The Best Way Hospitals Can Engage Physicians, Nurses, and Staff

By Dr. Bryan Oshiro

Engaging physicians, nurses, and staff can lead to improved quality and better patient care. However, getting engagement is tricky. This article will cover how hospitals can successfully engage their clinicians.

Successful Engagement: Physicians

Most Americans would agree the U.S. healthcare systems provide the best care possible anywhere in the world. The ability to save and extend life as well as reduce the suffering of those who are in the final stages of life is nothing short of miraculous. According to Journal of Patient Safety preventable medical errors are now the third leading cause of death in the U.S., behind only heart disease and cancer. In addition, more than 10,000 serious complications are also attributed to medical errors and are estimated to cost the U.S. $1 trillion dollars annually.

The U.S. ranks first in the world for per capita health expenditures, two and a half times the average for industrialized countries. Approximately half of the $2.9 trillion spent annually in healthcare expenditures could be saved by taking waste out of the system.

Healthcare Revolves Around Physicians

In order to reduce waste, hospitals will need to engage physicians. After all, physicians play a critical role in every aspect of healthcare. Physicians guide processes and decisions that are made inside and outside the hospital walls. Every strategy to fix problems in healthcare today revolves around the buy-in of one critical group—the physicians. Physicians determine 75 to 85 percent of the decisions that drive quality and cost. Gallup reported that at one health system whose physicians were in the top quartile for engagement increased outpatient volume by 17.5 percent, while disengaged physicians in the bottom quartile saw their outpatient volume decline by -11.7 percent.
The Challenge

Physicians are also impacted by the changes happening in healthcare—and not always for the better. The industry is transforming, leading clinicians to experience a shift in autonomy and possible changes in income and social stature.

Overwhelmed and ill equipped (along with a limited understanding of risk-based payment models or how their behavior contributes to healthcare waste and inefficiency), physicians are going through something akin to the five stages of grief. While most are beyond the denial phase, many are stuck at the anger stage.

Adding to the frustration, providers and payers are focusing only on employment as a means to engage physicians. Organizations over-weigh the importance of compensation to influence physician behavior. Most physicians are not business people, so financial incentives rarely influence their behavior.

Physicians are working long hours, are not compensated for their assistance, and are uncertain if management supports them. Malpractice concerns, a lack of meaningful measurements, and poor data analytic support also contribute to the feeling of frustration.

In my own experience, I have found implementing a new EMR resulted in clinicians working several more hours after seeing patients just to complete their documentation and other EMR functions. Although it would seem that an EMR system should help a clinician practice more efficiently, this is not always the case. Finding information is more streamlined, but there was also an increase in the EMR functions assigned to the physicians as well.

That’s not to say physicians are completely unwilling to change their behavior to remove waste from the healthcare system—it just depends on where the waste is coming from.

When changes were instituted for clinical integration programs at Intermountain Healthcare, it was determined there were too many elective deliveries occurring before 39 weeks. Many of the physicians looked at this and said, “It really isn’t a problem for us.”

When shown the data, however, physicians realized that there was a problem within the system. They saw that too many of these patients delivered early and the newborns were being harmed by this practice.
Today, we see a great deal of discussion around financial benefits as a reason to get physicians engaged. But, surveys show that if the change is only a cost benefit to the hospital, there is less interest from physicians.

The conclusion? If the change has a direct impact on patient care (making patient care safer) physicians are more likely to respond positively. Today, we see a great deal of discussion around financial benefits as a reason to get physicians engaged. But, surveys show that if the change is only a cost benefit to the hospital, there is less interest from physicians. This cost benefit approach doesn’t drive engagement or change physician behavior.

**Stages of Physician Engagement**

Similar to the stages of grief, there are also stages of engagement. Generally, physicians either don’t like change (aversion), or are okay with the change but not really enthusiastic about it (apathy). Finally, only after a lot of education and when they can see the value, does commitment to the change occur (engaged).

**A Matter of Trust**

So what can healthcare organizations do to deepen the engagement of physicians? First, physicians must believe the hospital can be trusted to consistently deliver on its commitments, such as promising to make OR slots available so surgeons can perform surgeries in a timely fashion. Even when seemingly simple things like creating a space for physicians to gather comes to fruition, trust is built between the hospital and the clinician. Physicians must also believe the hospital has integrity and they will always be treated fairly with satisfactory resolution for problems that may occur.

Physicians want to feel good about using the hospital and want to be sure that hospital use reflects positively upon them. This translates to having the hospital create services to support the delivery of exceptional patient care.

Physicians are passionate about caring for their patients. They view the hospital as irreplaceable and an integral part of their lives and their practice of medicine. When hospitals focus too much on the bottom line and cut services, physicians may no longer feel that the hospital is irreplaceable or functions as an integral part of their practice.

**Driving Change**

Max Weber, a German sociologist, said there are four things that motivate and drive people to change. These four levers must be implemented together, not in isolation. The Institute for Healthcare Improvement calls this a “Shared Quality Agenda.”
1. Discover a Common Purpose

The idea of identifying a common purpose cannot be overemphasized. The entire purpose of why doctors became doctors is to care for—and improve the lives of—patients. This must be the primary focus of everything done at hospitals or facilities or anywhere that engages physicians. This is what drives the physician base.

Healthcare organizations must also refrain from asking physicians to increase their time, busyness, or activities. Organizations must be very cognizant to ensure changes are implemented efficiently. Hospitals must also understand the culture of the local organization. Are the physicians, nurses, caregivers, and the hospital administration ready for change? A readiness assessment may be necessary, and, if possible, learn best practices from other industries that have successfully implemented quality initiatives.

The organization’s leaders must also understand the legal opportunities and barriers. Physicians are concerned about possible litigation, and although it may not be in the forefront of their thoughts, there can be a tendency to over-order tests and over-order procedures to protect themselves from malpractice concerns.

2. Reframe Values and Beliefs

Physicians should be treated as partners with the hospital, not customers of it. Many times hospital administrators appease physicians because physicians are viewed as customers. By partnering with physicians, hospitals can ensure better care for patients, which is the key focus of clinicians anyway.

Accountability for quality must be promoted for both the system and the individual. Personal responsibility for quality is powerfully engrained in all physicians. They do what’s best for patients. Many physicians are willing to spend an extra 20 minutes, even though it may mean delaying other appointments for the remainder of the day. Personal responsibility for quality is very much engrained in what clinicians do each and every day.

3. Segment the Engagement Plan

At the very beginning of the implementation of the quality initiative, identify and activate champions. Don’t overlook participants who may not have a senior title, as many clinicians who aren’t department chairs or in any type of management role still hold a position of influence within the community.
It’s important also to educate and inform structural leaders, such as department heads or medical directors. Show them the evidence and be transparent about the data because these leaders have the authority, given the natures of their positions, to influence change.

4. Provide Support and Education

The development of project management skills in these leaders can be provided by support and education; and not only for them, but for the rest of the staff as well. Physicians do not work well in an environment when there is a lack of understanding as to the strategy and purpose of the initiative.

5. Engage the Physician’s Intellect

Help the physician understand why the changes are taking place. Allow her to review improvement ideas or tests of change. Much like Deming’s 14-Point Philosophy, showing physicians how they fit in to the process and why they are important to the success of the initiative will increase the level of engagement and support.

6. Use “Engaging” Improvement Methods

It’s important to not only understand how the change will be implemented, but also the best way to gather support and commitment. Oftentimes checklists and institutional practices are viewed as cookbook medicine. It needs to be clear that what should be standardized will be standardized and no more. Physicians need to engage in those areas that fall outside these standardized practices.

Data must be used sensibly with a focus on the system’s performance first, not the individual’s performance.

All protocols that are changed need to be implemented in an open and transparent manner, making it easy to do the right thing while allowing for change as the initiative progresses. Nothing is written in stone.

7. Build Trust

Building trust is the most important piece of the process. Communicate often and candidly. Address concerns and issues in a timely and obvious manner. Identify and overcome barriers to engagement. The administration and leadership within the organization must be very responsive.

8. Show Courage

Sometimes physicians don’t feel it’s really safe to change due to doubts of the commitment and support of senior leadership or lack
of proper resources. It is important for physicians to understand that their requests for resources are not falling on deaf ears. Leaders must have the courage to ask, especially if the request is in the best interest of the patient.

9. Adopt an Engaging Style

Physicians want to be involved from the very beginning. Ask them how patient care can be improved. Because the underlying supposition is that improving patient care will allow for fewer mistakes, reduce waste, and provide patients the right care at the right time in the right place.

Working with the real leaders and early adopters and the early majority will come and follow. Don’t waste time on the laggards because they may never get on board. Spending more time and energy engaging the leaders and early adopters will move the entire curve.

Choose the messages and messengers carefully to ensure the message is delivered in a positive manner that appeals to physicians and encourages engagement.

Make physician involvement very visible. Physicians feel camaraderie with other physicians—a closed club perhaps. As physicians are placed in leadership positions, others will take notice and begin to believe the administration supports them because colleagues they respect and understand are part of the process.

Allow the clinicians to feel ownership even if it’s an issue like supply chain management that may be viewed as topic they wouldn’t care about.

Communicate early, candidly, and often. Value the physicians’ time as the culture and the workflow of physicians is very different from others in the hospital. Remember, for a physician to attend a meeting means taking their time either before clinic or during clinic hours, impacting their ability to see and care for patients.

Physician Engagement Requires Leadership and Trust

People, including physicians, resist loss (or possible or perceived loss), not the change itself. Keep the patient as the “North Star” with the end goal being the delivery of better care for patients.

Identify real leaders and early adopters; those who drive change from within the hospitals, clinics, and the organization. Equip them with the right tools, the right education, and the right resources.
Create a support structure and align resources within the institution to provide the infrastructure for change. Without this, it is really difficult to implement and sustain change.

Understand and mitigate real and perceived loss and realize it may take a lot of discussion and a lot of contemplation. There is no magic formula or cookie-cutter solution that can be mandated across the entire organization. It must be addressed at the local level.

And finally, create trust. Whatever promise is made, must be delivered upon. Use each success as a building block to drive long-term, sustainable change in the future.

Successful Engagement: Nurses

While all clinical teams are focuses on providing patient-centered care, it is impossible to emphasize enough how critical nurses are to ensuring patients receive optimal care. Nurses drive the triage process and assess patients immediately to ensure they receive the appropriate attention with the requisite degree of urgency. Nurses also partner with physicians, pharmacists, physical and occupational therapists, nurse practitioners, and others to develop a care plan. Nurses are the key link between the clinician, the patient, and the family. They provide education on the plan of care, define expectations, and address questions and concerns.

Because nurses play such an important role in delivering superior care, engaging them as active participants in a system of quality is absolutely essential. They must be viewed as an integral part of improving care. Include the nursing perspective early in any care improvement process, actively listen to feedback from nurses, and, of course, respect their contributions.

Engaging Nurses and Driving Improvement

Nurses are passionate about caring for their patients. The entire reason nurses became nurses is to care for and alleviate the suffering of their patients. Many feel healthcare systems are too focused on the bottom line at the expense of patients. Patients must be the central focus of every improvement initiative.

So, with all this in mind, how do healthcare systems deepen the engagement level of their nursing staff?
Data and analytics empower care teams to scrutinize each step of the care process and provide accurate facts allowing for corrective action in a non-judgmental way.

5 Dimensions for Improving Nurse Engagement

According to a 2014 report from The Advisory Board, *The National Prescription for Nurse Engagement*, there are five dimensions to consider when improving nurse engagement. Each dimension contains improvement opportunities, which I’ve explained in a bit more detail.

**Executive Actions**

Executive actions ensure that leaders in the organization act in accordance with the mission and the values of the organization. And most importantly, that leadership effectively communicate and translate the values and the mission of the organization to the frontline staff in a meaningful and effective manner. It is difficult to drive improvement in a culture that lacks an open, safe environment where discussions can take place regarding errors and their prevention. The tendency is to play the blame game. Historically, this has led to an unwillingness of making changes. Fortunately, the culture in healthcare has become more transparent over the last decade, and there is less concern (and fear) over assigning blame. Data and analytics empower care teams to scrutinize each step of the care process and provide accurate facts allowing for corrective action in a non-judgmental way. This helps create a culture of trust and continuous improvement.

Hospitals need to ensure that clinicians really trust this shift away from the blame and shame. Because this culture is entrenched, it takes time and consistency to create transparency. This is a lesson I have learned during my career. One example was when a patient experienced a cardiac arrest. Fortunately, the patient survived and after the incident I called a general meeting with the entire unit, who were understandably nervous. I told the team I wasn’t seeking to place blame on anyone. I simply wanted to understand what had transpired so that we could be much better prepared for other similar incidents that may occur in the future. While the nurses, staff and clinicians were skeptical at first, by the end of the discussion they understood what we were trying to achieve. As a direct result of this incident, we instituted a program to debrief the team following every incident. Indeed, we made debriefing a standard practice after all of our surgeries as well. We asked three questions: What went right? What didn’t? What can we do to do better? This process should become an integral part our culture.

I believe that only by being consistent in this approach and by committing to using the information and insights from this process for improving patient care can you establish a culture of transparency,
Frankly, medical errors and bad outcomes usually result from a series of errors rather than one individual’s mistake. Looking at the issues as a systems issue, rather than seeking to blame a particular clinician, is therefore much more productive.

Stress and Burnout

Burnout is an enormous problem when it comes to nurse engagement. According to a 2006 study in Nursing Leadership, 53 percent of nurses in the survey were in the “severe burnout category.” In a 1999 article in Journal of Health and Human Services Administration, Leiter and Maslach identified six interrelated areas of work life that directly contribute to burnout. When there is a mismatch in one of these areas, the result is often burnout:

- **Workload**: Be cognizant of work demands in relation to time and resources. For example, if an organization restructures its nurse management approach in a way that reduces the number of nurse supervisors who can help cover breaks and other events, be aware that having less support will negatively affect the workload of the nurses on the floor.

- **Control**: Ensure there is a clear understanding of expectations and responsibilities for each nurse’s role within the unit and within the organization. This will allow nurses to work with more confidence, more efficiently, and more independently.

- **Reward**: I’ll touch on this below, but the basic idea is to make sure nurses feel recognized for their efforts and that their work is valued across the organization.

- **Community**: Social relationships are important. When nurse managers are pulled off the floor to attend more meetings, they start to lose touch with the unit, its nurses, and that social connection.

- **Fairness**: As outlined in the section above on Executive Actions, trust and respect within a culture creates an
The development of a team creates an atmosphere of comradery where each member of the team (nurses, doctors, respiratory therapists, and others) function with a common purpose—they all work off the same game plan (care plan) for the care of the patient.

environment that is not only safer for patients, but more efficient.

- **Values**: When what’s expected of nurses and what they see from administration and physicians aligns with the values of the organization, nurses will be more engaged

Additionally, there is a direct link between empowerment and burnout. To help foster empowerment, flatten the hierarchical nature of hospitals through a **team-based approach** to patient care. The development of a team creates an atmosphere of comradery where each member of the team (nurses, doctors, respiratory therapists, and others) function with a common purpose—they all work off the same game plan (care plan) for the care of the patient. Nurses who know exactly what the plan is don’t have to defer patients and family member questions about the care of the patient. They are an integral and invaluable, active participant in all aspects of care. This leads to less frustration on the part of the nurse and empowers the nurse to work at the top of his or her license.

Nurses are suffering from improvement initiative fatigue. As the federal government announces new incentives, penalties, and timelines for the **transition to value-based care**, healthcare systems are implementing more and more strategies to improve the quality and reduce the cost of care. Programs are put in place, new protocols are instituted, and consultants are brought in for these ever-increasing initiatives.

Nurses can soon find themselves drowning in protocols that often require additional education and documentation—resulting less time spent caring for patients. The need to complete more documentation or enter additional data can easily add significant overtime to a 12-hour shift...not an ideal situation for increasing engagement.

Streamline care protocols and standardize order sets to enable nurses to implement care plans more efficiently and decrease unnecessary variation as much as possible. It’s important to use data to help clinicians understand how this will improve outcomes. This will help combat the impression that they are just doing tasks to meet some regulation or requirement. Validate nurses' expertise and training by allowing nurses to evaluate, critique, and have a mechanism to submit potential improvements to protocols and processes. Having a level of control in what they do on a regular basis goes a long way to empower nurses; it gives them a sense of purpose, allows then to feel engaged, and decreases a sense of frustration and burnout.
Staff Input

With any new improvement initiatives, nurses need to be involved from the very beginning and play an active role in the development of the program. After all, nurses are the only ones who can identify how the new program will impact their workflow, identify documentation issues, and see how these things will affect the care of the patient. Implementing a new program or changing an existing process will take longer (or will need to be changed later) if early nurse engagement is not employed routinely.

Data must be used sensibly with a focus on the system’s performance first, not the individual’s performance. Allowing for one, and only one strategy, provides the organization with a rallying point, increasing the chances for success and driving greater engagement.

All protocols that are changed, or new protocols that are introduced, need to be implemented in an open and transparent manner, making it easy to do the right thing while allowing for necessary changes as the initiative progresses. Nothing is written in stone.

The nurses must also have a committed leadership team behind them. Once a team identifies an improvement area that will have a big impact on the organization, senior leaders must support the initiative with resources—people and dollars. Successes lead to increased engagement and improved performance.

Recognition

In a truly meaningful way, respect and recognize the many contributions nurses make to both their patients and the organization. This can be done in public forums or be as simple as a hand-written thank-you note. I have found that being specific and timely with a compliment or appreciation goes a long way in developing a sense of pride and organizational allegiance in people. In addition, when the appreciation and recognition is bestowed upon them by their manager, this creates a sense of team cohesion at the unit level. For example, once during a particularly difficult fetal procedure, the scrub nurse performed an exemplary job in ensuring the procedure went off without a hitch. Immediate recognition personally by the surgeon and by her manager later greatly increased her sense of pride, not only for herself, but for her unit and institution. Honest and meaningful recognition of a job well done, increases loyalty and engagement.

Professional Development

Help nurses with training and development opportunities, including offering a clear career path. This not only helps ensure that nurses
have the right skills and knowledge for their work, but it increases engagement because nurses feel confident about their roles within the organization. Managers and leaders should always look to see how they can help their nurses develop new skills and encourage them to have stretch goals for their careers. Continuous opportunities for growth and development will keep the job from becoming stagnant. Nurses are highly educated individuals and thrive in such an environment.

Nurses and Physicians: A True Partnership

Physicians rely on nurses as true partners in care delivery. A strong team mentality is essential to creating a culture of continuous improvement. The number one way to ensure that nurses feel like they are really part of a team is for physicians to actively listen to them and value their input.

Nurses can sometimes be reluctant to challenge a doctor’s opinion or decision, leading to a lack of communication, which ultimately puts the patient at risk. I once had the experience of looking at a fetal monitoring strip, and determining an emergency C-section was needed. I ran down to Labor and Delivery to see what was going on and learned the nurses wanted to take the patient down to the OR, but hadn’t done so yet as the physician-in-charge hadn’t made the call. They were anxious about expressing their concerns, despite having recently received in-depth training regarding what constitutes a real obstetrical emergency. They knew the drill. The physician-in-charge needed to listen and take action based on their recommendations.

In my years as a physician and in various administrative roles, I’ve come to understand the vital contribution nurses make, how hard they work, and the extent of the burden we place upon them. It’s our job as a medical community to help ease that burden as much as possible. When we keep nurses in the know and demonstrate that we value their contribution and their feedback, we create truly effective teams of caregivers.

I recently heard a story on this topic told by a prominent chairman at a prestigious university hospital. At the time this story took place, his department was second to last in the state in quality metrics. His efforts to determine the root cause of the issue and improve outcomes triggered blame games. One day, he called an open forum with the senior residents. A resident complained that a nurse had challenged her decisions in labor and delivery. When asked, the resident reluctantly gave the nurse’s name. The next day he sent flowers to the nurse to thank her.
I love that story. Times have changed. Hospitals need dynamic, empowered care teams. Nurses are no longer subordinate to doctors. They must surface concerns and be treated as equal partners in care delivery. Without engaging nurses as true partners—as valued members of the improvement team—a hospital’s improvement initiative cannot achieve its full potential.

About the Author

Bryan Oshiro, MD joined Health Catalyst in January 2014 as the Medical Director. He received his medical degree and completed his residency in Obstetrics and Gynecology at Loma Linda University School of Medicine and completed his fellowship in Maternal-Fetal Medicine at the University of Texas in Houston before moving to Salt Lake City to join Intermountain Health Care and served as the Medical Director of the Women and Newborn Service line. He also was a member of the department of Obstetrics and Gynecology at the University of Utah. He then joined Loma Linda University where he became the division director of Maternal-Fetal Medicine and the vice-chairman for the department of Obstetrics and Gynecology. He co-chairs the American College of Obstetricians and Gynecologists Patient Safety Committee for District IX and received the Elaine Whitelaw Service Award from the March of Dimes for his work on a 5 state initiative to eliminate elective deliveries less than 39 weeks gestation.

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