PRACTICING EXCELLENCE:

Physician Engagement:
A Pathway to System Integration

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Author, Practicing Excellence and Engaging Physicians
Physician Director, The Sharp Experience
Sharp Rees-Stealy Medical Group

Evolving and Progressing Systemness:

• Over 80% of medical school graduates are looking for salaried positions with hospitals or big medical groups
• Hospital-employed physician positions nearly doubled over a 5-year period from 23% in 2005 to 45% last year

Merritt Hawkins, 2010

Interesting Integration Research

• Physicians said half their compensation should be fixed salary, and the remainder, incentive/performance based
• Over 80% of physicians who are considering hospital employment said they expect to be paid the same as or more than they are now
Frightening Facts Regarding Health Care

• Current cost of health care = $2.5 trillion
• 17.3% of US GDP
• Over 3X “variance” in per Medicare beneficiary expenses between the top-spending and bottom-spending regions
• Over $700 billion of waste
• If historic cost growth continues, health care cost will occupy 100% of our GDP in under 70 years

Our New Reality

• Accountable Care
• Pay for Performance
• Value-based Purchasing
  – HCAHPS
  – Core measures
• CGCAHPS
• Web-based Transparency

Executing System Based Care

A delivery model in which clinicians, nursing, administration and leadership work collaboratively towards shared goals with a unified mission. The execution of the system mission manifests in top decile quality, safety, patient satisfaction, growth and cost efficiency metrics that are reported within and outside of the organization
Integrated Health Care Delivery System Strengths:

- **Talent:**
  - The capacity to select, deselect and develop the team

- **System Integration:**
  - Shared information/patient record/manage data
  - “I’ll be down to take a look”

- **Performance:**
  - Measure performance and set goals
  - Hold individuals accountable to perform
  - Report performance to payers and public
  - Adopt evidence-based clinical practices

System Integration Predictors:

- A consensus destination of what the new system will look like
- Shared governance and strategic planning
- Physician loyalty to the new enterprise
- Performance leadership in place

System Integration Predictors:

- Clinicians who are trained to deliver a new shared system vision
- Physician performance measurement aligns physician behaviors to system execution
- Clarity and consensus of expectations for all members
**System Physicians make for Successful Systems**

- Patient-centered, communicates well, high patient satisfaction
- Respectful with staff
- Collegial and collaborative with administration and physician colleagues
- Adopts clinical pathways
- Clinically productive/efficient

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**Top Drivers for Physician Satisfaction**

<table>
<thead>
<tr>
<th>Top Driver</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationships with patients</td>
<td>7.45</td>
</tr>
<tr>
<td>Relationships with colleagues</td>
<td>6.98</td>
</tr>
<tr>
<td>Family issues</td>
<td>6.97</td>
</tr>
<tr>
<td>Personal growth</td>
<td>6.76</td>
</tr>
<tr>
<td>Freedom to provide quality care</td>
<td>6.36</td>
</tr>
<tr>
<td>Availability of office &amp; hospital resources</td>
<td>6.18</td>
</tr>
<tr>
<td>Prestige for role as physician</td>
<td>6.10</td>
</tr>
</tbody>
</table>

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**Organizational Outcomes of Successful Systems:**

**Quality**
- Reportable clinical outcomes and measures
- Patient safety/readmission rates

**Service**
- Patient satisfaction
- HCAHPS

**People**
- Physician satisfaction/retention
- Employee satisfaction/turnover

**Growth**
- Market share and growth

**Finance**
- Revenue and margins
- Cost/adjusted discharge
System Integration and Physician Engagement Pathway:

- **Stage 1:** Creating Physician “Buy-in”
- **Stage 2:** Creating and Communicating System Vision and Goals
- **Stage 3:** Building Physician Confidence and Trust
- **Stage 4:** Creating a Performance Leadership Structure
- **Stage 5:** Using Measurement to Assess and Report Physician Performance
- **Stage 6:** Developing and Training Physicians
- **Stage 7:** Creating a Physician Code of Conduct

Stage 1: Creating Physician Motivation

Organizations that fail to place the patient at the center of their integration efforts are unlikely to succeed

Coddington et al. 2001

Physician Benefit of Integration:

- Greater economic security
- IT/HR/Marketing support
- Smooth transition of care from one provider to another
- Shared information
- Relief of administrative burdens
Making the Case for Patient Centeredness to Physicians:

"People place more importance on doctors’ interpersonal skills than their medical judgment or experience, and doctors failings in these areas are the overwhelming factor that drives patients to switch doctors."

The Wall Street Journal 2004

Rank of “What patients want”:

1. Treats you with dignity and respect
2. Listens carefully to your health concerns
3. Easy to talk to
4. Takes concerns seriously
5. Willing to spend enough time with you
6. Truly cares about you and your health

Harris Poll, 2004

Patients’ Global Ratings of Their Health Care Are Not Associated with the Technical Quality of Their Care

1. Treats you with dignity and respect
2. Listens carefully to your health concerns
3. Easy to talk to
4. Takes concerns seriously
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6. Truly cares about you and your health

The Wall Street Journal 2004
The Case for Service:

- For every customer that complains, 20 dissatisfied customers do not complain.
- Of those dissatisfied customers who do not complain, 90% do not return.
- It is 10X more expensive to recruit new patients than to keep established ones.
- The average wronged customer will tell 25 others.

Press Ganey, 2007

Patient Satisfaction Performance

- In samples ranging from 1798 hospitals for acute myocardial infarction to 2562 hospitals for pneumonia, higher hospital-level patient satisfaction scores were independently associated with lower 30-day readmission rates for acute myocardial infarction, heart failure and pneumonia.

Am J Managed Care. 2011;17(1):41-48

The Case for Service as a System Mission for Physicians:

- Improves patient compliance
- Improves clinical outcomes
- Improves patient satisfaction
- Increases growth and market share
- Reduces malpractice risk
- Improves physician satisfaction
Stage 2: The Communication of Vision and Goals

A clear, specific, plausible, logical and bold vision for what the System seeks to become

The Vanderbilt Commitment:

“Our goal is to be the best, most expert, friendliest, kindest, most compassionate ED in the Nation. We want our patients and families to “love” coming to the Vanderbilt ED if they require emergency care.”
Strategic Planning

• Strategic planning is setting the course for the future
  – Defining an overarching vision
  – Allocation of resources
  – Identifying strategies and actions to execute the vision

Why Include Physicians:

• The dialogue and process of planning is as important as the plan itself
• Physician will own and support a plan they help create
• Open and responsive dialogue fosters physician trust
• Planning for a collective future will reduce physician suspicion of administrative activities

Basic Directives

• Include physician leaders that are reasonably well aligned
• Physicians involved in strategic planning become the vessel to other key stakeholders
• In order for physicians to gracefully integrate, they must have representation in the new system
The Measure of a Transformational Vision:
• Consensus
• Visibility
• Orientation
• Trained
• Upheld by a Code of Conduct
• Communicated to the Marketplace

The Organizational Vision Test:
• If a clinical frontline physician were pulled aside and asked about the vision of the organization, what would he/she say?
• If frontline staff were asked the organizational vision, what would they say?
• Could patients who receive care within the system articulate its “character?”

“Vision without execution... is hallucination”

Thomas Edison
“World Class Care, World Class Service”
Health System Strategic Goals:

<table>
<thead>
<tr>
<th>Service</th>
<th>Quality</th>
<th>People</th>
<th>Finance</th>
<th>Growth</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve Patient Satisfaction to 90th percentile</td>
<td>Improve quality markers to top 3% in all publically reported measures</td>
<td>Reduce turnover to 7.5%</td>
<td>Improve employee satisfaction by 10% compared to 2009</td>
<td>Improve generic medication use to 80%</td>
<td>Increase community service</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Stage 3: Building Physician Confidence and Trust

- Physician satisfaction as an organizational goal will retain physicians, improve performance, increase revenue, facilitate integration and create receptiveness to the organizational mission.

![Graph showing changes in physician satisfaction and patient care satisfaction]
Top Priorities for Meeting Physician Needs:

National Physician Priority Index

<table>
<thead>
<tr>
<th>Aspect of Partnership</th>
<th>Priority Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsiveness: Responsiveness of the hospital administration to issues and needs of medical staff members</td>
<td>1</td>
</tr>
<tr>
<td>Ease of Practice: Degree to which this facility makes caregiving for your patients easier</td>
<td>2</td>
</tr>
<tr>
<td>Agility: Degree to which hospital administration has positioned the hospital to deal with changes in the healthcare environment</td>
<td>3</td>
</tr>
<tr>
<td>Trust: Your confidence in the hospital administration to carry out its duties and responsibilities</td>
<td>4</td>
</tr>
<tr>
<td>Communication: Communication between yourself and the hospital administration</td>
<td>5</td>
</tr>
</tbody>
</table>

Represents the responses of 2447 physicians practicing at 360 hospitals/effectively, between January 1 and December 31, 2002

Core Principles of Physician Trust:

1. Determine physician issues
2. Set a physician concern priority index
3. Solve reported problems
4. Communicate solutions

What Are The Issues?

Hospital Practice

<table>
<thead>
<tr>
<th>Quality of Life Physician Questionnaire</th>
<th>Site: Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Rate your satisfaction on a scale of 1-5, with 1 being not at all and 5 representing all the time</em></td>
<td></td>
</tr>
</tbody>
</table>

1. I am satisfied with the efficiency of treating my patients in the hospital.  
   - Not at all: 1  
   - Sometimes: 2  
   - All the time: 3

2. I am satisfied with the nursing care for my patients.  
   - Not at all: 1  
   - Sometimes: 2  
   - All the time: 3

3. Communication from inpatient with concerning my patients is timely and concise.  
   - Not at all: 1  
   - Sometimes: 2  
   - All the time: 3

4. The hospital has the equipment I need to care well for my patients.  
   - Not at all: 1  
   - Sometimes: 2  
   - All the time: 3

5. I am satisfied with the way test results are posted on my patient’s charts.  
   - Not at all: 1  
   - Sometimes: 2  
   - All the time: 3
More on Hospital Practice Issues...

<table>
<thead>
<tr>
<th>6. Chart documentation and medical records keeping (including space to oil and transcription) is efficient and organized.</th>
<th>1 2 3 4 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Scheduling of procedures (OR, Lab and Imaging) is easy and efficient and /-time.</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>8. The hospital is focused on meeting my needs as a member of the Medical Staff</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>9. My overall experience of working in the hospital and caring for my patients there is superior.</td>
<td>1 2 3 4 5</td>
</tr>
</tbody>
</table>

Communication of system response to physician’s concerns is **Crucial** . . .

Physician Leadership to Group

You asked. We responded.

- Additional Clinical Review Stations Located on Medical and Surgical Floor.
- Computers in Waiting Areas for Patient/Visitor use.
- Additional Nursing Staff Hired. Medical Department RN Staffing.

Administration to Physicians:

**BREAKING DOWN THE BARRIERS**

You asked. We responded.

- Hospital Cerebral Palsy Conundrum.
- Changing Attitudes: Tales of the Times.
- The Doctor’s Office: A window on the World.
- The Power of the Pen: Writing Stories that Matter.
- The Art of Persuasion: Negotiating for Success.
- The Future of Medicine: Innovations that Will Shape the Practice of Medicine.
Tactics to Building Physician Trust:

- Physician Satisfaction Team
- Physician Orientation/Mentor
- 3 and 6 month post-hire meetings
- Physician Hotline

Physician Satisfaction Team:

- Goal: Improve Physician Satisfaction
- Tasked to create visible response to physician issues
- Reports to CEO
- Include physician membership
- Empower to act quickly and decisively
Physician Orientation: Effective “On boarding”

- Introduce to all key leaders. Build relationships
- Heavy emphasis on culture, history, character and values
- Aligned New Physician
- Clarity of physician expectations. “Who we are.” Sign Code of Conduct. Mentorship
- Share physician satisfaction initiatives underway

3 Month and 6 Month Post-Hire Physician Meeting Questions:

- How do we compare with who we said we were?
- Has there been anyone who has been especially helpful to you?
- Is there anything that you need that we are not providing?
- Based on your prior practice, what are some things we could do better here?
- Is there any reason that you feel this is not the right place for you?

Medical Staff Hotline

We are here to provide you the best place to care for patients, 24 hours a day, 365 days a year. If there is anything that falls short of what you need, let us know and we will do what is necessary to make it right. Our leadership team will respond and communicate a response within 48 hours of your call. Guaranteed.
Building a “Best-in-Class” Physician Experience:
• Improves revenue and volume
• Improves physician satisfaction and loyalty
• Facilitates integration
• Creates receptiveness and willingness to participate in the organizational mission

Stage 4: Building Performance Leadership

“Leadership has been identified as the most important ingredient in transformational improvement”

From Joint Commission Resources presentation; Executive quality improvement survey results. Journal of Patient Safety. 2 March 2006

A Leader Paradigm:

“Great physician leaders conduct themselves as if a patient was at their elbow”

Annals of Internal Medicine, 1998
The Role of the Physician Leader

• Create and project a specific destination
• Create consensus around that destination
• Create goals to verify execution across pillars
• Deploy and manage strategies to execute goals
• Measure, report and communicate progress
• Manage low performance
• Recognize high performance

Key Elements to Getting Leader Results:

• Attributes of effective leaders
• Leader Competencies
• Leadership training and development
• Assess leaders by execution of system goals

Effective Physician Leaders:

• Can communicate a vision and articulate a strategy to achieve results
• Are not slowed or distracted by individual protest that runs counter to the group mission
• Depend on measurement, not opinion, to assess performance
Effective Physician Leaders:
• Are high performers in the organization, who have the ability to influence others
• Are progressive and students of change and know the requirements for marketplace differentiation
• Are collaborative by nature and have the ability to create consensus

Key Competencies to Lead
• Run a meeting
• Have difficult conversations with difficult physicians
• Recognize high performance
• Hold themselves and others accountable to execute goals

Leadership:
“Leaders begin to lead when they see the Light, or feel the Heat”

Martin Luther King Jr.
“If there are only a few things you do... let one be the adoption of an objective measurable leader evaluation tool. Then hold leaders accountable for those results.”

Hardwiring Excellence, Quint Studer

Comparison of those organizations that have the leader evaluation process hardwired and those that do not

When physicians and nurses see a performance culture from the leaders around them, they become more willing to be held accountable for their own performance.

Source: Studer Group® October 2008 Measurement Spreadsheet. Organizations that hardwire the leader evaluation process in their organizations, show patient perception of care ratings that are significantly higher than those that do not. Patient perception of care measure score includes all different selected vendors including: Arbor, Avatar, Gallup, HCAHPS, Healthstream, Jackson, MIC, PRC Picker, Press Ganey, RPM, and Statisquest.
Deployment of the Physician Champion

- Physician Champion: A selected physician responsible for leading an important and specific organizational initiative
  - Improve the patient experience
  - Improve utilization of clinical evidence based protocols and order sets
  - Deployment of CPOE
  - Improve physician coding

The Physician Champion

- Appointed position
- Created and developed as an internal “expert” in area of responsibility
- Provide administrative time
- Provide stipend
- Position with high visibility
- Comprehensive executive and physician leader support

Clarity of Expectations: A Contract

<table>
<thead>
<tr>
<th>Position:</th>
<th>Physician Champion for “The Sharp Experience”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal:</td>
<td>Improve patient satisfaction to 80% as delivered by physicians</td>
</tr>
</tbody>
</table>
| Responsibilities: | 1. Coach/train medical group physicians  
2. Coach low performing physicians  
3. Provide performance feedback to physicians regarding the patient experience |
| Administrative Time: | ½ day per week |
| Pay: | $2500/month |
| Reports to: | Medical Group Board, Quarterly |
Stage 5: Physician Performance Measurement

Measurement, reporting of performance and clarity of expectations are requisites for physician effort to achieve an outcome.

Basic Truths:

• Systems will be defined by performance measures in quality, service, turnover, LOS, cost per adjusted D/C, readmit rates, adjusted mortality
• Physician score cards are an alignment engine for physicians to execute system goals

Performance Measurement:

• Measurement drives performance in the absence of any other intervention
• Dissemination of *comparative data* to physicians is more compelling than raw data
• *Transparent data* is more compelling than veiled data
What do we measure to improve physician performance?

Measure what you want to achieve...

Physician Performance Measures:

- OUTPATIENT
  - Diabetes composite of care
  - LDL<100 in CAD patients
  - BP<140/90
  - ACE in DM with HTN
- INPATIENT
  - CMS Core Measures
    - HCAHPS
    - AMI Management (9 measures)
    - CHF Management (4 measures)
    - Pneumonia (7 measures)
    - Surgical Infection Prevention (4 measures)
- EMERGENCY DEPARTMENT
  - ASA/beta-blocker documentation for AMI
  - EKG on CP patients over 40
  - Antibiotics within 4 hours for CAP
  - EKG for syncope patients

Physician Performance Measures:

- Patient Satisfaction
- Complaints
- Compliments
- Transfer rates away from practice
- "Likelihood of recommending Physician"
Physician Performance Measures:

- Charges
- Patients seen per day
- RVUs
- Peer Review
- Nurse Review

Patient Satisfaction Dashboard:

<table>
<thead>
<tr>
<th>Physician: Dr. Green</th>
<th>Time interval: 04/01/2008 - 03/31/2009</th>
<th>Total Surveys Returned: 81</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Raw Score</td>
<td>National Percentile Rank</td>
</tr>
<tr>
<td>Physician Overall Raw Score</td>
<td>95.2</td>
<td>97</td>
</tr>
<tr>
<td>Friendliness of Physician</td>
<td>96.6</td>
<td>96</td>
</tr>
<tr>
<td>Explanations of condition</td>
<td>95.4</td>
<td>97</td>
</tr>
<tr>
<td>Concerns for questions/worries</td>
<td>95.1</td>
<td>95</td>
</tr>
<tr>
<td>Efforts to include patient in decisions</td>
<td>93</td>
<td>82</td>
</tr>
<tr>
<td>Information about medications</td>
<td>94.6</td>
<td>96</td>
</tr>
<tr>
<td>Instructions on follow-up care</td>
<td>95.1</td>
<td>97</td>
</tr>
<tr>
<td>Spoke using clear language</td>
<td>95.7</td>
<td>96</td>
</tr>
<tr>
<td>Time spent with the patient</td>
<td>94.1</td>
<td>97</td>
</tr>
<tr>
<td>Patient confidence in Physician</td>
<td>96.3</td>
<td>97</td>
</tr>
<tr>
<td>Likelihood of recommending Physician</td>
<td>96</td>
<td>97</td>
</tr>
</tbody>
</table>

What Physicians Might Say:

- “This sample size is not significant”
- “This measurement data is flawed”
- “My patients are…”
“I think of myself as a physician who aggressively controls risk factors. Then I got my list…”

<table>
<thead>
<tr>
<th>Summary of diabetes composite</th>
<th>% of patients at goal</th>
<th>Goal for composite measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>28 of 69 patients have LDL over 100 (goal: Pts c DM have a LDL&lt;100)</td>
<td>40.5%</td>
<td>70%</td>
</tr>
<tr>
<td>34 patients have a HgA1C over 7.0 (goal: Pts c DM have HgA1C&lt;7.0)</td>
<td>51.4%</td>
<td>65%</td>
</tr>
<tr>
<td>28 patients have a systolic BP over 130 (goal: Pts c DM have SBP&lt;130)</td>
<td>59.4%</td>
<td>65%</td>
</tr>
<tr>
<td>10 patients smoke and 5 were not asked (goal: Pts c DM who smoke are counseled)</td>
<td>50.0%</td>
<td>90%</td>
</tr>
<tr>
<td>39 patients are not on aspirin (goal: Pts c DM on ASA)</td>
<td>47.8%</td>
<td>85%</td>
</tr>
</tbody>
</table>

Applying Measurement:

<table>
<thead>
<tr>
<th>PCP</th>
<th># of pts</th>
<th>LDL measured</th>
<th>LDL&lt;100</th>
<th>A1C measured</th>
<th>A1C&lt;7</th>
<th>Syst BP &lt;130</th>
<th>No tob</th>
<th>ASA</th>
<th>Statin</th>
<th>Complete DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD A</td>
<td>15</td>
<td>87%</td>
<td>54%</td>
<td>87%</td>
<td>54%</td>
<td>60%</td>
<td>87%</td>
<td>100%</td>
<td>87%</td>
<td>13%</td>
</tr>
<tr>
<td>MD B</td>
<td>59</td>
<td>93%</td>
<td>66%</td>
<td>95%</td>
<td>48%</td>
<td>72%</td>
<td>92%</td>
<td>91%</td>
<td>76%</td>
<td>24%</td>
</tr>
<tr>
<td>MD C</td>
<td>53</td>
<td>96%</td>
<td>82%</td>
<td>89%</td>
<td>62%</td>
<td>68%</td>
<td>89%</td>
<td>98%</td>
<td>89%</td>
<td>28%</td>
</tr>
<tr>
<td>MD D</td>
<td>56</td>
<td>93%</td>
<td>64%</td>
<td>100%</td>
<td>41%</td>
<td>61%</td>
<td>88%</td>
<td>93%</td>
<td>71%</td>
<td>14%</td>
</tr>
<tr>
<td>MD E</td>
<td>39</td>
<td>89%</td>
<td>88%</td>
<td>89%</td>
<td>38%</td>
<td>78%</td>
<td>100%</td>
<td>89%</td>
<td>78%</td>
<td>38%</td>
</tr>
<tr>
<td>MD F</td>
<td>44</td>
<td>72%</td>
<td>38%</td>
<td>70%</td>
<td>16%</td>
<td>48%</td>
<td>84%</td>
<td>68%</td>
<td>68%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Physician Peer Review

Physician interaction and conduct are major determinants in the well being of our group and the patients we take care of. Please evaluate your physician colleague in a thoughtful and honest manner. Results will be collated and reported to physicians in confidence and used as feedback for performance improvement.

Physician: _______________________
Reviewer: _______________________
Date: _______________________

Scale:
5 – Excellent / Consistently performs / Example to others
4 – Good / Performs on most occasions
3 – Fair / Inconsistently performs / Average
2 – Below Average / Usually does not perform
1 – Poor / Never performs / Needs major improvement
Bringing it All Together

The Physician Dashboard

Pillar Balanced Scorecard- Outpatient
**Pillar Balanced Scorecard - Inpatient**

**PRINCIPLES OF MEASUREMENT**

**APPLICATION:**

**SELECT PHYSICIAN PERFORMANCE MARKERS**

- Cascade from Organization goal Matrix
- Include physicians "at the table" in Goal Selection

**REPORT PHYSICIAN PERFORMANCE TO PHYSICIANS**

- Results need to be comparative to peers
- Goals should be reported relative to Goals

**PROVIDE CONTINUOUS FEEDBACK**

- Physician goals should rise consistent with organizational improvement
- Recognize physician who do well, Help physicians who don't

**Pillar Balanced Scorecard - Emergency Dept.**

**PRINCIPLES OF MEASUREMENT**

**APPLICATION:**

**SELECT PHYSICIAN PERFORMANCE MARKERS**

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Stage 6: Developing and Training Physicians for System Performance

The measurement of physician performance must be coupled to specific training to achieve measured outcomes.

How are physicians doing in the care of patients?

Significant differences exist between patients’ and physicians’ impressions about patient knowledge.

![Diagram of Patient Knowing Physician Name]

Significant differences exist between patients’ and physicians’ impressions about patient knowledge.

**Patient Knowing Diagnosis**

- % of Physicians believe patients know diagnosis
- % of Patients that know diagnosis


**Physician Discussing Patient Fears**

- % of Physicians stated they sometimes discussed patients’ fears and anxieties
- % of Patients that said physicians NEVER did this


The Chasm for Physician Excellence:

- **Physician Communication When Prescribing Medications**
  - 26% failed to mention the name of a new medication
  - 13% failed to mention the purpose of the medication
  - 65% failed to review adverse effects
  - 66% failed to tell the patient duration of treatment

_Arch of Int Med, 2006_
The Chasm for Physician Excellence:

- 74% of patients are interrupted by physicians giving the initial history
  \[JAMA\text{ 1999 281: 283-287}\]
- 91% of patients did not participate in decisions regarding treatment plans
  \[JAMA\text{ 1999 282: 2913-2920}\]

Physician Training works when...

- A clear, bold, embraced patient-centered Organizational Vision is in place
- Physicians believe it is important
- A collaborative, trusting relationship with leaders exists
- Trained behaviors are specific and prescriptive
- Opinion leaders “stand up for this”
- Progress is measured and transparently reported
- Incentives are in place to hit performance goals
- Visible recognition is in place

The Purpose of Physician Training is...

- To clarify the physician’s role in the new system
- To provide physicians tools and training to make them more successful
- To create “system physicians”
Components to Physician Training

- Treatment of Patients
- Treatment of Staff
- Treatment of Colleagues
- EHR use/CPOE
- Clinical Protocols/order sets

How to Train Physicians: Evidence-based Behaviors

- **The Beginning**: The first impression
- **The Middle**: Gathering and explaining information, and the creation of a collaborative plan
- **The End**: Review of information and ending strong

The Exam Room-The Beginning

- Know what you are doing prior to entering the exam room
- Knock, pause 2 seconds prior to entry
- Shake hands, smile and establish eye contact
- Acknowledge the wait
- Sit at eye level, facing the patient
- Non-medical query
The Exam Room-The Middle

- Tell me about...
- Let the patient speak without interruption (2 minute rule)
- Paraphrase the patient history
- 80 percent of time spent with “eye contact”

“Questions for Your Physician?”

- Please respond to
  - Patient and/or Family member
- Please give this inquiry to your nurse/assistant. Thank you.

Diagnosis-What patients want

- The diagnosis
- The natural history of their condition
- What they need to do
- What do they need to worry about
New Medication

- The name of the medication
- The purpose of the medication
- Potential side effects
- Duration of therapy
- A query of understanding
- A query of comfort with the treatment plan

Exam Room-The Middle

- Convey physical exam findings while doing the exam
- Empathy- “I am sure this must be tough for you”

The Exam Room-The End

- Establish treatment goals
- A clear summary of the treatment plan
- Provide written materials
- Clarity on what will happen next
  - Appointments
  - Testing information
- Finish With:
  - “Are there any other questions I can answer for you?”
  - “You are doing very well, keep up the good work…”
### An evidence-based approach to the patient experience:

“**Charm** is a set of clinical communication skills than can be taught and mastered”

*Smith, Ann of Internal Med 1998*

### Transforming System Care:

- Discharge Phone Calls
- Keeping patients informed of wait times

### Discharge Phone Calls:

- Unsolicited calls to patients treated to check on clinical status a day or two after discharge
- Drives clinical quality, loyalty and institution reputation
Keeping Patients Informed of Duration

Duration

Post Visit Calls

Likelihood of Recommending - ED

Source: New Jersey Hospital, Total beds = 775, 2007-2010
Post Visit Calls

**Likelihood of Recommending – Inpatient**

Source: New Jersey Hospital, Total beds = 775; 3Q2007 – 2Q2010

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Post Visit Calls:

**Clinical Quality**

Source: New Jersey Hospital, Total beds = 775; 3Q2007 – 2Q2010

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Post Visit Calls:

**Patient Perception of Care: Inpatient**

Source: Inpatient, Advocate Christ Medical Center, Oak Lawn, IL, Admissions: 38,877, Total beds = 648

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Post Visit Calls: Inpatient

Tactic and Tool Implemented:
Post Visit Calls - Discharge Call Manager

Post-Visit Phone Call Sample

Empathy and Concern
"Mrs. Smith? Hello. This is [name]. You were discharged from my unit yesterday. I just wanted to call and see how you're doing today…"

Clinical Outcomes
- "Mrs. Smith, did you get all your medications?…"
- "Is your pain better or worse than yesterday?…"
- "Smith, we want to make sure we do excellent clinical follow-up to ensure your best possible recovery. Do you understand your discharge instructions?…"

Reward and Recognition
- "Mrs. Smith, we like to recognize our employees. Who did an excellent job for you while you were in the hospital?…"
- "Can you tell me why Sue was excellent?…"

Service
- "We want to make sure you were very satisfied with your care. How were we, Mrs. Smith?…"

Process Improvement
- "We're always looking to get better. Do you have any suggestions for what we could do to be even better?…"

Appreciation
- "We appreciate you taking the time this afternoon to speak with us about your follow-up care. Is there anything else I can do for you?…"

Stage 7: A Physician Code of Conduct

The Joint Commission is introducing new standards requiring more than 15,000 accredited health care organizations to create a code of conduct that defines acceptable and unacceptable behaviors and to establish a formal process for managing unacceptable behavior

Joint Commissions, 2009
A Code of Conduct:

- Translates system culture and values to physician behavioral expectations
- Used for physician orientation and training
- Represents the identity and character of an integrated system

Physicians are Receptive to Behavior Standards When...

- They have input into creation and launch
- Standards are consistent with communicated strategy and vision of the organization, created with physicians “at the table”
- Behavioral Standards are reached by consensus

Behavior Standards Impact

- **High**
  - Used for orientation/signed
  - Used for “Selection”
  - Consistent with “Vision”
  - Physicians trained in Behavioral Standards
  - Supported and projected by Leadership
  - Consequence for violation

- **Low**
  - No upfront signing/orientation
  - No training of physicians
  - Low leader visibility
  - No consequences for violations of Behavioral Standards
  - Low leader visibility
  - No consequences for violations of Behavioral Standards
A Physician Code:

**SHARP Rose-Arroyo Medical Group**

**PHYSICIAN CODE**

The mission of Sharp Rose-Arroyo Medical Group is to improve the health of our community through a caring partnership with patients, physicians and employees. Our goal is to offer quality services that set community standards and exceed expectations in a caring, convenient, affordable and accessible manner.

The delivery of the care we provide is dependent on physicians. Each of us is a leader within our system of influence and how we care patients, colleagues and staff will set the tone for the care we deliver. We can only expect better than those around us if we do better ourselves and thereby example.

We seek to create ideals that define the type of physician who works for Sharp Rose-Arroyo. Most importantly, we seek to provide an atmosphere to help physicians flourish professionally and personally and to create a group, which is defined by providing exceptional care to its patients, staff and fellow physicians.

The Physician Code:
Predictors of Successful Integration

- Clear, bold and well understood Vision
- Physician buy-in that the new way is better for them
- Effective and Accountable leadership
- Physician trust in the leadership team
- A voice in strategies of the new system
- Performance measurement and feedback
- Training and development to execute measured outcomes
- Clarity of expectations
- Unity of the Mission

Executing Health System Integration:

Downdoc Clinic is an independent, longstanding primary care group with 45 physicians. Downdoc has an excellent reputation in the community. Despite patient loyalty, administrative costs and diminishing reimbursement has squeezed Downdoc. Recruitment has become difficult, revenue is down and there is little money for an EHR that was planned 4 years ago. Leadership at Downdoc looks to the future and the clinical operations are not sustainable. Discussions of joining their arch rival, Welldoc Health Care System, follow.

Welldoc has a large hospital, a multispecialty group of 110 employed physicians and a health plan. They have taken market share at Downdocs expense. Welldoc System seems to have “bought” market share through practice acquisitions, but struggle with the “patient experience” and has earned a less than stellar reputation in the surrounding community.

The Boards of each entity meet. Welldoc has been gesturing the leadership at Downdoc for the last 6 months. The acquisition prospect is brought to the physicians at Downdoc Clinic. Downdoc has no choice. Consensus for an acquisition is achieved. Downdoc physicians will now become employed by Welldoc Health System.

Welldoc Health Systems leadership is genuinely interested in improving its community reputation and looks at the acquisition as a good opportunity to improve. The prospect of a Downdoc physician being employed by the uncaring, bottom-line driven, dark side at Welldoc Health System crushed the spirit of many of the seasoned physicians at Downdoc. The acquisition is set. Leadership on both sides are nervous, and Downdoc physicians are not happy.
Table 1: Create a New Vision

• Create a new unified vision
• Explain how the vision is created
• Explain how this vision will be communicated to Welldoc and Downdoc physicians
• Explain how you plan to make this a “vision driven” organization

Table 2: Create System Goals

• Create a goal matrix for the new outpatient, 155 physician Welldoc System Clinics
• Explain how you create buy-in for these goals from both physician groups
• Describe how you use the Organizational Goal Matrix to create a performance driven system

Table 3: Leadership Structure

• Describe a leadership model to create fair Downdoc leadership representation
• Describe selection criteria for leader positions within the new Welldoc Systems
• Describe how leaders performance will be assessed, and how the assessment tool will be used to drive outcomes
Table 4: Creating Physician Buy-in
- Describe a comprehensive leadership strategy to unify and convince markedly different group cultures to move together in a shared, new mission.

Table 5: Establishing Physician Trust
- Physician trust of leadership on both sides is marginal, at best. Describe a comprehensive strategy to restore physician trust and confidence in the new, merged Welldoc System enterprise and the leadership team.

Table 6: Creating Physician Scorecards
- Craft a method to assess and report physician performance
- Describe which indicators will be tract and why?
- Describe how leadership “sells” physician accountability for performance to frontline physicians.
Table 7: Roll-out Behavioral Standards

- Craft the outline of physician behavioral standards for the new, integrated enterprise
- Explain your methodology in terms of how you will create the Code of Conduct
- How will the Code of Conduct be used to truly influence physician behaviors

THE POWER OF YOUR LEADERSHIP

“Never doubt that a small group of thoughtful, committed people can change the world. Indeed, it’s the only thing that ever has.”

Margaret Mead