

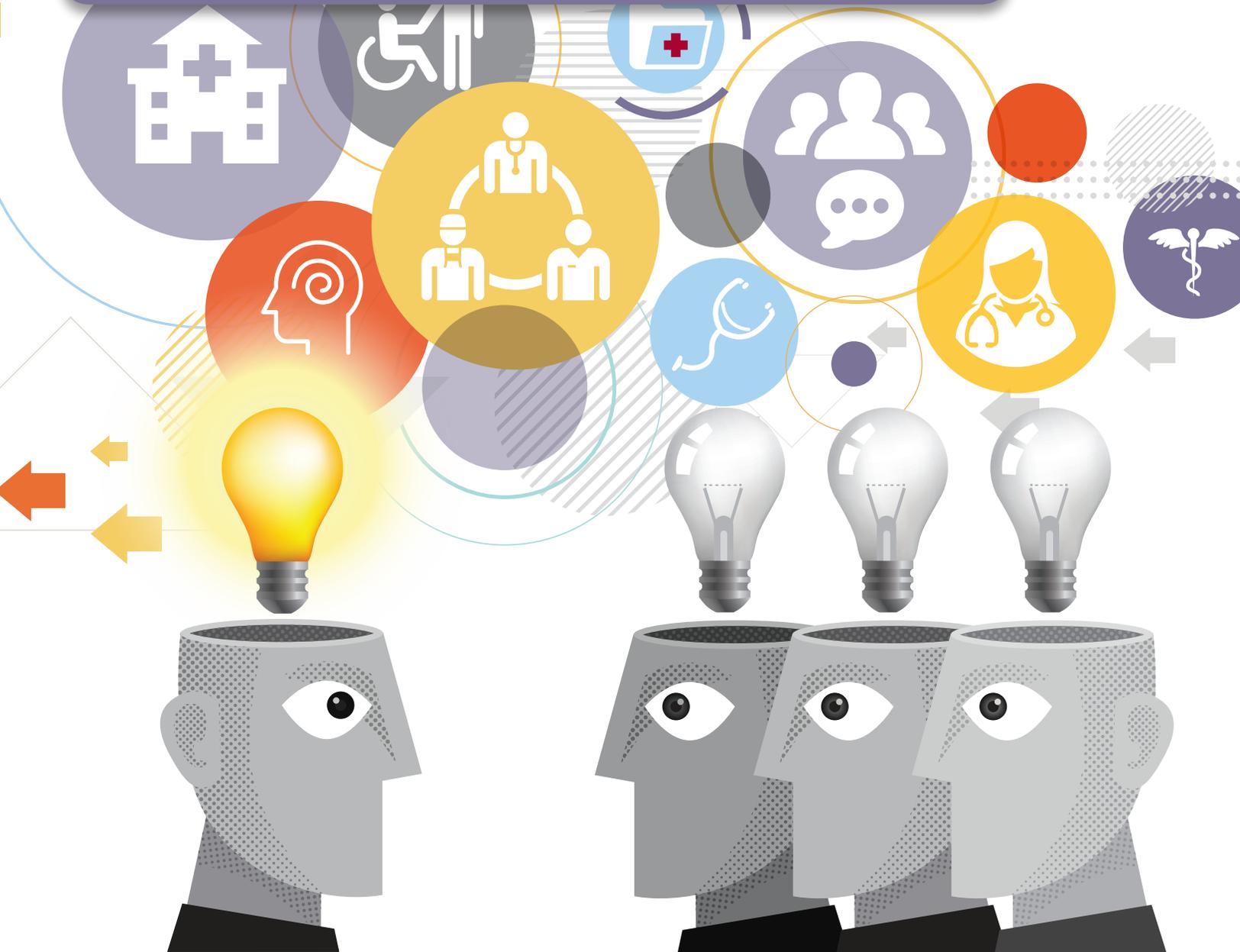


Critical
Conversations™

Critical Conversations on the Changing Health Environment:

PHYSICIAN ENGAGEMENT

PASADENA, CALIF., JUNE 16, 2016



For the past 30 or so years in health care, there's been a divide between clinical leadership and hospital administration. While the physicians and other clinicians focused on patients, administrators focused on logistics and the financial aspect of health care delivery. In the new era of health care, as economics shift from volume to value, these two worlds are coming together to deliver quality care and improve health outcomes for populations and communities.

This transformation cannot happen without physician engagement – and physician leadership.

On June 16, 2016, the American Hospital Association assembled a group of clinicians and hospital administrators in Pasadena, Calif., to discuss physician engagement and physician leadership and the role they play in the transformation of health care. AHA Solutions, a division of Health Forum, the strategic business enterprise of the American Hospital Association, organized the program as part of its Critical Conversations series. The event was designed to offer ideas and resources for eliciting the closer involvement of physicians in improving the quality, cost effectiveness and accessibility of health care in communities across the country.

New Relationships in Health Care

The Triple Aim of improved quality and patient satisfaction, improved population health, and reduced costs requires a team approach – a new way of looking at relationships in health care. It requires a concerted effort that involves administrators, clinicians, communities and patients. A key ingredient for the success of these efforts is physician engagement.

In 2013, the American Hospital Association and the American Medical Association held a joint conference to look at new models of care, especially integrated care models in which the health care players – clinicians, administrators and payers – work together for the health of populations by coordinating care and effectively managing chronic disease. It was one of those “light bulb” moments, John Combes, MD, chief medical officer and senior vice president of the AHA and president of the Center for Health Care Governance, told the clinicians and administrators gathered in Pasadena.

“To achieve an integrated care model, we need a leadership model that is also integrated,” Combes said. “This starts with a functional partnership between organized physicians and hospitals,” and it requires the capability to accept and manage clinical and financial risk and to improve quality and reduce costs. It also involves decisions that affect quality improvement and population health that should be made jointly by physicians and hospitals.

Patients can't be left out of this picture either, he quickly added. “We have to look at the individuals that we work with as full partners in their care.” For example, he explained, most people with diabetes manage their care themselves 24/7. Yet when they come into the hospital, the hospital staff take over. “Do we know their care as well as they do? Absolutely not. We have to have patients as full partners.”

Providers who figure out how to do this – and organizations like Kaiser Permanente are making strides – will serve their patients well and thrive in the new health care environment. Technology and teamwork will play a big role in facilitating this, but none of it will happen without physician engagement and physician leadership.



With the right skills, physician leaders can be the catalyst for meaningful changes at all levels of their organizations. “There are many challenges out in front of us,” Combes said. “We’re not going to get them answered today, but I think we’re going to begin the first small steps within our own organizations by creating an integrated structure where physicians and other clinicians are empowered to share in decision making and to lead the organizations forward to serve both their patients and communities.”

Transition in a “World of Dualities”

Unfortunately, a variety of factors over the years have eroded the trust between hospital administrators and clinicians.

Combes traced the origins of the split between doctors and administrators to the Diagnosis Related Groups introduced in the ‘80s and ‘90s. The policy divided how doctors and hospitals were paid, with most hospitals getting predetermined sums based on diagnosis and severity and doctors continuing on a straight fee-for-service basis. This led to tension between the two “sides” of health care, creating an “us” versus “them” mindset that is difficult to overcome.

Other developments have contributed to the situation. With the increasing use of hospitalists and intensivists, many office-based physicians feel disconnected from hospitals. “I have a medical staff of 325,” said Richard Allen, chief executive officer of Palmdale Regional Medical Center in Palmdale, Calif. “Out of those, there are maybe 75 who are engaged at all in the hospital.” The rest, Allen said, are in private practice and don’t spend much time at the hospital. These office-based physicians are more likely to be involved in leadership roles in their specialties or communities.

The Accountable Care Act has the potential to align physicians and administrators through goals and incentives that emphasize value, outcomes and addressing the social determinants of health. The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 may further help align hospital and clinician interests.

But we’re not there yet.

For now, health care is living in a world of dualities, said Mark Gamble, chief operating officer of the California Hospital Association. While health care is moving to a value-based reimbursement system, most

DEFINING ENGAGEMENT

It’s hard to have a conversation in health care today without encountering the term “engagement.” Health care administrators and policy makers talk about patient engagement, employee engagement, and, now, physician engagement. Despite its widespread use, the concept behind the term is actually quite squishy – it means different things to different people in different contexts.

According to Mo Kasti, founder and CEO of the CTI Physician Leadership Institute, engagement is an emotional connection, involvement and commitment that is demonstrated in our behaviors and leads to discretionary efforts. People who are engaged in a specific mission or project are fully present and energized to go beyond the minimum requirement and put in the extra time and effort to get the best result. People who are engaged in a meaningful and relevant vision are more likely to be optimistic and open-hearted; they inspire and trigger the best instincts in others.

“That’s what we’re really looking for,” Kasti explained. “Engagement is a multiplier for any solution. That’s when true transformation happens.”

You can see why it’s on everyone’s minds right now.



reimbursement continues on a fee-for-service basis. Hospitals are compelled to create new programs and capabilities to adapt to the new priorities and payment system at the same time as they are receiving lower payments based on reduced patient censuses. Many larger hospitals are expanding their services area and their service lines to attract a larger pool of patients and push volume – and revenues – back up.

At the same time, the locus of control in health care is shifting towards the consumer. Combes pointed out that the most popular plan on the Health Insurance Marketplace is the Bronze plan, in which patients pay up to 40 percent of their medical bills. More than ever before, patients are looking for convenience and value, especially when purchasing routine care such as annual physicals and vaccinations. The retail industry has quickly responded with in-store clinics that make care more accessible and less expensive.

In this crowded and competitive marketplace, bread-and-butter care is moving to retail settings while larger hospitals attract patients who can travel for specialty services. Increasingly, smaller hospitals serve patient populations with more complex needs, more comorbid conditions and fewer resources.

In this situation, physicians and hospitals “don’t have the luxury to mistrust each other,” Combes said. “We have to work together to manage the clinical enterprise and get outcomes that bring value to health care.”

Developing Physician Leaders

Physician engagement and physician leadership, then, is key to moving health care into the second curve of transformation,” said Mo Kasti of the CTI Physician Leadership Institute. “Our mission is to enable the clinical transformation, and you can’t get to those exceptional outcomes if you don’t have an engaged culture and clinical leadership. When medicine meets leadership, everything changes.”

At first, physicians may not see the value in getting involved at the leadership level. It may look like just another task to add to their already very full plates. Many are actively looking for ways to reduce work responsibilities so that they can spend more time with their families.

“The level of stress that our physicians are under right now, it’s really reaching the point of burnout,” explained Kasti. “We have to be careful how we introduce ‘one more thing.’”

Telling a physician — or anyone else for that matter — to “get engaged” is not likely to have a positive effect. Engagement is not a command or a one-time effort. It’s a long-term process that works best in a culture of trust and aligned values.

At any organization, Kasti said, about 20 percent of people will be engaged in a given task, and 20 percent will be disengaged or resisters. The remaining 60 percent are just doing their jobs, neither putting an extra effort nor working against it.

A common impulse when seeking engagement is to focus first on getting the resisters on board, but Kasti said it’s more effective to start with the engaged physicians so that they can get the other physicians involved. “It’s not a straight line to go from the current disengaged state to a future engaged state. It takes purposeful process and effort,” he explained.



Engagement is not a command or a one-time effort. It’s a long-term process that works best in a culture of trust and aligned values.

Those seeking physician involvement must find what it is that will compel physicians to get engaged. It might be a quality issue, work/life balance or the opportunity for advancement. While aligning reimbursement incentives can help encourage engagement, physicians will feel more motivated towards involvement in an environment where they can tap into their intrinsic motivations such as professionalism, identity, career growth and their personal goals around patient care.

It can be tempting to think of employed physicians as engaged physicians, but that’s not the case, added Dana Rodrigue, chief quality resource officer and compliance officer at Thibodaux Regional Medical Center in Louisiana. “Employment does not equal engagement. It just means we supply their paycheck. We can’t tell the physicians how to practice.” In fact, lack of autonomy only encourages disengagement. Employed physicians who feel like they don’t have a say in the organization may be difficult to pull back in to take a more active role.

Developing physician leadership skills can make the difference. “Physician engagement is actually a physician leadership imperative,” Combes said. “Leadership is a part of our professionalism as physicians, and that includes leadership not only of our own practices, but also in the delivery of health care to communities and to populations. Physicians have to lead this engagement effort themselves.”

However, physicians are trained in medicine, not necessarily this kind of leadership or even teamwork. Practicing medicine requires lots of decisions to be made with limited time and on limited information. Medical decision making is similar to the leadership style needed in a mass casualty event, Richard Bogue, PhD, associate professor at the University of Iowa College of Nursing, pointed out. But population health and chronic disease are evolving situations that play out over the long haul. They require a different style of leadership than acute medicine.

Fortunately, they can learn the skills. Leadership training, such as that provided by the CTI Physician Leadership Institute, can help build and develop their “engagement muscle.” It can also address issues related to stress, work/life balance and career advancement so that physicians feel more satisfied in their professional lives.



Road Map to Physician Engagement

An important first step is to narrow and focus your engagement efforts from being one size fits all to a specific context or issue. Physicians may feel engaged in some issues, but not others. Those who are directly impacted by the issue – such as sepsis care – not only have more reason to get involved, they also have more influence on other physicians.

Administrators can set the stage for closer engagement by reaching out to clinicians and being more visible on a regular basis. Nicole Falgout, clinical quality improvement officer for University of California – Los Angeles Health System, said that making administrative rounds helps build relationships with physicians and other clinical staff. Another participant at the meeting said that he tried to have breakfast with members of the medical staff at least once a week. Richard Allen suggested that administrators can gain major points with clinical staff when they show up at the hospital at 2 a.m. to see how the overnight shift is faring. These respectful and caring gestures can mean a lot to physicians dealing with the frustrations and stress of patient care. It transforms the “us-versus-them”

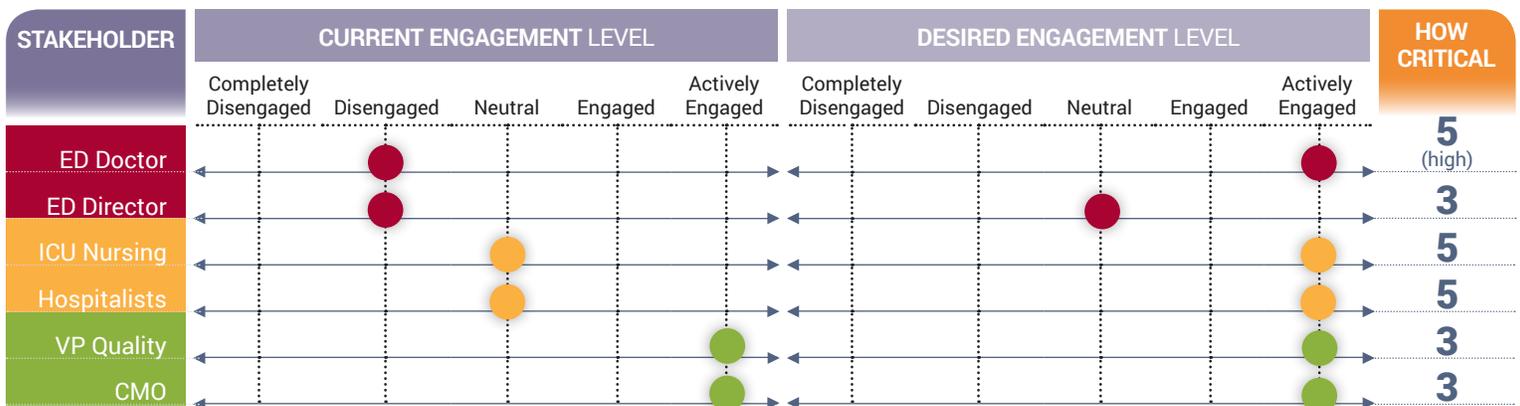
mentality into a “we’re-all-in-this-together” attitude that sets the foundation for cooperation and collaboration.

Determining who should lead a specific initiative takes some consideration: You want leaders who combine passion with a positive attitude. Picking the wrong person can have disastrous effects, especially if the person can’t fully commit to the idea. However, Rodrigue pointed out, it is possible to deliberate too long. When putting together a steering committee for one initiative, three physicians with complementary traits came immediately to mind: one was mild mannered, another blunt, but all were passionate about the topic. “We should have named them sooner, because the same names kept coming up.”

Once you have the leaders assembled, it’s important to agree on a common vision and goals. “We have to share the vision of where we are going,” said Kasti. “Sometimes we move so fast that we forget to set that common vision.”

At Thibodaux Regional Medical Center, every care transformation team specifies a purpose or goal for the efforts. That helps create that common vision that helps identify who needs to be involved in the effort and then helps motivate those team members to work together to make the vision reality.

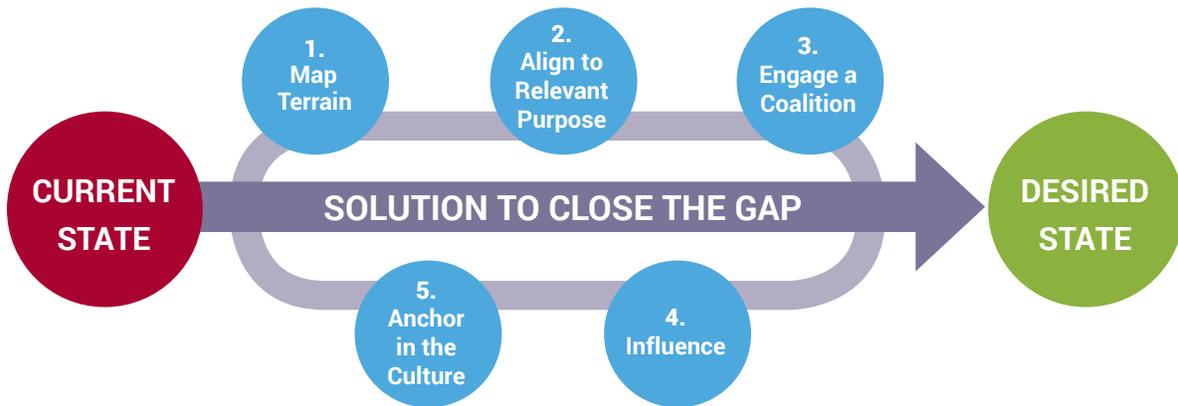
How You Begin On Physician Engagement



1. Define the purpose or project for which engagement is required.
2. List the individuals or roles that need to be engaged (i.e. Dr. Jones or ED Medical Director)
3. Determine how crucial, on a scale of 1-5, that individual’s engagement is to achieving the purpose.
4. On a scale of 1-5, with 1 being completely disengaged and 5 being actively engaged, define the level of engagement desired and the current state of engagement for each individual or role.

Results will reveal where work is needed.

Physician Engagement Roadmap



From the Critical Conversation on Physician Engagement, presented by Mo Kasti, President, Physician Leadership Institute and Author of Physician Leadership <http://www.physicianleadership.org>

Another way of engaging physicians is to let them choose the initiative to start with. Administrators at Thibodaux selected six active staff physicians – including one of the hospital’s busiest internal medicine physicians – and took them off-site for leadership training with a project focus. The physicians brought forth issues that bothered them most, and their choices surprised the administrators: wound care, blood cultures and radiology scheduling. But instead of shifting their attention to other matters, the hospital let them come up with solutions and approaches. The result was six actively involved physicians who were able to articulate their goals and their concerns to their colleagues and improve care for their patients.

Spreading the Message

Mo Kasti encourages those looking to engage a specific physician in an initiative to put together an “elevator speech” that conveys the complete vision of the initiative in 10 seconds. He said the statement should include the 4 P’s:

- Picture, or vision for the project
- Purpose, or why it is important (from the physician’s perspective)
- Plan, or how it will be implemented or how we will get there
- Place, or a specific role or key behavior for the physician

“You need to be able to reach deep into where physicians are to communicate” the goals and vision of the initiative with a robust communications strategy, said Combes.

Kasti gave this example to engage physicians in a sepsis initiative. “I am working on reducing sepsis through early detection and sepsis bundle implementation. This is a critical effort to ‘do no harm,’ reduce length of stay and improve quality outcomes. We’ve identified a sepsis bundle that helped other organizations achieve this goal and I’d like your team’s help to pilot it in your department. Can I schedule a time with you and your team to discuss this?”

It often takes multiple messages and ways of communicating to engage the full spectrum of players. “You have to keep saying it in different ways until it is heard,” Kasti said.

Success stories can be the most powerful influencers. When physicians start talking to their peers and telling them how a new procedure or protocol made a difference, real change can occur.

Rodrigue saw that in person when trying to get physicians at her hospital to implement the sepsis bundle recommended by the Surviving Sepsis Campaign. At first physicians resisted the protocol, especially administering fluids to patients who might be at risk for congestive heart failure. Although the literature supported the protocol, it went against long-standing recommendations.

Different doctors responded to different messages, Rodrigue explained. For some, the need to bring down



the length of stay convinced them to try the protocol while others were moved by the chance for better quality scores. But patient stories were the most convincing. “All it really took was for one patient to do well and for that story to get around,” said Rodrigue.

Fueled by Data

Individual success stories are powerful, but they need to be backed up by reliable and relevant data. “You have to look at the clinical learning environment,” said Combes. “Do we create an environment in which people continually learn from their practices and improve quality? We need to look at specific metrics and figure out how to improve them rather than issue a vague directive of improving quality.”

Fortunately, thanks to electronic health records and efforts to track health care quality and costs, there is no lack of data in health care. The key is to turn that knowledge into action, to inspire others to achieve.

Various technology solutions help hospitals and physicians turn quality, claims and other available data into actionable information

Speaking to the clinicians and administrators in Pasadena, Zahid Butt, MD, chief executive officer of Medisolv, explained that with the introduction of MACRA, it will become even more important for those spearheading quality initiatives to work hand-in-hand with the IT department to extract and analyze data to track and spread their message.

For example, Medisolv’s ENCOR Quality and Reporting Management software can help hospitals and physicians meet regulatory requirements while also improving performance and patient safety, leading to more effective and efficient care. Thibodaux Regional Medical Center uses predictive models developed by Medisolv to rate patients’ risk for readmissions and to flag situations that may need extra clinical attention. “We’re focused on the Triple Aim. It’s not just about the cost. It’s about the quality and doing what’s right for patients,” Rodrigue said.

Another company, Verras, has developed a way to look at medical record data to help physicians and hospitals identify duplicative or excess care that leads to cost overruns, inefficiencies and unnecessary risk to patients. The goal of this is to reduce clinical variation, improve quality of care and reduce costs.

“My experience with physicians is that they are data analysts,” said Bill Mohlenbrock, MD, founder and

medical director of Verras and its Clinical Variation Solution. “We are in the business of managing clinical information.” If they have the data and they believe its validity, it doesn’t take much more than that to inspire important changes in behavior, Mohlenbrock said.

For example, the Centers for Medicare & Medicaid Services has selected certain hospitals to test the Comprehensive Care for Joint Replacement (CJR) model to encourage better and more efficient care and reduce the complication rate for Medicare patients receiving hip or knee replacements. The average cost of a joint replacement varies widely. Medicare said its expenditures for surgery, hospitalization and recovery ranges from \$16,600 to \$33,000 across geographic areas – about a 100 percent variation.

While it’s tempting to attribute that variation to the patients’ overall conditions – age, comorbid conditions, etc. – Mohlenbrock said that analysis of medical record data often shows a different picture. He has developed a way to take three years of medical record data, rank cases by severity and show each physician his or her own personal variation in resource utilization from patient to patient. The process often reveals systemic problems – such as inadequate documentation, inefficient communication among care providers or duplicative testing – that lead to excess costs and longer lengths of stay. It also shows physicians what they have been doing right and allows them to develop their own clinical pathways that build on their best performance. Reducing clinical variation while improving quality care not only saves money, it also improves outcomes and patient satisfaction.

Combes pointed out that transparency and information like this can be an excellent way to bridge a lack of trust. It can take time, but building that foundation is necessary to get the physicians’ attention and engage them in a shared initiative. “You sit down, you look at the information and at better ways to do your work and decide jointly how to proceed, and you hold yourself accountable. This kind of model appeals to the professionalism within the physician, and that’s the first step of engagement,” Combes said.

Rodrigue agrees, referring to Thibodaux’s model as a “team approach to quality improvement,” with team members representing different specialties in medicine and administration. Although you can’t force change, information can point the way to it, she

said. “Knowledge is power. They have to see what the issues are and come up with a solution” that includes evidence-based guidelines as well as specific metrics and goals. Rodrigue said that their goal is to be in the top 5 or 10 percent nationally for all projects. “Is that attainable in all things? No. but if you set your goal high you’re going to try harder.”

For example, as Thibodaux embarked on its effort to improve sepsis care, it tracked bundle usage with mortality, updating results on a daily basis. Just by looking at the dashboard, clinicians could easily see the relationship between the two: When clinicians followed the bundle protocol, mortality rates went down. The numbers told the story – and made the difference.

Going into the project, Thibodaux had a mortality rate of 12 percent for sepsis patients – lower than the national average of 22 percent, but still higher than it wanted it to be. As the team worked to encourage physicians to implement the sepsis bundle recommended by the Surviving Sepsis Campaign, the mortality rate moved to 11 percent, then 9 percent – a 16 percent improvement – in just two years. The efforts paid off – literally – in 20 percent savings in the cost of care, and resulted in a huge boost in patient experience ratings – from 87 to 99 percent satisfaction rate.

“The biggest difference is the level of physician engagement,” said Rodrigue. “It’s great to see that happen.”

TO LEARN MORE about products and services that have earned the AHA Endorsement and the AHA Solutions Signature Learning Series™, contact us at solutions@aha.org or visit www.aha-solutions.org.



Medisolv: Quality Reporting and Management Solution



Physician Leadership Institute: Physician Leadership Training and Development Services



Verras: Clinical Variation Solution

Critical Conversations on the Changing Health Environment

In early 2016 the American Hospital Association invited human resource and talent professionals to participate in a Critical Conversation about workforce challenges and innovations in today’s health care environment. Also participating were representatives of a selection of health care solutions providers whose solutions have been exclusively endorsed by the AHA.

The American Hospital Association (AHA) Endorsement Seal is the exclusive property of the AHA. AHA Solutions, a division of Health Forum, the strategic business enterprise of the AHA, is compensated for the use of the AHA marks and for its assistance in marketing endorsed products and services. By agreement, pricing of endorsed products and services may not be increased by the providers to reflect fees paid to the AHA.

