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How to Scale Clinician Coaching Across a Medical Group: How Colorado Permanente Medical Group Coached 1,200 Physicians

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Stephen Beeson, M.D., Founder, Clinician Experience Project; and **Thomas Rehring, M.D., FACS**, Vascular Surgeon and Chief Experience Officer, Colorado Permanente Medical Group

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How clinicians show up in the exam room and how they act as leaders can have a profound impact on the performance and culture of a healthcare organization. Coaching clinicians on essential skills in these areas is invaluable, but individual coaching is rarely feasible given the resources required. Dr. Stephen Beeson from the Clinician Experience Project at Practicing Excellence and Dr. Thomas Rehring, vascular surgeon and chief experience officer for the Colorado Permanente Medical Group (CPMG), shared information on the Clinician Experience Project coaching tool and how CPMG implemented that tool to coach 1,200 CPMG physicians synchronously.

The Clinician Experience Project

Dr. Stephen Beeson spent most of his life in the exam room as a family medicine physician. Then, about 20 years ago, he was tasked to coach, train, and develop clinicians in a medical group environment. As a result, he became a student of coaching. "How do we coach, train, and develop clinicians so they do essentially two things: Number one, advance their skills to better contribute to the mission of the organization, and number two, do the things that allow them to find joy, contentment, and meaning and durability in this life."

Over a 12-year-long process at Sharp Rees-Stealy Medical Group, it became clear that coaching works, and Beeson's experience there and since has led him to three important conclusions about coaching physicians. First, he said, while organizations and patients certainly reap benefits, the principal beneficiary of coaching is the people who are recipients of it. "I have seen extraordinary restoration and rejuvenation of clinicians who were struggling, and coaching was used to allow them to become the clinician that they always envisioned when they joined this profession." Second, coaching is not about remediation. It's for everyone. "It's about building coaching cultures of continuous improvement, building learning organizations that are constantly striving to become better on the things that matter." How do we better connect and serve our patients? How do we better collaborate with one another? And how do we lead to bring the best out of everyone, rather than focusing only on clinicians who are getting patient

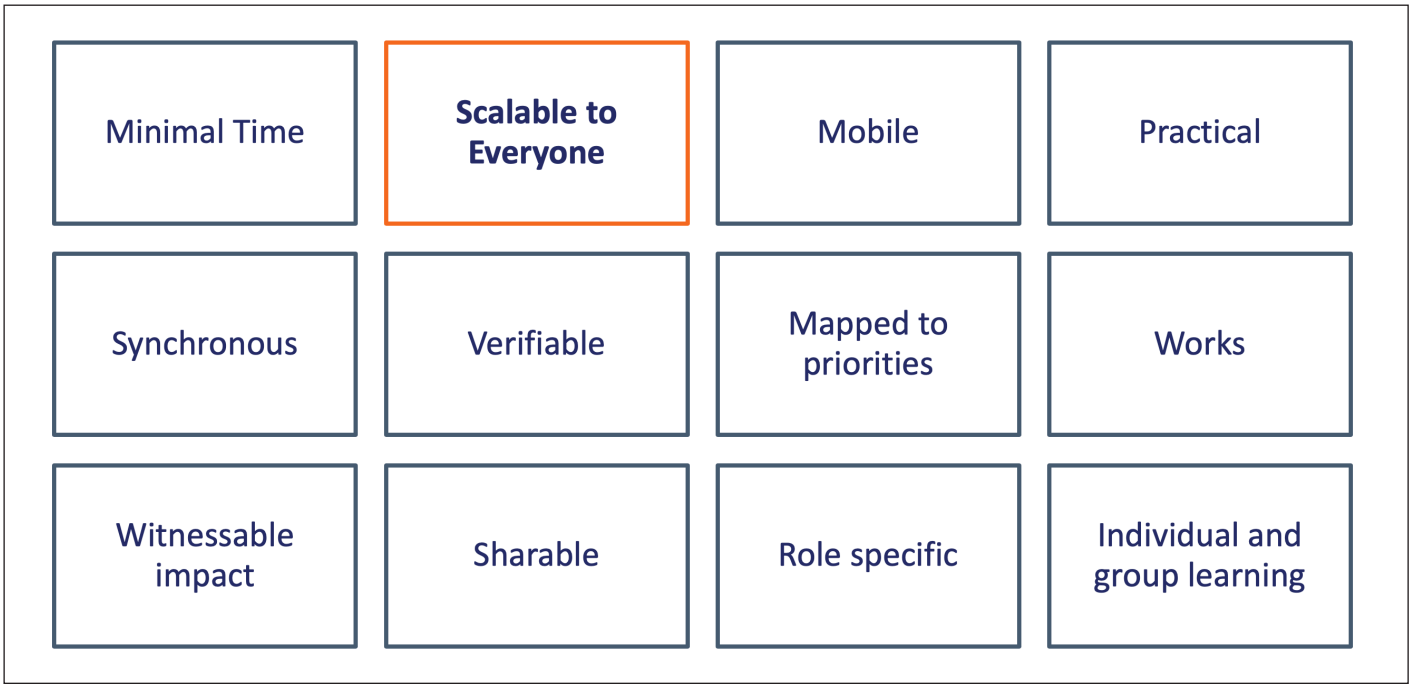
complaints? Finally, Beeson said, "clinicians don't know the very basic things that we're now accountable for." Examples include basic skills to build patient rapport, to build patients' confidence, to include patients in decision making, to manage clinical uncertainty, to close the clinical encounter with a compelling impression, to manage patients requesting antibiotics for viral illnesses or demanding medically unnecessary tests. "I've yet to meet a clinician who struggles, who could articulate why patients say what they say about them."

Seeing the profound impact coaching provided in helping clinicians develop skills to connect with patients, collaborate with teammates, and influence the people around them, Beeson has since dedicated himself to utilizing technology to bring those advantages to others. "How do we overcome the headwind of coaching and developing people when it's really hard to do?" asked Beeson. Clinicians are "totally overwhelmed right now" and giving them "one more thing to do or come to this classroom and learn how to do things or even get shadowed for an hour, not only is that very hard to scale, it's very isolated and siloed." "How do we scale it to everybody? Because that's a notable challenge."

Meeting that challenge began with identifying the key features of a good coaching engine. Beeson's team identified 12 (see Figure 1). Those 12 features ultimately became the infrastructure and the delivery method of the Clinician Experience Project, a technology-enabled, micro-learning coaching app that provides hundreds of skill-building tip videos, prescriptive programs mapped to organizational priorities, and reporting and analytic functions to track progress. Participating organizations have access to a client success team for support, and CME credits and certifications are available for participants.

A major key to the success of the project is the five-minute tip video format. "Coaching doesn't take a lot of time," said Beeson. The mantra at the Clinician Experience Project is "five minutes a week," and they now have 13 case studies demonstrating the efficacy of that micro-learning approach. These tips are curated by industry experts and each tip is delivered each week as part of a prescriptive program—a sequence of skills that drives pre- and post-metrics monitored through the use of analytics on the backend. "It's got to work," said Beeson, "meaning nothing gets inside [the app] unless

Figure 1: Effective Care Team Coaching Features



it's demonstrated through minimally observational studies that the techniques work. We don't have time to waste our time on things that are not proven to work."

The information also has to be specific. You can't give a hospital a family medicine tip. Ensuring everyone in a particular group is working from the same material provides the power of synchronicity and shared common understanding, and Beeson's team has found the ability to share content and skills is critical. So, the app includes the ability to save content and share it, via text or email, with fellow members of your organization. Then, the analytic engines work individually and collectively to track progress.

Beeson noted that the data in learning literature shows a precipitous drop-off between learning and doing. The Clinician Experience Project bridges that gap by providing very tangible and simple prompts to take the learning to the doing. "The correct cycle of learning is learn, try, share; learn, try, share; learn, try, share." So, clinicians are coached to use a tip at their next patient encounter and to carefully observe what happened when they did something. Then they have an opportunity to get feedback from their colleagues. Within the app, said Beeson, "you're going to see hundreds of comments," clinicians sharing their stories, facilitating a sort of debrief, and providing feedback and what others experienced, given what they've seen. "Everybody's sharing that wisdom and those skills at the same time." That experience of patient response and colleague feedback supports the change.

Another key feature of the Clinician Experience Project is the ability to adapt to each participant organization's goals. "You don't just randomly coach things," said Beeson. "You coach to achieve a future state, to execute with your behaviors, your north star. So, whatever your organization's goal is, we have to embed behaviors that allow those things to manifest." As a result, they may implement multiple programs across an organization. Each program focuses on a different domain (see Figure 2), including, to name a few, skills related to patient connectivity and creating moments of care that render patient loyalty and transformatively impact patient perception, skills for team collaboration and support of one another, and leadership skills focused on "leading to bring the best of others, leading with servant leadership and purpose driven leadership."

Beeson noted that "how leaders lead is the biggest driver of burnout probability and well-being likelihood, talent retention, and recruitment. So just like we deploy skills for clinicians to connect with patients,

Figure 2: Clinician Experience Project

synchronously and instantaneously on a different program, leaders are learning how to lead, to bring the best of others." Each program provides deliberate and specific sequences of content that are mapped to particular enrollees, integrated with activation tips on how to apply the skills, as well as pre and post measures of outcomes."

This process works. Beeson shared results experienced by several organizational participants. In one six-month study, Northwell Health found Maslach burnout scores reduced significantly and 74% of physicians felt enhanced patient connectivity. St. Luke's Health System had 97% of its physicians participate and included staff and nursing in the program. In six months, they saw top quartile performance in most key patient metrics. Providence Northwest Medical Group saw first-year turnover drop 3% in 12 months and patient provider ratings moved 4.9 raw points to the 87th percentile.

With that background, Dr. Thomas Rehring took over the presentation to provide details on how CPMG implemented their program with the Clinician Experience Project and the results seen there.

The Colorado Permanent Medical Group Experience

CPMG serves about 600,000 people across Colorado. It has 30 different medical office buildings with over 1,200 physicians, about a third of whom are primary care and the remainder including specialists of all kinds. They provide 24/7 service, including telehealth, which, of course, has been an emphasis over the past year.

Dr. Rehring, a vascular surgeon, has been practicing at CPMG for over 20 years. After being an operations leader for several years, he became the director of clinical quality. At that time, CPMG had quality outcomes that were "second to none in Colorado." They had excellent quality metrics, including five-star Medicare ratings year over year, and dedicated protocols, with systems and people in place "to make sure that quality metrics, whether it was statin compliance or childhood immunizations or diabetic foot exams, were really up to par."

The problem was service metrics, in particular Consumer Assessment of Healthcare Providers and Systems (CAHPS) ratings, including rating of health plan, rating of health care, and even access measures. "In our commercial deductible population, we had a net promoter score of negative three at the time," Rehring noted. CPMG's high-level quality benchmark ratings were at risk due to their CAHPS performance, and they realized special attention needed to be directed to CAHPS measures. This led to the creation of the chief experience officer position, which the organization believed "was best led by a clinician if we were really going to drive this work forward." Rehring had a new task.

"We knew that these quality outcomes and connection to patients were pivotal," said Rehring. They started from scratch, conducting analyses and identifying the drivers behind their performance gaps in CAHPS. They found that "the connection between physician and patient, patients' perception of their doctors' communication skill was the most important driver of their overall experience. Even more than access." They had a relatively stable total number of members, but "when you looked under the hood," Rehring explained, although the region was adding members year over year, "we didn't see overall net growth because of patient loss." Data showed that patient connection to their primary care physician held the strongest correlation to retention.

"And it shouldn't be any surprise," said Rehring. "There's 30 years of robust and compelling data that suggests provider communication skill is the key driver of all the quality outcomes you're looking for, from medication adherence and utilization to retention or even things like

medical malpractice, cost and utilization. Those are all dependent on how we connect and communicate with patients."

To address this, you first need to measure that performance, and it's important to make sure you're providing accurate, robust, actionable data. Rehring noted, "Physicians tend to overestimate our communication skills." CPMG adjusted the tool they had. "I think many of you probably have a tool that you're using to evaluate the communication skills of your physicians." You "really need to dedicate time and effort to provide a useful and reliable instrument that physicians will trust."

It's also important that the tool provide benchmarking to an appropriate peer group. "Comparing ED physicians to pediatricians isn't fair. ED physicians have all the challenges of a highly stressed, non-tenured patient population they're taking care of, whereas everybody loves their pediatrician." As well, you need specificity within that tool to drive areas of opportunity, "whether it's listening or explaining or understanding or managing fear and anxiety. All of that matters." Finally, give clinicians "enough data with sufficient frequency to demonstrate the effect of behavioral changes they have made in their clinical practice. Annual reporting is not enough."

Once you have that tool, however, what do you do with it? It's incredibly unfair to push across the table a PDF of someone's communication performance and say, "you really struggle with listening," and then just walk away. CPMG had some self-study books and tips, as well as a fairly intensive three-day communication skills workshop but, at the time, these were "seen almost as remedial. These were the bad doctor workshops." One-to-one coaching was available, but it wasn't particularly robust. "Honestly," said Rehring, "with 1,200 doctors with variable bell curve performance, we couldn't coach the way we wanted to. Recognizing this is a key driver of our outcomes and we have areas of opportunity, how do we get better? So, we were looking for something to bridge the gap between self-study and resource and time-intensive workshops already in existence."

CPMG engaged with the Clinician Experience Project to fulfill that need. They wanted a tool that could help coach physicians with information tailored to opportunities identified from their "Art of Medicine" survey data. A solution that could provide a place to skill-build, tying specific, digestible, and easy-to-get to information that clinicians could work on independently. They worked with the Clinician Experience Project adapted to those needs and began a pilot program.

Rehring's team advised 400 adult primary care physicians that the tool was available, what they could do with it, instructed them on the use case scenario, and tied it to performance evaluation. About 140 doctors actively engaged with the tool, which Rehring explained, "meant 60 minutes over the course of about a six-month period. So about 10 minutes a week." Those active users "showed a statistically significant improvement in their communication skills as measured by our internal survey," said Rehring. For those who didn't utilize the platform, engagement was flat and, in some cases, even went down. For CPMG, that was a proof of concept and was the impetus to expand the program to all 1,200 physicians.

"You know," said Rehring, "every physician harbors an innate desire for mastery. To be that master clinician, whether it's gaining the most up-to-date knowledge, best practices or guidelines, or technical prowess. We strive for mastery." The coaching provided by the tool furthers that goal. "When you connect with another human, really connect, the side effect is that you go home feeling like you were a pretty good doctor that day. A powerful burnout countermeasure." In other words, the tool helps in multiple ways. "Improving your communication skills, how you connect, can impact everything from quality outcomes and service experience to clinician well-being.

There are intrinsic rewards to mastery and the nobility of purpose that is inherent in caring for others. Connecting to humanity, and doing it well is the key."

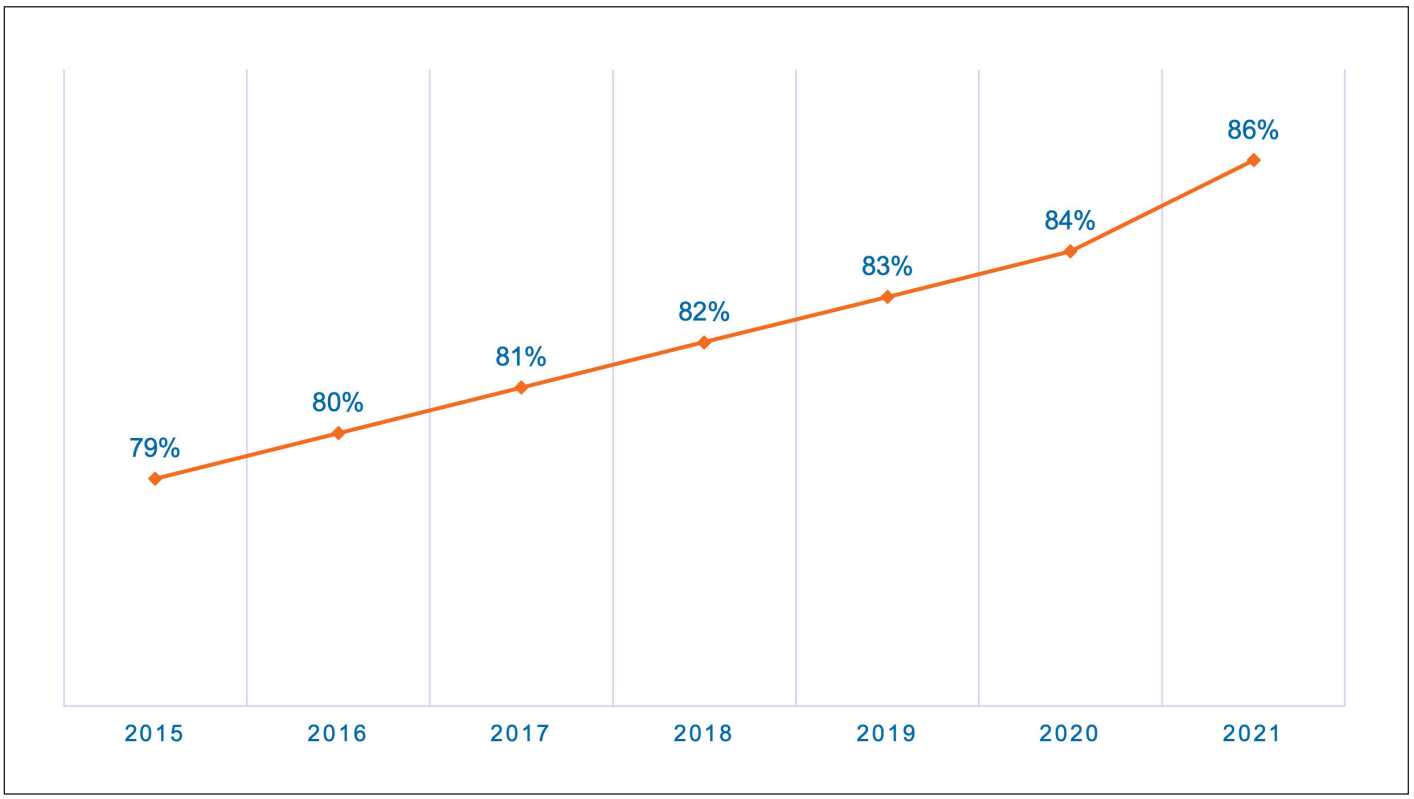
CPMG's Art of Medicine survey instrument yields approximately 200,000 survey responses per year, providing results of about 30 to 40 surveys per quarter for each physician. It was clear early on that overall satisfaction was tied to provider interaction. Without that, Rehring said, "all the other service measures plummet." In fact, they found that if provider interaction wasn't rated excellent, overall satisfaction and likelihood to recommend dropped by 60 percentage points. At the beginning of the program, about 79% of patients thought that their overall interaction with their doctor was excellent, but Rehring said that was "clearly not good enough. So, we embarked on a program of regional prioritization, giving our physicians actionable, detailed, refreshable data, and holding each other to a high bar with clear explanation of the why." Adapting to the new system was a challenge.

Rehring emphasized it was important to focus on growth and mastery. "This isn't about remediation. This isn't the bad doctor program. I'm not shaming you. This is about how do we all get better at something that's crucially important to what we hold dear and patient outcomes as the measure of that."

Rehring noted the minimum of 30 or 40 responses per quarter were essential to measuring performance and that performance measures must be tied to specific domains. "So, if their performance on listening or explaining is low, there will be tailored content for them within that report that they can work on. Then, a quarter later, they'll see if the behavioral changes they attempted in the office have manifested as meaningful changes in their data."

CPMG's approach has led to significant improvements since the program began in 2015 (see Figure 3). One or two points a year may seem small, but over time, Rehring noted, "this kind of movement is enormous."

Figure 3: Overall Provider Interaction



That translates to things like Google reviews and star ratings. CPMG's physicians now, on average, receive 4.8 stars, and they don't have any physicians below 4.1 stars. Ninety-nine percent of CPMG physicians have a rating of 4.5 or higher. "And," added Rehring, "as social media is the currency for how people find doctors and these data have merit and impact where patients will seek care." More recently, they have demonstrated gains in their CAHPS performance as well.

Indeed, while the program began with a need to improve physician communication skills as the key driver for outcomes, cost, and utilization, Rehring noted that the "side effect" of clinician well-being was the real benefit. "When you navigate a tough clinical conversation, be it delivering news about a poor prognosis or ambivalence about a treatment plan, and even when that goes well, that is a profound burnout countermeasure. That connection is something that makes you go home feeling good about what you did and brings you back the next day for more."

Using the Clinician Experience Project at Your Organization

Going back to his comments about St. Luke's Experience, Beeson noted that the Clinician Experience Project isn't just for physicians. The ambulatory patient experience program includes role-specific programs for nursing and support staff. "We have tremendous engagement data on that front," said Beeson. "And it's an amazing signal to send to the group that we're in this together. This is not a staffing or nursing thing or a leader thing or a doctor thing. It's an us thing. And we all have a role in this."

Rehring had several tips for others implementing a similar program. First, common cause is essential. Whether it's member experience or developing physician mastery, he said, "this is a hearts and minds campaign about getting back to what we do in medical care and what brought us here in the first place." It can't be seen from a physician perspective as a mandate about scores or performance or CAHPs. It's "about getting back to what we do in medical care and what brought us here in the first place. Why did I write that junior year college essay about helping people getting me in a medical school? It's this work. It's how I connect to humanity."

He also suggested using recognition and rewards, special things you can do to help recognize excellence and/or improved performance. "This is a mastery journey and it's really about taking everybody and where their performance is now and just shifting it to the right a little bit for all the right reasons." One of the things they've done at CPMG is to invite top performers to dinner and asked them to bring a significant other, spouse, or parent. There, each person is individually recognized, including a reading of patient comments. Rehring described the experience of sharing the recognition event with people close to the physicians as "totally moving."

Beeson noted other aspects of the Clinician Experience Project that go beyond the app and can provide similarly touching moments. When he has a group of physicians in a room, Beeson likes to do an exercise in which they reflect on their best moments in health care. Those shared moments, Beeson said, "rarely were they about clinical sequelae. They were about impact and connection, and often in the context of clinical failure, where they were going to a memorial service, or they did a home visit and that they were not very excited about, but ended up having a brandy with the family, talking about their loved one and who they were caring for and driving home at the end of that, saying, 'this is why.'"

The program also provides other options beyond the app, such as boot camps for leaders to kick off projects, addressing things like how to use the tool, as well as how to frame or position the new program

and how to utilize and communicate data. Another is a 45-tip program for leaders on how to lead the patient experience, how to create a cause-driven movement, and how to communicate your future state to enroll people with "an enthusiasm that deeply sings with their value system." Participants also have access to a library with information on a vast array of topics for additional independent learning.

The moments physicians create by "making the lives of those we serve better have been displaced by administrative burden and clerical demand," said Beeson. "Despite all the difficulty that our profession has been through, I think happiness, fulfillment, and meaning and purpose are at our fingertips, and sometimes you just have to remember and choose to be better for the patients that we serve, for one another, and find what we envisioned in this amazing healing profession."

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