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Hospital
executives take
a few simple
steps to improve
relationships
with their

PHYSICIANS

BY CHRISTINA ROMÁN

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Whatever the politicians in Washington, D.C., decide to do about health reform, the pressure to improve quality will never let up. Providers increasingly will be measured and paid based on their success at cutting

costs, reducing errors and improving outcomes.

None of that can happen without full-scale cooperation between hospitals and their physicians. Given the traditional tensions between the two sides, achieving meaningful cooperation may seem unlikely at best.

But a number of hospital leaders have found that building bridges with their medical staff—whether employed or contracted—doesn't require a complicated set of management techniques. They've taken a much

less formal, more commonsense approach to reach out to physicians to better understand the issues these

men and women face day to day. By doing so, they have gotten past the misunderstandings and hostilities that prevent executives and clinicians from working together more productively, and they've greased the wheels for what has come to be known as accountable care.



Shared financial risk and shared governance definitely are required to build effective accountable care, says David Fox, CEO of Advocate Good Samaritan Hospital in Downers Grove, Ill.

“But it also has to be based on a foundation and history of trust and alignment,” Fox emphasizes. “You can’t control people into great behavior. People behave well because they are inspired by your mission, the alignment of incentives, and your investment in their success.”

Great Results, But How?

Good Samaritan, which won the prestigious 2010 Malcolm Baldrige National Quality Award for performance excellence, employs just five of its 950 physicians. The average size of physician group practices in the hospital’s local physician-hospital organization modules is just 2.5, disproving the theory that you have to be big to get impressive outcomes.

Good Samaritan scores above the 90th percentile for the Centers for Medicare & Medicaid Services core performance measures and it boasts a 6.8 percent operating margin. Its scores for physician satisfaction have jumped up from the 69th to 97th percentile in HealthStream ratings over the last five years. Inpatient satisfaction is in the top quartile and market share is up 15.5 percent in four years in a highly competitive marketplace. Thompson-Reuters ranks the organization as a Top 50 cardiovascular hospital.

How do they do it? Advocate’s leaders say their partnership with physicians is key.

The boards of the physician-hospital organization and the system itself are a 50-50 split between management and physicians. Administrators listen to physicians and consistently act on what’s important to the clinical staff.

Importantly, they measure and report back

everything so that improvement can be an ongoing, robust process.

Physicians Are People, Too

Hospital leaders with the best results all say the same thing: Get to know your doctors on a personal level.

“Do you know your chief of staff’s birthday? Where that doctor grew up? How she ended up at your organization? Why she chose her specialty?” asks Michael Hunn, senior vice president and regional chief executive for Providence Health and Services, a system with 10,000 employees and more than 3,000 physicians at five medical centers in southern California.

Hunn led the culture change at Providence’s Little Company of Mary Medical Center in Los Angeles County, where he was CEO for four years before being promoted to his new post. During that period the medical staff’s confidence in the administration jumped from the 14th to 91st percentile, according to Press Ganey data. Cash flow more than doubled to \$34 million and net operating income rose from \$3.5 million to \$13.4 million. Physicians’ likelihood to recommend the medical center increased from the 27th to 84th percentile.

Ready to get started? Hunn suggests this exercise: Divide a piece of paper into two columns. In column A, write the name of the doctor with whom you have the best relationship. In column B, list your two or three most challenging physicians.

Then, Hunn suggests, ask yourself: When is the last time you have asked those difficult doctors for advice? When did you last grab a cup of coffee or lunch with them? When did you last say, “I know how committed you are to providing quality patient care. Is there anything I can do to help you succeed at that?” And have you followed through on your promises to them?

Too Much Communication? Never

Hunn—who had a standing Tuesday lunch date at his desk with key members of the medical staff when he was at Little Company—recalls the time he invited the physicians to sushi at a local Japanese restaurant. One of them pulled a 3 x 5-inch note card from his shirt pocket and carefully made a line through an item.

“Should we tell him?” the physician asked his colleagues. When they gave him the go-ahead, he told Hunn, “We made a list of all the promises

5 Things Physicians Want in Hospitals



Source: 2007 Press Ganey survey representing the experience of 27,671 physicians practicing at 302 hospitals in 2007



you made to us when you started here and sushi was the last one you had left to fulfill. We think we can trust you now.”

“Whatever you do, don’t tell a physician that you will deliver something by a specific date and then not deliver,” Hunn says. “You will lose his trust. Erase the phrase, ‘I’m working on that’ from your vocabulary. Instead, explain that you will pick up the phone the minute that piece of equipment is in to communicate that it’s arrived. Then follow through and overcommunicate what you delivered.”

In early January, 23 clinicians from five of Providence’s medical centers reached unanimous agreement on how to pursue and realize a single clinical-integration model.

When Hunn couldn’t figure out an equitable system for how specialists should provide emergency-call coverage, he asked his chief of staff to appoint a physician task force and make a recommendation. He promised to live with whatever they decided as long it was fair, affordable, legal and sustainable.

The results? When physicians were empowered to make a decision and faced the stark economic realities of the problem, they unanimously agreed that while the hospital would always reimburse for indigent care, it would not pay for on-call work in general, and that all disciplines would take call.

Create a Shared Agenda

In many hospitals today, service and product lines are co-managed by teams representing major disciplines. And yet, most have yet to achieve that same level of coordination of care at the patient level to prevent avoidable readmissions and medical errors.

“We need to re-examine the social compact between physicians and hospitals,” suggests John Combes, M.D., president and chief operating officer of the American Hospital Association’s Center for Healthcare Governance. Combes also is heading up the AHA’s Physician Leadership Initiative, which is aimed at improving hospital-physician coordination. “More and more, physicians don’t need hospitals as a place to work. Boards and managers need to define mutual expectations to rewrite this quid pro quo of service for a place to work in favor of mutual accountability for care.”

Mark Clement, CEO of Rochester (N.Y.) General Health System, says, “It’s about creat-

ing a work environment where it’s easy for everyone to do the right things for patients.” Rochester General employs roughly 40 percent of its 1,000 physicians and was ranked as one of the nation’s top 100 most integrated health networks this year by SDI, a health care analytics firm.

In addition to drilling down on doctor wish lists from its annual physician survey, the hospital uses a physician council—comprising physicians and members of the executive team—to drive improvement and enhance the practice environment.

An example: Five years ago, primary care physicians in the community were unhappy with inadequate communication after they referred their patients to the hospital. The physicians complained they weren’t consulted when major clinical decisions needed to be made and that hospitalists did a poor job with handoffs when patients were discharged.

As a result of work by the council, Rochester General has hardwired hospitalist protocols to ensure that they thoroughly communicate with every primary care physician every time, and patient discharge records now are forwarded electronically to primary care doctors.

“It’s also critical to create meaningful dialogue among stakeholders that are important but physically separated, like OR and inpatient medicine,” says Walter Polashenski Jr., M.D., associate chief of medicine. “Big surgery days mean there is less room for inpatients, and vice versa. They impact each other.”

Efficiency, for example, is in everyone’s best interest. Reducing length of stay is good for patients, good for hospitals and good for physicians. A physician action team, which meets with employed physicians and those in private practices, gathers data on the challenges and then feeds back agreed-upon solutions.

“The more physicians talk to each other, the more patient care improves,” Polashenski says. “Now we make it easy to touch base by phone. Page operators will hunt physicians down so they don’t have to wait on hold.

Align Incentives”

One of the most effective ways to establish a shared agenda is to ensure that leaders are evaluated on the same things and incentivized for performance. At Rochester General, leaders at

5 Tips from the Experts

Experts list five things hospital leaders should do now to improve relationships with physicians.

1 | BE VISIBLE

Round on your doctors one-on-one. Ask what’s working well and what they need from you to deliver better patient care. Then do it. Michael Hunn, senior vice president and regional chief executive of Providence Health and Services, likes to wear a neon yellow safety vest for rounding on physicians. They know what he’s doing when they see it.

2 | APPOINT A PHYSICIAN CHAMPION

Identify a well-respected physician who is adept at facilitating difficult discussions and getting buy-in from other physicians. Physicians need to talk to physicians.

3 | CREDIT DOCTORS FOR SUCCESS

Express frequent appreciation privately and publicly. Remember, you can’t overdo it. If something’s going well, credit the docs.

4 | BE TRANSPARENT

Share and post results publicly. Some hospitals use a stoplight report to show progress on doctor-requested items. Green means “completed,” yellow means “in progress” and red means “evaluated but can’t go forward.”

5 | ALIGN INCENTIVES

The annual evaluation is where the rubber meets the road. If you want administration and physicians to align their behaviors, align their goals with weighted, objective and measurable expected outcomes.

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Data that Move Performance

What if you were able to segment your physician data in such a way that you could learn which of your top performing physicians were splitting their business with other hospitals; or which of your most loyal physicians were serious outliers in say, high length of stay, poor patient satisfaction or clinical quality? Then when physicians wanted to join your accountable care organization, you could evaluate their performance and cost efficiency before you made a decision.

That's the idea at Hackensack University Medical Center, a 7,700-plus employee health system in New Jersey with just 2 percent voluntary employee turnover.

First, medical center administrators scored their physicians according to data in three domains: efficiency (e.g., length of stay, cost per case), effectiveness (e.g., readmission rates, mortality rates, core measures), and patient perception of care (e.g., patient satisfaction survey scores, HCAHP scores). They can categorize the doctor by domain or by an overall composite score. Based on the rankings, doctors are grouped in a matrix according to best performers, middle performers and lower performers.

By definition, of course, one-third of doctors always will show up in the lower third of the performance matrix, even as overall performance improves. It doesn't mean the physician is a poor performer, just that two-thirds of his colleagues currently outperform him.

More recently, the medical center has overlaid that data onto an Advisory Board Company database for physician performance, which includes information on volumes. The goals are to express appreciation to high-performing doctors loyal to HUMC with a handwritten, personalized thank-you note; recruit more business from high-performing doctors who split their business by learning what else they need; and to dig deeper with lower-performing doctors on staff.

"The numbers can be a smoke detector," says Louis Teichholz, M.D., division chief of cardiology and director of cardiac services at HUMC. "Smoke detectors go off when there's a fire—and sometimes when you're making pizza—so the data should be the beginning of a dialogue."

The Advisory Board software makes it easy for doctors and leaders to drill down in a particular patient case to see what the confounding factors are.

The data is also transparent. Division chiefs and their physicians can log on and see how their performance stacks up on a dashboard.

What do the doctors think? "It's sort of like Kubler-Ross' five stages of grief," says Jay Goldstein, administrative director of HUMC's department of medical administrative affairs. "Some go through denial, anger, bargaining and depression on the way to acceptance. But nobody wants to be an outlier."

HUMC has a long tradition of proactively engaging with physicians and giving them the tools they need to succeed. High-performing physicians are committed to doing more of what works and less of what doesn't work to deliver more quality and value for patients.

—CHRISTINA ROMÁN ●

all of the affiliates—the flagship hospital, long-term care facility and medical groups—have objective, weighted goals that cascade from directors and managers. Goals are customized around each department's ability to impact such key drivers of physician satisfaction as rapid turnaround times and radiologist availability in the evenings.

Similarly, Advocate Good Samaritan aligns goals for senior leaders to managers across six key areas: health outcomes, patient satisfaction, physician engagement, associate engagement, growth and "funding our future."

The health outcomes goal, for example, makes up 30 percent of the organization's annual goals. Results are measured by performance on nine metrics that range from falls and readmissions to core measures and length-of-stay index.

In 2010, physicians at Good Samaritan achieved 96.7 percent of their clinical integration goals and earned an extra \$5.9 million in reimbursement. The doctors improved in 116 metrics that measure both clinical and efficiency outcomes.

CEOs: Please Stand

In the end, physicians want what hospitals want: quality care for patients. But John Kotter points out in his book *The Heart of Change*, enrolling others in a vision to transform care requires an appeal to the heart, not just the brain.

Physicians want the organization to succeed because they feel connected emotionally, socially and even spiritually to its mission, vision, and purpose. While data is useful, trust, partnership, and leadership are what will transform American health care.

At a recent conference where he talked about how to engage physicians, Providence Health and Service's Michael Hunn asked the CEOs in the room to stand.

"It starts with you," he told them. "You can't take your staff further than you take yourself. In fact, what you permit, you promote."
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