Physician Engagement: Successful Strategies for Meaningful Use by Clinicians

“Template for high level engagement plan”

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Trinity Health & Michigan

- 44 Hospitals (32 Owned and 12 Managed) Across 8 states
- 8,074 Active Staff Physicians
- 44,500 Full-Time Equivalent Employees
- Revenue of $6.3 Billion
- Fourth Largest Catholic Health System in the U.S.
Trinity Health IT: Circa 2001...

<table>
<thead>
<tr>
<th>Operating Units</th>
<th>Silver Spring, MD</th>
<th>Columbus, OH</th>
<th>Port Huron, MI</th>
<th>Mt. Clemens, MI</th>
<th>Pontiac, MI</th>
<th>Livonia, MI</th>
<th>Ann Arbor, MI</th>
<th>Battle Creek, MI</th>
<th>Grand Rapids, MI</th>
<th>Muskegon, MI</th>
<th>South Bend, IN</th>
<th>Clinton, IA</th>
<th>Dubuque, IA</th>
<th>Mason City, IA</th>
<th>Sioux City, IA</th>
<th>Boise, ID</th>
<th>Fresno, CA</th>
</tr>
</thead>
</table>

Clinical Operations Improvement

Trinity Health IT Unification 2010...

**Consistent Tools + Best Practice Processes = Operational Excellence**

29 of 40 planned facilities brought live with CPOE, FirstNet, and ancillary systems. 63% of staffed beds live (as of Oct 10th).
While fewer than 5% of U.S. hospitals have a comprehensive electronic records system, Trinity Health has incorporated a deliberate readiness and training approach to achieve physician adoption.

100% of orders are electronic AND prescribers directly enter 74%.

Trinity Health Improving Care Systematically...

Consistent Tools + Best Practice Processes = Operational Excellence

26 of 40 planned facilities brought live with CPOE, FirstNet, and ancillary systems. 63% of staffed beds live (as of Oct 10th).

100% of orders electronic with 74% entered by prescribers.

Despite successes, this magnitude of change imposes burdens on our clinicians, e.g. cognitive burdens, information retrieval, and time consuming navigation...

we need methods to better engage our clinician and respond to more quickly to their concerns....
### Determinants of Success of Inpatient Clinical Information Systems: A Literature Review


<table>
<thead>
<tr>
<th>Variable</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance</td>
<td>High</td>
</tr>
<tr>
<td>Participation</td>
<td>High</td>
</tr>
<tr>
<td>Beliefs driving technology acceptance behaviors among physicians</td>
<td>High</td>
</tr>
</tbody>
</table>

**Conclusion:** Psychological ownership's highly significant associations with user participation and crucial beliefs driving technology acceptance behaviors among physicians affirm the value of this construct in extending our understanding of POE adoption.

### The Effects of Creating Psychological Ownership on Physicians' Acceptance of Clinical Information Systems


If technical and functional aspects of the system are addressed, what remains are Culture & Change.

### Developing a Plan for Engagement

Successful change depends on consistent steps and tactics.

**From Kotter and Cohen “Heart of Change” (2002)**

- Increase Urgency
- Build the Guiding Team
- Get the Vision Right
- Communicate for Buy-In
- Empower Action
- Create Short-term Wins
- Don’t Let Up!!
- Make Change Stick

See physician engagement tool kit & web site: "Heart of Change by Kotter & Cohen: Relating a Classic Change Management Text to IT Change PPT."
Clinician Engagement

Engagement Plan Framework/Pillars:

1. Engagement overview (Link)
2. Essentials of clinician engagement
   - Leadership and teams (Link)
   - Communication (Link)
   - Physician training (Link)
   - Cultural management (Link)
   - Assess & Respond (Link)
3. Other tactical tools (Link)
4. Starter set tasks (Link)
5. Appendix and more detail (Link)

Engagement Starter Set Overview

Physician Engagement Starter Set
- The readiness liaison will use a task based project methodology.
- There are ~100 tasks over 16 months for the physician leadership.
- The final MO physician detailed engagement plan includes a revised version of this document AND the detailed plans that are produced by the functional leaders and includes...
  - Physician training, superuser and schedule, communication plan, engagement and training tracking tool with reporting, synonyms review, physician documentation, discharge and medication reconciliation roles review (in collaboration with nursing), assessments of engagement plan
- This template pack includes all of the tasks associated with the most current starter set in slides called “Checklists” These can be edited right in the ppt template
- Each physician lead and liaison should review and check off on those tasks that will be the best use of local resources.
### Overview (cont.)

#### Detailed Engagement Plan Role Responsibilities

<table>
<thead>
<tr>
<th>The physician leadership will be responsible for the following executive deliverables...</th>
<th>The physician leadership will be responsible for medical staff risks and concerns. For phase II these may be...</th>
</tr>
</thead>
<tbody>
<tr>
<td>• High level engagement plan</td>
<td>• CPOE and verbal order policy</td>
</tr>
<tr>
<td>• Compelling argument</td>
<td>• Expectations of CPOE usage (bylaws?)</td>
</tr>
<tr>
<td>• Physician support schedule</td>
<td>• Med reconciliation</td>
</tr>
<tr>
<td>• Communication plan</td>
<td>• Transfer order review vs rewrite,</td>
</tr>
<tr>
<td>• MO physician training plan</td>
<td>• Clinical documentation clarification process</td>
</tr>
<tr>
<td>• MO Specific Physician Documentation Strategy</td>
<td>• Document deficiencies</td>
</tr>
<tr>
<td>• Modification of medical staff bylaws and hospital policies if necessary.</td>
<td>• Signature of unsigned verbal orders</td>
</tr>
</tbody>
</table>

These responsibilities are shared between, CMO (VPMA), CMIO, physician champion. Please identify in this slide who will address these issues.

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### Communications
Compelling Message and Rationale for Change:

- The physician team will develop a relevant message and justification to our clinicians based on interviews of leaders, surveys, cultural expectations, and other needs.

- Describe the imperative, urgency, and success:
  - Examples:
    - We are pushing our current clinical care processes to the limitations of human vigilance.
    - Threats to patient safety and quality of care require levels of attention and reliability that cannot be managed by clinicians alone.
    - Information and medical technology have overwhelmed the capabilities of our paper processes.
    - When we have a complete electronic record, information will be available whenever patients are seen.

- We will identify clinician issues and refine the message and incorporate the frustrations of physicians in our Ministry.
  - Using “Problem Based Marketing” – the team will interview and/or survey clinicians to develop a message that will personalize and localize the message that is used later in the implementation.
    - See Physician Engagement toolkit for Advisory Board best practice #6
    - Use existing physician surveys, e.g. TH 2006 “Physician Satisfaction Survey”
    - Consider the existing “pre-go live assessment survey” as a method to develop.

- These messages will be incorporated into the detailed communications engagement plan describing major communications channels and events for the project. Detailed tasks and responsibilities will be part of the detailed communications work-plan.
  - Included imperative and expectations in these messages
  - The following slides include some specific messages and expectations

Sample Messages

“By computerizing health records, we can avoid dangerous medical mistakes, reduce costs, and improve care.”

- President George W. Bush, State of Union Address, 1/2004

“...build your compelling message on the next few slides. This message should be relevant to the product and to the audience that you are working with. It should be specific to the ministry and the concerns that the staff have.”

- More than 40% of Americans have experienced “poorly coordinated, inefficient, or unsafe care” at some point during the past two years, according to a survey from the Commonwealth Fund’s Commission on a High Performance Health System. Respondents to a telephone survey of 1,023 U.S. adults in June 2006.
Communications: Setting Expectations

Clinician Prescriber Expectations:
In order to achieve the highest safety and benefit to both patients and providers, we will communicate and measure the following adoption metrics.

- CPOE saturation (% orders) vs. CPOE participation (% physicians)
  - Computerized Order Entry
    - Residents – 100% use
    - Active Medical Staff
      - 50% use within 30 days – heavily focused on “employed” and aligned physicians
      - 90% by 90 days
  - Inbox – signing documents and viewing notifications
    - 100% of physicians visiting the hospital
- PowerNotes –
  - 100% of x document types
- PowerNotes ED

See “Making the Count.ppt” in the physician engagement toolkit & web site to understand CPOE penetration and saturation calculations: [LINK](#).

Setting Expectations Online Records

<table>
<thead>
<tr>
<th>Department</th>
<th>IP/OP</th>
<th>Orders</th>
<th>Documentation</th>
<th>% Electronic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialysis</td>
<td>IP</td>
<td>PowerChart</td>
<td>PowerChart – PN2g</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>IP/SDS</td>
<td>PowerChart</td>
<td>PowerChart – PN2g Escription</td>
<td></td>
</tr>
<tr>
<td>OB</td>
<td>IP</td>
<td>PowerChart</td>
<td>OB system – intrapartum</td>
<td>PowerChart – post partum</td>
</tr>
<tr>
<td>Therapies / Rehab</td>
<td>IP</td>
<td>PowerChart</td>
<td>PowerChart – forms</td>
<td></td>
</tr>
<tr>
<td>Cath / IR</td>
<td>OP</td>
<td>PowerChart</td>
<td>Cath System text/data interface</td>
<td>PowerChart - PN2g -</td>
</tr>
<tr>
<td>Critical Care</td>
<td>IP</td>
<td>PowerChart</td>
<td>PowerChart</td>
<td></td>
</tr>
<tr>
<td>Med/Surg</td>
<td>IP</td>
<td>PowerChart</td>
<td>PowerChart – PN2g Escription</td>
<td></td>
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</tbody>
</table>
Post Go-Live Communications

• Monitor usage of top admitters and offer focused support to encourage system use
  – Employed Physicians
  – “Dedicated” physicians
  – Resident physicians
  – Identify trusted “connectors” to influence them

• Promote increasing usage of inbox/orders among community physicians

• Solicit system performance feedback

• Identify ongoing training needs for new users and enhanced training for existing users

Teams and Leadership

“I think we need to reconsider our strategy.”

“So how is CPOE going.”

CMO  CMIO
The following slides describe many of the new roles and their responsibilities. Cross training and interdisciplinary coordination is essential and expected.

See “Genesis Transformation Steering Team Charter…doc” - Appendix 1 for informatics training opportunities.

### Chief Medical Officer / Vice President of Medical Affairs

**A leadership champion for Genesis clinical systems and processes**

**Knowledge:**
- Understand Genesis milestones and tasks, MO Readiness structure, technical build and testing activities, training approach, cutover approach, and post live transition.
- Align and champion organizational decisions to support the UEM standards
- Represent all business operations and processes within the Medical Staff
- Utilize physician engagement practices to address clinical transformation and culture changes throughout the readiness and post activation phases
- Act as UEM Accountable Executive and represent UEM considerations and standards in local requests and decision-making. Recognizes opportunities to represent local needs within the UEM and thereby mitigating the perceived loss of local decision making

**Execution:**
- Co-Chair MO Care Experience Integration Team
- Guide resolution of major medical staff issues surrounding Genesis readiness and post implementation
- Address escalated issues
- Ensure that medical staff bylaws, hospital policies and medical staff changes are identified and completed prior to go live
- Collaborates with the CMIO to develop a compelling message for Genesis clinical staff at the MO
- Is expected to be visible and at the elbow to practicing physicians at go live
- Ensure that quality and outcomes are maintained during go live

**Oversight:**
- Provides guidance and support to the medical staff components of Genesis
- Identify and develop a plan to engage high risk clinicians
- Ensure adherence to Trinity Health leading practice processes
### Team Roles & Responsibilities

**Physician Champion/CMIO: <insert name>**
- a.k.a. Chief Medical Informatics Officer/Medical Director of Clinical Systems/Employed Lead Physician Champion
- A leadership champion for Genesis clinical systems and processes
- Represents the medical staff of the MO in all areas related to the Genesis implementation
- Will help inform the implementation of Genesis and use of clinical information technology to serve the clinical mission of the Ministry

**Execution:**
- Collaborate with CMO on development of the Physician Engagement Plan
- Chairs the MO Physician Leadership Team made of department champions in the review, implementation and management of the MO Physician Engagement Plan
- Partner with CMO to guide resolution of major medical staff issues surrounding Genesis readiness and post implementation
- Ensures appropriate medical staff participation in Genesis related (1) assessments, (2) process reviews, (3) testing (4) simulation opportunities and (5) UEM design discussions
- Works closely with HIM to develop the physician documentation plan
- Works closely with the physician liaison to develop the Physician Support Strategy
- Ensures that all targeted physicians receive the training they need by go live
- Provide go live support
- Participate in daily Go-Live status meetings
- Provide post live support
- Genesis meeting participation
  - Physician Leadership
  - Care Experience Integration
  - Integrated Ops
  - UEM Physician Advisory Group

### Training and Support
Training & Go Live Support

An analysis of physicians will determine the priority for physician training. Trainers coordinator will be ... <insert name> The lead for physician training will be <insert name>
All physicians must receive training before being allowed to practice after go-live. <insert name> Will manage the medical staff decision making and communication.

All physicians will have a communication method that can be used to communicate changes in process and functionality.

Training approach: <list all that apply>
• Classroom vs. One on One
• Learning Labs,
• eLearning, deployed via Web, Jump Drives or CD-ROMs
• Just in Time & super user
• Docing station and drop in training
• In office or office based training

Tracking and Management of Training
• We will use the Quickbase "Clinician Readiness and Training Database"

Content:
• Process – included in System Training or Separate?
• Devices – included in System Training or Separate?
• Windows Training Required?
• Consideration of on-going training due to upgrades, new physicians, etc

Training Metrics

high admiters
consultants
ambulatory clinicians
ED/Anesthesia
Outspoken Critics
Cultural influencers
Others

= Total number of training plans needed

[ ] Meet with COI and Readiness to build training tracking reports
Clinician Readiness and Training Planning Tool

Objectives: Ensure that physician training is a reliable process that can be tracked and managed in such a fashion that MO, Home Office, and readiness stakeholders can understand progress towards specific milestones. Ensure that all physician stakeholders are properly identified and that a personalized training plan is constructed for every member of the ministry staff and their associates. Develop a proactive approach to identify clinicians who may not have a level of engagement, training experience, or other barriers to safely using the system.

Guiding Principles: Training will be interdisciplinary based, include simulation and scenario-based training models and scenarios whenever possible.

"RECOMMENDED" training should be achieved for 100% of frequent Genesis users before go-live.

"We will not require training before allowing a prescriber to practice using the system."

"We will not change the medical staff by-laws to require the use of the system and CPOE"

Each provider should have a training plan of 1 of 3 types:
1) Recommended training for all physician type users
2) Advanced early training early for specific groups of physician leaders
3) Ad Hoc training for all other users before and after go-live

- We will target high influential physician types for advanced training prior to go live
- We will not expect advanced training for all physician users but it will be encouraged
- Advanced training candidates should be explicitly defined prior to go-live and updated as they achieve training goals.

https://trinity-health.quickbase.com/db/bc2r7kh54

Culture:

“Culture is everything” - multiple sources

“Culture is a biological drive for humans. It is not something that we just add on at the end, after we’ve dealt with all those survival problems, but something we keep doing all the time.” - Brian Eno

“The only thing of real importance that leaders do is to create and manage culture.” “If you do not manage culture, it manages you, and you may not even be aware of the extent to which this is happening.”

-- Edgar Schein, professor MIT Sloan School of Management

“It is not possible to have a safe environment where disruptive behavior is accepted.” - Eric Knox, MD
Building a Culture to Support a Successful Change

• Create the vision and communicate the reasons for change

• Understand issues
  – Process changes
  – Training on new tools
  – Reasonable expectations of system

• Respond to end users (physicians) needs
  – Workflow efficiency
  – Reassure users about the complexity or fear

• Plan for communication and problem resolution

Phases of Dying - Kübler-Ross model

1. **Denial** - The initial stage: "It can't be happening."
2. **Anger**: "How dare you do this to me?!"
3. **Bargaining**: "Just let me be a little longer…"
4. **Depression**: "God please don't take him away from our family"
5. **Acceptance**: "I know my we will be in a better place"
Other Tools and Tactics

Fix physician processes that are unreliable or ambiguous pre-go live so to avoid the later implication that the change was due to the technical implementation.

- CPOE and verbal order policy <accountable lead>
- Expectations of CPOE usage (bylaws?) <accountable lead>
- Expectation of training prior to go-live <accountable lead>
- Transfer order review vs rewrite <accountable lead>
- Clinical documentation coding clarification process <accountable lead>
- Oversight of discharge process <accountable lead>
- Participation in UEM order set design <accountable lead>
- Hand off practices <accountable lead>
- Documentation deficiencies <accountable lead>
  - TAT on document signature (30 days)
  - TAT on discharge instructions (48 hrs)
  - Signature of unsigned verbal orders
- Standing orders and protocols, <accountable lead>
  - Medical staff approval of protocols
  - Initiation order for protocols
  - Advanced treatment protocols
  - Physician in Triage
- Medication reconciliation <accountable lead>
- ED admission "holding" orders <accountable lead>
- Ambiguity in nursing and physician responsibilities <accountable lead>
- Training will be required <accountable lead>
- Communication methods will be recorded and maintained <accountable lead>
### Available Assessments

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Assessment</th>
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</thead>
<tbody>
<tr>
<td>14 months prior to go live</td>
<td>• <strong>EMR/CPOE “Cultural” Assessment</strong> – identifies discordant expectations and identifies areas for additional messaging. Begins the process of identifying cultural barriers in the organization and between stakeholder groups. (required)</td>
</tr>
<tr>
<td>8-12 months prior to go live</td>
<td>• <strong>Preliminary Physician Assessment</strong> – brief web based survey tool to assess early messaging regarding imperative. Can assist in developing problem based marketing. (highly recommended)</td>
</tr>
<tr>
<td>4 months prior</td>
<td>• <strong>Readiness &amp; Training Dashboard</strong> – dashboard of key physician readiness metrics, Should be used by the physician team to track and manage progress on training, order sets, and other measures. (required)</td>
</tr>
<tr>
<td>At Go-live</td>
<td>• <strong>Pre-go Live Readiness Assessment</strong> – Home office led discussion with clinical and operational teams. Used as an opportunity to review and identify remaining high risk processes and change issues. (Required)</td>
</tr>
<tr>
<td>2-4 months after go-live</td>
<td>• <strong>Quick Feedback Survey</strong> – immediate post implementation tool. “Rapid Feedback Button” monitored post go live. (Highly recommended)</td>
</tr>
<tr>
<td>12 months after go live</td>
<td>• <strong>Post Go-live Survey</strong> – detailed assessment of organizational change, culture and issues. Designed for 12 months after go live. (optional)</td>
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</tbody>
</table>

### Assessment of Engagement

Begin by developing an assessment of physicians in the ministry organization. The high level engagement plan should begin with this assessment.

- Who are the physician champions, key stakeholders, skeptics, nay-sayers, respected clinical leaders, and early adopters?
  - High influence within medical staff or specialty
  - Significant volume or admissions
  - Highly visible
  - Elected medical staff leaders
  - Department chiefs
  - Residents
  - Who will be invited to be on clinical leadership teams?

- Identify Levels of Engagement or risks
- Levels Ranging from 1 (Least Engaged) to 5 (Most Engaged)
- Levels determined by measurable behaviors
- Develop action plan for each physician stakeholder with the goal of moving to a higher level of engagement
- Identify “Physician Connectors” to work with each physician stakeholder
- Heavy clinical liaison and/or physician liaison involvement in the plan
- Super users will become future liaisons
Engagement Assessment

Initial Engagement Assessment:
• <number> physicians employed.
• <number> physicians on staff of <type>.
• Describe top admissions and service lines
• Facilities – Beds, services, infrastructure, etc.

Key points from Leadership Interviews about engagement risks:
• Clinical Interviews <insert>
• Physician leaders <insert>
• Nursing leaders <insert>
• Ancillary leaders <insert>

Physician Assessment

• Focus in on physicians needs
  – Problem based marketing – Advisory board

• We will continue to develop the imperative and messaging based on this assessment.
Issues & Enhancement Management

<MO> will have

1. Local Genesis projects and issues tracking (examples in this folder – MC)
2. A method to promote issue to Unified Enterprise Ministry pre-go-live
3. A method to promote issues to a UEM post-go-live 6 months after go-live

Discuss pre-go-live process with Mike Kramer and Irene Hatz (currently under revision).

Supporting teams to <MO> for issues in the Excellence in Care Experience Governance Structure:

(will be revised Fall 2009)

Data Collection – “Pre-go Live Physician Dashboard”
**T- 4 months: Clinical Readiness Assessment**

**Go Live: CPOE rates**

**Setting Expectations CPOE**

- Clinical expectations
  - CPOE **saturation** (% orders) vs. CPOE **participation** (% physicians)
    - Computerized Order Entry
      - Residents – 100% use
      - Active Medical Staff
        » 50% use within 30 days – heavily focused on “employed” and aligned physicians
        » 90% by 90 days
  - Inbox – signing documents and viewing notifications
    - 100% of physicians visiting the hospital
CPOE rates

Engaged Physicians = SUCCESS

Comments and Questions?
PowerChart Training

Clinical Operations Improvement

Physicians as Leaders in Computerized Order Entry
Shifting Focus of Physician Leaders

**Gartner**

*Industry Research*

**Publication Date:** 23 November 2005  
**ID Number:** G09135484

**Market Implications:** Although CPR systems adoption has been slow, products are maturing and more and more CPR initiatives are under way globally. With this change has come a profound shift in focus for the most advanced CDOs — from physician adoption to obtaining full value of the system. The role of clinician champion as proselytizer is receding and will be replaced by one charged with bringing EBM to the point of care and ensuring improvements in overall clinical quality. Progressive organizations with support from the highest levels have recognized the flaw in having a fractured approach of multiple overlapping quality and efficiency initiatives, and they are consolidating responsibility and accountability. It makes the most sense to move these efforts to the office of the CMO. Cultural receptivity is essential, so executives must lead aggressively while treading carefully in these efforts to ensure that front lines are not alienated and political goodwill is maintained. It is imperative that all types of clinicians be included in the process.

CPR = Computerized Patient Record  
CDO = Care Delivery Organization  
EBM = Evidence Based Medicine

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**Trinity Heath Clinical & IT Leadership**

CEO  
Chief Clinical Officer  
Chief Information Officer  
VP Nursing  
SVP Quality & Safety  
CMIO  
Clinical Process Design  
Decision Support, Quality & Outcomes  
Information Technology  
Shared Services  
Ministry Organizations  
Local Health & Information Transformation Teams  
CMIO, RN/MD Director of Informatics, Clinical Liaisons, Quality/Outcomes, HIM, Ancillary Leads

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Trinity Health
Clinician Informatics Roles

• CMIO at Trinity Health
  – Engagement in clinical applications strategic planning,
  – System wide issues tracking and management
  – Clinician engagement and adoption
  – Infrastructure for clinical process redesign & CDS
  – System wide clinical leadership

• Medical Informatics Directors at home office (2)
  – Leadership for specific management process and procedures, (order sets, rules, templates, etc.)
  – Clinical leadership for migration projects
    • E.g. Voice Recognition, online notes,
    • Automation of specific clinical outcomes
    • System and issues requirements

• Medical Director of Informatics at the Ministry Organizations (all sites)
  – Change management, local adoption and roll-out
  – Local process redesign and issues management
  – Develop Centers of Innovation and Excellence for each Ministry

Physician Roles in Genesis Teams

Potential Supporting Groups to the Genesis Clinical Integration Team:

Revenue:
- Revenue Leads
- Revenue Decision Support Coordinator
- Charge capture/Coding - HIM

Evidence Based Practice:
- Clinical Leads
- Physician Leads
- RN Leads

Rapid Issues Response:
- Physician Leads
- Clinical Liaisons
- Readiness

Care Area Work Groups:
- ICU/Acute/ED/etc)
  - Clinical Leads
  - Clinical Informatics / Others

Quality Health Record:
- HIM
- Physician Leads
- Other clinical leads
- Reporting/MPR
- Clinical Decision Support lead

Informatics and Special Projects:
- Clinical Leads
- Clinical Informatics / Others

Data Analysis:
- Clinical Leads
- QAPI Leads
- Clinical Informatics
- Clinical Liaisons
- Clinical Decision Support Coordinator

Physician Leadership Team:
- Clinical Informatics
- Clinical Liaisons
- Physician Superusers
- Allied Health
- Readiness

Communications Team:
- Marketing lead
- Service Line Centers of Excellence:
  - Project Manager
  - Clinician Leads
  - Analytic Leads

Clinical Operations Improvement
What Type of Physician is needed?

**Traditional Physician Leaders**
- Strong leaders
- High intelligence quotient
- Decisive
- Base decisions on deep training & literature
- Authoritative
- Deliver value immediately with hands on skills
- Works with small teams and clinical teams

**Manager Physician Leaders**
- Strong leaders
- High emotional quotient
- Collaborative decisions
- Decisions based on emerging literature and organizational goals
- Collaborative influence
- Deliver value at the organization over longer range
- Work with large teams and across domains

References