A Call for Physician Leadership at All Levels

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In this article...

Check out the critical success factors and tactical leadership development strategies for physicians at three distinct levels of leadership: leading systems, leading teams and leading physicians.

We are in the midst of a seismic shift from volume-based to value-based health care delivery. This shift is having significant ramifications across the industry. Strong physician leadership at all levels is required to drive change and position organizations for success.

In a study conducted with members of the American College of Physician Executives in 2011 by The Leadership Development Group (TLD Group), several unique challenges facing physician leaders were revealed:

- Identifying and communicating metrics to define physician "value" to patients and health partners.
- Understanding clinical systems thinking and applying the concepts to new models of care delivery.
- Communicating effectively to engage physicians and other health care providers to work as a high-performance team.
- Implementing patient-centered clinical integration.
- Leading culture change rooted in trust between physicians and the health systems they support.

TLD Group conducted further research in collaboration with the Group Practice Forum (GPF) to understand the critical success factors of high-performing physician leaders resulting in our physician leadership success model (see Exhibit 1). Much like a road map, the model serves as a foundation for physician leadership development programs.

Case studies

The following three vignettes showcase innovative physician leadership development options using a variety of tools and learning methodologies implemented at various leadership levels.

1. Physicians Leading Systems

Situation

A non profit, multi hospital health care system with more than 2,750 affiliated physicians recently became a CMS Shared Savings ACO. The organization was determined to develop their physician leaders to drive the necessary changes through the system to be positioned for success. Instead of sending its leaders off-site to a learning event, it understood the value of developing a tailored on-site physician leadership process for chairs and department heads.

Solution

The system instituted the Applied Physician Leadership Academy™ (APLA), a physician leadership development program (see Exhibit 2). Commitment for APLA came from the top and was led by an internal steering committee composed of the system's president, site presidents, physician champions, and various C-suite executives. The multi faceted physician development program was designed around a formula based on best practice adult learning methodologies and included:

- Action learning projects based on the system's organizational priorities: Small groups of physician leaders led initiatives that were identified by the system as a strategic imperative. Physician leaders were required to draw upon their leadership skills while driving tangible results. Initiatives included topics such as improving quality while reducing costs, growing the business,

improving patient outcomes, as well as executing on leadership roles.

- Coaching and mentoring: Physician leaders received feedback on their leadership competence, emotional intelligence, and demonstrated effectiveness from their site presidents. Coaching was offered to all physician leaders, where each leader was paired with an executive coach with deep expertise in behavioral change.
- Classroom didactic training: Driven by the system's unique needs, the APLA participants were exposed to group learning through customized case analyses, small-group learning exercises, interactive lectures and discussions, and application-based readings delivered in a workshop setting by APLA faculty and academics. Topics included creating high-performing clinical care teams, business fundamentals for physician leaders, enhancing physician performance, as well as emotionally intelligent leadership.

It is important to note that the program began with assessments to identify the system's unique behavioral gaps and organizational priorities to tailor APLA for the system. The program included time for networking, fueling collaboration and change across the system.

Results

APLA has addressed organizational priorities and leadership competency development needs simultaneously.

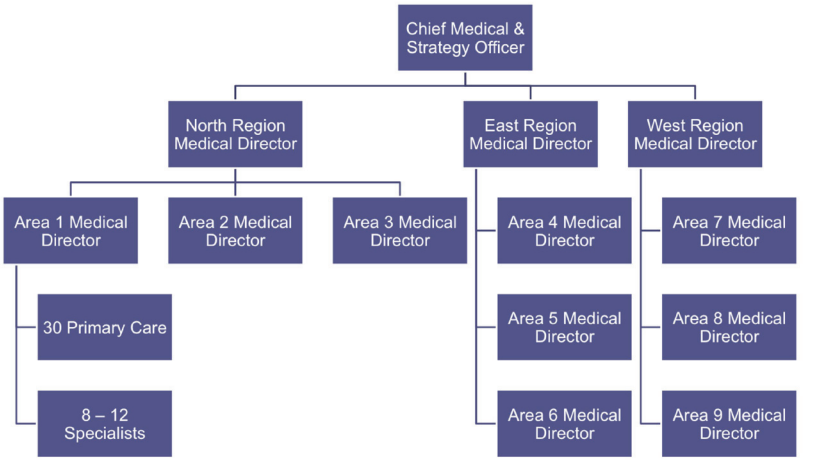
- The program has enabled the system's physician leaders to develop their leadership prowess real-time and create solutions addressing many of the system's most pressing needs.

Exhibit 1: The Physician Leadership Success Model

Exhibit 2: APLA™ Components & Benefits

Components	Benefits
Organizational priorities assessment	*Identify projects based on strategic objectives and organizational priorities of the organization.*
Leadership assessment, feedback and individual development planning	*Identify specific behaviors to develop for enhanced leadership effectiveness.*
In-classroom didactic training	*Learn from national experts and faculty.*
Action learning	*Work with colleagues to derive solutions to strategic/management issues while developing leadership skills.*
Network with peer physicians and leaders	*Foster relationships.*

Exhibit 3: Creating Physician Accountability



- The leaders have learned valuable skill sets including how to enhance physician performance in their departments, how to create high-performing clinical care teams, how to lead with authenticity, and business fundamentals for physician leaders.
- The program has received very positive feedback.
- "Considering the diverse vantage points from which people approach APLA, the sessions... have struck a responsive chord in everyone," said the chair of rehabilitative medicine.
- "Great presentation....Very smart guy who has 'been there and done that'...It was a great message and an exceptional presentation. It exceeded my expectations (and my expectations are usually very high)," said the medical director of the continuum of care department.

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2. Physicians Leading Teams

Situation

This primary care practice of 25 providers was on its third generation of PCMH Level 3 Recognition. The physicians were also founders of a successful regional health plan, enjoying above-average clinical outcome metrics and shared savings financial success. Although they were seemingly successful, the group was struggling to implement team-based collaborative care to manage chronic diseases. The group had the desire to move from above average to best-in-class clinical and financial outcomes. In order to do so, the group had to overcome the "I vs. us" mentality and imbed a collaborative care approach in its clinical care work flow.

Solution

The medical group designed a model to instill a team-based vision

McDonald on Communications

Susan McDonald, MD • VP, Medical Affairs, St. Joseph's Medical Center • Anesthesiologist • Centrally involved in the hospital's strategic partnership with PerfectServe • Here, from a recent interview, are a few jewels from Dr. McDonald.

On physician-to-physician communication:

"Having a way for physicians to communicate directly with each other in a very simple way really can dramatically effect length of stay. Any way you can streamline and enhance communications and make it easier for everyone to communicate and get the information across, the better the care can be. We see that every day, whether it's a critical lab value that needs to be communicated, a patient status from the nurse to the physician or a need for a consultation between physicians."

On care across the continuum:

"A lot of medicine is becoming much more specialized. There are hospital-based physicians and there are office-based physicians in the primary care community, so the continuum of care I see is between a patient coming from their primary physician as an outpatient into the hospital, being cared for by a hospital-based physician and then being returned back to the community. Having good communication between the outside physicians, the office-based physician and the hospitalist physician is very important in the continuum of care."

On physician adoption:

"Physicians do not want solutions that are going to add time to their schedule, and it helps a great deal if it's something they see value in. They want things that are going to save time because they get bombarded with so much more than they have to do, they don't have enough hours in the day to do it. On top of that, customer service in implementing it has to be there. So, physicians need to have some way of getting help in setting it up, help when they are having difficulties for whatever reason and make it extremely user friendly. Before implementing PerfectServe, we talked about various communication issues and solutions for a number of months before we actually implemented it, so the physicians knew it was coming, and they knew the reason it was coming."

On communication variability:

"For example, we have three cardiac surgeons. To reach cardiac surgeon #1, you have to call him on his pager because he doesn't ever have his cell phone on. Surgeon #2 always forgets his pager in his coat pocket in his locker, so you have to call his cell phone. And if you try to call surgeon #3 after 7 pm, you're going to get yelled at. Before PerfectServe, nurses had to have that contact list somewhere, and invariably someone would call the wrong way. Instead of getting good communications, you get "I told you to call me this way." Now with PerfectServe, physicians can decide how they want to be called and the nurses don't have to think about, they don't have to worry about it and it's up to the physician to make sure he's customized his contact methods. The physicians like it, and the nurses love it."

On clinical communication:

"As a physician executive, it is far easier for me to reach physicians at any moment, find out who's on call and reach the appropriate physicians. It has made my job as VP of medical affairs far easier than I could have ever anticipated. I don't have everyone's phone numbers, so when I'm at home and there's a problem with a patient and I need to get in touch with a physician — before PerfectServe, it was almost impossible. Now, let's say I need to get in touch with Dr. Smith about an issue and it's 7 pm on a Friday night, I just call PerfectServe and I get in touch with Dr. Smith. PerfectServe has dramatically made it easier for me to communicate with physicians at any time of day. This is one of the best things we've done for our hospital, patients, physicians and nurses."

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and approach, through the Patient Care Journey ™ Process Map, developed by Group Practice Forum (GPF) for its chosen priority disease state, COPD. The map incorporated tools to engage every member of the team. The following tools were developed:

- Patient-centric process map: The map serves as a strategic framework to align the team around the patients' care pathway.
- Task grid: The grids outline the tasks that need to occur as well as the responsible team member for implementing the task and evaluating outcomes. The tasks as well as the team went beyond the four walls of the office to ensure optimal patient engagement within and outside of the office visit.

Results

- The medical staff leveraged the model and tools for other disease states.
- The project led to a team-based incentive structure aligning teams around patient outcomes.
- Staff experience scores improved dramatically leading to less turnover (plummeting to nearly zero percent) across the physician group.

3. Physicians Leading Physicians

Situation

A primary care practice with 300 primary care providers recognized the need to move from volume-based delivery and financing to that based on value. As they began their journey, only 15 percent of the providers were utilizing electronic records. In addition, the group operated in a traditional provider-centric, fee-for-service model. In order to navigate the change toward value delivery, the group had to adopt a focus on population management.

Solution

The newly hired chief medical and strategy officer (CMSO) brought the independent physicians together to seek their opinions, get a sense of their needs and build alignment. He discovered they aligned on wanting to be Bridges to Excellence (BTE)-recognized.

This goal worked well as it helped align the physicians to a

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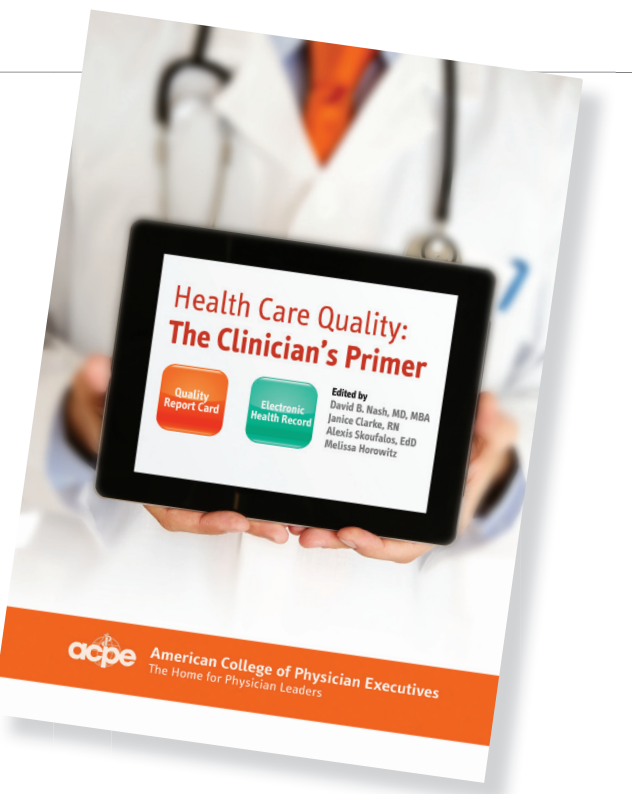

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shared value orientation. The CMSO then proceeded to build an infrastructure to enable the physicians to meet their BTE goals. He developed three important management tools to enable tactical change:

1. **Physician dashboard**: The dashboard openly displayed total score, lab and patient data for each physician, allowing them to see their performance and to reach out for patients.
2. **Organizational chart:** A governance structure was designed that created and aligned three medical directors with nine area directors as the key leaders and points of contact for groups of 30 PCPs and 8-12 specialists (see Exhibit 3).
3. **A Regional and Area Bridges to Excellence Performance Report:** This report demonstrated the number and level of BTE recognitions within each region/area.

Results

- The physician dashboard highlighted the high-performing physicians. Interestingly, the high performers were often the unassuming introverts, not those who spoke out or those with big personalities. Needless to say, the physicians were very surprised by the data. The dashboard enabled the understated leaders to shine and assume more influence.
- The physician dashboard also provided detailed patient data that demonstrated gaps that needed to be addressed, allowing physicians to empower their staff to use this information to perform outreach to their patients. Patients were grateful for the outreach, office staffers felt more empowered, and the physicians saw their income go up while reducing their work.
- The annual office staff turnover rate went from 75 percent in some offices to 20 percent due to the medical staffers feeling more like a members of the health care professional team.
- The group practice gained 163 Bridges to Excellence recognitions in 15 months.
- The group practice generated a savings of $38/patient/month at a total premium dollar level while increasing the per visit revenue for the primary care doctor by $12 - $25/visit on average, even though the effort from volume to value was primitive. This savings to the system and increased revenue to the physician was used by many offices to fund bonuses to all staff members.

Conclusion

Physician leaders should be proactive in creating the change toward a sustainable and best-in-class healthcare system. This change requires a concentrated effort including the right tools, techniques and leadership proficiency at all levels of physician leadership: physicians leading physicians, physicians leading teams and physicians leading systems.

One size does not fit all when it comes to the formula and tools for successful change. Physician leaders need to pay close attention to the culture, level of sophistication, gaps, and goals of the organization and start by taking small steps forward.

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