

Engaging With Physicians Around Quality: Six Steps to A Different Way

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April 23, 2008

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The things that unite us...are more
important than the things that divide
us.

—John Gardner, 1970, Founding "Common
Cause"

Overview

- The sources of pressure for collaboration between hospitals and physicians around quality
- What causes tensions?
- What is your starting point?
- What makes physicians different?
- Six Steps to a different way

Sources of Pressure

- The rise of the quality zeitgeist
 - IOM, purchasers, NQF, IHI, Congress
 - The industry of infrastructure support
- Transparency, data, performance measurement
- Patient safety and efficiency
- Pay for performance
- The 100,000 Lives Campaign and tort
- The 5 Million Lives Campaign

Why the Physician's Business Case for Quality Is Critical to the Hospital

- Physician centrality
 - Plenary legal authority
 - Portal to the system
- Their critical and fundamental role in the hospital (AMA Monograph)
- Expertise (Reinertsen's Axioms)
 - Explain, predict and change patient futures: the healing relationship

The Physicians' Quality Agenda

- Better Outcomes
 - When all was said and done, how did my patient do?
 - Professional reputation
 - Personal sense of excellence
- Less Wasted Time
 - Hassles
 - Bottlenecks and delays
 - Rework
 - My day was going well until...

New Quality Initiatives That Will Require Physician Engagement

- CPOE – Cedars Sinai and more
- “Lean” manufacturing – eliminating *muda*
- Flow
 - ICU beds; OR scheduling; getting patients out of ED to floors; getting patients from one department to another
- Redeployment of personnel
 - Hackensack, red lights, rapid response teams
- 100,000 Lives Campaign Six Planks
- 5 Million Lives Campaign
- Pay for performance and reporting

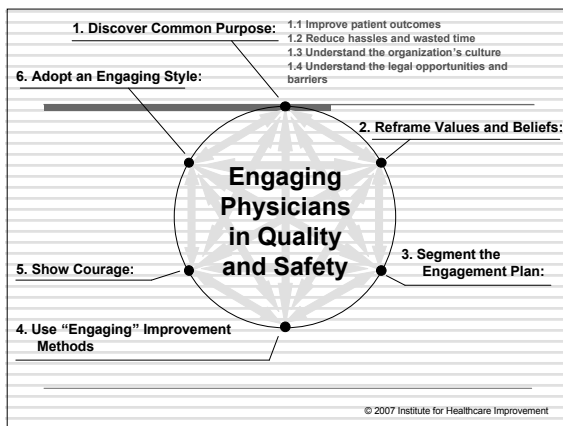
The Tensions

- Hospital success turns on physician engagement
- Physicians have their own business problems –reimbursement decreases, malpractice expense increases
- Together they create their own quagmires: economic credentialing, conflict of interest policies, investment in competing enterprises, derailed CPOE initiatives
- “The law won’t let us” be more positive

- Can this marriage be saved?

What Makes Physicians Different?

- Responsibility for individuals
- Accountability for life and death
- Legal captain of the ship
- Collegiality and "groupiness"
- Evidence based, scientific decision-making
- Outcomes and quality improvement feedback (the dynamism of medicine)
- Due process as the scientific method



Engagement Degree of Difficulty Factors

Score your hospital. 1 = Easier, 3 = Harder

Physician Involvement	Very high attendance at medical staff meetings; intense interest in hospital work; widely shared. 1	Physicians primarily relate to their departments where they do attend meetings and perform committee work; not so much interest in the medical staff activities as a whole. 2	A small group of physicians get called on to do everything; tough to get a quorum at the medical staff. 3
Departmental Cross Border Issues	Very few issues with cross-department privileges. 1	There are some departments and specialties where cross-departmental boundaries are being crossed and there are struggles. 2	There is open hostility among specialties regarding turf battles. 3

More Factors

Medical Staff-Hospital Vision	The medical staff is clear about the hospital's quality vision and mission. 1	The medical staff understands the hospital has an interest in improved quality but does not understand its role in achieving it. 2	The medical staff has no idea what the hospital's vision of quality is. 3
Hospital-Physician Ventures	If the hospital engages with physicians in a variety of arrangements which provide medical directorships, gainsharing, joint ventures, payment for medical staff service or leadership or other relationships of financial support, those arrangements are doing well. 1	The hospital has a few relationships with selected physicians; some of these are secret. 2	The hospital has or has had JVs and more which failed or are failing and the taste lingers. 3
Physician Competition	The physicians see the hospital as their significant other and do not create competitive services outside of the hospital setting. 1	There have been limited forays into competition (e.g., ASCs, endo suites, imaging) but no real trouble. 2	The physicians openly compete. 3

The Rest of The Factors

Currency of Medical Staff Bylaws	Bylaws are dynamic, up to date, reflect reality 1	Bylaws revised in some measure in the last few years to reflect reality. 2	Bylaws have not been amended in years to reflect current state. 3
Medical Executive Committee Authority	Balanced: MEC is the Supreme Court for the staff; resolves inter-departmental feuds; procedural presumption it acts effectively 1	MEC "represents" the medical staff: Board doesn't cede 'too much' power; approves officers and chairs; credentials committee reports to Board 2	Civil Libertarian: Individual physician rights dominate; high levels of due process; reactive and formalistic 3
Board Engagement with Medical Staff on Quality	Direct Board-Medical Staff involvement, high input from medical staff, early role in quality activities 1	Board watches quality, depends on administration for monitoring and surveillance of medical staff to be reported. 2	Board thinks quality is purely a medical staff responsibility; no real engagement. 3

Cultural Engagement Status

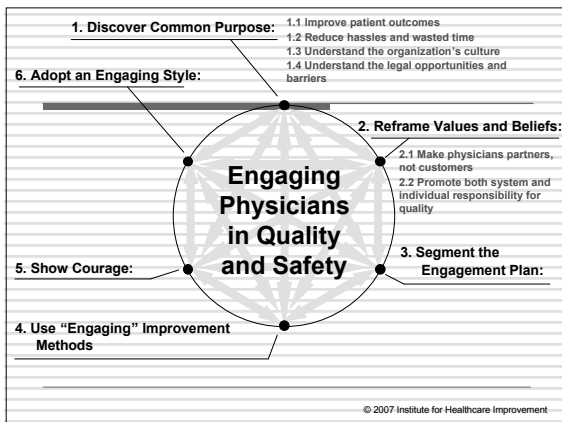
Openly Hostile	Mutual suspicion; loss of trust; past grievances won't die; big emphasis on medical staff competitive challenges (economic credentialing, loyalty oaths, financial disclosures); Board and administration focus on bottom line and financial results; medical staff suspicion of current strategies 7
Mutual Detente	Separate spheres of influence; medical staff focuses only on credentials, some privileging, rare corrective action, privileges reside in departments with little overlap or interaction with other departments; no cross department resolutions of problems; struggles between medical staff and nursing 6
Minimal Engagement	Medical staff leaders respond to some hospital initiatives through traditional structures only; sometimes more response in departmental projects; (e.g., laminated cards to help the medical staff members remember whatever; hospital provides lunch to finish charts); little cross-departmental action 5

Cultural Engagement

Some Engagement	Some physicians identify and champion small departmental based projects, some isolated interdisciplinary action; board does not make quality a priority ⁴
OK Engagement	Physicians participate in cross-departmental quality projects and work across boundaries with nursing, administration, quality staff and/or finance; board has interest in quality but relies on administration; there are pockets of real engagement and some successful, visible projects ³
Good Engagement	Many physicians participate in design and implementation of quality initiatives; MEC is convener, arbiter and communication conduit, with and to administration and board; nursing has a big role in teams ²
Full Engagement	Most of the physicians who do inpatient work initiate, implement and improve quality initiatives; community based physicians are engaged in hospital quality initiatives which relate to the continuum of care; administration is seen as a helpmate in responding to medical staff; interdisciplinary teams are the norm; CEO salary reflects quality results; Board supports medical staff ¹

Common Agenda: Keys to Success

- Frame the quality challenge in terms that are important to physicians.
 - "Reduce needless deaths, readmissions, nosocomial infections, hassles..."
 - Not "Make our scores look better," or "Reduce LOS" or "Improve productivity"
- Measure and display the results on what's important to doctors--show them that together, you're actually making these things better.



Reframing *Administrators'* Values, Habits, Beliefs...

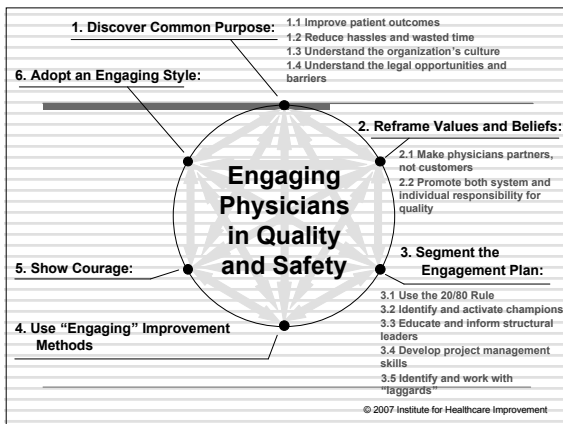


- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Physicians are customers. <input type="checkbox"/> Physicians make care decisions, we run the finances and facilities. | <ul style="list-style-type: none"> <input type="checkbox"/> The patient is the <u>only</u> customer. <input type="checkbox"/> Physicians are our <u>partners</u> in running the system. |
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Reframing *Physicians'* Values, Habits, Beliefs...

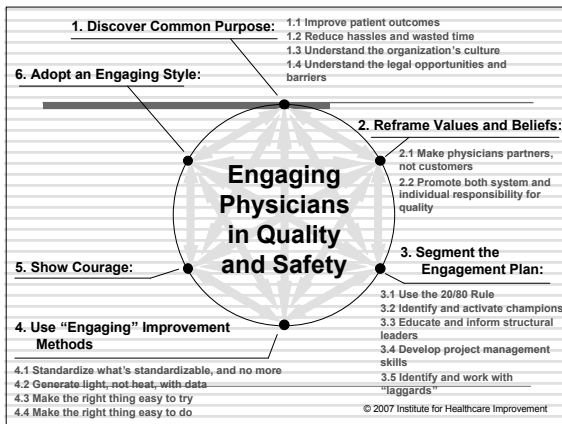


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|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> I must have complete autonomy for everything. <input type="checkbox"/> I am personally responsible for the patients I take care of directly. | <ul style="list-style-type: none"> <input type="checkbox"/> I need autonomy for the <u>art</u> of medicine, but I share it with other physicians for the <u>science</u> of medicine. <input type="checkbox"/> I am responsible for the care given broadly throughout the system that I am part of, <u>including my own</u> patients. |
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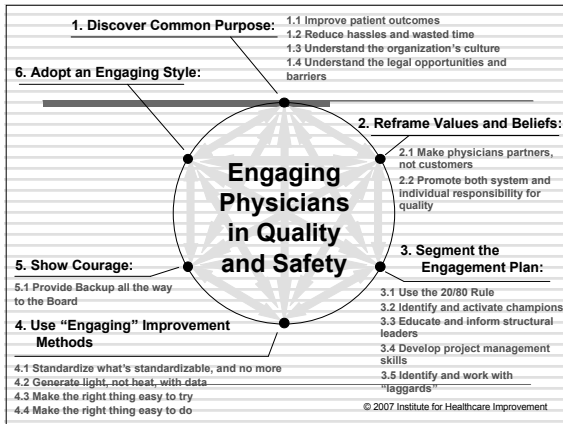
Questions to Guide a Segmented Engagement Plan (for any specific quality initiative)

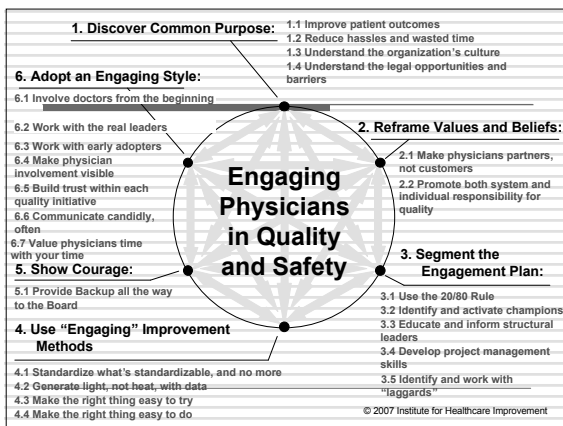
- Which physicians must be engaged in this initiative, if it is to succeed? (And which physicians are not relevant at all?)
- Who is on our short list of potential champions for this initiative? How will we select one or two champions? What is our plan to support them?
- What will be the role of the formal leaders: Medical Exec Committee, Department Chairs, Committee Chairs, and Medical Directors in this initiative?
- Does a physician need to be the "project leader" for this initiative? If so, how will we train and support that physician so that the project will be effectively led?
- Which physicians are likely to vocally oppose and potentially derail this initiative? How could we mitigate that risk?



Questions to Ask Yourself About "Engaging" Improvement Methods

- Are you trying to standardize too much?
- Do your data reports to doctors make things worse?
- Do you have endless meetings trying to decide on the "right answer," as if this is the one and only opportunity you'll ever have to get it right?
- Have you ever faced a doctor rebellion after implementing the "right answer?"





Hospitals Helping Physicians (Friends With Benefits)

- Give them time
 - Standing order sets – Park Nicollet
 - Templated documentation --
 - Empowering nurses on the units -- Hackensack
 - Standardize processes
- Offer staffing services – (big groups too)
 - NPs, PAs, CNSs

More

- Compliance training exception under Stark
- Physician recruitment for quality
- Information technology support: new safe harbors – content is basically the same but there are two – Stark and AKS
 - Electronic prescribing
 - EHR

Conclusion

- Quality is a strategic mission and a measure of success for the hospital enterprise and its executives
- It is the essence of what hospitals and physicians have in common
- It provides leverage for significant new ways of collaborating to meet the business needs of both parties
- There is no prince charming; you have to save yourselves – GET HELP

“Cooperation can get started by even a small cluster of individuals who are prepared to reciprocate cooperation, even in a world where no one else will cooperate. There are two key requisites... reciprocity and the shadow of the future.”

---Robert Axelrod

Resources

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