Engaging the Medical Staff

Partnering with Doctors to Achieve Mutual Goals
Clinical Operations Board

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## The Advisory Board Company in Brief

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<td><strong>Memberships Offering Strategic Guidance and Actionable Insights</strong></td>
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<td><strong>Seasoned, Hands-On Support and Practice Management Services</strong></td>
<td><strong>Partnering to Drive Workforce Impact and Engagement</strong></td>
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<td>• Dedicated to the most pressing issues and concerns in health care</td>
<td>• Millions of admissions flow through our technology platforms</td>
<td>• Years of “operator” experience in hospital and doctor surgeries</td>
<td>• Impacted the achievement of 76,000+ executives, doctors, clinical leaders, and managers</td>
</tr>
<tr>
<td>• 300+ industry experts on call</td>
<td>• Over 1.5 million user sessions annually</td>
<td>• Principal practice areas: hospital-doctor alignment, care transformation, surgery department optimisation</td>
<td>• 17,000+ outcomes-driven workshops tailored to partners’ specific needs</td>
</tr>
<tr>
<td>• 200+ customisable forecasting and decision-support tools</td>
<td>• Key challenges addressed: surgical efficiency, supply costs, and emergency department efficiency</td>
<td>• Range of engagements from strategy/diagnostic to best practice installation to interim management</td>
<td><strong>Survey Solutions</strong></td>
</tr>
</tbody>
</table>

| 165,000+ health care leaders served globally | $500+1 million in realised value per year | 1,300+ engagements completed | 6,200+ employee-led improvement projects |

1 USD.

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Over the past several years, the Clinical Operations Board has developed numerous resources to help members improve medical staff engagement. The most relevant of these resources are outlined on the right. All resources are available in unlimited quantities through the Clinical Operations Board membership.

**Collected Best Practices for Creating Capacity**

- **Doctor Leadership Effectiveness Compendium**
  Practices for Elevating Medical Staff Leadership Performance
  - Growing the leadership base
  - Advancing leadership development and support
  - Delivering structured performance reviews
  - Aligning compensation with performance goals

- **Achieving Breakthrough Engagement**
  Lessons from High-Performing Organisations
  - Elevating employee engagement through tactical or strategic approaches
  - Diagnosing organisational engagement needs and implementing a targeted improvement plan
  - Examining common factors among organisations with high sustained levels of employee engagement

- **Transformational Quality**
  Leading the Organisation to Clinical Excellence
  - Defining the executive’s role in clinical improvement
  - Identifying and enfranchising clinical leaders
  - Inspiring the front line to expend discretionary effort in quality work
  - Using data to drive organisation-wide improvement

- **Building the Evidence-Based Organisation**
  Supporting System-Wide Clinical Practice Change
  - Identify underleveraged Evidence Based Practice support tactics
  - Enfranchise doctors in Evidence Based Practice strategies and adoption by surrounding them with effective data and support
  - Ensure maximum return on Evidence Based Practice efforts by scaling clinical best practices across the organisation

- **Recovering Physician Loyalty**
  Lessons on Crafting a True Hospital-Doctor Partnership
  - Bringing quality to the fore
  - Addressing the operational efficiency concern
  - Supporting clinical practice
  - Demonstrating consistent patient service concern
  - Sharing decision-making authority

- **The New Quality Compact**
  Partnering with Doctors to Advance a New Performance Standard
  - Conducting effective doctor performance improvement conversations
  - Promoting the adoption of evidence-based practice
  - Aligning medical staff incentives through performance-based practice

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### Advisory Board International Membership Programs

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<td><strong>Transforming Organisational Strategy</strong></td>
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<td><strong>Service Line Strategic Planning and Investment Guidance</strong></td>
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<tr>
<td>Best practice research to support senior clinical and operational leaders who work tirelessly to provide safe, effective, and efficient care for their communities.</td>
<td>Keeping pace with disruptive change</td>
<td>Achieving excellence in care quality and safety</td>
<td>Improving governance and management of IT</td>
<td>Identifying strategic investment opportunities</td>
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<tr>
<td></td>
<td>Sustaining prosperity in a turbulent care environment</td>
<td>Improving the patient experience</td>
<td>Leveraging IT to improve care quality</td>
<td>Optimising investment decisions</td>
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<td>Partnering with clinicians</td>
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<td></td>
<td>Ensuring efficient use of resources</td>
<td>Managing nursing diversity and culture</td>
<td>Engaging doctors in IT adoption</td>
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<td>Cultivating clinical leadership</td>
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<td>Analysing vendors, applications, and industry trends</td>
<td>Increasing efficiency in investment evaluation processes</td>
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<td>Managing patients with chronic disease</td>
<td>Enhancing nursing staff efficiency and productivity</td>
<td>Optimising business intelligence and executive data strategy</td>
<td>Creating insights into future disruptive innovations</td>
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Raúl Sevilla
The Engagement Mandate
What Is Success in Health Care?

The Doctor’s Changing Role

The definition of success in health care is changing.

For centuries, heroic, life-saving action by a highly trained and talented medical practitioner has been perceived as the pinnacle of success in medicine.

There is still a place for individual heroics today, but excellence requires strong, consistent collaboration from a broad team of clinicians, non-clinicians, managers, data analysts, patients, families, and communities. The doctor’s critical role must expand.

Evolving Definitions of High Performance in Health Care

Heroic Action of Individual Doctors

- **Story in Brief:** Man Saved by Vodka Drip
  - Tourist presents to McKay Base Hospital in Queensland, Australia, with ethylene glycol poisoning requiring treatment with medicinal alcohol
  - Emergency doctor diagnoses patient, realises hospital’s supply of medicinal alcohol insufficient to treat patient
  - Doctor improvises; authorises purchase of case of vodka from local liquor shop
  - Patient drip-fed three drinks per hour for three days and makes complete recovery

Multidisciplinary Team-Based Care

- **Study in Brief:** Collaboration Key Factor in Quality
  - Examined levels of collaboration between nurses and doctors at three ICUs
  - Increased collaboration and communication improved patient outcomes across all three wards
  - Predicted negative outcomes declined by as much as 45% as collaboration increased
  - Fewer patient deaths and lower readmissions rate resulted from increased communication between clinical teammates

Globally, hospitals face strong operational imperatives that require doctor involvement. Meeting emergency and elective access targets and cost savings mandates demands process changes and redesign.

Such process changes often require new medical staff workflows. For the changes to succeed, doctors must lead process design and implementation and agree to comply with the results.

**Doctors Critical to Meeting Efficiency Challenge**

**Selected Global Efficiency Targets**

<table>
<thead>
<tr>
<th>Country</th>
<th>Target Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>£20B Efficiency savings by 2014-2015</td>
</tr>
<tr>
<td>Australia ED 1</td>
<td>4 hours To treat the patients in all five triage categories by 1 January 2015</td>
</tr>
<tr>
<td>New Zealand</td>
<td>&lt;4 weeks To provide radiotherapy or chemotherapy to all patients</td>
</tr>
<tr>
<td>Saskatchewan, Canada ED</td>
<td>0 hours Targeted wait time by 2017</td>
</tr>
</tbody>
</table>

**Sample Medical Staff Roles in Length of Stay Reduction**

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rapid Emergency Triage</td>
<td>Senior doctors agree to participate in 24-hour ED coverage to speed decisions to admit, discharge</td>
</tr>
<tr>
<td>Timely Patient Care Planning</td>
<td>Doctors attend multidisciplinary meetings with nursing, allied health, patient families to discuss patients’ treatment plans and post-acute needs</td>
</tr>
<tr>
<td>Morning Discharges</td>
<td>Doctor commits to rounding on discharge-ready patients in the morning, freeing beds</td>
</tr>
</tbody>
</table>

Doctors also play a central role in the drive to improve quality. To achieve government and accreditation standards, and more importantly to provide excellent care to patients, hospitals must engage in continuous quality improvement across all dimensions of clinical practice. But these improvements can’t succeed without the leadership and collaboration of doctors.

As one example, surgical safety timeouts are widely recognised as a method to improve surgery outcomes. They are also increasingly part of government and accreditation quality mandates. The successful implementation of a surgical checklist requires the leadership of surgeons; the safety-oriented culture required for consistent checklist use is impossible without the buy-in of doctors.

Without Medical Staff Cooperation, Quality Mandates Impossible

**Concept in Brief: Surgical Safety Checklist**
- Short perioperative checklist completed by surgical team, including review of patient identity and discussion of potential complications
- Reported results with complete adoption include reduction in complications from 11.0% to 7.0% (p<0.001); reduction in in-hospital rate of death from 1.5% to 0.8% (p=0.003)

**Selected National Quality Mandates**
- **United Kingdom:** Quality, Innovation, Productivity, and Prevention Program
- **Canada:** Canadian Institute for Health Information Health Quality Indicators
- **Netherlands:** Performance Indicators on Patient Safety and Effectiveness
- **Sweden:** National Health Care Quality Registries
- **Australia:** National Safety and Quality Health Service Standards
- **New Zealand:** Health Quality and Safety Commission Quality Indicators

**Rate of compliance with the sign-off portion of the surgical checklist at several United Kingdom hospitals**
8.8%

**Rate of complete compliance with surgical checklist in observational study at one New Zealand hospital**
0%

The executive agenda over the next decade will be shaped by five disruptive forces which will continue to require strong collaboration between hospital executives and the medical staff. Executing this agenda and transforming care delivery will require an effective partnership with doctors.

### Forces Transforming Healthcare

<table>
<thead>
<tr>
<th>The Greying Patient (and Provider)</th>
<th>Ensure top-of-license practice for all health care workers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Expand use of non-medical providers</td>
</tr>
<tr>
<td>The Lifestyle Epidemic</td>
<td>Support multidisciplinary management of chronic, multimorbid patients</td>
</tr>
<tr>
<td></td>
<td>Create cross-continuum care pathways</td>
</tr>
<tr>
<td>The Information Revolution</td>
<td>Implement electronic patient records</td>
</tr>
<tr>
<td></td>
<td>Develop and implement decision support to improve delivery of evidence-based care</td>
</tr>
<tr>
<td>Technology Advancement</td>
<td>Determine required technology investments</td>
</tr>
<tr>
<td></td>
<td>Ensure use of most clinically appropriate, cost-effective implants and supplies</td>
</tr>
<tr>
<td>The New Health Care Consumer</td>
<td>Improve the patient experience</td>
</tr>
<tr>
<td></td>
<td>Meet demands for transparency on quality and efficiency performance</td>
</tr>
</tbody>
</table>

*Source: Advisory Board interviews and analysis.*
Across almost all critical initiatives and strategies in the organisation, three major types of involvement will be required from doctors beyond high-quality care of individual patients: cooperation, contribution, and leadership.

 Virtually every successful initiative, change, or priority in the organisation will require doctors to participate in these ways.

 The Advisory Board’s Talent Development division’s work with over 76,000 clinicians indicates that doctors’ involvement at the most successful organisations is close to the model illustrated here. Almost all doctors across the organisation cooperate, quite a few contribute, and a smaller group leads.

 For a hospital to succeed now and in the future, the organisation will require this level of involvement from their medical staff.

**Doctor Roles Must Transcend Individual Patient Care**

**Engagement with the Hospital Required**

**Essential Medical Staff Roles for Organisational Performance Improvement**

**Leadership**
Leaders act as the motivating force for proposing and carrying out initiatives; influence peers to adopt, participate in, and sustain improvement

**Contribution**
Contributors participate in hospital committees and initiatives, providing time and expertise

**Cooperation**
Cooperators willingly act in accordance with hospital policies for clinical practice, standards of behaviour, and operational procedures

**Roles Played by Doctors at Organisations with High Levels of Engagement**

- **Leaders**
- **Contributors**
- **Cooperators**

Number of Doctors

Source: Advisory Board interviews and analysis.
Despite substantial efforts to improve, many organisations report that they lack sufficient numbers of doctors willing to act as leaders, contributors, or cooperators.

The Clinical Operations Board conducted a global survey to study medical staff engagement at hospitals. Most respondents felt that many doctors neither contribute to organisational improvements nor cooperate with policy. Unsurprisingly, nearly half of surveyed frontline managers indicated that poor doctor support stymied recent improvement efforts.

Even worse, respondents indicated that a number of doctors are actively or passively resisting efforts to improve: 93% of executive respondents felt that at least one in five doctors did not consistently follow hospital policy.

Current Situation Far from Ideal

Too Few Doctors Playing Required Roles

Too Many Uninvolved or Actively Resistant

Typical Doctor Involvement Model

Leaders

Contributors

Cooperators

Resisters

Failing to cooperate with hospital initiatives or actively trying to undermine them

Initiatives Fail When Doctor Support Lacking

40%

Clinical managers reporting failure of recent initiatives due to lack of doctor support\(^1\)

Executives Perceiving That Doctors Follow Policy Inconsistently\(^2\)

n=340 global hospital executives

More Than 80% of Our Doctors Consistently Follow Policy

93%

Fewer Than 80% of Our Doctors Consistently Follow Policy

7%

\(^1\) Clinical managers responding to the statement, “Our organisation was successful in securing sufficient doctor engagement to ensure the success of our recent initiatives”, options included, “Strongly disagree”, “Disagree”, “Agree”, and “Strongly Agree”. n=347 clinical managers worldwide.

\(^2\) Hospital executives responding to the statement, “In your opinion, what percentage of doctors almost always comply with hospital policy?”, Options included “0%-20%”, “21%-40%”, “41%-60%”, “61%-80%”, “81%-100%”, and “I don’t know.”
An Ambition Beyond Just Preventing Dissatisfaction

Four Primary Factors in Organisational Engagement

Defining the Engaged Medical Staff Organisation

Doctors self-identify as part of the organisation and are personally motivated to help it succeed

1) Engaged individuals strongly agree with at least two of the four statements in grey boxes, and at minimum agree with the others, on a scale of strongly disagree to strongly agree.

Source: Advisory Board Survey Solutions Physician Engagement Survey; Advisory Board interviews and analysis.
Many hospital leaders see the engagement gap they face and are making efforts to improve. This graphic outlines some engagement initiatives at a typical hospital. Common tactics address specific problems in various departments and wards, respond to complaints from staff, and share more information with doctors.

However, these efforts to engage the medical staff are failing to mitigate resistance and to inspire the levels of cooperation, contribution, and leadership required by hospitals.

**Typical Hospital Engagement Initiatives**

*Engagement Survey* conducted across hospital, participation varies by department

*Oncology Leadership Program* designed to identify new leaders, necessary due to high medical staff turnover

*Executive Rounds* occur quarterly on general medicine ward in effort to combat low staff morale

*Doctor Newsletter* created following complaints from medical staff on oncology ward that they felt uniformed about improvement initiatives

*Mentorship Program* used on surgical ward to improve compliance with quality standards and rules

*High Performing Staff Recognition Boards* instituted on cardiac ward to encourage staff compliance with surgical checklist

Source: Advisory Board interviews and analysis.
Medical staff engagement has remained limited so far because this engagement is fundamentally based on the strength of the relationship between the organisation and the doctors.

The Advisory Board’s engagement survey division has collected nearly 8,000 responses from doctors to examine the factors that increase and decrease engagement. Five factors correlate most highly to doctor engagement. These drivers are notable because they relate specifically to the relationship between the hospital and the medical staff. They also represent the areas where most hospitals are performing poorly.

A strong relationship aligns both executives and doctors behind shared goals, enables a give and take of ideas, and inspires doctors with a desire to take on leadership roles.

### Strongest Engagement Factors: Doctor/Management Relationship and Quality

<table>
<thead>
<tr>
<th>Engagement Driver</th>
<th>Beta</th>
<th>Percentage of Doctors Who Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would recommend this organisation to a friend or relative to receive care</td>
<td>0.184</td>
<td>47.6%</td>
</tr>
<tr>
<td>The actions of this organisation’s executive team reflect the goals and priorities of participating clinicians</td>
<td>0.122</td>
<td>13.5%</td>
</tr>
<tr>
<td>This organisation provides excellent clinical care to patients</td>
<td>0.118</td>
<td>34.5%</td>
</tr>
<tr>
<td>I am interested in medical staff leadership opportunities at this organisation</td>
<td>0.112</td>
<td>19.4%</td>
</tr>
<tr>
<td>This organisation is open and responsive to my input</td>
<td>0.105</td>
<td>14%</td>
</tr>
</tbody>
</table>

Three of the top five engagement drivers require strong relationship: hospitals typically are performing poorly on these drivers.

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1) Determined using multivariate regression analysis; model contains 14 of 28 drivers. All drivers correlate with the engagement index in individual regressions.
Fundamental Flaws in Approach

It is not surprising that attempts to improve engagement by implementing a range of discrete tactics do not have the desired effect. This approach fails to strengthen the relationship between doctors and managers for three reasons:

• It is fragmented; few organisations report having a formal strategy to improve doctor engagement. In addition, some leaders at organisations that did have formal strategies felt the strategy was not integrated with the organisation’s goals and values.

• It is reactive, focusing on responding to crises, problems, and complaints as they arise.

• It is delegated to medical staff leaders; with the exception of the chief medical officer, few senior executives are involved.

As a result, the current approach may achieve some functional changes in governance procedures or communication protocols, but it ultimately makes it impossible to create the strong connection between hospital leaders and the medical staff required for strong engagement.

Efforts Not Designed to Foster Relationship

Three Key Problems with Current Approach

**Fragmented**

*Hospital Executives Reporting Formal Strategy for Increasing Doctor Support*

n=55 global senior hospital leaders

<table>
<thead>
<tr>
<th>Yes</th>
<th>11%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>89%</td>
</tr>
</tbody>
</table>

**Reactive**

*Typical Process for Addressing Engagement Issues*

- Oncology consultants report low morale, feel uninformed

**Delegated**

*Executives Ask Managers to Address Common Problems*

- Executive focus on strategy, finances; limited time to address engagement

- Managers do not view hospital-wide efforts as part of their role

- Performance improvement team lacks authority to enact real change

Some Strategies Off-Target

“[Our doctor engagement strategy]…doesn’t have a strategic component to it, and there isn’t clarity for me about how it fits with the trust’s overall purpose, and how it connects to the values we may or may not have as an organisation.”

*Medical director, UK trust*

Source: Advisory Board interviews and analysis.
Successful Organisations Invest in Relationship with Medical Staff

Hospitals that have been most successful at improving medical staff engagement focus intently on developing a strong relationship between executives and doctors.

To achieve this, successful organisations took a coherent, proactive approach that was clearly led by the executive team. Executives displayed a clear personal commitment to building strong relationships with the medical staff and consistently implemented and refined engagement improvement strategies before crises or complaints could arise.

As a result, with the relationship as a foundation, doctors were much more likely to work with the hospital’s leadership on the organisation’s most critical goals.

Source: Advisory Board interviews and analysis.
Unclear Answers to a Complex Problem

To understand a coherent, proactive, executive-led approach to building a strong relationship in practical terms, it is first necessary to examine the underlying causes of the present poor relationship between the medical staff and the leadership team at most hospitals.

Unquestionably, the poor relationship has many complex causes. It is no surprise that in interviews with the Clinical Operations Board, many senior executives suggested that overcoming these long-standing issues would be too difficult, given the more immediate crises and pressures they faced. Yet a strong relationship with the medical staff is such a vital underpinning of hospital success that no organisation can afford to postpone this work.

### Underlying Causes of Poor Doctor-Hospital Relationship

<table>
<thead>
<tr>
<th>Cause</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician earnings</td>
<td>For nonclinical time typically lower or nonexistent; work often in addition to full clinical load</td>
</tr>
<tr>
<td>Doctor decisions on clinical matters</td>
<td>Usually supersede management policies; managers unable to challenge</td>
</tr>
<tr>
<td>Limited value seen in relationship with executive team</td>
<td>Both parties frequently perceive divergent goals</td>
</tr>
<tr>
<td>Limited numbers of influential doctor leaders</td>
<td>Who are also strongly aligned with executive goals</td>
</tr>
<tr>
<td>Few doctors accept personal responsibility for organisation’s success beyond provision of care</td>
<td></td>
</tr>
<tr>
<td>Involvement often requested for projects to benefit organisation</td>
<td>Doctors may see limited benefit</td>
</tr>
<tr>
<td>Doctors typically answerable to governance body</td>
<td>Outside hospital management structure</td>
</tr>
<tr>
<td>Entrenched lack of trust from current or previous managers’ failures to solve problems raised by doctors</td>
<td></td>
</tr>
<tr>
<td>Doctor leaders frequently lack key management, leadership skills</td>
<td>Needed to be effective advocates</td>
</tr>
<tr>
<td>Little understanding among medical staff of wider hospital context, threats, and imperatives faced</td>
<td></td>
</tr>
<tr>
<td>Historically poor doctor-manager relationship</td>
<td>Produces culture discouraging future association</td>
</tr>
<tr>
<td>Medical staff tenure</td>
<td>Frequently much longer than that of managers; can “wait out” decisions that are unpopular</td>
</tr>
<tr>
<td>Executive-doctor contact</td>
<td>Often not direct; limited personal relationship with most doctors</td>
</tr>
<tr>
<td>Low respect accorded to medical staff leaders by peers</td>
<td>Deters potential supporters</td>
</tr>
</tbody>
</table>

Source: Advisory Board interviews and analysis.
The Path Forward

Focusing on What Makes a Difference

How should hospitals shape their relationship strategy?

The high-level root causes of poor doctor-hospital relationship can be categorised into several groups. The first two are a misalignment of incentives for doctors to support the organisation, beyond their clinical role, and a lack of “clout” or ability on the part of management to compel medical staff to cooperate. Challenges in these two categories are difficult for hospital leaders to inflect as they are embedded structurally and culturally into the health system.

However, the final three categories are within the control of hospital leadership. First is a lack of trust in the executive team, or a belief that senior executives cannot be relied upon to support the medical staff. Second is a lack of supporters aligned with the organisation’s goals who can lead and influence others. Finally, there is a lack of ownership or personal investment in the success of the organisation.

To improve the relationship between the hospital and the medical staff, leaders must solve the issues of trust, support, and ownership.

Trust, Support, and Ownership Most Essential

Underlying Causes of Poor Doctor-Hospital Relationship

<table>
<thead>
<tr>
<th>Lack of Incentives</th>
<th>Lack of Clout</th>
<th>Lack of Trust</th>
<th>Lack of Support</th>
<th>Lack of Ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinician earnings for nonclinical time typically lower or nonexistent; work often in addition to full clinical load</td>
<td>Doctor decisions on clinical matters usually supersede management policies; managers unable to challenge</td>
<td>Limited value seen in relationship with executive team; both parties frequently perceive divergent goals</td>
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<td>Low respect accorded to medical staff leaders by peers deters potential supporters</td>
<td>No sense of ownership for organisation’s decisions among medical staff leaders</td>
</tr>
</tbody>
</table>

Difficult to change

Actionable areas

Source: Advisory Board interviews and analysis.
This study proposes seven lessons for building a relationship with doctors, ultimately partnering with them to achieve mutual goals.

Leaders must begin by laying a strong foundation. For most hospitals, misalignment between the executive team and medical staff means that the first step must be to repair the relationship and develop faith in the organisation’s leadership.

Second, hospital leaders must cultivate a group of allies among the medical staff who will help influence others to support the organisation’s goals.

With a strong foundation in place, the next step is to reset the relationship, moving from a transactional footing to a more equal, supportive relationship. This requires a frank conversation about the responsibilities of both parties towards each other and to the organisation and a true sharing of ownership for strategic decisions with the medical staff.

While many organisations have implemented some of these tactics, a coherent, proactive, executive-led approach and the correct order of implementation are critical for success.

### Partnering with Doctor to Achieve Mutual Goals

<table>
<thead>
<tr>
<th>Lay the Foundation</th>
<th>Reset the Relationship</th>
<th>Develop Shared Ownership</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Repair Executive-Doctor Relationship</strong></td>
<td><strong>Cultivate Medical Staff Allies</strong></td>
<td><strong>Define New Organisational Roles and Responsibilities</strong></td>
</tr>
<tr>
<td>1. Prove Commitment to Addressing Medical Staff Issues</td>
<td>3. Make Medical Leadership Positions Attractive</td>
<td>6. Define New Organisational Roles and Responsibilities</td>
</tr>
<tr>
<td>2. Guarantee Communication Reaches Doctors</td>
<td>4. Ensure Concrete Return on Skills Investment</td>
<td>7. Share Authority with Medical Staff Leaders</td>
</tr>
<tr>
<td>5. Invest in Relationship with New Hires</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Ultimately, the path forward is an organisational transformation from a situation where too few doctors lead, contribute, and cooperate, and many actively or passively resist, towards a situation where every doctor is willingly involved.

We don’t suggest that any organisation can reach a point where resistance never occurs. Yet our research has uncovered various organisations that have been able to make meaningful gains. This suggests that all hospitals have the potential to improve their relationships with their medical staff.

The executive-doctor relationship is so fundamental to the organisation’s success that it is worthwhile to invest in moving closer to the ideal.

Source: Advisory Board interviews and analysis.
A Moment of Opportunity?

Multiple Factors Pave the Way for Resetting Relationship

Several factors may make engaging medical staff easier today than in the past. Some act to increase doctors’ influence within the organisation, and others act to decrease it.

This relationship is in a state of flux. In addition to a strong need to improve the relationship with doctors, organisations may also have an opportunity to do so that did not previously exist.

Factors Decreasing Medical Staff Influence
- Development of technology that substitutes for medical decision making
- Increasing importance of team-based care
- Proliferation of new clinical positions that substitute for part of doctor roles
- Increasingly informed patients willing to question doctors’ diagnoses and decisions
- Rising scrutiny of, and accountability for, quality performance

Factors Increasing Medical Staff Influence
- Medical staff shortage in some regions and specialties
- Increasing patient complexity requires greater clinical expertise

Source: Advisory Board interviews and analysis.
Chapter 1

Repair Executive-Doctor Relationship

Lesson 1: Prove Commitment to Addressing Medical Staff Issues
Lesson 2: Guarantee Communication Reaches Doctors
Progress Requires Good Relationships

A strong relationship between the executive team and the medical staff is the first essential element to persuade doctors to work towards the organisation’s goals.

Medical staff engagement is directly correlated with how strongly doctors feel that the organisation shares their priorities and that leaders are actively working to address their concerns or act on their input.

Responsiveness to Doctor Input Correlated with Engagement

Level of Doctor Agreement That “Organisation Is Open and Responsive to My Input”

n=7,047 US doctors

Level of Doctor Agreement that Management Team Actions Reflect the Goals and Priorities of Participating Doctors

Influence Key Factor in Successful Management

“Instead of working in a hierarchy-driven system where power comes from authority, managers will need to exert influence, or soft power... Heroic leadership will not work, while engagement will be critical. Managers will need to win people round emotionally with a compelling vision, and employ political skills to get the right people in the right places to come round to their way of thinking, building communities of influence.”

“Leadership and Engagement for Improvement in the NHS: Together We Can”

The King’s Fund

1) Responses to the question “This organisation is open and responsive to my input”, against mean engagement index score of doctors in each response category.
2) Engagement index is a score from 1 (highly disengaged) to 6 (highly engaged).
Mistrust Undermines Relationships

Unfortunately, at most organisations the relationship between the executive team and the medical staff is weak. Clinical Operations Board interviews with hospital executives indicated that frontline doctors often do not trust the motives or promises of senior leadership. Interviews with frontline doctors likewise suggested that management is often seen as “unhelpful” and having conflicting goals and priorities.

Of course, this attitude is not shared by every doctor, but it was nonetheless widespread in every country in which we conducted interviews.

For any hospital, overcoming this mistrust must be the first step towards improving doctor engagement.

In Doctors’ Eyes, Executives Are…

“Irrelevant and Unhelpful
“Our contracted employees pretty much ignore us. They don’t see what we ask as very relevant to what they do.”

Executive, Australian public hospital

“Always at Fault
“In general, when something goes wrong, doctors blame managers.”

Consultant, NHS acute trust

“Seen as Out of Touch
“The goals come down from on high…For example, we've got this new mission statement about how the patient comes first, which is well intentioned, but slightly patronising because we're the people who are here at 3 a.m., not the managers. Of course the patients come first. Do we really need managers telling us that?”

Doctor, New Zealand district health board

“Failing to Communicate
 “[There’s] a lack of trust in the management. The main goals are given by the management and they seem very administrative to doctors. So there’s a lack of trust, due to a lack of communication and a lack of common goals.”

Medical director, Swiss hospital

“On a Different Page
“Hospital leaders share some of our values, but I am not always clear if their priority is patient satisfaction or government targets.”

Frontline clinician, UK hospital

Source: Advisory Board interviews and analysis.
Lesson 1: Prove Commitment to Addressing Medical Staff Issues

Senior Executive Role Critical to Change the Dynamic

Of course both doctors and executives have a role to play in overcoming this mistrust. However, in most cases, hospital senior leadership will need to take the first steps.

At organisations that have successfully improved medical staff engagement, senior executives have played a prominent and proactive role. Despite differences in personal leadership style, each leader followed the principles outlined here.

Defining Characteristics of Influential Leaders

Styles Differ, Foundations Set Stage for Success

Focus: Commit Resources
- Set aside resources dedicated to increasing engagement
- Invest in nonclinical time for medical staff to participate

Focus: Invest in Future
- Prioritise relationship-building across organisation
- Provide training opportunities at all leadership levels

Focus: Set Ambitious Goals
- Clearly and consistently share strategy and goals for organisational engagement
- Highlight and follow through on most important goals and actions

Focus: Raise the Bar
- Involve the medical staff in setting and refining goals
- Clarify expectations for attainment across hospital

Focus: Embed Excellence
- Actively support continual improvement opportunities
- Continue to prioritise engagement efforts, encourage staff contributions

Follow Through on Vision

Continually Seek Improvement

Focus: Grow Organisational Capacity
- Identify and address leadership shortcomings, in self and medical staff

Make Firm Commitment

Engagement Level

Investment Level

Source: Advisory Board interviews and analysis.
Many executives noted that doctors typically feel comfortable making their needs, priorities, and complaints known to senior management. But further investigations at some organisations show the situation illustrated here: a minority of highly vocal doctors offer feedback regularly, which creates the illusion of a robust conversation. Meanwhile, the majority of doctors feel that they do not have a voice.

Hospital leaders must evaluate their own dialogue with doctors in order to determine whether this is the case at their organisation.

Vocal Few May Be Dominating the Conversation

Common Doctor-Executive Communication Model

Executive

Vocal Minority
Small group of doctors frequently participate, complain

Silent Majority
Most doctors rarely offer input, feedback

Source: Advisory Board interviews and analysis.
Listening to Feedback from Many Sources

Ultimately, executives must pursue an approach that ensures their commitment to addressing doctor issues is apparent.

Many organisations already use multiple approaches to surface feedback from their medical staff: email, the hospital’s intranet, staff surveys, or in person discussion. However, simply surfacing feedback is not sufficient.

Many Leaders Open to Doctor Feedback

<table>
<thead>
<tr>
<th>Key Avenues for Listening to Doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Online Forums and Email Communication</strong></td>
</tr>
<tr>
<td>Hospital intranet site includes section for submitting feedback; doctors may also use email and other online communication to share concerns with executives</td>
</tr>
<tr>
<td><strong>Engagement Surveys</strong></td>
</tr>
<tr>
<td>Engagement surveys include open-response sections to solicit feedback and comments; allows doctors to provide anonymous feedback</td>
</tr>
<tr>
<td><strong>Culture of Open Feedback</strong></td>
</tr>
<tr>
<td>Managers and executives open to receiving feedback in formal and informal forums; many staff comfortable providing feedback directly to organisational leaders</td>
</tr>
<tr>
<td><strong>Access to Senior Executives</strong></td>
</tr>
<tr>
<td>Senior executives easily accessible to doctors; conduct ward rounds, spend time in doctor’s lounge, or have an open door policy</td>
</tr>
</tbody>
</table>

Source: Advisory Board interviews and analysis.
Doctors commonly complained that although executives were aware of the challenges they faced, little was done to solve the issues that were raised.

Lack of action on these issues reinforces the perception that the executive team is not interested in the problems doctors face, and it decreases the likelihood that new issues will be raised in future.

**Understanding Doctor Concerns Not Enough**

**Prove Commitment to Addressing Doctor Needs**

Listen

- Provide forums for doctors to voice their opinions and share feedback

Act

- Follow through on feedback and take steps to resolve problems

**Doctors Desire Noticeable Action**

“I'd really just like to see some action on key things. It's not just having chats with [managers]. I actually want things to happen…they meet with us and make soothing noises, but our feeling has consistently been that they're fobbing us off.”

*Doctor, New Zealand district health board*

Source: Advisory Board interviews and analysis.
Despite Efforts, Doctors Still Feel Ignored

In many cases, organisations are acting on doctor feedback when possible. However, such action is often insufficient. It is clear that despite these efforts, many doctors continue to feel that their issues are not addressed.

This problem occurs primarily because doctors are not aware of actions taken on their behalf. Executives must begin to rebuild trust not only by listening to doctor concerns or even acting on them, but by publically proving their commitment to address medical staff issues.

### Opaque Process for Resolving Doctor Issues Fails to Solve Frustrations

#### Typical Process for Resolving Doctor Issues

<table>
<thead>
<tr>
<th><strong>Listen</strong></th>
<th><strong>Act</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors submit feedback and comments to managers through a variety of forums</td>
<td>Management begins work to address problem raised by doctors</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Doctors Feel Ignored</strong></th>
<th><strong>Fail to Get Credit</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem addressed, but doctors may hear about it after the fact or not be content with the solution</td>
<td>Management lacks mechanism to explain what actions they were taking to doctors</td>
</tr>
</tbody>
</table>

Source: Advisory Board interviews and analysis.
At the Sydney Adventist Hospital, a 360-bed private hospital in Australia, the management team has been working to improve their relationship with doctors for many years. Notably, senior executives respond personally to feedback received through their engagement survey and other means. Despite these efforts, leaders were concerned that doctors were unaware of actions taken by executives in response to their feedback. They introduced a traffic light spreadsheet to update doctors on the status of issues that they and their peers have raised. The spreadsheet is completed by the director of medical services and shared at department meetings.

The traffic light colours indicate the status of the response and the action taken or planned. Green indicates that management has solved the issue. Amber indicates that management is working on addressing the issue. Red indicates that the hospital will not, or cannot, address the issue, and explains why.

This system allows all doctors to learn about the work managers are doing on their behalf, sending a clear message that the executive team prioritises doctor needs.

Transparency Changes Dynamic

<table>
<thead>
<tr>
<th>Engagement Survey Administered</th>
<th>Executive Review and Response</th>
<th>Update Status with Traffic Lights</th>
<th>Confidence Improves</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visiting medical officers complete survey about their engagement levels and provide feedback on operations</td>
<td>Executives review all surveys and respond directly to those individuals who provided their names along with comments</td>
<td>Hospital updates doctors about the status of complaints, using multiple communication channels, including a traffic light system</td>
<td>Over time, volume of feedback and number of doctors providing their names on surveys has increased</td>
</tr>
</tbody>
</table>

Case in Brief: Sydney Adventist Hospital

- 358-bed private hospital in Sydney, New South Wales, Australia
- VMOs\(^1\) take engagement survey every two years, provide feedback through other means; hospital executives review and respond to all input received
- Hospital uses “traffic lights”, among other communication systems, to update staff

A Common Challenge

“Doctors can be critical of management, and we’ve had that issue in the past, but through engaging with our doctors individually and at the department and Medical Advisory Committee level, our doctor engagement survey scores have significantly improved.”

Dr. Jeanette Conley, Group Director of Medical Services, Sydney Adventist Hospital

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\(^1\) Visiting medical officers, independent specialists working at the hospital.

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advisory.com
Sydney Adventist’s executives have been working to improve their relationship with doctors for several years and have seen impressive results—notably, doctors are now rating management performance higher than managers rate themselves.

Engagement Ratings Improvement 2002-2012

- "Hospital Consistently Meets My Most Important Expectations" 267%
- "Hospital Management Are Competent Administrators" 247%
- "Hospital Management Provide Effective and Timely Information" 152%

"In our most recent doctor engagement survey, doctors rated our organisational culture very highly, which was higher than we rated ourselves…I think a lot of that is related to how staff and management interact with them, because we’re talking to our doctors more.”

Dr. Jeanette Conley, Group Director of Medical Services, Sydney Adventist Hospital

Executive Response to Feedback

- 100% Named respondents receiving replies
- 280% Increase in number of named respondents, 2002-2012

1) In 2002, 20 respondents provided their name on the survey; in 2012 56 did, an increase of 280%.

Meaningful Action Changing the Relationship

Source: Sydney Adventist Hospital, Wahroonga, New South Wales, Australia; Advisory Board interviews and analysis.
Three elements are essential for executives to prove their commitment to addressing doctors’ needs.

First, listen to and understand doctors’ concerns, feedback, and problems. Second, act on the issues that are raised or, at minimum, respond to feedback items. Third, ensure that medical staff are aware of actions taken on their behalf.

Each of these actions reinforces the other, and missing any single step can negate the effect of the whole. This commitment to addressing doctor priorities is the first critical step that executives must take to lay the foundation for doctor engagement.

Omitting Steps Damages Trust

Three Elements Essential to Building Doctor Trust

Listen
Provide forums for doctors to voice their opinions and share feedback

Take Action
Follow through on feedback and take steps to resolve problems

Get Credit
Ensure doctors understand what action, if any, has been taken to address issues

Failure to take action or get credit for actions can lead to staff reluctance to raise issues in future

If action is not taken when feedback is sought, executive-doctor relationship worsened

Failing to get credit for taking action undermines benefit of action

Source: Advisory Board interviews and analysis.
Communication Not an Issue?

In tandem with proving executive commitment to addressing doctors’ issues, strong lines of communication are key to avoiding misunderstandings about motives or mistrust.

Many organisations have spent substantial time and effort to build strong communication processes.

Most Executives Communicate with Doctors Through Multiple Means

Sample Communication Channels

- **Newsletters**
  Share information with all hospital staff about hospital operations, events, and performance

- **One-on-One Meetings**
  Doctors meet face to face with executives or managers to share information and feedback

- **Town Halls**
  Executives present on topics of strategic importance and provide opportunity for questions and feedback

- **Intranet Sites**
  Used to post information for medical staff, including performance data and new policies

- **Department or Grand Rounds Presentations**
  Managers bring information directly to doctors at preexisting meetings

A Common Strategy

“Around three times a year…our Chief Executive and many members of the executive team go to each of our major sites, and some of the community sites, and hold town halls and give an update about what our performance is, about our targets, and our strategy at the moment, and maybe some of the key pieces of work that are going on at the moment.”

*Director of Human Resources, Australian public hospital*

Source: Advisory Board interviews and analysis.
Doctors Still Feel in the Dark

Despite these efforts, however, doctors report that they often feel ill-informed about their organisation’s priorities, projects, and challenges. This is the second major barrier to repairing the relationship: despite the many channels of communication that exist, doctors still feel disconnected from the organisation and its management team.

**Little Insight into Key Decisions**

“We have the black box approach: they don’t understand why decisions are being made, they can’t understand why certain elements of care are not provided, why other groups seem to be getting inequitable access.”

*Executive, Australian private hospital*

**Feeling Marginalised**

“Initiatives are seen as coming down from high, by people who have probably never set foot in the ward or seen a patient, and [doctors] are not able to translate it into real life. It’s not seen as engagement with people who actually understand what being a doctor or running a hospital means.”

*Doctor, New Zealand district health board*

**Information Frequently Ignored by Medical Staff**

“The primary means of communicating with doctors at this hospital is by a newsletter—which most doctors don’t read.”

*Consultant, UK hospital*

**Speaking Different Languages**

“Doctors [in my hospital] feel managers don’t listen to them, that they only focus on the budget…Managers need to realise doctors have a particular training and passion centred on serving their patients…so managers need to appreciate this and talk to doctors about their ideas, but also explain to doctors the resource restrictions they face.”

*Doctor, Australian public hospital*

**Not Getting Through**

“Communication is always a challenge. We are communicating with doctors a lot but people are still complaining that we don’t communicate enough. So we’re obviously using the wrong strategies because I think we are giving more than enough information but the receiver doesn’t get the message”.

*Chief Medical Officer, European public hospital*
Multiple Challenges Prevent Connection

This problem has two causes. First, many disengaged doctors are reluctant to attend optional face-to-face forums, the communication method most commonly used by executive teams. These doctors may also not read emails or newsletters.

Second, the hospital hierarchy is tasked with communicating with frontline medical staff, not held accountable for clearly and reliably transmitting messages.

The first issue will primarily be solved by raising the level of doctor engagement across the organisation. The second issue, however, is more amenable to intervention.

Failing to Get Through

Typical Hospital Communication Channels

Direct Communication Between Executives and Frontline Doctors

Common Methods
Open forums, town halls, executive breakfasts, emails, newsletters

Problem
Disengaged medical staff can opt not to attend meetings or read mailings

Cascading Communication Through Management Hierarchy

Common Methods
Medical staff hierarchy passes on key messages; ward or department managers communicate with doctors

Problem
No accountability for clear transmission of messages

Not for Lack of Trying

“We have a multipronged approach, we’ve got emails that go directly out to consultants, we have divisional team meetings, we have meetings about projects, we have the chief executive’s bulletin, we have the intranet…but it is amazing how many people can fail to have a hit on any of those, because though it is in their inbox, it has been deleted; though the intranet is there, they don’t look at it; they don’t read the chief executive’s bulletin, and no one has personally gone to talk to them on a one-to-one basis.”

General manager, UK Hospital

Source: Advisory Board interviews and analysis.
Baylor Healthcare, a 30-hospital system in Texas, struggled to communicate with all of their doctors system-wide. They used their quality committees to solve the problem. These groups, called “Best Care Committees,” were originally set up to promote evidence-based care.

Doctor champions are tasked with ensuring reliable communication between the system and local level. Champions have strong relationships with local management and are also well respected among their peers. Each champion shares regular updates with frontline doctors on governance issues and system strategy. They provide insight into the rationale behind decisions and what they mean for the front line. Champions also solicit input and report back to the local committee. This task is written into their job descriptions and they have paid time to do it. They meet with the system committee cochair monthly to discuss their performance and any barriers.

Clearly designated responsibility and accountability are key to the success of this strategy. This structure has helped Baylor spread initiatives more readily throughout the system.

## Case in Brief: Baylor Health
- 30-hospital system headquartered in Texas, US, with 600 doctors
- System and local committees ensure evidence-based care, and oversee clinical quality initiatives
- Each local committee has at least one designated doctor champion who is charged with disseminating information to frontline doctors
- Champions record preferred communication methods for assigned doctors to ensure information always gets to the intended recipient
- Hospital credits program with increasing hand-washing compliance from 50% to 96%

1) Chief Medical Officer
Effective Communication Principles

Organisations must evaluate their communication processes to ensure that communication is guaranteed to reach all doctors. The principles here provide guidelines to ensure that communication is effective and accessible to doctors.

<table>
<thead>
<tr>
<th>Elements of Effective Communication Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Convenient</strong></td>
</tr>
<tr>
<td>• Is information easily accessible to doctors in my organisation?</td>
</tr>
<tr>
<td>• Does my organisation proactively provide information to doctors?</td>
</tr>
<tr>
<td>• Do I provide a variety of forums through which doctors can access and share information to ensure that everyone has the opportunity to stay informed?</td>
</tr>
<tr>
<td><strong>Frequent</strong></td>
</tr>
<tr>
<td>• Are meetings and forums held regularly to allow doctors to access information and provide input?</td>
</tr>
<tr>
<td>• Do I make an effort to continually share important information?</td>
</tr>
<tr>
<td><strong>Tailored</strong></td>
</tr>
<tr>
<td>• Does my organisation track preferred communication methods for doctors?</td>
</tr>
<tr>
<td>• Are various forms of communication utilised—such as email, social media, formal meetings, and informal review sessions?</td>
</tr>
<tr>
<td><strong>Reviewed</strong></td>
</tr>
<tr>
<td>• Do doctors always know about the hospital’s most important priorities and understand the impact on them personally?</td>
</tr>
<tr>
<td>• Does my organisation regularly review the effectiveness of our communication methods and adjust as needed?</td>
</tr>
</tbody>
</table>

Source: Advisory Board interviews and analysis.
Building a Foundation for Influence

To repair the executive-doctor relationship, leaders must ensure that two foundational elements are in place.

First, leaders must prove their commitment to addressing doctors’ issues in advance of seeking their support.

Second, leaders must clearly, frequently, and effectively communicate with the medical staff, keeping them informed about the organisation’s key priorities and projects.

While these tactics are not new, this relationship and trust must be at the core of an ongoing strategy to create a partnership with doctors. No other engagement tactic can be successful without this foundation in place.

Key Components to Improving the Relationship

Prove Commitment to Addressing Medical Staff Issues
- Seek input from doctors
- Quickly address issues where possible
- Ensure doctors know issue has been addressed

Act Upon Suggestions
“Physicians want to be listened to and to see that their suggestions for improvement are acted upon. If leadership listens and follows up on physicians’ concerns, these physicians feel significant influence and control over their work environment.”

“Ten Evidence-Based Practices for Successful Physician Retention”
The Permanente Journal

Guarantee Communication Reaches Doctors
- Routinely share information with medical staff
- Ensure information is clear, concise, easily accessible

Proactively Share Information
“Share the thinking behind policy decisions. That is a key strategy that hospital executives need to adopt. Doctors will always respond well when they know what the thinking is. I also think accessibility to executives for the average doctor is also important: making an invitation to go and talk to them. Executives could also do a much better job of going to departments and talking to people. They should be more proactive about it.”

Doctor, Australian public hospital

Cultivate Medical Staff Allies

Lesson 3: Make Medical Staff Leadership Positions Attractive
Lesson 4: Ensure Concrete Return on Skills Investment
Lesson 5: Invest in Relationship with New Hires
Enlist Doctor Leaders to Engage Others

Repairing the relationship between executives and doctors is only half the battle. The second crucial step to lay a foundation for doctor engagement is cultivating a group of reliable allies among the medical staff who will influence their peers to support the organisation’s goals and actively contribute to important initiatives.

The top two groups from the successful doctor engagement model are the organisation’s most essential allies. Contributors devote time and provide expertise to hospital initiatives. Leaders act as the motivating force for initiatives, chair committees, and take up management roles. These roles may have a formal title and job description, but they may also be informal.

Identifying and supporting these medical staff leaders is a process that should be ongoing and continuous; as engagement increases, the group of supportive allies will grow.

Model of Doctor Support at Successful Organisations

Leadership
Leaders act as the motivating force for proposing and carrying out initiatives; influence peers to adopt, participate in, and sustain improvement

Contribution
Contributors participate in hospital committees and initiatives, providing time and expertise

Source: Advisory Board interviews and analysis.
Extending Influence, Informing Strategy

There are three main reasons why hospital leaders need strong medical staff leaders as allies. First, medical staff leaders are more influential with their peers than are managers. Second, they serve as the leadership team’s main connection to frontline doctors. Third, they provide essential advice and input on hospital initiatives to the organisation’s management team.

Key Benefits of Strong Medical Staff Leaders

- **Influence Peers to Adopt Change**: Clinical background and common motivations enable medical staff leaders to persuade peers to cooperate, and may circumvent negative attitude towards management.

- **Serve as Communication Link to Front Line**: Medical leaders are well placed to relay information to front line; can communicate information in terms of impact on day-to-day clinical work.

- **Inform Hospital Strategy, Initiatives**: Senior medical leader expertise and insight aids decision making and ensures that hospital strategy is aligned with clinical needs.

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**Successful Executives Forge Strong Doctor Bonds**

“Successful CEOs have strong relationships with their doctors. They have a reliable group of physicians who they can depend on for honest feedback regarding hospital initiatives, and who will serve as champions to rally other clinicians to support efforts to improve the hospital.”

*Radiologist and Doctor Engagement Expert*

Source: Advisory Board interviews and analysis.
Although all acknowledged that medical staff leaders were essential to achieving their organisation’s goals, hospital leaders across all regions of the world indicated that they had too few skilled, motivated medical staff leaders.

Good Leaders Scarce

Not Willing to Get Involved
“Doctors have problems being leaders and being led... they are too often reacting, usually negatively, to the ideas of others rather than taking the lead, helping to move things forward.”

Preoccupied with Other Priorities
“As doctors, many of us are busy and have other priorities. Few of us are willing to give up our practicing careers to devote the time to a leadership position in a hospital.”

Insufficient to Achieve Goals
“There is a shortage of leaders... there was a time some years ago, when we thought we could pilot quality of care or coordination from the top, not involving clinicians. And it’s not sufficient.”

Limited Options
“There are not enough ideal [doctor leader] candidates. The higher up you go in medicine, the less capacity there is to find talent. So I’m interviewing for a director of gastroenterology, and I have one candidate even though I’ve canvassed. I’m going for director of cancer services, and I have two candidates.”

No Aspiration to Lead
“If you asked them their aspiration, I don’t think many clinicians would say their aspiration is to be a chief medical officer... You’re sacrificing what you’ve trained for your entire life, basically, to possibly go along and sit in a series of meetings which you may not feel are particularly productive.”

The Wrong Skills
“You might have a doctor in a leadership role, but they have enormous difficulty... Part of their training is about how they are ‘it’ and that their view of the world is dominant, so they don’t get trained in collaboration, teamwork, or how to get things done from a team perspective.”

Willing Candidates Not Ideal
“You always have persons who think they have the right to be a leader, without asking themselves if they have the capacity to be one.”

Poor Role Models
“There is a desperate desire to have interested, smart, and realistic clinicians involved... but some of the people who have been involved with clinician engagement and leadership have not been good representatives or good advocates for the staff.”

Source: Advisory Board interviews and analysis.
Clinical Expertise: Still the Primary Criteria?

In the absence of strong candidates, many organisations have resorted to promoting doctors respected by their peers for their excellent clinical skills. This approach, while logical, often proves problematic. The story of Marino Hospital, a pseudonym, illustrated here is common: a highly respected doctor proves not to have the critical leadership skills needed, yet is difficult to replace once in the post.

With Limited Options, Clinical Skill Becomes the Primary Filter

Typical Leadership Selection Process

<table>
<thead>
<tr>
<th>Few willing candidates for leadership role</th>
<th>Clinical excellence earns respect of peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candidate displays strong clinical skills</td>
<td>Selected as leader</td>
</tr>
</tbody>
</table>

Result
Leaders may lack strong leadership qualities, management training, and personality traits for effective leadership

Case in Brief: Marino Hospital

• Senior medical leader chosen by executives based on respect of peers for excellent clinical skills
• Frontline doctors became alienated due to weak communication skills, and poor attitude
• Hospital unable to easily replace leader

Deficit Felt on Front Line

“In Australia, often, senior leadership positions are filled by the person who is a great doctor, who people look up to. But there is zero guarantee that this person will have great managerial skills…So we have a bunch of wonderful people in management roles, who can’t manage.”

Frontline doctor, Australian public hospital

Source: Advisory Board interviews and analysis.

1) Pseudonym.
Instead, hospitals must tackle the true root causes of the medical leadership shortage: poor recruitment, unappealing leadership roles, and insufficient training. Each of these factors prevents potential strong leaders from taking on leadership roles or from being effective.

Factors Contributing to Limited Pool of Good Leadership Candidates

<table>
<thead>
<tr>
<th>Potential Leaders</th>
<th>Poor Leader Recruitment</th>
<th>Unwilling to Take Role</th>
<th>Inadequate Skills</th>
<th>Good Leaders Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited efforts to identify and persuade potential leaders to adopt leadership roles</td>
<td>Medical leadership positions often poorly supported, thankless roles with few rewards</td>
<td>Current and potential leaders lack access to management training, or do not put acquired skills into practice</td>
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</tbody>
</table>
Poor recruitment is by far the easiest issue to resolve. Before addressing other root causes, hospitals should determine whether they could do more to identify potential doctor leaders and encourage them to take on leadership roles.

At McLeod Health, a five-hospital system in South Carolina, hospital executives realised that they relied on a core group of medical staff to lead any new initiative, in part because those were the staff that they knew.

To broaden their doctor leadership ranks, executives divided the medical staff list among themselves. They assigned each senior leader responsibility for cultivating relationships with a group of doctors. This initiative improved relationships with the broader medical staff and helped hospital leaders to better understand doctor priorities. Through the process, they were able to recruit more doctors to lead specific improvement projects that aligned with their areas of greatest interest.

In short, some doctors simply need to be asked to lead and to feel like their participation would be valued. That alone is enough to persuade them.

Identification of Additional Doctor Leaders at McLeod Health

Executives realised they all worked with a core group of doctors and needed to build relationships with broader medical staff

Each executive assigned to a group of doctors; met with all doctors to build relationships and understand interests

Conversations identified doctors eager to lead projects and take on leadership roles

Casting a Wider Net

“We found that we would all gravitate to those that were most engaged…There were many doctors that none of us had relationships with, and we wanted to break that pattern. The process teased out more doctors who then became leaders once we were dedicating focused time to see where they were coming from and what they wanted or needed.”

Donna Isgett
Senior Vice President, Quality and Safety

Case in Brief: McLeod Health

- Five-hospital health system based in Florence, South Carolina, US
- Seeking to increase number of relationships with medical staff, hospital executives created plan to meet individually with all doctors
- Meetings cultivated relationships, and uncovered cohort of doctors interested in taking on leadership roles
A more challenging issue is potential leaders’ unwillingness to take on these roles.

Leadership roles can be—or are perceived as—low impact. With little nonclinical time to lead, busy doctor leaders may waste what little time they have on tasks that could be performed by someone without a medical degree. For doctors to spend their time on these roles, especially in the absence of strong financial incentives, it is essential that they perceive these roles as worthwhile.

### Medical Staff Leadership Roles Typically Under-Supported

#### Practical Barriers to Effective Leadership

**Little Dedicated Time to Lead**

Clinical leaders do not have protected time to focus on their leadership responsibilities

> "Management for doctors is sort of the culture of ‘Oh, you’re head of your unit. [You can] fit it in between the patients and see how you go, see how it all works.’ And then it doesn’t happen."

Chief medical officer, Australian public hospital

**Inadequate Administrative Support**

Doctor leaders may waste scarce time in clerical or low-value tasks that could be completed by other staff

> “As clinical lead…I have no secretarial support and no dedicated risk coordinator. I have lots of ideas to improve our governance and risk management but nobody to help me with it.”

Clinical lead, New Zealand public hospital

**Perception of Little Support**

68% Doctors who do not feel they have sufficient support to engage in leadership activities1

**Challenge Shared by Most**

71% Doctors who do not feel they have sufficient time to participate in hospital improvement projects2

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1) n=42 New Zealand doctors.
2) n=154 global doctors responding to the question “I feel that I have sufficient time to participate in projects to improve hospital quality and efficiency.” Answer choices included: “Strongly disagree,” “disagree,” “agree,” and “strongly agree.”

Source: Advisory Board interviews and analysis.
Auckland District Health Board has taken an approach to address both problems. The largest health care organization in New Zealand, they are responsible for primary, sub-acute, and acute care provision for nearly half a million Auckland residents. Recognising that past improvement projects had not been as effective or as efficient as they had hoped, they invested in a Performance Improvement Team. This team is comprised of nonclinical staff with strong skills in change management, data analytics, Lean or Six Sigma approaches, coaching, and communication. They are a decentralised team and one or two members are paired with clinical leaders on any major project within the organisation.

**Case in Brief: Auckland DHB Performance Improvement Team**

- Performance Improvement (PI) team within Auckland District Health Board, major public system with over 10,000 staff serving over 460,000 residents in greater Auckland, New Zealand
- Decentralised team provides change management, analytical, and facilitation expertise to improvement projects
- Team members have Lean, Six Sigma backgrounds, strong skills in data analytics, coaching, communication, and developing sustainable solutions
- Performance Improvement team member partnered with doctor leaders to lead improvement projects; their expertise complements doctor leader skills and reduces time required of medical staff leaders

**Partnering Maximises Medical Staff Leader Value**

Performance Improvement staff paired with doctor leaders to aid in building business case and planning and managing improvement projects.

Tasks include data collection to prove need for change, facilitation, change management, solution development and implementation, and monitoring results.

Performance Improvement team provides doctor leaders with evidence, and change management approach to allow doctors to focus on leading the change, contributing expertise to solution design, and convincing sceptical colleagues.

Combined efforts of doctor leaders and Performance Improvement partners improve efficiency, effectiveness of change efforts.

Source: Auckland District Health Board, Auckland, New Zealand; Advisory Board interviews and analysis.
Combined Skill Sets Support Successful Projects

The Performance Improvement Team have worked with medical staff leaders on numerous projects across the health system. Just one example, a project to reduce wastage during blood transfusion, has saved the health system NZD$6 million to date.

Leaders at Auckland DHB report that the effect has been impressive. Medical staff leaders are now able to focus on the elements of improvement projects that they're best equipped to deal with: convincing skeptical colleagues and contributing their expertise to the design of solutions.

Most importantly, it has enabled Auckland DHB to persuade more medical staff to take on leadership roles for change and improvements that matter to them personally.

### Blood Transfusion Reforms Proposed

- Doctor leader realises clinicians often transfuse two units of blood though one is usually effective.
- Improvement committee approves proposal to redesign blood transfusion process; assigns PI\(^1\) staff member.

### Partnership Leads to Reform Success

- Doctor leader heads clinician-led redesign of blood transfusion protocol, rewrites junior doctor transfusion training, and raises awareness of reform project.
- PI staff member collects data to prove transfusion inefficiency, spearheads change management campaign, “Why use two when one will do?”

### Partnership Approach Yields Significant Results

- **$6M**
  - Savings generated from reduction in use of blood and blood products through better application of clinical guidelines\(^2\).

### Team Efforts Prove Most Effective

“...we have been successful by partnering doctors with people with change management and process improvement skills. We are seeing more and more clinicians taking advantage of this resource to get things done with great effect.”

*Greg Balla, Director Performance and Innovation, Auckland District Health Board*

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1. Performance Improvement.
2. NZD.
Doctors may also be reluctant to lead due to the limited prestige of these roles among the medical staff. This is a more challenging issue to solve and will take time to address. However, hospital leaders can and should take steps to support this evolution.

One organisation, Sentara Healthcare, identified 65 influential doctors who they wanted to take on the role of "safety champion". Although not all of the doctors were enthusiastic, Sentara publicised the selection and patients quickly began to notice whether or not their doctors were safety champions. This public recognition quickly reconciled the new safety champions to their leadership roles. This has enabled Sentara to double the number of champions that they have.

### Case in Brief: Sentara Healthcare

- Ten-hospital not-for-profit system based in Norfolk, Virginia, US
- As part of hospital-wide focus on safety, designated 65 medical staff as formal "Safety Champions"
- Champions did not volunteer for role; publicity generated by hospital and respect accorded to role by patients served as powerful incentive to participate
- More than 130 Safety Champions now willing participants in the program

### Safety Champion Program Outline

1. **Selection**
   - 65 Safety Champions selected based on influence over peers

2. **Formal Training and Role**
   - Safety Champions trained in error prevention and asked to support safe practice for peers

### Patient Respect the Best Motivation for Participation

- Safety Champion status is listed on the hospital website
- Doctor photo appears on Safety Champion poster in hospital lobby

### Swelling the Leadership Ranks

130+ Safety Champions now serving the organisation
No Motivation to Break the Cycle

There is no magic bullet to make doctor leadership roles more attractive: hospitals must simply invest in making the roles more effective.

Unfortunately, for many executives it can be easy to discount the potential effect. Because doctor leaders aren’t well supported, their value and impact on the organisation is limited. This makes it harder to build a business case for further investment in doctor leadership.

However, to seriously improve the caliber of doctor leadership, it is essential to break this cycle.

Past Ineffectiveness Prevents Leadership Investment

Poor Outcomes of Under-Supported Leaders Discourages Future Investment

Low Attractiveness: Potential leaders unwilling to take a role they know has insufficient support to be effective

Low Effectiveness: Leader achieves little due to insufficient support

Low Investment: Managers unwilling to invest in role due to low ROI

1) Return on Investment.

Source: Advisory Board interviews and analysis.
Defining the Effective Leader

Persuading doctors to become leaders is half the battle. The other key factor is ensuring that those leaders have the right skills to be effective. These leadership competencies, developed by the Advisory Board’s Talent Development division, are those associated with the behaviours and skills demonstrated by high performing health care leaders.

### Key Leadership Competencies

#### Leading
- Managing Vision and Purpose
- Taking Initiative
- Motivating and Influencing

#### Managing Relationships
- Building and Strengthening Relationships
- Upward Management

#### Developing People
- Identifying and Recruiting Talent
- Developing and Retaining Talent

#### Managing Standards and Accountability
- Accountability
- Service Orientation and Patient Focus

#### Planning and Decision Making
- Constructive Thinking
- Financial Acumen
- Process Management
- Prioritising and Delegating

#### Communicating
- Giving Feedback
- Communicating Effectively

For full Leadership Competency descriptions, please see p. 119 of the appendix

Source: Advisory Board interviews and analysis.
Lesson 4: Ensure Concrete Return on Skills Investment

Lacking Key Skills

Many hospital managers noted that most current and potential medical staff leaders lacked some of the critical competencies required. Given that leadership training is seldom part of medical education, this is not surprising.

To improve, organisations must overcome two barriers: many potential leaders simply don’t access available training. And those who do often come back and never apply or practice the skills they’ve learnt, resulting in little benefit for the organisation.

Many Obstacles to Cultivating Skilled Leaders

Doctor Leaders Feeling the Gap

“A consultant anaesthetist, recently interviewed not long after appointment to a position of significant leadership, described herself as ‘wholly unskilled for the job.’”

C. Gordon, “How to Design and Deliver a Clinically-Led Organisation”

Only for Self-Starters

“The only training doctors get is the training they find themselves. There is no promotion of programs to doctors.”

Clinical manager, Australian public hospital

Not Part of Clinicians’ Training

“We [doctors] don’t get taught anything about management or leadership development. If you’re interested in this, you must do additional training on your own.”

Frontline doctor, Belgian hospital

Barriers to Effective Training

Not Accessing Training

Most medical education programs do not include opportunities to develop leadership and management skills

Doctors may not be aware of available training opportunities; some training programs may have insufficient places available relative to demand

Limited or no practical support, time, or opportunity to apply training

Doctors do not have mandate to lead after completing training

The need for doctor leadership training is well recognised at the system level and many excellent training programs are available at the state and national level. A relatively simple solution to the skills gap, therefore, is to ensure that current and potential doctor leaders are effectively accessing the preexisting training programs.

### Options Abound

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Education and Training Institute</strong>&lt;br&gt;New South Wales, Australia</td>
<td>Develops and evaluates management, and leadership development programs to improve workforce capacity</td>
</tr>
<tr>
<td><strong>Canadian Certified Physician Executive Program</strong>&lt;br&gt;Canada</td>
<td>Applies a standardised process to educate and empower doctors across the health care spectrum</td>
</tr>
<tr>
<td><strong>Physician Management Institute</strong>&lt;br&gt;Canada</td>
<td>Gives doctors the skills and tools they need to deal with challenges in the system</td>
</tr>
<tr>
<td><strong>NHS Leadership Academy</strong>&lt;br&gt;United Kingdom</td>
<td>Broadens the range of leadership behaviours and raises the impact of health care providers in the entire system</td>
</tr>
<tr>
<td><strong>Western Australian Clinical Training Network</strong>&lt;br&gt;Western Australia</td>
<td>Trains health care leaders; expands staff capacity to meet the health care needs of the future</td>
</tr>
<tr>
<td><strong>Public Health Leadership Program</strong>&lt;br&gt;New Zealand</td>
<td>Equips participants with practical and tested leadership tools and resources to improve the health system</td>
</tr>
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</table>

Townsville Hospital and Health Service, a large tertiary hospital in Queensland, Australia, took a twofold approach to ensuring they made the most of statewide training programs. First, the Executive Director of Medical Services identified several current and potential leaders that would benefit from additional leadership training. The selection was made based on the doctors’ interest in systems improvement, alignment with the hospital, and existing leadership traits.

The executive director persuaded these potential leaders to attend training courses by removing barriers to their attendance. After the courses, leaders were encouraged to take up projects important to the organisation. This approach has allowed Townsville to make progress on some of its most critical goals, notably reducing emergency department wait times.

### Process for Ensuring Value from Health System Training

**Careful selection** for course attendance based on observed leadership qualities and interest in system improvement

**Active persuasion** of prospective attendees to attend by ensuring full program funding and clinical coverage during absence

**Improvement project design** encouraged upon return to apply skills learnt to daily work

### Learning in Action

- Directors of Internal Medicine and Emergency Medicine attend course
- Apply new skills to reshape divisional operations to meet NEAT\(^1\); teach leadership and management skills to others during process

### Improvement in NEAT performance

88%

### Case in Brief: Townsville Hospital and Health Service

- 600-bed tertiary hospital in Queensland, Australia
- Promising leaders recruited to attend fully sponsored state leadership training courses; encouraged to implement improvement projects on return
- Outcomes include 88% improvement in NEAT performance

### Fostering a New Leadership Approach

“You really do see people thinking about their techniques in leadership and management… They are thinking about how they need to go [get] things done, and that really is a fabulous change.”

Andrew Johnson  
Executive Director Medical Services,  
Townsville Hospital and Health Service

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\(^1\) National Emergency Access Target.
Many Organisations Bringing Leadership Development In-House

In many cases, hospitals are bringing leadership training in-house, hoping to train more staff than health system-level training programs allow, and to encourage collaboration among leaders across the hospital by training them together. These advantages of in-house leadership training are by no means a given, however, and indeed many hospitals fail to see much return on this investment.

However, some organisations see substantial returns from investment in doctor leadership. These hospitals have three factors in common.

Careful Planning Required to Reap Benefits

Key Elements of Effective In-House Training Programs

- **Develop a Principled Selection Process**
  Select participants based on leadership capability, interest in performance improvement, and potential to become more engaged with organisation

- **Clearly Link Learning to Practical Outcomes**
  Devise pathways for newly trained leaders to make practical use of skills taught in day-to-day work and through improvement projects

- **Strengthen Doctor-Hospital Connection**
  Develop doctor loyalty to hospital through transparency about training investment with emphasis on prestige of training course

Source: Advisory Board interviews and analysis.
Western Health is a large public hospital system in Melbourne, Australia. In 2008, poor performance in the emergency and outpatient departments triggered executive concern. They worried that the low engagement scores on a recent survey could be a root cause of poor performance.

They convened several “listening sessions” with their medical staff to work out what was causing this disengagement. One problem stood out: doctor leaders felt ill-equipped for success in their roles. They also had no insight into strategic matters, and no opportunity to make decisions.

**Case in Brief: Western Health**

- Public system with 5,000 staff in Melbourne, Victoria, Australia
- In 2008, low investment in medical staff leadership was identified as root cause of performance improvement challenges, poor engagement survey results
- Decision to invest in in-house clinical leadership development program led to improved performance on key organisational challenges; improved doctor engagement

**Impetus for Doctor Leader Program Development**

- **Serious Organisation-Wide Performance Concerns**
  - Poor patient flow in emergency department
  - Inefficient outpatient practice
  - Limited support for research
  - Department-specific quality, efficiency challenges

- **State Engagement Survey Reveals Opportunity**
  - Organisation performing poorly on cultural index
  - Low ratings of executive performance and quality of communication in particular

- **Doctor Disengagement Driven by Low Investment**
  - Key Frustrations
    - No support for doctor leadership
    - No insight into decision making
    - Limited opportunity to provide strategic input
Investing in Doctor Leadership to Change Behaviour

The hospital’s executive team decided that they needed to invest in leadership training as a first step to better support their medical staff leaders. As part of this training, they hoped to give doctors greater insight into executive priorities and develop necessary skills to play a larger role in decision making.

Western Health took several key steps to ensure that their investment led to a return for the organisation. First, they carefully selected the doctors who would be invited to the first training program using a number of filters. Importantly, selections were made with a view to the performance and engagement goals of the organisation.

Candidates Selected with Organisational Goals in Mind

Program in Brief: Doctor Leadership Academy

- Series of leadership development courses for doctors taught by Advisory Board Talent Development faculty
- Three sessions of two full days taught over six- to nine-month period for each clinician cohort
- Course content customised to organisation’s needs; topics include leading change, data-driven decision making, facilitating effective teamwork, and managing disruptive behaviour
- Program taught through health care specific, real-world examples, practical exercises, and application tools

Tactics for Selecting the Most Impactful Candidates

- Executives, department leaders able to nominate potential candidates for leadership training
- Leaders meet to determine candidate selection
- With organisational goals firmly in mind, multiple filters used to determine who should be asked to attend

Sample Selection Filters

- Department leadership needs
- Future leadership potential
- Influence with peers and across organisation
- Likelihood of increased engagement due to course attendance
- Need to manage undesirable behaviour

Source: Western Health, Melbourne, Victoria, Australia; Advisory Board interviews and analysis.
Ensuring Practical Improvements for the Hospital

Second, Western Health’s executive team established an infrastructure to support leaders who participated in the training program. Participants were given a clear mandate to lead. Some were asked to commit to solving specific organisation-wide problems that doctors and managers had collectively identified, such as poor emergency department flow. Others, especially those doctors who did not yet have formal leadership positions in the organisation, were given department-level leadership opportunities such as the chance to run morbidity and mortality review meetings.

Leaders were given a small amount of nonclinical time to support work on key initiatives, and received project management assistance from dedicated project managers.

The training has also demonstrated benefits beyond the skills that leaders acquired and the projects they implemented: participating clinicians were able to build relationships with other clinical leaders, which has improved collaboration across the organisation.

An Action-Driven Approach

Methods for Ensuring Practical Use of Newly Trained Skills

- Participants Asked to Complete Key Hospital Projects
  - Example: Clinicians work together to identify and remedy bottlenecks, inefficiencies that create outpatient clinic scheduling frustrations for staff

- Train-the-Trainer Approach Supports Department Change
  - Example: Anaesthesiology director, part of initial cohort, led visioning, leadership, and problem-solving projects at department level to share learning

- Graduates of Program Given More Responsibility
  - Example: Senior and junior-level cardiology doctors who complete program given option to lead morbidity and mortality review meetings

- Multidisciplinary Attendance Improves Later Collaboration
  - Example: Doctors, nurses, and allied health staff collaborate to identify necessary resources to improve clinical research processes

Organisational Toolkit for Doctor Leadership Accountability and Support

- Defining a Commitment
  - Initial cohort of leaders asked to commit to solving key organisation-wide problems

- Providing Additional Time
  - Leaders committing to programs of strategic importance to hospital given additional 30% nonclinical time

- Funding Project Management Support
  - Teams committing to programs of strategic importance to hospital supported by dedicated project manager

Source: Western Health, Melbourne, Victoria, Australia; Advisory Board interviews and analysis.
Third, the organisation deliberately used the training program to cultivate doctor engagement with the hospital. They worked to make training attendance a sign of prestige within the organisation. The first cohort of influential doctor leaders selected to attend were paid for their time, but word of mouth built interest in the program to the point that later cohorts were willing to attend without compensation.

The hospitals’ senior leadership were also transparent about the investment made in the course and the importance of doctor leadership to the organisation. Senior executives, including the Chief Executive, co-lead courses, and the hospital Board attended cohort graduations. Executive attendance at these sessions has also served to address doctors’ complaints about a lack of insight or input into decision making: the executives actively provide hospital-specific context for the concepts discussed in the training session, take questions, and accept feedback.

Executive involvement emphasises high importance placed on program:
- CEO attends each cohort launch, Director of Human Resources co-leads classes, Board attends cohort graduation
- High investment proves value:
  - Program sponsors are transparent about investment of time, resources in doctors attending leadership program

“Endorsement from Later Training Cohorts Confirms Program Value”
- Alumni discussion, enthusiasm ensures future interest and desire to participate

“Staged Approach to Increase Program Prestige Within Organisation”
- Highly influential doctors selected as initial attendees:
  - Initial cohort paid for time taken for course to encourage participation
- Reputations of initial attendees piques interest in course:
  - Course established as prestigious offering, later candidates willing to attend without compensation

“The program value and reputation has grown and it’s now seen as a reward… Programs like this engender loyalty, particularly when other places don’t offer them.”

Claire Culley,
Director of Surgical Services, Western Health

Source: Western Health, Melbourne, Victoria, Australia; Advisory Board interviews and analysis.
Targeted Training Pays Off

Western Health’s investment has paid off. One example of their success is the turnaround in their troubled cardiology department. After its leaders went through the training program, they were able to effectively manage disruptive behaviour in the department and were inspired to take on key efficiency and performance reforms with the organisation’s support. As a result, they have seen a 25% increase in clinical output and a million dollars in savings.

Now, approximately half of the medical staff and other clinical leaders across the organisation have attended the leadership training program. Hospital executives now feel that they can rely on their clinical leaders to effectively drive change in the organisation.

Cardiology Department Fixes Culture, Improves Performance

1) A Problem Department
   Department experiences chronic bad doctor behaviour, poor financial performance

2) Leaders Selected for Training
   New department head, other leaders attend formal leadership training program; share lessons learned with other cardiology staff

3) Training Utilised to Execute Reforms
   Program graduates develop new department communication, ordering protocols to increase spending awareness and loyalty

Notable Improvements in Cardiology After Just 18 Months

- 25% Increase in clinical output
- $1M Savings within 18 months

Creating Momentum for Change

Approximate percentage of medical staff leaders across organisation trained: two-thirds directly through course; one-third through peers

Clinical Skills Overvalued

“Two years ago, this was seen as the most [problematic] unit, it never had any money, the department never had any money... Now, it’s winning awards, saving money, and that’s phenomenal... It defeats me that some organisations do not think they have this potential, do not believe they can achieve something like this.”

Claire Culley,
Director of Surgical Services,
Western Health

Source: Western Health, Melbourne, Victoria, Australia; Advisory Board interviews and analysis.
To support your work in developing doctor leadership, the Clinical Operations Board has compiled a compendium of resources available to you on our website, outlined here.

To cultivate allies across the organisation, hospital leaders must ensure that leadership roles are attractive to doctors and that doctor leaders have the right skills to be effective in those roles. This is the second critical element to lay a foundation for a stronger relationship with the medical staff.

**The Doctor Leadership Effectiveness Compendium**

**Selected Practices for Promoting Doctor Leadership Success**

1. **Growing the Leadership Base**
   - 1. Grassroots Leadership Identification
   - 2. Leadership Skills Evaluation
   - 3. Stakeholder-Led Selection Process

2. **Advancing Leadership Development**
   - 4. Physician Leadership Rotations
   - 5. Targeted Training Trajectories
   - 6. Applied Skills Training
   - 7. Hybrid Leadership Training Model

3. **Providing Ongoing Leadership Support**
   - 8. Integrated Leadership Teams
   - 9. Strategic Coaching Partnerships
   - 10. Diversified Support Positions

4. **Delivering Structured Performance Reviews**
   - 11. Successive Internal Reviews
   - 12. Strategy-Aligned Annual Review
   - 13. Comprehensive 360-Degree Review

5. **Aligning Compensation with Performance Goals**
   - 14. Leadership-Based At-Risk Incentives
   - 15. Goal-Driven Compensation
   - 16. Achievement-Only Compensation

**Doctor Leadership Effectiveness Compendium**

- Available online at advisory.com/cob/LeadershipCompendium
- Includes an appendix with implementation tools and templates

Source: Advisory Board interviews and analysis.
Hiring and onboarding is a final crucial opportunity to cultivate allies that many organisations miss.

First, hospital leaders may have the opportunity to be selective from the beginning of a doctor’s tenure. Not all managers have a role to play in hiring decisions. But for those who do, this can be a crucial area of opportunity.

Three potential filters for new doctor candidates are key: high-performing, strategically important, and culturally compatible. While almost all organisations apply the first two filters, few consider culture. But utilising this third filter can avoid poor fits and ultimately improve new doctor integration and safeguard the culture in the long term.
Creating an engaged group of new hires requires more than a selective hiring process. The second opportunity, onboarding, is also important.

Doctors who have just joined a new hospital, regardless of their seniority, are on average much more engaged and typically more flexible in their attitudes towards management. This opportunity to improve is accessible to all hospitals.

First Year Best Chance for Engagement

New Doctors Easiest to Influence

“Specifically target junior doctors because of their connection to the clinical processes going on and their ability to rally people around them. At a more senior level, you’re more removed from that. Junior doctors are motivated, tend to get involved, and influence quite a lot of people to act.”

Senior doctor, Australian hospital

“No doubt senior doctors are more difficult to work with. They’re more difficult to influence or change their way of thinking. It’s easy to influence the behaviour of junior doctors, which is why I say the key is to get them early.”

Associate medical director, UK hospital

Source: Advisory Board Survey Solutions, Physician Engagement Initiative, 2010; Advisory Board Interviews and analysis.
Geisinger Communicates Pertinent Details Throughout Recruitment

Geisinger Medical Center, in Pennsylvania, found that proactively screening new hires for cultural fit was unnecessary for their organisation: they could equip doctor candidates to screen themselves.

To enable this self-selection, Geisinger provides information to candidates about the organisation, its culture, and the expectations and rewards of practicing there. As well as high-level information on the organisation’s values and care philosophy, they also share granular details on expected patient load, performance expectations, and organisational goals to make the information more concrete.

This transparent information is shared throughout the recruitment process, which is used not only to learn about the candidate but to educate them about Geisinger. At each point, doctors can withdraw their candidacy if they feel that the organisation is a poor fit for them.

### Case in Brief: Geisinger Medical Center

- 548-bed hospital located in Danville, Pennsylvania, US
- Doctor candidates given detailed information on organisation and its culture at multiple recruitment steps
- Aim to allow culturally incompatible candidates to self-select out of process before job offer extended
- Efforts began in 2000 due to high turnover; since implementation, turnover has been reduced from 10% to 3%

### Key Topics Addressed in Up-Front Expectation Sharing

- Organisational values
- Patient care philosophy
- Community responsibility
- Community
- Patient load
- Productivity goals

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Source: Geisinger Medical Center, Danville, Pennsylvania, US; Advisory Board interviews and analysis.
Self-Selection Leads to Greater Compatibility

For Geisinger, this tactic is an effective way to screen for cultural compatibility without drastically changing hiring protocols. While the tactic itself is simple, Geisinger has seen a sharp drop in their turnover, a measure commonly associated with strong engagement as well as reduced staffing costs.

Geisinger Sees Lower Doctor Turnover

Approximate Medical Staff Turnover Rate

- 10% in 2000
- 3% in 2005

Geisinger began efforts to improve screening process; system took several years to fully develop

Source: Geisinger Medical Center, Danville, Pennsylvania, US; Advisory Board interviews and analysis.
At Northumbria Healthcare, a nine-hospital system in northern England, the chief medical officer noticed that a few newly hired doctors were struggling to adapt to the hospital culture. However, they had been hired through a rigorous process on the basis of their excellent clinical skills.

**Newly Appointed Consultants Struggle to Adapt**

**Newly Hired Consultants Possess Strong Clinical Skills**

Consultants hired for strong clinical skills and experience

**Consultant Struggles Alarm Chief Medical Officer**

- Subset of new consultants face challenges
- Poor behaviour due to:
  - Unclear expectations about role
  - Difficulty fulfilling nonclinical responsibilities, balancing workload
  - Struggle to fit in culturally, connect with colleagues, and adapt to new environment

**Case in Brief: Northumbria Healthcare NHS Foundation Trust**

- Nine-hospital Foundation Trust, providing care to over 500,000 people in Northumbria, UK
- Chief Medical Officer noticed that some newly hired consultants had difficulties settling into roles
- Trust implemented a behavioral-based interview system to ensure that new staff possessed requisite clinical skills, and would fit in with hospital culture

Source: Northumbria Healthcare NHS Foundation Trust, North Tyneside, UK; Advisory Board interviews and analysis.
Concerned, the medical director hired an external consultancy to assess the organisation’s challenges and learned that some newly hired doctors, despite their excellent clinical skills, lacked some of the nontechnical skills such as communication and empathy that were needed to fit into Northumbria’s culture.

Next, multidisciplinary groups from across the organisation met to discuss the ideal nonclinical skills needed by new consultants. Their discussions were distilled into 11 key competencies and embedded into the hiring process.

**Establish Criteria for Professional and Cultural Fit**

**Process to Establish New Hiring Criteria**

*Seek External Insight*

Worked with external consultancy\(^1\) to assess improvement areas, including recruitment

*Identify Desired Criteria*

- Multidisciplinary groups met to develop important consultant competencies
- Answered the question “What do you value in consultants?”
- Selected most important assessment competencies

**Northumbria Consultant Competency Framework**

<table>
<thead>
<tr>
<th>Key Competencies</th>
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</thead>
<tbody>
<tr>
<td>1 Empathy and Sensitivity</td>
</tr>
<tr>
<td>2 Communication and Influencing</td>
</tr>
<tr>
<td>3 Personal Organisation</td>
</tr>
<tr>
<td>4 Coping with Pressure</td>
</tr>
<tr>
<td>5 Team Working</td>
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<tr>
<td>6 Openness, Learning, and Self-Awareness</td>
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<tr>
<td>7 Leading and Managing</td>
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<tr>
<td>8 Organisational Awareness and Commitment</td>
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<tr>
<td>9 Decision Making</td>
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<tr>
<td>10 Teaching</td>
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<tr>
<td>11 Clinical Capability</td>
</tr>
</tbody>
</table>

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\(^1\) Edgecombe, psychologists for the National Clinical Assessment Service.

Source: Northumbria Healthcare NHS Foundation Trust, North Tyneside, UK. Advisory Board interviews and analysis.

For a complete version of Northumbria’s Consultant Competency Framework, please see p. 125 of the appendix.
In-Depth Interview Process Identifies Best Fit

Building a Better Interview

Now, new doctor candidates at Northumbria undergo a two-day interview process designed not only to assess their clinical skills but also their nonclinical competencies.

**Candidate Interview Schedule**

**Day One:**
- Take psychometric tests
- Meet care team
- Discuss job role and expectations

**Day Two:**
- Receive psychometric results and feedback
- Simulated skills assessment
- Structured team skills assessment
- Formal interview, minimum one hour

**Psychometric tests provide baseline assessment:** measure attitudes, behaviour under pressure, candidates’ reasoning ability, motives, and values

**Simulated assessments yield behavioral insights:** can include ward rounds, providing feedback, or a consultation, and allow hospital to observe key behaviours in high pressure environments

**Skilled interviewers ask targeted questions:** interviewers, including Medical Director, Director of HR, and Clinical Directors use behavioural-based questions to gauge candidate quality

**Behavioural Based Interview Toolkit**

For an additional behavioural-based interviewing best practice, please see p. 128 of the appendix

Source: Northumbria Healthcare NHS Foundation Trust, North Tyneside, UK; Advisory Board interviews and analysis.
Selective Hiring Only Part of the Solution

Northumbria’s new hiring process resulted in greater confidence across the hospital in new doctor hires and almost eliminated the number of new hires who were found to be poor cultural fits for the organisation.

It also revealed another opportunity. Throughout the interview process, many excellent candidates proved to have small areas of weakness against the competency framework. Rather than reject those candidates, Northumbria instead decided to tailor onboarding and training plans to each individual based on the initial assessment made during the hiring process.

Targeting Weakness to Improve Leadership Quality

“We understand the people we are appointing much better than we ever did, so we understand their strengths, but we also understand their weaknesses. So in effect we are writing their first years’ development plan when we appoint them. We say…‘We believe that we’d like you to work with us, but everything we’ve learned says you may have some issues with communication, so we’re going to put you on a communication skills course’.”

David Evans, Chief Medical Officer
Northumbria Healthcare NHS Foundation Trust

Source: Northumbria Healthcare NHS Foundation Trust, North Tyneside, UK; Advisory Board interviews and analysis.
The development plan is well structured. As well as being tailored to each individual’s development needs, the plan is supplemented by a formal training program. Each new doctor is also paired with a mentor from among their peers to help them adapt to the role.

### Candidate Competency Assessment

<table>
<thead>
<tr>
<th>Consultant Competency</th>
<th>Doctor Smith</th>
<th>Doctor Singh</th>
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</thead>
<tbody>
<tr>
<td>Communication and Influencing</td>
<td>![Graph]</td>
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<tr>
<td>Leading and Managing</td>
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<tr>
<td>Clinical Capabilities</td>
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<td>Team Working</td>
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<tr>
<td>Organisational Awareness</td>
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### Growth Opportunities Identified

**Development Plan Tailored to Structure Consultant Induction**

- **Candidate Development Goals**
  - focus on areas of improvement identified during interview process
- **Peer Mentor**
  - works with new hires to share information about hospital and support development
- **New Consultant Development Program**
  - provides targeted orientation and training for new consultants
- **Induction Plan**
  - geared toward supporting consultant to meet development goals

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Source: Northumbria Healthcare NHS Foundation Trust, North Tyneside, UK; Advisory Board interviews and analysis.
Changing the Tone

Northumbria’s leaders report that their new hiring and onboarding process has changed the organisation’s relationship with its new doctors. In the years since the program was introduced, the trust has had a more engaged group of new doctors and no “problem” hires.

New Doctors More Engaged

Eliminating Behaviour Problems

0

Behavioural problems with newly appointed consultants in the eight years since the program was instituted

Contributing to Overall Engagement

3.79

Overall staff engagement score at Northumbria, placing in the top 20% of trusts in the UK for engagement scores.1

Hiring for Fit, Building a Culture of Support

“We were appointing people to fail rather than understanding what the potential weaknesses or risks were and supporting them in their first couple of years. Since we’ve had this program…our new people are supported, we understand more about them, and we’re developing them, and helping them, and introducing them to the trust. …we all think it’s fantastic, we wouldn’t go back to the old system and everyone’s very happy with the way we recruit people now.”

David Evans
Chief Medical Officer
Northumbria Healthcare NHS Foundation Trust

Creating a Detailed Road Map for Doctor Onboarding

A successful approach to onboarding will combine a number of different elements into a cohesive strategy for developing cultural alignment. To support the development of such a strategy, the Clinical Operations Board has created a Doctor Onboarding Toolkit. This toolkit contains a comprehensive onboarding plan with tactics that cover three important phases of new doctor tenure.

To successfully cultivate medical staff allies, hospitals must take advantage of the immediate opportunity to develop their medical staff leadership ranks as well as the longer-term opportunity to build engagement among new hires.

For complete Doctor Onboarding Toolkit, please see p. 132 in the appendix.

Source: Advisory Board interviews and analysis.
Develop Shared Ownership

Lesson 6: Define New Organisational Roles and Responsibilities
Lesson 7: Share Authority with Medical Staff Leaders
Defining Your Hospital’s Ideal Doctor

Repairing the organisation’s relationship with the medical staff lays the foundation to reset the relationship. This means moving from operating on a transactional footing with the medical staff to creating a feeling of shared ownership for the organisation’s success: a partnership.

The first step in resetting the relationship is establishing the terms of this new relationship, which requires new things of doctors.

The attributes laid out here are those that executives globally considered most important to enable a partnership with their medical staff: high performance and cultural compatibility are of equal significance.

Ideal Medical Staff Demonstrate Cultural Compatibility, Accountability

Culturally Compatible

- **Strategically aligned:**
  Shares organisational values, embraces partnership approach

- **Team focused:**
  Collaborates with hospital, other doctors, entire clinical team

- **System oriented:**
  Willing to address strategic priorities; prioritises hospital needs over individual ambitions

High Performing

- **Technically excellent:**
  Provides high-quality, low-cost patient care

- **Value conscious:**
  Actively works to improve patient care in cost-effective manner

- **Evidence driven:**
  Standardises clinical protocols, devices

- **Open to transparency:**
  Views performance data as opportunity to improve

Source: Advisory Board interviews and analysis.
Effective Relationship a Two-Way Street

Of course, hospitals don’t evaluate potential medical staff in isolation. At the same time, doctors are critically assessing their options, often weighing competing opportunities at other hospitals.

Here, the doctor’s perspective on the same two categories of attributes is summarised. Doctors typically seek hospital partners that can offer quality, efficiency, and shared values.

Many organisations have not yet formally or clearly defined the kinds of doctors they hope to attract, nor actively worked to recruit doctors who match those characteristics. Each organisation should work through this exercise as a first step to resetting the relationship.

Doctors Also Assessing Fit with Hospital, Executive Team

Ideal Executive Partner Attributes

Culturally Compatible

- Strategically aligned: Embraces partnership approach, shares doctors values
- Willing to share ownership: Engages doctors as equal partners in decision making
- Open to transparency: Communicates openly, provides avenues for feedback

High Performing

- Highly efficient: Maintains efficient workshop, resolves performance shortfalls rapidly
- Operationally excellent: Ensures access to clinical and information technologies, offers financial stability
- Quality Focused: Invests in quality improvement, creates infrastructure for evidence-based care, facilitates seamless cross-continuum care

Source: Advisory Board interviews and analysis.
The majority of interviewed executives felt that few doctors exhibited these ideal characteristics or felt much responsibility for the success and failure of the organisation at which they work. This issue is even more challenging when doctors split their time between several organisations.

That does not imply that these doctors are unprincipled or would never be involved. Some of these quotes suggest that many managers have simply given up on having doctors treat the hospital as anything other than a workshop. And doctors feel that, since they are not treated as owners, there is no reason for them to behave as though they are.

As organisations begin to ask more from their doctors than they have in the past, it is essential to define exactly what it is that the organisation needs from them: specifically that their role needs to expand to working with the organisation on priorities and strategies outside direct patient care. Defining this responsibility—as well as what they can expect from you in return—is the first step to resetting the relationship and creating a sense of shared ownership.

### “Hospital as Workshop” Mentality Persists

**No Commitment**

“Doctors come in, do their job, and get out. They don’t feel they have a part to play in developing the strategy of the organisation.”

*Junior doctor, Australia public hospital*

**No Accountability**

“[Doctors] see clinical responsibilities as being their number one priority, and they see their accountability as primarily to the patient, not to the organisation. And I think therein lies a fundamental issue regarding engagement.”

*Operations manager, Australia public hospital*

**System Changes Erode Hospital Connection**

“Thirty years ago…[doctors] felt engaged with their district health board, they felt that they were an integral, key part of it, and I guess like they owned it. That all got thrown away in the nineties, and people felt very disengaged and managed. And it has been a long road to try and pull that back.”

*Department head, New Zealand district health board*

**No Part in Organisational Improvement**

“They think they can just come to work, do their patient, do their bit, and go home again. And they say that the Trust should do this, the Trust should do that. But *they* are the Trust. Don’t talk about the Trust like it’s somewhere else.”

*Clinical director, UK hospital*

**No Sense of Community**

“You have to try to get doctors to see the hospital not as an instrument, but that they are accountable for what they’re doing. In history, doctors viewed hospitals as a place where they came to work…They have to feel a part of it, that if the hospital is not performing then they won’t be able to do their job.”

*Executive, Belgian private hospital*

**Limited Involvement**

 “[Most doctors] are not active participants in most initiatives…the doctor who is only with you a few hours each week wouldn’t get involved.”

*Executive, South American private hospital*

**Limited Contact Undermines Ownership**

“A lot of senior medical staff in Australia are visiting medical officers, not employed, full-time medical staff. That makes it difficult. Because if they are only in the building three times a week it is very hard to engage them.”

*Manager, Australian department of health*

Source: Advisory Board interviews and analysis.
Ottawa Hospital, a large hospital in Canada’s capital city, is a clear example of how defining clear responsibilities can make a difference. In 2008 the Ottawa Hospital executives and board set an ambitious goal to reach the top 10% of quality performance among all North American hospitals. They knew that the literature found excellent doctor engagement was a common factor among all top-quality hospitals but felt that the levels of engagement at their organisation, shown in a recent survey, were not sufficient.

With an eye towards their larger quality goal, the hospital began to explore ways to better engage their medical staff, and realised that neither doctors nor managers were certain about their responsibilities towards each other or what they could expect.

### Unclear Roles, Responsibilities Hinder Ottawa Hospital Goals

#### Doctor-Hospital Relationship Barrier to Achieving Quality Goal

<table>
<thead>
<tr>
<th>Ambitious Quality Goal Established</th>
<th>Greater Doctor Engagement Needed</th>
<th>Unclear Expectations Identified as Barrier</th>
<th>Engagement Agreement Identified as Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital executives set ambitious goal; aim to achieve top 10% quality performance</td>
<td>Doctor engagement survey reveals engagement levels are below those hospitals in the top 10% of quality performance</td>
<td>Executives learn that doctors and managers are unsure of responsibilities towards each other and towards organisational goals</td>
<td>Hospital decided to work with doctors to develop an engagement agreement to harmonise expectations and encourage commitment</td>
</tr>
</tbody>
</table>

### Case in Brief: The Ottawa Hospital

- 1,195-bed hospital in Ontario, Canada
- In 2008, set goal of attaining top 10% performance in quality and patient safety among North American hospitals; doctor engagement identified as barrier
- Doctors led development of compact detailing doctor and manager commitments
- Signed by all medical staff and managers; incorporated into hiring and onboarding practices

Source: The Ottawa Hospital, Ottawa, Ontario, Canada; Advisory Board interviews and analysis.
Redefining the Relationship

Setting Clear and Specific Expectations to Rally Support

Doctor-Led Approach to Defining Roles and Responsibilities

1 Engagement Agreement Led by Medical Staff
   • Hospital invites medical staff to lead compact development¹ based on hospital’s four main values
   • Representative sample of 44 doctors assembled to lead effort²

2 Structured Process Ensures Initiative Focus
   • Doctor volunteers form eight facilitated groups; two groups dedicated to each hospital value
   • Focus on doctor and manager roles and responsibilities for achieving each value

3 Support Takes Pressure Off Scarce Doctor Time
   • Facilitators analyse results of discussion, identify 20 themes and nine larger topic areas
   • Submit analysis to focus group doctors for feedback, approval

4 Doctors, Executives Define Mutual Compact
   • Using key concepts defined by focus groups, doctors and executives draft each other’s roles and responsibilities
   • Drafts exchanged and feedback incorporated

5 All Doctors and Managers Commit to Compact
   • Executives, focus group publicly commit to and sign compact
   • All doctors and managers asked to sign; leaders meet with hesitant staff to discuss concerns
   • Agreement incorporated into hiring process

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¹ Criteria for participation: active doctor at Ottawa Hospital serving in a non-administrative role that is “able and willing to contribute meaningfully” to compact development.
² Included 27 male and 17 female doctors from 10 departments with between zero and 29 years of clinical experience.

Source: The Ottawa Hospital, Ottawa, Ontario, Canada; Advisory Board interviews and analysis.
The final agreement defines not only how doctors and managers will support each other but also how both parties will support the performance goals of the hospital. For both managers and doctors, the definitions are primarily focused on their organisational responsibilities, though individual patient care is still clearly important.

Ottawa’s process stands out because it was clearly led by their medical staff, sending a message about the new tenor of the relationship. The process was arranged so doctors were able to lead without taking up too much of their scarce time. These two elements are critical to incorporate into any process like this.

The Ottawa Hospital/Doctor Engagement Agreement

Commitment to Quality

Hospital Commitment to Medical Staff
- Support commitment to quality by choosing measures that are relevant, context sensitive, meaningful, and objective
- Cultivate a culture of trust; to that end, evaluations of processes, systems, and people must be timely, candid, and constructive
- Ensure that organisational processes and clinical systems are effective, that they recognise and respect the relationship of doctors with the hospital and patients, and align with the hospital’s core values

Medical Staff Commitment to Hospital
- Champion development and adoption of organisational processes, practices, and policies that drive excellence in quality care within an academic environment
- Actively work with the hospital; acknowledge your key role in improving individual and hospital care processes to boost quality and safety
- Participate in decision making; practice in accordance with group decisions; work within and respect organisational processes and clinical systems

For a copy of the complete Engagement Agreement please see p.149 of the appendix

Source: The Ottawa Hospital, Ottawa, Ontario, Canada; Advisory Board interviews and analysis.
Collective Agreement Key to Success

Since the agreement was signed in 2010, Ottawa has seen a 19% increase in engagement: impressive as their doctors were already fairly content. The newly defined responsibilities have also helped the organisation improve quality.

This agreement proved successful at Ottawa in part because they already had some degree of doctor engagement. For organisations who are not yet at that stage, it is important to first focus on tactics in chapters one and two. If a commitment like this is made and then broken or not enforced, the management team will lose credibility and further damage the relationship.

This step is critical to resetting the relationship not only for its practical benefits, but also for its signal value: it indicates that the organisation is committed to moving beyond simply a supportive affiliation towards a partnership.

Well-Defined Commitment Improves Engagement

Source: The Ottawa Hospital, Ottawa, Ontario, Canada; Advisory Board interviews and analysis.

1) Compliance rate at initiative’s commencement: 72%; 90% average sustained since January 2012.
2) Savings resulting from decreased instances of C. difficile infections in hospital units.
3) 37% of inpatients rated care as “excellent” before initiative, most current results show 53% of inpatients rating overall care quality as “excellent”.

90+%
Sustained hand hygiene compliance rate

$400K
Annual savings from compliance with antimicrobial stewardship initiative

43%
Increase in patients rating their care as excellent

Source: The Ottawa Hospital, Ottawa, Ontario, Canada; Advisory Board interviews and analysis.
In addition to a clear definition of responsibilities, shared ownership also requires that medical staff and management share a vision for the direction of the organisation.

Canterbury District Health Board in Christchurch, New Zealand, took an interesting approach to answering this question. In 2008, Canterbury was struggling to manage demand and stay within their budget. There was a strong sense by management that clinicians across the organisation saw these challenges as “management’s problem.”

**Tactic: Shared Direction-Setting**

**Shared Threats Develop Solidarity**

In addition to a clear definition of responsibilities, shared ownership also requires that medical staff and management share a vision for the direction of the organisation.

Canterbury District Health Board in Christchurch, New Zealand, took an interesting approach to answering this question. In 2008, Canterbury was struggling to manage demand and stay within their budget. There was a strong sense by management that clinicians across the organisation saw these challenges as “management’s problem.”

**Future Vision Workshop Illuminates Challenges, Presents Opportunities**

**Challenges Faced by District Health Board**

- **Increased Demand**
  - Rise of chronic disease and other conditions requiring significant intervention

- **Demographic Changes**
  - Growth of at-risk populations, such as elderly patients, puts strain on health services

- **Financial Difficulties**
  - Budgets at risk of being outpaced by rise in demand and struggles to find staff

**Case in Brief: Canterbury District Health Board**

- Regional health service located in Christchurch, New Zealand
- Recognised that demographic challenges required substantial changes in service design
- Brought multidisciplinary staff together for a three-day workshop to develop shared understanding of challenges and solutions

**Shared Impetus for Action**

“‘The big theme was that the future was impossible. If we carried on doing what we were doing, the end analysis was we would need to double the size of the hospital by 2020. And even if we could afford to double the size of the hospital, we would never staff it, so therefore we couldn’t do that.

So there was no need to debate the need for change. I think that became widely accepted. It gave people a shared problem, a burning platform…

We leveraged off the idea that we can’t keep doing what we’re doing. It has to change.”

*Dr. Nigel Millar, Chief Medical Officer, Canterbury District Health Board*
Collective Approach Motivates Sustained Improvement Effort

In response, the organisation worked to create a shared understanding of the pressures facing the health system, and define a common direction for the whole organisation. They convened a three-day session for several hundred staff across all specialties and facilities. The time was spent discussing the external threats facing the system with the goal of building a shared “burning platform” for change and setting a better future direction for the health system.

Representatives from Statistics New Zealand were invited to present data, and staff from a local hotel, well known for service, and from Air New Zealand, which had recently gone through a successful turnaround, were invited to help brainstorm solutions.

Doctors at Canterbury feel strongly that this exercise marked a turning point for the organisation. Following the sessions, the DHB developed education programs and cross-continuum clinical pathways, and a number of medical staff were inspired to take on leadership roles. Now, Canterbury’s acute admission rate is 31% lower than expected when compared to similar organisations.

Vision 2020 Program Agenda

**Involve Entire System**
150 hospital and community doctors, nurses, and allied health professionals participated in three-day forum

**Identify Shared Threats**
Speakers from Statistics New Zealand shared information about demographic challenges; group discussed challenges, and improvement opportunities

**Develop Solutions Collectively**
Met with representatives from other industries, such as airlines and hotels, and brainstormed solutions for problems, new initiatives, and best practices

**Future Direction: Foster Innovation**
Vision 2020 Program was starting point for multiple initiatives, such as clinical leadership training and cross-continuum pathway development

Engaging Doctors by Valuing Their Contribution

“[Before] there was an apparent lack of respect for the views of people who far exceed the duration of any manager not being taken on board…now this group of managers have accepted that we have something to offer…I have a sort of moral obligation, I think, to participate. And that’s kind of why I do what I’m doing, because I think someone really needs to engage.”

Senior doctor, Canterbury District Health Board

Vision Sets Stage for Whole System Change

31% Admissions avoided compared with projections based on national benchmarks

Source: Canterbury District Health Board, Christchurch, New Zealand; Advisory Board interviews and analysis.
Clear definition of responsibilities and a shared vision for the organisation are important for frontline doctors to feel ownership. Medical staff leaders face an additional barrier—the feeling that their decision-making role in the organisation is just “token” and they have minimal influence over organisational strategy. In public hospitals, this can be exacerbated by the idea that hospital executive teams’ decisions could be undermined at the state level.

Though virtually all organisations do involve medical staff leaders in hospital strategy, the most common model is for hospital executives and the board to draft the strategy, make major decisions, and then ask a few senior doctor leaders for their input. Simply involving the chief medical officer at a higher level is insufficient for other doctor leaders to feel that they had a seat at the table.

**Token Involvement**

**Common Process for Gaining Doctor Input into Strategy**

- **Executives determine hospital strategy**
- **Board provides input and approval**
- **Adjustments made on basis of board opinion**
- **Incorporate Edits**
- **Request Doctor Approval**
- **Draft Strategy**
- **Consult Board**
- **Doctor approval sought only on final draft**

**No Opportunity to Impact Strategy**

- **54%** Percentage of doctors who disagree or strongly disagree that they play a part in defining hospital goals and strategy

---

**Doctors an Afterthought**

“What we see over and over again is that managers come to consult with doctors after the strategic and operational plans have been written. They bring it to doctors as sort of a final check, and frequently we can see how we will be unable to deliver what they’re talking about.”

*Doctor, Australian public hospital*

**Benefits of Doctor Ownership of Strategy**

- **Clinical Perspective Improves Strategy**
  - Provides insight into clinical implications of hospital strategy
  - Identifies additional improvement opportunities based on frontline experience
- **Doctor Involvement Confers Legitimacy**
  - Facilitates doctors’ acceptance of hospital strategy
  - Signals executive commitment to include doctors in key strategic issues

---

1) Responses to the survey question, “I play a part in defining hospital goals and strategy.” Options included “Strongly disagree”, “Disagree”, “Agree”, and “Strongly Agree”.

2) n=107 global doctors.

Source: Advisory Board interviews and analysis.
Most Organisations Holding Back

The final step to reset the relationship is to share ownership with doctor leaders, delegating some senior executive decision-making authority. This step moves the management team towards a more equal relationship with doctors, or even a partnership. Without taking this step, executives will struggle to convince doctor leaders that their commitment to a new relationship is genuine.

At present, however, most organisations fail to fully delegate responsibility: medical staff leaders may have nominal control over a department or specialty, but their authority is undermined by sharing final accountability with an operational manager or through a lack of insight into the priorities of the hospital as a whole.

Obstacles to True Ownership

Several Shortcomings Prevent True Ownership

1. Limited Influence Over Clinically Led Areas
   - Doctor leaders ostensibly managing a clinical division or specialty often share authority with an operational manager
   - Accountability for decision making is often unclear between medical director and operational manager; the latter frequently takes on much of the decision-making authority

   Result:
   Medical leaders step back from strategic decision making; avoid accountability for financial or operational shortcomings

2. Lack of Insight into Whole-Organisation Priorities
   - Doctor leaders often siloed into specialties or divisions, limiting understanding of hospital-wide impact
   - Limited insight into how individual decisions impact leaders and divisions outside their own sphere of influence; leaders unable to make effective trade-offs

   Result:
   Authority frequently undermined when decisions are incompatible with organisation-wide priorities

Source: Advisory Board interviews and analysis.
Designing Doctor-Led Programs for Success

To overcome the first barrier, doctor-led services must be carefully structured to ensure that they are led by medical staff in practice as well as in name.

Effective doctor-led services share four attributes: clear accountability, authority delegated to the doctor leader, strong communication, and best practice sharing across the organisation.

These attributes are impossible to cultivate without two prerequisites: leaders must be right for the job, and the role itself must be well supported.

Two Prerequisites

1. Select Strong Leaders:
   Identify good leaders, provide adequate training

2. Establish Support Infrastructure:
   Provide support team, dedicated time for leaders

Two Ambitious Goals

1. Encourage Innovation:
   Doctor-led service source of good ideas, progress within the hospital

2. Ensure Reliable Success:
   System is self-correcting, not reliant on perfect circumstances, able to adapt to change and pressure

Effective Doctor-Led Service Attributes

- **Clear Accountability**
  Expectations are clear, and service leads understand targeted outcomes

- **Doctor-Led Decision Making**
  Clinical leads have a defined role and ability to influence policy at the department level

- **Proactive Two-Way Communication**
  Medical leaders in service act as a bridge for communication between executive and front line

- **Frequent Best Practice Sharing**
  Work is not done in silos: ideas and best practices are shared across the organisation

Source: Advisory Board interviews and analysis.
Tactic: Committed Transfer of Authority

Ensuring Foundation for Success

Looking to improve organisational performance, Northumbria Healthcare transitioned to a Clinical Business Unit model nearly a decade ago. The Clinical Business Unit (CBU) model gives a doctor leader financial, clinical, and operational responsibility for a clinical service.

Recognising that they would need strong doctor leaders, they conducted a rigorous selection process. Successful candidates then underwent business training at the regional level and in-house. To ensure that leaders had enough time to dedicate to the job, they were given 50% nonclinical hours to dedicate to management work. This time was supported by professional managers who share the administrative workload and support the clinical business unit leaders.

Choosing, Training Leaders for Success

- CBU¹ Leaders all have extensive leadership training; three of four have attended regional leadership training
- All medical leaders in the hospital participate in in-house leadership programs
- Potential future leaders spend time with existing business unit heads to learn business functions and understand operations

Embedding an Effective Support Infrastructure

- CBU Leaders share workload with professional manager
- Executive suite is readily available for any leaders who have questions or need additional insight
- CBU Leaders are given 50% dedicated nonclinical hours each week for management work

Case in Brief: Northumbria Healthcare NHS Foundation Trust

- Nine-hospital Foundation Trust, providing care to over 500,000 people in Northumbria, UK
- Transitioned to Clinical Business Unit model upon becoming a foundation trust
- Clear accountability structure, rigorous leader training, and frequent communication ensure CBUs are efficient and successful

¹ Clinical Business Units.

Source: Northumbria Healthcare NHS Foundation Trust, North Tyneside, UK; Advisory Board interviews and analysis.
Embedding Key Attributes

Most importantly, Northumbria structured the day-to-day operations of the clinical business units strategically to achieve their performance improvement goals.

First, it is clear that the doctor leader in charge of each CBU has full authority to make decisions. To ensure continuity of leadership, the organisation also has succession plans in place for each position so that services are not dependent on the tenure of a single leader.

Second, leaders share practice among each other and with other clinicians throughout the system. A mentorship program supports this and helps leaders form stronger and more collaborative relationships across specialties.

Northumbria’s Advanced Clinical Business Unit Strategy

<table>
<thead>
<tr>
<th>Attributes of Effective Clinical Business Units</th>
<th>Doctor-Led Decision Making</th>
<th>Frequent Best Practice Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline Best Practice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All business units are doctor led, and are supported by service line leads who are clinicians. Leaders are expected to run units effectively with necessary support.</td>
<td></td>
<td>Business unit leads attend quarterly clinical policy group and describe how they are managing cost improvement programs with peers; discuss plans with other clinicians to ensure best possible clinical quality</td>
</tr>
<tr>
<td><strong>Advanced Strategy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Succession plans ensure continuation of process, stability in the role, and orderly transitions</td>
<td></td>
<td>Mentorship provides opportunities to share knowledge, learn from experience, and grow in role</td>
</tr>
</tbody>
</table>

Source: Northumbria Healthcare NHS Foundation Trust, North Tyneside, UK; Advisory Board interviews and analysis.
Third, each clinical business unit leader is held accountable for the performance of their unit. Frequent meetings with the senior executive team ensure that problems are caught early, but it is always made clear that final responsibility for performance rests with the doctor leader.

Finally, communication between the senior executive team and the clinical business unit leaders follows well-defined channels to ensure that it is consistent and clear.

**Northumbria’s Advanced Clinical Business Unit Strategy**

<table>
<thead>
<tr>
<th>Attributes of Effective Clinical Business Units</th>
<th>Clear Accountability</th>
<th>Proactive Two-Way Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline Best Practice</strong></td>
<td>Each of four clinical business units run by a clinician, and supported by a professional manager. Report to executive at weekly business meetings to ensure oversight of financial and clinical performance</td>
<td>Business leads have clinical and leadership training, work with executive and service line leads; bring concern for clinical issues and business success to the role</td>
</tr>
<tr>
<td><strong>Advanced Strategy</strong></td>
<td>Frequent meetings monitor progress, ensure accountability, catch and address problems early</td>
<td>Clear decision structure ensures that all projects follow the same process, prevents confusion, and guarantees clear lines of communication</td>
</tr>
</tbody>
</table>

Source: Northumbria Healthcare NHS Foundation Trust, North Tyneside, UK; Advisory Board interviews and analysis.
While it is difficult to quantify the impact of clinical leadership, Northumbria Healthcare NHS Foundation Trust has achieved considerable operational improvement in a challenging financial environment. Leaders at the organisation believe that this success could not have been achieved without the clinical business unit structure.

Coherent Structure Facilitates Growth

“We are managing challenging cost improvement programs, we are managing a £200,000 tenure investment program, and we’re managing the development of a new emergency care centre, all within the Clinical Business Unit structure…and I don’t think we could have done it without having that structure, because the clinical directorate structure didn’t have the necessary coherence.”

David Evans
Chief Medical Officer
Northumbria Healthcare NHS Foundation Trust

Clear Operational Gains

£1.3M
Budget surplus for 2012/13, up from £10.4 M deficit in 2011/12

£35.1M
Cash generated from operations in 2012/13

2013
Named Provider Trust of the Year by Health Service Journal

For some organisations, altering the formal leadership hierarchy may not be an option.

At Galon Hospital, a pseudonym for a large hospital in the UK, service improvements were implemented slowly or not sustained. An analysis by hospital executives suggested that one key root cause was the reluctance of current service managers to lead significant change initiatives within the organisation. Several of these managers also lacked the leadership or project management skills to successfully drive improvements. Worse, a unionised culture and organisational norms meant that it would be challenging, if not impossible, to appoint more effective service managers in their stead.

Challenges with Formal Leaders

- Lack Necessary Leadership Skills; Willingness to Lead Improvements
  - Established leaders unwilling to contribute to improvement projects outside of traditional scope of role
  - Struggle to identify and implement changes necessary for improvement; fail to sustain projects

- Organisational Structure, Culture Prevents Replacement
  - Formally appointed leaders very challenging to replace due to hospital, medical staff culture
  - Lack of action prevents hospital from reaching improvement goals and government targets

Progress Impeded by Recalcitrant Formal Leadership

“We were able to make a very strong case at the end of the day: why were we failing? Why have we not delivered over time? And we looked at a number of strategies and we always came back to the same problem: there wasn’t proper senior clinical engagement with consultants and they didn’t have the skill set to deliver this…. And a lot of this came from the lessons of not having achieved what we wanted to achieve.”

Service Improvement Lead
Galon Hospital

1) Pseudonym.
To achieve change despite a reluctant leadership group, hospital executives looked outside the traditional hierarchy. They identified a number of frontline consultants who had the desire and drive to effectively lead change. Then they persuaded existing formal leaders to allow these consultants to take over several improvement projects within the organisation.

These informal leaders attended training sessions to develop management skills. The organisation also provided additional support to assist their improvement efforts.

Two Steps for Identifying Informal Leaders, Enfranchising Them to Lead

Identify and Empower Informal Leaders
- Executives identified frontline consultants with innovative ideas who were eager to be involved
- Negotiated with existing formal leaders to establish improvement infrastructure separate from traditional hierarchy
- Willing frontline consultants with leadership potential participate in leadership and improvement training, given mandate to lead improvement

Formal Support Infrastructure Established
- New leaders given dedicated time to work with peers to consider and implement improvement projects
- Project support teams established to provide insight and administrative assistance to consultant leaders

Case in Brief: Galon Hospital

- Specialist hospital in the UK, treating nearly 100,000 patients each year
- After review, recognised that formal doctor leaders were often barrier to progress, which prevented hospital from reaching service improvement goals
- Developed training programs and support structure to identify and empower consultants to act as informal leaders of improvement projects throughout hospital

Source: Advisory Board interviews and analysis.
Empowering Informal Leaders to Enact Change

Galon Hospital’s leadership program was informal, but they followed the same underlying principles as Northumbria to ensure that their new informal doctor leaders were given true ownership over improvement projects.

Four Program Attributes for Effective Ownership

- **Doctor-Led Decision Making**
  Consultant leaders are empowered to actively lead operational improvements, and given the authority to make decisions around improvement opportunities based on clinical perspective.

- **Clear Accountability**
  Program administered by service improvement division, which provides oversight, support, and input on projects ensuring training and implementation reflect organisational goals and values.

- **Frequent Best Practice Sharing**
  Doctors work with colleagues from across the hospital, often in different specialties, to allow participants to provide fresh perspective, learn from colleagues with whom they would not normally work.

- **Proactive Two-Way Communication**
  Executive support for the program, and open commitment to improvement encourages consultants to propose new ideas, raise concerns, and lead change.

Encouraging Ownership from Across the Organisation

“People are now coming to say: “Well, if we’re going to make changes, I’d like to make a change like this.” So, there are lots more new clinical ideas coming forward, because there now seems to be an embryonic structure within the organisation that drives change and makes things happen.”

*Service Improvement Lead, Galon Hospital*

Source: Advisory Board interviews and analysis.
The second obstacle to overcome is a lack of insight by medical leaders into priorities and goals across the organisation.

Barwon Health is a 1,016-bed health system in Victoria, Australia. Their medical services department had a history of budget overruns and identified a siloed approach to decision making as one of the main causes: each service fought for their own resources and struggled to collaborate on department-wide priorities.

**A Challenging Financial Situation**
- $5M

Medical department budget deficit in 2011 fiscal year; department never in surplus to date

**Ambitious Investment Proposals, Modest Savings**
- Service managers proposed $3.9 million¹ in new projects and investments
- Managers suggested potential savings of $1.2 million

**Siloed Thinking, Competition for Resources**
- Service managers focused on individual needs, frustrated if projects not approved
- Hospital strategic priorities such as ensuring patient safety and providing right place, right time, right care

**Case in Brief: Barwon Hospital**
- 1,016-bed hospital system located in Geelong, Victoria, Australia
- Medical department in difficult financial situation with budget deficits and proposed projects more expensive than proposed savings
- Annual department-wide meeting held to assess budget requests, make collective decision on project priorities; demonstrated significantly improved financial and engagement outcomes

¹ AUD.
In 2012, Barwon’s executive director of medical services instituted a new, more collaborative process for budget allocation to try to break down silos across the department. The director succeeded in creating a more system-focused, collaborative culture.

The new process is outlined here. Critically, each cost center manager has the opportunity to advocate for their own requests and hear the case for the other requests. This simple process has created much greater insight into the needs of the department and its patients as a whole.

As a side benefit, the meeting has served as an opportunity to discuss the potential for collaboration to meet department-wide goals, such as increasing weekend discharges.

---

**Process for Approving Business Proposals at Barwon Health**

- Cost centre managers complete standardised Service Request Template to detail funding proposals
- Meet with Executive Director to review proposed requests and savings
- Director calls meeting to review business proposals and approve strategic decisions
- Cost centre managers given packet of all proposals to review

- Approved proposals must demonstrate adequate return within fixed period
- Projects failing to demonstrate return have funding revoked
Collective Action’s Collective Benefits

The new process has resulted in no complaints and helped the department to achieve its first ever surplus.

It also had an unexpected outcome—one service leader decided that their strategy could be carried out without the need for any additional budget.

While many organisations would like to delegate financial control to doctors, some find that they are unable to do so. Providing doctors with a broader perspective on priorities across the hospital is an actionable step even when financial delegation is not an option.

To move from a transactional footing to true shared ownership, organisations must work with doctors to reach agreement on mutual roles and responsibilities and to establish a shared vision for the organisation. Finally, hospital executives must share ownership over strategic decision making with doctor leaders.

Shared Ownership Drives Tangible Financial Results at Barwon Health

Medical Services Department Financial Year Budget Deficit

<table>
<thead>
<tr>
<th>Millions of Dollars¹</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$5.0M</td>
<td>$4.2M</td>
<td>$0.0M</td>
</tr>
</tbody>
</table>

Collective Approach Eliminates Complaints

Complaints about funding allocations since new procedure instituted

Seeing the Full Picture

“I’ve seen them be more engaged, a lot more engaged, with the process... They feel they are all very clear about what the constraints are, and where their ideas sit in the pack of ideas. There would not be any one of them that hasn’t had something approved.”

Felicity Topp, Executive Director Medical Services, Barwon Health

Collective Action's Collective Benefits

Source: Barwon Health, Geelong, Victoria, Australia; Advisory Board interview and analysis.
Crafting a Unique Value Proposition
Sharing a Vision, Not Sewing Patches

A classic Advisory Board study, *Achieving Breakthrough Engagement*, contains a critical message for organisations who are reconsidering their engagement strategies.

That research found that most organisations take a tactical approach to employee engagement: conducting a survey, isolating problem areas, and rolling out initiatives. This approach seems logical, yet organisations in any industry who have achieved and sustained stellar employee engagement take an entirely different approach.

Their strategic approach begins by distilling a unique value proposition from their market situation that is designed to resonate with their desired workforce. Their approach is then crafted around using their resources and expertise to animate that value proposition with specific tactics.

### Strategic Approach Hallmark of Most-Engaged Organisations

#### Engagement Frameworks

**Tactical**

Employee engagement survey drives engagement initiatives by surfacing manager improvement needs and guiding development of ward-level action plans.

**Strategic**

Compact between employees and organisation reflects shared core values animated through supporting engagement initiatives.

### Key Elements

**Tactical**

- Conduct engagement survey
- Identify improvement needs
- Identify initiatives, develop manager action plan
- Deploy supporting initiatives

**Strategic**

- Identify market challenges
- Articulate differentiated employment proposition
- Develop implementation approach
- Deploy supporting initiatives
- Verify employee engagement

Source: Advisory Board interviews and analysis.

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Achieving Breakthrough Engagement

Two examples indicate how a unique value proposition can animate an organisation’s engagement strategy.

Genentech is a biotechnology firm that was undergoing substantial growth. To attract and motivate talented employees, Genentech’s value proposition is that “employees’ daily work improves people’s lives.” To put this value proposition into practice, Genentech uses their marketing capabilities to ensure that their employees see the impact their work has on patient’s lives.

A second exemplar, PeaceHealth, is located in an economically challenged region. They champion the employment proposition that they “care about their caregivers,” to attract caring people who want to work in this environment. To animate their value proposition, they leverage existing resources to remove sources of concern from employees’ lives.

These dynamics are common across organisations with the best and most sustained employee engagement: they follow a strategy to engage staff in a unique value proposition.

Unique Value Propositions Animate Engagement Strategy

<table>
<thead>
<tr>
<th>Genentech</th>
<th>PeaceHealth Medical Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unique Value Proposition</strong></td>
<td>“Employees’ daily work improves people’s lives”</td>
</tr>
<tr>
<td><strong>Tactics Employed</strong></td>
<td>Turning Genentech’s marketing capabilities inward to publicise the experiences of patients who receive Genentech’s life-saving products</td>
</tr>
<tr>
<td></td>
<td>• Patient speakers at brown bag lunches</td>
</tr>
<tr>
<td></td>
<td>• Patient video during new hire orientations</td>
</tr>
<tr>
<td></td>
<td>• Company donation of drugs to in-need populations</td>
</tr>
</tbody>
</table>

**Case in Brief: Genentech**
- Cutting-edge biotechnology firm with over 11,000 employees headquartered in Silicon Valley
- High-growth requires addition of 150 employees per month; highly competitive recruitment market

**Case in Brief: PeaceHealth**
- Not-for-profit, religiously affiliated health care system located in economically challenged area of the Northwestern US
- Hospital conducts a large portion of charity care

Source: Advisory Board interviews and analysis.
Assessing Your Strengths

It is essential to have an underlying strategy to engage doctors, and determining the unique value proposition for your organisation is the most effective way to start.

Many organisations are hesitant to establish a distinctive proposition in case it deters some doctors from joining the organisation. However, this supposed drawback is a strength. Long-term engagement requires organisations to attract those staff who match their needs and culture and to discourage those who do not.

Shown here is a series of the most important considerations to assess what your organisation has to offer to doctors.

### Sample Vectors for Assessing Natural Advantages

<table>
<thead>
<tr>
<th>Geographic Location</th>
<th>Reputation and Prestige</th>
<th>Technology Adoption</th>
<th>Workforce Availability</th>
<th>Care Integration</th>
<th>Models of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where is the hospital located?</td>
<td>How well known is the hospital?</td>
<td>What resources does the hospital own?</td>
<td>Are medical jobs at the hospital in demand?</td>
<td>How integrated is the hospital?</td>
<td>How much autonomy do doctors have?</td>
</tr>
<tr>
<td>Urban</td>
<td>Prestigious</td>
<td>Advanced</td>
<td>Surplus</td>
<td>Integrated</td>
<td>Team Based</td>
</tr>
<tr>
<td>Rural</td>
<td>Less Well Known</td>
<td>Standard</td>
<td>Shortage</td>
<td>Stand-Alone</td>
<td>Independent</td>
</tr>
</tbody>
</table>

Source: Advisory Board interviews and analysis.
Crafting a Unique Value Proposition

Begin with the End in Mind

As well as determining your strengths as an organisation, it is also key to define the type of doctors that the organisation will require now and in the future.

This list of considerations serves as a starting point to analyse your own situation and craft a value proposition.

There is an enormous opportunity for hospitals, no matter what their current situation, to engage doctors by creating an underlying strategy centered around partnership—and to elevate that strategy beyond the generic by centering it around a unique value proposition.

Key Considerations to Craft Value Proposition

Analysis of Market Situation

- What are your organisation’s strategic plans and future performance goals?
- What employee skills or human capital needs will be required to execute the strategic plan and to achieve future performance goals?
- What is your organisation’s current reputation among prospective employees?
- What are the perceived strengths and weaknesses of your organisation?
- What kind of work environment would your desired workforce find most attractive?

Isolation of Unique Value Proposition

- Is your prospective value proposition different from your organisation’s mission statement?
- Does the prospective value proposition promote employee contributions which will advance the organisation’s strategic plan and help achieve future performance goals?
- Will the prospective value proposition engender support from your organisation’s senior leaders?
- Does the prospective value proposition articulate principles which your desired workforce will find meaningful?

Source: Advisory Board interviews and analysis.
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List of Engagement Drivers

<table>
<thead>
<tr>
<th>Doctor Engagement Drivers</th>
<th>Source: Advisory Board Company Survey Solutions: Physician Engagement Initiative.</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ This organisation provides excellent clinical care to patients.</td>
<td>✓ Clinicians and support staff work collaboratively.</td>
</tr>
<tr>
<td>✓ This organisation provides excellent service to patients.</td>
<td>✓ Disruptive behaviour is not tolerated at my organisation.</td>
</tr>
<tr>
<td>✓ This organisation is well prepared to meet the challenges of the next decade.</td>
<td>✓ Over the past year I have not been asked by this organisation to do anything that would compromise my values.</td>
</tr>
<tr>
<td>✓ This organisation is open and responsive to my input.</td>
<td>✓ I would recommend this organisation to a friend or relative to receive care.</td>
</tr>
<tr>
<td>✓ This organisation is pursuing an effective EMR/EHR strategy.</td>
<td>✓ This organisation recognises clinicians for excellent work.</td>
</tr>
<tr>
<td>✓ I have the information I need to assess my productivity and care quality.</td>
<td>✓ Clinicians and support staff work collaboratively.</td>
</tr>
<tr>
<td>✓ The actions of this organisation’s executive team reflect the goals and priorities of participating clinicians.</td>
<td>✓ This organisation understands and respects individual differences (gender, race, age, religion, etc.).</td>
</tr>
<tr>
<td>✓ I am interested in doctor leadership opportunities at this organisation.</td>
<td>✓ I receive the necessary assistance from clinical support staff to succeed in my practice.</td>
</tr>
<tr>
<td>✓ This organisation supports the economic growth and success of my individual practice.</td>
<td>✓ I receive the operational and business support services (IT, billing, coding, scheduling) to succeed.</td>
</tr>
<tr>
<td>✓ I am kept informed of the organisation’s strategic plans and direction.</td>
<td>✓ This organisation supports my professional development.</td>
</tr>
<tr>
<td>✓ Administrative updates I receive from this organisation are useful.</td>
<td>✓ My practice/office manager(s) are effective in their role.</td>
</tr>
<tr>
<td>✓ This organisation supports my desired work-life balance.</td>
<td>✓ I have the right amount of autonomy in managing my individual practice.</td>
</tr>
<tr>
<td>✓ I have good working relationships with clinicians within my principal practice area.</td>
<td>✓ I have good working relationships with clinicians in the organisation outside of my principal practice area.</td>
</tr>
<tr>
<td>✓ Clinical leaders (department chair, specialty director, lead doctor) serving my practice area effectively communicate difficult messages that my colleagues and I need to hear.</td>
<td></td>
</tr>
</tbody>
</table>
Additional Leadership Recruitment Tactic

Nebraska Medical Center’s Leadership Skills Evaluation

Formal Assessment Targets Doctors for Further Development

Nomination Process for Doctor Leadership Development Program

Current medical leaders identify promising candidates in their area based on demonstrated leadership skill

Formal assessment measuring five leadership competencies completed for each identified candidate

All assessments reviewed; selection based on three considerations: (1) overall score, (2) current role, and (3) bench strength

Final group of emerging leaders begins three-year development program including didactic training, and external coaching

Case in Brief: The Nebraska Medical Center

- 624-bed hospital located in Omaha, Nebraska, US
- Implemented formal “Leadership Qualities Profile” to measure leadership potential of candidates for Doctor Leadership Development Series

---

1) Committee consists of physician administrator, program director, program founder, chief of staff, and vice chief of staff.

Source: The Nebraska Medical Center, Omaha, Nebraska, US; Advisory Board interviews and analysis.
### Leadership Development Program Nomination Tool

#### Leadership Qualities Profile

<table>
<thead>
<tr>
<th>Professional Credibility</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Level of expertise and knowledge in clinical medicine</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Level of expertise and knowledge in quality of care</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Degree of objectivity</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Strong reputation as a clinician</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Recognised department medical leader, formal or informal</td>
<td>5 4 3 2 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal Commitment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>To hospital quality improvement philosophy and efforts</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>To clinical guidelines</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>To service (volunteerism, investment of personal time)</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>To innovation and risk taking</td>
<td>5 4 3 2 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Quality Improvement Behaviours and Skills</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Educates, communicates, and persuades</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Monitors performance and gives feedback to peers</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Negotiates and builds consensus</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Advocates for guidelines and requisite practice changes</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Empowers and supports others</td>
<td>5 4 3 2 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Institutional Linkages</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interaction with Senior Administration</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Interaction with Quality Administration</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Interaction with nursing and other non-physician health care providers</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Clinical connectivity with physicians, employed and private</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Organisational credibility as a formal/informal physician leader</td>
<td>5 4 3 2 1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Leadership Skills</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates ability to make and execute difficult decisions</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Collaborator, inclusive, shares information, coalition builder</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>National, state and/or community leadership positions</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Style of leadership; executes, focused, decisive, action-oriented</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>Strong communication skills: inspires others; models values of peers</td>
<td>5 4 3 2 1</td>
</tr>
</tbody>
</table>

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**Additional Leadership Recruitment Tactic (cont.)**

**Nebraska Medical Center’s Leadership Skills Evaluation**

**Assessment Instructions**

**Instructions:** Complete for doctor leaders, formal or informal, within your area of accountability as a means to nominate this individual for participation in The Physician Development Leadership Series. This form will serve as a guide to provide a consistent method to evaluate high-potential leaders in your area. Specific behavioural examples and comments supporting the rating are encouraged.

The Physician Development Leadership Series serves as a development program to assist those high-potential physicians in reaching their leadership potential.
Leadership Competency Descriptions

Tool in Brief
The “Competency Wheel”, which serves as a foundation for leadership development, is comprised of six imperatives and 15 corresponding competencies. Each competency is associated with behaviours—specific actions and activities demonstrated by high-performing health care leaders. These competencies and behaviours were selected for their relevance to health care leadership; successful leaders may exhibit many other skills that are not included on this list.

Source: Advisory Board Talent Development; Advisory Board interviews and analysis.
Leadership Competency Descriptions (cont.)

Managing Vision & Purpose
Formulates a future course that reflects needs of own area or project and that is aligned with the organisation-wide vision. Translates the course into goals and objectives for own team, sets priorities, and directs the efforts of staff towards accomplishing those goals and objectives.

- Articulates a clear and compelling direction for program or project that is aligned with the organisation-wide vision
- Updates direction as required to reflect changes in circumstances
- Translates program or project direction into actionable goals and objectives

Initiative
Recognises and acts on opportunities for growth and improvement to advance hospital and health system goals. Confronts problems quickly and enthusiastically

- Acts promptly and decisively to address issues and resolve problems
- Initiatives new and better ways of doing things even in the absence of apparent problems
- Acts as a catalyst for organisational change

Motivating and Influencing
Inspires staff enthusiasm for and generates commitment to program or project goals. Builds support for changes in direction among people with diverse interests, needs, and values

- Explains to others how their day-to-day work contributes to the accomplishment of departmental or organisational goals
- Persuades and encourages others to move in desired direction
- Builds commitment to initiatives among people with diverse interests by explaining rationale for goals and decisions

Source: Advisory Board Talent Development; Advisory Board interviews and analysis.
Leadership Competency Descriptions (cont.)

Constructive Thinking
Analyses problems systematically and logically, and is resourceful when developing and implementing solutions
• Analyses all relevant issues and available data before acting, keeping overall goals in mind
• Generates creative ideas and solutions to problems; able to think out of the box
• Detects patterns and connections not immediately obvious to others
• Breaks down complex problems into discrete components

Process Management
Develops and implements work plans with actionable components and measurable outcomes. Proactively monitors key performance indicators and makes real-time adjustments to ensure that projects stay on track
• Divides projects into concrete tasks and creates realistic implementation timelines
• Stays on course and meets deadlines even when unforeseen circumstances arise
• Tracks performance against established milestones
• Eliminates barriers and roadblocks that impede progress

Prioritising and Delegating
Regularly reassesses priorities and competing demands and adjusts allocation of own and staff time and resources to increase efficiency and effectiveness. Identifies and implements processes that facilitate delegation and shares responsibility and authority with others, leveraging their unique strengths and skills
• Focuses on the right issues at the right time; acts on important and urgent tasks before tackling less important and less urgent ones
• Leverages available resources (e.g., own time, staff time, financial resources) in the service of program or project priorities
• Regularly reviews own workload to identify delegation opportunities
• Implements systems and processes that enable others to perform work independently
• Provides clear direction when delegating work

Source: Advisory Board Talent Development; Advisory Board interviews and analysis.
Leadership Competency Descriptions (cont.)

Financial Acumen
Applies key financial concepts and analysis to decision making. Understands drivers of financial performance (e.g., doctor referrals, capacity utilisation, payment denials) and takes these into account in developing strategies and making decisions

• Considers financial impact of own decisions on program, project, and the organisation as a whole
• Uses core financial concepts (ROI, capital budgeting, financial ratios) when planning and making decisions
• Closely monitors ongoing financial performance in area of oversight

Accountability
Holds team and self responsible for maintaining the highest possible performance standards and for meeting agreed upon commitments even under difficult circumstances

• Demonstrates passion for excellence in every aspect of work
• Sets ambitious goals
• Holds self and others accountable for meeting standards and goals
• Takes responsibility for outcomes of actions and decisions
• Achieves results even in the face of challenges and setbacks

Service Orientation and Patient Focus
Sets and maintains high standards for service to patients, doctors, and other departments. Incorporates needs and concerns of diverse constituencies (e.g., patients, doctors, and colleagues) into decision making

• Assesses and often anticipates other’s (e.g., patient, doctor, and other departments) needs
• Holds self and others accountable for meeting or exceeding customer needs and expectations
• Takes other’s needs and interests into account when making decisions
• Seizes opportunities for improving patient satisfaction

Source: Advisory Board Talent Development; Advisory Board interviews and analysis.
Leadership Competency Descriptions (cont.)

Effective Communication

Articulates logical and well-founded arguments that support conclusions. Matches communication style to the message and to the audience. Actively solicits opinions from others. Routinely provides others with the information they need to do their jobs

- Expresses ideas clearly, succinctly, and logically
- Responds constructively to issues and concerns raised by others
- Informs staff about pertinent issues in a timely manner
- Seeks input from others when developing solutions to complex problems

Feedback Delivery

Routinely shares suggestions, advice, and insights on progress toward program and project goals. Provides performance feedback that is constructive and actionable and that highlights successes as well as areas for growth and is based on objective metrics

- Routinely provides fair, constructive, and honest feedback
- Helps others understand what they can do to improve performance
- Clearly articulates areas of deficiency without softening the message

Upward Management

Provides regular updates on program or project progress and works with own manager to minimise risks and resolve problems. Notifies senior management about progress towards project goals and informs them about issues that require their attention

- Regularly updates manager on project progress, including identification of potential problems
- Uses sound judgment in determining the right message and timing for delivering information to upper management
- Leverages knowledge and credibility to influence senior management's decisions

Source: Advisory Board Talent Development, Advisory Board interviews and analysis.
Leadership Competency Descriptions (cont.)

Relationship Building
Builds and maintains long-term relationships with others based on mutual respect and trust. Fosters cooperation and collaborative decision making among staff with diverse backgrounds and interests. Works effectively towards solutions and compromises that take the needs of all parties into account when conflict does arise

- Facilitates open communication among people who depend on each other to get work done
- Surfaces and diffuses potential sources of conflict before they escalate
- Demonstrates respect for others through both word and deed
- Negotiates solutions to conflict fairly and diplomatically

Talent Identification and Recruitment
Articulates logical and well-founded arguments that support conclusions. Matches communication style to the message and to the audience. Actively solicits opinions from others. Routinely provides others with the information they need to do their jobs

- Expresses ideas clearly, succinctly, and logically
- Responds constructively to issues and concerns raised by others
- Informs staff about pertinent issues in a timely manner
- Seeks input from others when developing solutions to complex problems

Talent Development and Retention
Defines development objectives for staff that support performance goals and progress toward future skill development. Assists staff in developing their own careers by encouraging them to articulate their career goals, offering challenging growth opportunities, and providing necessary coaching and training

- Gives staff stretch assignments and skill-building opportunities
- Creates actionable development plans for staff
- Encourages learning from setbacks

Source: Advisory Board Talent Development; Advisory Board interviews and analysis.
The framework below defines the required competencies of a Consultant working within Northumbria Healthcare NHS Foundation Trust and will be used to assess prospective candidate’s suitability.

<table>
<thead>
<tr>
<th>No.</th>
<th>Competency Heading</th>
<th>Behavioural Exemplars</th>
<th>Contra-indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Empathy and Sensitivity</td>
<td>• Understands patients’ needs</td>
<td>• Shows a lack of respect for others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Shows concern for individuals</td>
<td>• Puts people down</td>
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<tr>
<td></td>
<td></td>
<td>• Recognises work-life needs of others</td>
<td>• Lacks empathy (cannot see situations from others’ perspective)</td>
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<tr>
<td></td>
<td></td>
<td>• Shows awareness when others are tired/stress</td>
<td>• Shows little concern for colleagues/patients</td>
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<tr>
<td></td>
<td></td>
<td>• Willing to apologise</td>
<td>• Inappropriate comments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Approachable</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Communication and Influencing</td>
<td>• Gives clear information</td>
<td>• Does not keep others informed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Listen and acts on what s/he hears</td>
<td>• Vague</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Influences and negotiates effectively</td>
<td>• Cannot summarise</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Uses power appropriately</td>
<td>• Lacks clarity of communication and thought</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Accepts others’ views</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Confident without being arrogant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Able to put some pressure on individuals who are underperforming</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Personal Organisation</td>
<td>• Attends to mundane tasks</td>
<td>• Lacks forward planning</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Plans and prioritises</td>
<td>• Is not punctual/poor time-keeping</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Is punctual</td>
<td>• Unable to establish good working practices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Has the ability to read endless e-mails and remember them, file them away and then find them again when needed</td>
<td>• Poor organisational skills</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Procrastinates</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Fails to complete tasks</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Not coping with the pace of work</td>
</tr>
<tr>
<td>4</td>
<td>Coping with Pressure</td>
<td>• Calm in a conflict or crisis</td>
<td>• Unwilling to seek help</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Emotionally stable</td>
<td>• Unpredictable/volatile</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Controls temper</td>
<td>• Flaps in a crisis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Willing to face difficult issues</td>
<td>• Easily upset</td>
</tr>
</tbody>
</table>
## Northumbria Healthcare’s Consultant Competency Framework (cont.)

<table>
<thead>
<tr>
<th>No.</th>
<th>Competency Heading</th>
<th>Behavioural Exemplars</th>
<th>Contra-indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Team Working</td>
<td>• Manages boundaries appropriately</td>
<td>• Undermines team members (belittles, bullies)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Shows loyalty to the team</td>
<td>• Champions own needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Is inclusive</td>
<td>• Blames others for errors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cooperates with other teams</td>
<td>• Works in isolation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Helps team learn from errors</td>
<td>• Unable to delegate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Takes responsibility for team errors</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Cares about the team</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Develops others</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Openness, Learning and Self-Awareness</td>
<td>• Shows interest in how others do things</td>
<td>• Unwilling to change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Proactive about change</td>
<td>• Is threatened by change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Willing to change opinion</td>
<td>• Is insular in attitudes and behaviour</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Seeks and acts on feedback</td>
<td>• Is unaware of impact on others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Willing to try new activities or approaches</td>
<td>• Lacks insight</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Reflects on own behaviour</td>
<td>• Has a narrow focus on own specialty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Shows a desire for personal development</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Acknowledges poor behaviour</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Leading and Managing</td>
<td>• Drives up standards</td>
<td>• High control or no control over others</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Will follow as well as lead</td>
<td>• Unable or unwilling to delegate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Has realistic expectations of others</td>
<td>• Burnt out through not delegating</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Is clear and explicit about standards expected</td>
<td>• Leads by fear and intimidation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Visible</td>
<td>• Paternalistic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Modest/shows humility</td>
<td>• Always avoids conflict</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Keeps others on board</td>
<td>• Inflexible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Delegates appropriately</td>
<td>• One leadership style only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Adapts leadership style to the situation</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Encourages others to question and challenge</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Possess and uses a sense of leadership styles</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clear about direction of travel</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Deals with performance issues fairly but clearly</td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Competency Heading</td>
<td>Behavioural Exemplars</td>
<td>Contra-indicators</td>
</tr>
<tr>
<td>-----</td>
<td>------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 8   | Organisational Awareness and Commitment | • Understands and accepts the organisational priorities  
• Communicates these effectively to colleagues and staff  
• Engages in constructive debate about organisational issues  
• Willing to interact positively with managers—showing mutual respect and expects a similar level of respect in turn  
• Effectively balances loyalty to the service and to the organisation  
• Behaves corporately  
• Anticipates changes in the political climate  
• Shows awareness of where his/her team sits in the bigger picture  
• Shows financial awareness  
• Understands the financial impact of their, or their team’s, decisions  
• Willing to compromise and share resources  
• Understands the wider health economy and implications for the Trust business  
• Understands and works within organisational constraints | • Inability to see the wider (organisational) picture  
• Bypasses organisational structures and processes  
• Do not regard themselves as employees  
• Does not acknowledge pressures on managers |
| 9   | Decision Making                     | • Values different professional contributions  
• Supports decisions once agreed  
• Involves others in making decisions  
• Makes solution-focused decisions  
• Based decisions on facts not anecdote  
• Applies knowledge appropriately | • Judgemental  
• Does not involve others in decisions that affect them  
• Indecisive |
| 10  | Teaching                            | • Gives honest and constructive feedback  
• Creates supportive learning environment  
• Gives feedback opportunistically  
• Teaches by example  
• Encourages trainees to be curious | • Teaches by “humiliation”  
• Didactic methods  
• Fails to use current learning techniques  
• Unwilling to learn and develop |
| 11  | Clinical Capability                 | • Excellent clinical skills  
• Knows limits of own competence  
• Is safe  
• Is knowledgeable  
• Shows evidence of life-long learning | • Unwilling to seek help  
• Unpredictable/volatile  
• Flaps in a crisis  
• Easily upset |
**Behavioural-Based Interviewing Best Practice**

**Thedacare’s Doctor Cultural-Fit Assessment**

**Key Doctor Candidate Screening Components at Thedacare**

- **Standard Screens**
  - All applicants’ education and practice history is evaluated

- **Personality, Leadership Assessment**
  - Organisational development specialists administer 16-Personality Factors, Human Synergistic Lifestyles Inventory, MBTI¹

- **Behavioural-Based Interviewing**
  - Senior medical director, chief operating officer, organisational development specialist, and clinicians conduct behavioural-based interview

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**Case in Brief: ThedaCare**

- Five-hospital health system based in Appleton, Wisconsin, US
- Behavioural-based interviews added to screening process to better judge organisational fit; interviewing method associated with lower turnover, greater alignment of new hires
- Interview findings used to tailor integration, development efforts of hired doctors

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¹ Meyers Briggs Type Indicator.

Source: ThedaCare, Appleton, Wisconsin, US; Advisory Board interviews and analysis.
**Behavioural-Based Interviewing Best Practice (cont.)**

Thedacare’s Doctor Cultural-Fit Assessment

Leaders Pursue Discrete Lines of Questioning Based on Expertise

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Sample Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborative Nature</td>
<td>Tell me about a time you placed another doctor’s needs over your own. How did you feel about it?</td>
</tr>
<tr>
<td>Communication Effectiveness</td>
<td>What is the most recent difficult conversation you’ve had with a colleague?</td>
</tr>
<tr>
<td>Flexibility</td>
<td>How did you react the last time you were in an unsettled or rapidly changing environment?</td>
</tr>
<tr>
<td>Fiscal Responsibility</td>
<td>What is your philosophy for controlling health care costs?</td>
</tr>
<tr>
<td>Leadership</td>
<td>Tell me about the most important contributions you’ve made to your current organisation. Why did you do it?</td>
</tr>
<tr>
<td>Patient-Centredness</td>
<td>How did you resolve the last major conflict you had with a patient?</td>
</tr>
<tr>
<td>Clinical Excellence</td>
<td>How do you feel about sharing data and best practices?</td>
</tr>
</tbody>
</table>

**Representative Areas of Inquiry by Leader**

<table>
<thead>
<tr>
<th>Role</th>
<th>Sample Questions</th>
</tr>
</thead>
</table>
| Chief Medical Officer or Medical Director | *Skills assessed:*  
  - Clinical excellence  
  - Patient centredness  
  *Sample question:*  
  What are your favourite ways of keeping up your clinical skills? |
| Chief Operating Officer                   | *Skills assessed:*  
  - Fiscal responsibility  
  - Communication skills  
  - Collaborative Nature  
  *Sample question:*  
  What is the relationship between cost and quality? |
| Organisational Development Manager        | *Skills assessed:*  
  - Leadership  
  - Flexibility  
  *Sample question:*  
  Have you been involved in any hospital committees? |

Source: ThedaCare, Appleton, Wisconsin, US; Advisory Board interviews and analysis.
Behavioural-Based Interviewing Best Practice (cont.)

Thedacare Doctor-Specific Behavioural-Based Interview Guide

Patient-Centred, Customer-Focused Care

- Who has been your favourite patient lately? Why?
- How would your patients describe you?
- How do you feel about using alternate methods, such as email, group visits, or phone visits, to achieve access and meet patient needs?
- Tell me a story about a time that you had a conflict with a patient. How did you resolve it?
- How do you deal with a patient on whom you’ve made a medical mistake?
- Tell me a story about a time when you had a disagreement with a patient’s family. How did you resolve it?
- Tell me about a time when you went “over the top” for a patient.
- What type of complaints and compliments do you usually generate?

Flexibility

- What is a workplace “pet peeve” of yours?
- What excites you most about your job?
- Tell me about how you handle stress. What are your stress relievers?
- In a hectic work environment where you’re expected to manage multiple tasks, how do you prioritise them? What do you like most about this type of atmosphere? Least?
- How would you go about establishing a relationship with your fellow doctors? Support staff? Management?

Clinical Quality

- What are your strongest clinical areas? Why?
- What areas of clinical practice are most challenging to you?
- How would you feel about the results of your clinical quality data being made available to your peers?
- How do you feel about sharing data and best practices?
- How do you feel about the emergence of weakly reported measures?
- Tell me a story about a recent clinical triumph.
- What was your latest clinical disaster?
- What are your favourite ways of keeping up your clinical skills?
- What are things you dislike about your clinical specialty?
- Have you had experience using Electronic Medical Records?
- How familiar are you with clinical guidelines and protocols? How do you feel about their use?

Leadership

- Are you or have you been involved in any committees?
- What are committee meetings like at your hospital?
- What committees are you most interested in participating in?
- Tell me about the most important contributions you have made at your current organisation. Why did you do it?
- Tell me a bit about yourself as a leader.
Behavioural-Based Interviewing Best Practice (cont.)

Thedacare Doctor-Specific Behavioural-Based Interview Guide

Create a Positive Work Environment

• What is a workplace “pet peeve” of yours?
• What excites you most about your job?
• Tell me about how you handle stress. What are your stress relievers?
• In a hectic work environment where you’re expected to manage multiple tasks, how do you prioritise them? What do you like most about this type of atmosphere? Least?
• How would you go about establishing a relationship with your fellow doctors? Support staff? Management?

Recognition and Reward

• How have you been recognised for a job well done in your work setting?
• Have you ever been provided formal recognition, feedback, and/or praise to staff? To bosses/leaders and/or mentors? If so, how?
• How have you celebrated accomplishments in your work environment?

Collaboration and Communication

• What do your colleagues like best about you?
• What don’t they like about you?
• What are your greatest strengths? Weaknesses?
• What do nurses say about you? How do you know?
• When was the last time you had a conflict with a nurse, and how did you resolve it?
• What is the most recent difficult conversation or conflict you’ve had with a colleague?
• What was your last performance review like?
• Tell me about a time you placed another doctor’s needs above your own. How did you feel about that?
• What do you feel the Nurse Practitioner role is in health care today?
• How would you define your communication style?

Fiscal Responsibility

• How do you usually approach the work up of a patient with ____________?
• What is the relationship between cost and quality?
• Tell me about a time you helped reduce resource utilisation while increasing health outcomes for your patients.
• How would you go about increasing output in your department?
• What was your patient volume (billings, panel, RVU’s) last year? What did you do to maximise it?

Other

• What do you want to be in 10 years?
• What is appealing about this job opportunity?
• What sorts of activities do you like to do when not at work?
• What interests you about this community? Why do you want to work here?
• What do you see as your ideal position?
• What do you need from this organisation to be successful?
• In order to familiarise yourself with this organisation, are there any areas of interest that you would like to be accentuated during orientation sessions?
## Comprehensive Doctor Onboarding Toolkit: Checklist

### Tool in Brief
The checklists across the following pages provide detailed guidance on the three critical periods of a new doctor’s tenure: the period from signing to start date, from start date to the 90-day mark, and from the 90-day mark onward. At each state, different action items are suggested in order to sustain doctor engagement and accelerate integration into the hospital community.

### Ensuring Successful New Doctor Integration

<table>
<thead>
<tr>
<th>Phase I: From Signing to Start Date</th>
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<tr>
<td><strong>Description</strong></td>
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<td><strong>Key Objectives</strong></td>
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<th>Phase II: The First 90 Days</th>
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<th>Phase III: 90 Days and Beyond</th>
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<tr>
<td><strong>Description</strong></td>
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Preventing Buyer’s Remorse

Phase I: Signing to Start Date

Active efforts to retain a new recruit must begin the moment the contract is signed. Too often, communication “dead zones” develop between signing and start dates—a period of time when candidates could well be second-guessing their decision to join the staff. Hospital and doctor representatives must regularly reach out to the recruit to provide updates on the preparations for his/her arrival, ensure that the candidate has the resources necessary for the transition to the community (housing, day care, etc.), reiterate excitement about the doctor’s choice to accept the offer, and answer any remaining questions. In the background, all preparations must be made to allow the doctor to begin practicing medicine the day s/he arrives.

**Comprehensive Practice Start-Up Planning**

- Assist doctor in applying for licensure, as needed
- Ensure that doctor is credentialed prior to start date
- Order necessary practice collateral such as letterhead, business cards
- Set-up doctor’s email address
- Obtain photo of doctor to be used in media and for identification badge
- Ensure doctor is enrolled in necessary professional liability programs
- Add doctor to the ED and call center referral distribution lists
- Modify, update doctor office space, as needed
- Interview and hire additional support staff, as needed

**Affirmative Communication Strategy**

- Provide doctor with resources to aid in relocation efforts
- Send monthly update emails and letters from CEO and/or practice partners providing pertinent information about practice and reaffirming local excitement about the recruit’s arrival
- Identify formal doctor mentor and have mentor place initial introduction call to new hire
- Request that a member of the medical staff—the practice, if appropriate—call recruit the week prior to start date to reiterate excitement about him/her joining community
- Mail doctor’s lab coat and temporary badge with congratulations letter in advance of matriculation

Source: Advisory Board interviews and analysis.
Phase II: The First 90 Days

A new recruit’s experience during the first 90 days on the job sets the tone for the longer-term working relationship between the doctor and his/her peers, and between the doctor and the hospital. This is a stressful time for doctor and family, and the complexities of the new role can be overwhelming. Representatives of the organisation must be ever-present to support the needs of the new doctor across this period.

### New Recruit Welcome Sessions

- Welcome doctor with tour of hospital facility and practice location(s)
- Review organisational mission, goals, values, and governance structure for hospital and group
- Provide key contact information and ensure doctor understands that he/she can follow up with any questions or concerns—related to the workplace or community—throughout tenure
- Introduce doctor to staff at a regular or specially planned meeting

### Comprehensive Hospital Acclimation

- Conduct informational sessions with relevant clinical and administrative leaders\(^1\) to orient doctor to important policies/protocols and establish rapport with co-workers; include recruit in department and staff meetings as appropriate
- Hold meetings with hospital CEO or medical director at 30, 60, 90 days and one year to assess doctor’s level of integration and performance against expectations to date
- Evaluate opportunities for soft-touch congratulatory communications from recruiter (e.g., acknowledging first baby delivered at hospital, etc.)

### Formalised Practice Development Planning

- Establish initial productivity goals for new employed doctors, as well as understanding that targets will gradually increase with tenure
- Hold meetings with business development and marketing personnel; doctor liaisons to design, discuss, and launch a promotion plan
- Publicise new doctor’s arrival in local papers, hospital newsletters and affiliated websites, intranet, and other internal communication channels
- Reserve portion of doctor’s time for clinical work in addition to hospital and practice orientation sessions
- Provide access to after-hours clinics, ED rotations, and other clinical service programs that will help the recruit build his/her patient base
- Train doctor in effective coding tactics (these can raise immediate revenue potential of a new recruit by more than 20%)

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\(^1\) For example, IT, HR, employee health, health records, quality improvement, pharmacy, medical library, diagnostic/ancillary services, medical executive and/or other doctor leadership committees, relevant clinical department heads, clinical extenders, research and/or teaching leadership, and other specialty-specific leaders.
## Comprehensive Doctor Onboarding Toolkit: Checklist (cont.)

### Accelerating the Learning Curve

#### Phase II: The First 90 Days (cont.)

**Doctor “Start Classes”**

- Create peer groups of doctors who start at the same time, e.g., within the same quarter, to foster a spirit of camaraderie and mutual support among new recruits
- Host regular events and forums for doctors in start classes to socialise and discuss current challenges
- Schedule meetings at milestone points in start class tenure, and facilitate discussion of common challenges and concerns unique to those times in a doctor’s career
- Arrange informal social events for start class doctors and their families to build social ties and accelerate integration into the community

**Doctor Mentor Assignments**

- Establish a formal mentoring program that pairs new recruits with more experienced doctors
- Designate clear expectations for mentors and consider providing training to maximise benefit of program; ensure mentors are equipped to advance new doctors’ professional development
- Require regular meetings (minimum twice monthly) between doctor and mentor
- Support mentors by scheduling regular meetings where mentors can discuss common issues among mentees and share potential solutions

**Doctor Peer Support**

- Structure more informal relationship-development program that provides each new doctor with additional social support from an established colleague—ideally, a doctor of the same age, background, interests, and specialty—within the first 90 days
- Differentiate program focus from mentor relationship; doctors in support network serve as sounding board and are not directly responsible for recruit’s professional development
- Encourage relationships to continue after 90-day trial period

**First-Year Experience Preview**

- Discuss challenges common to transitioning/first-year doctors through session led by another recently hired peer doctor (one to three years of tenure is ideal)
- Reassure doctors that they are not alone in confronting current difficulties and have support to overcome likely future difficulties
- Review available resources for doctors and their families during the transition to hospital community; consider working with established doctors to develop tip sheets with recommendations on how to handle common issues, e.g., communicating with disgruntled patients, refilling medications, etc.

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Source: Advisory Board interviews and analysis.
Phase III: 90 Days and Beyond

While the support provided to new doctors past the 90-day mark may drop in intensity and frequency, it should be no less regimented. A liaison should serve as a standing resource and advocate for the doctor, managing concerns related to work-life balance, compensation, and relationships with peers and practice administrators. Some institutions require recruiters to fill this role for several months—even years—after the new doctor’s start date. In the short term, this approach ensures doctors who require counsel can reach out to a familiar face. In the long term, this approach ensures recruiters sign only those candidates they know they can support. Regular performance feedback and reviews, structured practice management advice, and executive-level check-ins are also critical to ensure that new doctors are receiving consistent guidance to help them adjust to the environment.

<table>
<thead>
<tr>
<th>Regular “Health and Wellness” Reports</th>
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<tr>
<td>- Conduct 90-day, 6-month, and 12-month surveys to determine basic satisfaction/engagement levels of new doctors, as well as any perceived root causes of dissatisfaction (where experienced)</td>
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<tr>
<td>- Ensure practice manager, doctor liaisons, and recruiters have well-defined roles and accountabilities for troubleshooting service problems</td>
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<tr>
<td>- Encourage new doctor participation in creating mutually agreeable solutions where onboarding problems are identified</td>
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<tr>
<th>Practice Acceleration Team</th>
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<tr>
<td>- Dedicate a cross-disciplinary team—including a finance analyst, coding counselor, marketing liaison, HR representative, doctor mentor, and others as desired—to continue assisting new doctors in maximising business development opportunities, honing practice management skills, and ensuring financial success; works best when team targets limited set of most common new doctor performance challenges</td>
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<tr>
<td>- Schedule group meetings at 90 days and one year to review opportunities for further business development and improvement</td>
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<th>Hardwired Administrator Service Touches</th>
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<tr>
<td>- Develop program whereby administrator and/or nursing director conduct rounds on doctors in the hospital; avoid interactions while doctor is on call (ED or trauma) or scheduled for surgery</td>
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<tr>
<td>- Require hospital and service line leaders to casually ask informal questions to identify opportunities for improving service, satisfaction</td>
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<td>- Establish and observe rapid service recovery protocols for administrators to use when problems arise</td>
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<th>Anniversary Check-Ins</th>
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<td>- Record goals of hospital and doctor at time of recruitment to identify objectives for the relationship</td>
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<tr>
<td>- Schedule annual meetings with CEO to discuss progress against goals and how hospital can continue to serve doctor in the future; reset goals or craft plans for remedial action if any measures are significantly off-target at the point of check-in</td>
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Comprehensive Doctor Onboarding Toolkit: Key Components

Three Key Components of Effective Onboarding

1. Ensure Early Interaction with Executive Leaders
   Northern Michigan Hospital
   200-bed hospital in Michigan, US
   - Monthly one-hour breakfast held by senior executives for all new hires to establish rapport between doctors, executives
   - Discussion focuses on how to better acclimate new doctors into the hospital’s culture

2. Encourage Sharing of Peer Doctor Experiences
   Mercy Health Partners
   1,897-bed hospital in Ohio, US
   - New doctors attend a “What I Wish I Had Known” discussion hosted by more tenured staff
   - Topics include assimilating to hospital culture, unique aspects of the hospital, CEO gives welcome message to attendees
   - Program accompanied by formal mentorship pairings and spousal support

3. Refine Onboarding Efforts Through Continual Feedback
   Overlake Medical Center
   337-bed hospital in Washington, US
   - Created post-onboarding survey specifically targeted to new doctors to identify program refinements; since implementing, response rate is 60%
   - Survey concentrates on a mix of doctor-specific and general orientation issues

Tools:
- Executive-New Doctor Discussion Guide, p. 138
- Overview of Peer Panel for New Doctors, Overview of Doctor Mentorship Program, and Overview of Spousal Support Program, pp. 139-143
- Doctor-Specific Post-Onboarding Survey Tip Sheet and Sample, pp. 144-147

Source: Northern Michigan Hospital, Michigan, US; Mercy Health Partners, Ohio, US; Overlake Medical Center, Washington, US; Advisory Board interviews and analysis.
Comprehensive Doctor Onboarding Toolkit: Executive-New Doctor Discussion Guide

**Tool in Brief**
The following tool provides discussion points and suggested scripting for a structured conversation between the executive team and new doctors. This discussion should focus on new doctors’ expectations, potential challenges of the first year, and available resources.

<table>
<thead>
<tr>
<th>Main Discussion Points</th>
<th>Sample Scripting</th>
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| **Introduction**       | • Clarify purpose of session:  
- Introduce doctors to executive team  
- Discuss challenges and highlights of first year of employment  
• “Hello, I'm [position title], the [position title]. I want to welcome you to our hospital and thank you all sincerely for spending time with me today. The purpose of this session is to explore your expectations of the upcoming year and to think together about how to bridge the gap between your expectations and the often challenging reality of your first year on the job.” |
| **The Ideal First Year** | • Ask participants to envision the ideal first year  
• “Imagine an ideal first year on the job. What are you looking forward to the most?” |
| **Potential Challenges** | • Encourage participants to imagine potential challenges they might face in the coming year  
• “No matter where you work, the first year in a job is naturally a challenging time. What are some of the reasons that the first year can be difficult? (Lack of social support? Unfamiliar environment? Steep learning curve?)”  
• “What do you expect to be the most difficult or challenging aspect of your first year? (Learning your way around? Learning hospital procedures?)” |
| **Hospital Resources** | • Emphasise hospital commitment to retain and engage doctors  
• Inform participants about resources provided by hospital to ease first-year transition  
• “We’re committed to making your experience here a positive one, and we recognise that the hospital has a large role to play in easing your transition.”  
• “Let me tell you about some of the resources we’ll provide over the next several months…”  
• [If discussion facilitated by CEO]: “Finally, I want to let you know that I and the other senior leaders care about your experience as an employee, and my door is always open to hear your concerns. You also have a great resource in HR, who is always available if you need to talk.”  
• [If discussion facilitated by HR]: “Finally, I want to let you know that I am the designated point of contact for new hires—my door is always open for your concerns. I'm now passing around my business card. Please contact me if you ever need to talk.” |

Source: Advisory Board interviews and analysis.
Comprehensive Doctor Onboarding Toolkit: Peer Panel for New Doctors Overview

**Goal:** Panel presentation on the topic, “What I Wish I Would Have Known” is provided to all newly on-boarded doctors. The panel offers practical knowledge from peers related to practice in their region or facility. The informal atmosphere enhances peer collegiality and support. Additionally, it provides another touch point for interactions with members of the executive team. The Chief Medical Officer has overall responsibility for coordinating the process.  
**Length:** One hour, offered quarterly

**Participants:**
- Four doctors recruited within the prior two years (panel members)
- All newly recruited doctors since the previous offering
- CMO\(^1\)
- COO\(^2\)
- VP of Employed Doctors/ Director

**Process:**
- Annually, the doctor panel is selected and their role explained
- Arrangements for location, room setup, and refreshments are made in advance
- Invitations are sent out one month prior to the next panel presentation to the appropriate newly on-boarded doctors and the executives
- The panel fields questions from the newly on-boarded doctors, provides anecdotal information about their own on-boarding process and experience, and explains nuances specific to the local area

**Sample Key Messages:**
- Welcoming comments by the CEO\(^3\) and/ or COO
- Introduction of panel members by the CMO
- Each panel member relates anecdotal information about their own on-boarding process that includes:
  - What worked or was very helpful for them
  - What they learned setting up their office practice
  - How they went about assimilating into the culture
  - How they found their way around the area
  - How they integrated themselves into the community
  - What did they encounter with their family assimilation to the area
  - An answer to the question “what I wish I would have known”, including what steps they took to solve any difficulty they encountered
  - What they have found to be “unique” or better about joining a CHP\(^4\) facility
  - Words of encouragement related to their successes since joining CHP
  - How their personal philosophies are supported with CHP’s mission
- Answering any questions from the audience
- A wrap-up and thank you by the VP of Employed Doctors/ Director

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\(^1\) Chief Medical Officer.  
\(^2\) Chief Operating Officer.  
\(^3\) Chief Executive Officer.  
\(^4\) Catholic Health Partners.
Comprehensive Doctor Onboarding Toolkit: Doctor Mentorship Program Overview

Criteria for Doctor Mentor Role

**Purpose:**
The mentor is an experienced doctor responsible for providing new doctors with a solid foundation for independent practice, improving integration into the organisation, and assisting with personal and professional growth for the first three years.

**Qualifications:**
The minimum qualifications for consideration as a mentor are listed below. These qualifications should be reviewed and evaluated annually in a joint effort between the HR manager and the department manager.

**Mentor Candidates Must Exhibit the Following Characteristics:**
1. Employed at the institution for a minimum of two years. However, the unit/department manager may determine that an employee is ready for this role sooner.
2. Job performance rated as "good" or above, with strong interpersonal skills and role modeling behaviours.
3. Interest in the mentor role
4. Flexibility in his/her work schedule to meet mentor program needs and contact with new hires

**Once Selected the Mentor Must Meet the Following Expectations:**
1. Participate in scheduled new doctor support program activities to help promote program growth, as well as personal and professional growth for himself/herself and new doctors
2. Plan mentor meetings; if group meetings not possible, mentor should check in frequently one-on-one with new doctors to ensure they feel supported in the transition into the organisation
3. Document mentor meetings and one-on-one mentoring moments.
4. Maintain good communication with the new doctors’ managers, HR, and the new doctors; in addition, proactively bring issues forward for resolution

**Position Objectives:**
1. Provide assistance for a designated period of time to doctors who are new to the organisation
2. Supplement the orientation program, helping new graduates and experienced doctors adjust to their role, with a focus on nonclinical issues that affect job adjustment and satisfaction
3. Help improve retention of new doctors by identifying issues and concerns early that can cause doctors to leave, and by helping new doctors adjust to the organisation
4. Offer new doctors unconditional support and an opportunity to work in a culture of support
5. Equip new doctors with a solid foundation for independent practice
6. Serve as a role model for new doctors to help them develop positive traits such as leadership skills, discipline, hard work, job dedication, honesty, persistence, tactfulness, dignity, and respect
7. Act as an exemplar of institutional mission and values while teaching service excellence skills
8. Give additional support to the manager as an integral part of the unit “retention team”
Comprehensive Doctor Onboarding Toolkit: 
Doctor Mentorship Program Overview

Doctor Sponsorship Program and Expectations

**Goal:** To assist new doctors’ transition successfully into the work environment, organisational culture and maximize his/her engagement with Catholic Health Partners early in his/her career. The assigned sponsor will be a ready reference and provide feedback to the new doctor on relationships, organisational structure and culture, job performance, technical information and role expectations. This program has benefits for both the sponsor and the new doctor. The new doctor benefits from access to an individual who is more experienced dealing with the dynamics and issues of a doctor within CHP. The sponsor passes on lessons learned throughout his/her career and as a result, feel they have had the opportunity to “make a difference” and have made a real contribution to their profession, organisation and own life.

**Length:** Six to 12 months.

**Participants:**
- VP of Employed Doctors
- Assigned Sponsor
- New Doctor

**Process:**
- Within seven days of signing the employment agreement, VP of Employed Doctors begins to identify a sponsor. Selection of potential sponsor should be made on the basis of the following:
  - Having commitment to the organisation
  - Someone who would be a good teacher, guide, counselor, sponsor or facilitator
  - Someone who has genuine interest in seeing this individual succeed
  - Is sensitive to others’ needs and development
  - Possesses good listening skills
  - Has available time
  - Is very confidential
  - Someone who avoids dominance, control or over-protection
  - Has good coaching and feedback skills
- When determining the appropriate sponsor, consideration should also be given to:
  - Personality styles and preferences
  - Proximity to new doctor’s physical location
  - Similarity to new doctor’s personal life, i.e., single, married, children, etc.
  - Business issues
Comprehensive Doctor Onboarding Toolkit:  
Doctor Mentorship Program Overview (cont.)

- Once a potential Sponsor is identified, the VP should contact the Sponsor to discuss their interest in this assignment. VP should discuss the role and expectations including:
  - Estimated amount of time required of sponsor: approximately 12-15 hours over the course of one year.
  - Regular contact/meetings/phone calls—monthly through first three months and at six months; to develop and maintain the relationship
  - Attending the welcome breakfast
  - Hosting the new doctor and spouse at minimum of three social events in first year
  - Helping the new doctor through difficult situations
  - Establishing clear, open, two-way communication
  - Being a source of information and encouragement
  - Providing clear guidance on professional issues
  - Helping new doctor navigate within the system
  - Acting as advocate for new doctor by connecting him/her with appropriate contacts
  - Helps new doctor set priorities for managing time and making wise decisions among options/opportunities.

- Within 21 days of signing the new doctor, the VP of Employed Doctor identifies Doctor Sponsor and makes new doctor aware of whom their sponsor will be.
- VP of Doctors sends the Sponsor a copy of new doctors CV, notes on doctor, spouse, family, start date, new address, hobbies, etc.; along with overview of guidelines for being a Sponsor.
- Prior to new doctor’s first day, Doctor Sponsor contacts new doctor to welcome him/her.
- Sponsor attends new doctor’s first day/welcome breakfast.
- Sponsor meets with new doctor in his/her first month—focus on developing a relationship/trust level, assisting the new doctor with his/her transition into the organisation, answering questions about whom to go to, and key things they should know.
- During first month—Sponsor invites new doctor and spouse (if applicable) to dinner/social event.
- Sponsor makes contact with new doctor in month two—focus on continuing to develop relationship/trust level, asks about their transition to date—how they are progressing, if they have met all those they feel they need to meet in the organization, if they have any questions on the clinical, quality and patient safety programs/expectations.
- Sponsor makes contact with new doctor in month three—focus on continuing to develop relationship/trust level; discuss how they are doing personally within the organisation and community (if new to area)—what is their comfort level with the culture of organisation, do they have questions on the faith-based part of CHP, do they have questions on the organisational structure or key metrics.
- Sponsor invites new doctor and spouse (if applicable) to dinner/social event between months three and six.
- Sponsor makes contact with new doctor in month six—focus on seeing if there are outstanding issues/concerns that the new doctor needs assistance with and getting those resolved.
- Sponsor invites new doctor and spouse (if applicable) to dinner/social event between months six and 12.
- Please note the above list is not meant to be exclusive and if the sponsor and new doctor desire to meet more than is outlined above it is completely acceptable and encouraged. This list is meant to serve as an outline of minimum requirements for contact.

Source: Mercy Health Partners-Southwest Ohio, Cincinnati, Ohio, US; Advisory Board interviews and analysis.
Comprehensive Doctor Onboarding Toolkit: Spousal Support Program Overview

**Goal:** A spousal support program helps the family adjust personally to their new environment. The goal is to stay abreast of how the family is adapting and to anticipate any problems.

**Length:** One year

**Participants:**
- VP of Employed Doctor Services
- Doctor Recruiter or Assigned spousal support resource person

**Process:**
- The VP of Employed Doctor Services introduces program and determines if the doctor’s spouse is interested in participating in this optional program.
- If there is an interest in the Spousal Support Program, the VP of Employed Doctor Services solicits the assistance of the Doctor Recruiter to fulfill this role. As this program develops more fully, there is the flexibility to include a like-matched spouse of an employed doctor as the spousal support resource person. Finding a spousal support resource person with similar interests, background, as well as living in close proximity to the spouse, ensures a more successful experience.
- The spousal support resource person is given information regarding the doctor’s start date, address, and other helpful information such as hobbies.
- The VP of Employed Doctor Services gives the spouse the name of the spousal support resource person who will be assisting in their transition.
- The spousal support resource person calls the spouse within one week of the doctor’s start date to introduce themselves, welcome them, answer questions, and begin to develop a rapport with the spouse.
- The spousal support resource person calls within one month and offers to meet the spouse for lunch. They discuss any upcoming events that they would both be attending. The spousal support resource person ensures that the spouse is introduced and welcomed at these events.
- The spousal support resource person continues to call on the spouse quarterly to check in for the first year.

Source: Mercy Health Partners-Southwest Ohio, Cincinnati, Ohio, US; Advisory Board interviews and analysis.
Comprehensive Doctor Onboarding Toolkit: Doctor-Specific Post-Onboarding Survey Tip Sheet

**Recommendation #1: Limit Survey Length**

**Description:** Survey limited to minimum number of questions necessary to capture new doctor engagement level and performance on key onboarding program elements. Surveys should be as brief as possible and not exceed 12 questions (including demographic questions)

**Rationale:**
- Decreases survey fatigue and increases response rate
- Shorter tools especially critical for surveys administered multiple times

**Recommendation #2: Focus Primarily on Engagement Drivers**

**Description:** Focus survey on diagnosing performance on key drivers of doctor engagement

**Rationale:**
- Demonstrates whether onboarding program is succeeding in impacting specific drivers of new doctor engagement
- Helps human resource leaders develop targeted action steps to enhance engagement by refining onboarding program

**Recommendation #3: Incorporate Limited Number of Questions on Onboarding Elements**

**Description:** Include limited number of survey questions about effectiveness of key onboarding elements

**Rationale:**
- Provides specific new doctor feedback on onboarding program elements
- Enables cross-check of efficacy of key program elements with overall new hire engagement

**Recommendation #4: Include Strategic Respondent Demographics**

**Description:** Ask survey respondents for demographic information of strategic interest to the institution, including tenure, job type, department

**Rationale:**
- Enables targeted HR intervention in departments or professions with greatest improvement need
- Provide operational leaders with unit/department specific survey results

**Recommendation #5: Capture Longitudinal Data**

**Description:** Survey new hires multiple times across first year of employment

**Rationale:**
- Pinpoints time period in which new hires at greatest risk of becoming disengaged
- Facilitates ongoing refinement of onboarding program by enabling crosswalk of timing of onboarding program elements to new hire engagement

Source: Overlake Hospital Medical Center, Bellevue, Washington, US; Advisory Board interviews and analysis.
Comprehensive Doctor Onboarding Toolkit: Doctor-Specific Post-Onboarding Survey

Part 1: Congratulations on your new job with Overlake Medical Clinics! We care deeply about our providers and want to make sure that as a new provider, you are receiving the help you need and the warm welcome you deserve. Please help us by letting us know how we are doing by completing this brief survey about your onboarding experience.

Question 1: Please select the month of your first day of work:
- January, February or March 2010
- April, May or June 2010
- July, August or September 2010
- October, November or December 2010

Question 2: Please select your job title:
- Physician
- PA¹
- ARNP²

Question 3: The information I received before my start date adequately prepared me for my first day. For example, I knew where to go, what I would be doing, where to park, etc.
- Strongly Agree
- Agree
- Tend to Agree
- Tend to Disagree
- Disagree
- Strongly Disagree
- Comments:

Question 4: How would you rate the overall hiring/recruiting process?
- Excellent
- Good
- Fair
- Poor
- Comments:
Comprehensive Doctor Onboarding Toolkit:  
Doctor-Specific Post-Onboarding Survey (cont.)

Question 5: The employment and credentialing process was well organized and documents were easy to fill out.
   □ Strongly Agree
   □ Agree
   □ Tend to Agree
   □ Tend to Disagree
   □ Disagree
   □ Strongly Disagree
   □ Comments:

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

Question 6: Within the first month of starting work in my clinic, I met one-on-one with my Practice Manager to discuss expectations for my role.
   □ Agree
   □ Disagree
   □ Comments:

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

Question 7: Within the first month of starting work in my clinic, I met one-on-one with my Associate Medical Director to discuss expectations for my role.
   □ Agree
   □ Disagree
   □ Comments:

   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

Source: Overlake Hospital Medical Center, Bellevue, Washington, US; Advisory Board interviews and analysis.
Part 1: The following team members have effectively demonstrated OHMCs/OMCs mission of medical excellence every day:

Question 8: My Practice Manager
- Strongly Agree
- Agree
- Tend to Agree
- Tend to Disagree
- Disagree
- Strongly Disagree

Question 9: My Associate Medical Director
- Strongly Agree
- Agree
- Tend to Agree
- Tend to Disagree
- Disagree
- Strongly Disagree

Question 10: My Medical Director
- Strongly Agree
- Agree
- Tend to Agree
- Tend to Disagree
- Disagree
- Strongly Disagree

Comments:
________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________
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Comprehensive Doctor Onboarding Toolkit:
Doctor-Specific Post-Onboarding Survey (cont.)

**Question 11:** My colleagues and I have established a professional working relationship.

- [ ] Strongly Agree
- [ ] Agree
- [ ] Tend to Agree
- [ ] Tend to Disagree
- [ ] Disagree
- [ ] Strongly Disagree

Comments:
______________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________

**Question 12:** Onboarding events (orientations) gave me an opportunity to get answers to my questions and I felt the process was beneficial towards my success as a provider with OMC.

- [ ] Strongly Agree
- [ ] Agree
- [ ] Tend to Agree
- [ ] Tend to Disagree
- [ ] Disagree
- [ ] Strongly Disagree

Comments:
________________________________________________________________________________________________________________________________
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Thank You for your time. Welcome to our community. We are glad you found your community here!
The Ottawa Hospital/Doctor Engagement Agreement

<table>
<thead>
<tr>
<th>The Hospital’s Commitment to Doctors</th>
<th>Values of the Ottawa Hospital</th>
<th>The Doctors’ Commitment to The Hospital</th>
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</thead>
<tbody>
<tr>
<td><strong>Commitment to Quality</strong></td>
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<tr>
<td>• Support this commitment to quality by choosing measures that are relevant, context sensitive, meaningful and objective</td>
<td>• Champion development and adoption of organisational processes, practices and policies that drive excellence in quality care within an academic environment</td>
<td>• Actively work with the hospital; acknowledge your key role in improving individual and hospital care processes to boost quality and safety</td>
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<tr>
<td>• Cultivate a culture of trust; to that end, evaluations of processes, systems and people must be timely, candid and constructive</td>
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<td><strong>Compassion</strong></td>
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<tr>
<td>• Create an environment that contributes to physical and emotional health</td>
<td>• Recognise patients as the primary focus of our collective efforts and advocate on their behalf</td>
<td>• Protect patient privacy and dignity</td>
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<td>• Provide care in a manner consistent with patient and family-centred principles</td>
<td>• Promote doctor and staff health and well-being</td>
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<td>• Communicate with patients and families in a clear, timely, supportive, engaged and empathetic manner</td>
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<tr>
<td><strong>Working Together</strong></td>
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<tr>
<td>• Make decisions and allocate resources in a consultative manner; listen to stakeholders, be transparent and assume accountability for those decisions</td>
<td>• Engage with others, actively listen to them, communicate respectfully, and consider their ideas</td>
<td>• Participate in decision-making; practice in accordance with group decisions</td>
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<tr>
<td>• Share information and communicate directly and proactively in an honest, consistent and meaningful way</td>
<td>• Use resources in an appropriate way and be accountable for utilisation</td>
<td>• Work within and respect organisational processes and clinical systems</td>
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<tr>
<td>• Ensure that organisational processes and clinical systems are effective, that they recognise and respect the relationship of doctors with the hospital and patients, and align with the hospital’s core values</td>
<td>• Treat coworkers as you would like to be treated</td>
<td>• Demonstrate clear, effective and transparent leadership</td>
</tr>
<tr>
<td>• Recognise and celebrate the accomplishments of doctors</td>
<td>• Ensure that organisational processes and clinical systems are effective, that they recognise and respect the relationship of doctors with the hospital and patients, and align with the hospital’s core values</td>
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<td><strong>Respect for the Individual</strong></td>
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<tr>
<td>• Treat everyone at The Ottawa Hospital with fairness, equity and respect</td>
<td>• Treat everyone at The Ottawa Hospital with fairness, equity and respect</td>
<td>• Value and respect diversity</td>
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<td>• Value and respect diversity</td>
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</table>

President and CEO

Doctor Name

Division Head Signature

Doctor Signature

Date

Source: The Ottawa Hospital, Ottawa, Ontario, Canada; Advisory Board interviews and analysis.

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advisory.com
SERVICE REQUESTS (Minor Business Case)
(Any requests for additional EFT/Service Enhancements- Complete this form for Discussion)

Service Name:
Requested By:

What is your proposal?

What are the benefits to your patients, service and Barwon Health?

What are the risks to your service and Barwon Health?

What will your request cost (include staff, consumables, drugs, space, equipment, IT)

What is the income stream for your request?
Medical Services

2013/14 Efficiency/Productivity Project Plan

Each service will be required to develop savings plans that will be measured throughout the year. Business managers will be available to assist with working out the finances within your plan. At this stage 2.5% of total budget is the target for each cost centre.

1. Project Description And Benefits

Project Title: Revenue Initiative: Cost Saving Initiative

Department: Manager Lead(s):

Project Outline and Impact:

Rationale:

Summary of Savings, Revenue and Implementation Costs (estimate of savings)

Resource Requirements:

Potential Project Risks:
2. Project Time Frame

Expected start and finish dates for project, with key milestones and resources

<table>
<thead>
<tr>
<th>Outline the key tasks (and/or project milestones) to implement this initiative.</th>
<th>Who will undertake this task?</th>
<th>When will this task be completed? format - dd/mm/yy</th>
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</table>
3. Measurement & Monitoring Of Initiative
(Please Ask For Assistance From Business Managers)

|                | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar | Apr | May | Jun | TOTAL | Info                                      |
|----------------|------|-----|------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-------|                                          |
| Baseline       |      |     |      |     |     |     |     |     |     |     |     |     |       | What is baseline based on                 |
| Forecast Spend |      |     |      |     |     |     |     |     |     |     |     |     |       | Which cost centres, budget lines etc      |
| Forecast Revenue|     |     |      |     |     |     |     |     |     |     |     |     |       | Costed across FY some variation due to    |
|                |      |     |      |     |     |     |     |     |     |     |     |     |       | staff leave clinic closures               |
| Actual Spend   |      |     |      |     |     |     |     |     |     |     |     |     |       | Where is data from e.g. ledger?           |
| Actual Revenue |      |     |      |     |     |     |     |     |     |     |     |     |       |                                             |
| Revenue Variance from Forecast | | | | | | | | | | | | | | Explain variance                          |

NB amend table to show expenditure requirements, revenue generation, etc. as required

Remember to include impact of EBA changes, CPI increases, etc. Total savings should be gross savings, therefore baseline may need adjusting into 07/08 terms to show full impact of savings
Medical Services Budget and Business Plan

Capital Requests

Review current capital equipment list (available from business manager) and use this form to add additional items which can be discussed when meeting with Felicity

**Service Name:**

**Requested By:**

What is your request/s?

Is this item currently on the capital equipment list? Yes No

What are the benefits to your patients, service and Barwon Health?

What are the risks to your service and Barwon Health if this item is not purchased?

What will your request cost (include staff, consumables, drugs, space, equipment, IT such as software)?