Organizational Culture, Clinician Engagement and Physician Integration: *Keys to Success*
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**Introduction and Overview**

The relationship between hospitals and the physicians who practice within them has undergone major transformation over the last 30 years. And, the pace with which that transformation has taken place has accelerated markedly during the last five years.

One textbook widely used in health administration master’s degree programs in the late 1970s and early 1980s defined the hospital-physician relationship as follows:

“The physician is traditionally described as a guest in the hospital and its primary customer. Except when a physician chooses to run a hospital for profit, he has no personal responsibility to see that the hospital is available to provide care for his patients. The physician uses the hospital as his workshop….

“Whenever a physician admits a patient to the hospital, he is free to order whatever tests or treatments he deems necessary. Thus he basically determines the amount of services used and consequent costs of individual patients’ care…. Physicians have every reason to want the best possible institutional setting in which to practice medicine, especially when it is provided at no personal cost to them.” (1)

As a result, hospitals generally went to great lengths to meet the needs—both personal and professional—of the physicians who practiced there. Perks like preferred parking, free meals, well-equipped physician lounges, free continuing medical education, and a variety of other inducements were offered to keep the medical staff in general, and high volume users in particular, happy with the hospital. Facility design, operating procedures and care processes were very much centered around the convenience of the physician, rather than the patient.

This dependence on the independent physician as the single most critical factor in the financial performance of the hospital led to significant inequities in the power and authority of hospital administrators when they came into conflict with well-placed physician leaders. Hospital executives who sought to increase their control over clinical or even non-clinical actions of physicians often did so at their peril, and many found such actions to be career-limiting decisions. As a result, concepts such as ongoing peer review and professional performance evaluation, organized quality improvement and patient safety programs, patient satisfaction measurement, and codes of professional behavior for members of the medical staff were relatively unknown.

Today, of course, the world of health care delivery is quite different. Purchasers of health care, both public and private, are increasingly demanding that hospitals and physicians be more accountable for delivering care that meets objective measures of quality, safety, cost-effectiveness, and patient satisfaction. The physician workforce has also undergone transformation. In the 1970s, physicians were predominantly male and increasingly members
of the baby boomer generation. Today, the majority of new medical school graduates are women, and the physician workforce is increasingly comprised of Generation X and Generation Y physicians with very different values and expectations from those of their older colleagues. For example, physicians from the baby boomer generation generally put their profession ahead of their family or leisure pursuits—often to the detriment of both their relationships and their health. By contrast, Gen X and Gen Y physicians, while no less committed to their profession than are their older colleagues, are much more interested in achieving a balance between their professional life, their families and their leisure activities. As a consequence, they tend to want more regular work hours and time in which they are genuinely free from the demands of their patients and their practices.

The difficulty of operating a financially viable independent medical practice also has increased steadily. Young physicians today are often saddled with large amounts of debt from their medical education, and the income forecasts from independent medical practice are less than rosy. Medical practice operating expenses also have risen steadily over the last decade. Figure 1 depicts the unhealthy growth in practice operating expenses, against a backdrop of flat rates of payment for services.

**Figure 1: Medical Practice Operating Expenses Compared With Payment for Services**

![Figure 1: Medical Practice Operating Expenses Compared With Payment for Services](image)

* 2010, 2011, and 2012 median operating cost values are three year moving average projections of previous years' data.
* 2010, 2011, and 2012 CPI figures are the July 2010 semiannual figure.
* 2011 MCF figure illustrates the estimated net impact of the 12/2010 legislation.

*Figure 1 shows the cumulative percent change since 2001 for the Medicare conversion factor, Consumer Price Index (CPI), and operating costs for multispecialty medical groups.*

*Source: Medical Group Management Association*
As the figure shows, medical group practice operating expenses rose by a cumulative total of 51.1% from 2001 to 2012, more than twice the 23.1% increase in the CPI (a measure of inflation in the economy at large) over the same period. The Medicare conversion factor, the rate that is paid by Medicare for a defined medical service, increased by only 2.9% over the same time frame. Since most private insurers mimic the Medicare rate of increase, their payment rates have been similarly flat.

Each year, medical practices face great uncertainty about what they will be paid for their services in the coming year. Since Medicare accounts for about half of payments to physicians, the annual melodrama centered on the Medicare Sustainable Growth Rate Formula for determining physician payments has been a major driver of that uncertainty. Current law requires that Medicare payment rates to physicians be cut by about 30% in January, 2013, absent action by Congress to postpone the cut. Historically, such postponements have been made at the eleventh hour. But the uncertainty created for physicians, especially those in smaller practices, pushes more and more of them to seek economic shelter by selling their practices to a hospital and/or by becoming hospital employees.

**Achieving Physician Engagement and Integration**

When the majority of a hospital's physicians were in independent, physician-owned practices, the traditional approach to developing a collaborative working relationship between the hospital and its physicians was to focus on “alignment”—creating both tangible and intangible incentives for cooperation between the hospital and its medical staff that produce a win-win arrangement for both parties. Some alignment initiatives focused primarily on building trust between administrators and physicians, improving communication, and providing opportunities to assure that physician perspectives on strategic initiatives were explored and considered. Others were more tangible and involved joint ventures on ambulatory surgery centers, free-standing diagnostic centers, imaging centers and other specialized facilities.

But as the demands of the changing environment have increased the need for closer coordination among inpatient, ambulatory, long-term and home care, and between physicians and health care organizations, there has been an evolution from “alignment” to “engagement” to “integration” of physicians into the health care enterprise (see Figure 2 below).

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**Figure 2: Critical Path for Performance Improvement**

Align ➔ Engage ➔ Integrate ➔ Perform

This figure shows the critical path for achieving measurable improvement in the performance of health care organizations. Trustees must set expectations for physicians and hospital managers to move along this critical path.
Regardless of the relationship of physicians to the hospital—whether they are in independent practices, in hospital-owned practices, or in a direct employment relationship—making this transition is essential. Hospital trustees play a crucial role in assuring that their organizations have a strategic plan for making that transition, and that hospital management and physician leaders are effectively implementing that plan.

In an article in the 2010 Futurescan, one of us described this transition as follows:

“Much has been written about the importance of achieving “alignment” between hospitals and the physicians who practice in those organizations. Futurescan 2009 included an essay on moving beyond alignment to “engagement.” The last stage in the evolution of physician-hospital relationships is to achieve true “integration” of physicians into the culture, operations, and economic life of their hospitals...

Traditional models of physician-hospital interaction simply will not work in the new environment. Rather, hospitals and physicians will be called upon to find ways to ensure they function effectively and efficiently as an integrated unit. Their shared economic fate will be tied directly to their success in maximizing efficiency, patient satisfaction, and quality outcomes while minimizing cost and patient risk.” (2)

The ultimate objective of these efforts is, of course, enhancing the performance of both individual physicians and of the health care enterprise as a whole to better meet patient and community needs. And, as payment for services moves away from a dependence on volume of services provided, to one based more clearly on value and results, improved performance becomes an imperative for the economic survival of the organization.

**Culture as a Driver of Engagement**

There has been a great deal of research published in the business literature about the culture of organizations and how it affects organizational performance. Perhaps the most frequently cited definition of organizational culture was that set forth by Schein in 1985:

“…the pattern of basic assumptions—invited, discovered, or developed by a group as it learns to cope with its problems of external adaptation and internal integration—that has worked well enough to be considered valid, and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to these problems.” (3)

Another definition of culture is the shared set of social values and beliefs, both explicit and implicit, that guides actions, behaviors and decisions within the organization (4). An organization’s culture is complex, dynamic and constantly evolving. The frequently made observation that “culture trumps strategy” indicates how strong a force organizational culture can be—especially when efforts to create strategic change run counter to the culture.
The fit between an individual’s personal values and beliefs and the organizational norms (or in other words, the cultural “fit” between the individual and the organization) is a powerful driver of “engagement” in the organization. Individuals who are a good cultural fit are generally supportive of the goals and objectives of the organization, and will focus their energy on supporting achievement of shared organizational goals. By contrast, the individual who is a poor fit with the organization may passively, or even actively, undermine efforts to achieve organizational goals—a state that can at best be described as one of “disengagement.”

In a health care organization, culture is determined not only by the shared values and beliefs of employees, but also by those of the medical staff, volunteers, and others who serve the organization, but who may not be employed by it, including members of the governing body. Understanding and managing organizational culture, and engaging both employees and non-employees (such as members of the voluntary medical staff), is an essential skill for health care leaders.

The Challenge of Measurement

It is a managerial axiom that “if you can’t measure it, you can’t manage it.” One of the major reasons for the current volume-driven health care payment system is the ease with which numbers of services provided can be measured. Whether it is days of care, or numbers of laboratory tests, or minutes of anesthesia, or the somewhat more complex number of Relative Value Units (RVUs)\(^1\) assigned to a particular service, volume is easy to measure.

“Value,” on the other hand, is more complex. It involves measuring the results of care (performance)—in terms of quality, safety and patient satisfaction—per unit of resources consumed (cost). Because of the greater measurement complexity, health care organizations have moved slowly in putting in place measures of performance, and in using them to manage the enterprise.

But as the payment system evolves from one based solely on volume, to one in which value becomes increasingly important, it is essential that internal management regularly measure performance and manage in ways that improve that performance. One of the most important functions of the governing body in this new era is to assure that hospital management and physician leaders do, in fact, have a robust program for measuring, analyzing and improving performance, particularly as measured by patient care quality, safety, satisfaction, and efficiency.

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\(^1\) Relative Value Units (RVUs) are a system for assigning weights to various medical procedures that can then be used in calculating the fee to be paid for that procedure. For example, a routine office visit has an RVU weight of 1.82, while a laparoscopic appendectomy is valued at 17.17 RVUs. Medicare determines the fee it will pay by multiplying a fixed “conversion factor” by the RVU weight. For 2011, the conversion factor was $33.9764 per RVU. Hence, the office visit fee was $61.84 and the appendectomy fee was $583.37.
Numerous sources have, over the last decade, introduced well-tested measures of performance that can be adopted by health care organizations. For example, the National Quality Forum (NQF) (5) catalogs more than 700 measures which are widely used in a variety of settings. Some of these are the subject of mandatory reporting to public payers (such as the Centers for Medicare and Medicaid Services) and to private insurers. In fact, a growing number of payers, from both public programs such as Medicare and Medicaid and from private insurers, are beginning to use these quality measures to assess value (performance on quality measures per dollar of cost) to set payment amounts to physicians and hospitals. But the greatest value of these measures lies in their use as an internal management tool, allowing performance to be measured, compared with benchmark data, and used to provide feedback to both employees and volunteers.

Measuring culture and engagement is similarly complex, but certainly feasible. The Agency for Healthcare Research and Quality (AHRQ) has developed an instrument and a comparative database to allow hospitals to assess the patient safety culture in their organizations (6). Researchers from the University of Minnesota have developed and published an instrument for assessing the culture of medical group practices (7). Some examples of questions from these survey instruments are in the sidebar on this page.

We have also created a suite of survey instruments that measure the extent to which employees and physicians are engaged with the hospital, and identify various workplace factors that will improve engagement, and thereby enhance performance. Based on our research, the following model (Figure 3) illustrates the key factors which most powerfully influence the engagement levels of physicians.

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**Examples of sample questions from two well-validated instruments for measuring culture in health care organizations**

**From the AHRQ Patient Safety Culture survey (6):** Rate your agreement with each of the following statements on a scale from 1 (fully agree) to 5 (fully disagree).

- We are actively doing things to improve patient safety.
- Staff feel like their mistakes are held against them.
- Things “fall between the cracks” when transferring patients from one unit to another.

**From the University of Minnesota Medical Group Culture survey (7):** Rate your agreement with each of the following statements on a scale from 1 (fully agree) to 5 (fully disagree).

- We have a team approach to patient care.
- We highly value decision support tools such as clinical guidelines.
- We view ourselves more as a business than as a community health resource.
- We have a strong shared vision of who we are and how we practice.
Although organizational scientists have failed to achieve consensus on a formal definition of engagement, we offer the following: *engagement is a pronounced state of enthusiasm characterized by belonging, pride and loyalty which fosters a mutually committed relationship between physicians/employees and organizations resulting in an enduring pursuit of organizational goals and career enrichment.*

Our definition of engagement is robust and multi-faceted in that it taps elements of positive excitement, deepening attachment and steadfast contribution. While other definitions and measurement approaches of engagement often consider these dimensions, ours uniquely encompasses career enrichment—more precisely, the extent to which an affiliation with a hospital serves to impassion a physician about the practice of medicine. While most measures of engagement seek only to estimate the benefits organizations derive such as loyalty and the exertion of discretionary effort, ours quantifies the concept of the “win–win” relationship. Stated differently, we suggest that engagement should be construed and measured as a reciprocal relationship through which hospitals directly benefit from physicians, but physicians are also professionally enriched through the relationship as well.

The payoff of developing and maintaining a highly engaged employee and physician population can be profound. Numerous studies support the notion that organizations are
significantly more likely to experience improvement and sustained success across an array of performance metrics when physicians are highly engaged. For example, links have been routinely established between engaged physicians and key operational outcomes such as productivity and efficiency, physician retention, clinical outcomes, quality care, and patient safety and satisfaction—with higher levels of physician engagement corresponding with more favorable states of performance.

Nine Steps to Improved Performance

Hospital trustees are key members of the leadership team in an organization that is committed to performance improvement and to providing value to its patients and community. Listed below are nine steps that organizations and their boards can take to better understand and influence organizational culture in ways that improve organizational performance.

1. Assess the culture of your organization — Knowing what your workforce and your physicians believe to be the normative values and beliefs in your organization is a critical first step to managing culture, engagement, and performance. Most organizations have explicit statements of organizational values, but those may not necessarily be shared by everyone in the organization. In addition to the AHRQ and Minnesota assessment tools mentioned earlier, there are several generic survey instruments for assessing organizational culture that can provide valuable information (8–10). Each of these tools can provide managers and leaders with valuable insights about how various segments of the workforce—nursing, other clinical staff, business office, support staff, physician employees, voluntary medical staff members, volunteers, and others—perceive the organization. In addition to pointing out areas in which there is cultural consistency, the instruments can identify areas where there is divergence. The latter are often a source of conflict within the organization.

Our own attitudinal research in the area of cultural consistency and organizational performance is striking. For example, our database demonstrates that award winning health care organizations such as recipients of the Malcolm Baldrige National Quality Award, “FORTUNE Magazine’s 100 Best Companies to Work For” and other renowned designations demonstrate marked cultural separation from typical health care organizations. Two key differences are immediately apparent within their employee and physician opinion results.

First, employees and physicians of renowned organizations rate culture and engagement items significantly more favorably than their counterparts in other health care settings. Second, in high-performing organizations, there is rarely any meaningful variation in the ways different employees and physicians rate culture and engagement—all groups tend to demonstrate a sort of “attitudinal lockstep” when it comes to their views of the workplace and their relationship with it. This is very different from typical health care organizations in which pronounced attitudinal differences often manifest across groups. These patterns suggest that a stronger sense of fit and alignment are often markers of world class organizations.
Questions for board members to ask:
• Do we know what our work force thinks about our organizational commitment to safety, quality, efficiency and patient satisfaction?
• Have we measured their opinions and are we using that information to better manage our culture?
• Is there consistency across organizational components, and across segments of our work force (including our physicians), in what they value and in their commitment to our mission and values?

2. Measure the engagement of employees, physicians and volunteers —
Once you have a clear picture of your culture, you can better understand the engagement—or disengagement—of the people in the organization. In general, where there is cultural consistency (i.e., most people share the same set of values and beliefs), there will be greater engagement of personnel than where there is significant cultural divergence. Hospitals are, of course, somewhat unique in that many of the key people in the organization (voluntary medical staff, volunteers, board members) are not employees of the organization. But the engagement of these parts of your workforce is essential to achieving high levels of performance. Accordingly, establishing baseline measurement of engagement is a critical step in developing initiatives to increase engagement and thus improve performance.

Of course, understanding what initiatives or interventions will be needed to improve engagement is the key challenge. Our recommended approach for solving this question includes drafting and administering an opinion survey that contains items which directly measure engagement as well as a constellation of workplace factors that influence engagement. Next the data must be thoroughly analyzed to identify the actions needed to improve engagement and ultimately alignment. For example, analyzing key drivers is an excellent approach for identifying workplace factors (i.e., leadership, quality focus, technologies, teamwork, etc.) and isolating individual survey items within those factors that are most empirically associated with engagement. Properly executed, this technique specifies the amount of change you can expect in engagement given improvement in the workplace factors and items that drive it—the real benefit being the ability to properly prioritize issues based on their relative influence on engagement.

Each health care organization is different. Therefore, the factors that most powerfully influence engagement in one organization may be entirely different compared to another organization. With this caution in mind, the most powerful drivers of physician engagement nationally tend to be items within the “Resources,” “Governance” and “Competitive Position” factors (See Figure 3 for a full depiction of our survey framework). This means as physicians shape their engagement, they often think critically about the state of patient care technologies, tools and equipment, as well as the stewardship of the organization and its ability to achieve excellence and outperform others.
Questions for board members to ask:
- How engaged is our work force with our organization and its strategy?
- How do we measure employee and physician engagement? How often?
- How are we increasing the engagement of our employees and physicians and assessing the impact of increased engagement on organizational performance (safety, quality, efficiency and satisfaction)?

3. Deploy clinical integration tools — The most highly engaged physicians and staff will not be able to achieve world class performance if they do not have the tools and resources needed to do so. Historically, patient care has been fragmented, particularly in the ambulatory care environment and on occasions when patients make transitions from one level of care to another (such as from the hospital to home care). Even inpatient care has not been immune to the significant adverse impact that lack of communication, duplication of services, and occasional fumbled handoffs have on patients. Among the many tools available today to improve care coordination, and hence the integration of clinicians into the operational life of the health care organization, are:
- Electronic health records;
- Patient-centered medical home models for primary care;
- Medical “neighborhoods” for improved coordination between primary care and specialists;
- Disease management programs embedded into the provider organization;
- Patient education specialists and Web-based patient self-care tools;
- Remote patient monitoring for chronic disease; and
- E-visits for routine medical problems.

All of these tools require investment on the part of the hospital, but all of them promise significant returns on that investment in an era where payment begins to be driven more by value than by volume.

Questions for board members to ask:
- Are we devoting adequate resources to tools for clinical integration that are necessary for our clinicians to perform at the highest possible level?
- Which clinical integration tools are having the greatest positive impact on patient care?
- What more should we be doing to support clinical integration?

4. Recruit physicians and employees for cultural “fit” — Recruitment, especially of physicians and other clinicians, is expensive. And recruiting or hiring a person who is a cultural misfit in the organization can have serious short-term and long-term costs, well beyond the cost of the recruitment itself. Cultural assessment tools provide information that can be used in the pre-employment screening process to identify candidates who share the values of the organization. Conversely, candidates who are not a good cultural fit may opt
out of the hiring process, or be ranked lower as potential candidates, because of the mismatch between the organization’s culture and what is important to the individual (11). Some organizations have developed an explicit statement of mutual expectations (a “physician compact”) that is shared with all potential physician recruits, and which any physician who is hired is asked to sign indicating his or her agreement (12). That has led to increased clarity about what the organization expects from its physicians, and what they, in turn, can expect from the organization. As a consequence, opportunities for subsequent conflicts or “culture clashes” are minimized.

Questions for board members to ask:
• Do we have a process for assessing the cultural fit between our organization and a physician or group of physicians that we want to recruit?
• Do we have a similar process for evaluating potential employees for their fit with our culture?
• Is there a clearly defined process whereby we make explicit what the organization will do for physicians who join us, and what we in turn expect those physicians to do for the organization?

5. Actively manage culture conflicts — One common source of cultural conflicts is mergers or acquisitions. In particular, many hospitals today employ large numbers of physicians who were formerly in physician-owned small- to medium-size practices. Each of those small practices had its own culture—and in some cases, the physicians in a practice simply didn’t like or get along with physicians in another practice. If both those groups are now part of the same hospital enterprise, the chances for internal dissension are significant. One of the most significant errors a hospital can make today is to acquire 20 or 30 physician practices, and then announce to all the newly employed physicians that they are now to function as a single multi-specialty group practice—it simply is not that easy. But the conflicts can be managed, as long as they are surfaced and their sources are known. Here again, cultural assessment of potential practice acquisitions can help identify areas of potential conflict, and allow active management of the issues.

Consider how the overall success rate of mergers and acquisitions might be improved if the acquiring organizations would take time to properly evaluate the opinions and cultural state of the group they are seeking to acquire. We believe it is remarkably valuable for organizations to actively measure employee and physician opinions. In the case of mergers and acquisitions we also encourage hospitals to seek opportunities to conduct “mirrored” measurement—that is, administering the same survey to measure opinions of employees of the acquiring organization as well as the targeted acquisition. Under this scenario, an organization could identify any attitudinal gaps between their staff and the staff of the group they are interested in acquiring. This approach offers an immediate understanding of how the two cultures may or may not enmesh and identifies what must be addressed in an effort to promote a successful fit.
Question for board members to ask:
• Does our hospital conduct a cultural assessment of a physician practice prior to aligning with or acquiring it to determine its cultural fit with the hospital and with other physicians employed by or aligned with the hospital?

6. Set clear behavior and performance expectations — One of the benefits of a physician compact is that it makes clear what is expected of members of the medical staff, both employed and voluntary, and what physicians should expect from the hospital as well. However, additional specificity about behavioral expectations—including specific behaviors that will not be tolerated—and about specific clinical performance measures that will be used in evaluating physician performance is essential. Similarly, clarity on staff behavior and performance expectations can make the process of personnel evaluation a much more meaningful one than it has traditionally been. Since patient care results are the product of teamwork and team interaction, measures that assess team effectiveness are particularly valuable.

Questions for board members to ask:
• Do we routinely inform our physicians and other clinicians how their performance will be measured, and how that measurement information will be used?
• Do we have a code of professional behavior that is uniformly applied and enforced throughout our organization?
• Do our performance measures evaluate care teams as well as individuals?

7. Provide regular feedback on individual and organizational performance — Feedback can be a powerful motivational tool. But it must be timely, meaningful, and accurate (13). Feedback is most effective when it is a regularly occurring activity throughout the organization—a normal part of the organization’s life. It is least effective when it only occurs infrequently, or only in cases of unacceptable poor performance. In health care organizations it is also important not only to provide feedback on the performance of the individual, but also on his or her team and the organization as a whole. That feedback provides valuable context for understanding how the performance of the individual relates to that of the organization.

Questions for board members to ask:
• Do we provide regular, frequent information on individual, team, and organizational performance to all segments of our work force (physicians, clinical staff, managers, support staff, etc.)?
• Is that feedback used in making personnel decisions, including promotion, bonuses, etc.?
8. Don’t tolerate cultural misfits or poor performers — One of the most difficult tasks that any manager must perform is to terminate an employee, whether because of performance or behavior. That difficulty is compounded when the underperformer is a physician, either employed by the organization or granted privileges by the board. Since physician-directed admissions are the primary driver of hospital income, there may be a tendency to want to avoid dealing with “problem physicians” for fear that they will take their patients elsewhere. Obviously, care must be taken to assure that any disciplinary action is based on well-documented performance or behavior issues, and that steps are taken to comply with any contractual or procedural requirements such as those found in medical staff bylaws. But failure to act, and to act consistently, can severely undermine morale and create an environment in which performance improvement becomes virtually impossible. If physicians and employees see that the organization tolerates poor performance, or bad behavior, it seriously undermines their own engagement with the organization and can create a downward performance spiral.

Question for board members to ask:
• Do we have a robust process for review of professional performance, including behavior, that is applied fairly and equally to all members of our staff?

9. Align compensation with performance measures — Recognition and reward are extremely important motivators for improving the performance of both individuals and organizations. But just as payers are now moving to tie their payment rates to organizational performance measures, so, too, should health care organizations begin to couple employee compensation with individual and organizational measures of performance. In many organizations, the senior executives have generally had some portion of their compensation linked to the financial performance of the organization. As we move into an era of value-based payments, the compensation formulas for executive staff are beginning to incorporate measures of quality, safety and patient satisfaction, as well as financial measures. Similarly, for physicians, department heads, clinicians and team leaders, linking compensation to measures of the performance of individuals, teams and the organization as a whole can be an important source of motivation and reinforcement.

Question for board members to ask:
• How do we use our compensation programs to encourage and reward performance?
Conclusion

In today’s health care organization, measures of performance in the areas of quality, safety, efficiency and patient satisfaction are increasingly of critical importance. Outstanding performance is driven by engaged physicians and employees, practicing in a coherent organizational culture, where there are clear performance expectations and regular feedback on performance. Managing the culture, engagement, and integration of the work force is essential to the success of the organization. While the operational aspects of performance measurement and management are a responsibility of the management team and physician leaders, the board must set the strategic vision and oversee the performance of these activities. The strategies and questions suggested in this document should help trustees carry out that important part of their fiduciary responsibility.
References


5. www.qualityforum.org


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