March 31, 2014

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Hospital Relationships: Understanding The Concept of "Switching Costs"

Perhaps the greatest benefit to an incumbent group with a hospital contract of any kind, from the traditional hospital-based specialties to cardiac surgery, is the fact that, for the hospitals they contract with, there's a significant cost to switching groups. That cost can be measured both in time, in money, and in liability.

Switching often causes turmoil within the hospital.

The physicians from the incumbent group were often on staff for many years, in some cases for many decades. Those familiar faces are now gone. Or worse, they are still there but about to lose their staff privileges, and they are not going without making a last stand, or, at least, a big stink.

Other contract holders, from other hospital-based groups to office–based physicians who hold medical directorships and other contracts, become concerned that the hospital will terminate their agreements, too.

As things progress and sometimes snowball, mid-level hospital administrators who participated in the decision to terminate the incumbent group often find themselves terminated as higher-level administrators run for cover – after all, someone has to be blamed.

There's the risk of potential litigation. The hospital may have staged a fictitious request for proposal process in order to project a patina of fairness while, in actuality, the decision had already been made not to award the contract to the incumbent group. They were lured into participating, but stood no chance of getting the contract – they were defrauded.

The change may result in upsetting and even driving away referring physicians. And, in some cases, switching results in a crisis in terms of staffing – the new group promised a lot but delivered a little.

In light of these potential costs, there generally has to be something seriously wrong with the incumbent group or with its performance or with its relationship with the hospital and hospital administration to cause the hospital to switch. Sure, there are outlier events, in which little is wrong but the hospital administrator just pulls the trigger, but that can be a very expensive "shot."

So while outliers exist, generally, critical mass must be reached in terms of factors that are either negative on the part of the local group or extremely positive on the part of a potential new group, before the seesaw flips, destroying the local group's leverage.

The idea, therefore, is to continuously add to the positive side of the balance while assiduously reducing and removing items from the negative side.

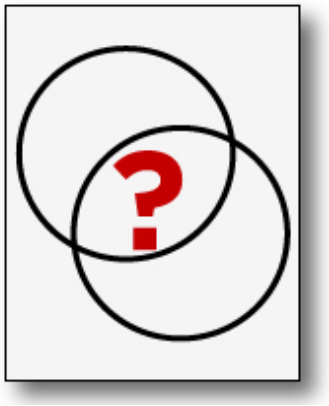
Although smart competitors will highlight your negatives, the deal really is yours to lose.

Wisdom. Applied. 63 - I Went To A Food Fair. Can Referral Sources Find You?

How easy, or hard, do you make it for potential deal partners to find you?

Upcoming Presentations

Date: April 11-13, 2014
Disrupt or Be Disrupted: How to Prepare for The Future of Anesthesiology
Location: **The Advanced Institute for Anesthesia Practice Management,** The Cosmopolitan Hotel, Las Vegas, NV



MFW Knowledge Products

If you're an independent learner or need a refresher on a current topic, click here to find out about our growing list of Knowledge Products.

Recent Interviews and Published Articles

Mark's article ***OIG Opinion Adds Clarity to Illegality of Company Model*** was published in the February issue of Anesthesiology News. Read or download here.

Mark's article ***Doctors Rush To Employment as Corporate America Lays off Workers*** was published in the December 2013 issue of General Surgery News and Gastroenterology & Endoscopy News.

Mark's article Anesthesia Profits Are Off-Limits was published on page 32 of the digital edition of Outpatient Surgery.

All Things Personal

In my role working with client medical groups, I've seen a lot of surveys. In a very real sense, we're moving into the post-healthcare world. Scores on surveys and one's performance checking boxes are easily observable and therefore, to bureaucrats, bean counters, and other business bozos, signify the value of care.

Take, for instance, emergency room physicians. Their most critically ill patients aren't in any condition to respond, let alone to respond to a Press Ganey survey. The E.R. doc saves the patient's life, the patient ends up in a room on the fourth floor, and some hospitalist gets glowing survey responses.

Other than pointing out the lunacy of "driverless data" and lobbying against it, there are things that physician groups can do:

Reactively, you can diligently sort through response data and challenge the survey's assumptions. Proactively, you can conduct your own surveys. And, metaphorically speaking, you can take action to put your finger on the hospital's survey's scale. (Some might call that gaming the system, I call it not being stupid.)

And, just so you know that I have data to support this, I reached out to some contacts. I can now report that 9 out of 10 doctors surveyed say that surveys are suspect. The 10th was a chiropract or.

Tuesday, March 25
Blog Post: Healthcare Executives In Prison

Wednesday, March 26
Videocast: Is Your Medical Practice A Social Service Or A Business?

Thursday, March 27
Blog Post: What Are The Standard Hospital Complaints?

Friday, March 28
Podcast: It's Not What You Said

Monday, March 31
Blog Post: What's It Cost?

More>>

Breaking News On Kickbacks: OIG Advisory Opinion 13-15- The Latest On The Company Model

I'll be hosting an encore presentation of my webinar, **Breaking News On Kickbacks: The Latest On The Company Model,** on February 20th at 2:00 p.m. PST/4:00 p.m. CST/5:00 p.m. EST. As before, the program is complimentary if you make a contribution of at least $100 to Operation Kindness, a no-kill animal shelter.

February 20th, 2014

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