Rebuilding the Physician-Hospital Relationship

Why do we still have 1918 medical staff structures to serve 21st Century needs?

Too Few Physicians Do the Work
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Library Committee

- Proliferation of committees and departments
- Endless paperwork and minutes

- Much physician dissatisfaction/apathy
  - “I have no idea what’s going on!?!?”
Is medical staff designed to achieve quality?

What will move us forward?

From chart review → To “prospective quality”
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From confidential peer review ➔ To publishable, quality data

From care in isolation ➔ To professional interaction/learning

From communicating in meetings ➔ To multiple communications
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Next Steps

• Establish a Task Force that is committed to the project

• Don’t load the Task Force with naysayers and nonbelievers (the process will probably be hard enough without them)

• Keep the process open and all informed
  • Newsletters
  • Drafts available
  • Invite written comments
  • Open meetings
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**Define objectives:**

- **a)** What do you wish to accomplish?
  - i) Excellent care
  - ii) Communications, coordination, teamwork
  - iii) Prepared – skilled physician leadership
  - iv) Community treasure
- **b)** What changes are needed to put patient care first?
  - i) Payment
  - ii) Cultural
  - iii) Technological
  - iv) Coordination with primary care sites (Walmart? Clinic?) and tertiary
  - v) Minimize number of “business entities”
c) What will attract physicians, others?

i) Community treasure

ii) Education/collegiality

iii) Technology

iv) Food

d) What is the best structure?

### Realistic Medical Staff Structure

<table>
<thead>
<tr>
<th>Salaried Positions</th>
<th>Medical Staff Core</th>
<th>Clinical Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMO</td>
<td>Pool from which leaders are drawn</td>
<td>Take care of patients</td>
</tr>
<tr>
<td>VPMA</td>
<td>Medical staff college</td>
<td>Valued &amp; respected clinicians</td>
</tr>
<tr>
<td>Quality Chief</td>
<td>Attend meetings relating to practice enhancement</td>
<td>Voice in clinical issues, not administrative matters</td>
</tr>
<tr>
<td>Chair of each Project, Protocol</td>
<td>Position descriptions</td>
<td></td>
</tr>
<tr>
<td>Position descriptions</td>
<td>Training</td>
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<tr>
<td>Contract</td>
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# Rebuilding the Physician-Hospital Relationship

## A. Tools
- Two-way hotline?
- Newsletter?
- E-mail/intranet?
- Faxes with “bulletins”?
- Periodic surveys?

## B. Structure
- “Town meetings”?
- Breakfast/lunch with small groups on regular basis?
- VPMA (or designee) “rounds”?
- Physician “advisory board” or “senior council”?
- “Blended” leadership

## C. “Thanks”?
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Organizational Alternatives

1. Traditional
   A. Three-legged stool
   B. Constantly “restructuring” for efficiencies
   C. Constantly in search of leadership
   D. Solving problems > Moving forward
   E. Stipends to soften blow
   F. Struggling to recruit
   G. Leaders who excel get worked to death

2. Traditional with a Twist
   A. “Open” but with “Centers of Excellence” or “Institutes” or “Service Lines”
   B. I.e, integrate one clinical area at a time
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3. Hospitalists and Beyond

A. Response to problems with call and coordination of hospital care
   i. Internists
   ii. Intensivists
B. Now specialists, surgeons
C. Currently many hybrid “medical staffs”

4. Academic Model in Community Hospital/System

A. CMOs
B. CQOs
C. Toward full-time clinical chiefs
   i. Trained in leadership
   ii. Long-term commitments

5. Joint Ventures

A. Frequently driven by financial interests
B. Between hospitals and “richest” physicians
C. “Partners” away profitable services
D. Sometimes resented by those excluded
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6. Fully Integrated

A. Kaiser/Mayo
B. Still several different forms
   i. Employed by health system
   ii. Multispecialty group clinic
   iii. Merger of clinic and hospital
C. Carilion adventure