Cleveland Regional Medical Center

Physician-Hospital Relationship: Strategic Vision and Relationship Model

Leader*Shift*® I Retreat

Pine Crest Inn, Tryon, NC

September 9-10, 2006

Andrew Epstein, MD

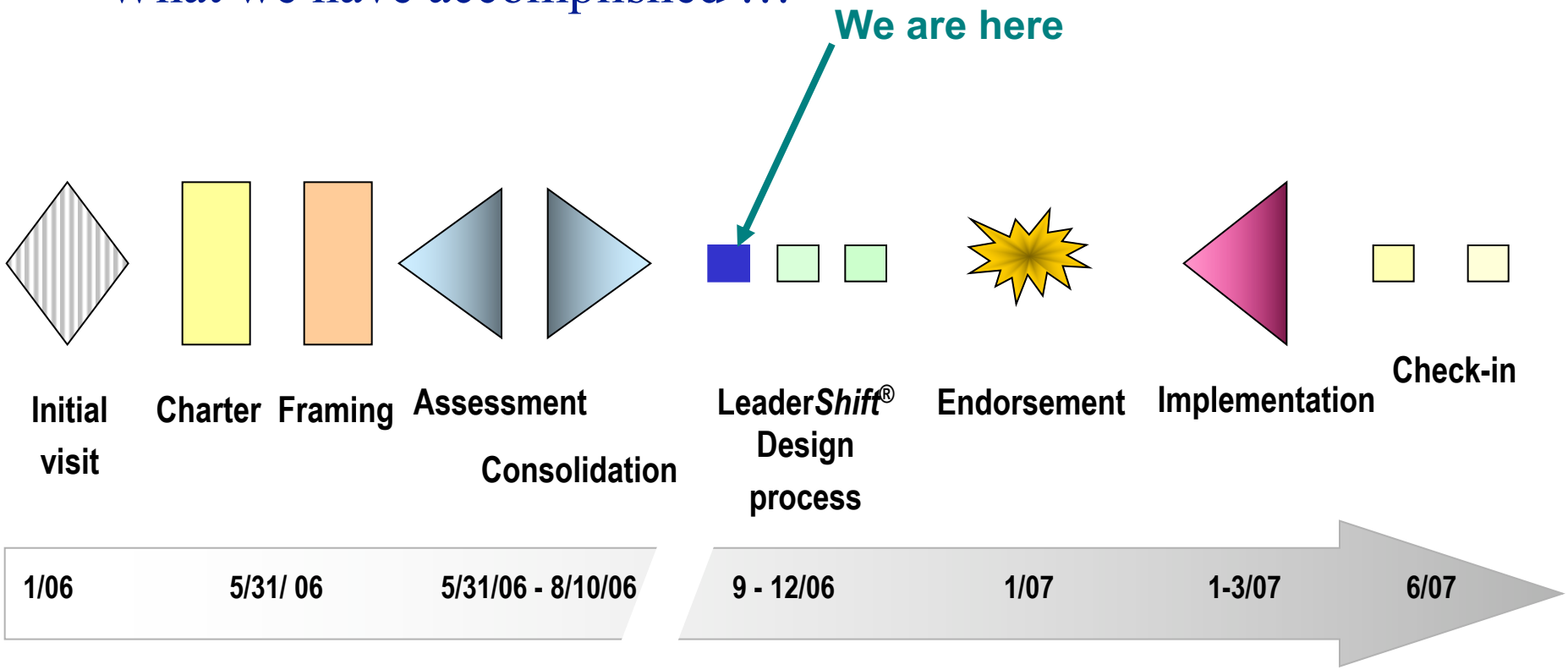
Judith Rich, RN MSN

Rachel Steele, MEd

theBARDgroup

Engagement timeframe

What we have accomplished …



and where we are going …

Meeting objectives

Day One

- Welcome, introduction, and update
- Develop a shared vision
- Present and analyze models

Day Two

- Review analysis, select, and develop model
- Define and commit to next steps

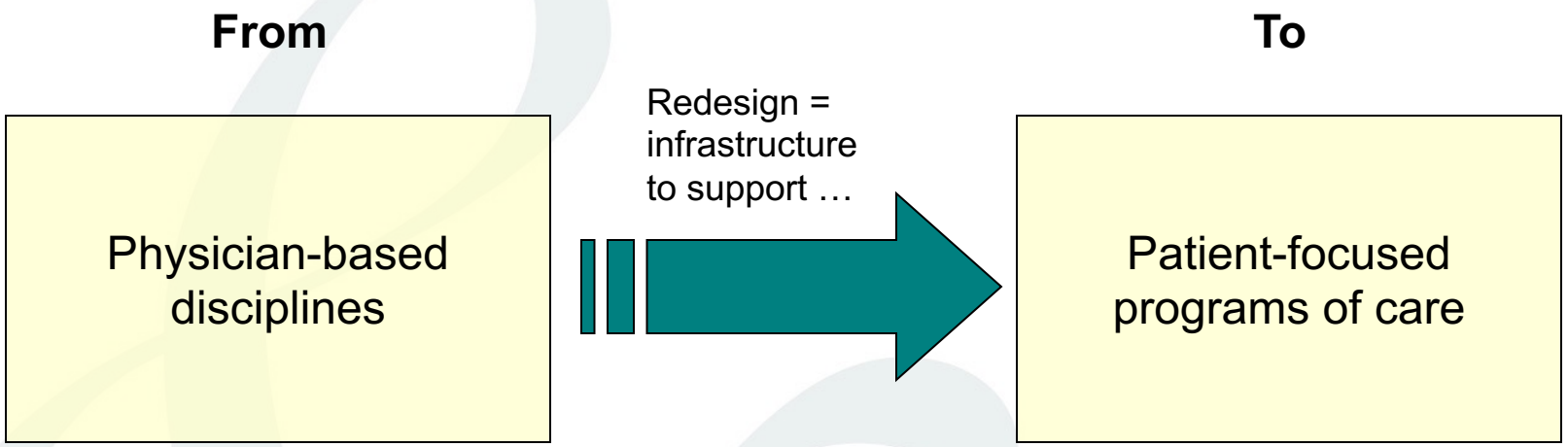
Meeting Agenda CRMC

Agenda item	Objective
Day One	
Welcome, introduction, and update	▪ Outline the context of our work—a look forward ▪ Update all about new developments
Develop a shared vision	▪ Why redesign? ▪ Opportunities and threats ▪ Commit to shared goals, finalize vision
Present and analyze models	▪ Review physician/hospital relationship models and assess in relation to the vision
Day Two **Review analysis and select model (or hybrid)**	▪ Finalize the model ▪ Identify questions to be answered, including the role of a CMO ▪ Review potential issues and concerns that may be raised by stakeholders
Define and commit to next steps	▪ Review next steps and timeline including selection of Implementation Team members ▪ Discuss critical success factors in organizational change ▪ Discuss work to be done next

Opening comments and updates

Framing our work

Nationally, we're seeing a shift …



Framing our work

And …

From

Quality as a property of individuals

Redesign = infrastructure to support …

To

Quality as a property of systems, starting with individual excellence

There are profound implications for medical staff and physician-hospital relationships. We recommend that you redesign for tomorrow, not yesterday.

Updates

What has happened or changed since our last visit that might impact our work?

Project context review

As a result of the ultimate redesign …

Today we are focusing on the long-term benefits …

- Short-term benefits will be …
  - Physicians accept that "the new way of being" is better for today's environment
  - Physicians are more engaged and experience increased ownership
- **Long-term benefits will be …**
  - **Demonstrated improvement in quality and safety of patient care, financial performance for physicians and the Medical Center, education and research, and patient and physician satisfaction and loyalty**
  - **Improved reputation and position for CRMC in the System, the market, and the nation**

Physician-Hospital Integration Strategies

Define Future State

- Obtain a clear understanding of the organization's mission, vision, and core values

Assess Current State

- Assess the gap between the current state of the organization and its vision
- Determine organization risks and readiness for change
- Determine which investments will make the most impact

Design Future State

- Develop future state operating model required to realize picture of the future and identify required change initiatives

Develop Change Agenda & Roadmap

- Ensure that all stakeholders understand the change agenda as well as their role in the achieving the vision
- Develop a roadmap for change and the plan on how the change will be managed and measured

Support Transition

- The goal of implementation support is to accelerate and optimize the transformation process by developing leaders, assessing performance, and making modification to design and/or roadmap

Developing a shared vision

Developing a vision

Redesign for the sake of what …

- We don't want to solve for today's reality, we want to look ahead and design for the tomorrow …
  - What do you want future reality to be, not tactical state of physician practices
  - Based on interviews and our research we developed a Picture of the Future, or "straw man" for your review and discussion …

Developing a vision

We based the Picture of the Future on the following questions …

- What is nature of the hospital, its position in the system and region?
- What is your local, regional, and nation reputation?
- How is your clinical quality and patient safety compared to other hospitals?
- Where are you leading edge?
- What is the draw for patients?
- What is the draw for physicians—why do they want to work here?
- What is your financial position and sustainability?

Developing a vision

When you read the Picture of the Future, remember …

Any hospital can be the best hospital in America …

Discussion and refinement

Break into three groups to identify the following …

- Please discuss the following questions
  - What is most appealing? (Top five areas)
  - What is less important or incorrect? (Top five areas)
  - What critical important element is missing?
- Select a group leader
  - Capture the group's thinking on a flipchart
  - Present your group's thinking

We will then discuss team outcomes with the larger group …

Physician-Hospital Relationship Models

What is a model?

A model is …

- A preliminary work or construction that serves as a plan from which a final product is to be made: *a clay model ready for casting*
- A schematic description of a system, theory, or phenomenon that accounts for its known or inferred properties and may be used for further study of its characteristics: *a model of generative grammar; a model of an atom; an economic model*

Or in this case …

- A description of the relationships between and among entities including responsibilities for decision-making, accountability, and control

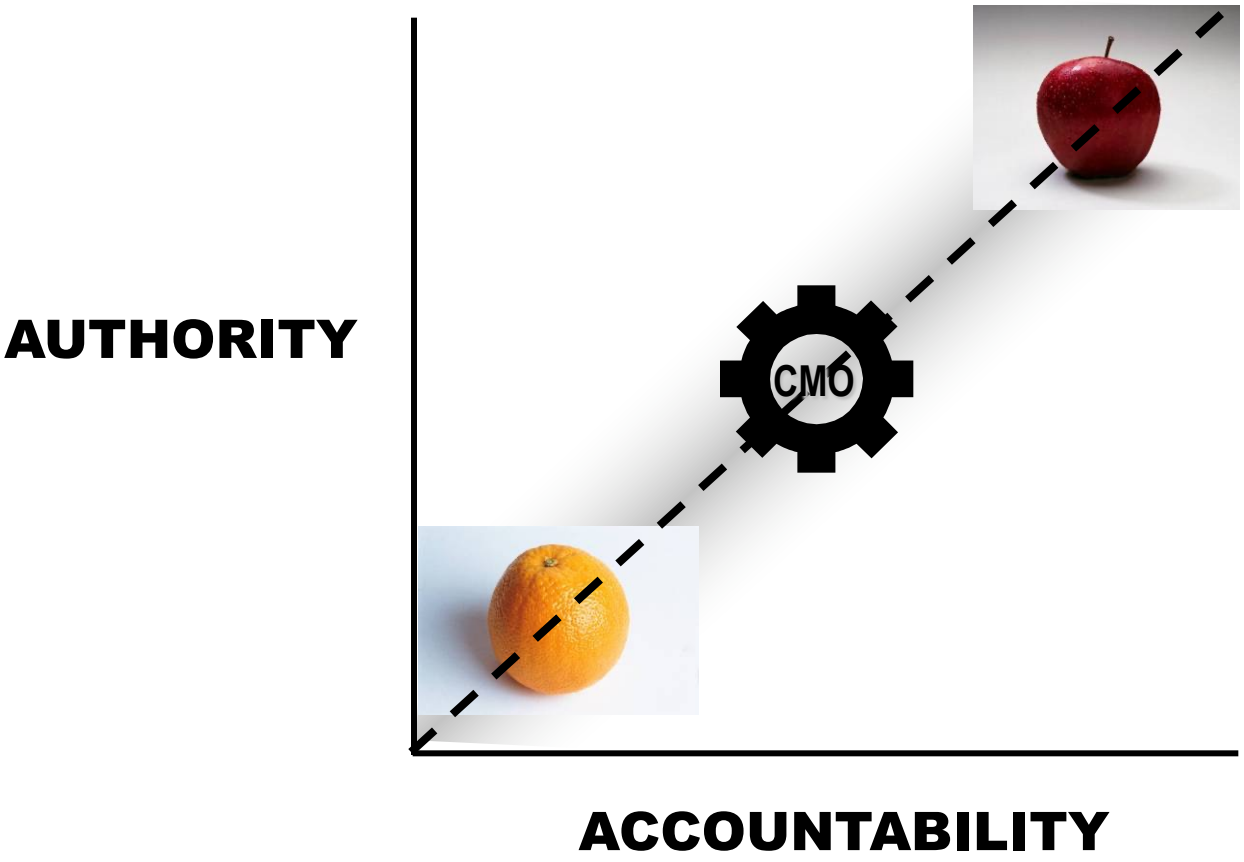
What's the *right* model?

It all depends on what you want to achieve: your vision, your goals and your strategies

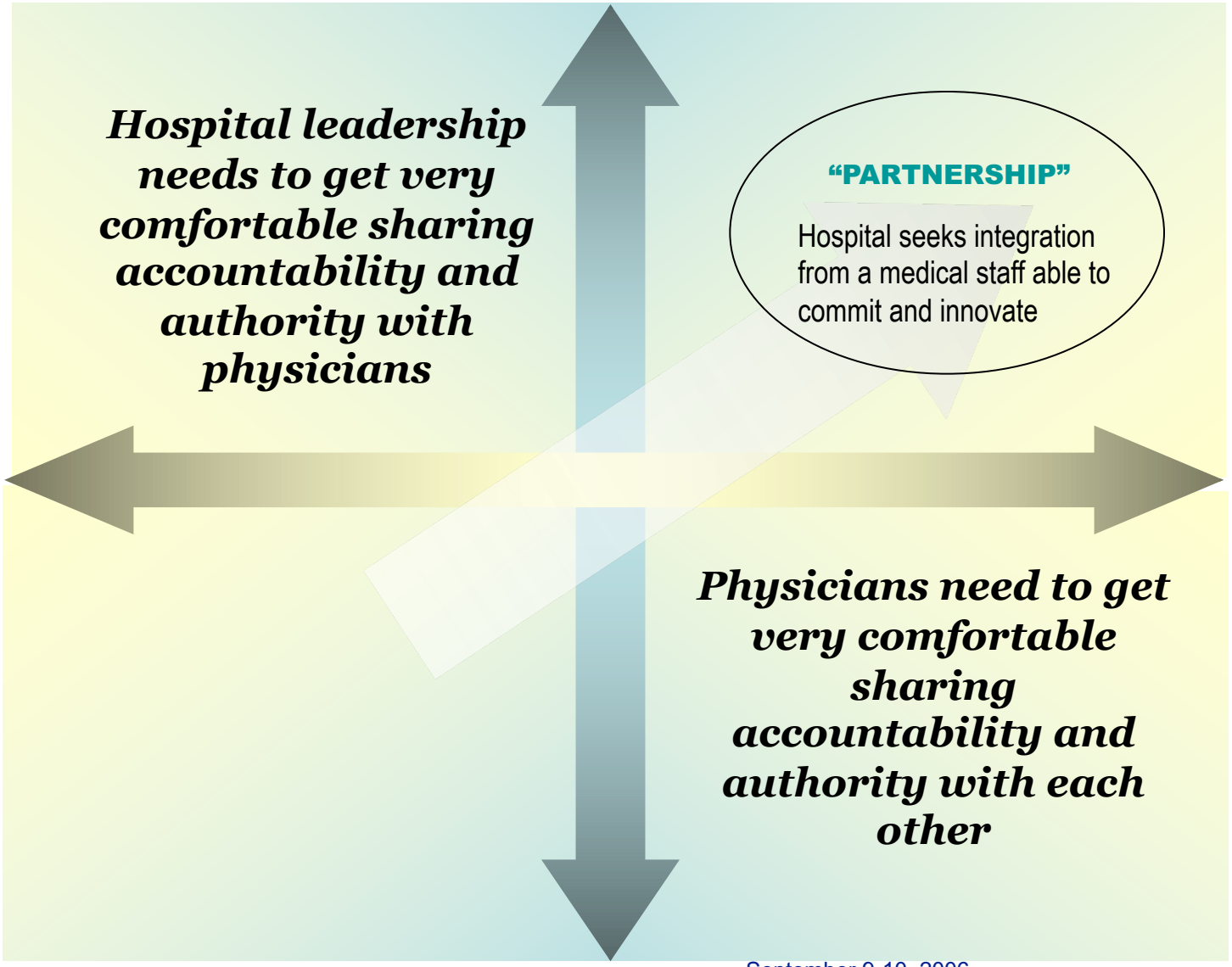
- There is no "right" model
- The "best model" is contextual
  - The nature of the situation
  - The interests of the participants
  - The locus of leadership effectiveness
  - The possibilities created by the "DOS"

} The four critical factors

Success requires a critical balance



Many hospitals and medical staffs are evolving



Redesign process

Today we will be assessing the benefits and limitations of three models in relation to the vision …

The models you will begin to review today describe:

- The relationships between entities (the physicians and the Hospital) and within each entity (the Medical Staff and Hospital) that confer responsibility for decision-making, accountability, and control

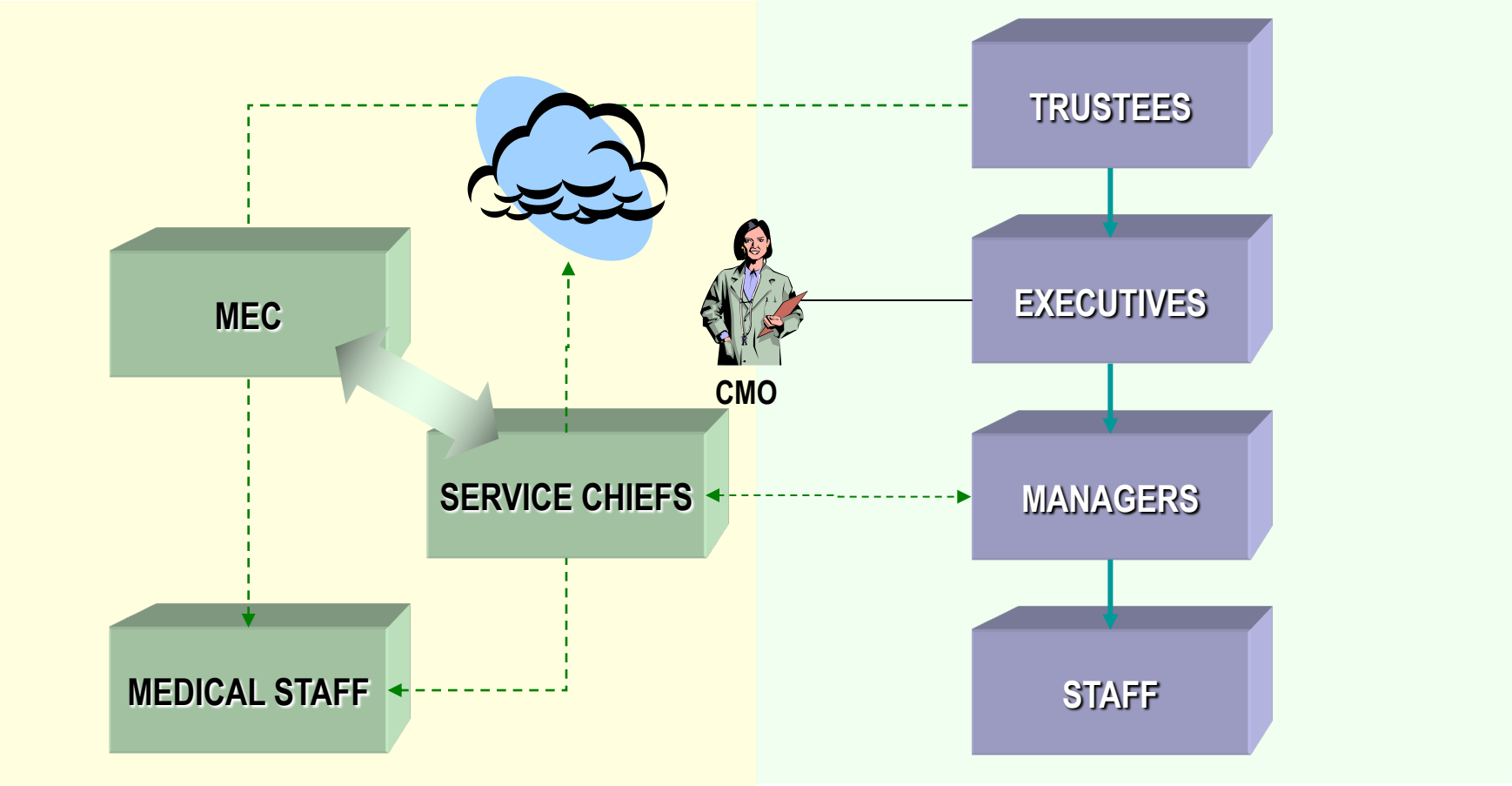
The models will help you choose the one (or hybrid) that:

- Allows each party to have control, manage accountability, and have decision-making authority over things that matter and enable you to achieve the vision

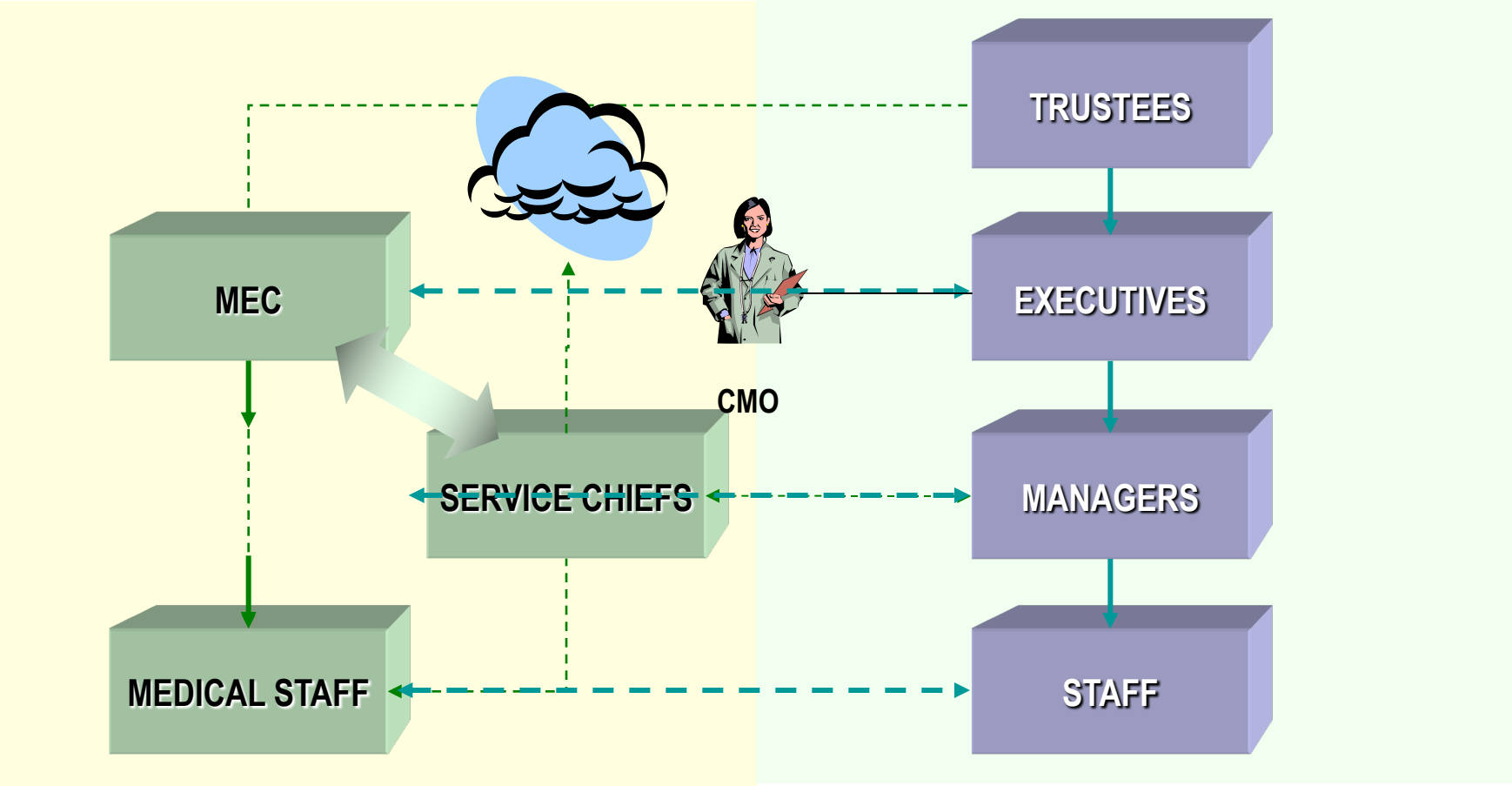
Three models of physician-hospital relationships …

- **Enhanced Traditional Model**
  - Accountable management relationships
- **Integrated Management Model**
  - Functional clinical management partnership
- **Physician Organization Model**
  - Structural and strategic partnership

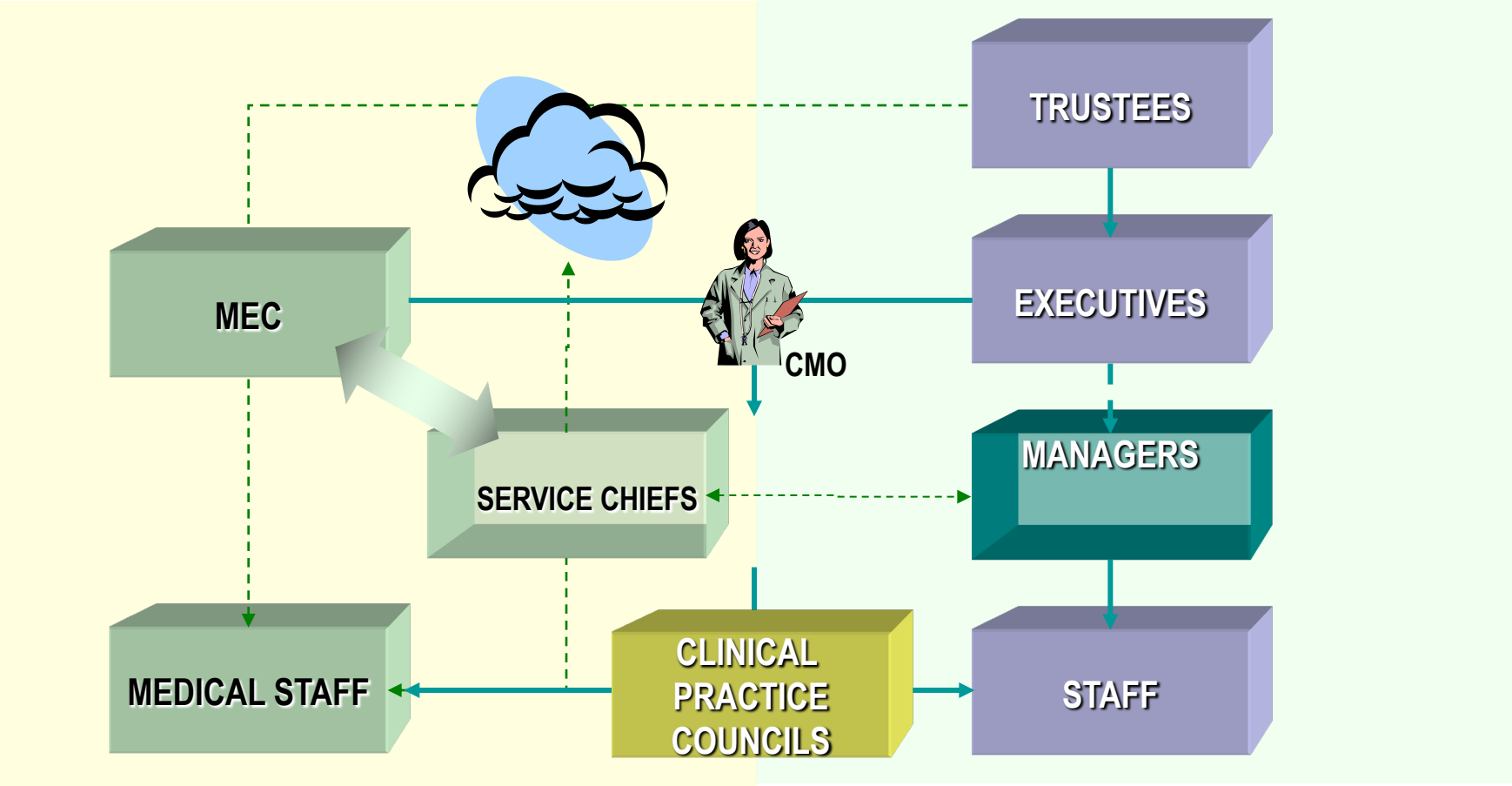
Physician governance model: Independent Traditional



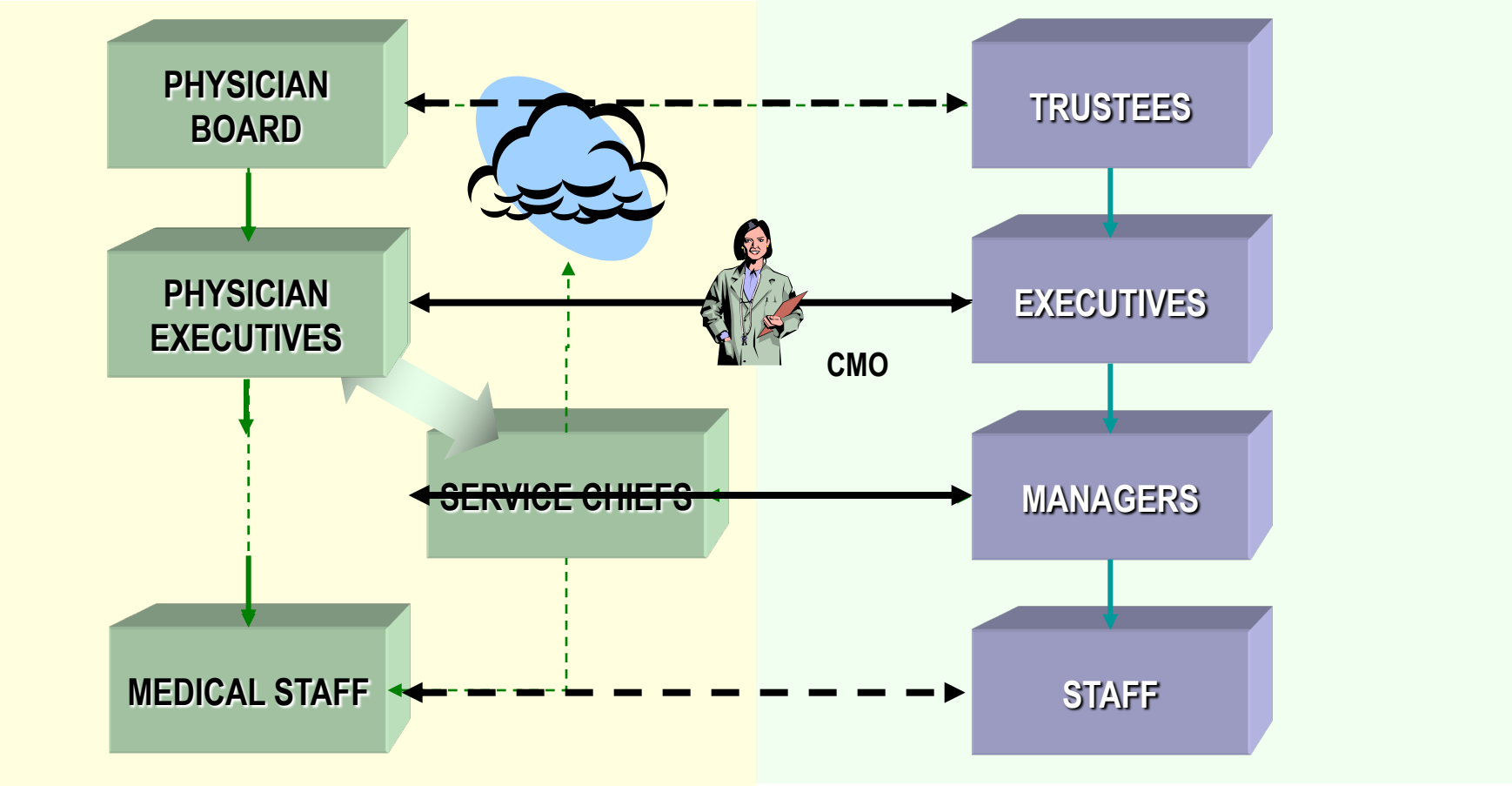
Physician governance ➡ physician management



Integrated Management Model: **Functional** partnership



Physician Organization Model: **Structural** partnership



Three hospitals—three solutions

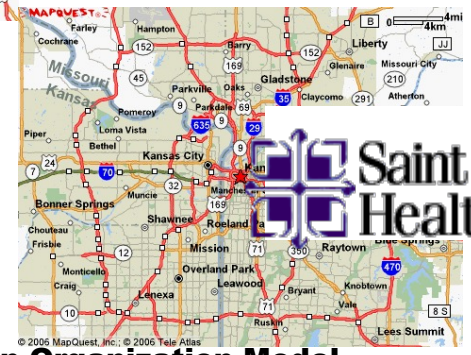
Each was in response to its own unique circumstances

BAYLOR Health Care System

Enhanced Traditional Model

Riverside Methodist Hospital
OhioHealth

Integrated Management Model



Saint Luke's Health System

Physician Organization Model

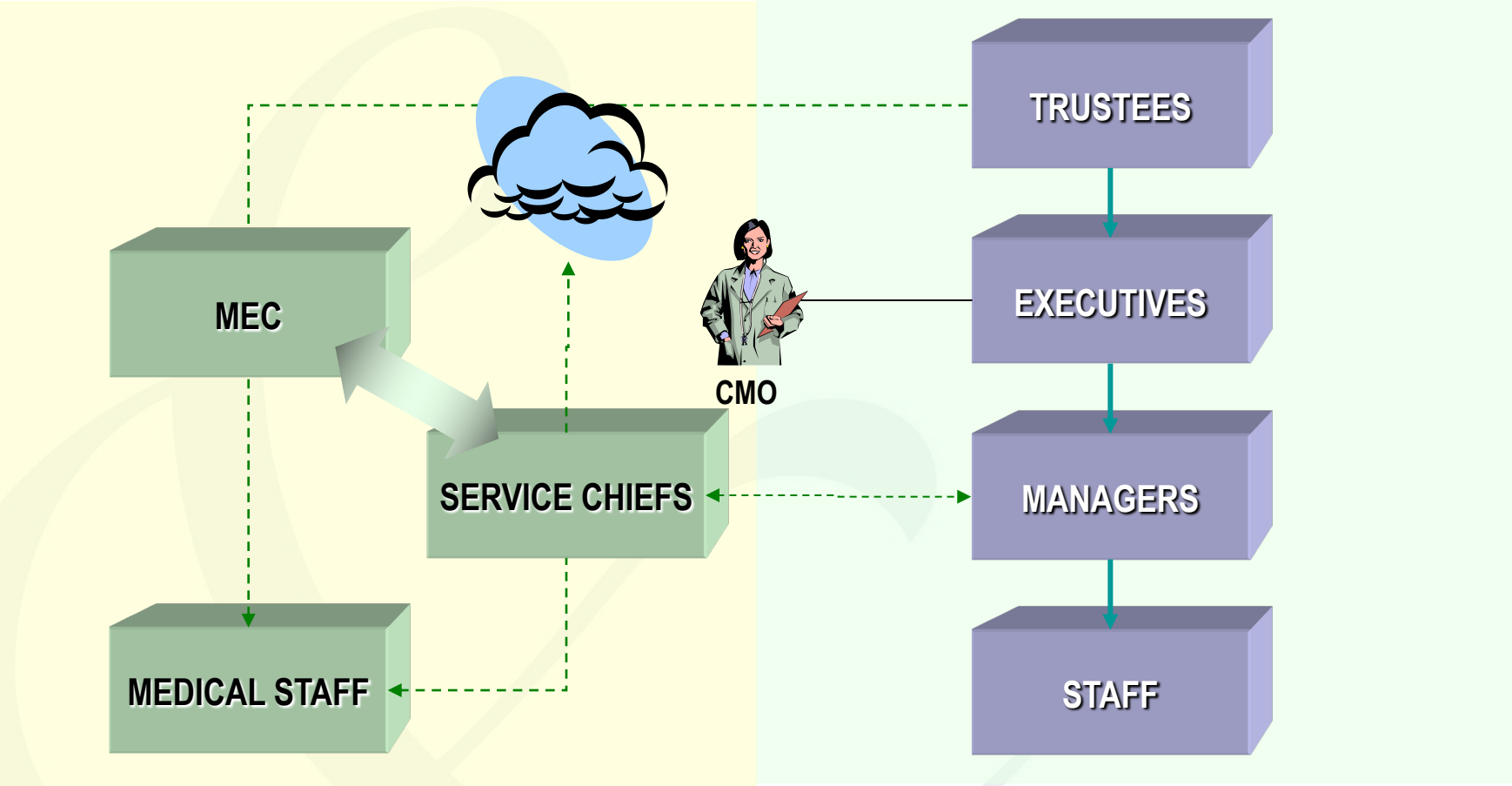
Discussion and refinement

Break into three groups to identify the following …

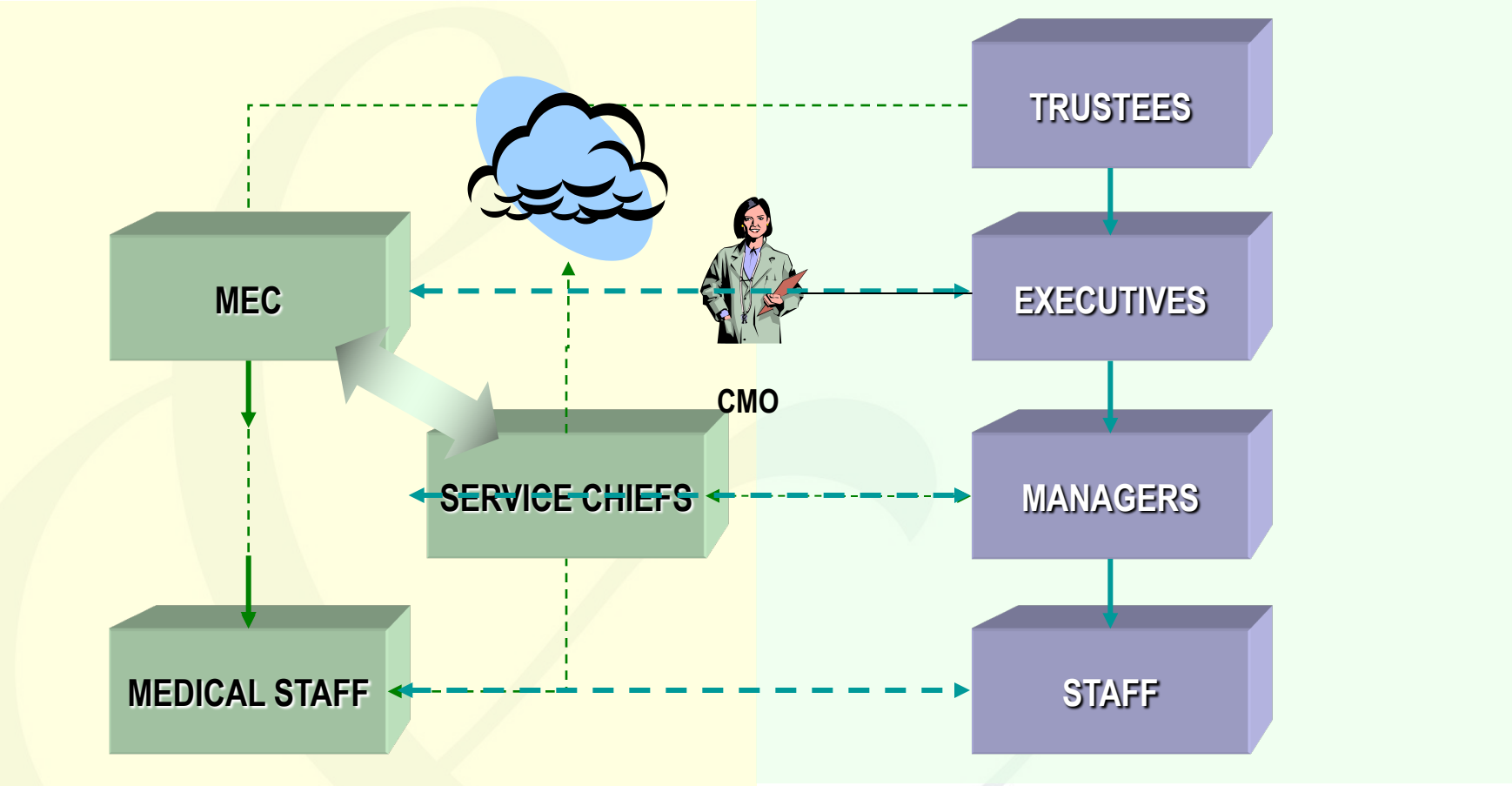
- Analyze each model with respect to the vision
  - What appear to be each model's strengths?
  - What appear to be each model's limitations?
- Select a group leader
  - Capture the group's thinking on a flipchart
  - Present your group's thinking

We will discuss team outcomes with the larger group …

Physician governance model: Independent Traditional



Physician governance ➡ physician management

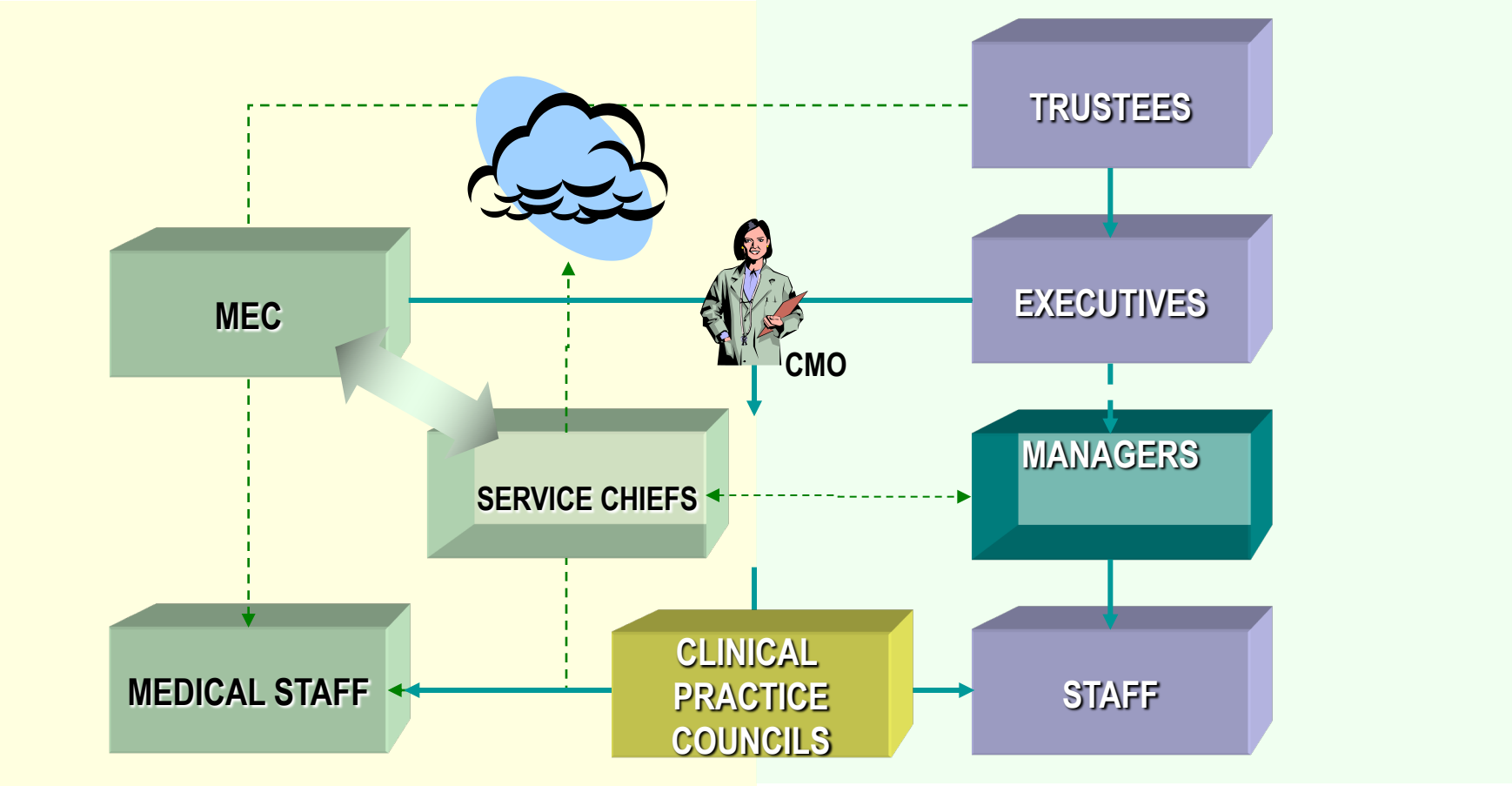


Redesign discussion: Independent Traditional model

What are the benefits and limitations of this model in relation to the vision?

Benefits	Limitations

Integrated Management Model: **Functional** partnership

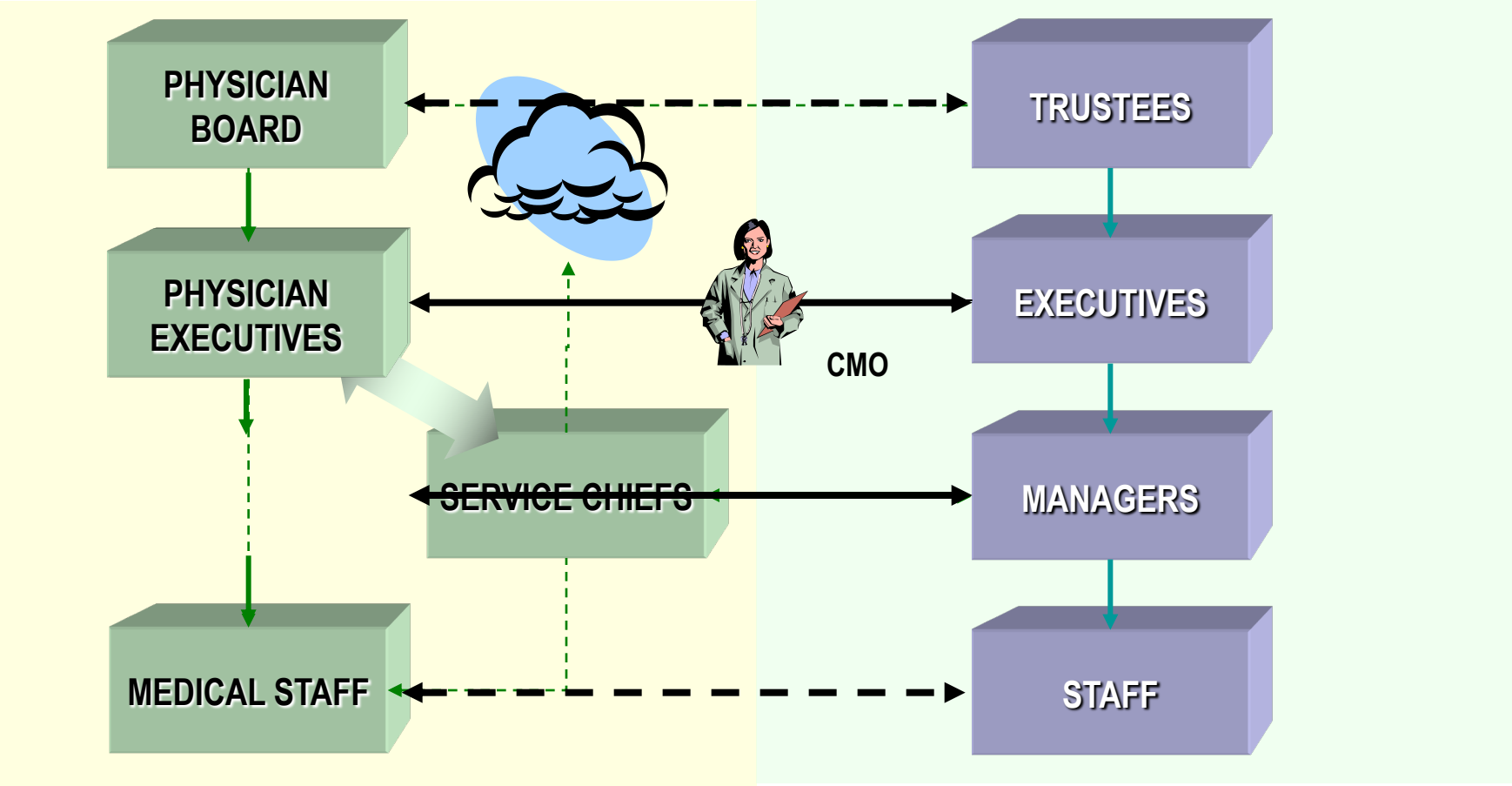


Redesign discussion: Functional partnership

What are the benefits and limitations of this model in relation to the vision?

Benefits	Limitations

Physician Organization Model: **Structural** partnership



Redesign discussion: Structural partnership

What are the benefits and limitations of this model in relation to the vision?

Benefits	Limitations

Redesign process

Discussion ...

- Group presentations and discussion
- What strikes you as being most supportive of solving today's problems and preparing the foundation for tomorrow's vision?

Day Two

Today's agenda

Model and implications

- Review yesterday's analysis and select model (or hybrid)
- Identify questions to be answered, including the role of a CMO
- Review potential issues and concerns that may be raised by stakeholders

Define and commit to next steps

- Review engagement next steps and timeline including selection of Implementation Team members
- Discuss critical success factors in organizational change
- Discuss work to be done next

Model comparisons

Compilation of benefits and limitations of all models; which model stands out? Can we agree upon developing this model further?

Benefits	Limitations

Validity testing–1

To ensure all understand and can discuss the agreed upon model with others, we must conceptualize and have answers to the following questions concerning the new model:

Physician:

- How could the new medical staff governance structure support decision-making with buy-in from physicians?
- What are the implications for physician leadership roles? The CMO? Chairs?

Physician-Hospital:

- What is the impact of the model on alignment of physician and hospital goals?
- What are the implications for accountability and authority between administration and the medical staff?

Structure and function:

- How would the new model stop the work-arounds that have developed in quality?
- Have we addressed the lessons learned from the ED Task Force and Surgical Leadership teams?

Validity testing–2

To what degree would the SWOT issues be addressed by this model? What would it take?

For each of the SWOT slides, we will ask how the new model relates to our findings and what it would take to ensure *strengths* are preserved or leveraged, *weaknesses* are reduced or surmounted , *opportunities* are pursued, and *threats* are mitigated…

Validity testing—SWOT

Strengths identified in assessment	Are CRMC's strengths preserved or leveraged in this model? If not, how could they be?
Commitment of hospital leaders and physicians to improve quality and serve the community	
Loyalty to CRMC which supports a bold leadership role in redesigning the future relationships	
Success in Surgical Leadership and ED Task Force proves that change is possible	
The vacant CMO position provides an opportunity to define and fill the role with a person ideally suited for the future	

Validity testing—SWOT

Weaknesses identified in assessment	Will CRMC's weaknesses be reduced or surmounted in this model? If not, how could they be?
Historically, the medical staff has been minimally involved in hospital strategy and operations	
Unclear medical leadership roles and authority	
Decision-making processes, including Quality, are outside the formal medical staff governance structure	
The size of the hospital is conducive to "sidewalk" information which can be inaccurate	

Validity testing—SWOT

Opportunities identified in assessment	Are CRMC's Opportunities pursued to their best advantage by this model? If not, how could they be?
The commitment of hospital leaders and physicians to improve quality and align goals is a foundation for a shared vision	
The vacant CMO position provides an opportunity to define the role and fill with a person ideally suited for the future	

Validity testing—SWOT

Threats identified in assessment	Are CRMC's Threats mitigated by this model? If not, how could they be?
External threats Competition for patients from Gastonia and other local hospitals	
The growing problem of the self-pay and uninsured patients and their impact on physician and hospital financial success	
Internal threats Apparently competing goals make physician-hospital alignment more difficult	
Perceived "imbalance of power" between nursing and medical staff can impair operations and create internal focus	

Addressing the model's limitations

What are the chosen model's limitations?	How will these limitations be addressed?

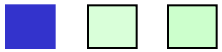
Plan to address model limitations

No model will result in instant approval by all; what issues or concerns will be raised and how will you address feedback from …

Stakeholders	Issues or concerns	Responses
Chairs		
MEC		
Medical staff		
Administration		
Trustees		
Other		

Next steps

Choosing the Implementation Team: What is it?



Leader*Shift*®
Design process

- **Purpose:** Provide a ***work plan*** for medical staff redesign; ensure stakeholders are at the table when developing new model
- **Commitment:** Four 3-4 hour meetings and critical follow-up after each
- **Engagement:** Feedback following each meeting
- **Process:** The team will take the agreed upon model and develop an implementation plan to bring to the steering committee
- **Support:** The team will have the support of consultants and be led by a carefully scripted process, workbook of tools, and models; client PM may also provide support as needed
- **Added value:** Team members will also receive leadership development training and tools

Implementation Team members' criteria

We recommend the following criteria for choosing Implementation Team members …

- The teams should consist of 8-12 members
  - A core from the Steering Committee plus carefully selected others
- We propose two Implementation Teams
  - One for Governance and one for Management & Operations
- New members should be selected based on principles proposed
- The Implementation Team should include:
  - The next generation of leaders
  - Representatives of all stakeholders (management, customers, peers)
- Team members must fulfill their responsibilities
  - Communicate outcomes and gather input effectively

Principles for Implementation Team selection

Implementation Team members should be individuals with the following current or potential capabilities …

- Seen as respected, communicative, creative, flexible, trusted
- Have influence and/or authority, credibility, charisma, political "clout"
- Include respected "opposition" to gain their input and ultimate support
- Provide diverse and complementary perspectives
- Reach beyond the expertise of SC members
- Demonstrate commitment, creativity, collaboration, expertise, experience
- Savvy about data and information, processes, capabilities, know peer needs
- Can and will commit time and will attend and participate reliably

Principles for selecting Implementation Team members

Successful Implementation Team principles identified by the Steering Committee to consider when creating Implementation teams …

- Invite all stakeholders–people at the table "own it"
- Set the stage up front–outline purpose, set and prioritize an agenda
- Resolutions are quick–pilot and monitor solutions
- Meetings are too important to miss
- Need strong leadership on both sides, hold each other accountable
- Poor behavior is not tolerated
- Explore root causes, address issues, allow structured venting
- Share minutes, provide administrative support, advance buy-in of agenda

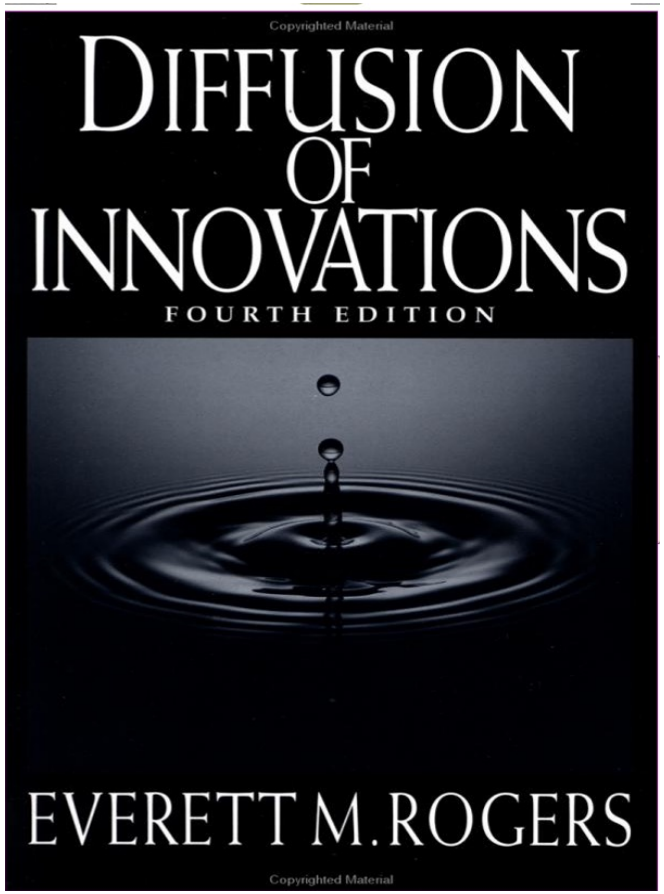
Communication and commitment

We are reaching the point in the engagement when this group will be counted on to vet information and complete intersession work …

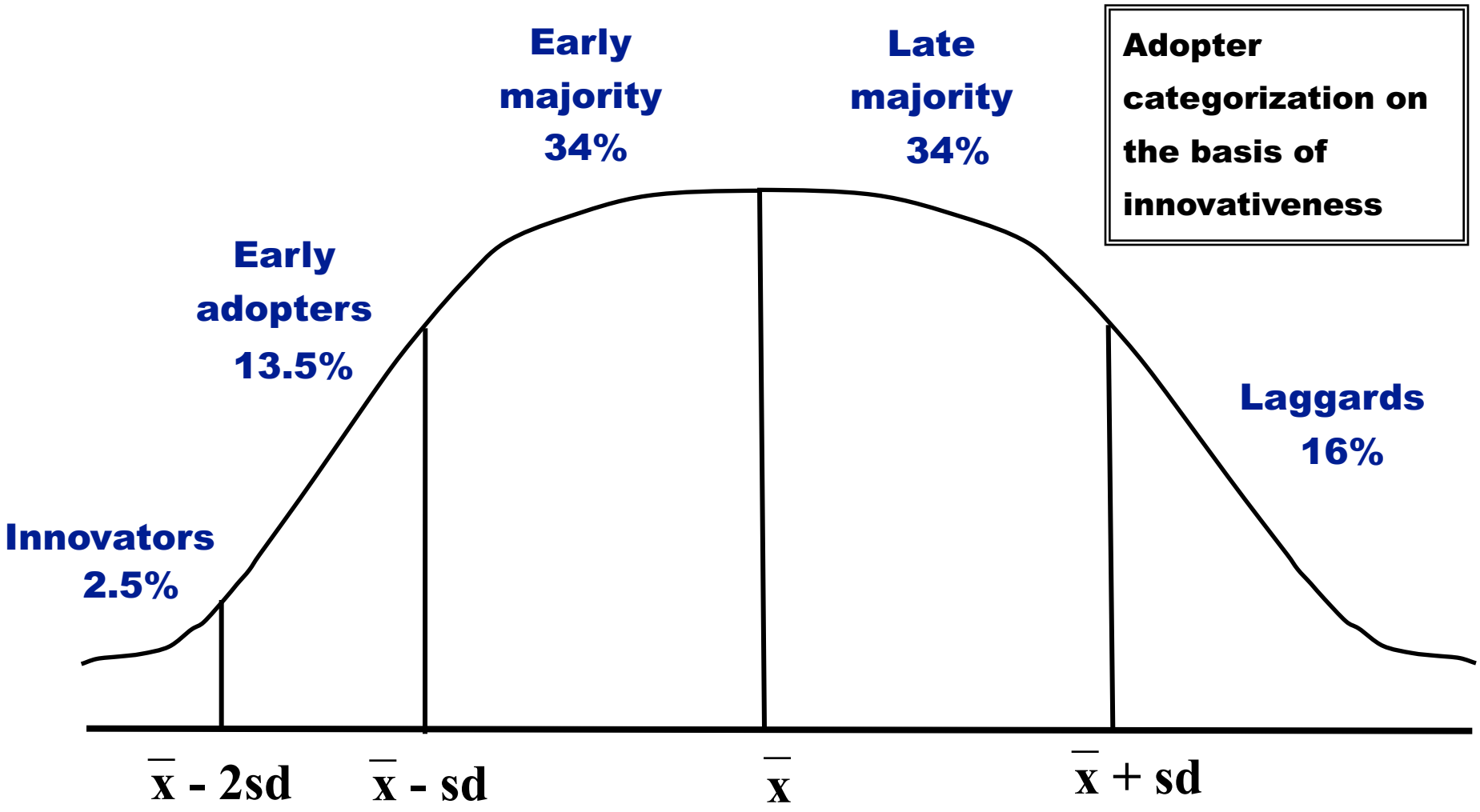
- It is important that we are all clear on what needs to happen to ensure project success and how those requirements translate into expectations of this group
- First we will review some relevant concepts about dissemination of innovation…
- Then we will review upcoming milestones and expectations of this group …

Diffusion of Innovations

The classic work on the spread of innovation



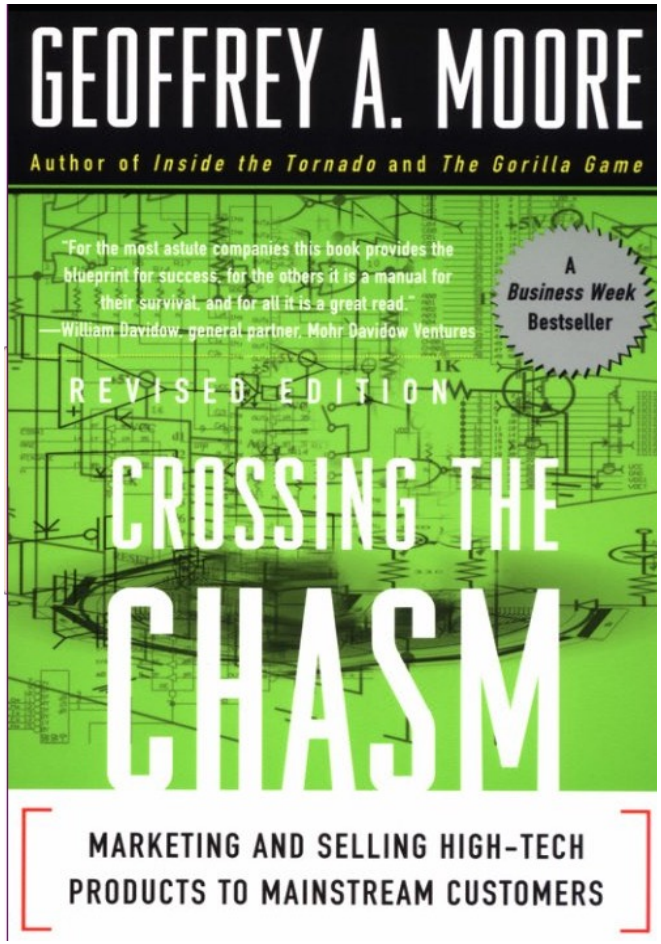
Research shows a bell curve for adoption



Rogers, Diffusion of Innovations, 1995 p. 262

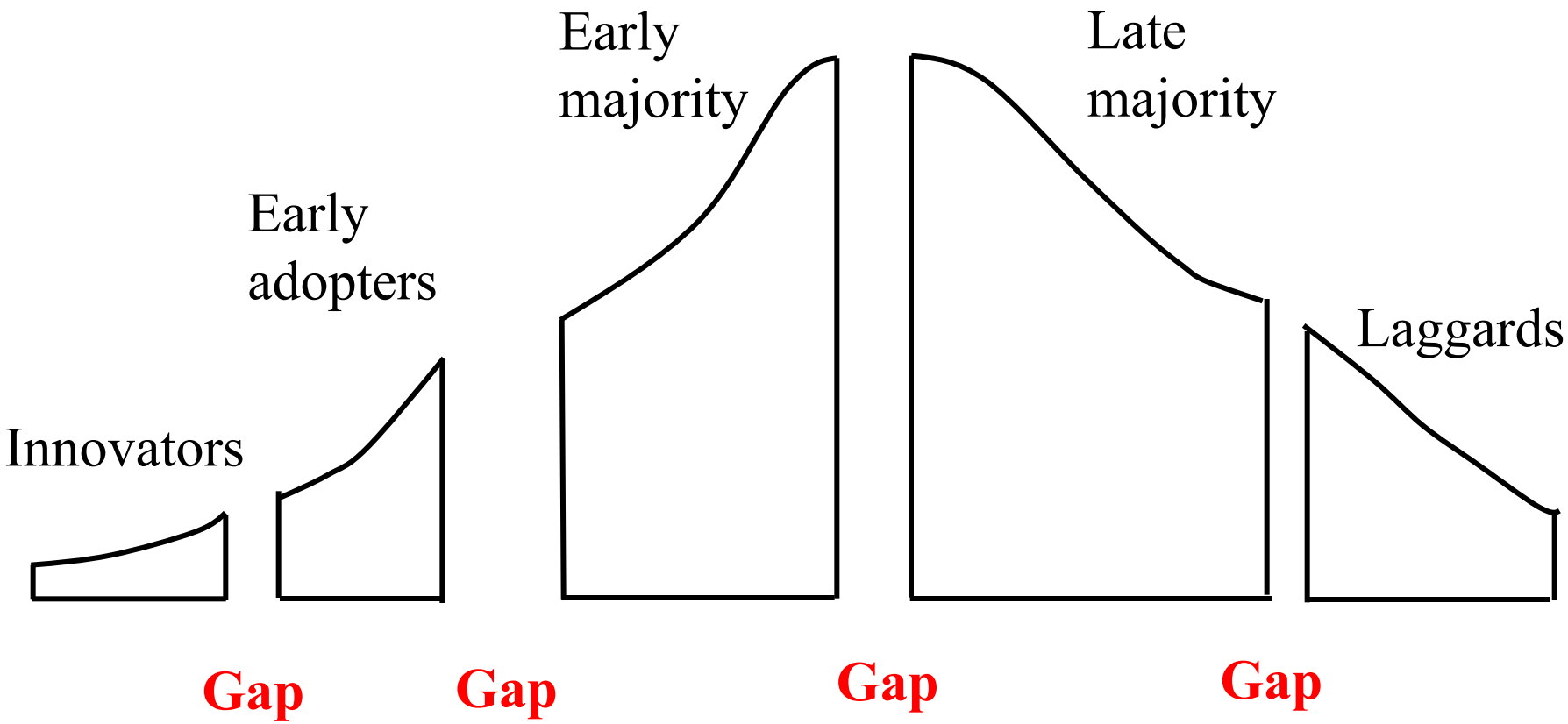
The adoption of new ideas

Geoffrey Moore's work built on Roger's adopter characterization



Moore's revised bell curve for technology adoption

Moore identifies gaps between groups in the bell curve



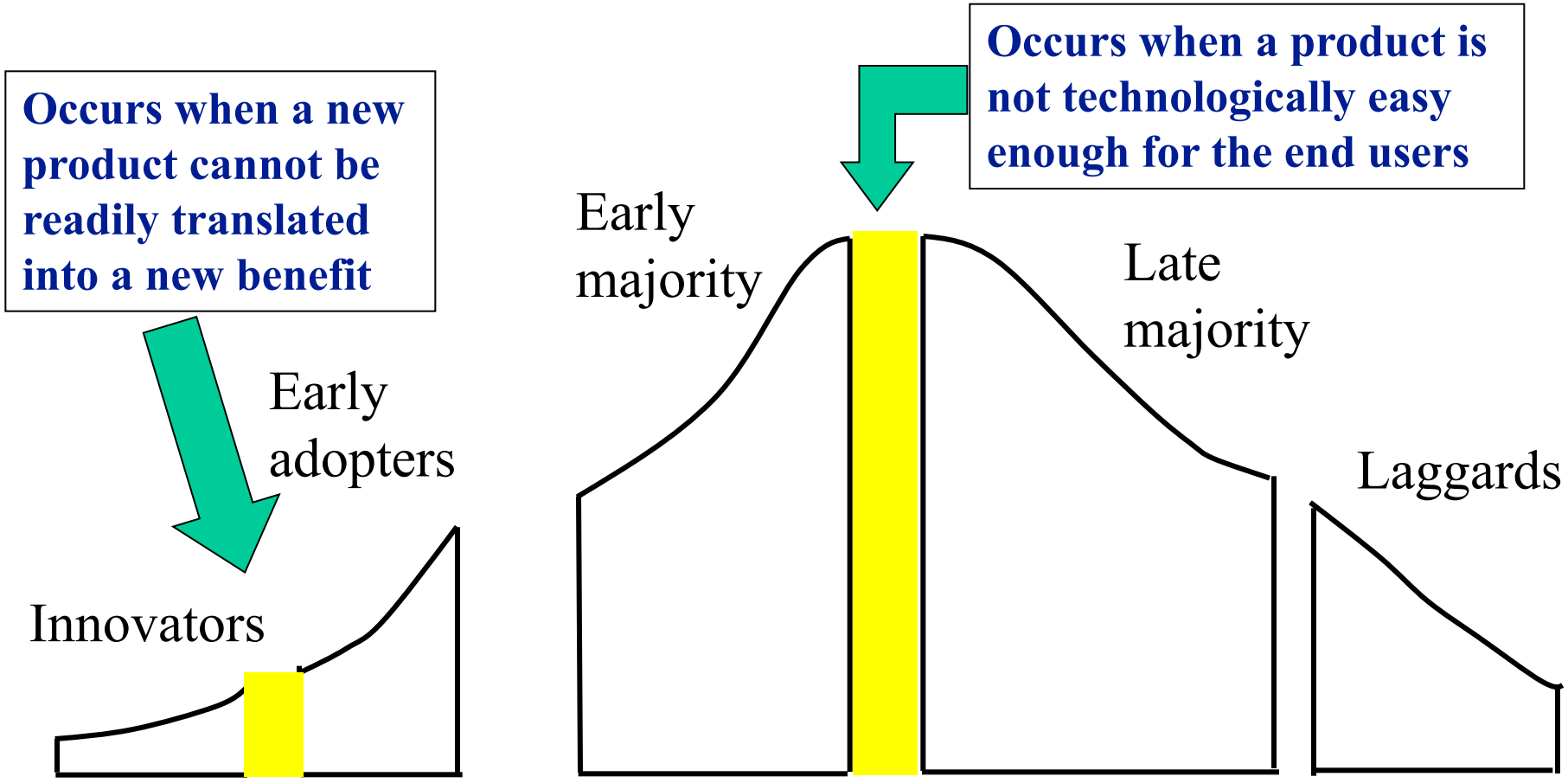
Moore, Diffusion of Innovation, 1991 p. 17

The implications of the gaps for getting buy-in

- Any group will have difficulty accepting a new product if it is presented to them in the same way as the group to the left
- Each of these gaps presents risk for marketing to lose momentum and the innovation to be abandoned
- Deliberate steps and actions need to be taken at each step to get buy-in for the innovation from all groups

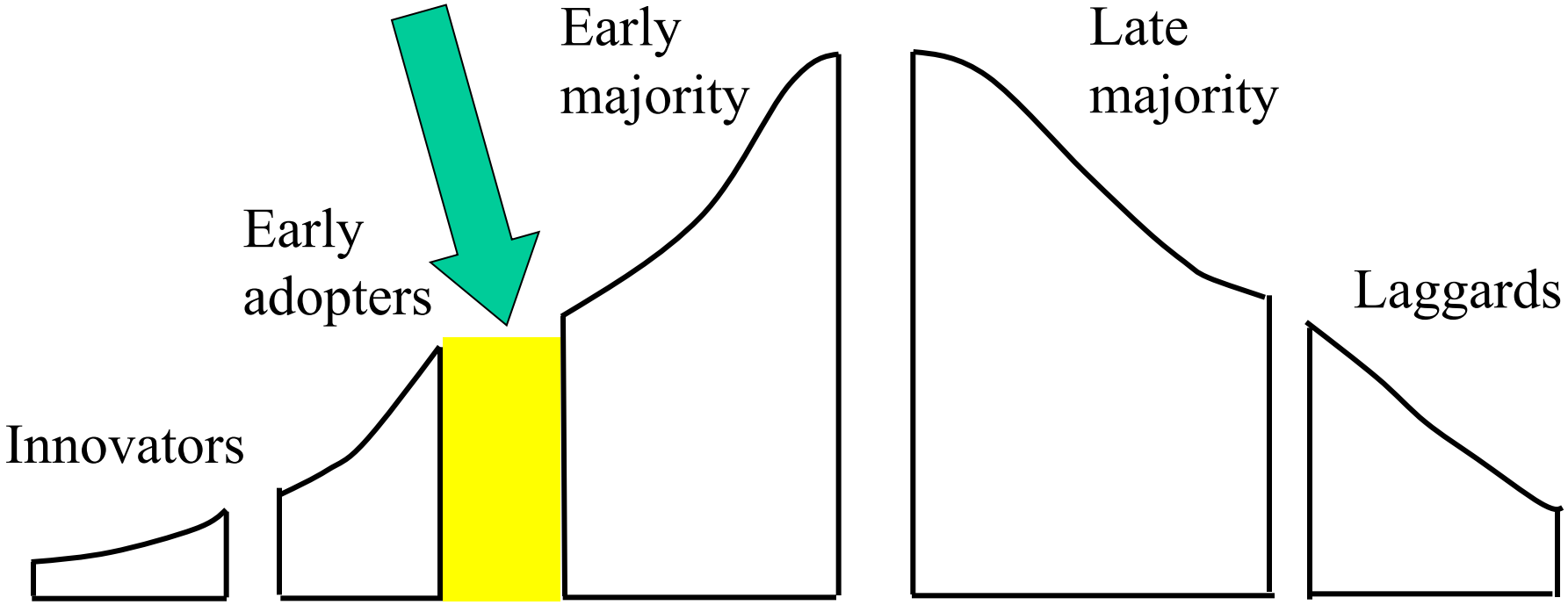
You need a comprehensive plan!

Two of the gaps are easier to overcome



But one is more like a chasm

Occurs because the early adopters do not make good references for the early majority



The chasm: early adopters and early majority have divergent views about new technology adoption

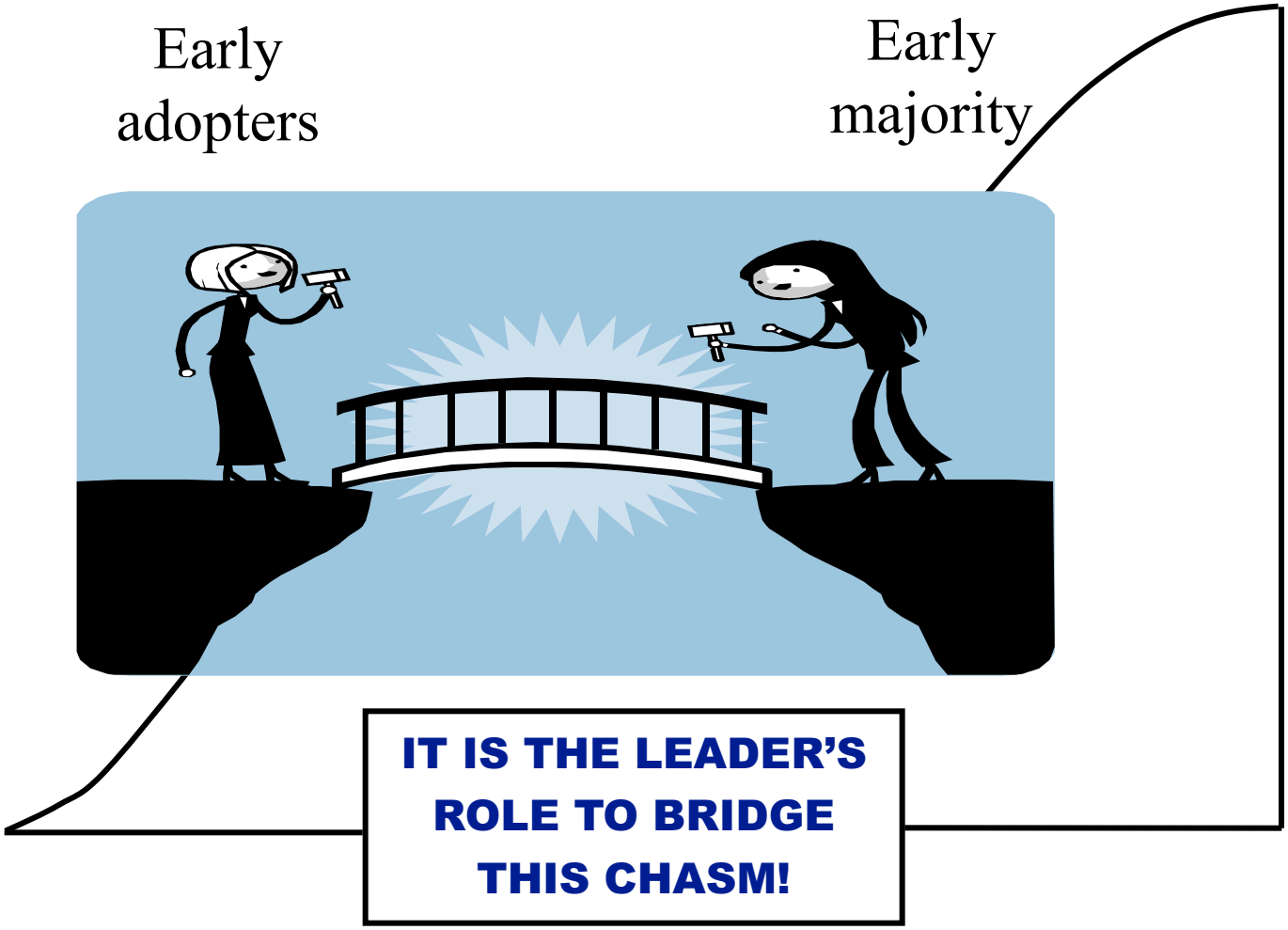
Early adopters

- Expect a change in operations and industry practice
- Expect discontinuity from old ways
- Want new technology to overthrow established ways
- Will accept new technology that is not fully complete
- Change agents; prepared to champion the new

Early majority

- Want productivity improvement for existing operations
- Want to minimize discontinuity with the old ways
- Want new technology to enhance established ways
- Want new technology ready to adopt without any changes
- Want references from others before buying

The leadership imperative: bridge the chasm

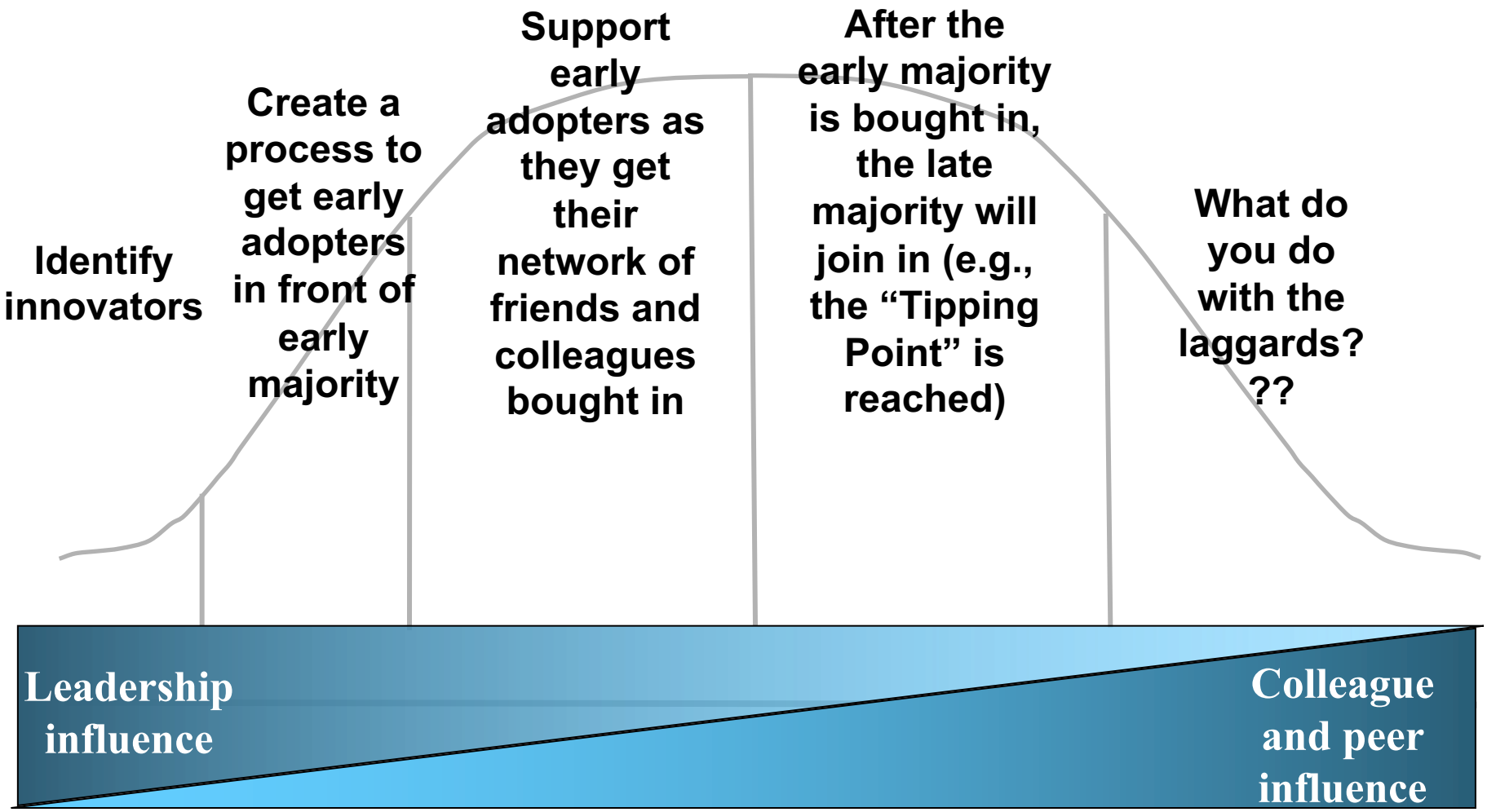


How to bridge the chasm

The leader must create a process that engages the early adopters and turns them into internal advocates who will then influence the early majority to buy-in.

This builds on the colleague and peer network

The process of gaining buy-in



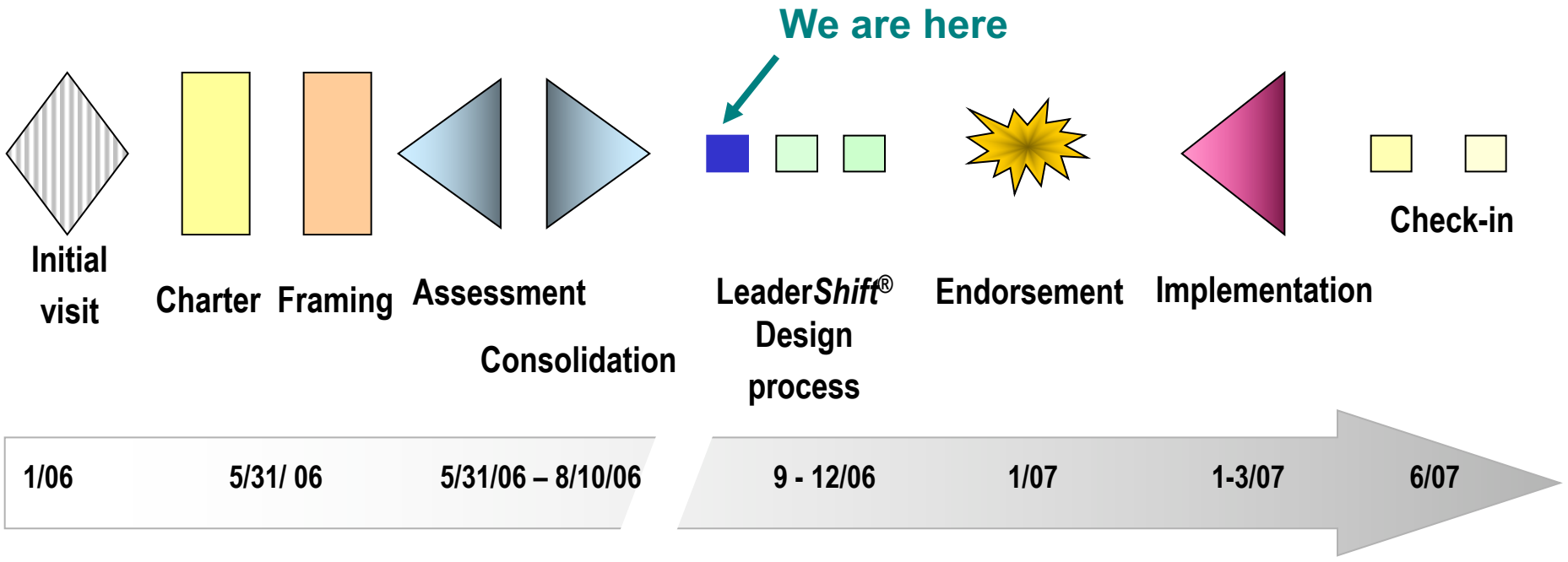
Communication and commitment CRMC

Draft upcoming milestones and expectations of this group (some dates TBD)

October DATE/FORUM/TASK	November- DATE/FORUM/TASK	December DATE/FORUM/TASK
October __ Complete September Intersession Work Schedule dates for LSIII	**November __** **Venue and process TBD** Complete Intersession Work	**December ___** **Venue and process TBD** Complete Intersession Work
10/9/2006 **Medical Executive Committee** ✓ Bring Picture of the Future to MEC Meeting for discussion; Ensure commitment to success & process ✓Present any other necessary updates	**November 13** **Full Med Staff Quarterly Meeting** Update Medical Staff on model chosen in October LSII meeting - obtain approval	**12/11/06** **Medical Executive Committee** **Update on final implementation work plan**
October __ **✓ Trustee Meeting** Bring Picture of the Future to Trustee Meeting for discussion; Ensure commitment to success & process	**Trustee Board meeting** Educate Board on chosen model	**12/18/2006** **Trustee Meeting** Update Trustees on final implementation work plan
October ___ LSII **Begin intersession work including Ensuring communication to Medical Staff**	**November ___ LSIII** **Begin intersession work**	

Engagement timeframe CRMC

- Leader*Shift*® II in October
- Present at the October MEC to vet and identify implementation challenges
- Develop implementation plan and prepare for endorsement



Closing dialogue

Thank you very much!

Andrew Epstein, MD, Partner
aepstein@bardgroup.com

Judy Rich, RN MSN, Consultant
jrich@bardgroup.com

Rachel Steele, MEd, Consultant
rsteele@bardgroup.com

The Bard Group
246 Walnut Street
Suite 302
Newton, MA 02460
617.630.1731