COMMUNICATION OF MAJOR STRATEGIC ISSUES TO DUKE UNIVERSITY HEALTH SYSTEM PROVIDERS

This report summarizes the current state of DukeHealth communication related to major strategic issues and recommends strategies for improving communication.
COMMUNICATION OF MAJOR STRATEGIC ISSUES TO DUKE UNIVERSITY HEALTH SYSTEM PROVIDERS

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EXECUTIVE SUMMARY

Background: This report summarizes work completed from February to June of 2019 by a Duke Clinical Leadership Project (DCLP) Team tasked with examining strategic communication to DukeHealth providers. The objective was to summarize the current state of DukeHealth communication and to recommend strategies for improving strategic communication. This task is critically important given changes within DukeHealth (e.g. proposed PDC-DUHS alignment) and across the state of North Carolina (e.g. Medicaid reform, value-based care initiatives).

Methods: The findings presented in this report are based on data collected during this project period from three principal sources: (i) informal interviews with DukeHealth Communication leaders; (ii) qualitative interviews with 21 clinical providers from across DukeHealth; (iii) a cross-sectional review of all system-level emails received by a spectrum of DukeHealth providers. A summary of the interviews with Duke Communication leaders was created to describe the current state, while clinical provider qualitative interviews were examined to identify key themes regarding their experience with current communication and to define effective recommendations for improving communication within the organization. System-level email analysis was performed to summarize email burden and effectiveness.

Key Findings: The current state analysis found that communication is a high priority for DukeHealth with both senior leadership and DukeHealth communications experts seeking improvements. A major barrier is the decentralized nature of communication across DukeHealth, with different entities having their own, separate communication teams, goals and priorities. While these teams strive to work collaboratively to deliver a consistent message, at times strategic objectives and messaging are not fully aligned.

Six key themes were identified from the 21 structured interviews including: personalization, pros/cons of modalities, quantity/quality, transparency, overall opinion of strategic communication, and pet peeves/suggestions. Themes are summarized and were used to guide recommendations; Overall, clinical providers were most interested in receiving strategic communication in a more targeted format, delivered by a known/trusted member of their local leadership, in concert with similar communication from senior leaders. Clinical providers also emphasized the importance of having a clear mechanism for providing feedback to senior leaders.

System-level e-mail analysis found that, six providers across DukeHealth received 220 emails in a single week from entities across DukeHealth. Overall, 66% of these were not read. Education-related and system announcements were the least likely to be read.

Summary of Recommendations: The DCLP team developed six broad recommendations with related action steps for improving strategic communication across DukeHealth. These recommendations are grounded in the key findings that providers are seeking clear messages delivered in a more personalized and transparent manner: provider-centered communication.

1. Prioritize development of clear strategic communication messages and materials
2. Implement a DukeHealth centralized communication structure to unify communication around strategic issues
3. Prioritize personalization of communication and transparency
4. Provide opportunities for bidirectional communication
5. Develop mechanisms to monitor quality & quantity of communication to clinical providers
6. Provide training for leadership at all levels on communication and relationship building

Creating stronger infrastructure for strategic communication will address a concern articulated by providers and increase their connection to the broader DukeHealth mission.
1.0 BACKGROUND

As the healthcare landscape continues to evolve due to policy, regulatory and payer changes, and the health system and school have grown and expanded, there is an increasing need for effective communication between health system leadership and front-line providers (MD, DO, NP, PA). Effective communication of major strategic initiatives, as well as the impact of changes in the healthcare landscape on DukeHealth, will optimize alignment of DukeHealth objectives with the day-to-day functionality of the DukeHealth workforce.

Central to an effective system-wide communication strategy is an understanding of the current communications landscape. In recent years, there has been a rapid proliferation of the tools used to communicate with providers and it is important to understand approaches that function effectively, as well as current limitations and challenges. Therefore, the overarching objective of this report is to provide recommendations to senior leadership regarding most effective strategies for communication of key strategic issues to providers across DukeHealth. To accomplish this objective, we compiled data from three principal sources: key informant interviews with DukeHealth Communication leaders and DukeHealth Senior Leadership; qualitative, 30-minute structured interviews conducted with 21 clinical providers from across DukeHealth and broadly representative of the DukeHealth provider workforce; and a cross-sectional review of all system-level emails received by a spectrum of six DukeHealth providers. These data are summarized with recommendations and related action steps for improving strategic communication across DukeHealth.

2.0 METHODS

2.1 DukeHealth Leadership and Communication Stakeholder Informant Interviews

Members of the DCLP team began our discovery process by meeting with senior leadership and communication stakeholders across DukeHealth to assess the current landscape of communication. The first meeting included project sponsors Drs. Rogers and Attarian as well as Associate Vice president for communications of the Physicians Diagnostic Clinic (PDC), Geelea Seaford. Other meetings included Jill Boye, Associate Dean and Chief Communications Officer for the School of Medicine, Doug Stokke, Vice President of DukeHealth Marketing and Communications, and Anne Brumbaugh, PhD, senior marketing research analyst for DukeHealth. Key findings and themes from these meetings are summarized to reflect the perspectives and recommendations of senior leadership and communications experts across DukeHealth. From these meetings, it became clear that there was a need for more information on the needs and preferences of providers with regard to communication around major strategic issues facing DukeHealth. The DCLP team elected to focus specifically on “major strategic issues” including topics such as PDC and Health System Integration, Value Based Care, and Population Health, based on feedback from senior leadership who emphasized the particular importance of a clear and effective communication strategy for these strategic issues. Additionally, we were made aware of a task force of DukeHealth leadership organized by the chancellor set to similar goals of understanding and improving communication. This initiative clearly demonstrates a commitment to improvement across all levels of our health system.
2.2 Qualitative Interviews with DukeHealth Providers

Within our continued group discussions and following on-going discussions with project sponsors, the overall complexity of communication infrastructure for an entity as large as DukeHealth became increasingly apparent. The DCLP team, and project sponsor, Dr. Rogers discussed multiple potential directions for this project. Options considered included reaching out to other complex organizations both within and outside of health care to assess for best practices regarding communication in large organizations, detailed analysis of various channels of communication – such as electronic, in person, video, etc., and the need for direct provider-level feedback from within DukeHealth to guide recommendations for optimal communication strategies. We discussed the pros and cons of the different directions including the unique structure of our different entities as well as the period for completing our project. Ultimately, the group recognized the unique structure of DukeHealth, the diverse needs of the front-line providers as well as the pending structure changes that could come with possible alignment of the PDC and the health system. These factors made it vital to focus on the people most affected by the communication strategy and so the option ultimately taken was to obtain information directly from front line providers regarding the adequacy of current communication and preferences toward future communication.

After the decision was made to pursue gathering further information from front line providers, the group had multiple meetings with Dr. Anne Brumbaugh, senior marketing research analyst for DukeHealth, an expert on communications in the DUHS Communications Office. Dr. Brumbaugh has significant experience in marketing, communication research and teaching, and her expertise guided us to the format of in-depth structured interviews rather than a survey as was initially planned. The reason for this change was that although the group members have first-hand experience as front line providers, group members experience was not enough to ensure that a survey would include all the appropriate questions within the limited time for project completion without potentially missing key themes amongst providers. In depth interviews, on the other hand, would provide many opportunities for providers to express their needs and wants, provide examples of good and bad communications and offer suggestions for improvement. With Dr. Brumbaugh’s assistance, an in-depth interview script was developed (See Appendix A), after which feedback and approval were sought and received from the project sponsors. Additional instruction and coaching were provided to the group regarding appropriate technique for in depth interviews. Group members each nominated five to six frontline providers to be interviewed with intentional focus on diversity of the providers nominated so that the resulting interviewees included individuals from the various entities and included MDs as well as APPs. Group members were then assigned providers that they did not know or work with to minimize bias during the interviews. Interviews were recorded when technology allowed with permission from interviewee and assurance of anonymity. Comprehensive notes were taken during each interview for subsequent review.

Upon interview completion, group members summarized interviews in structured reports including key quotes from interviewees. Group members then shared their experience with the interviews and we collectively discussed key themes that emerged during the interviews. Following internal discussion and review of the interview summaries, we chose consensus themes. Analysis of each
theme is provided in this report and was used by the group to formulate recommended next steps for the project sponsor.

2.3 System-Level Email Analysis

Concurrent with leadership meetings and provider-level qualitative analysis, members of the DCLP team considered the various methods by which we receive information on major strategic issues or initiatives. Recognizing that our DCLP members come from varied departments, professions (MD and NP), employment status (PDC vs employed) and practice location (DUH, DRH, clinic based), there was robust discussion of the various communication channels employed by different entities within DukeHealth as well as the varied sources from which communications are received. In particular, email was highlighted as a major source of communication that sometimes can be burdensome and is not always considered highly effective. To better characterize the provider-level email burden as well as effectiveness of email as a communication strategy, we compiled and analyzed a full week of system-level email content received by DCLP group members. Only emails sent to large groups or list-serves were eligible and all emails from a one-week period (7am Tuesday-7am Tuesday) were forwarded to a jointly created group project account along with whether that email was read by the intended recipient and, if read, whether the email was found useful.

2.4 Team Dynamics

Part of our focus as a group was to recognize group dynamics and cultivate strategies for effective team management as well as engage in a thorough and collaborative discovery process. These were considered important process goals given the robust discussions within the group regarding various directions for the project. The team therefore needed to establish some team norms to ensure that the team remained connected and that time spent working on the project was productive. The team was able to maintain inclusivity and ensure that every voice was being heard from the first meeting. One strategy utilized was to recognize the strengths within each team member and leverage those strengths as we continued working on the project. For example, one team member had significant experience with qualitative research, which was needed for our deliverable so the team leveraged this during analysis of our results. One lesson learned by the group was to listen carefully to each other’s ideas and to summarize and paraphrase when it seemed as if two or more members were expressing the same idea in slightly different ways during brainstorming sessions. Additionally, after the first meeting, it helped to have at least a rough agenda and tasks to be completed in order to maximize group project time. Furthermore, it helped to clearly discuss our planned deliverables in the context of our timeline and other commitments to ensure that the project scope was achievable. The final piece of the puzzle for effective team management was to ensure that we listened to feedback from our coach facilitator and that we remained in consistent contact with our project sponsor with monthly WebEx meetings where we updated them on project progress but also provided an avenue for them to ask questions and provide any guidance they had.

3.0 FINDINGS

Findings divided into a summary of the three types of data collected: expert opinion following key informant interviews with DukeHealth Leadership and Communication experts, a summary of the
findings from the qualitative interviews with DukeHealth Providers, and findings from the system-level email analysis.

3.1 DukeHealth Leadership and Communication Stakeholder Informant Interviews

Group members met with communication stakeholders throughout the health system to assess the current landscape of communication across the DukeHealth. From these meetings, several key themes emerged including:

- Communication is a high priority topic for DukeHealth. Senior leadership understands that suboptimal communication is an ongoing issue for the health system based on prior workgroups, surveys etc.

- Recognizing that current communication approaches and infrastructure are suboptimal, leadership and communications experts expressed a need for more information regarding provider preferences with regard to communication around major strategic issues. Currently it is unclear what the needs of the providers are and how those needs can be met. It is also unclear whether inadequate information dissemination reflects mechanisms of communication versus a need for greater clarity with respect to the underlying message.

- Duke Communication Leaders share a feeling of dissatisfaction with the current communication system (i.e. delivery of information) as well as ensuring that information is actually received and not just delivered. Some of the reasons given for this dissatisfaction included:
  - Lack of bidirectional communication. Currently communication is perceived to occur in a uni-directional fashion, meaning from leadership to staff
  - Challenges in identifying and coordinating broad communication message due to complexity of the system.

- DukeHealth is highly decentralized (Figure 1) in part due to the structure of the health system and its various entities. Decentralization is exacerbated by security concerns such as a need to securely transmit patient-related information in a HIPAA compliant fashion.
  - Each entity (DUHS, PDC, DPC, each hospital, SOM) has its own communication team. There is a component of seclusion of innovation or lack of buy-in from other entities when innovations are brought forth (e.g. the undergraduate campus has an app that they utilize for the undergraduate university staff and students). This could be leveraged for use within the health system as a whole after adjustment for security requirements. This is likely a simplistic overview of the innovation and the security requirements involved but there could also be compromise to utilize the innovation for non-patient care related information. Another example, which is likely a design by chance, is that the stakeholders are active within this proposed project represent one entity (i.e. SOM or PDC) thereby highlighting the silos within the health system. These silos are felt by the front line provider in seemingly disconnected and redundant communication (Figure 2).
Figure 1. Current communication infrastructure
- There is heavy reliance on electronic communication - based on findings from prior limited surveys - which does not always meet the needs of the staff as different information requires different delivery methods.

Although areas of improvement are highlighted above, several positive themes emerged during the interview with communications stakeholders. These included:

- Every stakeholder contacted by our group was willing to contribute in any way to the project demonstrating how invested they are in seeing progress made in resolving communication problems.

- There is consensus among communication experts that face-to-face communication is the most effective communication method for strategic communication. Although this is recognized, it is frequently difficult to coordinate face-to-face time and innovative solutions may be necessary to overcome this challenge.

- The established tiered email system could be leveraged to improve email communication.
There has been significant improvement in the communication expert visibility within the health system due to support from senior leadership on funding for communication expert positions in most entities. Previously, there were no communication experts for some entities so this made it difficult. For example, there are now standing meetings between the PDC, SOM and human resources communications experts so they can share strategies as well as keep open channels of communication between their departments.

Support from senior leadership including the Chancellor regarding continued work on improving communication.

Recognition that Duke has hardworking individuals who will work tirelessly to see improvement in the communication strategy until a resolution is reached. This was clearly evident throughout our interactions with DukeHealth leadership and communications experts as everybody contacted responded promptly and willingly offered their assistance as needed despite their already busy schedules.

### 3.2 Structured Interviews

Overall, 21 structured interviews were conducted by members of the DCLP communications team. Interviews were 30 min in duration and followed a pre-determined script (see Appendix A). Recordings of the full content of 21 of the interviews are available for review upon request and with permission of the interviewee. Table 1 describes demographics of the interview population, which represented a cross-section of Duke University Health System providers including representation from eight Departments, two surgical subspecialties, six medical subspecialties and five primary care providers. Interviewees included 18 M.D.s and three advanced practice providers and years in practice ranged from one to 22 with an average of 9.5 years. Participants included PDC members, DUHS employed providers, and DPC clinicians.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N=21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male gender</td>
<td>11 (52%)</td>
</tr>
<tr>
<td>Degree</td>
<td></td>
</tr>
<tr>
<td>Medical Doctor</td>
<td>18 (86%)</td>
</tr>
<tr>
<td>Advance Practice Provider</td>
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<tr>
<td>Department</td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>8 (38%)</td>
</tr>
<tr>
<td>Surgery</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Radiology</td>
<td>4 (19%)</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>3 (14%)</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>2 (10%)</td>
</tr>
<tr>
<td>Obstetrics-Gynecology</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>1 (4%)</td>
</tr>
<tr>
<td>Primary care specialty</td>
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</tr>
<tr>
<td>Years in practice</td>
<td></td>
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<tr>
<td>&lt;5</td>
<td>8 (38%)</td>
</tr>
<tr>
<td>5 - 15</td>
<td>7 (33%)</td>
</tr>
<tr>
<td>&gt;15</td>
<td>6 (29%)</td>
</tr>
<tr>
<td>Senior leadership role</td>
<td>2 (10%)</td>
</tr>
</tbody>
</table>

### 3.3 Key Themes

Several key themes emerged following formal team review of the structured interviews. These are summarized below with recommendations related to each of these themes provided in section 5.0.

#### 3.3.1 Personalization
Although personalization of communication was not highlighted as an area of specific focus in our structured interview template (see Appendix A), all 21 interviewees mentioned the importance of tailoring the message to the needs of the local community. Summarized by one interviewee,

“If we had the perfect form of communication it would be tailored communication to amplify the message. You need to tell people on the ground what the overall strategy is and how we fit into that strategy. If you can do that then it would affect what we do on a day-to-day basis.”

Several emphasized personalization as the most essential component of an effective communication strategy. Personalization was considered particularly important for major strategic initiatives and interviewees felt that personalization of the message was also important when the strategic initiative or topic of communication would directly affect them. Several specifically highlighted that communication related to PDC and Health System integration has been less effective because the message has not been sufficiently personalized. One provider highlighted the Maestro Care roll out as another example of a lost opportunity for a more personalized communication strategy that might have had down-stream benefits. He emphasized that there are many aspects of Maestro Care that function differently depending on the local environment, and that a more personalized roll out could have enhanced the overall functionality of Maestro Care.

Representative quotes regarding the need for more personalized communication

“I need to know how does this impact me specifically. Tell me why I need to be involved”?

“I grasp things better when I am able to hear something and then engage in a discussion about the relative merits. I respond much better when I see people and have a chance to interact”.

“I’d prefer it [communication regarding integration] to come from the Duke Primary Care group. I’d rather hear it from them so that I could understand how it impacts us. I hear rumors but I don’t know the details and I don’t understand them. I wish I could understand them within the context of Duke primary care”.

“The more important and controversial the issue the more it needs to be face to face. Typical faculty don’t have the opportunity to interact with senior leadership”

“There is a lack of personalized communication. I don’t feel that leadership comes out to see what things are like in the trenches. I would like them to understand the challenges that we face every day”

“My pet peeve related to current communication is that it needs to be tailored better to specific segments of the faculty. Our scope of work is different and the type of care is different. If it [communication] can be incorporated in a more direct way and more personalized approach that would be helpful.”

“Having the ability to ask questions is an important way to personalize the interactions...really important information should ideally be delivered in an informational session”.
Although all interviewees mentioned personalization, there were nuanced differences in what they considered an optimized personalized communication strategy. Several mentioned Town Halls as examples of personalized communication. Consensus benefits included the opportunity to provide feedback, the potential for face-to-face time with senior leadership, and the benefits of dialogue. In the words of one interviewee,

“Communication is often ineffective as there is no two-way interaction. Having the ability to ask questions is an important way to personalize the interactions”.

However, there was also a relatively unified consensus that the Town Hall approach is limited, as providers often do not have time to attend these meetings. In particular off-campus providers expressed frustration with the Town Hall approach as they generally felt it is sub-optimal to attend these meetings remotely. Instead of Town Halls, many interviewees expressed support for personalized communication via Department or Divisional meetings. These were generally considered invaluable opportunities to convey a message that could be directly tailored to the audience. Several interviewees specifically highlighted a need for hierarchies of communication with senior leadership communicating with local leaders who then communicate with the larger workforce of providers. Others expressed similar sentiments noting that they did not feel strongly that a personalized communication strategy needed to rely on face-to-face time with the highest echelons of senior leadership. Rather, they were content to receive the message from Divisional and Departmental leadership and expressed that the message would be better received if delivered by someone recognized as a leader in their realm. In the words of one interviewee,

“Communication needs to come from a source that I recognize as important, one that makes me sit up and pay attention”.

In summary, personalized communication tailored to the needs of the local community was a consistent theme mentioned by almost all interviewees. Lack of personalization was noted as an important deficiency of current communications regarding major strategic initiatives, most notably integration. Many providers feel that a hierarchical communication structure might be the optimal solution with a system whereby major communications is fed from global leadership down to Departmental or Divisional leaders who can then tailor the message to the local community. Most importantly, providers want an opportunity to engage in dialogue so that they can better understand key strategic issues and how they will directly affect their practices.

#### Representative quotes regarding best ways to deliver more personalized communication

“I would suggest that every 6 months we have some form of personalized communication regarding the most important and up to date challenges facing our health system. It doesn’t have to be a single person but we need more direct contact. An opportunity for providers to hear all of the challenges. We need a way for two-way communication.”

“Communication efforts would be most effective if there were some mechanism for creating groups of providers with common interests so that the message could be personalized. The more I felt that the message would affect me, the more attentive I would be.”
“It would be nice to have an annual or semi-annual opportunity to engage on a more personal level with senior leadership. This would contribute to a greater sense of comradery and would help individual departments and divisions to take greater ownership of new initiatives.”

“It would be great if there was actually a system in place for feedback. I’m not going to just go to the head of whatever and tell them what I think.”

“The best sessions are the ones where everybody is in the room together and they are more personalized to how it affects our patients and my little section of the cancer center.”

“If we had the perfect form of communication it would be tailored communication to amplify the message and tell people on the ground what the overall strategy is and how we are going to get there and then it would affect what we do on a day-to-day basis. If as a worker bee in the colony we’d know how we fit into the overall strategy. This is how I am caring for my patients as part of the larger system and align with the global strategy. A lot of us are subspecialists and are doing focused things and we may lose touch with the whole system and focus on our own corner. If the communication strategies were there to engage and integrate us then what I do day to day might help me feel more engaged.”

“Smaller group sessions are more effective. I’m never going to ask a question in a large forum, emails are going to get lost. Department specific meetings or division specific meetings are the best formats. Personalized and specific and in smaller group setting. Having it come from somebody who I know and trust.”

“It is important to get info via department or division leadership as you need someone to translate these issues into what is important for your specialty.”

“We need hierarchies of communication with senior leadership communicating with local leaders who then communicate with the boots on the ground folks.”

Small group meetings are most effective because they are better opportunity to question leadership both directly as a participant and to listen to others questions.

3.3.2 Pros/cons of modalities (current and preferred)

All interviewees agreed that effective and efficient communication is crucial. They also unanimously felt the need to improve communication within our organization and enhance employee engagement.

According to the interviewees, written communication remains the most prevalent form of communication, with emails being the most common form. Though this approach was considered to be effective for communication of issues that require immediate attention, there were many perceived barriers for workplace communication via email. These include, for example, information overload. According to a review of the email load from different sources of Duke Healthcare, a general provider receives seven list serve emails per day (see section 3.4). A substantial amount of this information is perceived to be redundant or not directly applicable to the email recipient. Furthermore, emails are not a collaboration tool, posing major challenges for the discussion of complex topics or troubleshooting problems.
In the words of some interviewees,

“There are so many emails that it’s hard to know what matters”

“We get so many (emails) that the information gets buried”

“In general, sending out an email to cover an important topic is not ideal.”

Though most interviewees recognized the value of emails as a powerful source of communication, they also suggested possible strategies to improve their effectiveness. These include, for example, email classification based on this level of priority (i.e., low, medium, and high), strategic control of the timing of email communication, creation of memos for communication from multiple sources around the same topic. One provider said,

“I find it very annoying when I get multiple emails about same issue from different sources (president, chancellor, dean)”

“Ideally timing would be bi monthly via email that highlighted the top three most important business or strategic issues.”

Other strategies that were discussed to further improve the effectiveness of email communication to providers included better utilization of visual tool of communication, as well as the use of Situation, Background, Assessment, Recommendation (SBAR) techniques or Professional Communications Toolkits. The former communication strategy (which was initially introduced to rapid response teams) allows short, organized and predictable flow of information.

“The use of colorful graphs and charts distill often complicated ideas into easy-to-understand images.”

Most interviewees concurred that newsletter and bulletin were not very effective for communication as critical information may be lost by mixing it up with other less important topic.

As emphasized previously, all interviewees recognized the value of direct forms of communication as the most impactful way to transfer information to providers, particularly around complex matters. These forms of communication are most effective when plenty of time is allowed for questions and the information is shared before the meeting to foster a discussion.

“Anything that involves important strategic communications should be personalized and delivered in person.”

“Opportunity for back and forth”

This one-on-one interaction may be provided at different levels, including departmental and divisional meetings, periodic huddles, as well as small sessions among providers among local work groups.

“I respond much better when I see people and have a chance to interact”

“Small face to face interaction is preferred method of getting information (>20 people is too much)”

“I’m never going to ask a question in a large forum”
Many providers were not enthusiastic about the use of town halls as a means of communication. Two compelling reasons for this criticism included inconvenience due to location and/or time of these meetings, as well as difficulty in asking questions due to the large audience.

“Town halls are not usually scheduled at a great time and I am not interested in after work town halls.”

“It is very difficult for me to attend the town hall meetings.”

“Town halls would be a great form of communication but time commitment is a problem.”

Other forms of communication that were recommended by a few interviewees include the use of internal websites, internet forums with write in questions, and twitter messaging.

One provider also emphasized the need to measure results of effective communication.

“Our organization should strive to collect qualitative and quantitative information to evaluate its efforts”

Quantitative data may include measures such as turnover rates, productivity rates and employee satisfaction benchmarks.

**3.3.3 Quantity and Quality:**

During the structured interview, clinicians were asked to rate the quality and the quantity of communication they receive regarding important strategic issues within the health system. The rating was on a scale of 1 to 10 with one being the worst and ten being the best (Figure 3).

*Figure 3. Provider satisfaction with quality of communication (1 Worst, 10 Best)*

N=20 as 1 provider did not provide a rating
In general, none of the clinicians interviewed rated the quality or quantity of communication below four out of 10 indicating some amount of acknowledgement that the communication has some positive aspects currently despite the obvious need for improvement in some aspects. The majority of ratings were above a five out of 10 indicating the participants see areas in need of improvement but either are neutral or have an overall positive perception of the communication. When looking at individual ratings across the ten-point scale however, most clinicians were either neutral with a rating of five or were dissatisfied and rated the quantity and quality of communication as poor. Five clinicians gave a neutral rating of five for both the quantity and quality of communication. Comments justifying this rating included that information is inadequate and is not meeting the needs of the clinicians. One clinician said,

“It’s just not very relevant. There is not enough information and I just have to trust that they are working in our best interest”

Five clinicians gave a poor rating of four for the quantity and quality of communication. One clinician gave a rating of “poor” but did not give a quantitative rating. Some of the comments made that explain this rating were:

“Information is just not enough”

“There is not enough detail”

“Not tailored to what I need”

One clinician gave a rating of nine and another gave a rating of 10. The clinicians, one working at DRH and one working in the DPC felt that communications had improved over the years with addition of tool kits often prepared and delivered in combination with a daily huddle within their local practice setting. Some of the comments included:

“Quality of communications within the DPC is markedly improved since I first came to Duke”

“Unlike DUH where I trained for residency, the Duke Community hospital provides a very different environment where leaders and providers feel part of the same community and share goals and values. The communication process, whether emails, daily huddles, or divisional meetings, becomes effective as providers are invested in the hospital and actively involved in gathering information”

When the results are viewed as aggregate data in three separate categories of dissatisfied or poor rating, Neutral rating and satisfied or good rating, the overall rating appears to be in the good category despite the expressed feelings of dissatisfaction presented by the clinicians interviewed. Ten clinicians gave a good rating of the communication between six and ten compared to five who were neutral and five who were dissatisfied and gave a rating of four out of 10. Some of the comments made to explain this good rating between six and nine rating were

“The timing and duration of communication regarding alignment is appropriate. Information has been pushed out in a number of ways via different people providing some degree of redundancy”
“What is working is the timeliness of communication because gives appropriate attention to urgent issues”

“Monthly meetings with department chair work really well”

Generally, clinicians in leadership positions were more likely to give a good rating on the quantity and quality of communication. One of the common reasons given for this was information delivery in face to face at meetings that were part of their leadership roles. It appears from this observation that there is an issue with information delivery as information is transferred from one level of leadership to the next so frontline clinicians never receive the information, or by the time it is delivered, it is not in the preferred mode and the quality and quantity are affected. This is also supported by the aggregate data showing that more clinicians actually rated the communication as good (between a six and a nine) despite expressing a feeling of dissatisfaction. Although there certainly is room for improvement in the way information is delivered, the data regarding the ratings might indicate more of a feeling of dissatisfaction with the relationship building aspect of communication especially related to face-to-face interactions and workplace culture than actual information delivery.

3.3.4 Transparency

Most interviewees expressed a desire for transparency from the health system regarding issues of strategic importance as well as more day-to-day operational decisions.

“How does this impact me and tell me why I need to be involved?”

“I really have no idea how any of these issues will impact me.”

“I want to know why we are doing what we are doing.”

Providers receive significant amounts of communication on a daily basis regarding updates, changes to operational practices, and larger strategic issues. For the frontline clinical provider during a busy clinical day, it is crucial to spell out how these issues will affect providers and their patients. One provider cited the recent communication around measles outbreak, which included electronic communication from leadership, followed by a clinical “toolkit” and then reiteration in person during daily clinic huddle. In the case, the “why” was very clear. In other cases, the rationale behind decisions is not clear to front line providers. Some providers mentioned “metrics” that they understood were a goal to meet but without having a clear understanding for how meeting this goal would advance patient care on an individual or population level or advance the overall mission of the organization.

“I wish that I could hear more, what are the major strategic goals, what are the challenges? I'd like to hear more”.

“Lack of detail is more anxiety provoking”

Nearly every provider interviewed wanted more information rather than less but at the same time, many recognized the barrage of low yield communications that makes it difficult to sort the wheat from the chafe. However, most providers quickly identified issues such as PDC alignment and transition to value-based care as major strategic issues affecting Duke Health in the near future. Knowing that substantial changes are coming without understanding the organization’s plans (and
rationale for those plans) contributes feels of significant uncertainty for providers and adversely affects provider well-being.

“I want honesty. Be upfront and don’t pretend you’re enlightening me when you’re only giving me half the story”.

“Communication should be clear and simple and it doesn’t necessarily have to be delivered by the highest levels of leadership as long as the message is honest and consistent.”

Providers want health system leadership to be as honest as possible about the challenges and opportunities that changes in health care will bring to Duke Health. At the same time, providers recognized that some information might be privileged, particularly as certain issues developed. Providers want as much information as possible but also want to know if certain information is unavailable and why. As mentioned above, most providers quickly and correctly identify major strategic issues and are aware to some extent of potential changes. When communication is perceived as agenda driven and incomplete, providers lose trust in the organization and subsequent messages. Conversely, one provider cited the recent NIH penalty settlement communication as an example of well-done, consistent and honest communication about a difficult and complex topic.

“I hear rumors but I don’t know the details and I don’t understand them. I wish I could understand them within the context of Duke primary care”.

“Some people are getting the rationale that must be where the rumors come from”

Sources of communication also contribute providers’ feelings about lack of transparency. Multiple providers remarked on hearing “rumors” about developments in key strategic issues such as PDC alignment. Providers remarked on the assumption that “somebody” must be getting information that they were not hearing directly. Without clear, open and foresight communication from designated trusted sources, providers assume that they are left out of the loop either carelessly or deliberately when neither may be case.

“I don’t feel that leadership comes out to see what things are like in the trenches. I would like them to understand the challenges that we face every day”.

The desire for transparency and honest communication was not unidirectional. Several providers expressed frustration that leadership did not understand the “on the ground” reality. When asked if they would like to be able to give feedback or ideas to senior leadership, most providers indicated yes but the method varied. One provider posited a “Slack-like” (online platform) where bidirectional communication with senior leadership could be an option. Others preferred that ideas or feedback be carried up the hierarchy from lower levels of leadership to senior leadership but in a way that allowed providers to know that information would be passed on. Still others preferred small group meetings hosting senior leadership to discuss strategic issues and have the opportunity for questions and suggestions.
3.3.5 Overall Opinion of Strategic Communication

When looking critically at the results of the interviews, interviewees felt unenthusiastic about overall strategic communication. Overall, strategic communication, in this context, includes all forms of message delivery (i.e. email, departmental/divisional meetings, newsletters, websites, etc.) from leadership in regards to important DukeHealth strategy. The most objective data obtained, interviewee rating of strategic communication (Appendix A, Topic 3, Question 6), resulted in an average score of six on a 1-10 scale. Advanced Practice Provider ratings were slightly better than MD’s (7 vs. 5.8) and MD’s with leadership positions had only slightly higher opinions (7). Years of service in the Duke University Health System had only a minimal positive impact in interviewee's rating of strategic communications (Figure 4).

Subjective evaluation of all 21 interviews yields the same relative opinion, neither pleased nor significantly displeased with the current state. One occasional bright spot, revolved around the communications approach for PDC/DUH Alignment. While there still is much angst and uncertainty about this issue, interviewees have noted the personal engagement of leadership at departmental/divisional/faculty meetings combined with pointed emails about particular parts of the merger (pay and retirement changes) to be clear, concise and effective. Despite these positives, many of the interviewees did not feel as though they had a firm understanding of the individual impact, why now or long-term effects of alignment.

“However, with PDC integration, lots of communication with different levels of detail from different sources has been helpful – complimentary communication rather than redundant.”
Email communication is generally viewed in a negative light. Common complaints consist of sheer volume, long-form prosaic style, vague or unrelated to providers’ specific situation, and unidirectionality. General interviewee recommendations to improve email addressed these complaints by: targeting particular faculty with particular email communication, which are directly germane to their practice or interests, providing a bulleted format with the potential for links to more detailed information, minimization of redundancy by reducing sources of email. Despite the relative distaste for email, there is a sense of its general usefulness and role in communication.

“In general, sending out an email to cover an important topic is not ideal. I spend a lot of time on email but I don’t find it as effective.”

Routinely positive opinions of communication revolve around personal, individualized and sectionally directed efforts. Departmental and divisional meetings where individuals have come to present and discuss, or messages relayed from chiefs and chairs are seen in an optimistic light. Reasons for this positivity centered on two-way communication, questions and answers, group discussions, and peer interactions for important strategic issues. However, there is some concern of dilution or messenger translation of the information if given by a third party and not leadership itself.

“Ideally information is given at faculty meetings with chairs and division heads. This way leadership and the health system are aligned or can be discussed. Additionally, questions can be asked by our peers and we can learn what questions they may have.”

While most respondents have not interacted directly with or provided feed to senior leadership, the vast majority of interviewees felt that they would like to be able to do so. The idea of two-way communication was strongly viewed as a beneficial aspect of good communication. Some of the perceived limitations to that were lack of clarity in who to communicate to, concern that leadership would not listen, and fear of retribution.

“I’ve never communicated directly with senior leadership but I would like to speak with them.”

“I have never had a chance to convey my thoughts to senior leadership. I do not have a sense of who is in charge.”

“At Duke it could be better to go under the radar so you need to be careful what you say.”

There is a consistently negative sense as to what are the missions, goals, strategy and unified vision of the PDC. It appears very unclear to faculty that one hand knows what the other is doing. The siloed approach that we have had for years has led to disjointed interactions and planning without a clear mindset of how Duke and the PDC are moving forward. As examples interviewees discussed: 1) How divisional hires in urology would likely impact the need for pathologists and radiologists but this is not communicated to those departments for optimal planning, or 2) How the Department of Radiology had a yearlong initiative to improve and provide outpatient imaging in Wake County only to be called off at the last minute without explanation.
3.3.6 Pet Peeves and Suggestions/Recommendations

As part of the interview, script participants were asked to describe their “pet peeves” or biggest concerns about the current state of communication, as well as any suggestions or recommendations that they had for improving communication. In general, as described in discussion about themes above, concerns related to means of communication, time for communication, directionality of communication, and function of communication. Similarly, the suggestions were targeted towards addressing these concerns.

Means of Communication: A common concern articulated was the use of email as a primary mechanism of communication given that providers already feel overwhelmed with electronic written material. Suggestions included providing communication from trusted leaders and pairing that with information summaries such as white papers that summarize particular issues and then backing that up with personalized communication. New technology was brought up as a means to improving communication, either using a video format for communication of important topics or using collaboration software such as Slack. Using a toolkit approach paired with dissemination of a common message from senior to local leaders was also described as a coordinated approach that could be successful.

Directionality: Overall, there was a concern that communication too often was uni-directional. Messages came from leadership without effective means of response. In addition, there was concern that there not effective or efficient means for important information to be shared with senior leaders. Suggestions included implementing a communication hierarchy that allowed for information from providers on the front lines to be shared with local leadership and then moved up the hierarchy.

Orientation: Several providers described the challenge of prioritizing communication messages. They described being disoriented and not knowing how to situate a particular issue and understand how it fit into their daily clinical work. Suggestions included providing high-level context and having transparency regarding communications about major initiatives and issues. In particular pairing high-level context communication with local messaging was described as an integrated approach to creating relevant communication.

Time: Time was frequently cited as a barrier to effective communication. Providers described not having time to participate in town halls or not having time to keep up with email as barriers to communication. Suggestions included providing local leaders with pertinent information that they could share during protected time. Several providers pointed to protecting time on a regular basis, monthly, quarterly, or twice a year, for critical conversations as a potential strategy.

Biggest Concerns: representative quotes

“There is no good way for great ideas to be disseminated up the leadership ladder.”

“What is the elevator pitch because I still don’t know it and I have been at Duke for 14 years”

“Policies made for people strapped for time who don’t have time to do them are an example of administrative resources not being paired with bedside resources.”
“My pet peeve is all the filler. My attention span is not great.”

“I There is too much secrecy … It would be great if they could communicate more directly regarding reasons why, what we plan to gain or lose, the various choices, who are the stakeholders, and then if we could have some additional corroboration”

“The biggest [problem] is when we are only contacted when there is a problem so no relationship building.”

“Bad communication has occurred when the info has been last minute or after-the-fact via email. This is one way information and the late information sends the message that your opinion doesn’t matter.”

Suggestions: representative quotes

“The quality of the message has become much more polished with “toolkits” often prepared and delivered in combination with a personalized communication via the “daily huddle”. This multi-modality approach is highly effective and includes a polished message from leadership and then the same message delivered from local representatives.”

“I feel that level of detail should vary depending on the topic and receiver and I suggest a combination of “bullet points” and higher-level detailed documents such as a “white paper report”

“It would be nice to have an annual or semi-annual opportunity to engage on a more personal level with senior leadership.”

“Within our group we make it work by setting times to address certain things, so like having an hour dedicated towards a specific thing and so having space and time for focused discussions. So if the department or division had info sessions about the issue and we target groups to meet and discuss in smaller setting. Putting time towards this would be very helpful.”

“In my high school had a morning report. Which was a brief to the point update and you could see it each day. Something like a daily video that is brief and then with links to more details. This worked really well. Could go to people’s phones.”

“Maybe this is millennial but collaboration via Slack or other technology with ongoing chats.”

“Best method of communication is in person potential by a proxy with monthly updates on important issues. There needs to be discreet blocks of protected time to review info that is provided via video, webinar, WebEx. Time is the biggest barrier especially for clinical providers, emails are very low on the list and there is no incentive to follow through on them.”
3.4 Email burden

As part of examining the current state of communication for DukeHealth providers, email communication was identified as a central means of strategic communication. Email also was noted to be a particularly challenging means of communication for clinical providers given the perceived volume and density of email communication. To better characterize the types of system level emails that are received by clinical providers the DCLP team tracked our own emails over a 1-week period in February.

Emails were collected; counts were generated by day and provider, and were categorized as related to education (such as medical student or GME), training (i.e. class for providers), local announcement (new menu in cafeteria), system announcement, and important local (major local announcement). In addition, we indicated if each email was read or unread.

Table 2 contains a basic description of the 220 emails received by the six providers from one week with the local announcements accounting for 45% of all emails. Only one third of the emails were read with the education updates and system announcements being read at the highest rates. Figure 5 and Figure 6 contain charts that summarize the daily email rates in aggregate and the mean number per provider per day. Figure 7 is a graphic representation of the broad email subjects and Figure 8 provides a graphic summary of words found in providers emails.

<table>
<thead>
<tr>
<th>Table 2. Description of emails</th>
<th>N(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of providers</td>
<td>6</td>
</tr>
<tr>
<td>Time period of emails</td>
<td>7 days</td>
</tr>
<tr>
<td>Number of total emails</td>
<td>220</td>
</tr>
<tr>
<td>Mean emails per weekday</td>
<td>7</td>
</tr>
<tr>
<td>Number of emails read</td>
<td>75 (34%)</td>
</tr>
<tr>
<td>Number of emails per category</td>
<td></td>
</tr>
<tr>
<td>Education Update</td>
<td>19 (8.5%)</td>
</tr>
<tr>
<td>Local Announcement</td>
<td>99 (45%)</td>
</tr>
<tr>
<td>Important Local</td>
<td>1 (0.5%)</td>
</tr>
<tr>
<td>System Announcement</td>
<td>53 (24%)</td>
</tr>
<tr>
<td>Training</td>
<td>48 (22%)</td>
</tr>
<tr>
<td>Number of emails UNREAD per category</td>
<td></td>
</tr>
<tr>
<td>Education Update</td>
<td>10/19 (52%)</td>
</tr>
<tr>
<td>Local Announcement</td>
<td>1/1 (100%)</td>
</tr>
<tr>
<td>Important Local</td>
<td>62/99 (63%)</td>
</tr>
<tr>
<td>System Announcement</td>
<td>33/53 (62%)</td>
</tr>
<tr>
<td>Training</td>
<td>34/48 (71%)</td>
</tr>
</tbody>
</table>

Figure 5. Aggregate number of daily emails from DukeHealth to six providers

Figure 6. Average daily provider email burden from DukeHealth
In summary, in one-week members of the DCLP team received approximately seven emails per workday from different sections of DukeHealth. These announcements often went unread. While this is not meant to be a representative sample, one theme that emerges when looking at this data is that the level of email burden is distracting and it is hard for clinical providers to determine which emails are to be prioritized. We did not examine duplication explicitly, but that is another anecdotal concern regarding the lack of coordination of emails across different entities across the system.

Figure 7. Email subjects

- Important Local
- Local Announcement
- System Announcement
- Training
- Update
- Education

Figure 8. Graphic summary of words in subject of one week’s worth of emails
4.0 RISKS AND ALTERNATIVES

- Inaction would permit perpetuation of status quo. As evidenced by our interviewee ratings from our in-depth interviews, the status quo is not optimal. To be best in class we need to go beyond our current state, thereby making inaction unacceptable.

- Through speaking with leadership, providers and within our DCLP group, several suggestions and options arose.
  - Email optimization was an initial early focus. Ideas such as color coding and standardized timing were discussed and reviewed. Email is clearly part of the future of our communication but is considered ineffectual as a sole method to correct the current state. Email lacks the personalization that providers desire, and given the present volume and redundancy, is often ignored. However, leveraging the tiered email system that already exists within the different entities and adding adjustments like color-coding and timing could revitalize this communication channel regardless of any future innovations.
  - Technologic solutions such as social media utilization or smartphone App creation were considered. Use of an app would allow the ability for push notifications for passive users of the app who can then be primed to specifically seek the information pushed out by the app. This would involve significant strategy around what providers want to know and at what intervals. These technology solutions may also risk leaving out a large portion of our providers given the discrepancy of technology uptake and engagement, thereby rendering technologic solutions inappropriate at this time.

- Current recommendations as outlined below require multimodal approaches and personalization of the message. There is not a one quick fix given the complexity of communication and the diversity of the needs and interests of the stakeholders. The above alternatives can be incorporated as part of the process but cannot be standalone fixes and therefore are individually rejected.

5.0 RECOMMENDATIONS

Because of this analysis, we have identified an overall goal of creating a clinical strategic communication process that follows “the 4 rights” by providing the RIGHT message to the RIGHT person at the RIGHT time from the RIGHT source. This goal is aspirational and the recommendations below are designed as steps towards improving strategic communication across DukeHealth at Duke. The ultimate goal is to focus on the process of communication, not just the delivery of a particular message.

In order to achieve this goal, the DCLP Team has made several recommendations to move toward provider-centered coordination:

1. Prioritize development of clear strategic communication messages and materials
2. Implement a DukeHealth communication structure to unify clinical strategic communication
3. Prioritize personalization of communication and transparency
   a. Utilize existing leadership structures to personalize message through increased visibility of senior leadership within clinical settings
   b. Provide clear communication on processes
4. Provide more opportunities for bidirectional communication
5. Develop strategy to monitor receipt of messages by clinical providers
6. Provide training for leadership at all levels on communication and relationship building

**Specific recommendations**

1) **Prioritize development of clear strategic communication messages and materials**
   - For each top strategic goal, there is the need for a consistent process for the creation of a clear message that can be shared through multiple venues/formats.
     - A process for creating a unified message:
       - would involve senior leadership identification of a strategic goal
       - clarification of message with a range of DukeHealth communication personnel
     - For each strategic goal a set of materials/talking points would be developed
       - Communication materials related to each strategic goal would be developed that could then be disseminated
       - Communication materials could be used by leaders across the institution including senior leaders and local leaders to provide a consistent message
       - Materials could be disseminated in a range of multi-media formats as well as part of presentations

2) **Implement a DukeHealth communication structure to unify clinical strategic communication**
   - Implement a unified communication structure to link all entities within DukeHealth to ensure provider-centered communication (Figure 9).
     - Central DukeHealth strategic and communication leadership should organize messaging around important strategic issues
     - Central DukeHealth communication leadership should coordinate directly with other components (e.g. DUH, DRH, DPC, PDC or successor) to ensure consistency in messaging
     - Communications leadership and senior strategic leadership of component entities should then tailor message to their specific areas
     - A communications cascade process or hierarchy would be implemented to promote dissemination of this information by leaders throughout the health system to frontline providers.
     - Example of communication cascade:
       - Goal: Senior DukeHealth leadership want to communicate about Value Based Care to the Department of Medicine Faculty. They would communicate with the Chair of Medicine regarding strategy around Value Based Care (VBC). Chair then communicates with division chiefs. Division chief’s communication with section chiefs, particularly in large divisions such as General Internal Medicine. Section chiefs should then communicate with front line providers.
Messages created with appropriate materials by communication staff would allow for a coordinated central DukeHealth leadership message. Chairs, division chiefs and section chiefs should work with their local communications staff to ensure that messaging remains consistent while still addressing how VBC will affect each individual section.

- To facilitate the communication cascade resources, are needed. Leaders at all levels need protected time to receive training regarding effective communication and have time to devote to providing local updates as part of the communication cascade process.

- This same communication structure could be used for all channels of communication (emails, blog posts, newsletters)

**Figure 9. Provider centered communication**

3) **Personalize communication and transparency**

- Utilize existing leadership structures to personalize message as described above, using local leaders to share and personalize messages
- Increase visibility of senior leadership within clinical settings
  - Strong efforts need to be made to create a sense of personal interaction between leadership and providers
  - Continued participation in Departmental / Divisional meetings
  - Explanation of Leaders goals, initiatives and plans within their purview
    - Personal engagement and interaction will allow faculty to feel closer connection to senior leaders, facilitating engagement with future messages
  - Providers are more likely to engage with communication if they know who it is coming from, what their roles are, and why this issue is important to this leader
- Provide clear communication on decision making processes
- Transparency is a value
  - Multiple sides of issues need to be presented.
Information regarding the processes that result in decision-making is of interest to providers.

Minutes or Bullet-pointed take home points from leadership meeting should be available and pushed out
- Example: Minutes from PDC Board meetings emailed or posted for review

- When there are important issues or rationale behind plans that cannot be divulged due to legal or competitive ramifications this should be shared.

- Providers believe leadership has our best interests at heart and will likely be understanding of limitations for the above reasons.

- Bi-annual or Quarterly Update from Leadership
  - This should be overarching big picture goals and could be sent out via a bullet pointed email with links for detailed information as well as with follow-up communication using the cascade process
  - Materials such as a slide deck or talking points to be created by communication team and then communicated through Departmental meetings and then brought out to more local / departmental / divisional meetings

4) Provide opportunities for bidirectional communication

- Provide mechanism for providers to share local updates or concerns to senior leadership.
  - Specific mechanisms should be explored to promote the bidirectional communication as a means of engagement.
  - Similar to the huddles being used in the Commit to Zero initiative, strategic priority huddles or a similar process could be employed via local leaders.
- Provide clear mechanisms for local leaders to bring forward concerns of providers in their area.

5) Develop strategy to monitor quality and quantity as experienced by clinical providers

- Monitoring quality of communication received by clinical providers is essential to success
  - A process for routinely surveying providers either using interviews, focus groups or electronic surveys should be used to monitor the perception of the quality of communication from the perspective of clinical providers.
- Monitoring quantity communication received by clinical providers is essential to success
  - A process for sampling the number and type of emails received by clinical providers should be developed to monitor on a monthly basis the nature and type of system level communication
  - Target efforts to reduce redundancy of email communication should be undertaken
  - A process for monitoring the number and type of strategic content received by clinical providers regarding key strategic priorities should be developed to track the effectiveness of the clinical cascade and other communication methods

6) Provide training for leadership on communication and relationship building strategies within their teams.

- There are specific training classes within Duke Health for which new managers or leaders in some entities are required to attend. However, leaders that have been in their positions for
longer periods may not be required to take these classes since they are not necessarily new leaders.

- An example is the managing at Duke Class series that provider leadership and management tools as well as strategic mission communications. It is assumed that everyone in a leadership position within the health system has these skill sets and has information to access these resources. However, this is not necessarily true.
  - Provide a yearly opportunity for each level of leadership to have a full day wherein strategic mission, leadership tool kits, management resources etc. can be shared and leaders can have questions or concerns addressed by senior leadership.
  - Provide at the elbow support from communication professionals for guidance and feedback to leaders as this communications infrastructure is implemented.

It should be noted that the DukeHealth leadership task force on communications has noted a number of similar themes in their interviews with leadership members across the health system. These findings and their parallels will provide a cohesive set of goals and objectives for DukeHealth going forward.

6.0 NEXT STEPS AND KEY ELEMENTS FOR SUCCESS

In order to implement this vision of intentional transparent communications, the first step is reorganizing the current communication infrastructure and expectations among key communicators. Without first providing the structure for communication coordination and training for key communicators, efforts to coordinate messaging will not succeed. Once there is a clear communication structure for coordinating messages, the next step would be to evaluate the expected communicators and implement additional support, education and resources for them to be successful in communication. This will also likely require direct effort from these leader-communicators. Having more face time with senior leadership for all providers can start at any point in the process with senior leadership dedicating scheduled time to visiting providers at various sites. These recommendations can be enacted at any time. With the upcoming potential PDC alignment, this may be a perfect opportunity to reorganize the structure. Success in optimizing communications should be measured in a number of ways. First, provider satisfaction with communication can be gleaned from Culture Pulse surveys, although this tracks to the local leadership more than senior leadership. Dedicated surveys after changes would be needed to assess more senior leadership communication initiatives or a repeat of these structured interviews could be used to assess more opportunities for improvement. On a more local scale, as supported by the employee interviews above, poor communication contributes to feelings of unimportance, anxiety and dissatisfaction. Improvement in provider burnout and turnover would also be considered a measure of success.

Dedicating time and resources to improving communication will certainly involve an upfront cost in terms of work hours for communication staff and as well as percent effort for communicators. Enhanced training and support will also require financial resources. Putting resources of time and money into optimizing communication will also pay dividends in terms of employee satisfaction,
decreased burnout and turnover. Using methodology from Shanafelt et al. \(^1\), the table below shows the potential return on investment for scenarios assuming different rates of burnout reduction and different intervention costs. National mean for burnout rates (50%) and turnover rates (7%) as well as a conservative estimate for the cost of physician turnover ($500,000) were used for calculation and number of physicians at risk at Duke was the number available clinically in Duke Health database. These numbers were chosen for conservative estimates – better communication is likely to improve burnout among nonclinical MDs as well as advanced practice providers and these numbers underestimate this. These calculations could easily be replicated with internal data on turnover and burnout if available.

### Table 3. Return on Investment for different levels of intervention as a function of decreased burnout from improved communications

<table>
<thead>
<tr>
<th>Cost of intervention in dollars</th>
<th>Estimated reduction in BO</th>
<th>Estimated ROI (%)</th>
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<tr>
<td>100,000</td>
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</table>

7.0 ACKNOWLEDGEMENTS

We would like to acknowledge Joe Rogers, MD, David Attarian, MD, and Geelea Seafor for their project proposal, guidance and oversight.

We would like to acknowledge Anne Brumbaugh, PhD for her knowledge, input and mentorship on structured interview creation, implementation and analysis.

We would like to acknowledge Mira Brancu, PhD for her assistance in bringing our group together and keeping us on track.

We would like to acknowledge the clinicians and communication experts who were willing to be interviewed and willing to share their knowledge of the current state of affairs.
8.0 APPENDIX

8.1 Appendix A – Structured interview template

**Topic 1: Introduction, identify strategic issues of importance to respondent (4 minutes)**

**Goal:** Identify broad topic of interview, get permission to interview, and anchor respondent on issues of strategic importance.

*Hi, I’m XXXX in the YYYY department and I’m conducting this interview as part of a Duke Clinical Leadership Project. Thank you so much for participating – I’ll get you out of here in 30 minutes. It would be helpful if I could record this interview – is that OK? All your feedback will be anonymous and never linked back to you personally.*

*Our project is looking into how senior leadership communicates with providers about important strategic issues facing Duke Health and how providers may provide feedback back to senior leadership. Senior leadership includes people like Joe Rogers, John Sampson, and Tom Owens.*

1. **What do you think are some of the most important strategic issues facing Duke Health?**

*Note:* Write down the order in which they mention them. This indicates how important, salient, and top of mind they are.

- If they mentioned one not on your list: *Tell me more about* [pick the first one they mentioned one not on your list as it’s most salient/important to them].

- If they mentioned one on your list: *Tell me more about* [pick the first one they mentioned on your list].

2. **Some people think that value-based care, population health, PDC integration, and pending NP independent practice legislation are crucial issues that Duke is now grappling with.**

*Do any of these resonate with you as major issues affecting Duke Health?*

*Note:* Write down the order in which they mention them. This indicates how important, salient, and top of mind they are.
• For the first one they mention if not discussed above: What impact do you think [first one not discussed] is having/will have on Duke health?

• How has it affected you and what you do here at Duke?

**Topic 2: Current modes of getting information on strategically important issues and satisfaction with modes (8 minutes)**

**Goal:** Have participants identify how they currently get information from senior leadership on strategic issues facing Duke and assess their satisfaction with them.

3. **Think back over the past six months or so. How have you received information about important strategic issues from senior leadership?**

   If they have (they may perceive they’ve received no information here):

   • *Can you give me an example of communication from senior leadership on an important issue that you thought was really good – right way of getting you the information, level of detail, information you needed, timing? What about it worked for you?*

   • *Can you give me an example that was really bad – wrong communication channel, not enough detail, not timely, etc.? What about it didn’t work for you?*

   If they perceive that they have not:

   • *Interesting. How do you stay on top of important strategy issues like these?*

   **Note** whether sources are internal to Duke or external (journals, news, etc.).

4. **Senior leadership could communicate with providers in any number of ways – via town hall meetings, videos, email, newsletters, briefings with chairs/division chiefs/sections that are expected to be shared with providers, etc.**

   • *What method would most get your attention – what would most likely make you sit up and listen? What about that method makes it so effective for you?*
• What method would be least effective for you – you would either not engage with it (for example, ignoring emails) or it just doesn’t have much punch or credibility? What about that method makes it so ineffective for you?

5. Communication is a two-way street not only from senior leadership to providers, but also from providers to senior leadership.

• When was the last time you were able to connect with senior leadership and convey your thought on important strategic issues to them? Tell me about that.

If there was a time, probe for when that was, what circumstances, and what they told leadership.

If they can’t recall one: Would you like to have an opportunity to do so?

If yes: What would that opportunity look like? Who would you want to talk to? What would you want them to know?

If no: Interesting, tell me more about why you wouldn’t want to do that.

Topic 3: Satisfaction with quality and quantity of communication from senior leadership on these issues (5 minutes)

Goal: Delve more deeply into (dis)satisfaction with communication about these issues.

6. Again, think back over the past six months or so and information you’ve received from senior leadership about these important issues. Overall, on a scale from 1 to 10 with 1 being very dissatisfied and 10 being very satisfied, how satisfied are you with the quantity and quality of the information you’ve receive?

• Base follow-up on number given.

  o If 7-10: That’s not bad. What in particular has been working well for you?

  o If 4-6: That’s kind of meh. It sounds like there are some good aspects of their communication and some bad aspects. What’s been working for you?

    What’s not been working for you?
7. **What is your biggest pet peeve overall regarding communication between senior leadership and providers on these important issues?**

- What could be done to resolve that for you?

**Topic 4: Gain insight on what respondent needs/wants (10 minutes)**

**Goal:** Generate open-ended data on what works and what doesn’t

8. **Imagine you were in charge of the communication link between senior leadership and your provider peers and that you had a magic wand and could make anything happen. What would communication between senior leadership and you and your peers look like?**

If respondent doesn’t specifically mention these, probe for each as time permits.

- How often would be ideal for you to hear from senior leadership on these issues?
- Is it senior leadership who is sharing the information or someone else – who?
- What channel is the information coming from – in person, email, video – how?
- What level of detail is ideal? Is it “white-paper” level detail or “bullet points” level detail?
- How do get your feedback back up the leadership chain so you can be heard?

9. **Ok, let’s say your wand worked and the perfect communication system that you wanted exists. You’ll now receive the right type of information on important strategic issues from the right people, in the medium you prefer, and on the frequency you prefer, and there’s a feedback mechanism that would allow you to voice your views.**

- How would that affect what you do at Duke Health?
- How would that affect what you think of the organization?
- How would that affect your opinion of senior leadership?

**Wrap up (3 minutes):**
We’re doing this project to help define and improve the communication between providers and senior leadership about key issues affecting the health system. What else would you like senior leadership to know about your needs in terms of communication on important issues?