Engaging with the frontline: The physician perspective

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Meeting Your Goals for Preventing Venous Thromboembolism

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Overview

- Traditional healthcare delivery model
- Call for a new model
- Understanding the provider perspective
- Strategies to increase MD participation

The traditional model

- Healthcare professionals responsible for safe and quality care
  - Undergo extensive training and evaluation
  - Evaluate new knowledge and adjust practice accordingly
  - Bound by oath, ethics – commitment to the patient good

The traditional model

- Focus on the needs of individual patients
  - Unit of care is the provider-patient encounter
  - Trained using case-based examples
  - Provider-patient relationship paramount

The traditional model

- Doctors practice autonomously; not system/ hospital employees
  - Historical relationship
    - hospitals restructured to a bureaucratic model
    - physicians responsible to patients; to a third-party would constitute conflict of interest
    - Thus relationship with institution – through the Medical Staff Organization
  - Felt to protect patient advocation
  - Practice in multiple locations

The traditional model

- Hospital provides infrastructure, support and resources to deliver patient care
  - With formation of MSO – Doctors responsible for patient activity, safety, performance – oversight by MSO
  - Administration provided oversight of the plant, employees, finances, resources

Sounds like a good model built on good intentions

Does the model work? What happens when you measure?

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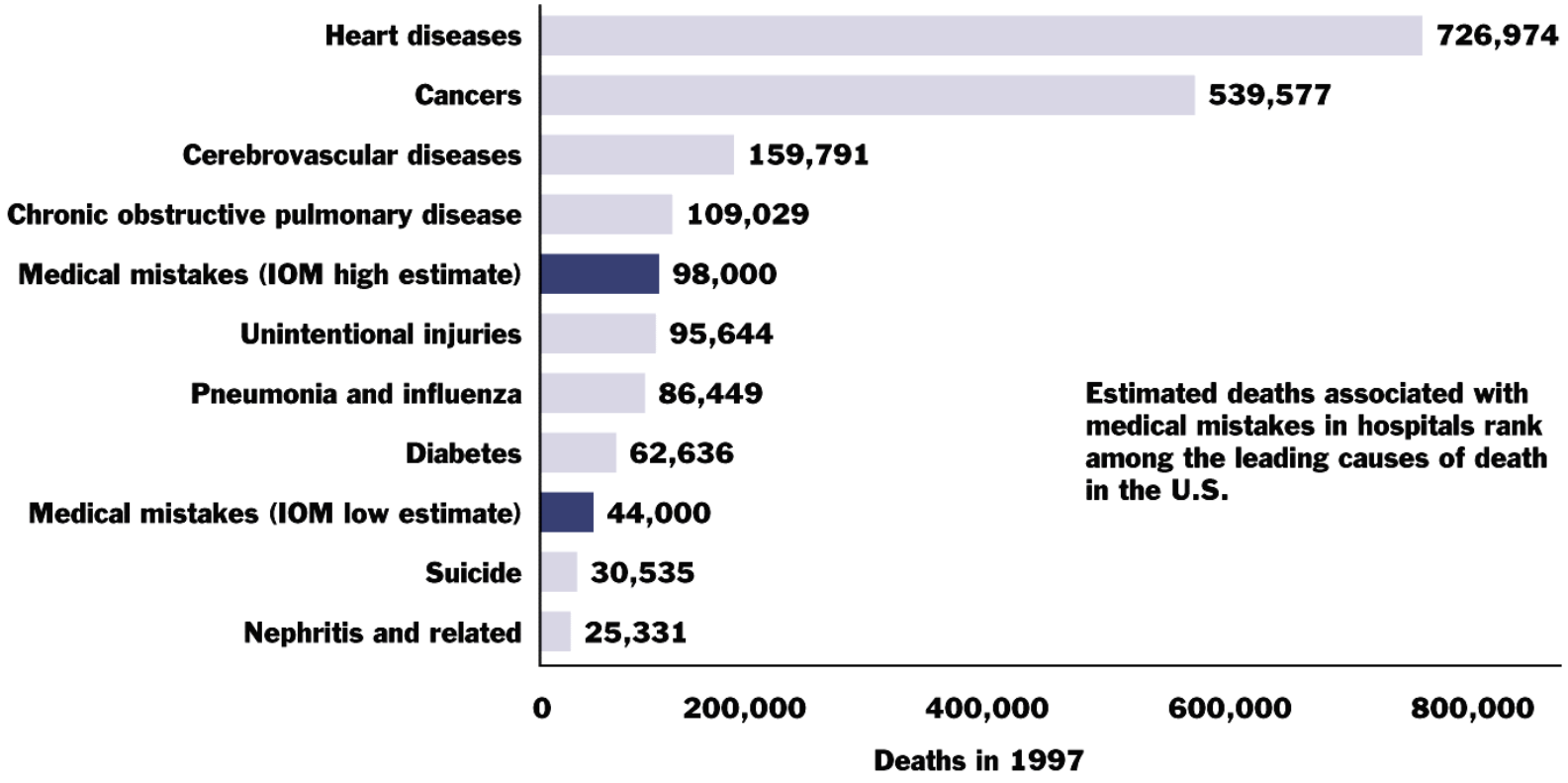
Chart 2–1

Estimated Deaths Associated with Medical Mistakes Compared to the Leading Causes of Death in the U.S.



Sources: IOM 2000; Kramarow et al. 1999 (deaths).

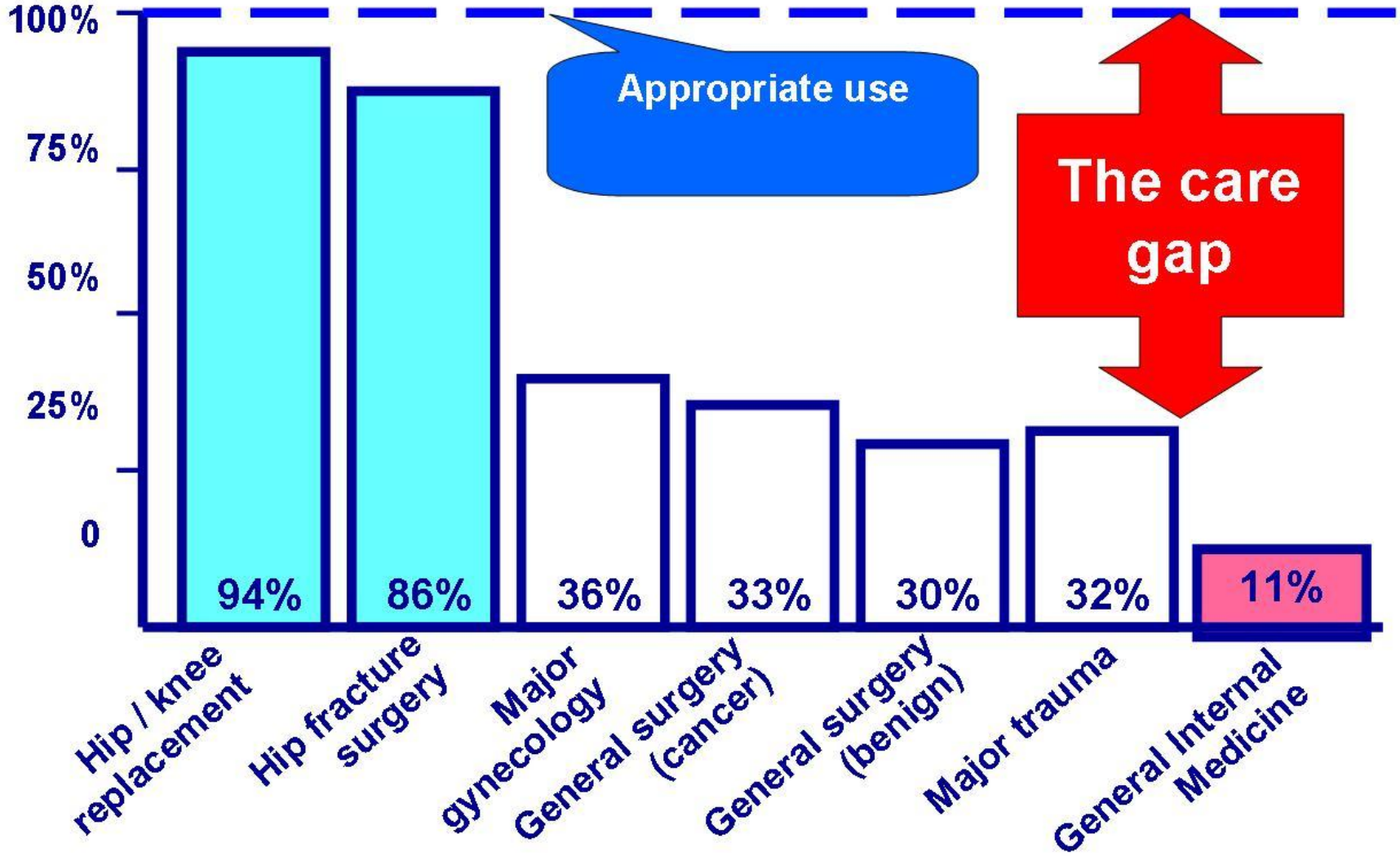
Table 3. Adherence to Quality Indicators, Overall and According to Type of Care and Function.

Variable	No. of Indicators	No. of Participants Eligible	Total No. of Times Indicator Eligibility Was Met	Percentage of Recommended Care Received (95% CI)*
Overall care	439	6712	98,649	54.9 (54.3–55.5)
Type of care				

Table 5. Adherence to Quality Indicators, According to Condition.*

Condition	No. of Indicators	No. of Participants Eligible	Total No. of Times Indicator Eligibility Was Met	Percentage of Recommended Care Received (95% CI)
Coronary artery disease	37	410	2083	68.0 (64.2–71.8)
Hypertension	27	1973	6643	64.7 (62.6–66.7)
Congestive heart failure	36	104	1438	63.9 (55.4–72.4)
Cerebrovascular disease	10	101	210	59.1 (49.7–68.4)
Chronic obstructive pulmonary disease	20	169	1340	58.0 (51.7–64.4)
Colorectal cancer	12	231	329	53.9 (47.5–60.4)
Asthma	25	260	2332	53.5 (50.0–57.0)

Routine Use of Recommended Prophylaxis in Canadian Hospitals



Why?

- Medical science and technology have advanced at an unprecedented rate
- Healthcare has become very complex
- Humans are fallible
- The system assumes that well intentioned and knowledgeable healthcare professionals will provide quality and safe care through hard work, vigilance and use of evidence

A call for a new model

- The healthcare system needs to see the implementation of evidence-based, safe and quality medicine as an system responsibility, rather than the sole responsibility of individual clinicians
- Physicians (and all clinicians) are essential partners in system redesign – if true improvement is to be realized

The pressure to change is on

- Growing attention to quality/ safety issues
- Era of accountability
  - To accreditors – safety/ quality ROPs
  - To government – public reporting
  - To public – access, wait-times
  - To patients – disclosure, apology
- Everyone is getting in the new game

What about at the front line?

- Change is slower than hoped
- Hard to change practice patterns
- Agenda has been perceived as administratively/ politically driven
- Lack of involvement of frontline in change initiatives
- Lack of understand of the perspective of front line providers (physicians)

A physician's perspective

- Safety and quality is at the core of physician practice
  - "Primum non nocere"
  - Striving to do their best for every individual patient they see
  - Hold accountability for life and death
  - Deeply rooted in medical education – perfection is the necessary goal

A physician's perspective

- Different view of safety and quality
  - Individual outcomes over population
  - Clinical outcomes over administrative
  - Tension between patient-centred care and whole-system improvement

"I'm less concerned about the care of your last 9 patients; I am concerned about how well you will care for me and my kids"

A physician's perspective

- Fiercely autonomous
  - Embedded in training, CME/ CPD
  - Duty to advocate for patients despite resources, financial pressures, politics
  - "Legal captain of the ship"
  - We've been given it = the traditional model

"If I'm personally responsible then I must have complete control and autonomy in the decisions about care"

A physician's perspective

- Physician as personal identity
  - What we do is what we are
  - Mistakes are seen as personal failures
  - Fear of being shunned by community; need for belonging
  - Fear of being publicly labelled

A physician's perspective

- Evidence and data driven
  - Trained to seek and use data
  - Show me the numbers; raw
  - Pressure to change practice – evidence from rigorously conducted research
  - BUT…discuss/ debate knowledge collaboratively; implement it individually
  - AND…essentially no training in QI methodology/ science

A physician's perspective

- Time is limited and precious
  - Time devoted to patient care = better time spent
  - Administrative activities of less value
  - High demand for clinical time – no time for less valued activities
  - Frustrated by system inefficiencies

Becoming more involved

- Understanding the physician perspective
  - Enables physicians to seek/ create opportunities to become more involved
  - Enables staff/ administrators to design initiatives using strategies to attract/ engage physicians
- Understanding that physician culture is a barrier
  - Need to be more open to change

INSTITUTE FOR HEALTHCARE IMPROVEMENT

Innovation Series 2007

Engaging Physicians in a Shared Quality Agenda

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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 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:

- 3.1 Use the 20/80 rule
- 3.2 Identify and activate champions
- 3.3 Educate and inform structural leaders
- 3.4 Develop project management skills
- 3.5 Identify and work with "laggards"

4. Use "Engaging" Improvement Methods:

- 4.1 Standardize what is standardizable, no more
- 4.2 Generate light, not heat, with data (use data sensibly)
- 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. Adopt an Engaging Style:

- 6.1 Involve physicians from the beginning
- 6.2 Work with the real leaders, early adopters
- 6.3 Choose messages and messengers carefully
- 6.4 Make physician involvement visible
- 6.5 Build trust within each quality initiative
- 6.6 Communicate candidly, often
- 6.7 Value physicians' time with your time

Engagement strategies

- Discover common purpose
  improve patient outcomes, reduce hassle and wasted time
- Create partnerships
  Physician not contractor; hospital not supplier/controller
  Share responsibility with individual and system of patients
- Involve physicians early
- Work with medical leadership
  Division director, Chair MAC, Physician in chief
- Identify/ be a champion
  find/ be a vocal believer, consider making/ being project lead

Engagement strategies

- Standardize/ protocolize evidence
  Start with aspects that are agreed upon with evidence
- Use (local) data to drive change
  use aggregate data to show change is needed
  use meaningful/ agreed upon quality indicators
- Make the right thing easy to try
  involve MDs in PDSA/ reliability tests
- Make the right thing easy to do
  avoid plans that add more work for MDs or others
- Make physician involvement visible

Summary

- The traditional medical model is failing to deliver the care that we and the public expect
- A new model is emerging which requires partnership, flexibility and change between all parties – including physicians

Summary

- Physician professional culture important factor in level of involvement in quality improvement activities
- Opportunities to develop strategies for physicians to seek involvement and hospitals to gain engagement
- Higher quality is obtainable while maintaining our individual commitment to patient care

Thank you

- Questions??
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