Why Should Physicians Care About Hospital Finances?

Introduction

The medical staff of Community Care Hospital is increasingly frustrated. Reimbursement is down; overhead costs are up. Physicians in practice are working harder and harder for less and less. On top of that, the hospital wants physicians to continue to take voluntary call at a time when it is no longer in their professional interests to do so and seems to be unable to make its operations “physician-friendly” in the face of growing financial pressures. Management keeps telling physicians that operating margins are shrinking and there are fewer resources to invest in the medical staff. Giving up medical staff membership and privileges, investing in more ancillary revenue, aggregating clinical practices into large entities, or direct employment seem to be the only options to escape from this economic collision course.

So why should the medical staff care about helping management achieve its financial goals? After all, isn’t the role of the medical staff to practice clinical medicine in an evidence-based manner and for management to count the beans and manage the books? Particularly, why should physicians in community practice care at all? Isn’t the object to capture as much revenue as possible while reducing costs, regardless of what the hospital decides to do?

Overview

Life is more complicated today. The medical staff and hospital are inexorably intertwined in their mutual goals to provide quality services at reduced costs, despite the fact that hospitals are rewarded through bundled prospective payment for decreasing lengths of stay and physicians receiving retrospective fee-for-service payments are rewarded for extending them. For hospital-based physicians, the connection is obvious: No hospital equals no contract. For non-hospital-based physicians, the connection is a little more subtle. Think of the ways in which a successful hospital and medical staff support an independent ambulatory based practice through providing:

- Quality inpatient care with attendant support services
- Quality leadership to ensure that colleagues are qualified and maintain clinical skills
- A stable referral base from colleagues and staff members
- An overall healthcare network that commands the respect of those within and beyond the community
In addition, physicians from Community Care Hospital need things that the hospital may be able to provide, but which cost money, including:
- A functional electronic medical record
- CME to support ongoing certification
- Payment for call coverage
- Resources for medical staff leadership

For those in non-hospital-based private practice, there may be a need for:
- IT support to track hospitalized patients
- Support for improved billing and collections
- Training for office staff members
- Investment for joint ventures

The problem is that all of these things cost money and require that Community Care Hospital generate an adequate bottom line to be able to support the medical staff and its varied needs. So how can both hospital- and non-hospital-based physicians work with the hospital towards mutual success to support better outcomes, greater efficiencies, and greater value for all?

Ten initiatives toward greater financial medical staff/hospital alignment

The following are ten initiatives to build a more collaborative relationship between the medical staff and Community Care Hospital:

1. **Support all medical staff members and their leaders to become cognizant of, if not near-fluent in the arcane language of finance.** Too often, medical staffs are not exposed to nor have the opportunity to learn to read, understand, and interpret financial statements. The traditional bias is that this belongs to management and savvy board members and should be of little concern to anyone who is not directly involved in the operations or governance of the organization. Unfortunately, this prevents the medical staff from realizing its full potential through leveraging its clinical acumen with management and the board’s financial knowledge. When physician leaders fail to understand the financial implications of clinical decision-making, it is impossible to assist the hospital in reaching its goals in ways that would directly benefit the medical staff and the community at large.

2. **Go over annotated financial statements with interpretive dashboards and scorecards at MEC meetings.** Although the organized medical staff is not directly responsible for overseeing and sustaining the financial assets of the organization, everything that the medical staff does and all of the major decisions that it makes have a significant financial effect. When a new physician joins or leaves the staff, when the MEC recommends a new service line, a new procedure, or a new technology, there is a significant financial effect that may not be fully appreciated.
Evaluating both qualitative and quantitative benefits and risks will make the MEC’s input even more effective to management and to the governing board. Reducing complex financial information to easily read and understood red, yellow, and green color-coded dashboards and scorecards will help the staff to understand the effect of its decisions in real time.

3. **Provide financial training to medical staff members and their leaders on an ongoing basis.** Just as members of the management team and board receive regular educational training programs to support their positions and ability to make wise decisions, the medical staff would significantly benefit from training that would not only provide skills not taught in medical school to help it to understand global hospital issues but would be of enormous benefit in the management of their private and hospital-based practices.

4. **Demonstrate what decreasing length of stay (LOS) can mean to the hospital and the medical staff in terms of decreased costs and increased reinvestment.** Recently at a national program, I asked a chief financial officer what the financial effect on his 100+ bed hospital would be if the medical staff could work with management to reduce the average LOS by a single day. He estimated that his hospital would approximately earn an additional 2.5 million dollars per year. Imagine what could be done with that much additional operating margin every year—hire quality practitioners and employees, replace aging equipment and physical plant, invest in a state-of-the-art electronic medical record, develop a center of excellence, relieve the burden for physicians on call by creating a hospitalist program, or provide an effective outreach program for physicians in private practice to support their success. Monday-through-Friday clinical services might be replaced with effective weekend and holiday rounds or the provision of 24/7 services. Instead of waiting over the weekend, a stable patient with chest pain and EKG changes would get her stress test on Friday evening or Saturday morning, and weekend rounds would turn into multidisciplinary hospitalist rounds with an effective physician-driven utilization management process.

5. **Help management to understand the clinical implications of financial decisions.** I recently visited a medical staff where management made the unilateral decision to cut the staffing of the emergency department after two lower-volume months. The medical director felt that this was a short-sighted decision but did not press the issue. A month after the decision was made, the volume resumed to its previous level, leaving the department understaffed. Patients waited eight hours to be seen, departures without being seen or stabilized skyrocketed along with patient complaints, referrals away from the hospital increased, and morale suffered with significant physician and nursing attrition. What seemed
like a prudent decision turned out to be a disaster. Coming up with a more flexible and collaborative approach may have led to a better solution for both the hospital and the emergency department.

6. **Help the medical staff to understand the financial implications of clinical decisions.** When physicians order serial CT scans or MRIs due to a fear of liability, a consultant requests a diagnostic study before he or she has even had a chance to lay eyes on a patient, or an orthopedist uses an $8,000 instead of a $5,500 implant, there is an enormous financial effect that physicians may not fully appreciate. Often, the inpatient DRG is consumed before the patient is even admitted for postoperative care, and everything that the patient receives thereafter constitutes red ink. It would be helpful for management to share financial spreadsheets that illustrate the financial implications to the hospital and to the medical staff of these seemingly isolated clinical decisions and what small changes in decision-making can mean to both.

7. **Avoid the use of financial jargon and provide interpretive annotation whenever possible to enable non–financial professionals to understand the implications of financial data.** Instead of using the term net AR (net accounts receivable), state that these are the monies owed to the organization minus an allowance for people who have historically been unwilling to pay their bills. Instead of distributing a statement of cash flows, explain the major factors in descending order that have a significant effect on the organization’s present cash position. Instead of reporting financial ratios, place a definition of each ratio next to the number with a red, yellow, or green bar and an explanation as to why the number represents that color and what should be done about it. Just as physicians have had to learn to demystify clinical jargon to patients, management, and board members, management should demystify and simplify financial jargon so everyone at the table can participate in meaningful financial discussions.

8. **Invite medical staff participation at the level of the governing board.** Although the majority of governing board members should be “outsiders” who bring expertise and the community interests to the boardroom, effective boards also need a core group of “insiders” from the hospital management team and medical staff to bring essential operational and clinical input to enable wise and balanced decisions. Members of the medical staff who participate in the governance process have an invaluable opportunity to complement their clinical knowledge with a deeper understanding of global financial and community issues that significantly affect the medical staff’s clinical practices while providing invaluable input to nonprofessional board members to help their understanding of clinical issues. These physicians may also communicate this new level of understanding to colleagues and peers in either a leadership role or through better coordination of their clinical hospital- or non-hospital-based practices with hospital and community needs.
9. Invite both formal and informal medical staff leaders to participate with the senior management team. The average physician is not exposed to operational challenges in a multidisciplinary setting. Enabling dedicated physician leaders to sit and process complex operational decisions with the senior management team facilitates broad-based discussion toward mutually beneficial solutions. For example, the discussion of whether to start a hospitalist program has financial, political, and economic repercussions that involve every aspect of the organization. Managers may demonstrate what a subsidized service might mean to the hospital’s bottom line, and physicians can help management to understand the not-so-obvious clinical and political implications as well as unintended consequences for their colleagues in non-hospital-based practices.

10. Utilize financial and qualitative metrics when creating a medical staff recruitment and retention strategy. One of the best opportunities for the medical staff to collaborate with the management team and governing board is through the creation of a medical staff recruitment and retention strategy that balances medical staff, hospital, and community needs. In the past, this was an exercise in demographic analysis to determine how many physicians in what specialty were required to sustain the medical staff and to provide necessary services to the community. Today, with the variety of practice preferences (inpatient vs. outpatient, part time vs. full time, call vs. no call, participation vs. nonparticipation, collaboration vs. competition, etc.), it is more important than ever to consider the financial and strategic implications of recruitment and retention decisions. Having financial, clinical, and political expertise at the table will help to make decisions that will benefit the medical staff, the hospital, and the community at large.

Conclusion
The challenges that the medical staff and Community Care Hospital face will not go away; however, integrating traditionally isolated clinical and financial decision-making expertise will help the medical staff and Community Care Hospital make better decisions that will ultimately benefit both. The hospital will enjoy a better bottom line, enabling it to invest and reinvest in its medical staff, and the medical staff will receive the support it needs to build more successful hospital- and non-hospital-based practices, thus benefiting the hospital through improved quality and clinical volumes. Learning to share information and make respective areas of expertise more accessible will provide the impetus to improve working relationships and professional understanding at all levels of the organization and will ultimately provide more successful physician practices, a more successful hospital, and better care for the community.