The role of physician services in hospital transformation

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by Andrea J. Simon

After writing about my time as interim senior vice president for marketing, branding and physician services at Flint, Michigan's Hurley Medical Center from 2010 to 2012, I thought it was time to talk about physicians: services, relations and engagement.

Almost four years ago, Hurley employed only about 35 percent of the physicians--the rest were community doctors who typically divided their time between Hurley and another hospital. As a result, the hospital's inpatient admissions remained stagnant for several years.

When I arrived at Hurley as a consultant, they hired a team to build physician services, previously located in the medical staff office, which primarily focused on credentialing. To achieve real growth, physician services moved to marketing and branding and then reinvented into a business development and physician relations function, well beyond what they had been in their earlier iteration.

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Yet, they lacked processes and systems to do their new job effectively. Additionally, the team had no strategy or tactics and little ROI accountability, much less a clear understanding of how to move market share or the data systems to help achieve desired results.

Hurley needed physician services to overcome fast-moving trends:

- Increased competition for fewer profitable inpatient volumes
- Rapid conversion of many formerly inpatient care solutions to outpatient services
- Incentives from medical homes and insurance companies to provide integrated solutions also diverting patients from hospital services

Our job was to understand referral patterns and identify opportunities to increase referrals from splitters--primary care physician referrals to non-Hurley specialists, also known as leakage. We also had to identify nonusers from around the region we could convert into users and loyalists.

First, we began observational research and culture probes, including hanging out a lot in the hospital lounges to listen to the conversations. We searched for the stress points that the medical center created with its physicians, many of whom were familiar with other hospitals and told us a great deal about how different institutions dealt with their doctors. Our research revealed how physicians were dinged for not completing their medical records, how their system interfaces with the hospital rarely worked and how IT rarely fixed them, and--a pain point they mentioned often--how the leadership did not visit or help them build their practices. They also expressed concerns about nursing and patient care.

We could see this as a challenging starting point or an opportunity to bring about innovation and positive, lasting change. We chose the latter. We determined we could quickly fix some very solvable problems, and then tackle how to help physicians improve their practices and their relationships with the hospital.

During the information-gathering process, we learned something that seemed rather disturbing--many physicians felt that Hurley really didn't want their patients, citing poor complaint management, inattentiveness to block scheduling, and lack of awareness of and familiarity with programs, specialists and services.

The mission we had to accomplish (one that you might find necessary at your organization during these changing times): Build effective and empathetic relationships with physicians in the region to facilitate increased referral streams of patients to the medical center.

I cannot emphasize enough that this was as much about how the physicians felt about the hospital as it was about what the hospital actually did to or for them. We know that people buy with emotion and then justify their decisions with reason. While we might change functional methods, we need to focus on changing the emotional relationship between the hospital and the physicians.

Where to begin? We knew that drivers of referrals would emerge if we:

» Identified the root cause of issues and targeted our fix-it conversations in a way that was emotionally grounded in improving how physicians felt about the hospital

» Aligned the entire organization to fix things right and fast--no IT support was simply unacceptable. This was paramount for the entire organization, not just physician services.

» Determined the real reasons for missed opportunities in the referral stream

» Tracked outreach and managed accountability, ensuring that the staff delivered results, not promises

We first addressed the role of the physician services liaison. In the past, they defined their jobs in terms of windshield time, nonappointment visits and service recovery focus. Those were nice activities but neither results-driven nor sufficient to shift physician behavior. The calling officers had to transform their personal goals, daily activities and styles to become needs-based sales-and-service professionals. New training enabled them to provide needs-based solution selling, appointments and relationship development actions, value in innovative ways, targeted conversations to under-referring practices and fast-track problem resolution.

Newly grounded in developing target audiences around data-driven models with a strong business intelligence platform, the team began calling physicians regularly, getting calls from them to resolve issues and building trust--a critical, missing component of their relationships. Of particular importance was the data model that would set a benchmark and demonstrate progress as inpatient referrals increased, or didn't. The actions were targeted and results-driven, and the team soon realized that just showing up was no longer valuable or viable.

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Several comments:
1. Most of the elements you mention focus on your non-employed physicians, but your employed physicians need the same attention and maybe more. You use money to hire them, but you need to make their job so fulfilling that they wouldn't want to ever work elsewhere.
2. Physicians want minimal hassles, but they also want to be part of the planning and management. This doesn't require employment, but respect for their opinions, ideas, and support.
3. In the Studor model, "up-manage" your physicians through regular feedback- 3 positives for every negative, IMHO.
Good job. Thanks.