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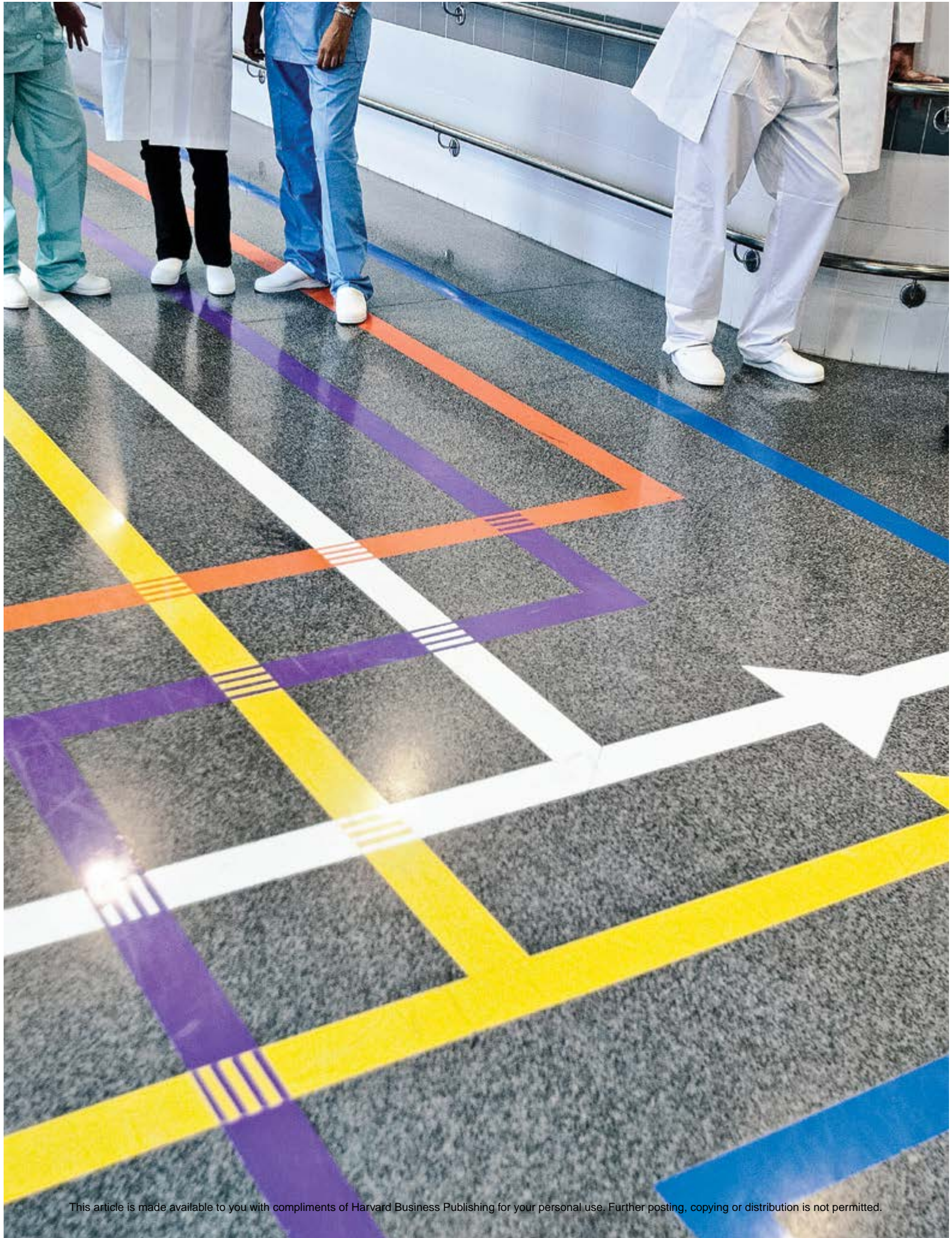
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Engaging Doctors in the Health Care Revolution

by Thomas H. Lee and Toby Cosgrove





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Despite wondrous advances in medicine and technology, health care regularly fails at the fundamental job of any business: to reliably deliver what its customers need. In the face of ever-increasing complexity, the hard work and best intentions of individual physicians can no longer guarantee efficient, high-quality care. Fixing health care will require a radical transformation, moving from a system organized around individual physicians to a team-based approach focused on patients. Doctors, of course, must be central players in the transformation: Any ambitious strategy that they do not embrace is doomed.

And yet, many physicians are deeply anxious about the changes under way and are mourning real or anticipated losses of autonomy, respect, and income. They are being told that they must accept new organizational structures, ways of working, payment models, and performance goals. They struggle to care for the endless stream of patients who want to be seen, but they constantly hear that much of what they do is waste. They're moving at various rates through the stages of grief: A few are still in denial, but many are in



the second stage—anger. Bursts of rage over relatively small issues are common.

Given doctors’ angst, how can leaders best engage them in redesigning care? In our roles in senior management of two large U.S. health care systems, and as observers and partners of many others, we have seen firsthand that winning physicians’ support takes more than simple incentives. Leaders at all levels must draw on reserves of optimism, courage, and resilience. They must develop an understanding of behavioral economics and social capital and be ready to part company with clinicians who refuse to work with their colleagues to improve outcomes and efficiency.

To help health care leaders engage physicians in the pursuit of their organizations’ greater goals, we suggest a framework based on the writings of the economist and sociologist Max Weber, who described four motivations that drive social action (that is, action in response to others’ behavior). Adapted for health care professionals, these are: shared purpose, self-interest, respect, and tradition. Leaders can use these levers to earn doctors’ buy-in and bring about the change the system so urgently needs.

Getting Started

The first step in any strategic transformation is to clarify the goal. What, exactly, do leaders want physicians to engage with? Traditionally, hospitals have defined physician engagement as the extent to which doctors saw their future as intertwined with that of the larger organization. Hospitals wanted physicians to be loyal—that is, to refer most or all of their patients to them, thereby increasing revenue. Even today, many hospital administrators believe that their true “customers” are the physicians who bring them patients—not the patients themselves. Working with physicians to reduce costs or improve quality is regarded as important, but secondary to increasing volume.

Here we describe a new concept of physician engagement. Such engagement requires more than mere cooperation—an agreement not to sabotage—and strives instead for full collaboration in relentless improvement. To be sure, we still need physicians to work hard as individuals and keep care within the family of the local hospital and physician community. But physician engagement can no longer be about short-term maximization of fee-for-service

Motivational Tools That Improve Engagement

This adaptation of Max Weber’s typology of social action describes four motivations that leaders can tap to engage physicians in redesigning health care.

MOTIVATION	HOW TO APPLY IT	EXAMPLE
To engage in a noble shared purpose	Appeal to the satisfaction of pursuing a common organizational goal.	The Cleveland Clinic reinforced its commitment to compassionate care by launching a same-day appointment policy.
To satisfy self-interest	Provide financial or other rewards for achieving targets.	At Geisinger Health System, 20% of endocrinologists’ compensation is tied to goals such as improving control of patients’ diabetes.
To earn respect	Leverage peer pressure to encourage desired performance.	Patients’ ratings of University of Utah physicians are shared both internally and on public websites to drive improvements in patient experience.
To embrace tradition	Create standards to align behaviors, and make adherence a requirement for community membership.	At the Mayo Clinic, a strict dress code and communication rules signal the “Mayo way of doing things.”

(See also Nikola Biller-Andorno and Thomas H. Lee, “Ethical Physician Incentives—From Carrots and Sticks to Shared Purpose,” *New England Journal of Medicine*, March 2013.)

Idea in Brief

THE CHALLENGE

Doctors must be central players in the sweeping changes transforming health care. Indeed, any change strategy they do not embrace is doomed. But many fear a loss of autonomy and income and are resistant to change.

THE ANALYSIS

Engaging doctors in change requires first clarifying the organizational goal. Leaders must shift the emphasis from the short-term maximization of revenue to the long-term strategy of increasing value, putting what's best for patients first.

THE SOLUTION

Leaders can bring doctors along by applying four motivational strategies: engaging them in a noble shared purpose, appealing to their self-interest, leveraging peer pressure to encourage desired performance, and emphasizing organizational traditions to align behaviors.

revenue; it must further the long-term strategy of improving outcomes and lowering costs—increasing value for patients. (See Michael E. Porter and Thomas H. Lee, “The Strategy That Will Fix Health Care,” HBR October 2013.)

Many organizations hope that they can win over physicians by combining good intentions with a few broad interventions, such as putting doctors in leadership roles and creating financial incentives for desired behavior. But as we have seen too often, such uncoordinated, piecemeal efforts are insufficient. Leaders need to tap into all four motivational levers in concert (see the sidebar “Motivational

Tools That Improve Engagement”). They must begin by focusing on shared purpose, without which the pursuit of the other three can seem perverse and may prove ineffective.

Engaging in Shared Purpose

Most discussions about health care these days dwell on its problems—spiraling costs, lack of access, uneven quality—and give short shrift to the possibility of a better future. To help physicians move beyond grief and anger about what they might be losing as the health care system remodels, leaders must shift the conversation to something different—something positive, noble, and important. They must articulate a vision of what lies on the other side of the turmoil ahead: health care that will be better—maybe even great—for patients. Improved patient care has to form the core of any change agenda that clinicians will embrace.

At the same time, health care leaders must frankly acknowledge the need for sacrifice. The journey will be arduous and might reduce autonomy and income for some physicians. But leaders must take the position that achieving the goal of high-value

care for every patient is more important than preserving the status quo for any individual physician. The alternative—that the organization will prioritize doctors' interests over patients' and shield doctors from the changes sweeping through health care—is impossible to defend.

Creating such a shared purpose starts with the same steps used to build consensus in any organization: listening, demonstrating respect for diverse views, and creating processes through which stakeholders can help shape the vision's implementation. But health care leaders face additional challenges: About half the physicians in the United States are not employees of the organizations where they provide care, so they don't respond to the perks and threats that managers commonly use to influence employee behavior. What's more, even those who are employees tend not to see themselves that way and view their duty to patients as preempting other obligations.

Far from being an obstacle, however, that perspective can be a path to meaningful change. Health care leaders can engage physicians by putting the focus on patients and their suffering, trumping all other concerns. During Hurricane Sandy and the Boston Marathon bombings, no physician worried about compensation or hours worked. All were solely focused on helping patients. In less dramatic contexts, when faced with individual patients whose lives are in crisis, a physician's instinct is similarly to put the patients' needs first.

Accordingly, discussions with physicians about reorganizing care cannot begin with talk of contracts and compensation. Instead the focus must be squarely on the stakes for patients. Leaders should use data to demonstrate how proposed changes can improve efficiency and patient outcomes and use vignettes about patients' struggles and triumphs to get physicians thinking about what kind of care makes them ashamed or proud. Of course, these

discussions must ultimately turn to business issues, but not until patients' welfare is front and center.

Statements of shared purpose, such as the Mayo Clinic's promise that "the needs of the patient come first" and Seattle-based Group Health Cooperative's commitment to "transform health care [by] working together," are effective because they establish an organizational orientation rather than set piecemeal targets. Such statements have three features in common: They are unequivocally focused on patients, they acknowledge that the status quo is inadequate and must change, and they affirm that group action is needed to pursue the shared goal.

Of course, a statement of purpose has little value unless leaders explicitly promote it and put its principles into action. The Cleveland Clinic uses an array of communication tools to reinforce its message of shared purpose. An internal training video developed by the clinic, for example, is a vivid reminder to physicians of the need for empathy and compassion (see the sidebar "Inspiring Shared Purpose").

Sometimes the story of a single patient is enough to galvanize doctors' buy-in. In 2008, for example, a patient called the Cleveland Clinic's urology department seeking an appointment because he was having trouble urinating. He was given the next available slot—two weeks away. A few hours later he arrived in the emergency department with acute urinary retention. Doctors quickly solved the problem, but the patient suffered greatly in the hours before treatment.

The physician leaders discussed the case, and one asked, "Do we want to be the type of organization that doesn't even *try* to figure out if patients should be seen right away?" In that light, the existing appointment system seemed intolerable.

As a result, the clinic instituted a same-day appointment policy whereby all patients who call are asked whether they want to be seen immediately. About one million of the 5.5 million visits a year now occur on the same day the patient calls. This policy occasionally disrupts physicians' schedules, but the new system is comforting to patients, and clinic doctors have come to embrace it. Other providers are now offering similar appointment guarantees.

Another organizational change that supports shared purpose comes from Advocate Health Care in Chicago. In the spring of 2013, senior leaders at Advocate banished all meetings between 8 and 9 AM on weekdays and instituted mandatory "huddles" to discuss safety issues. During the hour, nurses gather on each floor, hospital leaders have their

own huddle, and system leaders meet as well to discuss any safety events or near misses. Most of these meetings take just 15 minutes, but if an issue requires investigation, they can fill the hour or go beyond as needed. With the introduction of huddles, reports of serious safety events increased by 40% as staff members embraced leadership's commitment

to safety and transparency. Since then, falls and hospital-acquired complications have dramatically decreased. For the first time, six Advocate hospitals have gone at least a year without a central-line-associated bloodstream infection. In a striking vote of confidence in the program, in July 2013 frontline clinicians requested that the safety huddles occur seven days a week, which they now do.

Discussions cannot begin with talk of contracts and compensation but must focus instead on the stakes for patients.

Appealing to Self-Interest

Physicians, like everyone else, are motivated by financial incentives and job security. Even if their organization's noble shared purpose resonates deeply with them, they also care intensely about what measures are being used to gauge their performance and how the data are collected and analyzed. This natural self-interest can be channeled to reinforce engagement in a number of ways.

Some organizations make portions of physicians' compensation dependent upon performance. Pennsylvania-based Geisinger Health System, for example, ties 20% of physicians' potential compensation to their performance against certain goals or, in many cases, on how they do as a team. Cardiac surgeons, for example, are rewarded on the basis of how reliably they perform key processes such as screening steps and the prescription of medications to reduce complications after surgery. Meanwhile, endocrinologists at Geisinger are rewarded if control of glucose levels improves for all diabetes patients, not just those they see. These incentives are designed to reward leadership and collaboration and to inspire everyone to engage in enhancing patient care. In these and other areas, Geisinger has seen substantially improved patient outcomes, including fewer rehospitalizations after cardiac surgery and,

Creating Incentives

for patients with diabetes, reductions in vision loss, heart attacks, and stroke.

Other organizations put physicians on straight salary, believing that all financial incentives can have unintended negative consequences and are an invitation to game the system. The Cleveland Clinic's physicians are all salaried, without any performance-based bonus program. Instead of using overt financial incentives, the clinic hires all physicians on one-year renewable contracts, and they undergo detailed annual performance reviews. The physicians see the yearly reviews not just as a chance to receive feedback but also as an opportunity to communicate with hospital leaders about how the organization could improve. Like Geisinger, the clinic has seen marked improvement in quality and in volume of patients.

Either approach can have sustained effectiveness, we find, but only when used to advance goals that are consistent with shared purpose. If physicians believe that a particular management-endorsed behavior or practice will improve patient care, even minimal financial incentives will be enough to help them implement it consistently. If they are uncertain about whether it will actually improve care, even large incentives will produce only marginal success. (See the sidebar "Creating Incentives.")

Earning Respect

Nonfinancial rewards and penalties also have a role to play in getting doctors on board. Physicians appreciate positive feedback, and they particularly worry about losing the respect of their colleagues. High-performing organizations are increasingly reporting to physicians how their personal performance compares with that of their colleagues—and providing those data in ways that intensify peer pressure.

Such scrutiny can be excruciating, especially when the data are "unmasked" so that colleagues can see one another's results. Within physician groups at Partners Healthcare System, for example, unmasked data on individual physicians' use of radiology tests led to an almost immediate 10% to 15% drop in orders for high-cost tests, mainly due to decreases among the "outlier" physicians who ordered many more tests than their colleagues. Using peer pressure in this way can achieve cost savings without compromising quality. Even the physicians who dramatically reduced their use of the tests did not argue that patient care suffered as a result.

Some organizations now post individual physicians' quality-performance data publicly on their

Physicians care first and foremost about their patients' well-being, but that doesn't mean financial incentives are not of great interest to them as well. This motivational tool can be very effective, especially when the incentives are aligned with the organization's shared purpose. Here are a few strategies for designing effective financial incentives:

AVOID ATTACHING LARGE SUMS TO ANY SINGLE TARGET.

It takes a surprisingly small percentage of physicians' compensation to get their attention. We have seen that doctors will focus intensely on improvement targets when as little as 1% of their compensation is at stake. This finding aligns with the behavioral economics principle known as "loss aversion." In essence, people find it more painful to lose something of a given value than they find it agreeable to gain that same value. Thus, doctors typically pay more attention when they stand to lose 1% of income than when they stand to gain it. At Geisinger, where 20% of compensation is based on performance, the incentives are spread across four or more targets.

WATCH FOR CONFLICTS OF INTEREST.

Avoid financial incentives that are focused solely on reducing costs, particularly when the savings are generated by individual physicians' reducing their use of resources. Such incentives can create real or apparent

conflicts of interest when a doctor stands to gain by shortchanging patients. "Gain sharing" programs, in which the organization shares with physicians the savings from improved performance, have not been successful at most hospitals, in part because of their complexity.

REWARD COLLABORATION.

Create financial incentives that target outcomes beyond the control of any individual. Physicians (like most people) naturally prefer that their compensation be based on behaviors that they alone control, such as whether they order tests in specific circumstances—but that approach doesn't encourage teamwork.

COMMUNICATE.

Make sure physicians understand that financial incentives will be continually modified as the organization learns how best to support its shared purpose. This evolution should be transparent and physicians' participation welcomed.

websites. Whether consumers are using these data to make decisions is unclear, but doctors, knowing that their performance is on public display, are strongly motivated to improve. University of Utah Health Care used this kind of transparency to improve patient-experience ratings. First, leaders began sharing each physician's patient-experience data with him or her confidentially. Next, they began sharing the data internally so that physicians could see one another's ratings and patient comments. Finally, they began posting the data and comments—good and bad—for every physician on public websites. With each escalation in transparency, overall performance improved. One key to Utah's success with the program, we believe, was its gradual introduction, which allowed physicians to acclimate at each step.

Embracing Tradition

When physicians value membership in an organization—out of pride, a need for security, or some other

reason—they are motivated to adhere to that organization’s standards and traditions. For example, doctors have followed the Mayo Clinic’s dress code since the clinic was founded, in the late 19th century. The requirements today include neckties for men and hosiery for women, even in Mayo’s facilities in Arizona, where temperatures routinely top 100°F.

Mayo also has standards for how its physicians communicate with one another (for instance, when paged, they must respond immediately) and how they interact with patients (before out-of-town patients with complex conditions are discharged, physicians must meet with them for “exit” visits to discuss their ongoing care and answer questions). The symbolic connection between the dress code and Mayo’s standards for performance is clear: “There is a Mayo way of doing things. Don’t come here if you don’t want to adopt it—completely.” These standards and traditions translate into well-coordinated care that patients appreciate and physicians are proud of. They are also a key reason that Mayo is able to retain many of its students and residents for their entire careers.

Such standards, whether they’re related to appearance and etiquette or to the delivery of care, create consistency in the way physicians interact with one another—a basic step toward more-effective teamwork. Even newly minted standards, such as using checklists, can be effective motivators when physicians know that they could be shunned or even lose their jobs if they disregard them.

To successfully use this lever, organizations must be willing to part company with physicians who refuse to work with their colleagues toward a shared purpose. In the past, hospitals welcomed almost any decent physician who could bring in patients (and thus revenue), and doctors hardly ever lost their credentials or were fired. That is still rare, but when it does happen, colleagues usually ask, “What took so long?”

Making It Operational

Most health care organizations already use one or more of the four motivational levers described here. We’ve found that the most successful rely on all four.

Consider the “full disclosure” initiative launched by Ascension Health, of St. Louis, in 2006. Although the organization believed that communicating openly with patients and families after unexpected events, such as medical errors, was the ethical thing to do, disclosure at Ascension was occurring only 10% of the time. Ascension introduced the program

with a reminder about the organization’s shared purpose—to put patients first and provide the best possible care. It shared evidence suggesting that full disclosure leads to better outcomes for patients, families, and providers themselves and may reduce malpractice costs. It then focused its implementation efforts on obstetrics, where bad outcomes are particularly emotional, and even more so when they’re due to mistakes.

Physicians initially resisted the new policy, worrying that acknowledging errors would lead to malpractice suits despite the evidence to the contrary. Further complicating matters, many of the obstetricians were not employed by Ascension. To overcome resistance, Ascension negotiated premium credits from malpractice insurers for physicians who agreed to full-disclosure training. It also recruited respected local leaders to give talks and use their personal influence to encourage acceptance. And Ascension created a new operational standard: Doctors were required to consult with “event response teams” to address issues that might have been caused by errors. They understood that failure to adhere to this standard could cost them their jobs. In this way, Ascension effectively invoked all four motivational levers: shared purpose (ethical care), self-interest (premium credits), respect (peer pressure), and standards (event response teams).

As a result, Ascension’s culture changed with surprising speed. Three months after the protocol’s implementation, the disclosure rate for unexpected events rose to 24% percent. A year later it was 41%, and at 27 months it was 53%. Fully 86% of the documented disclosure communications were initiated by the practitioner who had delivered the baby. By pressing all four levers, Ascension had won active engagement from a resistant group of physicians in a challenging new value initiative.

Like Ascension, the emergency department at Brigham and Women’s Hospital, in Boston, has used all four motivational levers in a multiyear effort to improve dismal patient-experience ratings. As is true in many emergency departments, the staff initially felt hopeless about its ability to improve patients’ experience, because many emergency department patients have mental health issues, face complex socioeconomic challenges, or both. Hospital leaders decided to focus clinicians’ attention in a positive direction—on a shared purpose. In one of their first steps, they removed all negative comments from patient-experience surveys and pre-

Inspiring Shared Purpose

At a time when stress and uncertainty can undermine engagement, leaders need motivational tools to enlist physicians' support and collaboration. A short training video produced by the Cleveland Clinic appeals to clinicians' instinct to put patients' needs first, by inviting staff members to reflect on patients', and one another's, experiences. It asks, "If you could stand in someone else's shoes and feel what they feel, would you treat them differently?" A vivid reminder of the power of empathy and compassion, the video encourages physicians to embrace health care's higher purpose.

presented clinicians with just the positive ones. Then they asked the clinicians to figure out how to make good patient experiences happen all the time. The goal that emerged was "VIP Care for All."

Of course, the improvement efforts had to go beyond a slogan. The physical layout of the emergency department was streamlined and enlarged. The processes by which patients moved through the emergency department were redesigned after an intensive "lean management" study. Dashboards were developed to enable doctors to see how their performance compared with that of their colleagues on measures such as patients' length of stay (door-to-discharge or -admission times), patient-experience data, and number of visits. Standards were set governing how clinicians should work together, and leaders made it clear that adherence was not optional. Financial incentives rewarded improvement for both individuals and groups of clinicians.

The changes were dramatic and sustained. Door-to-bed time improved from 65 minutes in 2009 to 22 minutes in 2013, and more than half of emergency department patients are now in beds within nine minutes of arrival. "Walkouts" declined from 3.3% to 1.5%. And patient satisfaction rose from the 6th percentile to as high as the 99th percentile, remaining above the 90th percentile during most quarters since the effort began.

TRANSFORMATION OF health care requires the will to organize delivery around the needs of patients—and that reorientation means the end of the status quo and doctors' traditional perch within it. Clearly, getting physicians' buy-in to this strategic change will be hard, particularly from those who have long practiced under the old regime. Many organizations are cultivating "farm teams"—developing training programs that emphasize team-based, patient-centered care and then recruiting the graduates.

But health care leaders cannot wait for generations of physicians to retire from the scene. Engaging doctors, even the old guard, is a management challenge that can be tackled, measured, and improved. The organizations that can help physicians to live up to their aspirations as caregivers—to understand that giving up their autonomy is not actually surrender but a noble act of humility in the interest of their patients—will be the ones that improve efficiency, deliver the best outcomes, increase their market share, and retain and recruit the best people. ♥

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