Physician Engagement and Leadership for Health System Improvement

G. Ross Baker, IHPME, University of Toronto
Jean-Louis Denis, ENAP
and colleagues
9 May 2013
Physician engagement and leadership

• **Funder**: CIHR expedited synthesis grant

• **Sponsors**: Saskatchewan Health & Canadian Foundation for Healthcare Improvement

• Synthesis report completed in April 2013
Research team

• Jean-Louis Denis, Professeur titulaire, Ecole nationale d’administration publique (ENAP), Montréal
• G. Ross Baker, Professor of Health Policy, Management and Evaluation at the University of Toronto.
• Charlyn Black, Professor in the UBC School of Population and Public Health, and Associate Director of the UBC Centre for Health Services and Policy Research
• Bernard Lawless, Provincial Lead, Critical Care and Trauma, Ontario Ministry of Health and Long-Term Care and St. Michael’s Hospital, Toronto.
• Ann Langley, Professor of strategic management at HEC Montréal
• Diane Leblanc, Organizational psychologist, Capital District Health Authority,
• Charlotte Moore Hepburn, Hospital for Sick Children, Assistant Professor of Paediatrics, University of Toronto.
• Marie-Pascale Pomey, Associate Professor, Department of health administration at the Université de Montréal
• Maria Lusiani, Post-doctoral fellow, HEC Montréal.
• Ghislaine Tré, Post-doctoral fellow, St-Mary’s Hospital, Montreal
Motivating Question

Studies of health system change and quality improvement often cite physician leadership and physician engagement as critical factors contributing to the success or failure of change efforts.

But what factors or strategies determine whether physicians will be engaged in such changes?
Failing to engage doctors limits reform

“Whatever combination of approaches is used, there is a need to find ways of engaging front line staff in the process of reform.... [previous] reforms had not lived up to expectations because they had failed to make a real difference to the day to day decisions of front line staff. These ideas only really came to the fore in Lord Darzi’s next stage review, with the argument that reform should be driven locally and led by clinicians.”

Chris Ham, “Lessons from the past decade for future health reforms”, BMJ 2009
Medical Engagement and Performance

• In a study of NHS trusts, high performing organizations (based on Healthcare Commission ratings) reported 44% of doctors were engaged; lower performers reported only 15%.

• Most organizations saw “medical leadership” as the top 20 or so medical leaders in formal positions. But true engagement means attaining a strengthened contribution from all, rather than a potentially isolated few.

Clark, Spurgeon and Hamilton, 2008
Research questions

(1) What are effective levers (including remuneration schemes) for engaging physicians and forging an accountability relationship with the system to achieve better system performance and improved health outcomes for patients and the population generally?

(2) How can the influence of physicians be harnessed for leadership around quality improvement, organizational change and transformation?
Methodology

1. **Exploratory phase**: search to identify papers on physician leadership and physician engagement published between 1990 and 2012 in five databases: MEDLINE, Embase, Thomson Reuters (formerly ISI) Web of Science, ABI/INFORM and Sociological Abstracts: published works on the theme of physician leadership (n = 1,179) and on physician engagement (n = 679).

2. Papers were identified using search terms in six initial domains of inquiry: (1) High performing health care organisations, (2) Skills and competencies development for physician, (3) Quality and safety of care, (4) Patient centred care, (5) Health system reform, (6) Accountability health care organization.

3. Face-to-face meeting of the research team to assess the papers identified through the different domains based on a subset of 5 to 10 abstracts or papers rated as highly relevant within each initial domains. Based on this initial review the original domains were restructured to yield a new list of eight domains.
Domains of inquiry

I. High performing organizations
II. Quality and safety of care/quality improvement
III. Skills and competency development for physician leadership
IV. Patient-centered care
V. Health system reform/ transformation
VI. Physicians roles, identity and roles-conflict
VII. Physicians in organizations
VIII. Team effectiveness
Methodology

4. **Analysis phase.** Rating the new list of abstracts by pairs of research team members. Each member had an average of 150 articles to review and received a list of abstracts and a review form to rate them on a scale: (1) relevant, (2) marginally/possibly relevant, (3) not relevant, and (4) don’t know. In addition, raters had to indicate whether the articles also were related to other domains of inquiry.
<table>
<thead>
<tr>
<th>Domain of inquiry</th>
<th>Number of abstracts</th>
<th>Number of abstracts rated as relevant by at least one rater (i.e., single rating)</th>
<th>Percentage selected as relevant by at least one rating</th>
<th>Number of abstracts selected having a double relevance rating (and percentage of those with a single rating)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) High-performing organizations</td>
<td>86</td>
<td>30</td>
<td>34.9%</td>
<td>30 (100%)</td>
</tr>
<tr>
<td>2) Quality and safety of care</td>
<td>129</td>
<td>30</td>
<td>23.3%</td>
<td>23 (76.7%)</td>
</tr>
<tr>
<td>3) Skills and competencies development for physician leadership</td>
<td>168</td>
<td>38</td>
<td>22.6%</td>
<td>38 (100%)</td>
</tr>
<tr>
<td>4) Patient-centred care</td>
<td>100</td>
<td>46</td>
<td>46.0%</td>
<td>20 (43.5%)</td>
</tr>
<tr>
<td>5) Health system reform/transformation</td>
<td>121</td>
<td>77</td>
<td>63.6%</td>
<td>77 (100%)</td>
</tr>
<tr>
<td>6) Physician roles, identity and roles conflict</td>
<td>89</td>
<td>44</td>
<td>49.4%</td>
<td>44 (100%)</td>
</tr>
<tr>
<td>7) Physicians in organizations (+ACO)</td>
<td>151</td>
<td>83</td>
<td>55.0%</td>
<td>69 (83.1%)</td>
</tr>
<tr>
<td>8) Team effectiveness</td>
<td>71</td>
<td>46</td>
<td>64.8%</td>
<td>40 (87.0%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>915</strong></td>
<td><strong>394</strong></td>
<td><strong>43.1%</strong></td>
<td><strong>341 (86.6%)</strong></td>
</tr>
</tbody>
</table>
Methodology

5 - Research team analyzed 202 papers retained for this stage of the analysis. A subset of team members integrated the material.

6 - In addition, an intermediary analytical step was performed at mid-course of the review process to provide feedback to policy sponsors by means of a conference call.
Some Key Assumptions

• Health system changes and improvement at all levels require physician leadership and engagement

• As more doctors become directly involved in service change and innovation, performance and productivity will improve (Spurgeon et al. 2011; also see O’Sullivan, 2011; Merry, 1993)

• The influence of physician engagement on improvement is similar in different health care systems
  – An observation: There is not a well developed body of knowledge regarding physician leadership and engagement in Canada but literature from other jurisdictions provide valuable insights
Further Observations

• The literature on physician leadership and engagement is large, widely dispersed and variable in quality
• There are few empirical studies assess the physician-leadership hypothesis that healthcare organizations perform better when they are led by doctors (Dwyer, 2010)
• Physician leadership and engagement is a broader issue than having physician in CEO or in senior leadership position.
Definition: Physician engagement

• *Engagement* in a role “refers to one’s psychological presence in or focus on role activities and may be an important ingredient for effective role performance” (Rothbard, 2001: 656).

• Engagement incorporates identification with a role and commitment to a role.
  – Identification “represents the importance or salience of a role to an individual ..., whereas commitment represents the individual's attachment to a role .... Identification and commitment represent reasons why one might become psychologically present (*i.e.*, engaged) in a role.” Rothbard (2001: 657)
Definition: Physician leadership

- Leadership has been traditionally defined as a capacity of individuals in formal positions to influence the orientations of an organization or a group (Stogdill, 1948; Bennis & Nanus, 1985).
- While this view of leadership may be valuable, it is too restrictive and may not reflect the reality of leadership in health systems and organizations.
- Current conception of leadership suggest that leadership needs to be collective, shared, distributed or, in more general terms, "plural" (Denis, Langley, Sergi, 2012).
- For the purpose of this review, leadership consists of individual, collective and distributed efforts to engage physicians in improvement initiatives within health care organizations and health systems (Hartley and Bennington, 2011).
Leadership is necessary for broader physician engagement, while engagement refers to the active interest and participation of physicians in organizational and system change and improvement activities.
Three Critical Issues

1. How does health system evolution affect engagement and leadership of physicians for health system improvement?

2. How does organizational context facilitate physician engagement and leadership?

3. Which skills and competencies do physicians leaders need and how are these best developed?
I: How does health system evolution affect the engagement and leadership of physicians for health system improvement?
New Settings Create New Relationships

- The traditional view of physician – organization relationships is based on the tensions between professional practice and organizational pressures – much of the literature assumes the continuity of this tension
- But as physicians increasingly practice in organized settings (health care organizations, primary care groups, community practitioners linked to networks...) they accommodate to this situation and recognize that their practices are embedded in a broader context
- The traditional dichotomy between professional roles and organizations has yielded to organized professionalism and different patterns of engagement
- New approaches to leadership and leadership roles have evolved in concert with new educational opportunities that restructure relationships (Noordegraaff)
Primary Focus on Structures

• Various strategies can be used to integrate physicians more formally in the governance and management of health care organizations and systems
  – Involvement on the board
  – Formal executive or senior leadership positions
  – In dedicated formal structures (e.g., quality councils) to support quality and safety of care

• The interest in hybrid (joint medical-administrative) leadership continues, but there is increasing interest in developing integrated leadership structures
Structural Reforms are Insufficient

• To overcome the gulf between physician groups and hospital leadership, leading systems in the US and UK began in the 1970s to create matrix, program management and other “hybrid structures”
  – These new structures provided physician input to unit level decisions around budgeting and the organization of care
  – Local management groups were dyads or triads with nursing and administrative leaders
• There is little evidence that these structures overcame the cultural divide or improved performance
Are Structural Integration and Incentives Sufficient?

• The literature suggests that the incorporation of physicians into organizational structures/context is a necessary step, but on its own, this step is insufficient for engaging physicians in the redesign of health care processes and system improvement.

• Economic integration and economic incentives to involve physicians in health system improvement may play a supportive role but do not by themselves create genuine physician engagement and leadership for health system.

• These steps may create better accommodation, but not true engagement.
Integrated Leadership is More Challenging

“Most of the themes represent structural components of health care systems and are relatively easily implemented with the support of leaders. The complex “process” component of developing good leadership is more challenging, but there are many resources available that address the development of leadership skills. It is through the development of these skills that organizations will be able to effect and lead much needed change.” (Bradley, 2006)
Key Questions

• How can leaders convert physician autonomy, knowledge/expertise and power into resources for health system performance and improvement?
• What strategies and levers help to initiate and support physician leadership and engagement?
• To what extent are new structures necessary and sufficient?
II- How does organizational context facilitate physician engagement and leadership?
Analytical Strategy

• To explore the processes of physician engagement and leadership, we compare organizations identified as high performing, with lower performing organizations, and, in particular examine the role of physicians in quality improvement initiatives.
Four core process and organizational mechanisms for physician engagement and leadership

• Physician compact: Working on group norms and on the renewal of the social contract between physicians and organizations (O’Hare & Kurdle, 2007)

• Creating a receptive and/or facilitative organizational context: For example developing effective Microsystems at the point of care (Bohmer, 2011, 2012; Nelson, Batalden, Godfrey, 2007)


• Team-based organizations and “teamness”: reorganizing the work needed to lead and achieve improvement in cross disciplinary contexts (Lammers et al. 1996; Shumway 2004; Yen-Ju Lin et al., 2011)
In his recent discussion on the habits of high-performing clinical systems by Bohmer (2012) argues that “leaders at the lowest level of delivery organizations, where clinicians and patients interact, have control over a set of organizational levers that have been shown to have a meaningful impact on both intermediate medical outcomes (e.g., error rates) and terminal outcomes (e.g., readmission and mortality rates)”
Four habits of high-value healthcare organizations

• *Specification and planning*, including the management of specific subgroups of patients

• The *design of specific infrastructure* (e.g. staff, information, technology) to match the needs of subpopulations

• The *capacity to properly monitor* and provide oversight through process and outcome measures of care

• *Strong knowledge management* to learn from positive and negative deviations in outcomes and care  
  
  (Bohmer, 2011)
Creating an Integrative Approach

• Caldwell, Chapman et al (2008) report on a study of leadership and strategic change in a large physician organization in the western US (likely Kaiser Permanente) where the authors carried out interviews and collect surveys.

• Two broad conclusions that can be drawn from their findings:
  – First, intangible factors such as support for a new strategy, group norms, and leaders’ actions can influence implementation.
  – Second, the effects of these social processes are primarily interactive.
Leadership and Engagement are Overlapping and Reinforcing

• In these high-performing clinical systems the distinction between physician engagement and leadership begins to blur
  – Engaged clinical leaders within these systems get involved to create the conditions for broader physician engagement for improvement
  – Developing a cohort of engaged physicians creates a talent pool for leadership
Layer Accountability and Incentives

• Broader system and organizational elements (incentives, organizational norms/culture, performance management and accountability...) may play a supportive role in the development of high-performing clinical systems

• But physicians as leaders and team members play a critical role in the implementation of such system.

• These systems emerge slowly over time and are difficult to implement
III - Which skills and competencies do physician leaders need and how are these best developed?
Core competencies of physician leaders

- Leadership,
- Strategic planning,
- “Systems thinking”
- Change management
- Project management
- Persuasive communication (including negotiation and conflict resolution)
- Team building
Leadership Training is Insufficient

• Growing number of physician leadership programs along with expectations of their positive impact on hospital performance.

• Results from surveys and from informed experience indicate that managerial training is one important factor that predicts physician leader success (Williams & Ewell, 1997),

• However, managerial training on its own is not sufficient (Kindig, 1997), as other factors, such as clinical experience, building credibility and trust, and working collegially and not individualistically (Kusy et al., 1995) also appear to be critical
Key Themes

- Need to shift educational and organizational supports
  - Most leadership competencies require training in some capacity beyond that currently included in medical school curricula or post graduate specialty training.
  - CME training does not facilitate the very important inter-professional team-building necessary to facilitate health system change (Barratt et al, 2010; Schwartz et al. 2000)
  - Most papers assume the existence of tensions between managerial values and professional values which suggests that contexts that support and recognize the role and importance of physician leaders may be a crucial element in developing broader organizational and system roles
Key Themes

• The engagement of physicians in leadership roles is not a linear process, but an emergent, evolutionary one, that takes longer adaptation times than the speed of introduction of formal changes by organizations (Hoff, 2003).

• The development of physician leaders can be undermined by serious role and identity conflicts --by the need for physician leaders to assimilate and integrate undefined or seemingly competing values.

• This complex identity work has consequences in terms of social relations too: physician leaders’ work is characterized by little cohesiveness and fragmented solidarity, distrust and game playing, as opposed to the ideal typical collegiality of the medical profession.
Key Themes

• Overall, the strongest general learning that emerges from this pool of work taken collectively is that, because of the major ‘cultural problems’ posed by management-professional tensions, formal solutions (such as the establishment of physician leaders roles) do not automatically translate into a greater physician engagement.

• The key challenge is *to bridge cultures*. In other words, the establishment of physician leader roles and positions must be accompanied by careful “cultural work”.
Conclusions

• The literature reviewed in this synthesis suggests growing knowledge about the dynamics of physician engagement and leadership for health system improvement
• Creating effective leadership and engagement is not a matter of restructuring or economic incentives alone
• A complex cluster of elements that combines serious structural, cultural and operational work (real improvement initiatives and support at the clinical level) may facilitate changing norms of engagement and views of leadership within the medical profession
• A second key finding from this review is that the development and maintenance of trust between the medical profession and organizations and the system appears fundamental to support the transformational changes required
• Strategies are needed at the individual, organizational and system level to support improved physician engagement and leadership
• Full report available at
  – http://www.getoss.enap.ca(GETOSS/Publications/
    Lists/Publications/Attachments/438/Expedited_Syn
    thesis_CIHR_2013-04-10-Final.pdf