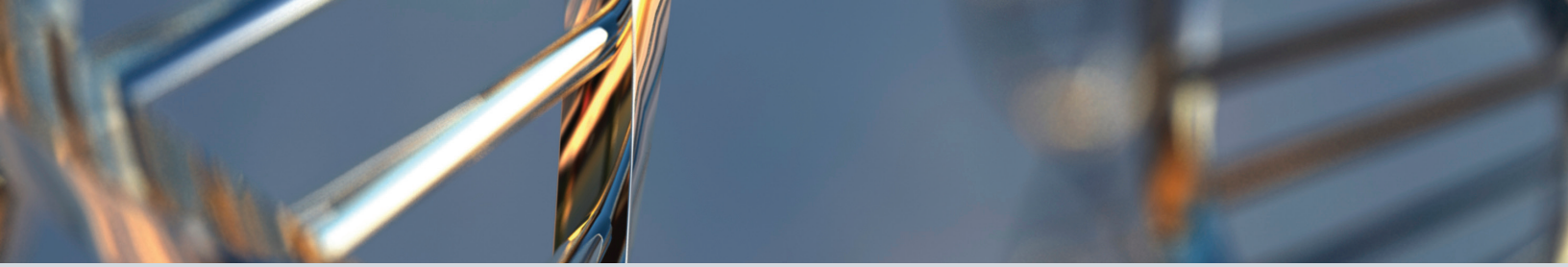

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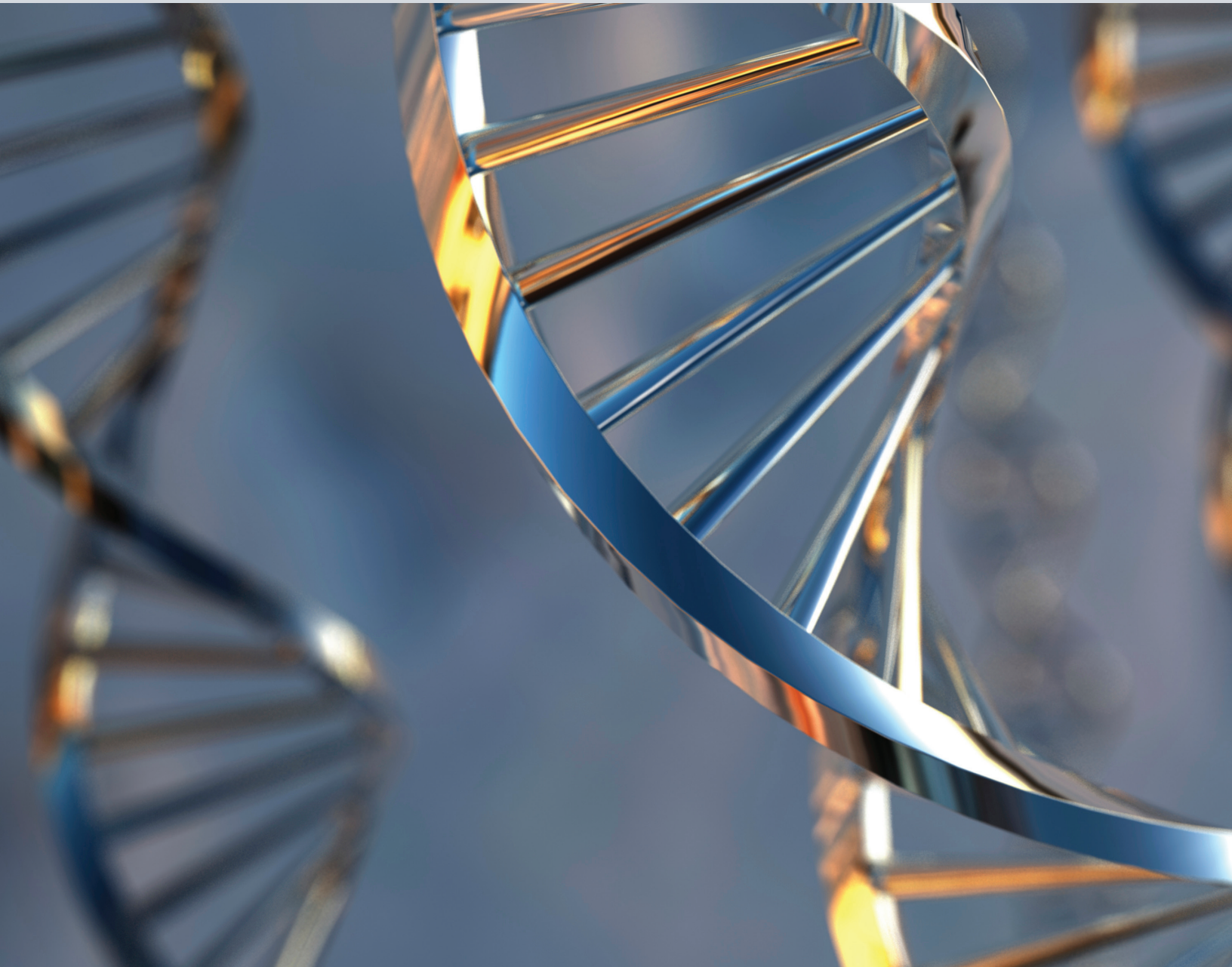

CREATING VALUE TOGETHER — COLLABORATION BETWEEN PHYSICIANS AND ADMINISTRATORS

This is the third in a series of four articles on improving collaboration in healthcare, in this case, between physicians and healthcare administrators. We will describe practical tools to enhance institutional performance through better collaboration — toward the primary goal of providing better patient care.

Improving Collaboration Between Physicians and Hospital Administrators

The Affordable Care Act is accelerating a transformation of the US healthcare system from one that is driven by volume and characterized by fragmentation, waste, high cost, and inconsistent quality to one where care is coordinated, costs are lower, and quality is higher.

Healthcare leaders are engaging in many experiments, such as Accountable Care Organizations and global payments—with institutions taking on greater risk for cost and quality of care—to position or reposition how their institutions fit within coordinated networks of care. While numerous networks of care exist today, coordination is missing. Leaders know successful coordination and integration require teams from the frontline to the C-suite that understand the critical nature of collaboration and how to effectively collaborate. Nowhere is this relationship more important than between hospital administrators and the medical staff.

But given the often-difficult nature of these relationships, how do you improve collaboration to increase productivity and performance?

Working with Resistance to Improve Collaboration and Performance

A multi-billion dollar health system believed it could best fulfill its mission by shifting from a historical focus as a "hospital company" to a focus on managing the overall health of the populations it served. This decision had immediate implications for their economics, network structure, leadership capabilities, care model and decision processes—and it would be impossible to accomplish this shift without a tight partnership with physicians.

The health system was working closely with employed physicians, but, like many systems, it had more tenuous connections to affiliated and independent physicians. While a handful of physician leaders had been involved in strategic planning, the system had largely excluded others. This was not intentional; the leadership assumed physicians would not want to spend time engaged in system-wide planning. Recognizing this assumption was no longer valid, we helped the system find ways to engage physicians in strategic decisions that directly impacted both the health system and physicians themselves.

Working with Resistance — We convened over 100 independent and employed physicians in a strategy summit with advance input and feedback on an emerging strategic plan. Physicians began to shape a future for the system, but complained their information systems and support were so bad the future they envisioned could never exist. Rather than hear these "complaints" as typical resistance, the system's leaders listened. While IT had fallen lower on the administrators' list, it was a top priority for physicians. At the end of the summit, the CEO committed to taking action. It was not an empty promise.

Collaborating on Strategy — The CEO invited those same physicians back to an IT Summit to better understand the issues and key concerns. Leaders explained IT was now the top strategic priority and invited the physicians to help devise a strategy. This plan is underway today - the system is addressing significant deficits in IT with a group of physicians who provide input and guidance.

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CREATING VALUE TOGETHER — COLLABORATION BETWEEN PHYSICIANS AND ADMINISTRATORS *continued*

By identifying and working with the chief barrier to improved collaboration in service of the overall goal, administration and physician "parts" could genuinely collaborate, creating a stronger, more actionable and sustainable strategy.

Structuring "Productive Pairs" and Working with the Culture that Exists

A large academic hospital with employed physicians had a history of top quality outcomes—and correspondingly high costs. Leaders recognized hospitals would be accountable for ensuring value and would need to reduce costs over time. This would be difficult - when ordering diagnostics and interventions, their physician culture was to leave no stone unturned. The hospital knew that changing the focus to what could be agreed to as "appropriate care" would require respect for the hospital's culture and physicians' expertise, while standardizing practice where it made sense.

We worked with hospital leaders to partner with physicians on maintaining quality outcomes and the institution's reputation, while lowering costs over time. To do this, we helped leaders launch several strategies across many sub-departments:

Physician-Developed Clinical Protocols — Leaders knew top-down care protocols developed by non-clinical quality experts would meet immediate resistance. Instead, they collected guidelines from specialty societies, advice from accepted leaders in the field, and literature on best practices. The change effort gained credibility by establishing the protocols as voluntary and works-in-progress. Modifications were considered when other methods achieved consistently better outcomes, including when the hospitals' top-tier practitioners were using innovative techniques not yet part of specialty-society guidelines.

Productive Pairs — "Productive pairs" join a leader representing the expert function of an organization, like medicine, with an administrative leader. We worked with the "productive pairing" of executive administrative and physician leadership to structure physician/administrator pairs at the sub-department level. This created a two-tiered engine for the change effort, with the top-level pair shaping the effort in the background. The physicians would influence their peers, with administrators providing evidence of the case for change and removing institutional barriers to using the protocols.

Found Pilots — Hospital leaders knew the protocols' success also depended on physicians talking about the implementation experience with each other. We helped the hospital look for "found pilots" — projects and people already innovating. Together we uncovered pockets where the culture was already changing — where sub-departments were already pooling knowledge on clinical outcomes in-person. For example, a group of surgeons was already collaborating to understand which patients would be the best candidates for an elective procedure. By using sub-departments with existing feedback loops to gain traction on standardization, physicians leveraged early successes to increase use of the protocols in other sub-departments.

Relying on two levels of productive pairs to guide adoption of protocols in their hospital's specific context, leaders found that strengthening collaboration within their culture of clinical excellence would help them achieve critical goals over time.

We discussed how to foster collaboration between physicians and administrators - by listening to physician resistance and using it to shape effective strategy and by creating "productive pairs" that influence physician leaders while ensuring institutional support. By committing to collaboration with methods like these, health systems can meet new expectations of shared accountability—delivering quality and value together.

The final segment will examine collaboration within inter-professional teams.

For more information on this topic or related materials, contact CFAR at info@cfar.com or 215.320.3200, or visit our website at http://www.cfar.com.