Engaging Physician Leaders For Improved Outcomes

By RICHARD VATH, MD

Delivery of health care services to patients is facing extreme levels of change and challenge, ushered in not just by the Affordable Care Act, but also by demands from insurers, payers and employers for improved approaches. At Our Lady of the Lake Regional Medical Center in Baton Rouge, La., the goal of our quality improvement efforts is — as always — to improve patient care. But we also want to better position ourselves for more rapid success in any of the new models such as clinical networks, coordinated care, accountable care organizations and medical homes.

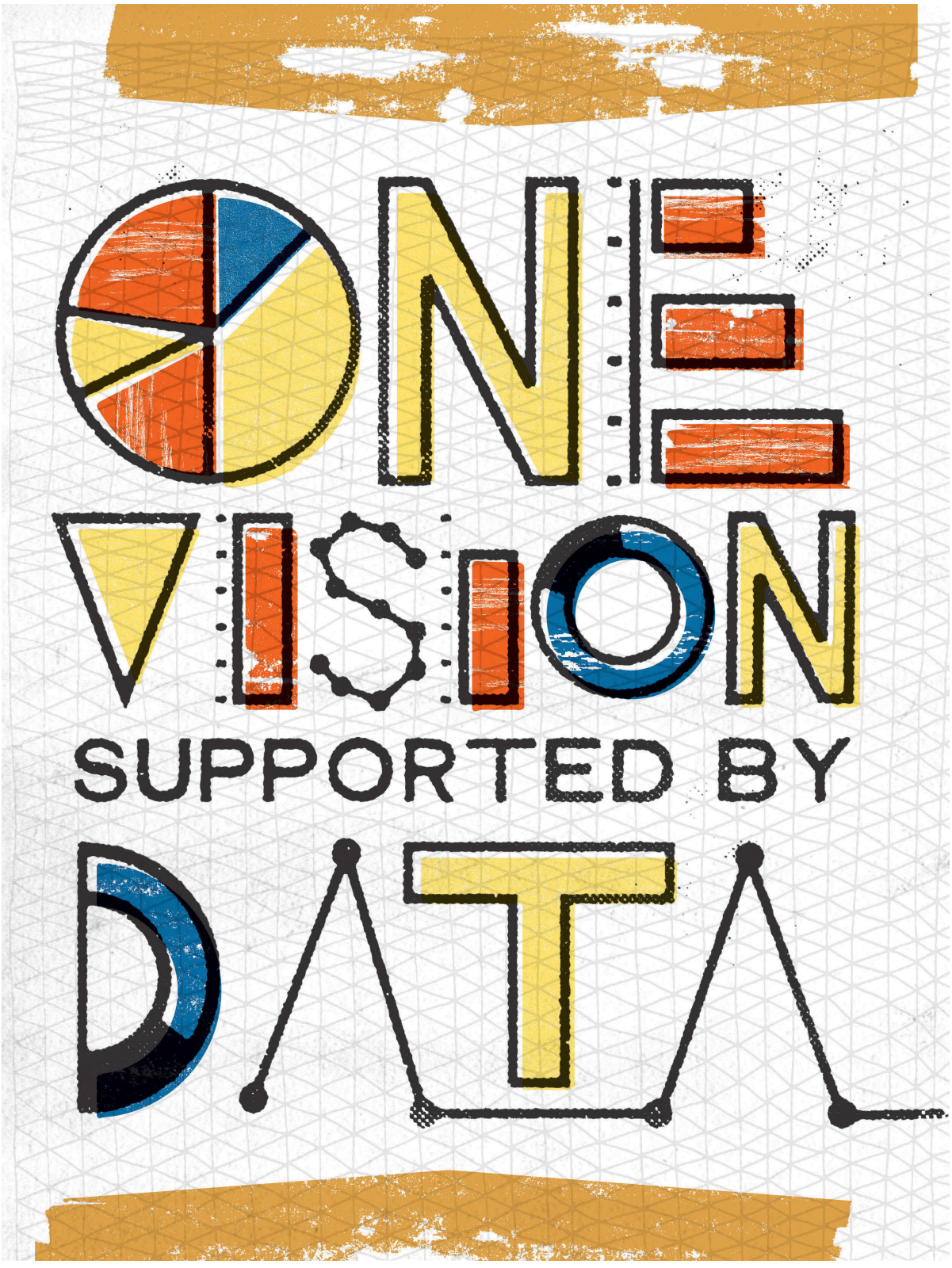
Demonstrating the value of our services is an important component of meeting new models of care, and, as the hospital's chief medical officer, I can say any and all such goals and changes hinge on support from the doctors. Over the past seven years, I have worked to involve our physicians in a collaborative process to improve inpatient quality and cost efficiencies, and then expand this work into the ambulatory side of care.

Our Lady of the Lake is the largest health care provider in the Greater Baton Rouge area. It also is the largest private medical center in Louisiana, with more than 816 licensed beds, 6,710 employees and 919 physicians on staff.

In 2006, the chief executive officer of Our Lady of the Lake brought to the board of directors the resolution to become the safest hospital in America. I was chosen to be the first medical director over quality and patient safety — that means I was the "physician champion," the leader who, among other things, would help navigate the barriers often created by traditional suspicions between hospitals and physician providers.

We decided almost immediately to begin our improvement push with a sharp focus on patient safety as a measurable quality, rather than on the concept of "quality" as defined by regulatory bodies and processes. It was clear to us that discussions about general quality improvements would be nebulous, poorly defined and, from the physicians' perspective, greatly driven by a reporting necessity for hospitals. If we began with patient safety — a target clear to everyone — we could later get into a more comprehensive discussion and approach to defining and achieving other kinds of quality improvement. Setting a bold quality target resonates with physicians and other caregivers.

To move forward, however, it was imperative to gain the support of our physicians and have them


ONE
VISION
SUPPORTED BY
DATA

become leaders in the effort. The hospital administration needed to recognize that such collaboration was paramount. We had to demonstrate to our physicians the importance of their serving as interpreters of health care value, accepting responsibility for quality outcomes and cost and creating new models of value improvement scalable to make a significant impact.

In Catholic health care, we have very powerful mission statements that drive our actions, but we sometimes fail to articulate and commit to something that, in my opinion, only strengthens our mission — that is, providing the best value health care to all those we serve.

The health care organization's vision of providing value must be carefully designed, communicated and lived by all. The chief executive officer and chief medical officer are key influencers;

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they must hold the vision out for all to see, constantly celebrate progress and always point out that the vision is an important part of our mission because it embodies what each patient deserves. In our experience, the CEO and CMO must be responsible for the relentless pursuit of the goal by building the culture, scaling from campaign to systematic projects to large-scale transformation.

ENLISTING THE PHYSICIANS

Building the culture requires identifying leaders among physicians, men and women who can set a value vision and engage colleagues to truly collaborate and make value-based decisions about the care they deliver.

We believe there is an art to identifying and working with physician leaders, but it is rarely discussed or taught. Engagement is one of those things you recognize, but it isn't easy to explain.

Some experts believe in using financial incentives to convince physicians to participate and lead their colleagues in a greater clinical cause. I disagree with this approach. Achieving goals requires a combination of excellent communications and interactions with physicians and other team members. To lead physicians, you have to understand certain important characteristics to successfully engage them. Through observation and decades of experience, I have come to believe most physicians are driven by some common motivators:

- Physicians are competitive
- They demand data to support what we ask of them
- They have great confidence in the validity of data that supports their opinion of current performance
- They are trained to be egocentric first, group-centric second and mission-centric third — and that's the way they think

Most physicians revel in swapping clinical stories, oftentimes ones that involve an atypical patient or someone whose case required complex decisions or care. Physicians like to debate care. They like to demonstrate their skills at solving complex diagnostic or therapeutic problems.

Think of how you can harness both the love physicians have of sharing their personal experiences and the competitive nature that pushes them to be the best diagnostician, the best clinician, the best healer. Those characteristics can come in very handy if you know how to tap them when you need to corral and motivate physicians to help you work toward a common cause.

As I began the process at Our Lady of the Lake, my first task was to select a group of physicians who were committed to the quality improvement effort and who could be influenced by the knowledge that within our organization, there was plenty of opportunity for improvement.

Because physicians are driven by data, I started my presentation to them with facts and figures to demonstrate the need for change. I acknowledged to them that there are, of course, no flawless data sets, so we can't hold out for any. Our reality is that

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the Centers for Medicare and Medicaid Services, insurers, employers and patients are using imperfect data sets to make choices and set policy.

Based on my experience, the initial presentation should involve "local" data — facts and figures for your hospital or system — compared to and measured against appropriate national benchmarks. That way, you can demonstrate the gap between your organization's performance and the best in the nation, and challenge your audience to reach for the top.

During these presentations, I move progressively — our hospital compared to hospitals nationally; our departments compared to specialists nationally; groups within the specialty compared to national best. Then it's time to compare physicians to national benchmarks. At each stage, I challenge the doctors to achieve at a higher level.

The sequence of data in the presentation is important because it systematically brings out physicians' native competitiveness at each level of comparison. At each level, I ask the physicians not to accept current performance when the data shows others are doing so much better.

Caution: I have found it's not a good idea to begin a presentation about quality with data measuring performance at the physicians' level. Start with comparisons between the system or the hospital vs. national numbers. If you start with quality comparisons at their own level, your physicians' competitive and egocentric drives won't let them move past reactions, rationalizations, explanations as to *why* they are not the best. They'll probably tune out and disregard the rest of the presentation you worked so hard to create.

Next comes introducing the idea that looking to the medical literature and standardizing best practices can be a map for achieving better performance. I talk about who in the hospital is performing at the highest level relative to national best performance — according to the data — and I focus the discussion on understanding how that best performance is achieved.

Caution: I do not take the approach of identifying the lowest performing outliers and working on "fixing" those. The goal is to understand who excels and how they do it, and then to share this information with other physicians in the hospital.

Anyone following this presentation plan can expect to encounter naysayers who don't want to help, and they might cite numerous "insurmountable" obstacles to achieving the desired outcome. To try to gain their support, I ask how I should feel if I knew that they, their spouse or child sought care with us and we failed to offer the best because the best was "too hard" to achieve. I challenge them, "Shouldn't everyone receive the best we can offer? Isn't that our mission?"

MAKING THE CASE

From politicians to the clergy, those whose livelihood depends on public speaking and convincing others often sprinkle their verbal presentations with interesting examples, stories and anecdotes to drive home their points.

While speaking with physicians and other caregivers, the subject of quality becomes more

FAIR IS FAIR

This experience illustrates how to make your case by making the situation personal. The situation involved several neurologists who used new data that supported a recommendation to change our approach to stroke care.

They approached me, showed me the data that supported fibrinolysis within the first three hours of symptoms. I expressed my support, and they then developed guidelines and worked through the process with the emergency room staff.

This new process was challenging to the neurologists because it required them to see the patient in the emergency department within three hours whenever they were called to evaluate a stroke case.

Several weeks into this new process of care, I was visited by two independent neurologists who told me that because they were solo practitioners, they could not leave their office to respond. I explained that this situation had already been considered by everyone, including them. Everyone understood that the new process was a best practice, and now knowing this, I could not make an exception for them.

They continued their argument until I turned to one of them and asked, "What would you have me do if it were you who suddenly slumped in the chair, hemiparetic? Would you prefer that I not consider you for all the best options, however inconvenient for me?"

He smiled and said that I was not being fair. I replied that I thought my question was all about fairness. They left and never questioned the new process again.

— Richard Vath, MD

relevant and personal through stories whose lessons are both positive and negative. In my presentations, I have used the example of a case that most of us are familiar with, that of Josie King.

Josie was a 17-month-old burn patient at The Johns Hopkins Hospital in Baltimore who died of preventable errors during treatment. I include a video of the child's mother, Sorrel King, describing how she pleaded with Josie's physicians at Johns Hopkins to make fixes — fixes to things that only they could change — in the broken processes of care that resulted in her daughter's death.

I also have used a more local example to make the point that cases such as Josie King's can and will occur in our own communities — perhaps with our own patients. I describe the time I had to inform the parents of a child in our care about the events that led to their son's cardiac arrest. It was personal for his parents, personal for me and a moment I will never forget.

SELECT THE RIGHT TEAM LEADERS

The goal of the initial presentation is to make a compelling case for improvement and for finding support from the physicians. Next comes selecting a small team from among physicians, nurses and administrative leaders to help lead improvement efforts. The CMO should choose these leaders after collaboration with the chief nursing officer and senior leadership.

Caution: Don't restrict choices to the existing elected medical staff leaders — they may not have the required skills. A CMO should be confident about creating teams and leaders under his or her direction outside of the existing group of elected leaders. Ideally, the selection of team members should be based upon their demonstrated leadership skills, and it is helpful if they are knowledgeable about leading organizational change.

The teams are responsible for designing better processes and implementing best practices to manage patient care. Choosing people who are engaged in and committed to the task will make the difference between success and failure. Hospital leadership and the CMO must provide unwavering support for these teams, as the scope of their work is sure to gradually expand to encompass larger-scale initiatives. The teams also need to be supported with data and with administrative help for meetings and other logistical concerns.

This approach has been remarkably successful at Our Lady of the Lake in gaining support for quality and patient safety initiatives.

GETTING TO COST CONTROL

This discussion would not be complete without a mention of effective methods of bringing physicians on board regarding the touchy topic of controlling costs. Physicians can be turned off by purely financial goals that leaders place before them. It is not that they don't understand their role in spiraling health care costs, but, rather, their role as the primary patient advocate oftentimes puts them at odds with hospital financial initiatives. They often don't know how to — or don't want to — address the cost side of value, so they place the blame for rising costs on hospitals and vendors.

To address ways to achieve cost efficiencies at Our Lady of the Lake, we used a strategy similar to the one for quality improvement. The best approach to engaging physicians' consideration for cost is to use comparative effectiveness to drive value into clinical decisions. Then, provide your colleagues with the rationale to address possible challenges from patients and other physicians regarding their decisions.

The approach to controlling costs that we used was modeled on our formulary for pharmacy and therapeutics additions. Applying this to surgical preference items, we reviewed Food and Drug Administration indications and data about clinical effectiveness and safety. We followed this with a cost comparison of current vs. new products. Our physicians accepted this approach, and we have been able to save nearly $2 million in high-cost supplies for the operating room in the last 18 months alone. More importantly, the surgeons chosen to lead the effort are now pushing us to move more quickly.

We now have expanded the process to each internal quality improvement team. This ensures that cost is always included with the quality metrics and that the teams are held accountable for those results as well. Lastly, we committed to sharing the cost per case/diagnosis-related group per physician along with quality outcomes as our reporting format, in the hope that we can, again, add competition into the mix.

PARTNERSHIP WORKS

Our Lady of the Lake has made substantial progress in lowering the patient mortality rate. Since

2007, we have steadily decreased mortality from 2.90 percent to 1.00 percent, a 66 percent reduction. This achievement is significant because Our Lady of the Lake treats some of the Baton Rouge community's sickest, most critically ill and injured patients.

What we have done in Baton Rouge is certainly not the answer to all the concerns that we, as health care leaders, share in these fast-moving times. But, we do believe it is vital to engage physicians as partners on the path to improved quality and better value. Understanding the conversations and the data that will resonate with physicians, selecting the right leaders and leading them carefully through the improvement process will allow to emerge their desire to challenge each other's approach (competition!) while committing to a cause larger than just their own performance — that is, always focusing on the patient.

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