Physician leaders play a vital part in guiding the practice toward exceptional performance.

PRACTICING EXCELLENCE: Your Role in Practice Transformation

Stephen C. Beeson, MD

Transforming health care performance isn't easy. I took a lesson in this in 2001 when our group, Sharp Rees-Stealy, decided to turn our "good" practice into the "best" practice. We wanted to be the best place for employees to work, the best place for physicians to practice medicine and the best place for patients to receive care. We called this lofty ambition the "Sharp Experience" (see "About Sharp Rees-Stealy" on page 30). In the process, we learned important lessons that can be applied in other practices. This article offers a framework for guiding a health care group of any size through transformation to better performance, a task that depends greatly on the engagement of physicians.

Getting off to a good start

We learned the hard way that physician participation would be critical to the success of our group's transformation. For the first two years of our improvement initiative, the emphasis was on training administrative leaders and frontline nursing staff and helping them learn new ways to improve the patient experience. Physicians were not actively involved in the training, and, not surprisingly, our performance did not improve. Staff members began to ask, "If this 'Sharp Experience' is so important, how come the physicians aren't doing it?" They gravitated toward the behaviors of the "untrained" physicians, and the improvement efforts lost traction. We, the physicians, had unknowingly become obstacles to change.

When our physician leaders realized the need for physicians to play a greater role, our medical director sought me out to serve as the physician champion, tasked with coaching, training, aligning and engaging physicians in our organizational effort. Physician support, visibility, leadership and example-setting became the cornerstone to changing our group's culture and executing our vision. If there's room for improvement in your group's performance, the following process will help you to lead the way.

About the Author

Dr. Beeson is a practicing family physician with the Sharp Rees-Stealy Medical Group in San Diego and is medical director of the Studer Group. He is author of *Practicing Excellence: A Physician's Manual to Exceptional Health Care* and *Engaging Physicians: A Manual to Physician Partnership,* which will be released in June. Author disclosure: nothing to disclose.

Downloaded from the Family Practice Management Web site at www.aafp.org/fpm. Copyright© 2009 American Academy of Family Physicians. For the private, noncommercial use of one individual user of the Web site. All other rights reserved. Contact copyrights@aafp.org for copyright questions and/or permission requests.

Stage 1: Articulate the vision

It is difficult to lead if the destination is unknown. A vision creates a road map for your practice to follow. Here's how to develop and implement one:

Stretch the imagination. The vision should stretch the boundaries of what is possible for your practice to achieve, and it should represent what every physician and staff member wants from the health care they provide. The vision should not be a description of current operations but a depiction of the future. Your vision should be homegrown and easy to convey. It is the theme that keeps your team working together. Physician input and support at this early stage will help the change process to move forward more quickly.

Establish goals. The vision unifies the practice, but improved performance depends on executing goals. A vision without goals will not fully engage physicians, and goals without a vision will fail to unify the workforce.

JOHN PATRICK

Your practice's goals should be aligned with what the physicians in the practice find important. Our group's goals are based on four "pillars" of performance: the quality pillar represents clinical measures, the service pillar represents patient satisfaction, the people pillar represents employee and physician satisfaction, and the financial pillar represents clinical revenue and market share. Our group cannot be successful if even one of these areas is lacking. Patient satisfaction can only happen in step with employee and physician satisfaction; clinical performance becomes more difficult without financial performance. Pillars of organizational performance depend on each other, and every pillar should be pursued with equal effort.

Communicate clearly. It is important to clearly and deliberately communicate the vision, how it will be achieved, and what the end result will look like to the physicians and employees in your practice. Everyone must know and understand their role in reaching the vision.

Execute with enthusiasm. Physician leaders are responsible for executing the vision with enthusiasm, passion, intensity and commitment. Indifference will cause change efforts to fail. In a large group, key physicians should be targeted early in the process to provide leadership and work in partnership with administration as a unified team.

Stage 2: Measure and report performance

Creating a vision for your practice and establishing goals will convey that something new

Article Web Address: http://www.aafp.org/fpm/20090300/28prac.html.

The room was quiet – until one of the physician leaders announced, "This will not be happening here any longer."

Leading a health care group through transformation depends greatly on physician leadership.

Articulating a vision and establishing goals will serve as a road map for your practice.

Performance measurement and reporting can motivate and drive change.

is coming and will provide direction for the future, but how do you kick-start the change effort? Performance measurement and reporting, if supported by the physician leaders, can motivate improvement and drive change. Consider this example from my group's experience.

Our group includes a busy urgent care department that manages more than 150,000 patient visits each year. In our past, the urgent care department struggled with delivering a positive patient experience. In fact, it was common for the department to rank in the single percentiles in patient satisfaction surveys. As our group moved forward with system changes, it was clear that urgent care should come along.

In a "diagnostic" effort, urgent care leadership decided to assess pain management in the urgent care department, since pain management is an important correlate to the patient experience in this environment.

They pulled 120 charts of patients who presented with a pain complaint (excluding abdominal and chest pain) to determine how frequently our urgent care staff assessed and treated pain during the clinical encounter. Out of 120 charts pulled, only 11 patients who presented with a chief complaint involving pain were assessed and treated for their pain. Patients with contusions, fractures and sprains were never asked about their pain and were not given anything to help treat it.

Our urgent care leadership team called a meeting to review the data. The room was quiet – until one of the department's physician leaders raised his 6-foot-3-inch frame from his chair and announced, "This will not be happening here any longer."

In the days that followed, they established door-to-doctor times, deployed discharge phone calls, hard-wired a system for informing patients of wait times and launched a pain management protocol to assess and treat patients quickly for their pain. Our urgent care system now ranks as one of the best in the nation for pain management and the overall patient experience.

This episode and others taught us that measuring performance objectively and providing comparative, transparent feedback intensifies the effort to achieve individual and group goals. Physicians care deeply about how their individual performance compares with their peers', and reporting their performance will motivate change. Group goals and individual goals should be aligned. For example, if your practice has a goal to get 80 percent of its patients with diabetes to LDLs below 100, then the performance measure should be tracked and reported for each individual physician.

It is important to measure performance along multiple dimensions related to your practice's goals. Clinical quality measures could include percentage of patients with hypertension who have blood pressures below 140/90; percentage of patients diagnosed with asthma who take controller medications; percentage of women age 40 and older who receive annual mammograms; or percentage of patients age 65 and older who receive pneumococcal vaccinations.

Service quality measures may include patient satisfaction survey results, including a patient's likelihood of recommending a certain physician. Productivity measures may include meeting attendance, generic medica-

ABOUT SHARP REES-STEALY

Sharp Rees-Stealy, part of Sharp Healthcare, is a 400-physician multispecialty group based in San Diego and founded more than 85 years ago. It has been ranked as the No. 1 medical group in the state of California for three consecutive years in clinical quality and the patient experience, based on the Blue Cross Quality Health Care Report Card, and has received the Acclaim Award for performance excellence from the American Medical Group Association. Sharp HealthCare was the recipient of the Malcolm Baldrige National Quality Award in 2007.

tion utilization and clinical charges. Some groups even include a nurse review of physician conduct, their treatment of nurses and physician-to-physician collegiality. In the end, the practice should measure and report on behaviors that influence the outcomes it wants to achieve.

Performance data should be reported as close to real time as possible and in the form of a consolidated dashboard that provides comparisons with peers and with a goal. This work can also be used as the basis for an incentive-based payment tied to clinical and service goals, which is another important component to motivating physician performance.

Stage 3: Work on your own performance – and help your colleagues do the same

Physician performance sets the tone for the group. For this reason, it is critical that you devote time and energy to improving your skills and to helping your colleagues improve theirs. Physicians who struggle with performance are not doing so purposely. In most cases, they simply need to be taught how to perform better.

Start with the basics. Physicians need to understand and practice specific behaviors that improve the patient experience and work environment. Topics to explore include the following (for more information on many of the topics listed here, see the reading list above):

- Creating a positive first impression,
- Collecting the medical history,
- Explaining the diagnosis,
- Explaining medications,
- Creating a collaborative treatment plan,
- Describing follow-up care,
- Expressing empathy,
- Managing the difficult encounter,
- Improving staff performance.

Appoint a trainer. Training is best performed by physician leaders who have been appointed and trained for this position. It rarely works for administrative leaders to ask physicians to do things differently.

When a group invests the time and effort to train its physicians and help them to be more successful, they will become more loyal to the practice and its vision. They will do for the practice as the practice has done for them.

SUGGESTED READING FROM THE *FPM* ARCHIVES

"How to See Your Practice Through Your Patients' Eyes." Stewart EE, McMillen M. June 2008; http://www.aafp.org/fpm/20080600/18howt.html.

"Have You Really Addressed Your Patient's Concerns?" Epstein RM, Mauksch L, Carroll J, Jaén CR. March 2008; http://www.aafp.org/fpm/20080300/35have.html.

"How to Manage Difficult Patient Encounters." Hull SK, Broquet K. June 2007; http://www.aafp.org/fpm/20070600/30howt.html.

"Physician Leadership: A New Model for a New Generation." Serio SD, Epperly T. February 2006; http://www.aafp.org/fpm/20060200/51phys.html.

"What Motivates Staff?" Thiedke CC. November/December 2004; http://www.aafp.org/fpm/20041100/54what.html.

"Building a Mind-Set of Service Excellence." Plsek P. April 2002; http://www.aafp.org/fpm/20020400/41buil.html.

"Helping Patients Take Charge of Their Chronic Illnesses." Funnell MM. March 2000; http://www.aafp.org/fpm/20000300/47help.html.

"Improving Patient Communication in No Time." Belzer EJ. May 1999; http://www.aafp.org/fpm/990500fm/23.html.

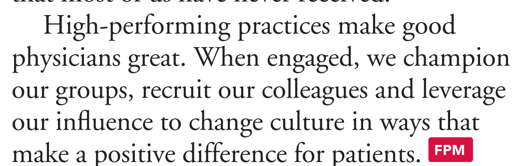
"Patient-Centered Care for Better Adherence." Lowes R. March 1998; http://www.aafp.org/fpm/980300fm/patient.html.

"Keys to a Positive First Impression." Baker SK. January 1998; http://www.aafp.org/fpm/980100fm/baker.html.

The heart of change

The core of physician behavior change is creating environments, relationships and experiences that prompt a personal and emotional decision to do things differently. Building high performance is not about mandating change but rather setting the stage to help physicians succeed personally and professionally. It requires leading with a vision that inspires physicians and staff to work together to make a difference and investing in and developing physicians by providing coaching and training that most of us have never received.

High-performing practices make good physicians great. When engaged, we champion our groups, recruit our colleagues and leverage our influence to change culture in ways that make a positive difference for patients. FPM



Send comments to **fpmedit@aafp.org.**