Engaging the Front Lines: Clinician—Executive Partnership in the Pursuit of Value-Based Care

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Scholarly Report Title: Engaging the Front Lines: Clinician—Executive Partnership in the pursuit of Value-Based Care

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Abstract

TITLE: Engaging the Front Lines: Clinician—Executive Partnership in the pursuit of Value Based Care

Purpose: As health delivery organizations prepare to shift from volume-based to value-based reimbursement, executives will need to effectively translate institution-level incentives into actionable change on the front-lines of care delivery. We sought to determine if an opportunity exists for health system leaders to leverage the collective knowledge of front-line clinicians in navigating this transition, and to ascertain which communication practices best enable senior managers and front-line clinicians to work in tandem to deliver higher-value care.

Methods: Following a literature review to ascertain best practices for intra-hierarchical communication among, we developed a semi-structured interview questionnaire in order to understand how such practices could be translated to the challenge of clinician engagement. We interviewed executives, mid-level managers, and hospitalist physicians at a leading academic medical center. Interviews were transcribed verbatim and analyzed for common themes.

Results: Four themes were identified: 1) front-line input is valued by executives and is willingly offered by clinicians, but organizations often lack reliable channels of communication; 2) effective front-line engagement strategies must fit into existing clinician workflow; 3) call-out systems only succeed if accompanied by closed-loop communication and organizational capacity to respond; 4) previously successful safety programs may serve as a template for value initiatives.

Conclusions: Front-line providers are well-positioned to detect current drivers of low-value care, presenting an opportunity for partnership with managers who seek their input. To translate institutional incentives into delivery of high-quality high-value care—and to actively engage their clinicians in the improvement process—health care executives will need effective, well-defined lines of communication with their front-line care providers, a value-oriented institutional culture that encourages front-line engagement, and capacity to incorporate learnings from front-line feedback into the institutional strategic planning process.

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Glossary of Abbreviations

ACA: Affordable Care Act

CEO: Chief Executive Officer

VBC: Value-Based Care

Scholarly Project Question and Student Contribution to Work

Student Contribution to Work

The initial conceptualization of this project was the product of meetings between myself and my mentor, Dr. Neel Shah, based on our mutual interest in value-based care and institutional innovation. Under Dr. Shah's subsequent guidance, I served as lead investigator on the design, execution, and analysis of the literature review, and in the drafting and validation of the semi-structured interview questionnaire. I subsequently conducted all interviews related to the project, transcribed the interviews, and conducted the primary thematic analysis. Following completion of the analysis, I served as primary author on the resulting manuscript, and presented our findings at two conferences.

Scholarly Project Overview

Through this project, we sought to explore ways in which health system leaders could better leverage the collective knowledge of front-line clinicians as they seek to navigate the complex transition from a volume-based reimbursement ecosystem to a value-oriented system. We hypothesized that front-line caregivers, by virtue of their daily work, are uniquely positioned to detect current drivers of low-quality and low value health care. Given that successful solicitation of front-line input and successful implementation of institution-wide value-based reforms require effective top-down and bottom-up communication, we additionally sought to assess the nature of intra-hierarchical communication in large health care organizations, and to explore drivers of potential communication disconnects between front-line clinicians, mid-level management, and senior executives.

We approached these questions in two steps—first through a literature review, and subsequently through in-person and telephone-based semi structured interviews with individuals from across the hospital institutional hierarchy, from front-line clinicians to the CEO. The literature review had two primary goals. First, we sought to gain an understanding of the intent, pace, and projections surrounding the volume-to-value transition in health care, and to get a sense of the ways in which institutions are responding to this challenge. Second, we sought to understand the literature regarding best communication practices within large organizations, both

in health care as well as in other industries. This additionally led us to explore the characteristics and communication practices of "high reliability organizations"—entities that conduct complex and often dangerous work in a safe and controlled fashion. Insights from the literature review subsequently informed our creation of a semi-structured interview questionnaire, which was tailored for use with front-line clinicians, mid-level managers, and senior executives (see Appendix A). The semi-structured interviews focused on three primary topics: flow of ideas and information, barriers to effective communication, and the impact of value-based care for front-line clinicians. By asking similar questions to both front-line clinicians and senior executives, we aimed to elucidate whether there existed substantive differences (or similarities) in opinion between these two camps.

Following completion of interviews and thematic analysis of the resulting transcripts, I presented findings from our work at two conferences—the Net Impact Symposium at the College of William and Mary (2016), and the Foster Scholar Symposium at Massachusetts General Hospital (2016). We subsequently drafted a manuscript for a long-form perspective article based on our findings (Appendix B).

Appendix A: Semi-Structure Interview Guide

THEME	PRIMARY QUESTION(S)	PROBES
Flow of ideas and information Assessing: how information and ideas normally pass from frontlines to leadership; formal or informal mechanisms of information transfer	• In the last year or so, can you recall a new quality or safety improvement program in your department? (or some other policy change related to patient care?) o Do you know how it came about? o How did you find out about it? o Is that how you usually find out about policy changes or new programs? o Did that program work? o Do they usually work?	• Do you ever find out what the rationale was for the policy change/new program? How? Are you ever consulted beforehand? How often do these new programs come about? Are they popular with the staff?
	• If you had an idea for a new program, or for how to improve an aspect of care in your hospital, who would you talk to? o Who would they talk to? o Who would actually have the power to act on your idea? How high up the chain of command? o If you wanted your hospital's top executives to hear this idea, do you think you could reach them? How would it get there? o Do these ideas tend to "go anywhere"?	• Is there one person you'd go to for all ideas, or does it depend on the kind of idea? (e.g. different contact people for quality versus safety versus cost savings?)
	• Is there a specific mechanism or reporting structure in place for you to make suggestions or report problems you've encountered? o Have you used it? o Do you know of any changes that came about as a result of this process?	• Would you be inclined to communicate your idea? Why or why not? Are ideas encouraged by your leaders?
Barriers to effective communication Assessing: Frequency and quality of communication with leaders; problems with communication; causes of such problems	• How well do you know the leadership structure at your hospital? o At the department level? At the executive level?	• Expand on answers- why do you say that? Examples? Are there communication "bottlenecks" between yourself and hospital leaders?
	• In general, how frequently do you (or your colleagues) communicate with hospital leaders, like the CEO or the CMO? o What about with mid-level administrators, like your department chair? o How good is this communication? How does it take place (meetings, email, memos, etc.)	
	• Do you feel like your department or hospital leaders <u>want</u> your input?	
	• What's the biggest issue you or your colleagues face when trying to communicate with your leaders?	
	• Could communication with hospital leadership be improved? With departmental leadership? How? o Are there any common "bottlenecks"?	• Strategies? Platforms? Things that wouldn't work?
	• In general, would you feel comfortable reporting a problem with your department's way of doing things to your leaders?	
	• What do you think hospital administration doesn't understand about your role and position?	
Value and the Front Line Assessing: Capacity of the front line to detect and report on low value care; interest of the front line in doing so	• Have you encountered examples of waste or inefficiency in your daily practice? What about instances of unnecessarily expensive care?	• Do you ever discuss these issues with your colleagues? Your superiors? What does "value" mean to you?
	• Do you think front-line clinicians could be a good source of ideas for how to safely lower costs in the hospital? o Is that part of your job? o What would it take for this to happen successfully? o Would <u>you</u> be interested in helping to lower costs of care delivered in your department? What about your colleagues?	• Do hospital administrators/leaders ask for clinicians' ideas on improving value? Should they? Advantages/disadvantages?

Appendix B: Manuscript

Engaging the Front Lines:

Clinician—Executive Partnership in the pursuit of Value Based Care

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Volume-to-value: an inevitable transition

Amid the political maelstrom of US health reform, there continues to exist one overarching point of consensus: America's staggering health care price tag demands a shift from volume-centric to value-based reimbursement. Underneath the common assumption that payment reform will improve health care value is a second assumption: that delivery systems actually know how to deliver high-value care, and are ready to do so once given the means and motive.

For all practical purposes, most health care organizations have been able to navigate a split existence thus far, with a cautious toe dipped in a value-based system and the remainder comfortably wrapped in a familiar fee-for-service payment model. However, faced with a new array of financial and regulatory imperatives, health system leaders will confront ever-increasing pressure to substantively commit their organizations to value-based operations. Indeed, most health care executives now predict that the majority of their revenue will be tied to value by 2020.[1]

However, modern health care delivery is complex, and the pathway from a clinical decision to an outcome is seldom linear. As a result, while incentivizing value-based care through market and regulatory change is an enabling first step towards improvement, it is by no means a silver bullet. Providing care within a constrained budget while meeting quality targets, attending to the patient experience, and meeting other objectives of the value-based health care era will require more innovation. Rather, this transition will demand a fundamental transformation in the way health care organizations care for patients—and, in turn, the ways constituents of these organizations communication and collaborate.

Adaptation to value-based care requires both external and internal alignment

A challenge herein presents itself: those who will be held most directly accountable for these transformations are not the ones directly responsible for providing care. Health care value performance is generally measured at the level of the aggregate delivery system, not at the level of individual clinicians.

As such, health system managers and executives—not front-line clinicians—have their feet closest to the fire. To be sure, C-suite pressure toward a fundamental shift to value is a significant and crucial development in our drive toward a higher-value health care system. Substantive reform is impossible without buy-in and active leadership from the top, and a healthy body of evidence demonstrates that health care executives can indeed wield tangible influence on the quality of care provided within their organizations.[2,3]

However, while executive commitment is necessary, by itself it is not sufficient. Fundamental institutional change requires an all-hands-on-deck approach, with substantive input and buy-in not only from leadership, but also from the front-line clinicians and staff who are uniquely positioned to detect drivers of low-value care, and who will ultimately deliver the high-value reforms we seek. Thus, there are *two* necessary alignments that must take place within health care delivery organizations seeking to adapt to value-based care: an *external* alignment with new reimbursement incentives and paradigms, and an *internal* alignment between senior management, mid-level supervisors, and front-line clinicians. The former is a challenging-but-straightforward matter of strategic and financial planning, for which most hospital business development offices are already well-equipped. The latter, by contrast, will require new competencies—namely, well-defined avenues of communication between executives and front-line clinicians, a value-oriented institutional culture that encourages front-line engagement, and an institutional capacity to translate learnings from front-line feedback into actionable operational changes.

Given that the relationship between clinicians and health care executives is frequently defined more by tension and acrimony than it is by cooperation and partnership, critical questions arise: how can senior managers effectively translate the external incentives they face into internal priorities for front-line staff? Do front-line clinicians have the interest and/or ability to contribute to value-based improvements - and do managers desire their input? What institutional factors will ultimately decide if these new value-based initiatives succeed or fail? In a series of semi-structured interviews with senior executives, mid-

level managers, and front-line clinicians at large academic medical centers, we explored these questions from each stakeholder's perspective, from which the following themes and principles emerged:

1. **Front-line input is valued by executives and willingly offered by clinicians. However, there must exist well-defined bilateral avenues of communication—something many organizations presently lack.**

"If physicians are not central to the transformation that is occurring and needs to occur in health care, then it is doomed to failure."
– Chief Executive Officer

"[80% of] your true cost saving ideas, or any quality improvement ideas, have to come from the front lines, and you need to engage those employees, because they're the ones that really know what the issues are, and know ways to fix them."
– Director of Value Analysis

"In general I think there's great enthusiasm, because people are smart here, they know what's coming, they know what we have to do…the fatigue comes from how frustrating it is to not have the systems and processes in place to make it easy to do."
– Chief Operating Officer

To navigate the volume-to-value transition, health care organizations will need to establish and make use of open, bilateral communication pathways spanning the front lines, departmental management, and the c-suite. If the rationale underlying significant value-related institutional policy changes are not clearly communicated to front-line staff—even if instituted with the best intentions and with a solid evidence base—such initiatives are liable to be met on the front-lines with apathy at best, and active resistance at worst. Front-line engagement in value transformation is critical; given that clinicians directly influence more than 80% of health care's costs,[4] meaningful value improvement is only achievable with buy-in from those who ultimately deliver care.[5]

There is an additional practical reason for senior management to actively engage clinicians in this effort—namely, front-line caregivers are ideally and uniquely situated to detect drivers of low value in their institutions. Operating within these organizations on an intimate, daily basis, front-line providers frequently have a vantage point that their leaders lack. By actively soliciting and encouraging insights from these clinicians, health delivery organizations can identify problem areas requiring further attention

without the need for external consultants or audits. Front-line insights could instead directly aid in the crafting institutional policies and priorities. Such an approach simultaneously empowers front-line staff to take co-ownership of the process of value improvement, thereby increasing the likelihood that new initiatives will enjoy front line support and staying power.

2. An effective front-line engagement strategy must fit into existing clinician workflow and require low activation energy.

"Some of the [changes] aren't physician- oriented, so some of the fixes they come up with are crazy—like, would never work. You could tell they would never work, you're not surprised when they don't work. They tend to be more protocol based, as opposed to workflow based. Check another box, fill out another form, that kind of thing. As opposed to just having it live within the workflow itself."
-Hospitalist

"I've been doing this for 15 years, and my clinical job has never been harder…when you're clinically busy, you just want to get off, and when you're off, you don't want to necessarily think about [what needs improvement]…it feels like it has to be a passion and the north star of an individual [if they want to] fix something."

-Hospitalist

"There's a fallacy in thinking that all we need to do is align monetary incentives…all you're doing is dangling a carrot in front of someone or hitting someone over the head with a stick. But it's not really enough to get change."

- CEO

Extra bandwidth is generally nonexistent for clinicians. With scarcely enough time in the day to complete clinical responsibilities, it is not reasonable to expect most front-line staff to devote significant individual time or effort to communicate low value care practices to management. This is not to say clinicians are so busy as to not notice missed opportunities for higher-value care; to the contrary, nearly every physician or nurse is capable of rattling off dozens of low-value quagmires they encounter on a regular basis while in the discharge of their clinical duties. For managers seeking front-line input, then, the key is not to get clinicians to notice such occurrences, but rather, to make the reporting of such observations as effortless and as minimally-disruptive as possible. Fortunately, there exist plenty of potential strategies to accomplish this, ranging from EHR-based reporting systems, to targeted management "walk-rounds" (coming to physicians on their own turf), to utilization of standing sessions such as grand rounds or departmental meetings.

3. **Simple "call-out" programs won't work in the absence of accountability, closed-loop communication, and institutional capacity to respond.**

"We ran an actual campaign, huge emphasis on 'everyone should call out problems'…and it really, just totally bombed. And the reason was we didn't create the capacity to address problems as fast as they were coming. We created the expectation among staff, 'call it out, someone's going to listen, someone's going to respond, someone's going to help you'. But, we didn't give our managers the tools to actually be able to meet that expectation….So it was pretty demoralizing."

- Chief Quality Officer

"Talking about suggestion systems, we had one here at [hospital] in the early 2000s…it was on the EHR when we first developed the EHR…and what happened was that it just became more of a mechanism for complaining. And they actually just eliminated it, it didn't really go anywhere."

-Director of Value Analysis

"I think for the average front-line provider, they know they can bring [a problem] to their peers and they can bring it maybe to their immediate supervisor. But whether it gets taken any higher up, I don't know if there's confidence in that."

-Hospitalist

While a simple and easy call-out system would certainly fit the aforementioned need for low activation energy, a system that merely serves as a "clinician suggestion box" for low value care observations will rapidly lose front-line engagement if instituted in a vacuum. Namely, any program involving solicitation of front-line insight will have an exceedingly short shelf-life if those responding lose confidence in the notion of their suggestion ever reaching the ear of an administrator with the power to implement a response. Acquisition of front-line suggestions is only the first step of front-line engagement; a sustained program necessitates a transparent chain of command, and a reliable system of feed-back and follow up. Such feedback need not be exhaustive—a simple acknowledgement of the input, and a brief follow up explaining why action (a) wasn't taken or (b) to whom the idea was referred would almost always suffice. To be sure, most ideas likely should not reach the level of a senior executive; as one CEO pointed out, "it's a dangerous thing to run down the rat hole chasing after everyone's pet peeve, desires, or complaint". Nonetheless, any organization seeking to implement a front-line engagement and

suggestion-solicitation platform must put in place, at minimum, a point-person who can evaluate and respond to front-line input, and who is empowered to elevate worthy proposals if and when they do come through.

4. Safety programs may serve as a template for value programs

While this degree of front-line—management interaction may seem a significant departure from the status quo, such arrangements are not without precedent in many industries, health care included. Extensive intrahierarchical communication is a common denominator across so-called "high reliability organizations", which thrive in risky and technically complex environments.[6] Case studies of such organizations reveal frequent interactions between organizational leaders, mid-level managers, and front-line workers, established mechanisms for communicating errors or missed opportunities, and cultivation of a "safety culture" which permeates all levels of the organization.[7] These techniques have been also instituted with success in the health care setting, especially in the context of the patient safety movement. Case-in-point: many hospitals utilize patient safety reporting systems, conduct "safety rounds" with department heads and hospital leaders, and/or place explicit focus on cultivation of a general "safety culture" applicable to all staff regardless of position.

As such, the building blocks already exist to implement a similar institution-wide focus on value. These same approaches presently used for patient safety can be adapted to promulgate a "value culture" in health care organizations. In enlisting the front-lines in this effort, it should be emphasized that such a culture does not simply benefit the hospital's bottom line, but does in fact exist for the good of patients—amid rising deductibles and co-pays, patients' financial toxicity and avoidance of waste *is* a meaningful consideration for caregivers. Cultivation of a value culture – endorsed at the top, owned by those at the front-lines— ensures that control of waste and low-value practices isn't simply an executive's, manager's, or even physician of record's "problem", but is in fact a shared responsibility for all members of the organization.

Looking ahead

We will soon pass the point of no return in the volume-to-value transformation, if indeed we haven't already done so. As with all new paradigms, the field will split into predictable segments; the early adopters, the late adopters, and the laggards. The coming years of this transition will be a critical time for health care organizations; those who make necessary changes now top will lead tomorrow's health system, while those who continue business as usual will struggle to catch up. There exists tremendous knowledge and opportunity on the front lines; executives directing this transition would do well to build a value culture which taps that knowledge and engages these individuals in the volume-to-value transition.

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