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Overcoming the Physician Engagement Conundrum

By John Findley, M.D., CPE, ACO Medical Director, Caravan Health

Hospital acquisitions of physician practices have increased dramatically over the last decade, and according to recent analysis, rural markets have outpaced their urban counterparts.[1] Community health systems confronted with the inevitability of payment reform, competitive market pressures, deepening socioeconomic needs, and declining margins knew that clinical integration was the only way they would survive the tectonic shift from volume to value. The founding fathers of rural primary care as we know it, overwhelmed by reporting burdens, expensive EMR conversions, and decreasing reimbursement, relinquished their autonomy and stepped into a perceived safe harbor of hospital employment.

Driven by necessity and fear, many rushed into well-intended yet thinly veiled contractual versions of clinical integration in preparation for the unchartered territory of value-based care. Instead of first building trust, improving systems, and figuring out how to work better together, hospital administrators and boards assumed this transaction would bring the desired shift in physician rapport. In hindsight, we all now know that employment doesn't necessarily beget engagement. Myriad rural communities around the country are now struggling with a post-merger "engagement" crisis. The results not inconsequential.

The organizational and cultural chasm between inpatient, outpatient, post-acute, and primary care can be quite vast regardless of community size. Stakeholders along the continuum have become accustomed to functioning as symbiotic partners, each contributing to patient care in proximity yet relative isolation from one another. Taking on the daunting task of coordinating care and closing this gap will require the work of many hands, as well as a fierce multi-level commitment to elevate and actively pursue ongoing conversations with those most invested in doing this work. Getting to high-value care demands an evolutionary leap from comfortable norms.

Although circumstances may vary, we have learned that soliciting the input of and actively involving physicians is essential to creating a unified ethos. Steadfastly working toward a mutual and strategically aligned call to action drives engagement and "helps transform physicians' mindset from that of a victim in a broken system to an engaged and empowered partner working constructively with leaders to shape their own future."[2] Doing so yields dividends—improving retention, engagement, and connection with your greatest asset: your people.

In our experience, working with rural communities across the country as they transition to high-functioning teams, top-performing organizations take the following actions to overcome the employment-engagement conundrum:

1. **Make sure formal physician leadership isn't optional.** Leading change is real work. Practicing clinicians understand best how to recognize and

"Control leads to compliance; autonomy leads to engagement."—Daniel Pink

1 Carol K. Kane, "Updated Data on Physician Practice Arrangements: Physician Ownership Drops Below 50 Percent," American Medical Association, 2017; Physicians Advocacy Institute, "Physician Practice Acquisition Study: National and Regional Employment Changes," October 2016.

2 Tait D. Shanafelt and John H. Noseworthy, "Executive Leadership and Physician Well-being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout," Mayo Clinic Proceedings, January 2017.

Key Board Takeaways

Board governance cannot happen in a vacuum. It's time to revisit board roles and responsibilities. Just as the board chair develops a relationship with the CEO, board members must take action and seek a greater understanding of the pressure doctors face day after day. The pressures are real, and if left unaddressed, can compromise the well-being and wreak havoc on your physician culture. Get to know physician leaders, from Chief of Staff to practice-level leaders. Leading change is hard. Host quarterly listening sessions, invite them to share perspectives with the board, and round at your practices to better understand their working environment. Getting to know and actively supporting these leaders will yield dividends.

Burnout is a symptom. Assessing provider well-being should be done annually and reported out to the board. Top-performing hospitals and health systems use this data as part of a comprehensive executive performance plan, viewing it no differently than other financial and operational performance benchmarks. Reviewing and acting on this data annually emphasizes your commitment to physician well-being.

Value-based work is quality work. Continuous process improvement is integral to primary care transformation. Holding practice teams accountable to this work should be approached with the same level of stewardship as any other quality effort. Boards should be routinely reviewing organizational progress toward stated annual goals.

An effective boardroom to bedside strategy must go beyond the hospital walls. It's time to look at primary care through a different lens. The expectation that primary care clinicians will take on even greater responsibility for management of patients across multiple domains is central to the "value proposition" of the Triple Aim and overall success in value-based arrangements. Team-based care is the new gold standard. Rural boards should be considering novel business relationships to remain competitive. Telemedicine, post-acute skilled care, and home health are key partners. A concerted effort must be made to engage and align efforts.

Dust off the community health needs assessment. We all recognize that social determinants have a real impact on overall health outcomes. Operationalizing an effective strategy will take a different approach. It's time we move beyond the community health needs assessment as a reporting obligation and instead view it as a community roadmap. Invite those invested in community well-being into your board meetings to explore optimal approaches. Housing authorities, transportation, food banks, and county health leaders need to work to avoid cross purposes and join forces. It will take a village.

redesign cross-departmental weaknesses. Clinicians need to formally be at the table helping drive strategy and implementing new care delivery models. Doing so reinvigorates a sense of contribution and control. Taking time away from patient care should not be a financial disincentive. Source this knowledge, protect this time, and reward appropriately.

2. **Return joy to the practice setting.** Lack of engagement and burnout are symptoms of system dysfunction. Contrary to popular belief, money is not the primary driver of happiness for physicians. Surveys repeatedly demonstrate that connecting with patients, intellectual stimulation, and community impact top the list of things that are most satisfying, while EMR, regulatory requirements, and loss of autonomy are the least satisfying.[3] Hospital leadership must recognize that successful recruitment and retention of primary care doctors committed to the community has much more to do with their *overall satisfaction in their practice environment.* As we all know, the bedside has been dramatically altered. About two-thirds of physicians indicate that the EHR detracts from patient interactions, and recent studies note that approximately 30 percent of the time spent with patients is in front of the computer. This equates to 23 percent of their total work hours. Identify and invest in the resources needed to offload and solve the most troubling clerical burdens that chip away at provider joy.
3. **Understand that you get what you reward.** If frontline physicians and providers are only compensated in an "eat what you kill" model, they will focus their efforts on maximizing patient volumes. Reward value-based work, such as the annual wellness visit and oversite of chronic care

3 *2018 Survey of America's Physicians Practice Patterns and Perspectives*, The Physician's Foundation, September 2018.

management. Guiding patient care plans and coordinating teams takes time. Perfection is deeply engrained in the way physicians think. Value-based care is a foreign language to most. Without formal training, most will avoid the risk of failure and not engage. Educate doctors, the board, and staff, and create a crystal-clear picture of what success looks like and what is expected of each person. Lean in, listen, involve, and iterate with doctors. Greater mastery and autonomy fuels innovation where you need it most. Revisit the organization's compensation philosophy and involve frontline physicians in the process. Recognizing and rewarding these efforts creates a cultural shift in the "way we do things," feeds purpose, and dramatically improves your likelihood of success.

4. **Ensure that primary care is no longer the task of one.** There is growing recognition that physicians cannot provide optimal care for all patients without the assistance of a team. Major recent clinical guidelines by AHA, ACC, CDC, USPSTF, and AHRQ recommend a multidisciplinary team to achieve desired outcomes. CMS has recognized that a physician-centric model of care will not work and is willing to pay care teams under indirect and direct supervision rules to provide critical wellness and between-visit care. Christine Sinsky, M.D., Vice President of Professional Satisfaction at the American Medical Association, and others have led the charge in recognizing that task delegation is critical to physician well-being. An investment in additional support staff for primary care is a win for physicians and patients, improving access and decreasing burnout.[4] Management should revisit policies and procedures to maximize the ability of their team to function "top of license" under a highly delegated model. Doing so represents a new margin opportunity with immediately available care coordination revenues as well as future success in risk-bearing arrangements.

5. **Resuscitate physician culture.** Physician culture has suffered many blows and professional isolation prevails. Organic opportunities to connect over patient care in the hospital hallways, doctor's lounge, or grand rounds have died away as fewer and fewer primary care clinicians provide continuous care in hospitals and nursing homes. Rural providers, with lack of immediate access to a group of peers, suffer the most. Busy physicians need opportunities to connect, commiserate, and occasionally collide over topics that matter most to them. Host regional grand rounds, invest in teleconferencing equipment with regional academic centers, invite in national speakers, or simply resurrect the physician lounge. These connections to a larger peer network matter now more than ever.

A lasting engagement strategy cannot be entirely transactional. It cannot be based on competitive market strategy. It cannot be coaxed with heavy-handed compliance efforts. It is the result of built relationships, founded in trust, and grounded in a shared purpose of better patient care.

4 Alexi Wright and Ingrid Katz, "Beyond Burnout—Redesigning Care to Restore Meaning and Sanity for Physicians," *New England Journal of Medicine*, January 25, 2018.

The Governance Institute thanks John Findley, M.D., CPE, ACO Medical Director, Caravan Health, for contributing this article. He can be reached at jfindley@caravanhealth.com.