Building a Physician Culture for Healthcare Transformation: A Hospital's Leadership Challenge

Robert A. Hemker and Leslie A. Solomon

Summary • Engaging and integrating physicians has become the veritable "brass ring" for many hospital systems: many attempts and few actual wins. This is especially true in California's managed care environment and for public entities such as Palomar Health in Escondido, California. Our commitment to engage and integrate physicians continues to be a vital element of a larger cultural shift toward delivery of care that puts the patients' needs first. A key determinant of success has been the ability to align a diverse medical staff culture with administrative priorities. This alignment involves a carefully executed strategy and a structure to build a collective identity among diverse players. Palomar Health is in the third year of the journey. Some of the critical milestones have been the implementation of a physician leadership development process, creation of a physician onboarding process to codify the desired physician culture, delineation of roles and expectations for physician leadership, and formalization of dyad and triad partnerships between physicians and their clinical and administrative partners.

FEATURE

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A Legacy of Mistrust

Historically, the medical staff at Palomar Health has operated as a separate and distinct entity with a clear separation between hospital locations. Most medical staff positions did not cross over to different locations, resulting in a lack of appreciation for colleagues at other campuses. Many of our physicians were singular in their focus, and only the hospital-based physicians understood the concept of operating as a healthcare system. This stance was reinforced by the previous medical leadership structure, which established site-specific and separate medical staff operating methods and executive committees. Things began to shift in 2010 as the preparations began for opening a new hospital. The healthcare system started to align along key outcomes, and medical staff became engaged in the planning and execution of those outcomes. Our focus has been on trying to bring medical staff into true partnership by redefining the relationship between physician and nonphysician leaders with an emphasis on collaboration. This means building trust so we can move from a "win–lose" mentality toward a focus on achieving common solutions. Engaging physicians as advocates for shared outcomes while respecting the autonomy of the medical staff is a balancing act and requires new levels of executive transparency.

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Trust and mutual respect are the key drivers of physician integration and engagement. Most administrators claim to uphold these drivers, but, in reality, we have taken shortcuts. We make decisions at executive meetings held during physicians' practice hours. We ask physicians for input on how to implement decisions, when they expect to be at the table to influence the decisions themselves. Inclusion and decision making are the key drivers to achieving trust. At Palomar, we operated with a set of assumptions about our physicians that allowed us to be exclusive. Administrators viewed our medical staff as self-interested, and they lacked confidence in the physicians' ability to align along shared goals. Consequently, the medical staff viewed the administration as pushing its own agenda without respect for the physicians' contributions. Many of our physicians stated that they were the only ones really working toward meeting the needs of patients and that this focus often was in conflict with what the administration was asking of them.

Leadership Development: Seeking Common Ground

Palomar Health's district covers an 850-square-mile area of northern San Diego County, and the healthcare system provides trauma services to people in 2,200 square miles of San Diego and Riverside counties. With several primary and ancillary facilities, including three hospitals, a skilled nursing facility, and express clinics, Palomar Health provides medical services in virtually all fields of medicine. These fields include primary care, cardiovascular care, emergency services, trauma, cancer, orthopedics, women's health, rehabilitation, robotic surgery, and bariatric surgery. In August 2012, Palomar opened its hospital of the future. The 11-story structure was the first new hospital in northern San Diego County in 30 years. It offers 288 private single-patient rooms, 50 emergency and trauma rooms,

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and 12 operating rooms, as well as the latest in medical technology. Though it was recognized as a world-class healing environment, the hospital opening placed additional stress on the medical staff. In the wake of the opening, medical staff rated their engagement at the 8th percentile nationally. All domains of engagement, including ease of practice, quality of patient care, communication, and collaboration, ranked in the bottom quartile nationally. With the move to the new facility, patient satisfaction experienced an initial uptick—from the 12th percentile to the 30th percentile nationally—but then leveled off for several quarters.

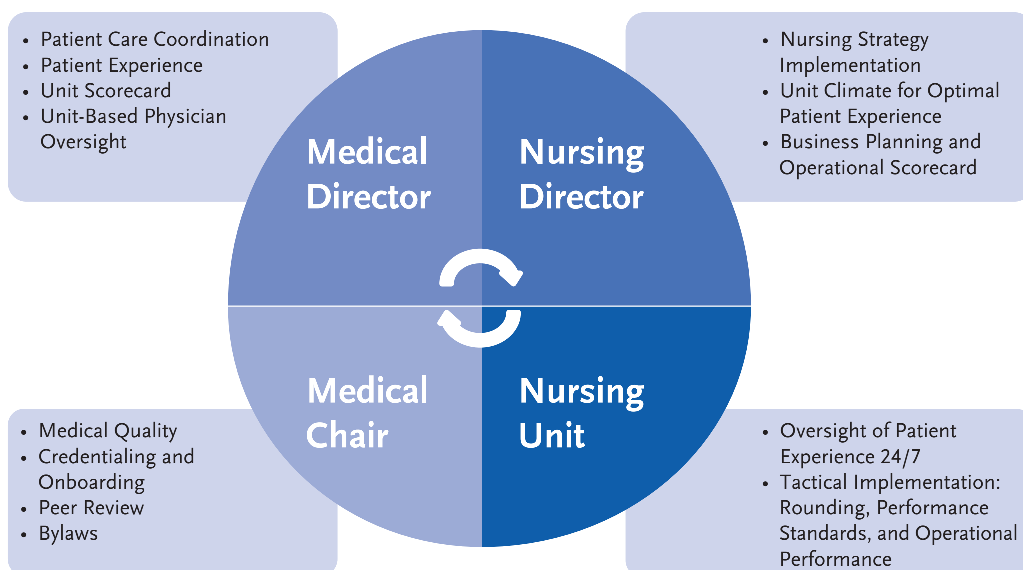
Roles and Expectations

Delivering excellent patient care in a more complex environment with increasing pressures to manage cost required strong medical leadership. Palomar crafted an enhanced medical director role to provide unit-based oversight focused on quality, service, and engagement. These unit-based directors were asked to deliver key outcomes in several areas: meeting frequency, trust, issue identification and resolution, communication, dashboards, quality and service, staff and physician engagement, and productivity. Different from the department chairs, these medical directors would have a more operational focus in service of patient care and a partnership-based approach that required collaboration with their unit management (Exhibit 1).

Leadership Competency Framework: Five Key Domains

While role clarity is important, the way in which roles are determined drives behavior and culture. Palomar's goal was to build relationships that were strong enough to challenge and continually redefine roles. We knew that key leadership behaviors would be important to

Exhibit 1 Roles of Medical and Nursing Staff



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implementing these roles. In 2013, Palomar adopted and customized a leadership competency model—Applied Physician Leadership Academy (APLA)—from The Leadership Development Group. Five key competencies were targeted for leadership development:

1. Leading oneself: taking ownership of self-awareness, self-management, and self-development
2. Leading others: building and developing effective teams
3. Leading change: building resilience and change management
4. Leading for results: applying strategy and decision making for outcomes
5. Leading for collaboration: building relationships for shared success

We defined dyad and triad relationships as partnerships aligned on common values with clear individual roles.

An internal design team aided by a consulting firm developed a 22-month curriculum based on a needs assessment. Brochures were created to market the program as Palomar's equivalent of an executive master of business administration degree. We customized the program to become the Academy of Applied Physician Leadership (AAPL, not to be confused with the American Association for Physician Leadership), and it became known informally as "Apple." The dual moniker "AAPL/Apple" was chosen to evoke a spirit of creativity, openness, and exploration.

AAPL/Apple faculty included renowned speakers, authors, and practitioners in healthcare, business, and leadership, and the curriculum was customized to deliver high value and high impact to healthcare. The faculty used multiple learning strategies, including a 1:1 assessment and coaching, learning and application modules, and action learning projects. Learning and application modules enable participants to practice specific skills such as empathetic listening, coaching, and conflict management. Action learning projects (e.g., joint physician–nurse rounding) centered on the themes of process improvement, clinical improvement, business growth, and patient experience. Using problem-solving tools, the teams shared progress on their projects and practiced listening, questioning, and providing feedback. A coach assigned to each team facilitated the process.

Dyads: Learning in Partnership

We decided early on to have physician leaders learn and work in partnership. Every medical director was paired with a nursing or an administrative dyad partner. If the medical director's nursing and administrative partners were both present, they worked in triads. We defined these dyad and triad relationships simply as partnerships aligned on common values with clear individual roles. Physician leaders would be stewards of clinical quality and desired provider behaviors in service of patient care. Nursing and administrative leaders would own the quality and safety practices on the units and build the functional pathways, including staffing, budgeting, and operational planning. Culture, values, and relationships were their shared domain. AAPL/Apple modules provided time for partners to learn together, practice new skills, and strategize for the future. The module content included the following:

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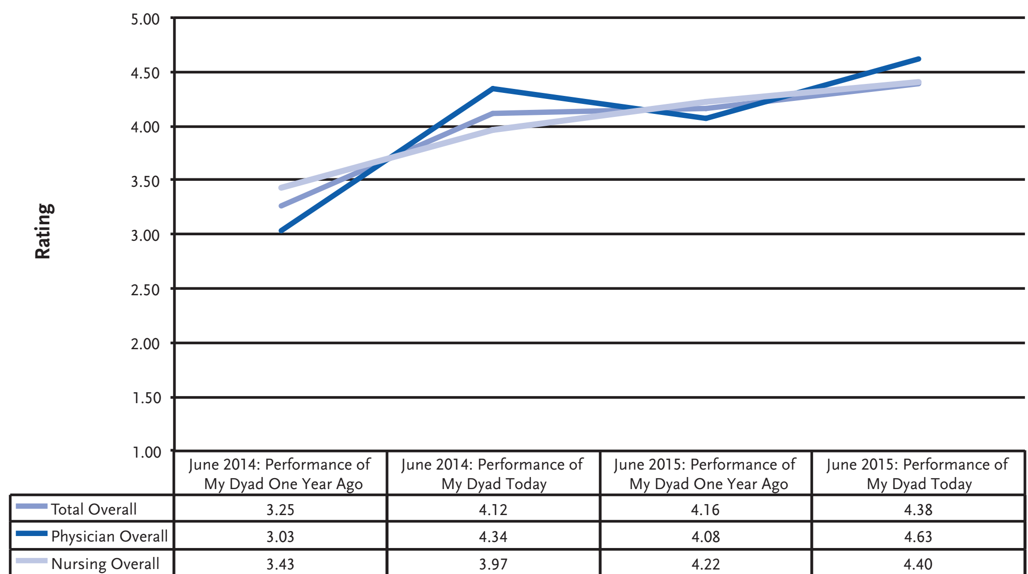
- Leadership roles
  - Physician leader
  - Dyad/triad members
- Leadership skills
  - Emotional intelligence
  - Change leadership
  - Business strategy and fiscal oversight
  - Coaching and motivating performance
  - Presentation skills
- Team skills
  - Building team trust and capacity for managing conflict
  - Action learning: coaching learning in others

The impact of learning on dyad relationships was assessed by asking partners to rate, on a five-point scale (1 = very poor and 5 = very good), the performance of their partnership in the previous year (retrospectively) and in the current year. This assessment was done at the end of the first year and at the close of the 22-month program. All of the dyad partners perceived significant improvement from the first to the second assessment in the areas of trust, communication, meeting frequency, operational scorecards, patient and employee engagement, and operational alignment. Exhibit 2 summarizes the two-year assessment. Physicians and nursing dyad partners were asked to separately evaluate the strength of their partnership retrospectively (how it was one year ago) and currently (how I would rate it today). Dyads reported significant improvement over both years, with physicians' ratings slightly more favorable than ratings by nursing partners.

At the midpoint of the program, physicians received an evaluation form asking how it made a difference for them. Here are a few of their comments:

Exhibit 2 Dyad Alignment Measures Across Two Years



	June 2014: Performance of My Dyad One Year Ago	June 2014: Performance of My Dyad Today	June 2015: Performance of My Dyad One Year Ago	June 2015: Performance of My Dyad Today
Total Overall	3.25	4.12	4.16	4.38
Physician Overall	3.03	4.34	4.08	4.63
Nursing Overall	3.43	3.97	4.22	4.40

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- "It has been quite a commitment, but well worth the journey! The program has been a motivator for our health system and has provided results to solve various problems."
- "I have an effective dyad so that is probably the biggest win. The AAPL/Apple projects and sessions have helped us to figure out how we can best work together to lead our teams. Personality tests like the emotional intelligence helped us learn how we could better work with each other based on strengths and weaknesses."

Physicians undertake three levels of project work to stretch their skill set from dyad partner to business partner and, ultimately, to strategic partner.

By building relationships focused on shared values, Palomar began to reframe the culture for medical staff leaders and their partners. As one physician noted, "Working with colleagues in the AAPL/Apple environment affects our performance together in the acute care setting. We look upon each other more respectfully."

Applied Learning: Development of Strategic Thinking and Operational Skills

In 2013, Palomar joined the Mayo Clinic Care Network. We were attracted to the Mayo model, which is physician led and professionally managed. Mayo Clinic leaders presented a grand round session to Palomar's physicians on its leadership-by-design process. Our physician leaders were inspired by the idea of intentionally cultivating leadership to build the physician culture. The Mayo model is a powerful demonstration of the commitment and intention needed to be a physician-led organization, and it clarified the distinction between leadership and management. We have to ask ourselves if we are asking our physicians to be managers or leaders. As a leader, you are formulating strategy and setting organizational direction as opposed to merely "doing it." This can be a challenge for physicians who want to take action and move on. Clarifying the difference between strategic leadership and operational management is important. Setting strategy requires patience and often runs counter to the desire for a quick fix today that can be implemented tomorrow.

Palomar continues to introduce applied learning opportunities as part of physician leadership development. Physicians undertake three levels of project work to stretch their skill set from dyad partner to business partner and, ultimately, to strategic partner.

As dyad partners, physicians undertook small projects in their own specialty area. They used the A3 problem-solving framework to identify the problem, characterize the desired state, identify obstacles and challenges, and generate solutions. Projects ranged in scope from modifying surgical preference cards to physician rounding practices. As part of the AAPL/Apple program, project teams participated in action learning sessions to help them address issues involving collaboration, conflict management, and scope of work. Physicians learned a great deal during this five-month process, including why "simple" problems could not always be fixed in a simple way. Before participating in these projects, physicians struggled to understand the bureaucracy and molasses pace of the hospital.

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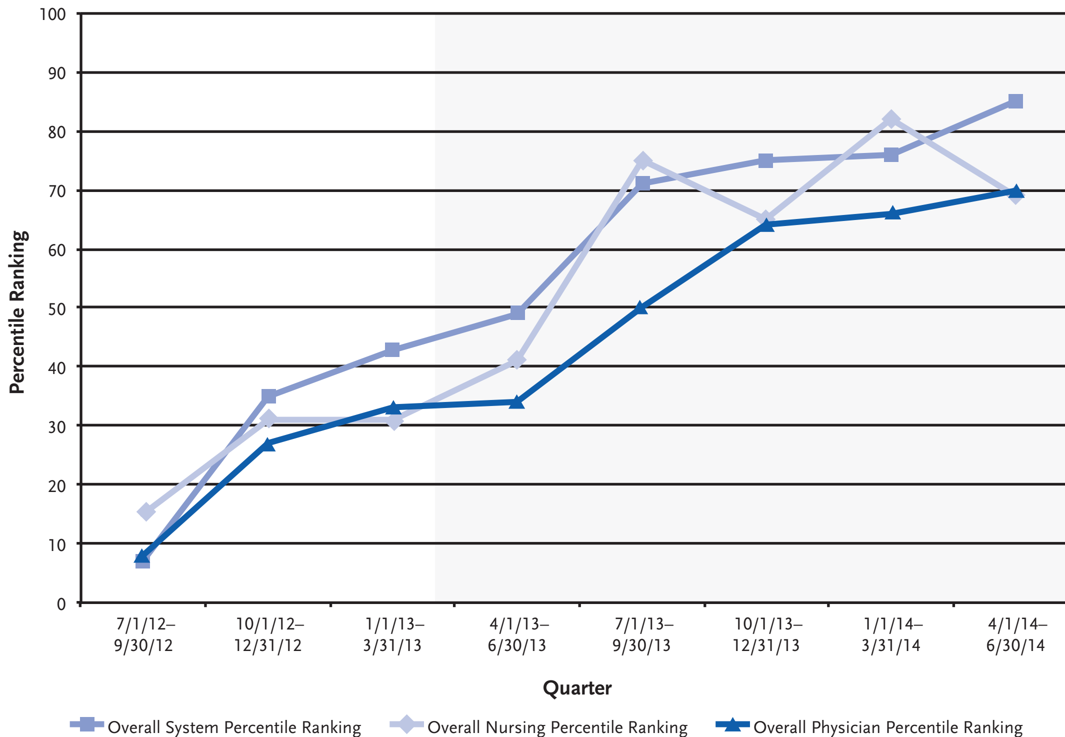
Exhibit 3 Patient Satisfaction Ratings



After the first round of team projects, we noticed that patient satisfaction was trending upward, especially in the areas of physician communication, nurse communication, and overall satisfaction. The organization's ratings in these areas had stalled at the second quartile (30th to 50th percentile); after the first round of projects, patient satisfaction ratings began a steady climb to the top quartile (Exhibit 3). These team projects empowered participants to take action at the unit level, which was reinforced during rounding and through coaching.

Alan Conrad, MD, Palomar's executive vice president of physician alignment, noted, "The effort that Jerry Kolins, MD, vice president of patient experience, put into the patient experience during the 2012–2014 period was really critical in raising our scores. Jerry created a standard for how physicians would conduct rounds on patients, rounded actively on the units, met with the unit dyads, and used every opportunity to catch people doing things right—often with an impromptu videotaping of a positive patient experience. These videos then inspired the standard of care for the hospital. Those efforts, combined with the written notes of Duane Buringrud, MD, chief physician leadership development officer to physicians about their performance on Press Ganey experience measures and the project work they undertook through AAPL/Apple, created a breakthrough in patient satisfaction for us."

In 2014, an opportunity arose for a more interdisciplinary project. Analysis of

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our physician engagement data indicated that timely order fulfillment was a universal concern across specialties. Our medical staff committed to addressing this issue as an interdisciplinary project that would be physician sponsored and led. A team of physicians provided input, analyzed the sources of dissatisfaction, and formulated task teams to implement solutions. We provided physicians with a facilitator, who met with them before and after each meeting to help structure and plan the meeting, refine presentations, and plan subsequent steps including stakeholder involvement. When we assessed physician engagement in 2015, order fulfillment was one of the items that improved the most in terms of ratings (i.e., mean improvement of 2.6 points, representing a shift from fair/good to good/very good). This shift—demonstrating the power of inclusion—happened even though many of the task forces continue to work on solutions.

As business partners, physicians and their clinical partners completed a second round of projects in 2015. They made a pitch to finance key clinical and business projects. Teams presented a simple pro forma indicating the improvement sought and projected costs measured against the anticipated return on investment. Nine of 13 teams received funding for projects ranging from a new magnetic resonance imaging protocol to ride programs for patients being discharged.

Key to successful projects is the ability of all parties to communicate well and understand and trust one another. Mutual trust is built into every conversation during which we share our assumptions, feelings, and desires. One key aspect of leadership is relationship management. Often, leaders are pushed to drive short-term solutions to maintain relationships, only to have problems resurface later. This recurring process can reinforce the cynical attitude that leaders are unable to implement effective solutions. Learning how to ask questions, collect data, and turn those data into actionable information affords leaders the resources to implement solutions that will be long lasting, rather than quick fixes.

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We see many of our physician leaders as strategic partners. In June 2015, the Palomar board of directors approved a motion to close the Palomar Health downtown campus. The aging facility housed three major service lines and was projected to cost the healthcare system hundreds of millions of dollars to sustain infrastructure over a five-year period. Our physician leaders were among the most vocal and compelling proponents of the change. One medical director commented publicly: "I might be personally impacted and lose volume if we make this change, but it's the right thing to do." This is the third level of applied leadership—when physicians can partner around strategic decisions that serve the future of the system and the philosophy of "patients first."

Engaging Medical Staff Leadership

As the commitment to engage physicians at Palomar grows, we have to begin to confront some of our practices that exclude physicians from key conversations and inhibit an integrated culture. Examples include holding meetings at times incompatible with physician practice hours or pushing influential decisions to late evening meetings when all parties are tired

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from a 12-hour day. Often, physicians who are passionate about being leaders need balance, so they will have to commit a certain amount of time to their leadership role, which might result in reduced practice hours. At the same time, new physician leaders seem to be more amenable to change because they entered practice more recently and are accustomed to environmental influences; they also understand the need to manage trade-offs. Physicians comment that taking a leadership role makes shift work easier and contractual obligations more achievable.

Onboarding and Mentoring

We have invested in leadership development and built an infrastructure for leadership. The next opportunity for Palomar is to continue to build a strong physician culture. We have many physician subcultures evolving from the different groups with which we contract. The challenge going forward will be to develop a strong Palomar culture that attracts physicians who want to contribute and support our commitment to a patients-first philosophy.

In 2014, we invited key medical leaders to identify the values of the physician culture at Palomar Health. They were asked to draw from previous positive experiences and discuss questions such as these:

- Why did I choose this profession?
- What contribution do I want to make?
- How do I want to interact with my peers?
- What values are important to me in our profession?
- How would I like to work with others in performing my job?

Key unifying values emerged, including excellence in patient care, supportive team relationships, leadership integrity, and accountability. These values serve as the framework for medical staff values that are being codified and vetted with the medical staff. The end product will be a medical staff compact—a set of explicit terms defining the relationship between physicians and administrators—that can be negotiated with the administration. Jeffery Rosenburg, MD, one of Palomar's chiefs of staff, commented, "From my point of view, and for many of our medical staff leadership, we would like to have values compel behavior, rather than have values enforced punitively to get people to behave in a certain way."

Many physicians at Palomar remember their early days in residency programs and how they felt about learning and growing on the job. Dr. Rosenburg said, "I had training through residency; we worked as a team. It was an inquisitive environment, and we didn't highlight people's errors. In residency, we used mistakes as training opportunities." A key step in building physician engagement is to mentor and onboard new physicians. Research conducted at the Mayo Clinic shows that physician leaders can significantly mitigate the effects of burnout with their leadership style (Shanafelt et al. 2015). Palomar Health's ultimate aim is to build a culture of physician leadership and mentoring that drives engagement and quality of work life.

When we opened our new hospital in 2012, we had to orient all physicians to the new facility. We learned a lot about what it takes to provide a warm welcome and to orient physicians. We created a physician concierge service staffed by employees who could connect with individual physicians, offer tours, answer questions, and refer physicians to information sources. In 2015, that model grew to include an

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information technology education team that greets new physicians, provides a facility tour, and educates physicians about the electronic health record.

In 2016, the next phase of onboarding will include a mandatory orientation session in which physicians network with key players in the system while learning about our mission, culture, and medical staff values. We will match each physician with a mentor who will meet with him or her quarterly to provide guidance on how to navigate the organization and become acculturated. This is part of building a leadership pipeline for the future. As one of our newly credentialed physicians commented, "I can be more than just a doctor who shows up for a shift; I can help the system grow if someone helps me understand the system's priorities."

Palomar Health is on a journey to build a more integrated and engaged physician culture.

Building a Physician Executive Presence

One of the most important changes recently implemented is the selection of Alan Conrad, MD, for the new role of executive vice president of physician alignment. Palomar has had a difficult legacy when it comes to a centralized physician executive role. When physicians make the move to administrative positions, they tend to be viewed as no longer being able to relate to the clinical practice concerns of the medical staff. They are thought to have lost that perspective and understanding.

Several medical executives have commented about how lonely the transition can be. They are no longer a bona fide member of their guild, yet they also do not relate fully to the administrator mind-set.

A perception exists on the administrative side that the medical executive role is designed to protect physicians. Our medical executives have to carefully balance clinical and administrative perspectives. If they maintain true neutrality, they will not have the same sense of loyalty from their physician colleagues. When we began the process of filling the position of executive vice president of physician alignment for the executive cabinet, we crafted the role to maintain clinical practice at 25 to 30 percent of work time. Our medical staff felt it was important that any physician who influenced policies affecting patient care should be in the hospital providing direct patient care. This model may not be the one practiced at other institutions, but it was critical to role acceptance at Palomar.

Summary of Key Learnings

Palomar Health is on a journey to build a more integrated and engaged physician culture. Leadership development, applied learning projects, dyad and triad partnerships, inclusion, onboarding, and executive presence are critical elements of this journey. Along the way, we have also gained perspective about the following guiding principles for success.

Honor Existing Cultures and Seek Integration

Palomar is fortunate to have many rich influences on our physician culture. Our hospitalist, intensivist, and emergency department physicians are contracted through California Emergency Physicians (CEP). We were the first CEP location, so we have grown with that culture over the past 44 years. Palomar's physician culture must aspire to integrate the best of its physician subcultures. For example, we might seek to embody CEP's strong sense

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of physician ownership and Mayo Clinic's service to patients.

Neutralize Conflict and Encourage Dialogue

Administrators and physicians must understand one another. Some of us are more skillful at expressing our opinions, but all opinions are valid. We may or may not be in alignment, but we need to learn to look at issues from the other person's perspective. Suppressed conflict will erode trust and destroy partnerships.

Develop Leadership Capabilities

Developing leaders through the AAPL/Apple program resulted in more than just skill development; it helped build shared models of thinking in the organization and lessened the divide between perspectives. As we move forward, we will continue to grow our leaders' learning agility and engage them in shared learning events.

Encourage Partnership and Community

For years, we wanted to develop a more unified Palomar culture, but we did not get all the players in the room. We still have work to do to engage and grow physicians, but we now have a core group of clinicians and administrators who will serve as role models for dyad and triad partnerships. Their role will be to build a broader community of providers who value partnership. One of the most important effects of the dyad model has been improved communication and collaboration ratings by physicians at Palomar. Since 2013, we have seen statistically significant improvements in physician ratings of physician–nursing collaboration, administrators seeking mutually beneficial solutions, and the responsiveness of administrators to the needs and concerns of medical staff.

Examine Assumptions Through Compact Development

The compact development process gives rise to expectations about roles, the definition of success, and requirements for achieving desired outcomes. The dialogue taking place during the compact development process drives learning. We are still learning about the values of the medical staff and their requirements of administrators. Medical staff are holding discussions at department levels. We hope to have a clear medical staff compact by the end of 2016. The completed compact will reflect the wisdom and input of the entire medical staff and, thus, will resonate with them.

Our work to build a more integrated and engaged physician culture is ongoing and requires us to be diligent and committed. Going forward, we continue to use the following mechanisms to transform the culture at Palomar Health.

Clarify Medical Roles in Administrative and Clinical Domains

Honoring the physician's need for autonomy and self-governance is important. Lines of authority can easily become blurred. To achieve success, we must work to identify roles, role boundaries, and role overlap.

Cultivate and Mentor a Leadership Pipeline

We are excited to see Palomar launch a physician mentorship program, which will provide an accessible first leadership role for many of our physicians. In return for their support, we will invite mentors to

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participate in leadership development activities. In this way, we will build and reinforce the leadership development pipeline.

Sustain Improvements with Infrastructure

As we look at our journey to date, many changes have been sustained by the leadership infrastructure. Our medical directors meet regularly as a collective entity with hospital administrators. Our medical staff officers participate actively in strategy development and drive engagement initiatives with physician-led projects. Finally, Dr. Conrad continues the work of building alignment across the continuum of care and in the medical community. He said, "It is critical that we continue to work on our values and refine our expectations of physicians in terms of leadership and living medical staff values. We need to continue to cultivate medical staff leadership that is adaptive and responsive to change. Administrators need to continually reaffirm our commitment to making Palomar a collaborative and desirable environment for the practice of medicine."

Conclusion

Transformation in healthcare cannot be accomplished without physician engagement and leadership. Strategies for transformation need to include developing physician leadership capabilities, building a strong physician culture, and engaging physicians as partners in planning and execution. This process is dynamic and requires ongoing dialogue about expectations, roles, and structures.

Reference

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