Section 1.4 Assess

# Physician Engagement in CCC

This tool describes the importance of engaging physicians in establishing a community-based care coordination (CCC) program, identifies challenges and their impact on developing a physician engagement strategy, recommends a resource for assessing physician engagement difficulty, and provides a framework for engaging physicians in CCC program planning.

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**Time needed:** 1 hour

**Suggested other tools:** CCC Maturity Assessment; CCC Fact Sheet for Providers

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## How to Use

1. As a healthcare community identifies the need for a community-based care coordination program, members should **recognize the context** in which such a change is to be implemented and the importance of involving physicians from the beginning.
2. **Use an assessment** of physician engagement tool to understand the challenges in engaging the specific physicians in the community and develop strategies for engagement activities that reflect the specific needs of the community.
3. **Create a framework** in which physician engagement will be undertaken, testing and modifying the framework as implementation of a CCC program occurs.

## Context for Physician Engagement

Recent dramatic changes in the healthcare system have led to significant challenges and demands in physicians' daily professional lives. Hospital and physician competition has grown significantly. Physicians are becoming increasingly employed through different employment structures, with a mix of employed and independent physician practices that contributes to separation rather than collaboration. On the surface, employment of physicians may create the appearance of normalcy of their daily activities, but underneath it tends to undermine physicians' ingrained sense of independence.

Value-based purchasing has increased demands for coordinated care and has shifted the focus of care to population health, where physicians have always focused on treating one patient at a time. In addition, new organizational structures and payment models are emerging which do not align well with the traditional organized medical staff model. Furthermore, traditional reimbursement is being lowered even though not all physicians practice in a community with value-based purchasing yet. Evidence-based protocols and rigorous safety practices are being implemented, oftentimes with quality measurement, reporting, and improvement pressures not fully understood or trusted.

Complicating these changes is the fact that business managers and physicians have vastly different cultures. Managers' basic modus operandi is *efficiency* as opposed to physicians' focus on *expertise*. Managers' primary loyalty is to the organization whereas physicians' loyalty is to their patients. Perhaps the most important difference is the nature of assumed responsibility. Manager responsibility is typically shared with other managers, staff, and board members while physicians have made responsibility totally personal. This deep-seated belief in sole responsibility is so strong that it puts physicians in conflict with a core tenet of improvement theory: that quality and safety are systemic. Often coupled with fierce independence, this sense of responsibility has led many physicians to cultivate a culture of blaming others, covering up mistakes – often characterized as "expected medical variation" – and consensual neglect[1] that often stymies a focus on quality measurement, reporting, and improvement.

Within this context is the need to help physicians operate in the "new world." A research study on physician engagement notes that it is very important not to ignore cultural differences.[2] While it is not possible or desirable to force physicians or managers to think similarly, there does need to be an understanding and appreciation for these differences first. Then there needs to be the development of a common set of values to solve specific problems—which, in this case, is the adoption of a CCC program that supports the level of quality, cost, and patient experience of care that everyone desires.

## Assessment of Physician Engagement

While cultural differences exist between managers and physicians, there remains a mutual, fundamental aspiration for the best possible care to be delivered, and most physicians recognize the reality that resources are not unlimited. What physicians may not have thought through consciously is that reducing the cost of care and keeping people healthy can result in savings that can accrue to physicians through better financial results (vs. a focus exclusively on reimbursement in a "one patient–one fee" model).

However, one size does not fit all in developing strategies for engaging physicians in the development of a CCC program. To help understand the level of difficulty a community may face in engaging physicians, the Institute for Healthcare Improvement (IHI) has created a ***Physician Engagement Difficulty Assessment***, which is designed to prompt leaders to think carefully about the current structural and historical factors in the community that will inform the degree of difficulty the CCC program might have in moving together with the medical staff to a higher level of partnership for quality and safety.

The following instrument is a slightly shortened version of the assessment.[3] Each factor is scored such that the "a" response is assigned a score of 1, "b" = 2, "c" = 3. The best score is **7**, which indicates that physician engagement that is not necessarily assured but is easier to effect than in an environment where the "most difficult" score is **25**. (See *Physician Engagement Difficult Assessment (Template)* for a fillable form.)

| Physician Engagement Difficulty Assessment | |
|---|---|
| ***Scoring:*** "a" = 1, "b" = 2, "c" = 3 | |
| ***Assessment Dimensions*** | ***Score*** |
| **1. Physician connectedness**<br>a. Employed<br>b. Affiliated<br>c. Independent | |
| **2. Physician loyalty**<br>a. Employed by hospital<br>b. Admit primarily to one hospital<br>c. Admit to multiple hospitals | |
| **3. Stability of medical staff structures, mergers, and relationships**<br>a. Same for years<br>b. Mergers sufficiently distant<br>c. Recent mergers | |
| **4. Currency of medical staff bylaws**<br>a. Dynamic, up-to-date, reflect current reality<br>b. Recently revised to reflect some measure of current reality<br>c. Not amended or revised in years | |
| **5. Medical Executive Committee authority**<br>a. Balanced in representing all constituents<br>b. Represents solely the medical staff<br>c. Reactive and formalistic, protecting physician autonomy | |
| **6. Hospital board engagement with medical staff in quality initiatives**<br>a. Seeks active input and involvement at the earliest states<br>b. Watches quality at a distance and depends on management reports<br>c. Views quality as purely a medical staff function with no real engagement | |
| **7. Historic cultural engagement in quality improvement**<br>a. *Full:* Most physicians are involved in initiating, implementing, and improving quality initiatives. Management is seen as assistive and the CEO's salary and/or bonus depend on quality results. Interdisciplinary team projects are the norm.<br>b. *Good:* Many physicians participate in design and implementation of quality initiatives. Board is engaged. Nurses are more empowered than in most organizations.<br>c. *OK:* Physicians participate in cross-departmental quality projects. Board is interested in quality, but relies on management to oversee.<br>d. *Some engagement:* Some physicians identify and champion small departmental-based quality projects; some interdisciplinary efforts on isolated units; board does not make quality its priority.<br>e. *Minimal engagement:* Medical staff leaders respond to some initiatives through traditional structures only. There is little cross-departmental interaction on quality.<br>f. *Mutual détente:* There are separate spheres of influence; medical staff focuses on credentialing, some privileging, and rare corrective action. There are often struggles between physicians and nurses over a range of issues.<br>g. *Openly hostile:* There is mutual suspicion, loss of trust, past grievances won't die, and emphasis on medical staff competitive challenges. Board and management focus entirely on bottom line; current strategies of hospital are suspect and challenged by physicians. | |
| **Total score out of a potential "most difficult" score of 25** | |

## Strategies to Use the Physician Engagement Difficulty Assessment

While IHI's assessment instrument is designed to focus on engaging members of medical staff in a hospital's quality improvement initiatives, it can translate well to a community in which a CCC program is being considered. If that community has multiple (and generally competing) hospitals and medical staff, participants should be asked to consider their relationship to their "primary" locus. Whether that is one hospital or more than one hospital in a larger community, request that those taking the assessment consider multiple environments as a collective unless there are significant differences. If there are significant differences, a facilitator may request two or more assessments be completed or completed solely in one clinic where there is minimal activity with a hospital (there will still be a board/managing partners, management, and physicians).

A community that has multiple healthcare organizations will tend to reflect the culture of the predominant players. For those planning a CCC program, it is recommended that the classification of individuals completing the assessment be captured as a checkbox at the end of the assessment:

- ❑ Board member
- ❑ Member of management
- ❑ Physician

The Institute for Healthcare Improvement recommends that the board, management, and medical staff members complete the assessment individually as a "self-assessment," then bring the results to a joint leadership meeting in which implications of the results are discussed and a shared picture of future behavior is drawn.

It is noted that the total score is not determinative of what might happen. However, it is a good way to acknowledge reality in an open and honest manner with as much objectivity as such an exercise could garner. If results are expected to be less than desirable, an external, objective facilitator should be used to assist in the process of introducing the tool, compiling results in a confidential manner, and helping to lead the discussion.

As a final note, providers who are not physicians (e.g., PAs and NPs) are not intentionally being ignored by this assessment. The reality is, however, that non-physician providers tend not to have the same cultural challenges, or inherent authority, within the healthcare practice setting as physicians. If a community has many or a growing number of non-physician providers, it may be desirable to include them as a fourth category of participants in addition to the board, management, and physicians.

## Framework for Physician Engagement

Armed with information about how difficult it may be to effect a clinical transformation to a CCC program with its inherent quality, cost, and patient experience goals, the following framework[4] may help initiate, expand upon, or strengthen physician engagement. Where assessment scores suggest difficulty, the steps in the framework will likely take more time and preparation for at least the early steps.

The ***Framework for Physician Engagement*** below is constructed as a matrix in which community leadership takes a three-pronged approach to physician engagement in order to create a shared picture of the CCC program and achieve desired goals.

| Framework for Physician Engagement | | | |
|---|---|---|---|
| **Steps** | **Individual Level** | **Group Level** | **Program Level** |
| **1. Understand culture** | Identify specific physician leaders and laggards | Identify key challenges in each of the Board, Management, and Physician groups | Conduct *Physician Engagement Difficulty Assessment* |
| 2. **Work to create a shared picture** that reflects what is best for the community (not imposed by community leadership) | Use leaders to listen to grass root recommendations for shared picture | Conduct group events to listen to views on a shared picture | Use a facilitated process to create a shared picture from what was heard; Continually listen for additional input as picture is refined |
| 3. **Create a culture of partnership** with full transparency to garner trust; Use a communication plan to ensure the right message gets to the right people in the right medium | Adopt a communication strategy of "walking around," literally using board, management, and physician leaders to communicate one-on-one regularly | Hold open forums with board and physician community, management and physician community, and key practice groups (e.g., physicians and nurses, primary care providers and specialists, management and community resources) | Promote a systems view of CCC while stressing the importance of individual responsibility and ensuring that benefits (e.g., shared savings) accrue to all as proportionally applicable |
| 4. **Engage in a meaningful way.** Value everyone's time, assure clear messages, and conduct meetings that only focus on decision making | Ensure that each physician knows "what's in it for me" | Take baby steps to educate, garner interest, gain understanding, see early efforts, and ultimately achieve results as applicable to each group | Prioritize CCC programmatic activities; Start with basic, essential components and move to optimizing strategies as opportunities present themselves |
| 5. **Actively manage conflicts**, provide continual feedback, and do not tolerate poor performance; Communicate clearly, candidly, and often | Adopt an open-door policy, deliver personalized communications, and provide access to counseling if necessary | Involve each group in monitoring results and regularly engaging with program to give feedback on successes and challenges | Engage physicians in setting performance expectations; Celebrate success and correct course as necessary |
| 6. **Align compensation and performance measures** for all stakeholders; Make physician involvement visible | Every individual physician, manager, and board member should know what to expect | Every member of the applicable groups should share in the benefits of success | Establish a workable and flexible approach achieving results in "unchartered territory" |

## References

[1] Reinertsen JL, Gosfield AG, Rupp W, Whittington JW. (2007) *Engaging Physicians in a Shared Quality Agenda***.** IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement. Available at: http://www.ihi.org/resources/Pages/IHIWhitePapers/EngagingPhysiciansWhitePaper.aspx

[2] Kaissi, A. (2012). *A Roadmap for Trust: Enhancing Physician Engagement.* Regina Qu' Appelle Health Region, Canadian Policy Network. Available at: http://www.rqhealth.ca/inside/publications/physician/pdf_files/roadmap.pdf

[3] The complete assessment is available in IHI's *Engaging Physicians in a Shared Quality Agenda*, available at: http://www.ihi.org/resources/Pages/IHIWhitePapers/EngagingPhysiciansWhitePaper.aspx

[4] This framework has been constructed specifically for CCC Programs drawing from the work of the Institute for Healthcare Improvement, other resources, and practice experience.

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For support using the toolkit

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952-854-3306 • info@stratishealth.org

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