

The Structured Dialogue Process

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The inception: Nearly 15 years ago, a member of my firm was talking to a physician who was exasperated by yet another potential round of consultants milling around his workplace.

The physician exclaimed, "Why doesn't anyone let us (physicians) tell you what the hospital needs to do to serve the community? After all, we are the ones who are closest to the patients and their families."

This conversation led my colleague to begin direct, open conversations with this physician and his peers about important issues rarely discussed in a hospital setting.

These informal discussions led to a structured dialogue—the beginning of a new approach to partnering with physicians to decide the hospital's clinical priorities. The dialogue acknowledged that:

- Once they understand the rationale for change, physicians are the most effective change agents in the hospital because of their understanding of clinical processes and influence over patient care and physician colleagues' behavior.
- Although physicians control many clinical decisions that impact costs, quality and patient satisfaction, the role they play in major strategic, policy and operating decisions often is not organized or consistent.
- Traditional efforts by hospital leadership to enlist the support of physicians through administrative committees and board representation tend to be hospital-centric and unresponsive to the needs of practicing physicians.

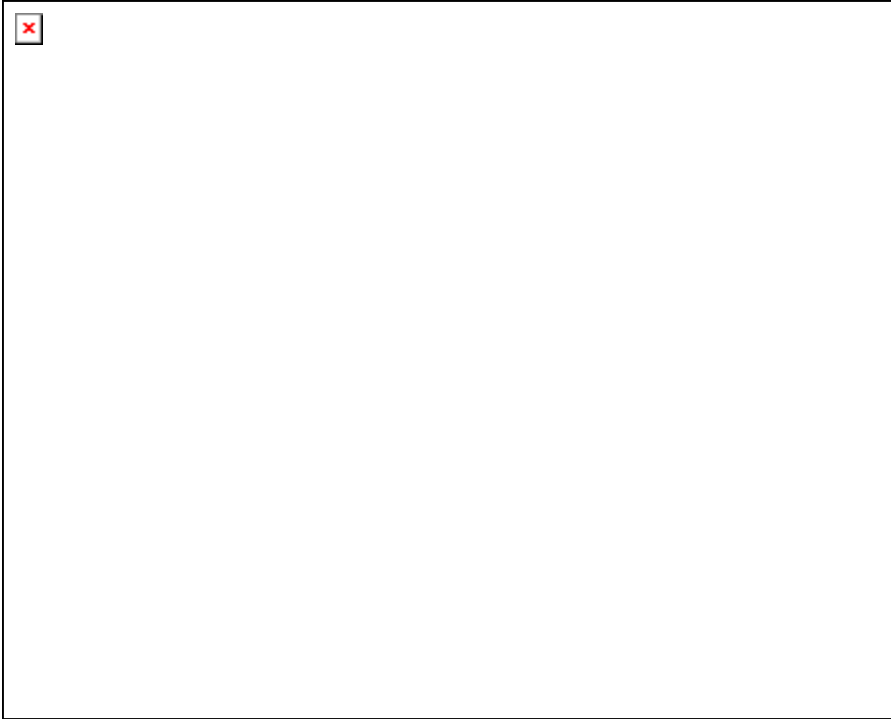
In the ensuing 15 years, the structured dialogue process created an environment for discussion and deliberation where practicing physicians truly attain a meaningful role in shaping the policies and programs in hospitals where they work.

This process engages physicians in a physician-led, peer-reviewed discussion that enables them to become leaders in setting clinical priorities.

Moreover, the process provides an opportunity for all physicians who wish to participate to have their opinions and recommendations considered. The advantages of this dialogue are that it:

- Acknowledges the role and influence of physicians and, by creating an environment where physicians are accountable to each other, encourages change
- Addresses major issues, such as the health care needs of the community, the clinical and economic needs of growing physician practices, the challenges of improving physician-to-physician and physician-to-management communication and the increasing focus on quality and safety in health care delivery
- Facilitates the generation of solutions to service problems that do not require major capital expenditures
- Supports the needs of nurses, who spend even more time with patients than physicians and are acutely aware of system deficiencies and the need for process improvements in hospitals.

Figure 1 illustrates the steps in the structured dialogue process.



The process is guided by a small group of physicians, the medical advisory panel (MAP), whose opinions and clinical expertise carry weight with their colleagues. The MAP is charged with overseeing the structured dialogue process, encouraging widespread participation of the medical staff and making strategic recommendations about clinical priorities. Dialogue in Action - Patriot Hospital in fiscal year 1999, Patriot Hospital, a 350-bed community teaching hospital, had gross revenues of \$200 million and an operating loss of \$20 million.

Figure 2 outlines the Hospital's major strengths, weaknesses, opportunities and threats in 1999.

Strengths, Weaknesses, Opportunities and Threats Facing Patriot Hospital	
Strengths	Weaknesses
Well-respected community teaching hospital Community leader in high-tech advances, especially cardiology	Caught in middle between nearby high-touch community hospital and high-tech academic tertiary care hospital High penetration of managed care <ul style="list-style-type: none"> dominant insurer negotiated per diem reimbursement, which makes it difficult to achieve economies based on decreasing length of stay Conservative climate among patients, physicians and state officials <ul style="list-style-type: none"> resistance to sweeping change over utilization of elective surgery relative to national benchmarks, e.g. spinal fusion and hysterectomy Inconsistent management team <ul style="list-style-type: none"> CEO has COO mindset community physicians ignore dept. chairs silos inhibit comprehensive solutions
Opportunities	Threats
40% of local market is undecided about hospital of choice Engaging physicians in differentiating and improving services to increase revenues, decrease costs, and increase quality and patient safety	Mature health care market Excess specialist capacity Services perceived to be undifferentiated

Patriot's weaknesses at that time exceeded its strengths.

Although the size of the operating loss was troubling, many physicians lacked a sense of accountability for the hospital's success and survival.

For example, several orthopedists and cardiologists viewed losses on expensive prostheses as the hospital's problem. Furthermore, current operational crises, such as a nursing shortage and capacity problems in the operating and emergency rooms, made discussions of long-term planning seem like a distraction.

Department chairs, community physicians and the management team expressed skepticism about any approach to change, especially one that involved external consultants.

However, a member of Patriot's senior management team who once worked at another hospital where the structured dialogue process was successful recommended further discussions with physicians and management.

So the hospital committed to the structured dialogue process. Forming a medical advisory panel The vice president of medical affairs led the process of convening the MAP by selecting the co-chairs , who selected 11 other panel members.

Patriot's MAP was intentionally kept separate from the hospital's medical executive committee. While there was some overlap in membership of the two entities, the MAP membership was broader and more representative of Patriot's medical staff.

Furthermore, the hospital needed the executive committee to focus on its numerous routine activities.

To develop its recommendations, the MAP solicited input from the medical staff through a series of meetings and presentations with each clinical department and section. The MAP asked each clinical area to present its goals, long-term strategy and short-term tactics, as illustrated in Figure 3.

Guidelines for Presenters

Overview

Presenters are recognized clinician-leaders chosen by their colleagues on the Medical Advisory Panel (MAP) to serve as liaison between their sections and the MAP. They convene members of their section, discuss the guidelines listed below, and obtain consensus on recommendations that they deliver in written and oral reports to the MAP.

Reports

Written reports summarize discussion on the following guidelines. They are due 10 days prior to the oral presentations, so that MAP members may familiarize themselves with the recommendations. Recommendations should reflect consensus within the section. No minority reports are allowed. The content includes:

- Executive Summary: prioritized list of recommendations
- Introduction: overview of section history, changing needs of community, and volume trends
- Practice Statistics: demographics, market share, profit and loss for 10 most common diagnostic related groups (DRGs), ages of section members, plans for succession and recruitment, quality/representative outcomes
- Relationships: other sections/departments and with hospital
- Obstacles: practice development and operations
- Actions: section and hospital can take to improve effectiveness and efficiency - what can the hospital do for the section, and what can the section do for the hospital?
- Scenarios: best-case, worst-case, and status-quo with assumptions and implications
- Three-Year Plan: prioritized goals, steps required to achieve goals, timetable, and budget
- Impact on Community: if goals are met/unmet

Oral reports are 15 minutes long, with an additional 15 minutes for questions and discussion. Presenters should assume that panelists have read the written reports and use the limited time to highlight their section's recommendations and rationale.

To support the clinical areas in developing their presentations, the hospital provided staff and data as requested by the sections.

The MAP met weekly for four months to hear the presentations from all major clinical departments and sections. The first presentation occurred approximately one month after the MAP convened, allowing time for MAP members and presenters to obtain necessary background information about hospital operations, nursing, marketing, finance, information services and managed care contracting.

This timeframe also gave the presenters sufficient time to meet with their colleagues and to write their reports. During this time, the consultants provided onsite coaching in management principles to individuals and small groups of physicians, facilitating learning without requiring physicians to attend special courses. The vice presidents for medical affairs, patient care services and managed care were invited to listen to the sessions and to develop familiarity with the process and the panelists.

Attending the meetings also benefited management since it gave them the chance to hear from a panel of clinical leaders and not merely squeaky wheels, as had occurred in the past.

Through section-wide discussions, written reports and oral presentations, the panel enlisted the clinical expertise of Patriot's medical staff, whose opinions could not be disregarded easily.

Everyone involved agreed that the process offered community physicians the opportunity to influence the hospital's clinical direction.

"This is the first time in over 20 years since I have been practicing at Patriot that I have felt that the hospital hired consultants because it did not know the answer," one participant said. "In the past, I surmised that they knew the answer but lacked the courage to implement it." The MAP's recommendations. Written and oral section reports allowed the MAP to weigh priorities. To establish a framework for evaluating the presenters' recommendations, the MAP agreed upon four themes for the physician community and the hospital to embrace:

- Improve customer service
- Enhance physician-to-physician communication and simplify the physician consultation process
- Implement protocols in all major diagnostic related groups to save money, limit variation and improve quality and safety
- Develop coordinated diagnostic and treatment centers

The panel incorporated these themes into a written report, which they presented to the medical executive officers and staff, to senior management and department chairs, and finally to the board of trustees, who gave them a standing ovation at the end of their presentation.

To outsiders, this positive reception may be surprising, as the four Patriot themes might be considered mundane. For Patriot, however, obtaining consensus on these issues was a major achievement, since its physicians had not embraced these themes previously.

The four themes were incorporated into the hospital's strategic planning. The fourth theme, to develop coordinated diagnostic and treatment centers, has been a major focus. Under this theme, the MAP proposed:

- A one-call interdisciplinary screening and management program for prostate cancer, whose planning became the blueprint for a generalized cancer screening program
- An advanced laparoscopy and robotics program for cardiothoracic and general surgery, urology, gynecology and orthopedics
- An interdisciplinary complementary medicine program to coordinate the services of internists, naturopaths, chiropractors, massage therapists and acupuncturists
- A vascular disease center coordinating the services of cardiologists, invasive radiologists and vascular surgeons and easing the process of referrals

In the year since the MAP concluded its initial work the hospital worked diligently to implement the MAP's recommendations, the MAP reconvened twice to monitor the status of implementation and several of the physicians from the MAP were involved in implementing the clinical care center initiatives.

As a result, there is a renewed emphasis on patient satisfaction, and surgical volumes and market share have increased, especially in minimally invasive cardiac surgery. Lessons learned at Patriot Hospital Both Patriot management and physicians found the structured dialogue guided by the MAP to:

- Improve the way that physicians relate to their colleagues and serve their community
- Put leadership for clinical direction back in the hands of physicians
- Provide an innovative approach to strategic and operational planning
- Ensure an effective learning experience for physicians
- Provide an excellent approach for grooming physician leaders

The experience at Patriot is consistent with lessons learned over 15 years of using a structured dialogue process to set clinical priorities, promote physician-to-physician accountability and build physician-management trust. These lessons include the importance of:

- Welcoming resistors early in the process—physicians, like others, tend to resist disruption of longstanding routines
- Stating clearly up front that management is committed to acting on the MAP recommendations
- Seeking counsel frequently and openly from physicians, nurses, allied health care workers and management—the unique culture of each hospital necessitates guidance from both formal and informal leaders to be successful
- Selecting co-chairs with complementary skills who share the common goal of improving patient care within the community
- Nurturing and coaching presenters to make them feel part of the process and assigning management resources to help presenters with their presentations
- Being patient with the process—it is a journey where seeds are planted rather than trees harvested
- Recognizing the value of embedding the structured dialogue process in the organization's culture as opposed to using it as a one-time approach to a project
- Considering nothing accomplished until implemented

Achieving success with structured dialogue The ultimate success of structured dialogue depends on the leadership of the co-chairs, the quality of discussion that the MAP fosters and the physicians' shared sense of accountability for implementing the MAP's recommendations.

To support these goals, physicians and management need to discuss and agree on the following principles at the beginning of the structured dialogue process:

- The first priority is the community, followed by the patients whom the physicians serve, the physicians themselves and, finally, the hospital.
- The personal integrity and professional standing of the physicians selected to chair the process and to be members of the MAP must be so great that the list of names tells colleagues that something of lasting significance, rather than a passing fad, is about to happen.
- The hospital executives, staff and the MAP play it straight. Patient care executives actively assist the physicians, as requested, realizing that the dialogue and output may not fit the current hospital model. The CEO and board have to commit to following the MAP's recommendations for the physicians to put in the time as presenters and panelists. Similarly, the physicians recognize their interdependency and responsibility for each other and the hospital; they scrupulously maintain confidentiality during and after presentations to the MAP.
- The dialogue and recommendations are comprehensive. Just as physicians realize that they have an opportunity to impact clinical resource investment decisions for the hospital, they also understand that their recommendations address the needs of the entire medical community. Long-standing feuds, petty jealousies and the wish to avoid the process are obstacles that must be overcome. The recommendations are by and for the physicians; no minority reports are accepted.
- The process is part of an on-going, long-term plan for physicians to engage in their own professional and economic affairs as well as in the decision-making and leadership of the hospital. The physicians must develop detailed descriptions of where they want to be as a community of providers now and over the next three years. In addition, physicians are reluctant to participate unless they know in advance how progress will be measured. A multi-dimensional set of outcomes and measures needs to be developed to track results and to manage performance.

Enlisting physicians in a process of structured dialogue is a long-term strategy that begins with building trust and credibility and culminates after four to six months with improved focus and clarity about future goals and with heightened ability of physicians to communicate with each other and with management. Although the weekly meetings consume a considerable amount of voluntary time, the end results decrease feelings of disenfranchisement and increase feelings of ownership and participation in a worthy cause, improvement of health care to the community.

Acknowledgements

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