ROUNDTABLE

The Secrets to Driving Market Share for Health Systems

Organizational success in the new healthcare environment requires implementing growth strategies that allow providers to meet patients' needs across the care continuum. That means developing an effective means of physician engagement, alignment and partnership, which are key to referral and market share growth as well as care continuum integration. Yet these familiar terms used to describe cooperation between administrators and physicians are often misunderstood, meaning the execution of a strategic initiative could fall short of goals. In this Roundtable discussion, we'll examine what physician engagement, alignment, and true partnership really mean, and discuss strategies for how to implement and achieve these concepts within healthcare organizations.

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Roundtable Highlights

HEALTHLEADERS: *From your perspective, how should the terms, "physician engagement," "physician alignment," and "partnership" be defined? Do physicians define these terms in the same way?*

JULIA ANDRIENI, MD, FACP: When physicians think about engagement, it means they have a voice and that they're heard. With alignment, it can be a more formal structure with a governance board. Partnership is the next phase in this evolution. When you achieve partnership, you now have a collaborative organizational culture between physicians and administration, with a shared mission and strategy. It's evolved beyond engagement and alignment. Partnership for me is based on trust, respect, and pride in shared organizational goals.

DENISE BROWN, MD: Alignment has to mean more than a referral base. Just because I have a logo on my business card that says "affiliated with X Hospital," that's not alignment. Are we rowing in the same direction? As a practicing physician, if I don't feel like I'm aligned with your goals, I'm not necessarily invested in your organization. I do my job. I do good work. My patients like me. They keep coming back. I'm indifferent to the hospital. Engagement is that next step in the evolution, and ultimately what we're trying to get to is that sense of partnership where I don't describe my docs as employed, affiliated, or something else. I have physician partners, and when I have a problem, they're going to be part of the solution.

HEALTHLEADERS: *If partnership is more of an unspoken contract, how do you hold up your end?*

NIYUM GANDHI: Overcommunicating and listening are really important. In any of the health systems that I've worked with, there's always some group of physicians that starts from the position of mistrust. And that's fair because they've probably been wronged three or four times.

BROWN: Or just once. That's all it takes.

GANDHI: But if you have credibility and you can listen and shape the strategy based on what they need and what works for them and do it jointly, then when something really does need to happen, you have a little bit more credibility. Of course, you manage each department differently, and in some, the system's going to invest and build some new functions. But overall, communication and openness and treating them like adults goes a long way.

BROWN: That's exactly it. Physicians are professionals who happen to be incredibly smart and tend to have opinions. Part of the problem is that what looks good on paper doesn't always translate. The biggest turnoff for a new initiative or new anything is the impression that you're treating physicians like a commodity, and that is anathema to them. They feel that once upon a time, medicine was profession. It was respected. And then it turned into an occupation. And now, a lot of people out there feel like it's a commodity. So you have to overcome their reluctance in the face of this built-in resistance, and the only way to do that is by slowly building trust and respect.

HEALTHLEADERS: *How do you handle the feedback that comes your way?*

LINDA BUTLER, MD: Physicians are often asking for help. They want to do something, and they don't know how to go about accomplishing it. At that point, you can make it a win-win for both parties. So it's important to them to feel that they can approach you and that you want to invest in their success in some way, shape, or form.

BROWN: Everybody wants extra resources for X, Y, and Z. So how do you navigate a long laundry list of docs saying, "I want this EMR and can you give me a patient navigator?" Is there a back and forth rather than a laundry list? You don't want a total quid pro quo relationship.

Julia D. Andrieni, MD, FACP
Vice President of Population Health and Primary Care
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BUTLER: I think it is interesting because if they find out that you've done a navigator for one group—

BROWN: As in, 'You did it for ortho.'

BUTLER: Actually, ortho complained we did it for oncology but yes. Sometimes it's just that they have an idea of something they'd like to do. At least, they all have been educated that we have a budget, and getting in the budget is a precursor to any initiative. They sometimes will say, "Well, if you do X, then we will work with you to reduce our usage in the OR," for example. But bundled payments accomplished that for us because all of a sudden now physicians are willing to talk to vendors, for example, to say, "We don't really need to use that implant. We'll use this other one because it's cheaper." That wouldn't have happened several years ago. But with bundles, it also makes sense to have an orthopedic

coordinator to help with the care management piece, such as getting people to outpatient physical therapy. So now we are doing it.

HEALTHLEADERS: *What about the changes physicians are not asking for, but that you decide to implement anyway?*

GANDHI: Here's a classic example. We recently made a commitment to put all of our patient satisfaction by physician transparently on our website. We started by sharing all of it internally, unblinded within the department and then basically said, "OK, this is when it's going to go out, so let's talk about it." There were definitely some issues. Leadership had a lot of tough conversations with department chairs and individual physicians, but also did a lot of listening, showed some flexibility, and actually changed what we had originally said in terms of how quickly things would be rolled out. Being flexible about all that helped us work through it in the right way because, otherwise, it certainly could have been a huge lightning rod.

ANDRIENI: So by doing it that way, the physicians felt like they had more control. A big issue with physicians is autonomy and control in decision-making. So it sounds like this solution gave them more control than the one that was already out there.

Linda Butler, MD
Vice President of Medical Affairs, CMO & CMIO
UNC REX Healthcare

GANDHI: And the days of no transparency are gone. In absence of good transparency, we'll have bad transparency [in the form of reviews and ratings from outside the health system]. When the University of Utah rolled out the same program that we're about to go live with, the improvement went exactly the way you would have expected. At the point they went transparent, 4% of the physicians were in the top decile nationally. After they went public, 46% of their physicians were in the top decile nationally. That's amazing.

ANDRIENI: Peer pressure and transparent physician recognition works.

GANDHI: And they stole market share from their competitors. And they communicated that to the physicians.

HEALTHLEADERS: *What about other types of data? Is there disagreement between physicians and the organization on what data is more important than other data?*

BROWN: Attribution is always the biggest thing with physicians. Take an inpatient setting where a patient might be interacting with more than one physician as an example. This is what destroys you on HCAHPS. Physicians might say, "Well, they saw a surgeon and then they saw a cardiologist and so on, and because I discharged them you're going to assign all that to me?" That's not fair. So you have to be able to tease that apart.

BUTLER: And they might have seen that physician for one day.

BROWN: The response is often that they'll resist discharging people. That's where transparency comes in because I can see what a physician's ratio of total encounters to discharges are, and they're just way lower than everybody else. Physicians are not dumb. They can figure out how to maneuver around this data. So then we need to explain what we're trying to do and get the data to support it.

BUTLER: They want it to be perfect.

BROWN: But it's never going to be.

BUTLER: We have to emphasize that we're just looking at the trend. We can't let perfection be the enemy of good.

HEALTHLEADERS: *What are other effective, or not-so-effective ways to engage physicians in the data?*

BROWN: The red, yellow, or green way of showing physicians where they are performing well or falling short does a real disservice to the idea of constant improvement. It's the tracking and the trending that matter more.

ANDRIENI: Yes, you have to remember that physicians are very busy. So giving them a 20-page book of information means it's not going anywhere. In a general wide audience, sometimes aggregate data is important for education and trends. But if you're asking them to improve something, you have to show them individual data. Always try to give them data they have control over that's meaningful and impactful to them.

HEALTHLEADERS: *Organizations are increasingly linking measures to compensation. To what extent does physician engagement come down to finances?*

ANDRIENI: Financial incentives are good for certain things. However, that only gets you so far, because after you hit the highest quality, the greatest productivity, then what do you do? I turn to the idea of true partnership, the pride of quality. In the long run, for continual quality improvement, they have to know they're going to become part of the fabric of a high-quality system and they're going to take pride in crafting it and seeing those outcomes improve. That's going to carry your organization even farther.

GANDHI: The compensation, the transparency—that's all extrinsic motivation. What about the intrinsic

motivation? We've started talking about and focusing on the joy of practice. Something like 63% of physicians when surveyed said if they had to do it again, they wouldn't even go to medical school. Forget about practicing their specialty. Just less than two-thirds said they wouldn't even go to medical school again. That says something about the state of healthcare right now, that we've taken this wonderful profession and people who really want to help others and beat the joy of practice out of them.

BROWN: One way we can help bring the joy back is by framing it this way: What could I do that could help support you in your endeavor? What is it that's driving you insane? Is it the computer? What can I do to offset that and bring forth that therapeutic physician/patient interaction? That's what I think gets lost in the data dashboards.

BUTLER: Even at the healthcare system level, we were talking about the use of the Triple Aim. We'd like to shoot for the Quadruple Aim: Preventing physician burnout.

BROWN: But preventing burnout and bringing joy are two different things. And preventing burnout, to me, is defeatist.

BUTLER: But that's where many people are.

ANDRIENI: I use population health as a platform for bringing joy back to primary care. I say, "I know you want to spend more time with your patients. You want more of that face-to-face time." You may want to centralize referral management or scheduling, and build a care navigator infrastructure that supports physicians by managing the patient outliers to close gaps in patient care.

HEALTHLEADERS: *Do some physicians resent the team-based model?*

BUTLER: It's an adjustment. You never go wrong by praising in public and counseling in private. When we have leadership meetings, our CEO reads a letter from a family. That is so powerful, showing the things that we did well as a team. With the physicians, the challenge helping them achieve a mindset that they can delegate some things to the team, because remember, at least when I was a resident, if you asked for help, that was a sign of weakness. That's a culture thing. We work with them to show them that this is their team and convey that they don't have to—and can't—take care of patients all by themselves. We say, "Let the team help you and you lead the team."

HEALTHLEADERS: *As leaders yourselves, how much of your responsibility is creating the environment that makes physician engagement happen? How are you supported in making that part of your job?*

BUTLER: It's not something you can do in a vacuum. You need the leadership team to prioritize not just patient satisfaction, but physician satisfaction, because they're the ones who are taking care of patients in the hospital, and if they're not part of your network, they're choosing to bring their patients to your hospital. Some of it is just giving them the opportunities to be educated outside of medical school. We're taught how to be physicians, but not necessarily how to be leaders.

GANDHI: It's part of everybody's job. There are parts of my team that are 100% dedicated to physician engagement related to specific initiatives. We have a whole team of people who are out meeting with certain practices on a set of key priorities, but as we think more broadly, we talk about important elements of physician engagement at our executive team meetings. We had a situation recently where a very influential physician leader was thinking about leaving the organization, because of legitimate concerns. He'd been with the organization for a long time, he was a critical part of this organization's fabric, and his values aligned with where the organization wants to go. If he's

Niyum Gandhi
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feeling like something is wrong, then something is wrong. We spent probably 45 minutes just talking about this situation and who was going to reach out to him, and what sort of conversations to have. It was an extreme example where the whole executive team was digging in on it. All that to say we have certain parts of the organization that are fully resourced and dedicated only to engaging physicians, but it's kind of everybody's job. Ultimately, he stayed, and has in fact redoubled his commitment in many ways.

BROWN: Isn't it fascinating when you have that person who is thinking about leaving, and if you approach him or her humbly and just listen to what they have to say with the goal of coming up with a solution that's going to work, most often, that is the response. When you approach a problem with true humility, vulnerability, and in an effort to do better, it's usually a redoubling.

ANDRIENI: Yes, and even when there is no crisis, just asking regularly, "What's on your mind and how can I support you?" goes a long way.

BROWN: Or a fast text message, "Got your message. Tell me what time this week is good for you?" And then suddenly it's like, "Oh, these people are listening to me." If it takes a couple of days to respond, then you have lost the war and the battle before it even started.

Denise Brown, MD
Executive Vice President for Business Development Incoming, Chief Strategy Officer
CEP America

HEALTHLEADERS: *Are there nuances in communicating with employed versus aligned physicians?*

BUTLER: I try to bring those groups together as much as possible, usually around educational events. These are just different employment models. We all have the same mission. I have CME dinners to bring them all together around whatever initiative we're doing. Also, whatever incentives that we have for population health with our own employed physicians are exactly the same for the aligned. It's totally transparent.

GANDHI: Regardless of the kind of formal or legal structure you have with the system, the strategy is the same. How we want to engage you is the same. How we want you to engage us is the same. The tools we have available are different, however.

BROWN: The how varies, but the why and the what are the same.

HEALTHLEADERS: *How do you simultaneously accommodate physicians' individual needs while still treating them as part of a team?*

BROWN: That's where you need leadership development within each one of these groups, so that you are generating a stable of individuals with whom you can work so that they can take that leadership back to the group.

GANDHI: Some things are one-size-fits-all. There are certain aspects that relate to quality that are just absolutely nonnegotiable. Those aren't hard to engage the docs on most of the time, but if they are, the fight is worth having. With some initiatives, it's more of an exercise in mass customization. For instance, there might be five different ways we can measure depending on what works for the group and then five things that are softer and relational. It depends on what it is you're trying to accomplish from an administrative burden standpoint, but there are limits. We're not going to have 6,600 different scorecards.

BUTLER: It helps to have more physicians around the table in leadership roles. At that point, it comes down to how you mentor the individual physician who you think has leadership aptitude. For example, we're paying for our regional hospitalist director to get an MBA so he can be part of the physician leadership team. We're sending one of our cardiologists to get an MBA because he's got an interest in research and education. We're trying to invest in the future with physicians who are in their 40s, who have enough clinical practice experience to have credibility with their peers, but they've also self-identified in areas where they can make a difference. One is interested in performance improvement. One really wants to be a physician advisor.

ANDRIENI: Truthfully, the more diversity I have around the table—even the naysayers—the better the team dynamics for creative solutions. I'm super-optimistic, and I need those naysayers because they're going to see something I may not see or that I thought was not that important. I'd rather expose obstacles in the planning stage to troubleshoot with a creative and diverse team.

BUTLER: We have hospital service line committees. As frustrating as it is sometimes to have to have several committees working to get to a resolution, you almost always end up with a better final product if you've got all of your disciplines around the table and they all have something to contribute. I've seen that with our sepsis work. We sometimes want to just jump right to what we think is the right answer. It's difficult to be patient, but if you are, you will almost always end up with a better outcome.

ANDRIENI: That is so true. People get frustrated with change when solutions don't work right away. We have to be patient, because if we rush through this, it's going to take more time in the long run.

BROWN: The rework is so much more painful.

HEALTHLEADERS: *Being the agent of change must be difficult even when you try to go slowly.*

ANDRIENI: In those groups, you have to respect cultural history. Even when you don't want to hear the story, you have to balance respect for the impact of history with new ideas generated by those who were not part of that history. When I arrived at Houston Methodist, my vision was that all the primary care practices should be patient-centered medical homes. So rather than just announcing we were going to do it, I brought in a national speaker to explain the concept. Following the presentation, I surveyed all the primary care physicians, and 86% said they wanted to be patient-centered medical homes. Then I could build a team from a platform of stakeholder buy-in to assist them in achieving this goal. To support the physicians, I assembled a multidisciplinary PCMH team and educated them on the concept and why we are doing it. In three years, 43% of our primary care practices are level 3 NCQA-recognized patient-centered medical homes. Now that momentum has built, practices are asking with enthusiasm, "Am I next?"

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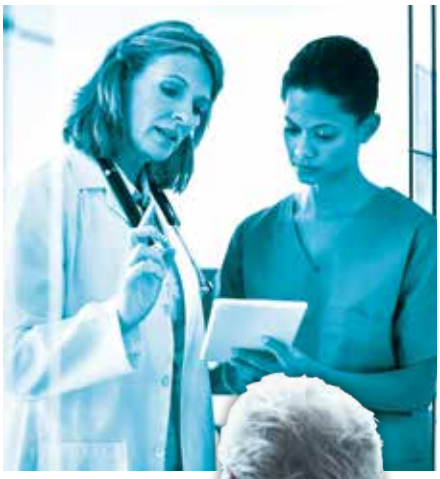

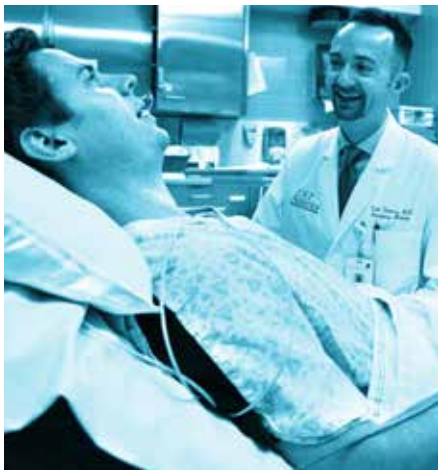

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