Sharing the Quality Agenda with Physicians

Physicians drive what hospitals do. Physicians write the orders that direct the services of nurses, pharmacists, technicians and support staff. Further, their authority for clinical quality is recognized in the hospital's bylaws, in which the board delegates responsibility for quality of care to the organized medical staff. In other words, the connection between physicians and hospital quality of care is fundamental to health care organizational success—now more than ever.

Yet, recent characterizations of the relationships between hospitals and their physicians range from "not a pretty picture" and "rapidly deteriorating,"[1] to "under greater strain" to "directly competitive."[2] The medical staff organization is seen by some as a moribund, "persistent anomaly,"[3] even as others find hope for improved hospital quality from measuring the performance of their "extended medical staff," which includes physicians who never set foot in the building but merely refer to the institution.[4] Still others argue that the best health care quality will come from tightly integrated physician-hospital organizations.[5]

Hospitals employ a variety of strategies to bond with physicians. Some institutions are winnowing their medical staffs to include only the most loyal physicians through economic credentialing and conflict-of-interest disclosures. Others aim to increase physicians' revenues through joint ventures, gainsharing and medical directorships. While these strategies may help strengthen the hospital-physician relationship in the short term, focusing on a deeply held purpose that physicians and hospitals share—improving quality and safety for patients—leads to a broader, more sustainable relationship.

This approach is more fully developed in a new Institute for Healthcare Improvement (IHI) Innovation White Paper, *Engaging Physicians in a Shared Quality Agenda,* which offers a framework to develop a detailed plan for engaging with physicians around quality. The purpose of this article is to further develop the specific role of the board in fostering medical staff engagement, beyond the IHI framework.

Whether the medical staff organization is the best vehicle for working with physicians to improve the hospital's quality and business results probably depends on the specific context. In some situations, joint business ventures and other structural and financial strategies might be very important to building more effective physician-hospital working relations.

But there is no situation in which the passionate engagement of physicians around quality is not a key to improved hospital quality performance. And the significance of the hospital's board

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in making this happen cannot be overstated.

A growing body of evidence indicates that boards play a powerful role in the quality of care delivered by hospitals.[6] How can this be? Boards don't deliver care directly, and most trustees are not clinicians.

The answer is that boards influence quality by sending signals—signals that channel the attention of executive and physician leaders, demonstrate the will to make needed changes, and influence the culture of the entire hospital.

When boards ask medical staff leaders probing questions about the risks of harm in their hospital, when they insist on useful, timely data on quality and safety, when they uphold key hospital safety policies, even when one or two prominent physicians disagree, and when they set bold aims for improvement, boards send powerful signals that can drive change. Of course, if trustees accept confusing data, waffle on key policies, or adopt vague, tepid aims, they are sending decidedly different signals.

The point is, the signals the board sends are critical to quality and safety and to the medical staff's engagement in efforts to improve care.

> **To initiate, support, sustain, foster and build a deeply quality-driven hospital culture, the board's involvement is critical, and physicians must be their primary partners and collaborators.**

Discovering a Common Purpose

A commonly heard lament among hospital administrators is, "If only we could engage the doctors in our quality agenda, we would get results." And when asked, "What results are you trying to accomplish?" the answers are typically framed as: "Bring up our CMS (Centers for Medicare and Medicaid Services) Core Measures to the top 20th percentile in the state" or "Reduce length of stay by 0.4 days." Often, the board adopts such aims and expects management to achieve them as part of the organization's annual quality plan.

There is nothing intrinsically wrong with these aims. Their purpose is admirable; but aims like "improve CMS scores" do not engage the hearts of physicians. The IHI "Engaging Physicians" framework suggests, instead, a fundamental shift in how hospitals frame their quality aims. The IHI's approach encourages boards to ask: "How can the hospital engage in the physicians' quality agenda?"

"Physicians' quality agenda" is not an oxymoron. Physicians care deeply about what happens to their patients—enhancing positive outcomes of care, such as prompt recovery and restoration of function, as well as preventing negative outcomes such as complications and sentinel events. They feel personally responsible for these outcomes as professionals, and their reputation and sense of their own excellence are deeply dependent on achieving good outcomes.

Doctors also care about time—particularly anything that wastes their or their patients' time, such as delays in lab results, waiting to admit a patient to the right unit, or snafus in operating room schedules. They are generally receptive to changes that they believe will reduce wasted time, both for themselves and for their patients—and they will spend some of that precious recaptured time with their patients, which may also contribute to improved quality.

These two elements—better patient outcomes and less wasted time—lie at the core of the physicians' quality agenda. Hospital and health system administrators (and trustees) who frame quality around these elements will have a much better chance of engaging physicians.

And not surprisingly, once administrators and doctors start working effectively on the outcomes/time agenda, it is highly likely that the hospital will start to look better on its CMS scores, and the hospital's lengths of stay will drop accordingly.

It is important for executive and board leaders to recognize that this new way of framing is not a trick, or some sort of "bait and switch" technique. Rather, it is about finding the common purpose at the heart of the professional mission of both doctors and hospitals: better care for patients.

Essential First Steps

To design an effective approach to medical staff engagement with quality, the most critical first step is to make a realistic assessment of the specific hospital-physician context. A host of factors influence the degree of difficulty associated with achieving enthusiastic physician involvement. The extent to which physicians are employed by the hospital, admit to other facilities, or are affiliated by virtue of a recent merger or acquisition can define vastly different contexts.

Also, the currency of the medical staff bylaws and how well they reflect the way the medical staff actually functions can inform how likely it will be for successful future physician engagement. In addition, the medical staff organization can be useful as the mechanism for change. A realistic assessment of the extent of the board's own commitment to improving quality is also essential. The IHI White Paper contains a scoring tool that can be used for this assessment.

Other factors may also be in play—for example, recent battles over exclusive contracts, cross-departmental turf fights, or unsuccessful managed care strategies. Once there is a good understanding of the physician-hospital history and culture, it becomes easier to design specific engagement initiatives to address the needs of defined segments of the medical staff.

Even though there may be one "medical staff organization," physicians' particular needs, both in improving quality and in meeting their own business demands, will vary among cardiologists, neurosurgeons, general internists, orthopedists and oncologists. What engages one group may not interest another. Developing a menu of engagement options for different specialties is important for achieving a broad positive response.

Tactical Choices

Findings from the assessment can provide a "road map" of potential choices. To develop practical initiatives, it's important to marshal the opportunities and limitations in the Stark and antikickback statutes. While financially driven strategies may have a role in engaging physicians in a quality plan, there are other opportunities available under these laws, and not all of them entail paying physicians.

These additional opportunities include clinical integration under the antitrust laws where otherwise competing physicians work together on quality strategies,[7] more physician education on evidence-based medicine and reimbursement, as well as providing physicians with electronic health record software. (Stark Phase III regulations have made the last option much more complicated.)

All of these strategies are financially beneficial for physicians and all comply with the law. But their driving purpose is not merely revenue enhancement to the physicians. These strategies also help hospitals achieve their quality goals.[8]

In some instances, the cultural assessment may make it clear that quick, visible success in meeting physicians' needs is more urgent than an initial concentration on building a long-term relationship. For example, standing order sets and other process improvements developed collaboratively among community physicians and hospital nurses in the emergency department or the coronary care unit may give internists and cardiologists precious recaptured time, as it did at Park Nicollet Health Services in Minneapolis. But such a change will mean little to the surgeons who would prefer to build their own ambulatory surgery center rather than struggle any longer with the hospital's inefficiencies. For them, a joint venture may be the most useful initial step.

And for primary care physicians, who may still carry the scars of a failed managed care strategy, acting as a staffing agency to lease nurse practitioners to physician practices to work with them on a part-time basis for whose services they can bill Medicare, may go far in providing a foundation on which to build more sophisticated quality initiatives.

Understand that multiple approaches may be necessary to build relationships with different types of physicians, and that a carefully segmented approach based on the cultural assessment may produce stronger overall quality improvement results than a "one-size-fits-all" approach.

Conversations About Quality Data

Lay trustees are often frustrated with the quality and safety data they review, and their frustration is compounded when members of the medical staff discount the data with comments such as "The measures aren't properly risk-adjusted" or "That measure really isn't clinically important at all."

How can the board let physicians know that it is serious about quality in a way that will matter to physicians, when physicians

Questions About Quality

Question	How Good Are We?	Are We Getting Better?
Data used for	Comparison with others	Improvement
Most important data requirements	Risk adjustment and comparability: This is where doctors will say, "But my patients are sicker" or "Our hospital sees different patients than theirs."	Includes timeliness, credibility and consistent operational definitions, looking at the hospital's or physicians' performance over time and using the data to guide improvement.
Measured as	Rates (e.g., central line infections per 1,000 line days)	Simple counts (e.g., the monthly count of central line infections)
Usual method of display	Rankings, in deciles, compared with 50th percentile; Red, Green, Yellow, etc.	Data over time (e.g., run charts, control charts)
Recommended frequency of board review	Annually, as part of "taking stock"	Monthly or quarterly, as part of the oversight of strategy to achieve quality aims
Best board practices	Use the best in the world, not the median performers in your state, to frame goals. Don't use these comparative measures to track performance.	Insist on improvement. Regularly engage administration and medical staff in honest dialogue on performance reports about what is needed to achieve the organization's aims.

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express such deep disagreement about the basic performance measures the board reviews?

The questions the board should be asking about quality—to the administration, to the staff and to themselves as stewards of the hospital—can be divided into two categories: "How good are we compared with others?" and "Are we getting better?" Both questions are important, but answering them requires different types of data. (See "Questions About Quality," page 16.)

Trustees will find that physicians are far more likely to quarrel with measures in the "How good are we?" column than in the "Are we getting better?" column.

Boards will generate much more light and far less heat from doctors if they focus their conversations about quality data on the right side of this table. In the process, they send a powerful signal that will resonate with physicians—that the board cares about results, not just about rankings.

Changing the conversation about quality can be difficult. To do better, inadequacies must be acknowledged at the baseline. Lay board members are often hesitant to question quality data they do not understand out of the fear of demonstrating their own ignorance.

But trustees are fiduciaries, ultimately responsible for everything that happens in the hospital. So it is important to muster the courage to ask probing questions about quality, if the board is to help forge a new culture.

Courage and Culture

The most powerful signals that boards send are those generated by the actions they take when facing serious tests. In the case of quality, a common test arises when there is controversy over a safety policy such as "full barrier precautions shall be used for all insertions of central intravenous lines."

If, despite general staff support, a few physicians strongly oppose the policy—and happen to be prominent members of the medical staff—the board's test is particularly difficult. Hospital administrators and medical staff leaders are asking the board of directors to stand behind the policy even if it means suspension of some doctors' privileges, possible legal action, and loss of hospital revenues. On the other side of the equation, patients' lives are at stake.

There is no universal recommendation for all such circumstances, but this sort of test is an extraordinarily important moment for the board in the ongoing evolution of the quality and safety culture of a hospital.

If the board "flinches," it will undermine the hard work and the resolve of the physicians and nurses who are trying to establish a safer environment for care, and it will thwart their further engagement. On the other hand, if the board stands behind the policy—despite the financial and legal risks—all those working on safety issues, including many stalwart physicians on the medical staff, will take heart because the board has sent the signal that the hospital is serious about the safety of patients' care.

Payers, regulators, and the public are all expecting hospitals to achieve significant improvements in measured quality and safety, at precisely the moment when tensions between hospitals and their medical staffs are at an all-time high.

Yet hospitals and health systems cannot optimize their clinical quality results without genuine engagement of key members of the medical staff. To initiate, support, sustain, foster and build a deeply quality-driven hospital culture, the board's involvement is critical and physicians must be their primary partners and collaborators.

How the board fulfills this fundamental purpose and finds common cause with the physicians—whose patients they both serve—is the essence of the hospital mission. It is also the most critical fulcrum to real change and potentially the most important challenge boards face.

Courage is infectious. By showing courage when tested, boards can play a powerful role in building a culture of safety and quality. **T**

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