

Physician Engagement: Moving from Me to We

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Overview

- Building a culture of collaboration: Case presentation
- Keeping the peace between employed and independent physicians
- Specific examples of physicians moving from me to we
- Ways to engage physicians, especially those who do not want to be engaged
- Implications for healthcare reform efforts: a call to action

I. Culture of Collaboration

Case Presentation: Overview

- What is culture
- Why is it important
- What is the paradox of culture
- WIIFM

Definition of Culture

- What organizations use to solve problems
- Reflects a shared view of the world
- Distinct from strategy:
 - Services provided
 - People served
 - Benefits of service
 - Differentiation

Cohn KH, Schwartz RW. Business plan writing for physicians. *Am J Surg* 2002;184(2):114-120.

Relevance to Physicians

“Strategy may be nice,
but culture eats strategy for lunch.”

Culture is the only sustainable source of
competitive advantage because it is the only
thing that no competitor can copy or steal.”

Tye J. 2010. All Hands on Deck: 8 Essential Lessons for Building a
Culture of Ownership. Hoboken: John Wiley, xix, 139.

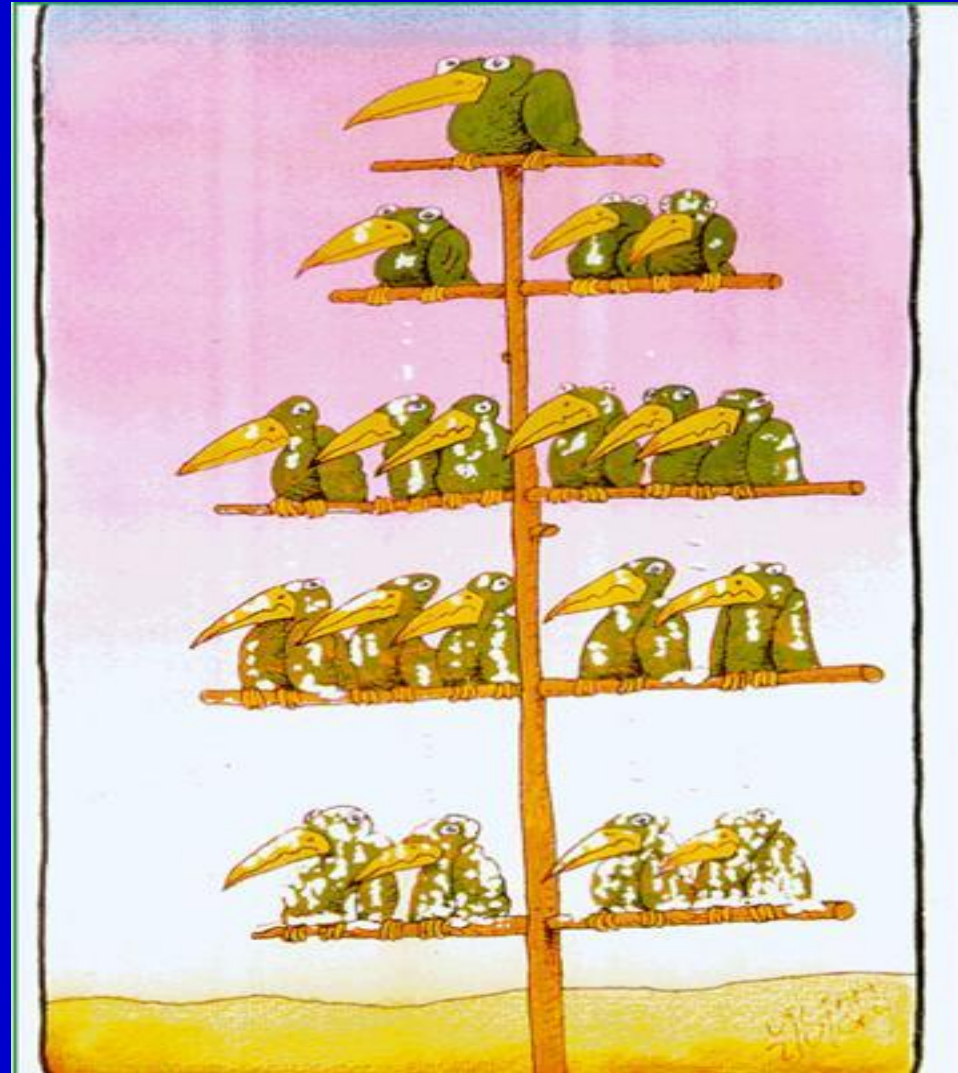
The Paradox of Culture

- Strong culture allows leaders to delegate tasks
- Key to becoming a dominant presence in a competitive marketplace
- Yet, bottom-up processes resonate with physicians, who prefer being inspired to being supervised

CohnK. 2008. Collaborative Culture.

<http://healthcarecollaboration.com/collaborative-culture/>

A Physician's Perception of Top-Down Management



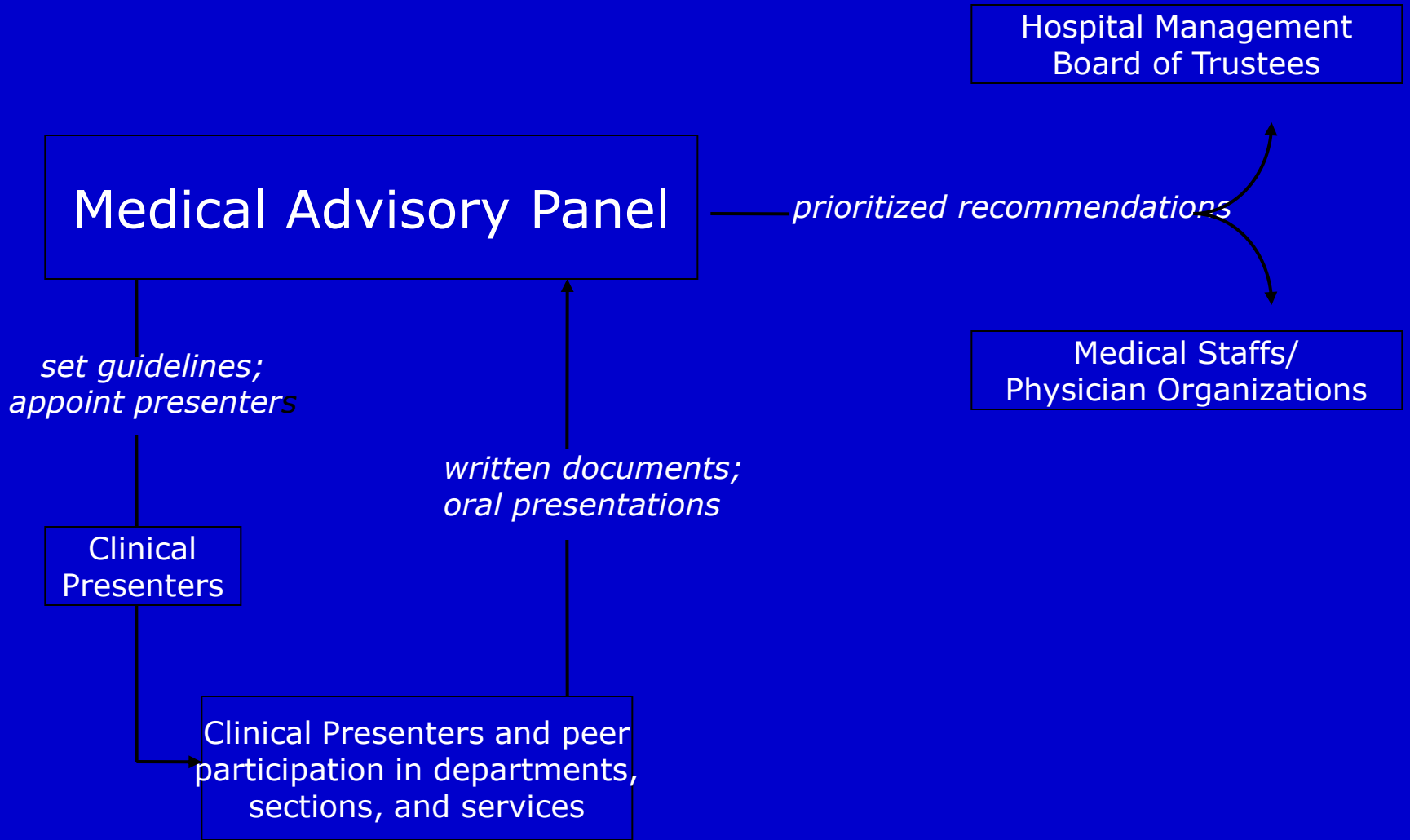
Case Presentation

Dilemmas:

- New hospital- what services?
- ASC: \$5 MM/ yr
- Outpatient pain and GI centers
- Hospitalists: freed PCPs
- Burden of call: “You’re nothing but...!”

Cohn KH, Allyn TR. Cultural transformation from the ground up: Being part of something larger than yourself. In O’Neil K. *Ignite Your Business: Transform Your World*. Orlando. Celebrity Press, 2010, 59-72.

Clinical Priority Setting Process



Deliverables

- A three-year clinical operating plan, expressing the vision of practicing physicians
- A list of approximately 100 prioritized recommendations, most of which are implemented without major capital expenditures
- A group of 10-15 clinicians, knowledgeable in all major aspects of the hospital's business, who become a major source of formal and informal medical staff leadership and trust-building

Results

- Orthopedics: consolidation of vendors, uniform pricing- \$5.5 MM savings
- Sepsis mortality decreased from 47% to 19%, saving an estimated 40 lives annually
- OR staff won 2009 GE Healthcare Centricity Perioperative Customer Innovation Award
- Acute stroke care center cares for over 300 patients per year with outcomes that consistently exceed other stroke care centers
- President, VP, and Secretary of MEC emerged from roles as MAP panelists and presenters

In his own words

- I am not a bureaucracy person
- For this process to work, the hospital had to undergo a cultural enema
- I enjoyed the data-driven presentations
- We obtained a new perspective of the hospital and the complexity of hospital operations

Cohn KH, Allyn TR. Cultural transformation from the ground up: Being part of something larger than yourself. In O'Neil K. *Ignite Your Business: Transform Your World*. Orlando. Celebrity Press, 2010, 62-64.

His own words, II

- *We evolved* from what the hospital should do for us *to how we could work with the hospital to improve care* for our patients
- The reason for my change in outlook is that *I am making my time count*

Ten Steps Toward Building a Culture of Collaboration

- 1) Engage your top performers, regardless of irascibility
- 2) Have ground rules to which the group commits, such as building on others' ideas, refraining from personal criticism, sharing responsibility for deadlines, developing win-win solutions, and respecting confidentiality
- 3) Focus both on workplace pains that lead to suboptimal outcomes and past successes where people transcended silos to achieve outstanding results
- 4) Quantify the costs of continuing the status quo in terms of productivity, revenues, expenses, outcomes, and workplace morale

Ten Steps, II

- 4) Visualize tangible benefits of improved processes and close the gap between the present situation and the desired future state
- 5) Write each step of a frustrating process on a large post-it note; put the notes on a wall; ask the group how should, does, and could the process work, removing non-value added steps
- 6) Prioritize efforts by first improving processes that will result in quick wins

Ten Steps, III

- 8) Celebrate success and build on the goodwill that success generates
- 9) Chunk complex tasks into a series of outcome measures that have deadlines of no more than 2-3 weeks
- 10) Repeat the process monthly in the beginning and at least quarterly thereafter

Potential Pitfalls to Avoid

- “We don’t usually do it that way”
- Impatience with consensus-building, which decreases buy-in and shared ownership
- Inability to implement solutions in a timely fashion
- Needing to be in control

II. Keeping the Peace Between Employed and Independent Physicians

- Ask a physician task force to suggest ways that the hospital can *streamline processes* and optimize care, so that everyone can be more productive
- Use wikis as a web-based repository of contacts and information and blogs as a virtual meeting place to implement task-force recommendations in a timely fashion

Cohn KH, Mohr G, Ives B. "Building Community and Collaboration with Blogs," in *Collaborate for Success: Breakthrough Strategies for Engaging Physicians, Nurses, and Hospital Executives*. Chicago. Health Administration Press, 127-142.

Keeping the Peace Between Employed and Independent Physicians, II

- Develop *multidisciplinary institutes* and medical staff models that permit a variety of practice infrastructures
- Assist physicians with recruiting new physicians in areas that have a documented community need
- Use a multidisciplinary physician retention task force to identify issues proactively, before physicians leave the area

Cohn KH, Brennan MF. "Collaborative Opportunities in Disease-Based Care," in *Collaborate for Success: Breakthrough Strategies for Engaging Physicians, Nurses, and Hospital Executives*. Chicago. Health Administration Press, 99-106

Peace Between Employed and Independent Physicians, III

Leverage the power of HIT:

- Subsidize the costs of electronic health record implementation
- Share information across inpatient and outpatient settings
- Take advantage of state and federal grants for information exchange

Engaging Physicians to Cut Costs and Boost Revenue

- Have physician champions encourage specialists to consolidate vendors for implant devices and heart valves
- Ask a physician task force to recommend additional ways to cut costs
- Facilitate surgeons coming to consensus to create standard packs for common operative cases
- Have a Palliative Care Service, which rounds with the ICU team daily

Cohn KH, Allyn TR. Making hospital-physician collaboration work. *HFM*. 2005. 59(10):102-108.

Cutting Costs, II

- Use virtual gainsharing to acknowledge significant changes by sharing savings with physicians in projects in renovations and/or equipment purchases
- Arrange ways that outpatient physicians periodically can meet specialists to facilitate referrals and minimize out-of-network activity
- Engage physician leaders in all capital building campaigns to avoid expensive rework

Cohn KH, Malkin J. "Using Evidence-Based Design to Improve Collaboration, Clinical Outcomes, and Financial Performance," in Cohn KH. *Collaborate for Success!: Breakthrough Strategies for Engaging Physicians, Nurses, and Hospital Executives*. Chicago. Health Administration Press. 2006.

Cutting Costs, III

- Institute a policy of apology for all untoward events
 - Acknowledge event
 - Explain what went wrong without jargon
 - Show remorse/ empathy
 - Make amends

Cohn KH, Thieme D, Feldman A. "Taking a proactive, collaborative approach to malpractice issues," in Cohn KH. *Collaborate for Success!: Breakthrough Strategies for Engaging Physicians, Nurses, and Hospital Executives*. Chicago. Health Administration Press. 2006, 107-126.

What a Hospital Can Offer

- Access to capital at market rates
- Participation advantages in purchase of rapidly changing, high-tech equipment
- Information technology software and support
- Market power to obtain bundled payment from payers for cutting-edge services
- Experience with regulatory and licensing agencies
- A known entity for patients that can provide comfort, security, and credibility

Cohn KH, Allyn TR. Making hospital-physician collaboration work. HFM. 2005. 59(10):102-108.

III. Specific Examples of Physicians Moving from Me to We

- Healthy competition
- Finding the win
- Data-sharing
- Positive deviance
- Physician compact
- Mentoring
- The ASC challenge
- Set up to fail

Healthy Competition: Case Studies

- Cardiac catheterization medical director faced closing of a procedure room due to proliferation of supplies
- Members of a physician hospital organization (PHO) felt that their ability to compete for managed care contracts was limited by their compliance with core measures

Finding the Win

Protocol development:

Anticoagulation clinic

Postoperative ventilator weaning

Computerized physician order entry

Lessons:

- Start small
- Focus on time-savings benefit (WIIFM)
- Build on and celebrate successes



Data-Sharing

- Dr. Leon Bender, President of Medical Staff at Cedars-Sinai, was seeking a way to increase physician hand-washing compliance to 90%, as mandated by JCAHO
- At a Chief of Staff Advisory Committee Meeting, epidemiologist Rekha Murthy gave physicians agar plates, cultured their hands, and photographed the images

Dubner SJ, Leavitt SD. 2006. Selling Soap. The New York Times, September 24. [Accessed 12/28/07.]
http://www.nytimes.com/2006/09/24/magazine/24wwln_freak.html?_r=1&ex=1160020800&en=0c4817f1e4d7f211&ei=5070&oref=slogin#

Illustration by Paul Sahre and Loren Flaherty

Data-Sharing, II

- Hand-hygiene compliance shot up to nearly 100%, where it has remained for the past several years

“With people who have been in practice ... 30 or 40 years, it’s hard to change their behavior. But when you present them with good data, they change their behavior very rapidly.”

Leon Bender, M.D.

Positive Deviance: Case Study

- Ave. 2 patients/mo readmitted for failure to comply with post-discharge medication plan
- Telephone survey: 80% of patients taking medicine incorrectly
- **Analyzed what worked for 20% taking medicine correctly**
- Phone call brought compliance to nearly 100%

Weber DO. 2005. "Positive Deviance, Part 1." *Health and Hospital Networks*.
<http://www.hhnmag.com>

Improving Physician-Physician Communication: Overview

- Work through existing physician-led organizations, such as the Medical Executive Committee
- Enlist and cultivate physician champions
- Consider engaging a Medical Advisory Panel or designing a physician-hospital compact

Improving Physician-Physician Communication

- Work through Medical Executive Committee to improve dialogue:
 - Stat consults
 - Radiology diagnoses, including ectopic pregnancy, pulmonary emboli, acute appendicitis
 - Operating room bumping
 - Timely consultation, especially in Emergency Department

Possible Roles for Physician Champions

- Present and discuss clinical data with physicians
- Create a safe environment for learning
- Minimize physician-hospital battles
- Help to build transparency and trust
- Through the process of discovery, act like owners
- Leave a lasting legacy

Physician Compact

- Needed physician collaboration to achieve goals
- Wanted to promote value-based behaviors among physicians
- Social contract, not a legal contract

Shukla S, Meyer L, Stingl D. Physician Compact: A Tool for Enhancing Physician Satisfaction and Improving Communication. *Physician Executive Journal of Medical Management*. 2009; 35(1):46-49.

<http://healthcarecollaboration.com/collaborative-compact/>

Compact Methodology

- Bottom-up process
- Compact group: 7 physicians/ 1 facilitator
- Discussed for 6 months till reached consensus
- Presented to all departments and department chair councils for input
- Revised and approved 1 year after start date
- Rolled out to all departments for signing

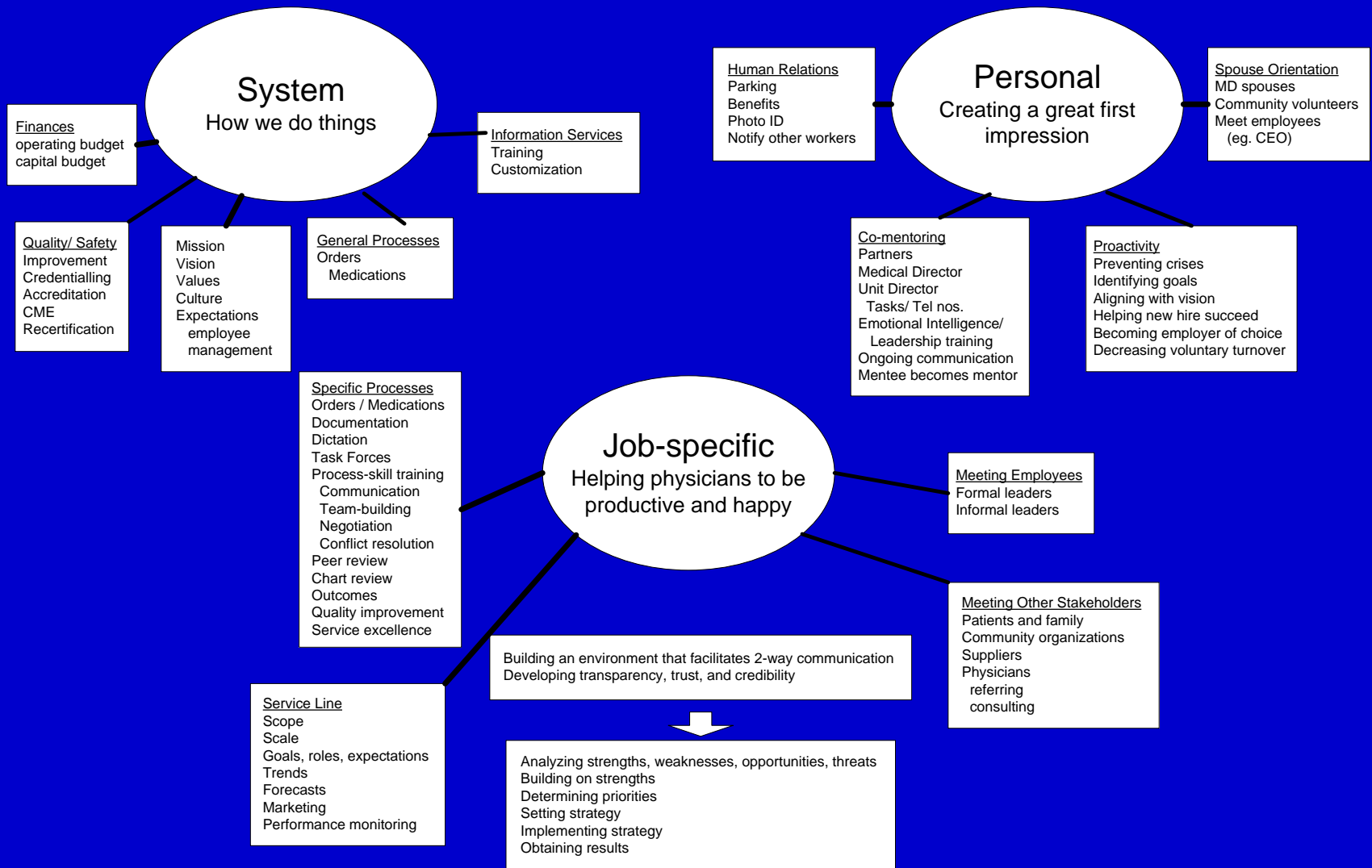
Physician Reaction

My initial thoughts were filled with skepticism, as I did not understand the purpose of it. However, after reading through it, I think it is a great outline of the commitment, expectations, and goals of the organization.

If we see this organization as physician led, then the foundation needs to be laid down. The compact is a great place to start in addressing the mission and the goals of the organization.

Also, the philosophy and expectations of the organization are spelled out to the physicians, staff, and patients. The compact makes expectations crystal clear in my mind."

The Challenges of Orientation



Cohn KH. 2005. "Orientation: Another Opportunity to Engage Physicians," in Cohn KH. *Better Communication for Better Care: Mastering Physician-Administrator Collaboration*. Chicago: Health Administration Press, 71-4.

Physician Retention: Case for Mentors

- Southwestern ten-hospital system began hiring physicians in 2004 to ensure adequate primary care coverage and to provide help with subspecialty call coverage
- Rate of physician turnover reached 10%
- Developed on-boarding program to orient new physicians
- Realized that needed to train established physicians to become better mentors
- For the past three years, not a single physician has left this hospital system

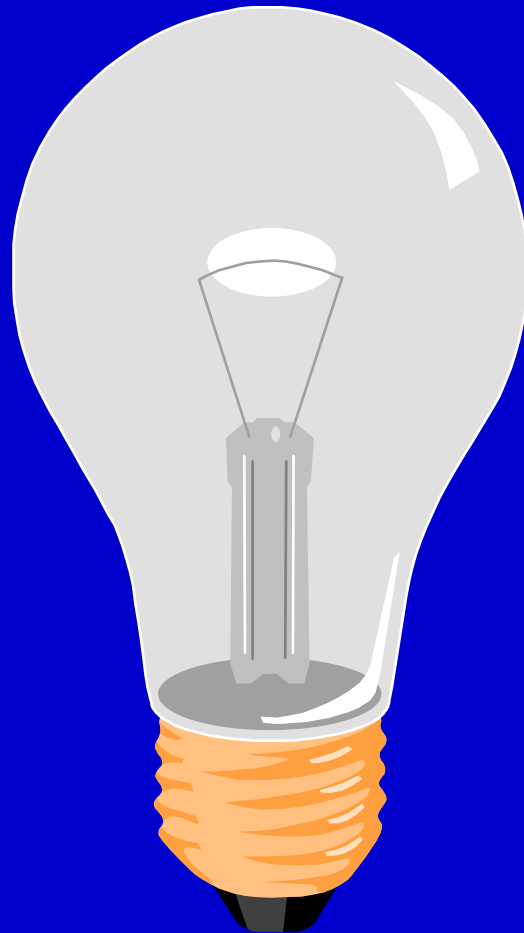
Cohn KH, Bethancourt B, Simington M. The Lifelong Iterative Process of Physician Retention. *Journal of Healthcare Management*. 2009; 54(4):220-226.

The Challenges of Ambulatory Surgery Centers (ASCs)

- Turnkey vendor
- 25% of hospital revenue at stake
- Civil war buff
- Antietam
- 1st time....

- Getting to know physician as a person was critical to preserving hospital's mission

How Many Psychiatrists Does It Take to Change a Lightbulb?



Set Up to Fail

- First female Medical Staff President
- CEO, CMO, and 1/3 Board asked to leave
- “Might as well be a woman.”
- Going to the balcony
- Became leading inside candidate for CMO position
- Now developing Neuroscience Institute at nearby hospital

Commonalities

- Doctors' doctors
- Skeptical but not cynical
- Willing to let data and action influence perspective
- Entering (peri-) menopause
- Marginal value of seeing one more patient decreasing
- Legacy

IV. How do we engage physicians who do not want to have anything to do with us?

That will only happen if they perceive that you have nothing to offer or they do not trust you....To me it is all about building trust and identifying areas of passion for them, and areas where you can improve their lives (processes) or their incomes (JV's etc)....you have to come up with something of interest to them...what can you do for them, not what they can do for you

Physician Engagement, II

If they do not want to have anything to do with you, ask them why not!!.....that is a definable set of reasons and (mis) perceptions you might have to dig out of them, realizing that you might not like and may not want to hear what they say, but once understood gives you something to work with

Physician Engagement, III

Don't tell me what I need to do. I don't care about the newest regulation. If someone's life is not at stake, don't tell me it is a crisis.

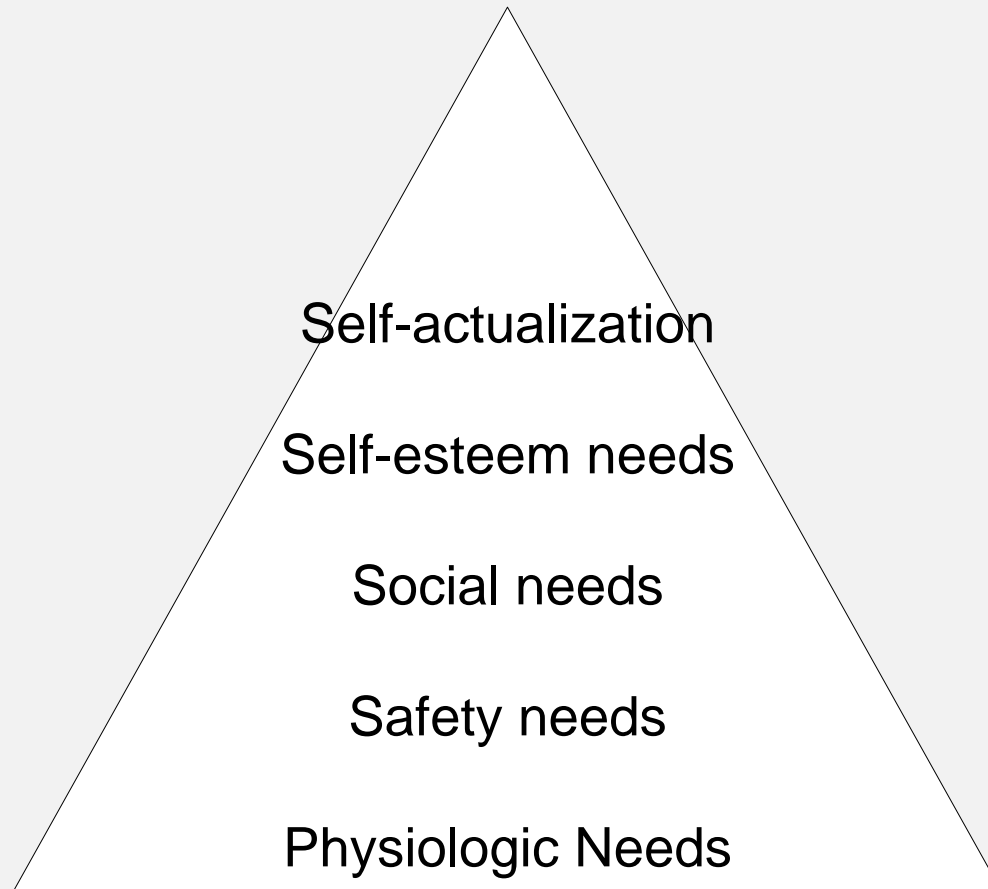
We all have crosses that we need to bear. Asking me for my input in helping you solve problems, sharing data with me that will improve care for my patients, or best yet, helping me make my time count are ways to get my attention.

Physician Engagement, IV

Both-and strategies:

- Get to know the physician's assistant, nurse, and/ or practice manager and ask their input on engaging a physician
- Allow physicians to enter the moan zone (briefly)
- Eye: eye conversation

Maslow's Pyramid



Maslow A. 1970. Motivation and Personality, 2nd ed., NY. Harper & Row.

Physician Engagement, V

When everything else fails:

- Make an appointment to see the physician as a patient

Action Plan

What needs to be done
Results

Who When

1.

2.

3.

V. Ten Steps We Can Take NOW To Engage Physicians and Improve Care

- Encourage practicing physicians to articulate future clinical priorities
- Include doctors who are users of radiology, anesthesiology, pathology, and emergency services to draw up contract specifications and monitor performance
- Establish a hotline for process improvement issues

Cohn KH, Friedman L, Allyn TR. The tectonic plates are shifting: cultural change versus mural dyslexia. *Frontiers of Health Service Management*. 2007; 24(1): 11-26, 41-43.
Winner of the Dean Conley Award, 2009

Ten Steps, II

- Treat top 20% as accounts, with (at least) quarterly visits
- Ask “go-to” docs, “What can we take off your plate,” at least semiannually
- Map out steps of policies and procedures to improve effectiveness and refine handoffs
- Have the Chief Information Officer and programmers round periodically with physicians

Ten Steps, III

- Develop hospitalist services to off-load call burdens
- Celebrate and reward all healthcare professionals who exceed their job descriptions to care for patients
- Establish a pool with fines from using hot-button words and killer phrases to support a worthwhile service or celebration

Wisdom from Jack Riemer's *Turning*

The leaves are beginning to turn from green to red and orange

Birds are beginning to turn, heading south once more

Animals are beginning to turn, storing food for the winter

For leaves, birds, and animals, *turning comes instinctively*

Cohn KH. A call to action for healthcare executives.

<http://www.hospitalimpact.org/index.php/2010/09/28/p1161#more1161>

Turning, II

But for us, turning does not come so easily
It takes an act of will for us to make a turn
It means breaking with old habits
It means losing face
It means starting over again, and this is always
painful
It means recognizing that we have the ability to
change these things, which is hard to do

Cohn KH. A call to action for healthcare executives.
<http://www.hospitalimpact.org/index.php/2010/09/28/p1161#more1161>

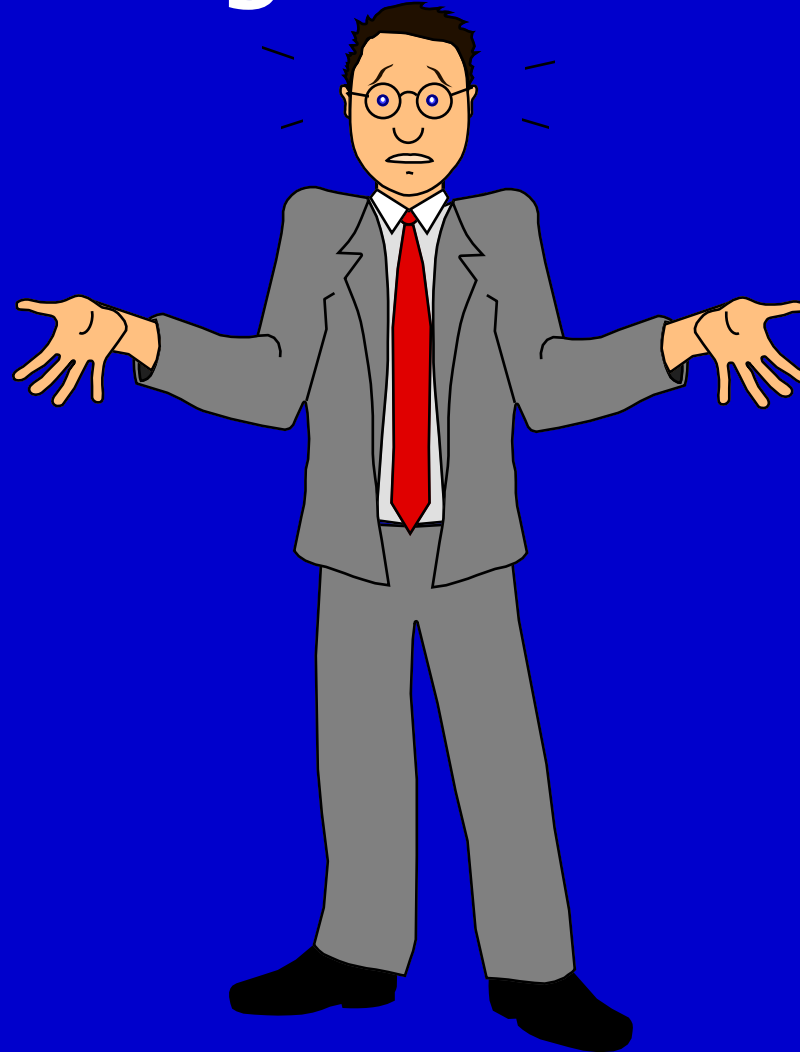
Change

Change is disturbing when
it is done to us.

Change is exciting when it
is done by us.

Rosabeth Moss Kanter
Professor, Harvard Business School

Admitting Uncertainty Energizes Team



Possible Approaches to Current Problems

Problem

Complexity

Victimhood

Exhaustion

Solution

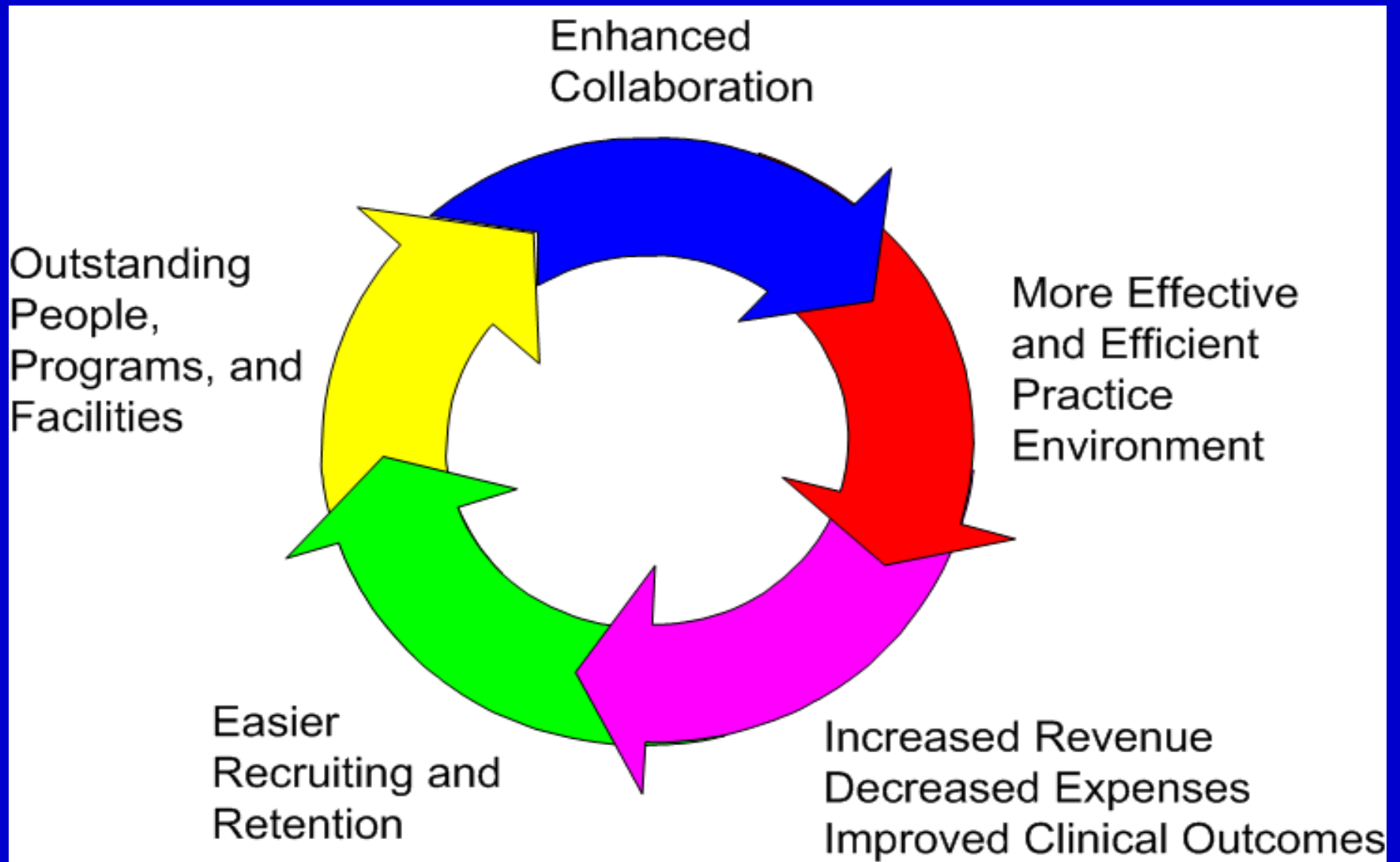
Dialogue

Leadership

Passion

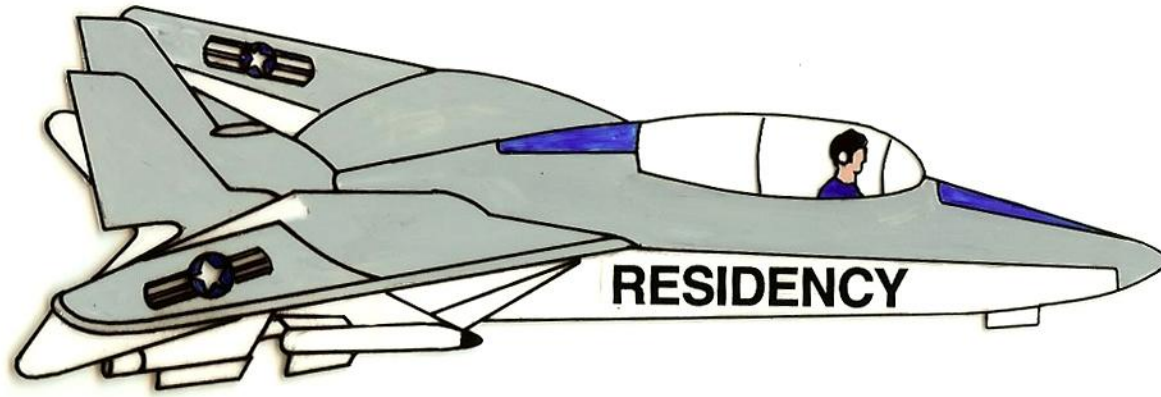
Cohn KH, Peetz ME. Surgeon frustration: Contemporary problems, practical solutions. Contemporary Surgery. 2003;59(2):76-85.

The Collaboration Multiplier

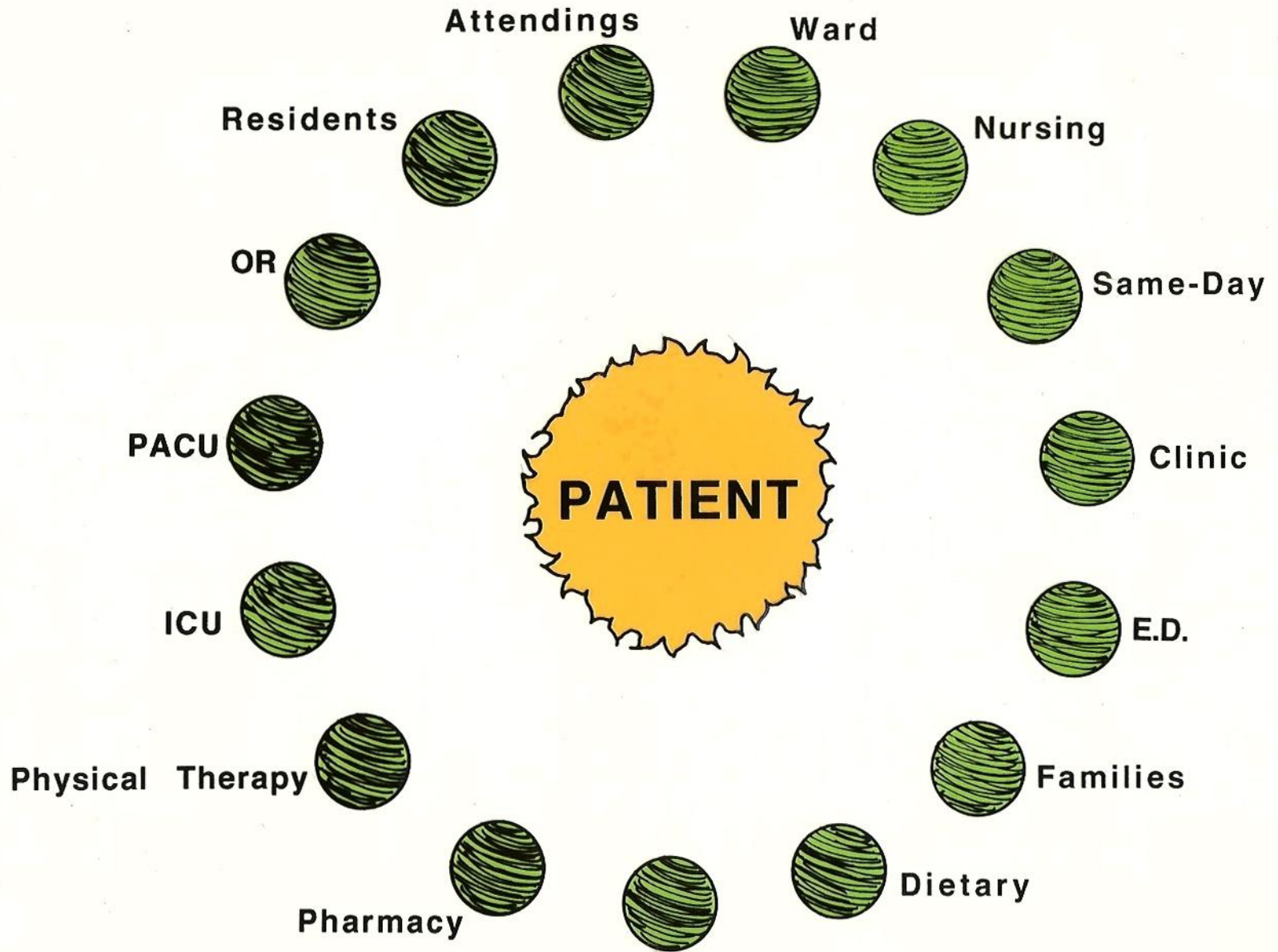




Residency Training The Top Gun Approach



Moving Toward a Copernican Care Model



KHC
&
VST

Reframing Our Perspective

- The golden age of medicine (1965-85) was an anomaly
- In 1913, the AMA estimated that no more than 10% of physicians were able to earn a comfortable living
- Intrinsic dissatisfaction can lead to social good
- "It's the sand in the oyster that creates the pearl."

Zuger A. 2004. "Dissatisfaction with Medical Practice." *New Engl J Med* 350(1):69-75

Moving Beyond Malaise

"Listen to patients talk about what was good about their healthcare experience.

They will often express it in terms that describe how much someone paid attention to them, really cared for them, listened to them, or improved their life on a very personal level.

There is no machine that can replicate that sensation."

Marcus LJ, Dorn BC. 2001. Beyond the malaise of American medicine. *J Medical Practice Management*;16(5):227-230.

Moving Beyond Malaise, II

- The pendulum has swung far from the center. What forces will it take to push it back toward a more balanced future for medicine and medical practice?
- This is a time of opportunity, one in which we define a new mission and role for ourselves... Consumers want us to remain key to the workings of the healthcare system.
- When our patients are facing a frightening procedure or a discouraging diagnosis, it is common for us to comfort them by offering a course of action, something that can be done to offer them a sense of hope, and with it, a future. This formula is what good medicine is about, and it is time we do the same for ourselves and for our profession.

Top Three Physician Desires

N > 1500

- Meaningful work that makes a difference in people's lives
- A sense of community and camaraderie
- Regular, reliable positive feedback that affirms participants' value

Wong B. A Prescription for Physician Reengagement. Futurescan 2009. Chicago: Health Administration Press, 23-26.

QBQ Prayer

God grant me the serenity to
accept the people I cannot change,
the courage to change the one I
can, and the wisdom to know... it's
me!"

Miller JG. *QBQ: The question behind the question.*
Putnam, NYC, 2004

Conclusion

- Improving physician-physician and physician-hospital communication is an iterative journey
- Differences in background, outlook, and training plus disruptive change in the healthcare marketplace make conflict inevitable
- Creating and building a sustainable culture of collaboration from the ground up boosts revenues, cuts expenses, and improves clinical outcomes

Discussion

- What resonated with you?
- What did you find unsettling?
- Where do **we** go from here?