Obtaining Physician Engagement

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## Engagement Definitions

<table>
<thead>
<tr>
<th>Actively Disengaged</th>
<th>Not Engaged</th>
<th>Engaged</th>
</tr>
</thead>
<tbody>
<tr>
<td>May be unhappy at work</td>
<td>Quality work and time put in – but not extra effort or passion</td>
<td>Actively interested in the <strong>quality</strong> of their workplace</td>
</tr>
<tr>
<td>May act out their unhappiness</td>
<td>“Checked-out” of organizational goals</td>
<td>Motivated to take an <strong>active leadership role</strong> in helping to improve their workplace</td>
</tr>
<tr>
<td>Actions undermine what their engaged colleagues and their organization are trying to accomplish</td>
<td></td>
<td>They <strong>drive innovation</strong> and move the corporation forward</td>
</tr>
</tbody>
</table>
## ROI of Physician Engagement

<table>
<thead>
<tr>
<th>Low Engagement</th>
<th>Average Engagement</th>
<th>High Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Admitted 10 – 25 patients per year to the hospital</td>
<td>• Admitted 51 – 75 patients annually</td>
<td>• Admitted more than 100 patients annually</td>
</tr>
<tr>
<td>• Contributed about $420,000 per year for the hospital</td>
<td>• Contributed about $1.5 million per year</td>
<td>• Contributed about $2.4 million per year</td>
</tr>
</tbody>
</table>

Data based on a sample of 6,000 staff physicians in a multi-facility health system (1)
Obstacles to Physician Engagement
Obstacles

• Physician burnout
  • Physicians feel overwhelmed and ill-equipped to accommodate change
  • Characterized by three dimensions: **cynicism**, **exhaustion**, and **inefficacy** (2)

• Fear of changes and loss of control
  • “Health system restructuring continues to be viewed by some physicians with **suspicion** and the concern that it is not about improving patient care, but about reducing physician autonomy” (3)
  • Confusion in the marketplace regarding the plans of the new Trump Administration
Obstacles

- Cultural differences between physicians and managers
  - Accountability versus personal autonomy, clinical pursuits versus financial realists, systemization of clinical work, and individual health versus collective health

- Physicians are oriented to work solo – to make independent decisions
  - Linear reductionist perspective
Obstacles

• “Problem of the apostrophe” – Dr. Joseph Bujak
  • Physicians act as the patient’s advocate (singular)
  • Managers act as the patients’ advocate (plural)
Obstacles

• “It is more noble to give yourself completely to one individual than to labor diligently for the salvation of the masses.”
  • Dag Hammarskjold – Second Secretary-General of the United Nations (1953 – 1961)
Obstacles

- Hospitals and payers relying on employment and compensation **alone** to secure engagement and align physician’s goals with institutional goals
  - Ignoring more effective strategies to drive behavioral compliance

- Some physicians have a narrow understanding of how their behavior contributes to institutional goals
  - Physicians have a poor understanding of the risk-based payment model along with being risk-averse
Methods to Improve Physician Engagement
## Financial Incentives

Financial Incentive Program Example

<table>
<thead>
<tr>
<th>Metric</th>
<th>FY 2014</th>
<th>Threshold</th>
<th>Bench</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality O/E</td>
<td>1.22</td>
<td>≤1.10</td>
<td>≤1.00</td>
</tr>
<tr>
<td>Readmissions O/E</td>
<td>0.98</td>
<td>≤1.00</td>
<td>≤0.90</td>
</tr>
<tr>
<td>LOS O/E</td>
<td>1.10</td>
<td>≤1.00</td>
<td>≤0.90</td>
</tr>
<tr>
<td>Pt. Satisfaction (Comm. Physician)</td>
<td>84%</td>
<td>≥81%</td>
<td>≥89%</td>
</tr>
<tr>
<td>Harm (PSI-90 Components)</td>
<td>8 @ benchmark</td>
<td>4 @ benchmark</td>
<td>8 @ benchmark</td>
</tr>
</tbody>
</table>
Financial Incentives

• Develop incentive metrics that are related to the conditions specialty physicians are expected to improve
  • Ex: Assigning a ‘blood pressure threshold’ metric for cardiologists
  • Rewards physicians for mastering their specialization
  • ‘Specialty Metrics’

• Citizenship Incentives
  • Timely completion of electronic health records
  • Reward physicians for attending meetings and organization development functions
Financial Incentives

• **Physician level** (individual) financial incentives, but not practice-level or combined incentives, resulted in greater key metric improvements (5).

• Employing Gainsharing incentive program
  • Physicians are compensated for reducing **unnecessary** medical services
    • Implementing more effective practice patterns
    • Using generic drugs whenever possible
    • Using ICUs and ORs in a more cost effective manner
    • Utilize cost efficient implantable prosthetics and other devices
Non-Financial Incentives

• For *intrinsically motivated physicians* – main motivator is the freedom, challenge, and purpose of the undertaking itself

• Current training and licensure requires most physicians are of adult age, and adults usually have to change their own behaviors, not have them “changed”
Non-Financial Incentives

- Traditional “if-then” rewards can:
  - Extinguish intrinsic motivation
  - Diminish performance
  - Crush creativity, and crowd out good behavior
  - Encourage cheating, shortcuts and unethical behavior
  - Become addictive
  - Foster short-term thinking
Intrinsic Motivation

- Intrinsic motivation tactics presume that humans have a drive to **learn**, **create**, and **better the world**

- Requirements for encouraging intrinsic motivation:
  - Purpose
    - Help physicians reach self actualization
  - Autonomy
    - What they do, when they do it, with whom, and how they do it
  - Mastery
    - Make it apparent when physicians are improving
Purpose

• Understand their dream
  • What motivates this physician, and what are their values?
  • Help them achieve self-actualization
Purpose

- Appeal to the ‘Higher Order Values’ (dreams) of physicians
  - Frame and present institutional goals in a way that aligns with the physician’s values and “dream”
  - Prove that their new behavior will allow them to deliver better patient care, and accomplish more of their original goals
Autonomy

• Involve physicians in **decision making**
  • Ask physician leaders to **work on what they want to** work on
  • Make the interests of the physicians equal (if not superior) to the interests of the organization
  • Encourage physicians to develop new quality metrics

• Develop physician **project managers**
  • Developing meaningful roles for physician leaders
  • Creating opportunities for physicians to lead **quality** initiatives
Mastery

• Establish improvement benchmarks and common goals
  • Discussing how the patients’ needs and key metrics are correlated

• Develop an overall **physician feedback communication plan**
  • Employ face-to-face communication often, especially from senior leaders.
  • Written/Electronic communication
    • “From My Desk To Yours” publication
    • Monthly physician newsletters
Communication

• Sharing **data and information** timely
  • Sharing performance data that encourages buy-in; data centered on the patient
  • Use a unifying language centered around established common goals
  • Being transparent and responsive

• Educate physicians on **anticipated changes** in **clear language**
  • Applying honest, factual, and timely communication principles between hospitals and physicians
  • Explain the “big picture” – how pending changes will contribute to improved population health
Build Trust

• Engage physicians early
  • Engage physicians from the moment of hire
  • Managers should become involved in physician induction, orientation, and educational programs
  • Communicate candidly and often
Build Trust

- Strive to **improve the quality of their lives** – especially the work/life balance.
  - Prevent physician burnout through education and normalizing discussion on the topic
  - Support physicians with “structure”
  - Pay any owed compensation promptly
  - Develop appropriate, effective, and legal compensation packages
Developing Physician Leaders

• **Identify** and **encourage** physician champions
  • Selection criteria
    • Highly respected in their areas of clinical expertise
    • Based on attitude, interest, abilities, and potential
    • Early adopters of institutional goals
  • Implementing recognition programs
  • Providing compensation for time spent on leadership activities

• **Educate** physician leaders
  • Sponsoring learning opportunities
  • Teach physician leaders the business behind healthcare so they understand how to align with institutional goals
Works Cited


5. Laura A. Petersen, MD, MPH, Health Services Research and Development (152), Michael E. DeBakey Veterans Affairs Medical Center, 2002 Holcombe Blvd, Houston, TX 77030