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# Executive Dialogue

## Fiscal Fitness

The Role of  
Physician Engagement



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# Fiscal Fitness: The Role of Physician Engagement

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Physician engagement is a critical success factor for hospitals and health networks navigating delivery system transformation. An engaged physician workforce is linked to enhanced patient care, lower costs, greater efficiency, and improved quality and patient safety. And, it is linked to higher physician satisfaction and retention. Achieving true physician engagement, however, remains a challenge for hospitals and health systems. Health Forum in July convened a panel of health care executives and industry experts in San Diego to discuss how hospitals and health systems can achieve and sustain high levels of physician engagement. Health Forum thanks all of the participants for their open and candid discussion, as well as VHA Inc. for sponsoring this event.





ways to align clinically and financially. So, in my experience, trust and alignment lead to good physician engagement.

**DOMINIC MOFFA** (AtlantiCare): Engagement is a very relevant term. Engagement certainly codifies an active, rather than a passive, relationship. It's a mutually dependent relationship; it can't be one-way. It's an accurate depiction of what we're trying to do as an institution relative to our physician population, especially the private physician population. How can we engage them in patient care and population health?

**MODERATOR:** Dominic, could you speak a little bit more about the two-way engagement?

**MOFFA:** We look at how we can support our physicians in their work. How can we enable them? How can we reduce the administrative burden so that they can focus on patient care? And how do we enable them to care for the population? That's an active role that we take on as an organization — to enhance physician engagement. We look for ways to simplify physicians' lives.

**MODERATOR** (John Combes, M.D., AHA's Center for Healthcare Governance): What do you think of the term "engagement" for physicians? I've received some pushback from physicians' groups about that term because they feel as though they are very engaged. What's your philosophy? How do you bring physicians into the organization as vital participants?

**STEVEN LINN, M.D.** (Inspira Health Network): Physician engagement, to me, means trust and alignment. Alignment, in particular, is something that's been missing historically. Hospitals and health systems need to find

**JEFFREY DILISI, M.D.** (Virginia Hospital Center): Communication and transparency are also important factors in physician engagement. We have to have effective communication with our medical staff. It's such a complex world. Even for us as physician executives in our organizations, we're always learning. We need to be able to get that information to our physicians to help them understand and feel better about the changes in the health care industry over the next few years.

Transparency is another huge driver of physician engagement. We have to show physicians the results [of our data].

Most physicians want to be engaged. They want to do what's best for the patient. If you show them something, they're going to want to get better and they'll work with you. It's a big step to get quality data in front of them and to be transparent.

**POLLY DAVENPORT, R.N.** (Ochsner North Shore Region): The days of hundreds of physicians showing up for medical staff meetings are long gone. It's our job to figure out the mutual interest for the outcomes of the organization and for the patient. We're doing a number of things to reach out to physicians to gain an understanding of what is weighing on their minds. We want to understand what we can do to make the clinical process better for them. What are we doing to help them prepare for the future? We want to create a dialogue to understand their perspectives as to how they are impacted by the Affordable Care Act. I'm sure the ACA has changed how all of us think about our relationships with our physicians.

**LINN:** It certainly has for us. Physicians, right now, are in a time of fairly high anxiety. There are many unknowns on the horizon and they recognize the need to partner with hospitals and health systems. That's a good development for us. It has brought physicians somewhat eagerly to the table to have discussions, because they recognize that partnering with our organization is in their best interest.

**MOFFA:** Our relationship with our physicians has changed considerably. One of the things we learned rather quickly is the need for physicians to be at the leadership table. We are bringing more physicians into leadership positions, both in governance and administration. By doing this early on, physicians have had significant input into our strategic development. Fifteen years ago, it was completely different. The administration developed and presented the organization's strategic plan to the medical staff. Now, it's about codevelopment and that's critical in terms of the reform environment that's underway. That's one of the key successes moving us forward — having the physicians partner with us on an equal basis in terms of strategic planning and development.

**DiLISI:** This year, we've been working with our service-line leaders to engage them in help-

ing us to be a better organization. It's critical. Historically, the chief medical officer would represent the medical staff, but the problems we're facing right now are complex and we need a wide range of input. We need physician leadership to help tackle some of these problems. Finding the right physician leaders and developing physician leaders will be critical for health care organizations in the coming years.

**DAVENPORT:** I'm excited by the increased interest among physicians to participate in leadership. They are seeking opportunities to provide their input and share their knowledge. That will benefit us in many ways.

**MODERATOR:** Have you received any pushback from physicians regarding concerns about their own clinical autonomy?

**DiLISI:** We're just starting to scratch the surface. Everybody is talking about value. At Virginia Hospital Center, we define value as safety, quality, cost, service and appropriateness of care. That gets to a lot of physician autonomy. We're looking at standardization for such things as hip replacements and deep vein thrombosis prophylaxis. That will help quality and costs. I'm sure there will be some initial pushback, but we need to drive through it. It's the only way we're going to be able to improve our value proposition.

**MODERATOR:** Is standardization driven by the administration or is there some other mechanism to make that happen?

**MOFFA:** I don't know that it's driven by administration as much as it's enabled by administration. It's enabled through information systems and transparency, among other things. That gives physicians the information and power they need to drive improvement.

**DAVENPORT:** That's a great way to put it. We enable our physician leaders by providing them with the tools and information they need.

**LINN:** I have seen greater receptivity from physicians over the last few years to standardize, whether it's through order sets or following clinical guidelines. There's a recognition, first of all, that they need tools at their disposal. They can't remember everything. They don't



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Polly Davenport, R.N.

want to try to remember everything. Physicians, today, are also being measured in ways they never were before. These measurement tools used to be applied to the hospital, but now apply to them as well. That makes them

more willing to come to the table and ask, 'How can we standardize some of these care processes?'

**DiLISI:** We've seen that shift in thinking, too,

# Panelists

**MODERATOR**  
**John Combes, M.D.**  
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**Steven Linn, M.D.**  
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One of the things we learned rather quickly is the need for physicians to be at the leadership table. We are bringing more physicians into leadership positions, both in governance and administration.

Dominic Moffa

and it coincides with the launch of the Centers for Medicare & Medicaid Services' Hospital Compare website. I don't think the public is looking at that data in large numbers, but there are a number of third-party websites that are taking the CMS data and publishing it in a way that is much easier for the general public to understand. Physician Compare doesn't have that much information yet, but it seems to be following the same timeline. We've tried to educate our physicians about that, and we have informed them that what they are doing today will be reflected in the 2016 data. There's a two-year lag on data. That gets their attention. Physicians want to do what's best for their patients, and no physician wants to look badly when compared with his or her peers. These discussions are starting to gain traction.

**MODERATOR:** What are you doing to integrate the various physician groups in your organizations? Have you seen the need to create these structures in which physicians have a voice and self-governance, but are also accountable and responsible for the care they provide even though they're independent physicians?

**LINN:** We developed a clinical integration committee led by a member of each of our large practices. We provide them with data and they are asked to develop tools to drive unexplained clinical variation out of our health system. I've tried this in the past and it failed. But, now that they're taking this leadership role, I've seen a significant transformation in our ability to get buy-in from their physician colleagues.

**MODERATOR:** That's a change in and of itself. My concern always has been with hospitals' acquiring physician practices. They haven't been organizing them. But, it sounds as though some self-organization is going on. Is that the case?

**DILISI:** We haven't started a formal clinical integration program, but we certainly are expanding our own employee physician group and concentrating on growing primary care. We understand that we have to have various leaders in all the different service lines to be able to put together a more integrated product and to take better care of patients across the continuum. Also, what I'm seeing is that

younger physicians are a bit easier to engage. It's tougher for older physicians to get their heads around this.

**MODERATOR:** Dominic, you're coming together with a renowned physician group practice. How is that affecting the physicians in your locale, who are primarily independent physicians?

**MOFFA:** You are referring to the relationship that AtlantiCare is developing with Geisinger Health System. Our employee base is growing. We have more than 300 employed physicians across multiple specialties at this point, but the majority of physicians in our community are still relatively independent.

As to our relationship with Geisinger, we've spent the past couple of years with physicians at the table analyzing whether or not we can remain independent moving forward and whether we have the tools and intellectual capability to succeed in the new environment. After an extensive process that took us more than a year, we decided that we needed a partner and we found our way to Geisinger. We're in the process of bringing our two organizations together. As you probably know, Geisinger is a clinic model; it is physician-led and -governed. It also has a track record of success, both locally and nationally.

One of the areas we're working on is knowledge transfer. Geisinger successfully has adopted a number of evidence-based models on the inpatient and ambulatory side. They can help us a great deal in those areas. Our physicians are anxious to access Geisinger's data. They are at the starting gate saying, 'When can we get access? We're ready to go.' Of course, we're working through a regulatory process, but it is coming together. I believe it's going to be a real accelerant for the marketplace and for the care that is delivered to our patients and our community.

**MODERATOR:** We've talked about how engagement has to be based on trust and transparency and the importance of physician leadership. What challenges have you encountered relative to physician engagement? What's impeding progress?

**DAVENPORT:** Time is a big factor. Physicians are already pressed for time and they're facing a

lot of challenges in their own private practices. Our greatest challenge is finding the time to interact with them and educate them about what we're doing.

**MOFFA:** There are also some structural impediments in how the medical staff are organized. The new model clearly transcends the hospital medical staff to incorporate the primary care physician network, many of whom are not members of the medical staff. And, although they are not members of the medical staff, what they do greatly impacts what goes on within the walls of the hospital. The shift to population health necessitates collaboration among the provider population to support the care delivery in the region.

**LINN:** It's going to require significant resources to make this transformation. The time frame is short and the resources are often limited. But there is good news: Primary physicians recognize that the hospital is an important partner in making this transformation. It's brought everyone to the table in a way that, I think, is important.

**DiLISI:** We are dealing with a challenging information technology environment. Our IT team is focused on attesting for Stage 2 meaningful use. It's almost as though they've shut down shop for the year and said, "This is our goal." It's important for us as an organization to be able to attest for Stage 2, although I'm not sure it's going to further improve the care we provide our patients. It's taking up so many IT resources that we are not able to get new things to try to advance the idea of managing patients across the care continuum. How do we get data out across the continuum and how do we use that data to enhance population health? It's a huge challenge, because our IT team is so strained.

**MODERATOR:** Have you received pushback from your medical staff around these new structures and decision-making, particularly around quality and safety?

**MOFFA:** No, we haven't. Our medical staff leadership — the elective leadership — has seen this as an opportunity. It goes back to transparency and sharing information, and providing physicians with the tools they need

to move forward. So, we haven't seen significant resistance in this area.

**DiLISI:** I think we're getting over the resistance in showing performance data. When we first started sharing physician performance data about three or four years ago, we did get pushback. But we've kept the information in front of them, and they are starting to trust the data and react to it. They know it's important and they are looking for ways to improve their performance.

**LINN:** The data still seem to be structured in silos, and that is a barrier for us. We have physician offices with their data metrics and the hospital with its data metrics, and they often do not communicate. And for the patients, there is no complete care tool that can track them throughout their year or their life or even their episodes of care. That's a huge challenge for us.

**DAVENPORT:** Some physicians were worried that their referral relationships would be impeded due to greater transparency with performance metrics. But now, there is a recognition that it can't be avoided. It's less of a concern for me.

**MODERATOR:** How have you addressed the issue of time? How do you work with physicians and engage them in light of their already busy schedules?

**DiLISI:** We focus on making their lives easier, so they can spend more time with patients. I visited one of our primary care physicians recently and he showed me the new electronic health record. They've already encountered a few problems. For example, if I'm listed in the EHR as Jeffrey DiLisi and Quest Diagnostics has me listed as Jeff DiLisi, it won't automatically populate lab values. So they have a stack of faxes, and someone has to go back and properly tag the results. We need our IT systems to get better so our physicians can take care of patients instead of dealing with this kind of stuff, which is not really advancing our care.

**LINN:** It does seem that some of the technological advances have taken folks away from patient care. There's hope that it will change at some point soon. But, we're not quite there yet.



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Jeffrey DiLisi, M.D.

**MODERATOR:** We've talked a bit about appropriateness of care. Are you seeing greater acceptance of midlevel providers among your physicians?

**LINN:** Yes, we are seeing greater acceptance.

**MOFFA:** We are as well.

**DAVENPORT:** Our physicians are showing greater acceptance of midlevel providers. On another note, we're working hard to educate the public, too, about the use of advanced practice clinicians, because many people feel they are getting lower-quality care if they are not seeing a physician. Our physicians work in a team model and they see the benefit of midlevel providers. But, the public is still trying to understand the value that advanced practice clinicians provide.

**MOFFA:** It's not just advanced practice. We're seeing a growth in the use of health coaches to help manage patients with chronic disease in terms of medication compliance and education to ensure that patients have various touch points with the system over time.

**DILISI:** This is extremely important, given the changes in reimbursement. We need all caregivers to practice at the top of their degrees. It's a huge challenge, particularly with the public. We're located in a pretty affluent area and people want to see their doctors, so it's been a challenge for us to really integrate midlevel practitioners into our primary care practices. Anecdotally, however, I do hear of people using urgent care and miniclinics when their children are sick, instead of waiting to

see their pediatricians. Trying to find that balance and get people to seek the right person at the right time is something we're all thinking about.

Our physicians are more receptive to this, as well. We've had success at various locations using scribes to help with the whole EHR and documentation. So, again, we're doing whatever we can to free up physicians' time so they can spend it with patients.

Another thing about midlevels is the management structure. Midlevels do need physician oversight. Some physicians are going to be good managers and will know how to delegate and what to delegate. We have to train our physicians to be good managers, and that requires a different set of skills than what physicians learn going through medical school or residency.

**LINN:** Team-based care is something that's not historically taught in medical school. It is to a greater extent now. But, many physicians do not have a comfort level in delegating some of those responsibilities to other team members, based on the culture in which they grew up.

**MODERATOR:** What are you doing now to develop physician leaders?

**DAVENPORT:** We conduct quarterly physician leadership training. We also have a new program that pairs a physician and a department manager to work together for a yearlong project. That helps physicians to learn management skills. We've had success bringing clinical and operational leaders together.

**MOFFA:** We invest in our up-and-coming physi-



## Key Findings

- Communication and transparency are critical factors influencing physician engagement in hospitals and health systems.
- Hospitals should capitalize on physicians' willingness to partner with the organization and provide opportunities to enhance physician leadership and management skills.
- Hospitals and health systems can foster physician relations by identifying processes and procedures that place constraints on physicians' time and find ways to enable them to spend more time with patients.

cian leadership. We created a group, in addition to the elected medical staff officers, that we call the physician leadership team. This is a group of internal leaders with whom our chief medical officer and other executives work on a monthly basis. They talk about organizational and industry issues and provide the physicians with educational opportunities to develop their leadership skills. We also provide joint physician and executive leadership and board development. The shared learning helps with collaboration and moving the organization forward.

**LINN:** We do that as well. We hold joint leadership retreats for our board and physician leaders. It's a great way to get those groups together. We just started a physician leadership academy with the American College of Physician Executives and we had about 50 people apply, many of whom were outside the typical hospital leadership roles. Twenty of them will go through a two-and-a-half-year program to become certified as physician executives. It just began, so I can't speak to the program's success, but the level of interest is amazing.

**DiLISI:** When I started my first leadership role, I was sent to a leadership conference. It was an eye-opener. I have my MBA and I had led a small-group practice prior to taking this role. My first thought was, 'How did I not have this information when I was managing a group of 10 doctors?' It was valuable to hear about how low performers pull down the performance of the overall group. It takes some training to recognize the impact and have the strength to address the physician's performance. When I returned from the conference, I recommended that we send as many physicians as possible to the meeting. And we've probably sent between 50 and 75 so far. We need to give our physicians the same tools to succeed that we're giving our other managers in the hospital. It's critical.

**MODERATOR:** Organizations are doing a better job of training physicians to become managers. Are you doing anything to educate your executive management about the clinical side of the equation?

**LINN:** That's a good question. I would say that

we aren't doing enough in that realm, but it is probably worth considering. I don't have any examples of doing that at our hospital.

**DAVENPORT:** We're doing a great deal of training with Lean and our front-line managers around some of the processes that the physicians deal with. Some of our Lean projects focus directly on physician and patient workflow. That's one way our managers are gaining a better perspective of physicians, but there's certainly room for more growth.

**DiLISI:** We try to bring our clinical and physician staff together with our management as much as possible. It's important for management to understand what's going on with our clinicians. We bring them together at off-site retreats. I'm not sure whether we're doing enough on this front, and that's something we need to think about going forward.

**MODERATOR:** Do you make any distinction between your employed physicians and your independent physicians in your engagement strategy?

**MOFFA:** We have increased the number of employee physicians significantly over the past few years, but it's equally important to have both employed and independent physicians participate in improvement teams. It's a bit easier for the employed physicians. Independent physicians need to be in their offices from a revenue-generation perspective. The compensation distinction drives accessibility to those learning opportunities.

**MODERATOR:** Do you provide any compensation to your physicians for their time?

**LINN:** We have paid in the past in some instances, particularly for participation in what I call the nontraditional medical staff committees. We don't pay for serving on the credentials committee, for example, but we did for participation in the clinical integration committee and some of the physician-hospital organizational development work, because it takes significant time away from their practices. To get the right people to the table, we've had to provide compensation in some instances.

The dynamic is different on the employed side. They are paid employees and are happy



Physicians also have recognized, more than ever, that they can't go it alone. They need the resources that the health system provides to assist them in achieving their goals. It's a perfect storm, bringing the relevance of physician engagement to the forefront right now.

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Steven Linn, M.D.

to participate. But we've had to develop unique compensation models that allow them to be recognized for the efforts they're making to advance the goals of the health system. We still have more to do to fully recognize their contributions.

**DiLISI:** We've found ways to compensate some of our physician leaders through medical directorships, essentially paying them for services that take them away from their practices. It's always a challenge. For one, where do we draw the line? How much administrative time should we expect from our employed physicians, and when is compensation appropriate?

**MODERATOR:** Some of you have mentioned the importance of bringing the physicians, the board and management together in retreats. Do you see a specific role for the board in the physician engagement strategy? How do you engage the board in this work?

**MOFFA:** Well, the starting point is having physicians on the board. That creates a dialogue, and physicians and board members can talk as equals and develop a mutual understanding.

**DiLISI:** We have a subcommittee of the board called the physician group oversight committee. It comprises board members and medical directors from each of our employee practices. That's been a great way for our board to get to know the doctors, and vice versa. Again, it's a subcommittee of the board that reports directly to the full board. It's really provided access to the board for our employee physician group and enhanced communication between the board and our physicians.

**DAVENPORT:** We have a similar physician representation as well. And the more information we share with them about organizational and clinical performance, the richer the dialogue. There's a healthy dialogue among the board and a great deal of trust being built around those discussions.

**MOFFA:** About five years ago, we started having nonphysician board members attend medical staff meetings. There was some anxiety at first, on both sides, but it's been successful. We send two board members to participate in the medical staff executive committee meetings

by listening to the dialogue and engaging with the physicians before and after the meetings. They rotate, so different members participate every year.

**MODERATOR:** How critical is physician engagement within your organizations? How critical is it to the success of your organization?

**DiLISI:** It's essential. We need physician leadership to help us get to the next level of providing value to patients.

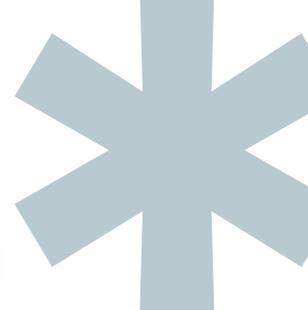
**DAVENPORT:** As chief executive officer and a nurse, I tell the nursing staff all the time that no one else can admit a patient but a physician. We work hard to remove the barriers and, as I call them, the irritants, because there are many. If nursing embraces the challenges that we're all facing and we work together as a team, we're going to be a lot better off together. Physician engagement is absolutely critical.

**LINN:** It's a unique time in that we recognize now, more than ever, that we can't accomplish our goals of managing cost, quality and outcomes without physicians at the table making these decisions with us. Physicians also have recognized, more than ever, that they can't go it alone. They need the resources that the health system provides to assist them in achieving their goals. It's a perfect storm, bringing the relevance of physician engagement to the forefront right now.

**MOFFA:** I agree. In the past, we would develop initiatives to assist our physicians. Now we're saying, 'Let's come together to cocreate the future for the populations that we serve. How do we become cocreators of the hospital, administrative structure, governance and the physician community? How do we cocreate a new model so that we can serve the physicians and the populations they're responsible for in a high-quality, cost-effective way? That's the key.'

**MODERATOR:** Let me ask a theoretical question. What's health care going to look like 20 years from now? What are we going to be doing and how will physicians fit into the equation?

**DiLISI:** That's a tough question. Even five years out is difficult to project. Technology definitely



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will shape where the industry is 20 years from now. We'll have even more data than we are dealing with now. And we haven't yet figured out how to put it all together and how to use that data to make good clinical decisions. Other industries are using big data to get smarter, to target the right people and become more sophisticated. Maybe 10 years from now, we'll be able to harness big data to become more sophisticated.

**DAVENPORT:** The relationship between the patient and the physician is going to change dramatically, just within the next few years. Technology will play a significant part by enhancing connectivity between physicians and patients. It's going to be a challenge for physicians who resist the technology boom. It's going to definitely change the relationship.

**LINN:** The fee-for-service model that we've all grown to love for many years is unsustainable and the physicians will have to evolve. In 10–20 years, the role of physicians will be managing more critical patients, and they will not be doing the tasks that, quite frankly, don't require a physician's expertise at this time. They will have to develop skills in managing a group of nurses and other providers to provide patient care that is going to be drastically different than how we're delivering care today. They're going to need new skill sets to do that. It's going to be a fairly transformational time in the next 10–15 years.

**MOFFA:** That's exactly right. When I think about what the health care field will be like 20 years from now, I think about the generations who are much younger than I. What do they want the physician to be? If their consumer habits hold true, 20 years from now when the 18- to 23-year-olds reach their 40s, they'll have some strong opinions about how they want consumer health care to be. The consumers will be what truly drives it. So, I'll answer your question, John, with another question. What role does the consumer want the physician to play?

**MODERATOR:** We're coming to a close and I want all of you to think about this phrase: 'Physician-led, professionally managed.' What does it mean to you? What comes to mind when you hear that statement? How does it resonate in your organizations?

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**MOFFA:** That phrase is probably relevant now, John. As we move forward, there will be less distinction between physician leadership and professional management. The line between the two is starting to blur. Physician leadership and professional management will be more integrated in the future.

**LINN:** There's going to have to be a recognition that a partnership is necessary for all of us to be successful. Neither party will be around 20 years from now if we go it alone.

**DAVENPORT:** I would hope that new physicians coming out of medical school would have a better understanding about the expectations and the changing role related to their involvement and engagement. That would help to enhance physician engagement.

**DILISI:** Some of the most successful organizations will be led by physicians who can professionally manage. We need to teach them how to do that. It's an important skill and the best physician leaders will have that skill set.

# Thanks

Health Forum would like to thank the panelists for taking part in “Fiscal Fitness: The Role of Physician Engagement,” with special thanks to our sponsor VHA Inc.

