



# PHYSICIAN ENGAGEMENT TOOL KIT PROJECT

*Practical Actions to Build and Rekindle Physician Relationships*

Studies by Integrated Healthcare Strategies and The Governance Institute – with local hospital boards, physician leaders, and managers – indicate growing concerns about how to improve hospital-physician relationships during times of competition, economic constraints, and intense regulatory and media scrutiny. Analyses of the arenas in which hospital boards and managers need to invest new creativity and resources for enhanced physician-hospital trust building and performance improvement suggest work is required in 14 areas:

1. Improve physician productivity
2. Change medical staff structure and improve communications
3. New credentialing and privileging systems
4. Quality and patient safety
5. Board work and governance
6. Strategic planning
7. Capital allocations
8. Co-venturing Ambulatory Centers
9. Practice support systems
10. CME and GME
11. Electronic Medical Records and E-Health
12. Social interactions between board and managers
13. Philanthropy
14. Community health enhancement work

It is not easy to rekindle or nurture physician-hospital relations in these areas, but the effort must be made and continuously enhanced if hospitals are to again live up to their potential to serve their patients and communities. How can you add to and refine the following series of strategies and tactics in your community setting?

## 1. IMPROVE PHYSICIAN PRODUCTIVITY

Physicians do not need the hospital in the same way they did ten years ago. Physicians also do not want to waste time in the hospital. Hospitals need to refocus on streamlined processes, hold fewer and better meetings scheduled more conveniently for doctors, and invest in great nurses, allied health professionals, and easy to use systems. Operating Room efficiency must be world class.

Physicians want the best for their patients so they can have a positive experience in the hospital. Efficiency and convenience are key goals for the patients, their visitors, and the physicians and their office staff as they interface with the hospital and its service departments.

### ENGAGEMENT ACTION TO DOS:

1. Invest in physician ombudsman to facilitate doctors' use of hospital resources for patient care.
2. Improve nursing pride and enthusiasm for the doctors and their patients.
3. Define "20 Moments of Truth" (i.e., interaction points for each doctor in your hospital) and optimize the experience.
4. Have a "greeter" at the door of the hospital and a one-stop registration process. The greeter gives directions, forewarns departments of the patient's arrival, etc.
5. Identify physician champions to participate in process improvement at times convenient to the physicians.
6. Establish MD committee that has access to hospital staff to redesign processes. Savings from these efforts should go into a pool for the respective specialty, and use of those funds is determined by the committee. (Funds are only used for hospital business, but also can be used for capital acquisitions.)
7. Establish a twelve to nine shift in the operating room to handle late surgical cases.

8. Chart max—immediate data available via the Web on physician charting productivity. Ask physicians for input into obstacles to using the web delivery system. Involve physicians with hospital staff to overcome bureaucratic delays and inefficiencies.
9. Partner with physicians and their key office practice managers in the design, planning, and implementation of clinical transformation systems (IT, EMR, CPOE).
10. Make sure hospital staff and systems are responsive to physician requests and needs.
11. Drive access data to the clinical department, chief level, and make the clinical administrative staff available to interpret/analyze data for physicians.
12. Include physician leaders on *all* projects.

#### ENGAGEMENT ACTION TABOOS:

1. Implementing new systems/programs without participation of physicians and other key stakeholders.
2. Setting productivity thresholds or goals generically across the medical staff.
3. Designing systems without physician input.

## 2. CHANGE MEDICAL STAFF STRUCTURE AND IMPROVE COMMUNICATIONS

The medical staff as a structure is increasingly being viewed as out of date and not a valuable use of physicians' time. Medical staff by-laws are being refined to streamline the number of committees, the access to minutes and meetings, and the role of the medical staff as a vehicle to stimulate, guide and focus the talents and time of the active physicians. New communications systems and commitments are being called for, not just to support medical staff effectiveness and efficiency, but also to rekindle rapport and trust among physicians, board and management.

#### ENGAGEMENT ACTION TO DOS:

1. Use a special physician advisory group or counsel to introduce new programs and projects to the medical staff.
2. Ask the Physician Advisory Council to meet with senior leaders on a regular basis.
3. Invite physician practice managers to medical staff meetings.
4. Have trustee(s) attend quarterly medical staff meetings.
5. Establish implementation teams composed of board, management, and physicians working on presence and voice in governance roles and decision-making, leadership development, peer review, and so forth.
6. Roll out options on different medical staff committee structures; put before the medical staff for a vote; test the new structure for six months to a year; adjust as necessary; then implement permanently.

#### ENGAGEMENT ACTION TABOOS:

1. Making changes or plans without physician input.

## 3. NEW CREDENTIALING AND PRIVILEGING SYSTEMS

Modern credentialing and privileging must increasingly be more rigorous, transparent and objective, and must be evidence based. In hospital systems, these functions are often supported by dedicated staff and a centrally maintained database to save time, money, and improve the quality of oversight and support for local medical staff committees administering the processes.

#### ENGAGEMENT ACTION TO DOS:

1. Require minimum number of admissions per year to ensure physician interest in the hospital and community.
2. Smaller hospitals have merged credentialing support with the business office.
3. Seek outside resources on how to best structure the credentialing and privileging processes.
4. Consider whether your hospital should require board certification for appointment to the medical staff.

5. Focus on quality and how it will improve clinical specialties.
6. Local systems should consider centralized credentialing to minimize time and paperwork for physicians.
7. Get physicians without a vested interest in a privileging decision involved in the process.
8. Consider requiring a certain percentage (e.g., 75%) of a physician’s activity (surgery, births, etc.) at the hospital as a prerequisite for participation in the hospital’s captive malpractice indemnity programs.
9. Try to condense the process for return to the medical staff after a leave of absence due to lapse of liability insurance.

#### ENGAGEMENT ACTION TABOOS:

1. Allowing hospital volume of a few dictate privileges for all.

### 4. QUALITY AND PATIENT SAFETY

Physician engagement is particularly important in the realm of continuous process improvement for clinical quality outcomes and patient safety initiatives. Boards must encourage management support of the physicians and nursing leadership when developing/modifying and implementing these processes.

#### ENGAGEMENT ACTION TO DOS:

1. Find champions, but don’t make them sit in meetings—take important bits of information to them.
2. Consider launching a “Patient First” program to drive your organization’s culture.
3. Add quality benchmarks to the credentialing process.
4. Physicians can be educators. Give them tools and venues to be successful as teachers.
5. Consider establishing a Clinical Planning Committee that focuses on quality and patient safety, reports directly to the board, and is not considered a part of the medical staff. This committee should have significant physician representation. Or set up an “operations” quality care council with physician representation to discuss day-to-day issues of quality and patient safety deployment.
6. Restructure the quality department so physicians have a person (i.e., can put a name with face) who works specifically on their projects and needs (one contact per person).
7. Consider forming a captive insurance company to help cover affiliated physicians for professional liability.
8. Share data and benchmarks with physicians.
9. Use a “physician quality associate” to work with medical staff. This person should be a physician.
10. Appoint physicians to various quality and patient safety committees.

#### ENGAGEMENT ACTION TABOOS:

1. Accepting JCAHO as the only measure of quality—<http://www.ihl.org/ihl> or <http://www.qualityforum.org/>.
2. Using faulty data.
3. Overlooking this pressing issue.

### 5. BOARD WORK AND GOVERNANCE

Physicians are invited to provide active leadership through formal board positions, as well as service on board committees and task forces. The board structure is less important than the board’s governance processes, which must have active physician involvement and a sense of enthusiasm and ownership.

## ENGAGEMENT ACTION TO DOS:

1. Accept physician input as a meaningful contribution.
2. Establish a medical staff development committee that reports to the board executive committee.
3. Dedicate time to trustee education on physician relationship dynamics, and physician education on board fiduciary duties, roles, and responsibilities. Talk about issues—hopefully before they happen.
4. Have the CEO meet monthly with the board chair and president of the medical staff to review issues and think of innovative ideas.
5. Educate...educate...educate.

## ENGAGEMENT ACTION TABOOS:

1. Allowing independent board members to exclude physician board members from “important” decisions.
2. Allowing the board leader to appoint his or her friends to gain power and votes rather than basing board appointments on what is best for the hospital and the community.

## 6. STRATEGIC PLANNING

Physicians must not only be active in their classic roles of assuring care quality and patient safety, but also in board decision-making processes, market analyses, and strategic business and financial planning. Special education and support staff for physicians to assure their effective and efficient engagement in the planning processes is essential.

## ENGAGEMENT ACTION TO DOS:

1. Include physician leaders on the strategic planning task force. Include physician “complainers” to help engage them.
2. Invite all clinical department and service chiefs to off-site planning sessions. Make them part of goal/objective setting.
3. Survey the medical staff to get the “big picture.”
4. Schedule regular breakfasts with the CEO and physician leaders to discuss strategy and challenges.
5. Schedule joint meetings with board and Medical Executive Committee.
6. Involve physicians in the review of demographic data; discuss competition – both with the hospital and within specialties.
7. Set up interviews with physicians before the planning retreat. Schedule the retreat based on physicians’ schedules.
8. Consider asking the board and a team of physicians to specify the physician selection process for participation in next strategic planning process, criteria for participation, and accountabilities to medical staff.
9. Have a monthly medical staff session where the board and administration listen and provide feedback.

## ENGAGEMENT ACTION TABOOS:

1. Formulating a plan and then asking for physician input.
2. Directing physicians to independently develop objectives, measures, metrics and deadlines.

## 7. CAPITAL ALLOCATIONS

Physician leaders must be actively and substantively engaged in the annual capital allocation processes within the hospital or health system. This involvement must be informed and supported by education and systems tailored for physician effectiveness and efficiency.



## ENGAGEMENT ACTION TO DOS:

1. Establish a joint committee with physicians and management to review all annual requests and set priorities.
2. Use a think tank to generate capital investment ideas, and involve medical staff representatives.
3. Ensure that capital allocation goes through the strategic planning group.
4. Ask the medical staff to develop a department-specific list of priorities.
5. Allocate capital according to strategic priorities, but work toward an equitable distribution whenever possible.

## ENGAGEMENT ACTION TABOOS:

1. Under-representation of physicians on the capital allocation team.
2. Excluding physicians.

## 8. CO-VENTURING AMBULATORY CENTERS

Most of the challenging aspects of joint planning and competition are evident in ambulatory surgery centers, imaging centers, CATH labs, dialysis centers and special centers for cancer, cardiac and orthopedic services. Creative strategies and tactics are needed to “disaggregate” projects into more discreet elements with different ownership, managerial, and financing roles and controls for aligning economic interests, while avoiding conflict with government regulatory standards.

## ENGAGEMENT ACTION TO DOS:

1. Consider joint venture with national firms specialized in surgery, imaging or related centers.
2. Consider joint venture relationships with specialty physicians.
3. Develop real estate venture with physicians and real estate specialty firms.
4. Consider participating tax-exempt bond transactions (PBT's).

## ENGAGEMENT ACTION TABOOS:

1. Overlooking the primary care physicians.
2. Neglecting to fully consider the various options and implications of joint venture relationships.



## 9. PRACTICE SUPPORT SYSTEMS

Income erosion and operational hassles have become very distracting in physicians’ offices and practices. They need help, may not know it, or are unwilling to ask out of control and cost concerns. Hospitals and systems must expand and enhance the range and quality of customized practice support staff and systems that build the economics and quality of physicians’ office practices if they are to earn physician enthusiasm and support.

## ENGAGEMENT ACTION TO DOS:

1. Have a physician liaison to work with physicians and their office staff.
2. Consider loans for office build-out.
3. Identify consultants that can improve office processes and cooperation between physicians and the hospital.
4. Commit to IT connectivity.

5. Consider setting up a program for educational outreach to physicians' office staff – conducted by health care professionals (for example, nurses) who bring informal or formal education programs to the physicians' offices. Sponsor an annual combined education and social event for all office staff.
6. Include physicians' office staff in hospital staff training programs.
7. Ask office staff to identify their needs and suggest solutions.
8. Offer retirement planning and participation in group plans for office staff.
9. For national health systems, consider assigning a regional physician manager for physician and office manager education.



#### ENGAGEMENT ACTION TABOOS:

1. Spreading a business manager over more than three practices.
2. Soliciting ideas and complaints, but not following through.

## 10. CME AND GME

Physicians remain interested in how they can meet their responsibilities for self-development and their role in assuring the quality and supply of future generations of well educated and trained physicians and allied health personnel. Investments to enhance the range and quality of these education and research commitments can help strengthen/rebuild rapport with physicians, board, and management.

#### ENGAGEMENT ACTION TO DOS:

1. Work with a nearby school of medicine and state area health education center to provide on-site CME.
2. Ask physicians to provide education to clinic staff.
3. Consider arrangements whereby the hospital endorses and/or sponsors business administration courses for physician leaders at a local university. Additional courses should include team building and leadership skills.
4. Implement two-way interactive video conferencing for CME & GME.
5. Use CME reimbursement as a tool to encourage physician participation on special committees and attendance at medical staff meetings.
6. Give training program directors/leaders time off from patient care responsibilities to effectively run their program.
7. Consider special sessions/brown-bag lunches with guest speakers on select topics such as malpractice, conflict of interest, and so forth.

#### ENGAGEMENT ACTION TABOOS:

1. Avoid investments without staff expertise to guide funding in best directions for success.

## 11. ELECTRONIC MEDICAL RECORDS AND E-HEALTH

Huge investments must be made into electronic records, coding, and order entry tools and systems to enhance the physician's capacities for diagnosis and treatment in and around the hospital care settings. These modern IT systems can also help support higher quality care, enhanced services, and convenience of patients and their significant others, as well as strengthen the evidence for payer contracting, process improvements, cost effectiveness maximization, quality assurance, and patient safety.

### ENGAGEMENT ACTION TO DOS:

1. Have a strong clinical informatics e-mail system that pushes out timely information to the medical staff. Consider having the CIO give a monthly report to the Medical Executive Committee to keep them informed.
2. Communicate plans for implementation early, often, and include the reasoning behind the decisions made. Involve physicians in identification of potential obstacles.
3. Set up a steering committee of physicians.
4. Find a physician champion and empower him or her to make changes.
5. Involve physicians in the selection of a system, building of screens, etc. Pick those with most resistance and those most computer literate.
6. Make hospital systems available in physicians' offices.

### ENGAGEMENT ACTION TABOOS:

1. Promising but not delivering.
2. Rolling out an electronic system that requires physicians to sign in multiple times.
3. Spending big money for untested systems.
4. Setting up/publishing a schedule for implementation without consulting with physicians.

## 12. SOCIAL INTERACTION BETWEEN BOARD AND MANAGERS

Board members and managers need to foster and facilitate expanded opportunities to meet with and become more familiar with physicians as unique people, community leaders, and neighbors. Social, sporting and civic events are necessary, but not sufficient, to enhance rapport and trust.

### ENGAGEMENT ACTION TO DOS:

1. Schedule dinners/receptions at least quarterly.
2. Include physicians in the hospital holiday party.
3. Take time for and schedule time with physicians for interaction. Identify each physician's outside work interests.
4. Schedule two to four social functions per year with physicians and the board. Check with board leaders and physician leaders to see if they are willing to alternately host these functions in their homes.
5. Consider a holiday ball/special formal dinner dance for the medical staff, the board, and senior executives.
6. Have an annual retreat off-site for two days. It should include social and recreational activities.



### ENGAGEMENT ACTION TABOOS:

1. Not involving physicians in planning or asking what they want to do.
2. Announcing events without checking the availability of the parties involved – key board members, physician leaders, senior managers.
3. Extreme insensitivity to “lavish” events/dinners paid for by the hospital.
4. Going “too big”—making the interactions impersonal.

## 13. PHILANTHROPY

Physicians used to be the first priority targets for philanthropic campaigns and programs. As tensions and payment arrangements have eroded physicians' take-home income, their receptivity for extensive donations of cash back to the hospital or health system is weaker. It can and should still be pursued, however, as a needed link for cooperation and collaboration that befits patients and the community but all board members and senior managers must also step up to the plate.

### ENGAGEMENT ACTION TO DOS:

1. Ask physicians to assist in identifying grateful patients and family members who may be willing to donate.
2. Shift more leadership energy to this important opportunity.
3. Encourage physician participation on the foundation board.
4. One organization's board has established a mission trust fund—a designated percentage of the hospital's operating margin is contributed annually to this fund to support health-related programs of interest to physicians, staff, and the board.

### ENGAGEMENT ACTION TABOOS:

1. Soliciting donations from controversial patrons (e.g., malpractice attorneys who have represented plaintiffs in actions against physicians on your medical staff).
2. Asking physicians to lead the way without giving them executive and board support.

## 14. COMMUNITY HEALTH ENHANCEMENT WORK

Physicians value the hospital as a partner for enhanced health gain, not just health care. As consumer, regulatory, and media attention remain focused on the charitable and community benefit responsibilities of the hospital, physicians will appreciate sincere board and manager involvement in meaningful community health enhancement strategies.

### ENGAGEMENT ACTION TO DOS:

1. Collaborate with physicians on community health initiatives.
2. Develop a list of physician experts on specific topics. Assist the physicians with scheduling speaking engagements.
3. Investigate programs that enable physician volunteerism; for example, Volunteers in Medicine. Involve physicians in discussions about volunteer programs.
4. Consider an overseas "mission" and send physicians and staff on week-long trips to serve a poor community.

### ENGAGEMENT ACTION TABOOS:

1. Avoid trying to improve health status without partnerships with local community health agencies and networks.
2. Don't over-promise what you can provide for public health protection and promotion.
3. Launching large program that does not have any hope of third party payment support.

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