As seen in **Orthopreneur**

Helping Your Hospital Help Your Practice

By Patrick Vega

Healthcare, and specifically orthopedics, is in a period of extended and dramatic change, driven largely by new models of reimbursement, increased hospital-physician alignment and a heightened focus upon demonstrable clinical quality with metrics collection and reporting. Because of an aging population and the prevalence of musculoskeletal conditions, orthopedics has long been among the most attractive specialties by hospitals.

One of the most important by-products of this change is the emergence of deliberate efforts by hospitals to collaborate with their medical staff. What this means in practice is that the management and delivery of the core elements of healthcare delivery (clinical, financial, outcomes and operational) are migrating away from hospitals and physicians working independently, and often at cross purposes to one another, toward increased collaboration. While fee-for-service reimbursement is currently the dominant model, payment is inexorably moving to models such as bundling, total episode of care payment, capitation and other fixed-fee arrangements. Under such models, the hospital may be the recipient of a single payment which is then dispersed to physicians.

These new models coupled with a palpable anxiety among physicians about the uncertain reimbursement environment, and hospital's efforts to protect market share through acquisition of physician practices, are accelerating the employment of physicians, both primary care and specialists. Additionally, hospitals are aggressively reaching out to private physicians to collaborate in truly unprecedented ways by providing opportunities to partner in care planning and delivery. One of the current challenges for executive administration is balancing the focus between employed and private medical staff. It is rarely realistic to achieve a perfect balance of attention between the two. Rather, an emphasis will be placed on equitability rather than equality, focusing resources based on medical staff leadership, initiative and assets.

From the standpoint of a consultant working with both orthopedists and hospital administration, both have numerous challenges to remain viable. For orthopedists, these include reimbursement pressure, malpractice concerns, competitive tensions and practice development. For administrators, all of the same concerns are present with the additional challenge of leading an organization that is dependent upon physicians to drive volume to their medical and surgical orthopedic services and specialty programming. Additionally, the hospital must balance the needs, aspirations and talents of multiple orthopedic groups and individual practices.

This article will provide guidance on how orthopedists can initiate, develop and sustain collaborations with hospitals. Historically, the relationship between surgeons and executive administration has been characterized by tension, misunderstanding and lack of collaboration. The days of small numbers of physicians receiving the majority of administration focus and resources are waning as hospitals recognize that fostering broad physician participation and support is a more strategic approach. Additionally, orthopedists must be careful to avoid the most common mistakes in collaborating with hospitals: a sense of entitlement, being unwilling to be a team member in addition to being a leader, the appearance of disloyalty, frustration with the pace of development, focusing on a single promotional strategy and neglecting the PCP referral base.

Understanding the Hospital

A frequent question asked by physician specialists is, "What does executive administration want from me?" It is a reasonable question and deserves an answer. Across the country in hospitals of all sizes and types, administration is looking for a physician that will partner in pursuing key goals to develop and sustain a strong reputation among customers: patients, primary care physicians and payors. More specifically, administrators are seeking orthopedists that bring:

- Leadership in a subspecialty, research capabilities and clinical excellence.
- Sweat equity; a willingness to lead or be part of team that is seeking to improve care or develop a specialty orthopedic service, understanding that in early stage initiatives there is often no compensation.
- An understanding that hospitals will typically market a hospital orthopedics program and affiliated physicians, not a specific practice. This makes sense. Hospital's preferential treatment of a single practice invariably results in accusations of bias and ill will among medical staff.
- A willingness to promote the hospital's orthopedic services and educate key audiences about the unique hospital and physician capabilities.
- An openness to work with friendly competitors. In most orthopedic programs, competition exists among the medical staff for administration's attention and hospital resources. The most effective orthopedists accept this as a reality and

are able to understand the benefits of collective specialty collaboration over singular self-interest.

- An appreciation of economic realities. Across healthcare, every provider is being asked to do more with less. With hospitals investing millions in facility development and technology, it is not uncommon that medical staff will be perplexed when they see penny pinching in staffing and services for their specialty. Administration views these types of investments as essential in maintaining competitiveness. Orthopedists who understand the hospital's perspective will not only be more highly regarded but also position themselves to voice their opinions and advance their programmatic aspirations for consideration.

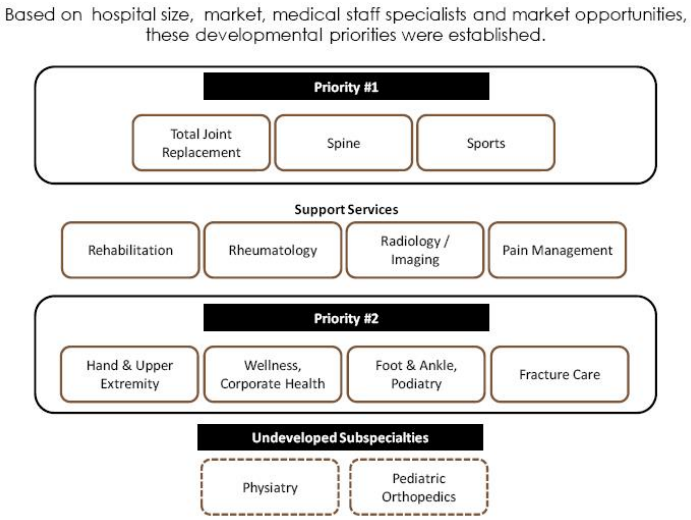
With new payment models accelerating increased hospital/ physician collaboration on programs that decrease cost, improve operations and increase quality, the most progressive hospitals are actively seeking to integrate medical staff into shared decision making, clinical, financial and operational. When seeking to collaborate, some advisory comments are in order for orthopedists seeking to partner with hospitals:

- While hospitals are interested in collaboration, orthopedists will typically need to be the initiative taker. The individual orthopedist is likely one of many and most hospitals will not automatically know of aspirations and capabilities unless voiced by their medical staff.
- Depending on the size and organizational structure of the hospital(s), to gain attention, focus program development overtures on key leaders whose job it is to identify opportunities; CEO, COO, Vice President of Service Lines and Chief of Orthopedics.
- Hospitals will tend to focus upon subspecialties that they can most readily support with existing staffing, facilities and technology resources. Subspecialty focuses that have been successfully developed include total joint replacement, sports medicine, spine, rheumatology, rehabilitation, trauma, fracture, pediatrics and others. The following two figures are drawn from a hospital engagement evaluating numerous musculoskeletal subspecialties for possible development. Figure 1 below illustrates the musculoskeletal subspecialties that were considered.

Exhibit 1: Musculoskeletal Sub-Specialties

Administration may initially devote resources to developing subspecialties that produce a greater margin with subsequent or concurrent development of less profitable but necessary support services. For example, joint replacement programming might be a primary focus while rehabilitation and rheumatology receive less attention, at least initially. Additional considerations included current specialists, facilities and available technology. Exhibit 2 illustrates the prioritization of development in sequence of subspecialty development and the relationship of support services for the same client in Exhibit 1.

Exhibit 2: Prioritization



- Hospitals will be responsive to and seek physician collaborators who contribute to and create sustained solutions and value for customers that will enhance quality and foster hospital brand loyalty.
- Think "quality." What does it mean to your customer: patients, PCPs, payors, hospitals? Most orthopedists are convinced that they should be collecting clinical and functional outcomes, but relatively few actually do it. Hospital/orthopedist collaborators must commit to the costs and time required to strategically develop and implement quality initiatives and reportable outcomes that are meaningful to each consumer audience. Understand if there are existing generally accepted measures of quality or if they need to be formulated.
- Hospital/physician collaboration can be compared to dating, engagement and marriage; lasting relationships are preceded by commitment. In successful collaborations, both hospital and physician are fully committed to development, especially before revenues flow to either party. Lastly, remember that in some organizations, these types of collaborations are uncharted territory for both physicians and hospitals and the novelty will result in early missteps.

Avoiding Common Pitfalls

With the relative novelty of deliberate hospital/physician collaborations, it is important that orthopedists avoid some of the common missteps.

- Don't be entitled, "The hospital should build this for me." The orthopedist is likely one of many.
- Don't expect that hospital staff will do all the heavy lifting and provide unlimited resources for every idea. The most highly regarded orthopedists will be available, involved and, while providing medical leadership, will also embrace a role of a team member.
- If the orthopedist attends at multiple hospitals, don't pit one against another and don't support competing initiatives in the same market. Hospital administrators will avoid partnering with doctors who do this, considering them as unreliable and high risk for sharing ideas with competitor hospitals.
- Don't be discouraged by a slow pace. Hospitals typically have a much longer process of evaluation, approval and implementation. A large service like joint replacement or spine might take 8 to 12 months to plan and fully implement.
- Don't focus on billboards. There is a common belief that billboards are effective at drawing patients to a practice. Experience and research shows that for orthopedists and most specialists, the vast majority of referrals are driven by primary care physicians. Billboards and advertising can support increased recognition for individual practices and hospital programs, but these are supplemental.
- Don't ignore primary care relationships. While referral patterns from primary care, especially hospital employed PCPs, are changing, referrals are still largely dependent on access to orthopedic consultation, perceptions of clinical competence and the quality of communication.

Sustaining a Productive Relationship

Once collaborations have begun, the challenge shifts to sustaining the working relationship and continuous improvement. One of the most common problems occurs when the long preparation and feverish launch of a new initiative concludes and the routine work of sustaining and growing the collaboration starts. The most successful long-term hospital/physician relationships are characterized by a shared vision for development in the near-, mid- and long-term, an evolving agenda and regular meetings that are goal-driven and action oriented. Additionally, it is critical to collect and report operational, clinical and functional data and to apply these data to key audiences: patients, PCPs, payors, hospital colleagues.

Conclusion

Dynamic changes in healthcare are leading to unprecedented opportunities for physician/hospital collaboration. Hospitals are actively seeking orthopedic specialists who are eager to partner in the planning, development and delivery of care. Both employed and private practice orthopedic physicians are pursuing hospital partners who provide medical leadership opportunities that cross all aspects of care: clinical, operational, financial and quality. By teaming in meaningful collaborations, hospitals and orthopedists can create and sustain services and quality in specialty programs that neither could achieve alone.

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