# Successful Practices in the Physician's Work Environment

## *Three Regions: Three Levels of Development*

**Tom Janisse, MD**
Editor-In-Chief

### Foundational Linkage Research

In 1998, *The Permanente Journal (TPJ)* published an article defining the value of linking performance measures from two different satisfaction surveys: employee and member.[1] The "Linkage" subgroup of the inter-regional Care Experience Council (CEC) explored the relationship between highly satisfied employees and highly satisfied members. They identified the employee survey questions that correlated with member satisfaction survey questions and then identified and interviewed those high-performing teams.[2] This information can be used to improve aspects of the work environment by focusing on activities that have the greatest potential return on investment.

**The key drivers of physician satisfaction were … found to be consistent with the key drivers of employee satisfaction.**

### Application of Research

As a refinement and follow-up process, the "MD Work Environment" subgroup of the CEC explored the linkage between physician and patient satisfaction. The key drivers of physician satisfaction were identified and found to be consistent with the key drivers of employee satisfaction. High-performing teams were again identified and interviewed. In 2002, *TPJ* published the research findings.[3] A summary of the key findings can be found in the sidebar below, "Summary of Successful Practice Findings," and the contrasting practices of the high-rated vs the medium- and low-rated teams are listed in Table 1.

### Transfer of Successful Practices

To begin to transfer these successful practices, the Care Experience Council, in partnership with four regions, sponsored a workshop at the 2003 National Primary Care Conference, at which high-performing physician team leaders and team members discussed, in interactive sessions, their team development, processes, and tools. Three of those teams present summaries of their work in four articles in this issue. Hawaii pediatrician Bill Pfeiffer, MD, describes early multidisciplinary team development (page 32), and Cynthia Copp, ARPN, reviews the Hawaii team's processes (page 37). Georgia internist James Hipkens, MD, recounts sustaining a high-performing team in the face of losing the founding team leader (page 29); and Southern California internist Darla Holland, MD, describes facilitywide implementation of improving efficiency and support in office practice (page 42).

This series of articles represents the culmination of linkage research leading to identifying key drivers of physician and employee satisfaction, leading to identification of high-performing teams, leading to team descriptions of processes and tools for high performance, leading to transfer of those practices. The two modes of transfer include interactive presentations at a national educational conference and publication in *The Permanente Journal* to communicate these

### Summary of Successful Practice Findings[a]

*The teams with the highest morale and patient satisfaction were characterized by:*

- The use of principles to guide behavior
- Leadership by example
- Team development
- Generous recognition, and
- Goal-setting within the team's sphere of influence

*The medium- and low-teams did well on some of the practice categories but hadn't consistently addressed others. There were multiple routes to success—Each high-performing team found its own way to accomplish these five categories of successful practices.*

**Table 1. Contrasting practices of highly rated vs medium- or low-rated teams[a]**

| Team practices | | Practices of highly rated teams (high physician and patient satisfaction scores) | Medium- or low-rated teams (medium or low physician and patient satisfaction scores) |
|---|---|---|---|
| Connect principles and values of team and region to daily work | Leverage principles and values | Use principles to solve problems, align goals, and unify team (eg, *"Treat patients & team like family," First in quality, first in service")* | Lack connection of principles to daily work |
| | | Value patients *and* team (spend time in team and individual development, eg, training, meetings, consultants, and facilitators) | Focus primarily on patient satisfaction |
| | Service beliefs | Believe clinical and service quality are compatible goals | Believe quality and service are mutually exclusive |
| Demonstrate physician leadership by example | Model expected behavior | Physicians communicate high standards, exemplify (not just talk about) what is expected | Less conscious of effects of modeling on each other |
| | | Include staff and Associate Providers (APs) in decisions *—"Everyone has a voice"* | Lack staff and AP input in decision making |
| | Dealing with challenge | Address complaints and translate into plans | Protect group, try to cope |
| | | Physician-leader sets clear direction | Physician-leader's direction is less clear |
| Emphasize team development | Selection | Emphasize selection for team fit—they will wait for the right person | Less emphasis on team fit |
| | Role clarity | Know roles of all team members (permit interdependency) | Have less clarity on roles of others |
| | Inclusiveness | Be respectful—use input from all team members | Have a physician-centered hierarchy |
| | Interdependence | • Support each other so all can finish on time<br>• Feel they are "in this together" so they can "give up the turf" | Have individuals struggling alone in silos |
| | Track performance | Use team-level data to track performance, including team satisfaction | Tend to track patient satisfaction only |
| | Team identity | Have meaningful, positive team identities | Lack a positive team identity |
| Set goals within team's sphere of influence | Set achievable goals | • Clarify scope of team influence<br>• Pursue goals within sphere of influence (start small) | • Set sights too high (eg, regional decisions)<br>• Perceive no team influence |
| | Source of improvement | Take responsibility for improvements, but use outside help (training, analytical support, consultants, leaders) | Look outside of team for improvement |
| Provide recognition and constructive feedback | Recognition | • Convey verbal, individualized, 1:1 recognition from members and patients<br>• Make staff and associate provider recognition a priority<br>• Provide recognition at the team level | • Have insufficient recognition<br>• Fail to convey patient comments to team |
| | Constructive feedback | • Address interpersonal concerns in a timely manner<br>• Give learning feedback to all (even physicians) | Tolerate interpersonal problems |

practices to all clinicians. We hope this will stimulate clinicians to seek out these teams, and possibly visit them, as a way to transfer the successful practices that can produce both highly satisfied physicians and employees and highly satisfied patients, as we contribute to creating the highest value and the highest health care quality for KP members. ❖

[a] *Reprinted from Tallman K, Steinbruegge J, Hatzis M. Successful practices in the physician work environment: We work together. Perm J 2002 Fall;6(4):39-42.*

**References**

1. Kam SM, Brooks SM. Touching the customer by understanding employees: preliminary linkage research findings from four regions of Kaiser Permanente. Perm J 1998 Spring;2(2):47-54.
2. Janisse T, Tallman K. Care Experience physician work environment update: physician key drivers [presentation]. Care Experience Council, Oakland, CA, Nov 2001.
3. Tallman K, Steinbruegge J, Hatzis M. Successful practices in the physician work environment: we work together. Perm J 2002 Fall;6(4):39-42.