician partnerships are constantly changing. Once the parties have agreed upon mutual goals and a business plan, a partnership agreement should be drafted with the help of legal counsel and other experts. Make sure that communication about this process is shared with the

doctors and that there is recognition about who, what, and when. Waiting can breed nervousness.

Whether the partnerships are structured employment contracts, joint ventures, consulting agreements, or the latest legal structure, they are all reduced to a written agreement between the two parties that identify a set of mutual goals and commitments. Partnerships are about accomplishing specific goals. Legal and organizational structures are the enablers, *not* the drivers.

Before the contract is signed, physicians and the organization need to understand their obligations at a very tactical level. This includes team building, quality obligations, performance expectations, and, yes, communication expectations.

BASIC CONSIDERATIONS

- Create a planned approach to earn trust postcontract. Assumptions about this will backfire every time.
- Under promise, over deliver. Keep track of what is delivered. Communicate this verbally and often—it needs to be in writing.
- Plan regular, face-to-face meetings for the first six months to review what was promised on both sides and what is being delivered, on both sides.
- Do not delegate all the communication to others. If it is the leader's vision to have the partnership in place, then the leader needs to stay engaged in the early implementation.

Several of these emerging business models will further push organization leaders and physicians together, says Keck. Business and financial decisions take center stage when the two parties discuss a more formal relationship. Leaders should plan for implementation specifics and obligations in advance. Challenges with the relationships, obligations, and communication may rear their heads after the two parties seal the deal.

One size never fits all

It is fascinating to observe market response and market sensitivity as different models are considered. The domino effect has long been observed with regard to employment of physicians. By market, when a few groups go, then many others follow. It seems like a permission thing—once a prestigious medical group opts into the business arrangement, others have the freedom to follow. For others, chronic financial challenges are a part of the equation. And for the doctor just finishing residency or fellowship, debt load and job security are front and center.

Payer ranks low—a no control issue?

Because this was a priority for less than 6% of the physician's surveyed, it may fall into the category of one of many important things, but not the most important for the majority of those surveyed. Is it safe to assume that the private practices have payer strategies in place, such as deciding which payer groups they want on their roster, and employed physicians have this managed by the employing entity? This area will likely get more complicated as a result of health reform.

Real Involvement

It is interesting to note that 12% of the survey respondents believe the number one leadership need is physician involvement and collaboration. At a time when many are feeling pulled in every direction, a small percentage of doctors want this to happen above all other leadership priorities for working with the medical staff. But does this mean they are enlightened or concerned?

If you ask, then listen, and make sure that they do, too

When asked to interview members of the medical staff, some of the messages I hear seem to be repeated regardless of geography or organization size. One is, “Now they have hired someone to hear the same message I have told them.” If I heard it once, it would not have had impact, but I actually hear this more than half of the time. Where is the communication breakdown? Is it a lack of listening, a lack of responding to the suggestion, or not doing anything about it—either because the organization can’t or shouldn’t?

On the flip side, maybe a reply was given to the doctors and they were not listening. The starting point is to really understand what was shared. If the request is outrageous or illegal, say so right away. If it is a fair request but you cannot address it, then promptly say so, verbally and in writing, along with rationale for why not. If there are alternatives, give them.

Physician surveys are an excellent way to gather suggestions or concerns en masse. The results allow you to understand the priorities and gauge the time frame and

approach for responding. It is a great way to understand topics of interest for communication. Once a survey has been evaluated, a solid approach for communicating the actions is in order. The following is an example of one option:

- Those who participated are thanked. A plan of action is detailed. Some medical staffs do not appreciate the length of time it takes to get the survey processed and to receive the report; let them know.
- When ready, a short list of priority actions needs to be communicated to medical staff leaders. They can suggest other medical staff members who may be interested in supporting the change.
- Communicate the first list of priorities in committees and through communication tools. Make sure that the message is brief and shows action and timelines.
- Once the suggestion is implemented, remind the medical staff of their request and the action. If you have a physician relations team, ask them to remind the medical staff again at year-end.
- Prepare a fair and balanced response to the expressed suggestions and needs that cannot be met. It's important to acknowledge them and give rational reasons why they can't happen.

It's important to note that you should only do physician surveys if your organization is in a position to react or respond to them. For example, if your organization has been jolted by a new market dynamic or an aggressive competitor, take the

time you need to get that in order before you start asking physicians to add to your already full plate of priorities that you may not have the time or resources to address. But because we're talking about communication, it's important to note here that, even in this case, the physicians should be involved.

The slow 'no' is detrimental

When physicians have ideas for growing their service, or improving the service, the typical approach was to take this information to a service leader or member of the C-suite. The usual result is that they would generally get an update about the capital budget expenditures, time frames, and priorities and be told by the leader, "We'll get back to you." Some leaders pride themselves on their ability to implement the slow no as a way to manage the medical staff. This approach erodes relationships at a time when they are already a bit suspect.

Do you remember hearing the quote by General Colin Powell, "The day soldiers stop bringing you their problems is the day you have stopped leading them"? It goes without saying that the magnitude of pain grows when there is a sense that decisions were made without input or the decision was made but not shared. In the past decade, many believed that a good CEO was able to share "just enough." In some schools, there is still a bit of this old thinking, and it is hurting communication at every level.

Summary

All successful partnerships are based on mutual respect and trust. Trust and mistrust are learned behaviors. One of the keys to establishing trust in effective hospital–physician communication is consistency and transparency. The structure of the healthcare system is increasingly putting hospitals and physicians into adversarial positions—usually around money.

A leader’s trust with the medical staff is built on predictability and transparency. Although both parties have work to do around these principles, hospitals have the greatest burden. Lack of accurate, timely, and consistent information is one of the big drivers of mistrust between hospitals and physicians. Hospitals must do a better job not only with their physicians but also with their staff and the public. Physicians are scientists—their currency is timely, accurate, and reliable information.

The survey shares where the medical staff believes leaders should focus. This paves the way for conversation and opportunity.