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Redesigning healthcare from the ground up

By Jessica Sweeney-Platt | November 17, 2016

What can a physician leader do to prepare an organization for a seismic shift in payment models? That was the subject of a conversation at this year's SUMMITX — an annual healthcare thought leadership event, sponsored by Revive Health — between Jeffrey Rosen, M.D., chairman of the department of orthopedics and rehabilitation at New York Presbyterian Queens, and athenahealth's Jessica Sweeney-Platt.

Sweeney-Platt, executive director of athenaResearch, began the interview by discussing athenahealth's 2016 Physician Leadership and Engagement Index. The survey of 2,011 practicing physicians found that engagement levels among physicians are strikingly low: Only 20 percent of physicians defined themselves as willing to stay in their jobs and go above and beyond in their efforts. It also found that engagement is strongly correlated with trust in leadership.

Q Is engagement something that you measure formally at New York Presbyterian? Or is it more an "I know it when I see it" phenomenon?

A We are measuring it in different forms. The hospital is in the middle of tremendous transformation and upheaval. We're a 530-bed regional hospital that's now part of the number one health system in New York. So we are starting to measure engagement, to determine where we are lacking and then develop programs on how to engage physicians and their employees across the board.

Q Are there any operational insights coming out of that work?

A A team approach to leadership is necessary. Forming teams to accomplish tasks that involve both primary care and specialist physicians, paired with somebody from a C-suite, a nurse leader, and an administrative leader separate from the C-suite, and including voluntary physicians from the community, has been the most successful model.

Q There is huge demand for physician leaders, but the supply of physicians who are willing to take on leadership positions is lacking. Have you seen that when convincing your colleagues to take on leadership positions?

A Yes and no. In the broader sense, there's a shortage. But at the same time, changes in healthcare are going to push people in that direction. They're going to want to be involved in change other than just grinding it down in their offices. Some of those people are going to rise to the top, and it'll be easier to find them.

Q **How do you see that healthcare change progressing at the moment?**

A Healthcare transformation is happening. What's dragging it down is the fact that we still run healthcare as a fee-for-service model. All the things that we want to do — redesigning healthcare, changing it from the ground up, having physicians involved in non-billable stuff — is hard when you still hold them accountable for that.

I was at a meeting in Washington, and somebody stood up in front of the CMS [Centers for Medicare and Medicaid Services] representative and said, "What you're asking us to do is to commit practice suicide, to stop doing what you pay us to do." I think it's a key problem with everything that we're trying to do across the board.

Q **You've been getting ready for the mandatory, bundled-payment Comprehensive Care for Joint Replacements (CJR) Program. What role is physician leadership playing in this?**

A I gave a presentation about bundled payment programs and healthcare reform, and I titled my slide presentation "We Are Not Prepared." I was talking about the hospital and the system — they have not taken it seriously enough. It's me driving the hospital and also dragging along the system.

We meet every week on Monday mornings — the senior vice president, a nursing person, an anesthesiologist, the head of the nursing home, my patient care coordinator, the head of case management. And the more we do, the more I realize how far behind we are, and how not engaged the system has been.

Q **One of the themes that we saw coming out of our data — which seems particularly important in this time of transformation — was the importance of trust between physicians and non-physician leaders. There is still an "us versus them" mentality. What can leaders do about that?**

A The way to solve it is to make us "them" and them "us." It's to blur the lines of who is who.

I'll tell you examples of mistrust. About five years ago, our institution asked physicians to punch in and out. I went to the administration, and their answer was, "We punch in and out. Why shouldn't the physicians?" I said, "Do that, and you will lose the trust and the cooperation of every physician at this organization."

Q **How did it turn out?**

A It never happened, but that's an example of poor decision-making that would have been a disaster. Tremendous mistrust exists because there is a lack of communication from administrative roles to what your goals are down to the physician level, and then below, from the physicians to the staff. Right now, I'm looking at redesigning healthcare for CJR. Every single person in the hospital, from nursing on up and down, needs to understand why it's important.

Your nurses may complain that they don't have great staffing ratios. But they don't know that there's $1.5 million at risk if you're not successful on certain measures of the program. They don't know that, if they participated and were engaged and passionate about the programs that you need them to be, that there'd be something in it for them because there's something in it for the hospital.

Most of the employees — and we're trying to change that — don't understand what's at risk with healthcare reform and value-based payments, whatever they may be. And they need to be engaged. You need to align their roles and their success with your success.

Q And how do you do that, on a structural level?

A I'll give you an example with the CJR. A nurse was discharging patients, too many patients, to a skilled nursing facility, that was not one of the preferred providers. And the reason she did it was because her evaluation was based upon decreasing length of stay. Even though the orthopedic CJR team — and this is not at my hospital — felt that actually increasing length of stay would be beneficial to keep people out of skilled nursing facilities. But that's not how the nurse got evaluated.

So the goals, evaluations, and roles of everyone that takes care of a patient are not completely aligned with what you as an administration or a physician leader needs them to be. I always say that the administration should determine what its goals are. They should communicate that out, and then seek answers from the bottom up.

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