CHAPTER 1

Preparing Physicians to Be Engaged

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A Scenario with a Challenge

It has been two months since you announced your newest program—Journey to Excellent Experiences. It was a masterpiece of data and evidence-based approaches to improve the patient satisfaction scores across the institution. You heard the feedback from your organization's Achieving Access initiative launched three months ago and made key changes to the rollout. You held a town hall at 7 p.m. to tell the physicians about the new program and to give them a chance to share feedback. You created a curriculum that explains the need for better patient satisfaction and gave practical tips for improving the patient experience. You developed a dashboard that pushes out data weekly so that the physicians can see their progress. Now, you let out a deep sigh as you click on your dashboard and see that only a handful have actually logged into the course and even fewer have completed it. Frustrated, you begin to wonder if you can ever figure out how to herd these cats.

Readers, place yourself in the preceding scenario. What would you do? At chapter's end are some answers.

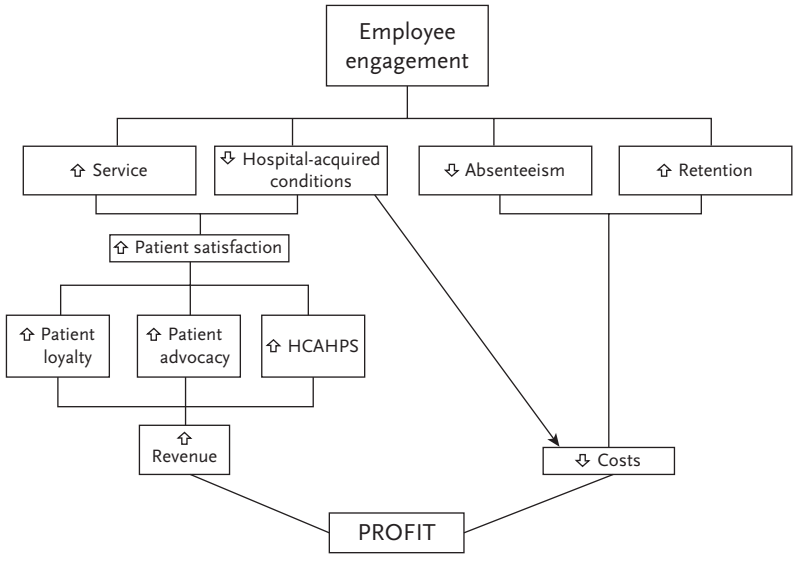
DEFINING ENGAGEMENT

Employee engagement is a management concept introduced in the 1990s and growing into widespread use in the 2000s (Kahn 1990). William Kahn, professor of organizational behavior and the "father of employee engagement," defines it as "the harnessing of organization members' selves to their work roles; in engagement, people employ and express themselves physically, cognitively, and emotionally during role performances"(Kahn 1990). He believed that when three primary psychological needs are met, employees become engaged. Employees need personal feelings of meaningfulness (one is valued and appreciated), psychological safety (one can do and work without fear of negative consequences), and availability (one has the physical and mental resources without distractions to engage at work) (Kahn 1990). Later industry leaders coined alternative terms such as *employee satisfaction* and *employee experience*. The consistent theme remains an attempt to identify the key measures linking the traditional concepts of job satisfaction, employee retention, and organizational commitment.

It did not take long for the healthcare industry to begin exploring the value of engaging physicians and staff in hospitals and other health systems as a driver of profitability and improved retention. Kruse (2015) shows the links between employee engagement and profit in what he calls the "Engagement Health System Profit Chain" (exhibit 1.1).

Initial efforts to better engage healthcare employees have been directed at nurses; studies show that clinical outcomes as measured by such key metrics as mortality rate correlated with nurse engagement (Blizzard 2005). As physicians' roles in hospitals and other health systems have changed over the years because of increased physician employee agreements and shared-payment models such

Exhibit 1.1 The Connection Between Employee Engagement and Profit in a Healthcare System



Note: ↑ = increased; ↓ = decreased; HCAHPS = Hospital Consumer Assessment of Healthcare Providers and Systems Survey.

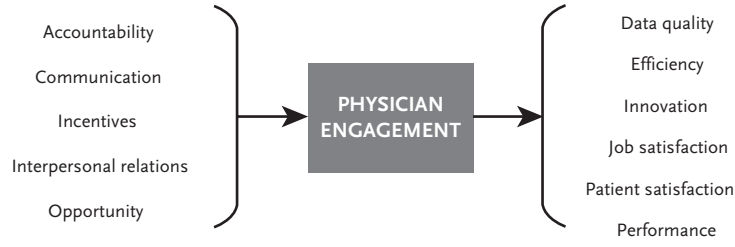
Source: Adapted from Kruse (2015).

as accountable care organizations, interest in ensuring an engaged physician community has intensified as well.

WHAT IS PHYSICIAN ENGAGEMENT?

Despite the number of hours that leaders have spent discussing, learning about, and writing about physician engagement, there is still no universally accepted definition. According to a literature review by Perreira and colleagues (2019), physician engagement is a "regular participation of physicians in (1) deciding how their work is done, (2) making suggestions for improvement, (3) goal setting, (4) planning, and (5) monitoring of their performance in activities

Exhibit 1.2 Key Input Drivers and Outcomes of Physician Engagement



Source: Adapted from Perreira et al. (2019).

targeted at the micro (patient), meso (organization), and/or macro (health system) levels." They went on to describe the five key inputs and six outcomes of physician engagement (exhibit 1.2).

If engaging physicians can be boiled down to five key drivers, why do so many systems appear to struggle at achieving meaningful and sustainable physician engagement programs? Common barriers include misalignment of intention, failure to achieve true involvement, and underestimating the level of commitment needed.

Misaligned Intentions: Differing Points of View

Physicians and administrators often find themselves in somewhat opposite roles in the healthcare system (exhibit 1.3). Administrators tend to view themselves primarily as businesspeople with skills and talents geared toward optimizing the operations and finances of the organization. Physicians view themselves as independent patient advocates who are best positioned to identify optimal care. These different perspectives create a natural source of tension as the overall market forces affecting medicine put pressure on health systems and practices to produce more at lower costs while pushing for enhanced quality.

Exhibit 1.3 Typical Characteristics of Physicians and Administrators

Physicians	Administrators
Science-oriented	Business-oriented
One-on-one interactions	Group interactions
Value autonomy	Value collaboration
Focus on patients	Focus on organization
Identify with profession	Identify with organization
Independent	Collaborative
Solo thinkers	Group thinkers

Source: Dye and Sokolov (2013).

Encouraging Involvement

Initially, systems look to engage physicians by including them in system-level decisions. When the inclusion is handled well, physician leaders gain insight into the rationale of decisions. Having a seat at the table empowers these physicians to own and champion initiatives and other projects. But involvement and input are not the same thing (exhibit 1.4). Unfortunately, many leaders mistake providing seats at the table for input as a surrogate for true involvement.

Commitment to Engagement

Healthcare organizations must continuously aim to engage physicians; the process requires commitment and dedicated resources. If leadership adds engagement to its system-level goals without giving this goal thoughtful attention, engagement is not likely to improve and could even be diminished. Similarly, bringing in outside consultants for a limited exploration of the culture of engagement will fail to yield sustainable progress alone. True commitment

Exhibit 1.4 Differences Between Involvement and Input

Involvement	Input
Physicians are always at decision-making meetings.	Physicians are sometimes invited.
Physicians are viewed as partners.	Physicians are viewed as tokens.
Executive leadership sees physicians as aligned.	Executive leadership seeks alignment from physicians.
Physician involvement is ongoing.	Physician input is sporadic.
Physicians remain in the process.	Physicians are occasional players.
Seeing physicians at the table is common.	Seeing physicians at the table is rare.

Source: Dye and Sokolov (2013).

requires an investment in data capture and assessment; identifying a team responsible for pinpointing opportunities; developing, implementing, and evaluating interventions; and making ongoing improvements.

Most experts recommend that physician engagement (and that of other healthcare employees) be measured annually and that results and plans for improvement be presented transparently. Major companies such as Gallup and Press Ganey offer surveys with additional services such as dashboards and consulting support. Some health systems will choose to develop and deliver their own internal tools.

Most engagement surveys ask a wide range of questions about the workplace environment, experience with key leadership, and individual personal development and experience. Key areas identified by Gallup in surveying physicians include the following:

- *Growth:* feeling that you are advancing and learning new things

- *Recognition:* feeling appreciated
- *Trust:* trusting that the organization has a bright future

One key insight consistent across surveys is that much like employee engagement, physician engagement is closely tied to the manager. Compensation, celebrations, and individual recognition programs are unlikely to improve overall engagement if physicians do not feel supported and appreciated by their managers. If senior leaders fail to prepare managers and physician leaders with the knowledge and skills to tactfully share the results with their teams, foster growth and discussion, and elicit specific improvement ideas from the front line, the overall engagement process will struggle to succeed.

PRACTICAL APPROACHES TO ENGAGE PHYSICIANS

Knowing what needs to be put in place to begin the journey to a culture of engagement and then implementing the steps to achieve goals can be challenging. Fortunately, the literature contains many case reports of successful engagement journeys. For example, Enloe Medical Center in Chico, California, improved its overall physician engagement from 44th percentile in 2009 to the 85th percentile in 2017 using a variety of techniques as shown in exhibit 1.5 (Nelson 2019).

Creating a Culture of Accountability

High-performing teams require mutual trust and commitment. If physicians are to be deeply engaged in an organization, both administrative and physician leaders need to feel a sense of mutual responsibility. In business models, this prerequisite is called *creating a culture of accountability*. To ensure a valuable, shared learning experience as organizations strive to improve performance and

Exhibit 1.5 Example of Actions for Physician Engagement

Administration Domain	Physician Group Culture Domain	Physician Leadership Domain
Seek physician input.	Create flexible schedules.	Hold annual off-site leadership retreats with medical directors, department chairs, and administrators.
Appreciate physician time.	Hold group social functions.	Prioritize physician leadership of quality initiatives.
Prioritize recruiting.	Promote journal clubs.	Hold regular medical director meetings with administration.
Use locum tenens physicians when needed.	Value physician participation on hospital committees.	Create monthly medical staff officer meetings with the CEO and chief medical officer (CMO).
Provide a comfortable physician lounge.	Lead quality initiatives.	Recognize and celebrate excellence in medical staff.
Host physician receptions.	Use technology, such as HIPAA-compliant texting, to connect with and support group members.	Create department meetings that value participation by all.

Source: Adapted from Nelson (2019).

raise their professional standards, the leaders must be transparent about their goals, their actual results, and their own responsibilities. One model, developed by culture management consultant Partners In Leadership and titled The Results Pyramid, reminds leaders that focusing exclusively on actions and results misses key foundational drivers of success (exhibit 1.6). In this model, leaders are encouraged to create experiences that enable physicians

Exhibit 1.6 The Results Pyramid

Source: Partners In Leadership (2019). Used with permission.

to examine their beliefs about their interactions and to make the desired change. This step helps physicians identify actions they can take to get the results everyone is hoping to achieve (Partners In Leadership 2019).

Set Expectations

Leaders must always set clear expectations. They cannot assume that each member of a team knows what is expected or which quality and performance measures are highest in priority (James 2019). By communicating the overall mission and vision of the organization, how this work supports that goal, and how each team member supports the work, leaders help get everyone on the same page. Some health systems consider using team charters or professional codes of conduct that are created by the organization to engage the frontline physicians in the discussions and to allow their input to help drive ownership of the final product.

Monitor and Report Progress

Improving physician engagement is a performance- and quality-improvement project. Like other initiatives, this project must identify key metrics, measure performance, and share the results. To reduce confusion, leaders need to include the full team when they identify the performance metrics and the sources of data being used to measure success. Shared agreements about critical definitions for professional behaviors or standards will make it easier for peer observation and assessment. In addition to helping the team see areas in need of ongoing improvements, leaders will be able to identify and celebrate areas of success. Feedback about progress encourages ongoing conversations, identifies roadblocks, and further engages teams as they work together to identify needed resources and support (James 2019). Leaders who check in with frontline team members will develop relationships and trust if they establish ongoing opportunities for communication.

Encourage Conversations About Accountability

Leaders can encourage people to share accountability with their peers by identifying how to have difficult conversations in a respectful way. In doing so, they will improve the chances that these interactions will occur. Setting the expectation that all team members are empowered to hold accountability conversations opens the door to bidirectional feedback that can identify and address concerns early. When a team member faces no consequences for poor performance, repeated failures to meet obligations, or unprofessional behavior, trust is quickly eroded and other team members will no longer feel obligated to commit to the established agreements. Although the person performing poorly may find the behavior easy, those who must give this person feedback may find doing so difficult. Leaders and peers may feel uncomfortable giving critical or negative feedback. Teaching specific feedback and conversation techniques can be valuable personal and leadership development for team members. Exhibit 1.7 gives examples of techniques and resources that leaders can use in encourage accountability among team members.

Exhibit 1.7 Examples of Feedback Techniques and Models

Cup-of-Coffee Conversation Example	
Technique	**Example**
Your aim is not to pass a verdict, but rather to raise awareness of the issue and to gain a better understanding from the other person's perspective. Be curious, and don't assume you have the whole picture already. Start with, "I was surprised to hear . . ." or "Perhaps you can help me understand this better . . ." After listening, you can then share your feedback in the appropriate context and remind the person how the individual actions play into the bigger picture.	**Manager: "**I was surprised to hear you have been late to the OR every day the past week." **Employee:** "My childcare has fallen through because of COVID-19, and I've been trying to get my daughter to school and still make it to my 7 a.m. start time. It has been really difficult, but I didn't want to just take the whole day off." **Manager:** "That sounds stressful. When you start late, it has a ripple effect on the other teams using the OR that day. Could we look at the schedule and figure a temporary rescheduling of your early cases until the childcare is covered?"
DESC Discussion	
Technique	**Example**
Describe: Use "I" statements to clearly describe the behavior you observed. Using "you" can come across as aggressive. Focus on just one recent action, and try to use nonjudgmental language. **Express:** Objectively describe the impact the action had on you, team members, and the business, including how it made you feel.	"I have noticed that you have been taking more than two weeks to finish your office notes. Twice, the physicians covering your patients were unclear on what the plan was, because the note was not completed in the chart. This was frustrating because they felt that they could not deliver optimal patient care. How can we help you finish your notes in a more timely way?"

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Technique	Example
Specify: Clearly specify what you would like the person to do differently next time. You can do this through a directive ("What I would like to see happen in this situation next time is . . .") or a participative ("How can we avoid this in the future?"). Request agreement from the individual. **Consequences:** Make it clear what the consequences of this behavior change will be. Ensure that the person knows the positive impact this change will have for both of you. If necessary, explain the negative consequences of not making these changes.	

McKinsey's Model	
Technique	**Example**
Part A is the action, event, or behavior you would like someone to change Part B is the impact of that behavior. Part C is a suggestion for what the person could do differently the next time.	"I notice you are late to clinic. It causes patients to be upset, and when you run late, the staff has to work overtime. I'd like you to arrive ten minutes before the session begins, so that you can start on time."

Stanford Method	
Technique	**Example**
Use a combination of these phrases in your feedback: "I like," "I wish," and "What if . . . ?"	"I like that you spend time with patients, getting to know them better. I wish you could do that without running an hour late during your clinic. What if we thought about ways to streamline your visits so that you continue to have time to chat with patients?"

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SKS Method	
Technique	**Example**
Use these three ideas in your feedback: • Stop • Keep • Start	"You are coming to the OR late, and I need that to stop. When you arrive, you are great at organizing the team and getting the cases done efficiently. Can we start moving your cases to the second slot so that you can be on time and still get your cases done?"
SBI Model	
Technique	**Example**
Situation: Describe the situation with specifics. **Behavior:** Describe the behavior observed; do not try to guess at motives or causes of the behavior. **Impact:** Describe the impact the observed behavior had.	"You have clinical sessions on Monday and Tuesday afternoons that are running more than an hour late. This is causing the staff to have to work overtime hours that they do not want to work, and patients are complaining."
BEEF Model	
Technique	**Example**
Describe the situation, using these aspects in order: • Behavior • Example • Effect • Future	"Your OR sessions are starting one hour late. For example, on Tuesday your first case was scheduled at 7 a.m. and you did not arrive until 8 a.m. The lateness caused the OR schedule for the rest of the day to be delayed. In the future, we need to start OR sessions on time.

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AID Model	
Technique	**Example**
Describe the situation using three ideas: • Action • Impact • Development or desired behavior	"Your office notes are not done within 48 hours as we have agreed on. This means your colleagues are unable to see your plans when covering your patients. We need you to finish your office notes within 48 hours."
BIFF Model	
Technique	**Example**
Describe the situation using these four approaches: • Behavior • Impact • Future • Feelings	"Your office notes are not done within 48 hours as we agreed on. This lateness means your colleagues are unable to see your plans when covering your patients. In the future, we need you to finish your office notes within 48 hours. Do you feel this is something you can do?"
Pendleton Model	
Technique	**Example**
Check that the employee wants and is ready for feedback. Let the employee give comments or background about the behavior or situation that has been observed. The employee identifies what went well. The manager identifies what went well.	**Manager:** "I need to give you some feedback about your OR start times. Do you have time to talk now?" **Employee:** "Yes." **Manager:** "How have your OR sessions been going recently?" **Employee:** "A bit stressful, to be honest. I catch up by the end of the day, but I have been starting

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Technique	Example
The employee states what could be improved. The manager states what could be improved. The employee and manager agree on an action plan for improvement.	late because I have to get my kid to school and the before-school daycare is closed because of COVID-19." **Manager:** "So, things going well include that the team is working well together and functioning efficiently during the day?" **Employee:** "Yes!" **Manager:** "And one area that could improve is the late start to the first session?" **Employee:** "Yeah." **Manager:** "Do you have any thoughts about the late starts?" **Employee:** "I don't know when the daycare will be open again, but I also don't want to take off, since we need to catch up on cases. Maybe I could move my first case to later in the day?" **Manager:** "That sounds like it might work. Let's look at the OR schedule together."
STAR Model	
Technique	**Example**
Situation/task: Describe a particular situation or task the employee was involved in; be as specific as possible.	"We are over on our budget for staff overtime hours this past month. Dr. X has been starting late each day and finishing more

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Technique	Example
Action: Write down the action the employee took, including details of what was said and done. This action could be positive or negative. Don't just use a generic phrase, but describe how the person accomplished the action. **Result:** Identify the result of the action so that the employee understands what the person did wrong or right.	late each day and finishing more than an hour late. Dr. X's sessions are causing overtime that the practice cannot afford. We need to find a way to arrive and finish the session on time."

Interpersonal Relationships

Relationship building can sometimes be overlooked in the workplace because it seems so basic, and yet it is foundational to a culture of engagement. The NEJM Catalyst Insights Council comprises a qualified group of US executives, clinical leaders, and clinicians at organizations directly involved in healthcare delivery. In this group, 90 percent of the group members chose interpersonal skills as the top attribute a leader needs to lead physicians, and 82 percent of them chose the same skills as the top attribute needed to successfully run a healthcare organization. Administrative skills, clinical training, and negotiation skills each received 69 percent or less (Zeis 2017).

Building and fostering relationships requires some intentional development and planning. To strengthen interpersonal relationships, leaders will want to be approachable, build trust, express gratitude, build alliances, and practice other interpersonal skills. Some examples of strategies to improve in those areas are listed in exhibit 1.8. One successful strategy for developing good interpersonal relationships is the use of leadership teams, a topic discussed in the next section.

Exhibit 1.8 Strategies for Strengthening Interpersonal Relationships

- Be approachable.
- Actively listen.
- Respect people: Refrain from talking down to them, avoid sarcasm, watch out for nastiness.
- Start conversations, and ask about the other person.
- Initiate repeated interactions and connections.
- Be mindful of cultural norms.
- Follow open-door policies.
- Avoid sweeping judgments.
- Have in place conflict management plans.
- Express gratitude.
- Build alliances.
- Don't blindside people—avoid ambushing your coworkers.
- Encourage team-building activities, such as ice breakers and other ways to learn how other think, communicate, and solve problems.
- Strive for optimism.
- Be flexible, adaptable.
- Build trust.
- Keep commitments and deadlines.
- Share credit for work and contributions of ideas.
- Respect others' time, and streamline business meetings.
- Be authentic; take responsibility for actions and decisions.
- Support teamwork.
- Plan occasional non-work-related social activities.
- Recognize people's birthdays, anniversaries, important life events, and so forth.
- Support other people, and help them find their greatness.
- Be inclusive; involve others in your discussion, projects, and activities.
- Share information about shared interests.

Source: Adapted from Baldwin, Dimunation, and Alexander (2011); Zismer and Brueggemann (2010).

Leadership Teams

Traditionally, healthcare organizations use an operations leadership model based on a team of supervisors, managers, and directors

working together under the leadership of a single vice president who coordinates and implements organizational initiatives (Baldwin, Dimunation, and Alexander 2011; Zismer and Brueggemann 2010). This hierarchy model diminishes physician engagement. Aside from the CMO, most physicians would be excluded from positions of legitimate authority and influence because they would lack a formal leadership role (Baldwin, Dimunation, and Alexander 2011).

Dyad and triad teams are a leadership partnership model that pairs leaders with different skills to oversee patient care, operational decisions, and clinical improvements for an organization unit (Zismer and Brueggemann 2010). There are various designs. Typically, an administrative leader and a clinical leader form a two-person team, or dyad. Each expert brings complementary skills and experience, ultimately forming a dynamic leadership team that shares accountability for outcomes. The triad model adds a nurse leader to the equation.

The dyad or triad model has several advantages, including these:

- It supports a shared vision.
- The model increases interactions between clinical and administrative leaders.
- It reduces leadership burnout.
- It allows access to a fuller spectrum of leadership skills than that afforded by one leader alone.
- The model maximizes the key skills and knowledge at the top of each leader's license or strengths.

Healthcare organizations are increasingly using these shared physician-and-administrator models of leadership. Just more than 70 percent of NEJM Catalyst Insights Council members say they use the dyad leadership model, and 85 percent think the approach is extremely effective, very effective, or effective, with 50 percent reporting extremely or very effective (Zeis 2017). The Medical Group Management Association surveyed 303 healthcare leaders, and 77

percent reported using a physician and administrator (dyad) leadership team model (Comstock 2019).

One example of successful implementation comes from Mayo Clinic. In 2015, the clinic reorganized the leadership structure of the emergency departments under a physician–administrator dyad. The pair worked together to develop regional steering committees, each committee led by a triad of a physician, a nurse, and an administrator. Mayo Clinic identified this change in leadership structure as a key driver in its successful transformation and key to gaining momentum for its journey toward system improvement. Buell (2017) discusses other organizations that have successfully implemented dyad models.

Dyads do have some potential pitfalls. First, selection of the leaders is critical. Their success will greatly depend on their ability to work together. Organizations should choose leaders who believe in shared leadership and who are system-level thinkers interested in problem solving. They should be well respected among their peers and be strong communicators. Second, the leaders must communicate with one another early in the relationship to set expectations and coordinate the work efforts. Having two leaders duplicating work or unclear about their own responsibilities would be ineffective and potentially harmful. The roles need to be transparent and shared with the whole team so that everyone knows whom to consult in different situations. In addition to the common goals and outcomes, leaders should consider identifying complementary key metrics and aspects each individual leader can own. Finally, the leaders in the dyad should have decision-making authority in their own domain of accountability (Baldwin, Dimunation, and Alexander 2011; Zismer and Brueggemann 2010).

Leadership Rounds

With a strategy called *leadership rounds*, system-level leaders intentionally make time to regularly visit each unit in the organization. Sometimes combined with other meetings such as daily team huddles, these opportunities for contact between the leadership and frontline staff are frequently beneficial. Although these visits could be simply social, most leaders will find that creating a purposeful

interaction can be a value-added connection that drives interpersonal relationships, improves communication, and builds trust. In one helpful model developed by a healthcare staffing company and labeled RELATE, the leaders are not only meeting with the clinical team but joining them on patient rounds and interacting with them as well (see exhibit 1.9).

Exhibit 1.9 A Model for Purpose-Driven Leadership Rounds

Reassure	Use this step to alleviate or reduce patients' fears about being admitted to the hospital or staff's fear about delivering care. Being present and empathetic during rounds can reduce these concerns. Be sure to introduce yourself and share your role and how long you have been with the organization.
Explain	Explain what rounding is and, without using any technical or medical jargon, explain its purpose. Employees should understand that rounding is a bidirectional opportunity for feedback, with the goal being to improve care delivery.
Listen	Encourage clinicians and staff to express concerns, ask questions, and be mindful of not judging anything that is said. Be aware that reading body language and other nonverbal expressions are an essential part of "listening."
Answer	Validate any questions that are asked, and clearly restate information. Use paraphrasing or teach-back activities so that staff and clinicians understand what is being explained or asked.
Take action	After gathering feedback, address any concerns that come up, and start to build a well-informed action plan. Manage staff and clinician expectations while taking proactive steps to exceed them.
Express appreciation	At the end of the interaction, thank employees, explain how the discussion will be followed up, and reiterate how nice it was to get to know the participants and understand their concerns.

Source: Adapted from HealthStream (2017).

Communication

Effective communication is critical in healthcare. Communication between healthcare leaders and between leaders and the frontline clinicians sets the tone of the organization and drives the overall ability of a group to deliver safe, high-quality, and patient-centered care across the continuum. Leaders must create an environment of open communication by modeling appropriate behavior, setting expectations, and investing in support systems in the structure of the organization. Managers and other leaders at all levels of the organization should promote patient-centered communication as integral to safe, high-quality care (Merlino 2017).

Effective communication is a skill that can be taught. Even good communicators can benefit from additional training, feedback, and practice. Training should not be limited to senior leadership. Enhancing the communication skills of all team members will increase efficiency, improve outcomes, and support team building.

Exhibit 1.10 shares highlights of best practices to consider for some common communication technology modalities, but these alone are probably not enough to improve the communication in your organizations. Having access to a variety of modalities and identifying which are preferable for your organization will be an individual decision. Most physician engagement work would benefit from a mix of modalities, with no one modality being optimal for all situations. For example, for a major new policy, it may be useful to deliver paper copies, send an e-mail, and follow up with a meeting (virtual or in person) to review the key details, while a small update could be sent out as a part of a standing e-mail newsletter or Yammer message. Knowing your physician audience and their preferences for access and communication will also help guide your choices.

Learning to communicate better will be a key development investment in better physician engagement. Communication training approaches can vary with the needs of an organization or a team, but some practical considerations include learning to adapt to another

Exhibit 1.10 Some Considerations for Communication Technology Modalities

Memos	
Pros	**Cons**
• Work well for physicians who prefer paper or who have limited access to internet	• May be lost or discarded without being seen • May receive limited attention because of large volumes of paper-based patient communications
E-mail	
Pros	**Cons**
• Is easy to send • Can create newsletters with multimedia • Imposes little or no cost	• May be screened out as spam, because of increased fraudulent e-mail • Many e-mails from multiple sources mean a single message can be overlooked easily
Texting	
Pros	**Cons**
• Allows short messages to go directly to physicians • Is accessible to most physicians through their smartphones • Is good for quick reminders	• Can share only limited information (which can be expanded with links to other sites, but links require physician action) • Can cost physicians not on an unlimited texting plan
Social Media	
Pros	**Cons**
• Offer a wide variety of options	• Typically require a separate account and log-in

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Pros	Cons
• Can be public (e.g., Facebook, Twitter, Instagram) or private (e.g., Yammer or Slack) • Can allow for conversation chains across groups	• Are potentially limited to physicians interested in social media • Can expose organization to potentially problematic external feedback when external accounts are used
Podcasts	
Pros	**Cons**
• Allow leaders to get deeper background to important issues and engage key physicians • Offer a discussion and learning tool for new concepts • Are easy for some frontline physicians to hear (familiar and common way to access continuing medical education and news)	• Require an additional modality to create and access • Require significant preparation by podcaster • Can be costly to produce and store depending on available resources
Video Messages	
Pros	**Cons**
• Can be combined with other modalities • Allow everyone to see the leader, allowing for an improved sense of recognition • Can share emotion along with message	• Require an additional modality to access • Can require time-consuming and costly filming, editing, and production, depending on the resources available • Can be blocked by e-mail servers

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In-Person Meetings	
Pros	**Cons**
• When planned well, promote group discussion and interpersonal interaction • Encourage transparency of discussion and decisions • Present opportunities for workshops and team-building and other activities	• Can be time-consuming • Are difficult to schedule, because of large groups and busy work schedules • Can be costly if refreshments are provided
Virtual Meetings	
Pros	**Cons**
• Allow for group discussion and interaction but with an additional barrier, given the video interface • Increase access for physicians unable to travel to the meeting location • Make discussion and decisions more transparent • Can encourage participation from traditionally silent members who will type comments but not speak in a large group • Can use polling and other interactive platform tools	• Require internet access • Can make one-on-one conversations difficult • Can leave participants distracted or not as engaged since they are not physically present

person's styles, learning to tell stories, and taking advantage of standardized communication tools.

Adapting to People's Communication Styles

Although personality testing may have fallen out of fashion, each member of a team has some preferences for how to communicate.

Exhibit 1.11 Four Basic Communication Types

Thinkers	Prefer numbers, graphs, and expert opinions. • Make quick, rational decisions. • Want to know "what if?" • Will bring you a computer printout of all their home-glucose readings (with trends).
Planners	Prefer organized information. • Need time to process, analyze, and reflect. • Want to know "what?" • Will take information home to think about it, and will follow up to share decisions later.
Dreamers	• Prefer big picture ideas. • Respond to creative examples and metaphors. • Want to know "how?" • Will take your one or two options for management and brainstorm ten more options.
Feelers	Prefer stories and people-based explanations. • Feel concern about impacts. • Want to know "why?" • Will tell you about their grandchildren and their last vacation before talking about any medical concerns.

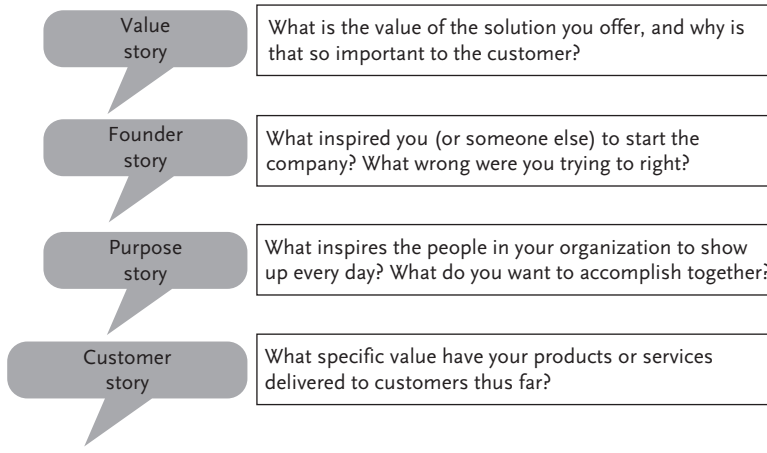
Source: Savoy and Yunyongying (2013).

Helping leaders and team members identify their preferences can help leaders communicate more effectively and in ways that feel more individualized to the physician (Savoy and Yunyongying 2013). Exhibit 1.11, reprinted from Savoy and Yunyongying (2013), describes the preferences of different types of communicators.

The Power of Storytelling

Regardless of the communication style, learning to tell an effective story will help leaders convey complex messages simply and evoke the emotion needed to rally a team to action. Storytelling allows leaders to communicate the values and beliefs of the organization and team using a method that makes the listener feel and think beyond the data or slides. Because stories attach emotions to the data, the memories become stickier, giving a leader who can create and share good stories a powerful leadership advantage (O'Hara

Exhibit 1.12 Types of Business Stories



Source: Adapted from Hall (2019).

2014). Fortunately, all leaders can hone their storytelling skills. As Kindra Hall (2019) explains in *Stories That Stick*, there are four types of business stories (exhibit 1.12), but leaders may need to use a combination, depending on their situation.

Becoming a storytelling leader does not have to be overly complicated. The process consists of three steps highlighted in exhibit 1.13 (Hall 2019; O'Hara 2014). The most effective stories

Exhibit 1.13 Tips for Creating a Memorable Story

Find	• Start with a clear message. • Mine your own (or the team's) experiences.
Craft	• Highlight a struggle. • Keep it simple. • Don't make yourself the hero.
Tell	• Practice makes perfect.

Source: Adapted from Hall (2019) and O'Hara (2014).

have a clear message or point and are relatable to the audience. Using examples from the team or your own personal experience will add a level of authenticity that cannot be matched. Give enough detail to help the listener understand the context and characters, but keep it simple. Having the main protagonist of the story hit a challenge that needs to be overcome and resolving the challenge (or prepping the team to discuss how to resolve the challenge) draws the group in and holds their attention. Avoid the temptation to make yourself the hero of your own story. While you can highlight the team, any statements about how great you are will probably be seen as self-aggrandizing and will backfire. Finally, remember that the more you practice and encourage the team to share stories, the better the group will become. Consider using leadership rounds as an opportunity not only to gather stories but also to share meaningful stories that help the team members see their contributions in action (HealthStream 2017).

Standardizing Communication Through SBAR

In addition to making it easier for your team to hear you by adapting to their preferred communication styles and telling stories that illustrate your key messages, using standardized team tools such as the SBAR (situation, background, assessment, and recommendation) protocol described in the next section or team huddles can also improve communication with the team.

Communication tools are most commonly studies in patient-care settings where one team or clinician needs to hand off or otherwise convey critical information to another team or clinician. The gold standard of patient handoff communication tools was originally developed by the US Navy to hand off information during shift changes on submarines. In a healthcare setting, the SBAR protocol was first introduced at Kaiser Permanente in 2003 as a framework for structuring conversations between doctors and nurses about situations requiring immediate attention (exhibit 1.14). The SBAR tool organizes information so that both parties know what to expect (Shahid and Thomas 2018).

Exhibit 1.14 Use of SBAR Protocol Across Healthcare Situations

Protocol Tool	Primary Question	Clinical Situation	Administrative Situation
Situation	Why are you calling or having this meeting?	I am calling because Mr. Jones in Room 3 is having chest pain.	We are meeting because we have had three patients complain today that they cannot get a timely appointment.
Background	What is the context or background?	He is the 65-year-old whom we admitted earlier for chest pain.	We have been working on improving access by adding additional appointment slots, but these were filled with hospital discharges.
Assessment	What did you assess?	I saw him, and he is diaphoretic and is clutching his chest. He has bradycardia, and his last troponin is elevated.	I reviewed the schedule, and there are open slots in the telemedicine schedules.
Recommendation	What do you recommend?	I think he is having an acute myocardial infarction. He needs an EKG, and cardiology needs to see him immediately.	I recommend we update our appointment script to offer patients telemedicine slots if we cannot see them in person in the time they prefer.

Team Huddles

Huddles are short meetings, typically ten minutes or less, held at the beginning of a clinical session or day to confirm that the team is starting out on the same page (Scoville et al. 2016). They are often used to actively manage quality and safety concerns, identify and brainstorm solutions for anticipated difficulties, and share key communication issues. These short meetings may also be an excellent place for leaders to hear and share stories about the practice—stories that can motivate the team. Some settings will hold a brief all-team huddle, in which the clinicians and staff working that day review practice or unitwide announcements. These huddles are then followed by smaller "teamlet" huddles (between, for example, the physician and a medical assistant) to review the specific checklists for the day. To run an effective huddle, most teams follow a standard agenda usually organized by a communication checklist or another tool. For maximum efficiency, the team members must typically do some preparation work before the huddle begins.

Incentives

The term *physician incentives* often conjures up the idea of paying physicians extra compensation for improved performance. While financial compensation is part of the concept of physician incentives, the World Health Organization defines incentives as "all the rewards and punishments that providers face as a consequence of the organizations in which they work, the institutions under which they operate and the specific interventions they provide" (WHO 2008).

While all incentives may include value, they do not have to be financial to be effective (exhibit 1.15). In addition to such financial incentives as wages, working conditions, and performance-linked payment, other incentives include career and professional development, workload management, flexible working arrangements, positive working environments, and access to benefits and support (WHO 2008). As noted in an earlier example in this chapter, a variety of financial and nonfinancial incentives helped drive Enloe Medical Center's success. Specifically, the center used physician

Exhibit 1.15 Types of Physician Incentives

Financial
Terms and conditions of employment: • Salary or wages • Pension • Insurance (e.g., health) • Allowances (e.g., housing, clothing, child care, transportation, parking) • Paid leave
Performance payments: • Achievement of performance targets • Length of service • Location or type of work (e.g., remote locations)
Other financial support: • Fellowships • Loans: approval, discounting
Nonfinancial
Positive work environment: • Work autonomy and clarity of roles and responsibilities • Sufficient resources • Recognition of work and achievement • Supportive management and peer structures • Manageable workload and effective workload management • Effective management of occupational health and safety, including a safe and clean workplace • Effective employee representation and communication • Enforced equal opportunity policy • Maternity and paternity leave • Sustainable employment
Flexibility in employment arrangements: • Flexible work hours • Planned career breaks

(continued)

Nonfinancial	
Support for career and professional development:	
• Effective supervision • Coaching and mentoring structures • Access to, and support for, training and education • Sabbatical and study leave	
Access to services such as the following:	
• Health • Child care and schools • Recreational facilities	• Housing • Transportation
Intrinsic rewards:	
• Job satisfaction • Personal achievement • Commitment to shared values	• Respect of colleagues and community • Team membership, sense of belonging

Source: Adapted from WHO (2008).

leadership development and solutions to barriers that the physician community was experiencing to deliver care as key incentives to drive engagement (Nelson 2019).

Create Opportunities for Professional Development

Senior leadership that actively creates opportunities for professional development will improve physician engagement. First, a leader needs to communicate and develop trust with physicians over time to be able to identify the skills that they should strengthen for their professional development. That initial investment demonstrates for physicians that the manager or other leader has a vested interest in their individual growth and sees them as a part of the overall future of the organization. Common concepts taught in leadership development include how to sharpen communication skills, deliver feedback, identify opportunities, and lead change. These skills

directly support the other practice techniques the senior leader has put in place. Who the organization chooses to develop, and how well these professionals will progress, will have a significant impact on the healthcare organization's outcomes. For this reason, leaders must carefully consider what type of professional development would benefit the organization. Hopkins and colleagues (2018) reviewed some models of physician leadership programs that are based on education models. The following are some questions to consider as you determine what leadership programming is needed:

- What leadership roles are you looking for the physicians to fill? (Are you looking to develop specific succession planning such as department chairs, service-line leaders, or more general skill building?)
- Among your medical staff, have you identified any common talent gaps for which universal training would be valuable? (If everyone would benefit from basic quality improvement, you may do wide-range training for everyone on the basics and then identify champions for additional professional development as needed.)
- Does your leadership team reflect the diversity of your organization and the community it serves? (Would any types of training encourage certain leaders to develop in a safe space?)
- Do you want to invest in building an internal leadership training program, send leaders out for training, bring in an external consultant, or implement a combination of these approaches? (Do you have local experts who can deliver the development programming you need?)
- How will you engage the physician leaders once they have been trained to use their new skills to support the health system?
- What metrics will you use to define the success of your leadership development program? (Will it be the completion of a training program, the outcomes of a project, the attainment of formal leadership roles, or something else?)

A Scenario with a Solution

Your Journey to Excellent Experiences program described at the beginning of this chapter may have been developed to apply data- and evidence-based approaches to improve the patient satisfaction scores across the institution. But you now realize that you have been gathering input from your physicians rather than engaging and including them. You open up a new document and begin to jot down some notes, including the name of a well-respected physician who can work with you as you move forward. You think about ways you can create more avenues for improving communication. For example, you could start leadership rounds to observe and hear more about what is going on at the front line. You will continue gathering data but will talk to the team about which metrics make the most sense to get to the goals and what barriers they see as preventing you from getting to the goal. Finally, you explore what incentives could be applied to help make the Journey to Excellent Experiences program a better success. It may not be an overnight fix, but you smile remembering the wise adage "If you want to go fast, go alone. If you want to go far, go together." This time, you are going together.

CONCLUSION

Physician engagement is a type of employee engagement that seeks to improve outcomes and profitability by ensuring that physicians feel appreciated, can work safely without fear of negative consequences, and believe they have the physical and mental resources to engage in their work without distractions. Organizations and senior leaders have to be willing to commit to physician engagement as an ongoing quality and performance improvement initiative that includes such resources as talent, time, and dollars.

Partnering administrative and physician leadership in dyad or triad teams can accelerate physician engagement by supporting each leader with the complementary skills from the other member or members of the team. Practical approaches to improving physician engagement often employ a culture of accountability, strengthen communications, identify proper incentives, and create opportunities for professional development.

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