Rural Focus

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Authentic Relationships = Reaching Goals

By Thomas W. Keller, President and CEO, Ozarks Medical Center

Relationships are complex—especially working relationships between hospital leadership and physicians. A 2008 ACPE survey asked physician executives how they would suggest their colleagues improve physician–hospital relationships.[1] The top response was to improve communication. Moreover, in a 2009 article citing this survey, authors Amy MacNulty and Dennis Kennedy said that two common remarks they hear from physicians are, "I don't know what or why something is happening," and, "No one is listening."[2] At Ozarks Medical Center (OMC), we heard, "You won't let me participate in decisions about my outpatient practice setting." Think about that for a minute. We actually wouldn't let the OMC Medical Group participate in decisions related to their practice.

As with most employed physician groups, OMC's Medical Group was developed over three decades of acquiring independent primary care practices and hiring specialists. The result was an organization with separate primary care clinics and specialty clinics each operating independently, each with their own set of expectations for patients and staff, and each with different thoughts on what a great physician clinic looked like. The reality was a collection of 60 providers without leadership, continuity, and consistency.

The only common thread between all of the practices was that Ozarks Medical Center owned the buildings, equipment, and medical records. OMC supplied financial support and paid the bills. As with most organizations, hospital leadership consistently attempted to build good relationships with physicians. While this is essential, strong relationships alone do not always equate to moving the organization forward and addressing key strategic imperatives. What the organization needed was physician leadership that is engaged and has input into decision-making processes, along with hospital management and ultimately, with the Ozarks Medical Center board of directors.

Key Board Takeaways

The board and senior leadership should consider the following questions:

1. Why do physicians need to be involved in decision making at the leadership level?
2. Are you willing to ask for their help?
3. What do you want from the relationship?
4. Have you created a shared vision with your providers?
5. What are the agreed tenants of decision making?
6. What are you unwilling to give up (the non-negotiables) and what can you give up?
7. How will you ensure the communication is enough?
8. How will conflicts and disagreements be resolved?
9. Does everyone agree to share accountability?

The Journey to a Shared Leadership Model

In 2016, Ozarks Medical Center, and more specifically the OMC Medical Group, started a new journey. This was predicated on an understanding that creating a model of shared leadership between an owned physician group, hospital management, and the board was absolutely necessary for long-term viability. The journey's most important and most difficult role was creating an authentic working relationship.

While saying, "Good morning," to the provider as you walk down the corridor or from across a medical staff meeting conference table helps to develop a relationship, there is little trust created in the casual day-to-day hospital happenings. It is imperative to actually know one another, and not just in a superficial

1 Amy MacNulty and Dennis Kennedy, "Beyond the Models: Investing in Physician–Hospital Relationships," *hfm*, Vol. 62, No. 12, January 2009, pp. 72–77.

2 *Ibid.*

way, but rather to have some understanding of the innate wants and desires of the other person. To have trust, both sides need to be able to passionately disagree and have conflict with our hearts and our minds, but be committed to getting to the other side of the conflict by putting our patients and Ozarks Medical Center first.

At OMC, we created a forum for communication with basic rules. First, we made a resolution that no decision will be made about the physician clinics without being discussed in our forum, which includes seven providers and three administrators. Second, we decided to be "all-in" in the shared leadership of our physician's outpatient practices. This means that providers and administrators are all fully invested in the process and decisions made by the shared leadership system.

The development of this authentic relationship unveiled shared goals and the means to reach them. One example we found early on was improving quality. In most organizations, the way regulators and national organizations define quality is much different than a physician's definition. Agreeing to improve quality and ensuring safety seems easily agreeable between providers and management. However, specifically stating and agreeing to the *exact* quality indicators is not as easy. Sometimes there is a difference in the underlying reasons why a specific indicator is important. Having a conversation about priorities and the correlating details is sometimes difficult without an authentic relationship.

Many hospitals and health systems would say chart completion is a quality indicator and by completing charts in a timely manner revenue cycle metrics improve. To the physician, the underlying reason to achieve this is rarely a financial issue; rather, timely chart completion is a pure clinical quality issue to the provider. If a patient sees a provider who does not complete their charts by the time the patient sees the next physician, the next physician has no way to know what the first physician diagnosed, treated, etc. How can we even talk about the Triple Aim if there isn't timely communication between providers? When one clinician has no knowledge of pertinent medical history, the clinician lacks all of the necessary information to make the best recommendations for the patient.

Without an authentic relationship between leadership and physicians, we would not have known that we shared the same goal. Without physicians involved in the decision making, the strategy to achieve the goal would have been drastically altered. In the end, Ozarks Medical Center was able to accomplish a four-day chart completion goal.

The Tenants for Decision Making

Our shared leadership team agreed to other basic tenants that guide our decision making including: 1) patient loyalty and service excellence, 2) productivity, and 3) financial viability.

If you ask a physician whether they want satisfied patients, the answer is nearly always, "yes." Physicians also have to remain true to their training on clinical decisions. Why not agree to improve patient loyalty by improving service? Customer service crosses all boundaries.

Productivity is definitely a conversation that administrators want to have because it directly effects the bottom line. However, physicians want productivity because it means they are helping more patients. Our authentic management–physician relationship focuses on how to help the provider be very efficient both in terms of time and in terms of seeing all patients referred and treating patients. Getting the right patients to the right provider is essential. For instance, using MGMA, we have a few providers at the 25th percentile and a few providers at the 90th percentile, while our average is around the 55th percentile. Our goal is the 65th percentile and our shared leadership team is committed to achieving that goal for every provider. For example, if a physician believes that adding another employee would result in them seeing more patients, than the decision would be supported by the shared leadership team. With that said, the physician would also be held accountable by his/her peers on the shared leadership team.

Financial viability isn't just a management issue. Most providers want to be associated with organizations that are financially sound. If the shared leadership team can agree that every decision will be viewed with a financial viability lens,

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organizations can get tremendous buy-in and understanding when the team has to say "no" and when the team has to say "yes."

Quality, patient satisfaction, productivity, and financial viability are the agreed tenants that are our foundation for making decisions at Ozarks Medical Center.

Leading the Organization with Shared Accountability and Guidelines

By no means has OMC solved the mystery of every provider being actively engaged in the relationship. We consistently search for new ways to reach out to every provider and we still have some who don't participate. We still struggle in accomplishing the shared expectations. But, we are working through all of it—together. The us/them, we/they has essentially disappeared as we both share accountability in leading our organization.

We got here by starting out with guidelines:

- Know what you really want from the relationship.
- Define it.
- Have robust discussions about the future of the organization and the importance of being aligned. (For organizations like ours, there is no "they lose, we win." We win if everyone wins.)
- Disagree.
- Find common things we can both agree on.
- Discuss the non-negotiables.
- Find some physicians that can speak with you.

There is no magic wand to develop an authentic working relationship. It takes work, patience, and time. In the end, it's worth it.

The Governance Institute thanks Thomas W. Keller, President and CEO, Ozarks Medical Center, for contributing this article. He can be reached at thomas.keller@ozarksmedicalcenter.com.