Finding Common Cause in Quality: Confronting the Physician Engagement Challenge

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“...Like colorful Darwinian ecologies, like a coral reef, with predators and prey, territories, hierarchies, pecking orders and few rules of any kind, holding the hospital accountable for the behavior of its community physicians outside the hospital is about as realistic as holding the Lebanese government accountable for the behavior of Hezbollah.” —Jeff Goldsmith

Many frustrated physician executives might well recognize the creatures in Goldsmith’s ecosystem. Although his comment was made in the context of responding to the argument that it would be a good idea to hold a hospital accountable for the extramural quality results of its “extended medical staff”—community physicians in no formal relationship to the hospital—it could very well describe the feelings of hospital leaders trying to achieve quality results within the core activities of the hospital itself.

Few would disagree that the engagement of physicians around quality is essential to produce the improved results Americans are demanding from hospitals, and increasingly from physicians themselves. How to engage physicians in quality improvement has become a central challenge for the health care system in general, and for hospitals in particular.

The acuity of the problem is especially fierce when one considers that the November/December 2006 issue of The Physician Executive included no fewer than six articles in its special report on the debasement of physician morale, including a sobering survey reporting widespread physician loss of joy in the essentials of their work.

The challenge is well recognized, but solutions and techniques to deal with it have been largely lacking.

In a recent white paper for the Institute for Healthcare Improvement, Engaging with Physicians in A Shared Quality Agenda, we have created a six-step framework to develop an organized, custom-crafted, context-specific plan to confront this challenge. An outline of the complete framework is presented in Figure 1.

Changing the question

We have encountered many hospital leaders who express skepticism that physicians care about the hospital’s quality results, or even their own.

Other commentators focus on alignment strategies that invariably entail the hospital spending money to create joint ventures, or to pay for physicians’ time, or to construct elaborate gainsharing or product-line management programs to bond with their physicians, or even to employ some of the physicians directly.

While these methods may actually have some value as strategies within a broad engagement plan, they don’t directly address the quality pressures on either the hospital or the physicians.

At best, with respect to quality, these financial engagement strategies are a sort of “bank shot,” through which the hospital leaders hope that closer relationships will produce more physician engagement in the hospital’s quality agenda.

We believe that hospital leaders should consider reframing the engagement question. Instead of asking “How can we get doctors to engage in the hospital’s quality agenda?” they might ask “How can the hospital engage in the physicians’ quality agenda?”
Engaging Physicians in Quality and Safety

1. Discover Common Purpose:
   1.1 Improve patient outcomes
   1.2 Reduce hassles and wasted time
   1.3 Understand the organization’s culture
   1.4 Understand physician mindset
   1.5 Understand the legal opportunities and barriers

2. Reframe Values and Beliefs:
   2.1 Make physicians partners, not customers
   2.2 Promote both system and individual responsibility for quality

3. Segment the Engagement Plan:
   3.2 Identify and activate champions
   3.3 Educate and inform structural leaders
   3.4 Develop project management skills

4. Use “Engaging” Improvement Methods:
   4.1 Standardize what’s standardizable, and no more
   4.2 Generate light, not heat, with data
   4.3 Make the right thing easy to try
   4.4 Make the right thing easy to do

5. Show Courage:
   5.1 Provide backup all the way to the board

6. Engage Responsibly:
   6.1 Engage responsibly, or support those who do
   6.2 Maintain confidentiality
   6.3 Trust your leaders
   6.4 Support the process you’ve agreed to
   6.5 Value process more than structure, but…
   6.6 If structure is an impediment, change it
Physician quality agenda

Hospital leaders are worn down by battles such as:

- Endless compensation requests for on-call coverage
- Protracted privileging battles among competing groups
- Constant threats of competitive activity

Taking your temperature

One of the most critical steps to create a realistic, actionable engagement plan is to start with a brutally honest self-evaluation of the state of the physician-hospital relationship in your organization.

Many factors—structural, cultural, and historical—influence the openness of physicians to more involvement in your quality initiatives. Whether they split their admissions among hospitals in the community, whether the hospital employs them, whether the hospital has recently merged or acquired major partners or practices, the currency of the medical staff bylaws and the extent to which they actually reflect what goes on, the level of board concern about quality—all help define the organizational context for engagement.

The IHI paper contains an assessment scale that is designed to be used by a range of constituencies—senior management, physician leadership, potential physician quality champions—to obtain broad views of current barriers and opportunities and begin a real conversation about what might need to be addressed in order for engagement to improve.

The engagement of physicians around quality is essential.

They've become cynical and are understandably startled by the notion that members of their medical staff might have any agenda other than money. But much of physician focus on compensation and revenue actually is not directly about money, but rather, about the loss of time in their lives and how that affects their ability to provide high-quality care.

Because of various pressures (some self-inflicted, others beyond their control) doctors do not think they have enough time to carefully listen to, think about, guide, and teach their patients. Often they are right. Lost time makes them worry about the potential for poor outcomes of their care—misdiagnosis, complications, and even major injuries and death.

These two concerns—time and outcomes—are the core of the physicians’ quality agenda. If hospital leaders can show that working on quality and safety issues can simultaneously free up time for physicians and improve outcomes of their care, they stand a real chance of engaging physicians' hearts, not just their wallets.

The 100,000 Lives and 5 Million Lives campaigns conducted by the Institute for Healthcare Improvement demonstrate the idea of outcomes as a central aspect of the physician quality agenda.

Instead of “reduce length of stay” or “improve supply costs in surgical services” these campaigns framed their aims in ways that are intrinsically appealing to physicians: reduce preventable deaths and decrease harm. And these campaigns appeal to physicians’ quality agendas not only in their aims, but also by their methods of achieving the aims.

The campaigns do not say “and we’ll achieve these goals by making the physicians work harder, and more carefully.” Instead, they lay out a clear, practical set of process and system changes that have the potential to achieve the aims.

Over the past two years, we observed several hospitals in which the medical staff enthusiastically engaged in these campaign initiatives despite lukewarm engagement in quality in the past, or even in the presence of otherwise serious conflicts and tensions between the hospital administration and the medical staff on other issues.

The lesson here might be that if the stated purpose of the improvement work is important enough to physicians, their engagement is more likely than if you are asking them to work on what they perceive to be “the hospital’s quality agenda.” Setting the goals of improvement in terms that might appeal to physicians is no guarantee of their enthusiastic engagement. But it is a very good start.

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These are not the only issues that may be relevant in any specific institutional context. Others might include whether there have been failed managed care or PHO strategies around which the physicians still bear scars or anger, whether a formerly open department has been made subject to an exclusive contract, or how long the CEO has been in office.

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Segmenting the plan

An effective plan for physician engagement must be segmented—fit to the specific needs and roles of many different subgroups of the medical staff. It is well known that 20 percent of the members of the medical staff actually generate 80 percent of the work in a typical hospital. So your approach to this 20 percent should be different from the efforts directed at the 80 percent.

It is not that the 80 percent are unimportant: doctors who only refer and never attend in the institution can affect quality in less direct ways by the acuity of their patients’ conditions when they are admitted, for example. But it is the core 20 percent of the staff that needs the most attention, for most initiatives. And within the 20 percent, there are multiple different segments to be considered.

Segmentation entails thinking about the medical staff members and a menu of options to engage with them in terms that reflect a range of variables:

• The role you wish them to play in a given quality initiative: project leaders, champions, and “structural leaders” such as department chairs all require different approaches for optimal engagement in their specific roles.

• Specialty

• Length of their tenure with the organization

• Respect they enjoy within their peer culture

• Political position within the medical staff organization

• Volume of their admissions

Standing order sets in the cardiac care unit will save time for the cardiologists and empower nurses to take actions that save the physicians from having to disrupt office hours to come to attend to a worsening patient. These will be meaningful to the cardiologists but will do nothing for the orthopedists.

Leasing nurse practitioners on a part-time basis to oncologists to do in-hospital work with them for which they can bill, or even to family physicians to help them in their offices, will not capture the enthusiasm of the gastroenterologists.

To develop segmentation strategies, a good understanding of the Stark, anti-kickback and antitrust laws can be extremely useful. To pay physicians for the work they do for the hospital is an obvious tactic, but in the last analysis, to earn that money they must spend time doing something other than their primary work. And time is the scarce commodity they most need.

There are many other possibilities to give them back time while improving quality that can entail Stark issues, but are also legitimate.

Clinical integration, compliance training including templatized documentation, coding and billing guidance, electronic health record support are all in-kind support hospitals can give to physicians and their staffs that will save them time once implemented.8

Principles and techniques

The professional culture of physicians is strongly imprinted by their training and practice experiences. For example, physicians are taught to feel personally responsible for each individual patient’s care, and therefore place great value on their own individual autonomy in care decisions.

This sense of personal responsibility leads physicians to see any proposed change in how patients are to be cared for as a personal judgment about the care they have been providing.

And when these cultural features are combined with the natural human inclination to defend one’s professional integrity, an argument (spoken or unspoken) arises that goes something like this: “If I’m doing it this way now, what I’m doing can’t be bad, because I’m a good doctor and I’m trying hard to do the best for my patients. Therefore any change in what I’m doing now has a high risk for making things worse, not better, so we’d better be real sure before we make any changes.”

Physicians also form deep unspoken bonds with other physicians who have come through the same gauntlets as they have, and therefore give special weight to the views of those colleagues.

Those who wish to engage physicians in quality improvement need to both understand these and many other aspects of physician culture, and adopt improvement methods with improvement styles that respond and accommodate to this culture.

A few examples from the IHI paper illustrate this idea:

• Involve physicians from the beginning, and offer them access to the “raw” unpackaged data, so that you earn their trust with your own transparency.

• Make it easy to try suggested changes. Physicians are understandably defensive about the status quo. So instead of proposing a change as “the way things are going to be done from now on,” frame all proposed changes as tests—e.g. “Let’s try it this way for a week or two, and then let’s review how it’s going. If it’s not going well, let’s try something else, until we see clear evidence that it’s really better.” Even those physicians who believe that the proposed change will bring disaster will begrudgingly go along with a temporary trial, especially if others try it first.
• Use data on individual physician performance with care. Many doctors are understandably upset by “physician quality reports” that rank physicians against their peers on some process or outcome measure. Because they see such reports as judgments about their individual professional abilities, physicians often spend more energy attacking the quality of the data than on attacking the defects in their care that the data expose. A good rule for using individual physician data is “don’t display them publicly unless you’re confident that your culture is capable of using the data for improvement, rather than for judgment.”

• Choose your messengers and messages carefully. Don’t ask an internist to be the champion of a project to improve the practices of the orthopedic surgeons. Always use language that addresses how the project speaks to the physicians’ and patients’ needs and not the hospital’s.

These sorts of “engaging” improvement methods may seem basic, but are often not evident. If intentionally and steadily applied to your improvement efforts, they can earn physician enthusiasm despite many other countervailing forces.

In the end, Goldsmith’s coral reef—with its “survival of the meanest” dynamics—presents a bleak picture of the prospects for physicians and hospitals to work together to improve quality of patient care. While his view is grounded in a number of hard realities, we believe it underestimates the deep desire of many physicians to address things that go wrong in their practices and at the hospital, to improve the care for their patients.

The dynamics between hospitals and physicians can change. A number of community hospitals, with independent medical staffs, fierce competition, and all of the other tensions of Goldsmith’s reef, are achieving stunning improvements in reliability of evidence-based care, patient safety, and mortality rates.

With improvement, the physicians find more pride and joy in making these changes real for their patients. By deploying one or more elements of the framework in our IHI paper, hospital leaders and physicians are learning that real improvement can be found, far from the coral reef.

References