Physician Champions for Quality and Patient Safety

Bala S. Chandrasekhar, M.D., M.M.M., F.A.C.S.
Chief Medical Officer
Methodist Hospital of Southern California
Arcadia, California
A Patient Story

- 87 year old retired meteorologist
- Married for 61 years, two sons
- Active, excellent health
- Prior history of M.I, single stent
- On Plavix and Aspirin
Trigger event

- Tripped and sustained a fall
- Minor head bump
- Progressive loss of consciousness
- Transported to the ER by car
- Intubated, I.V. fluids
- CT scan in ER
CT scan in ER
Repeat CT Scan
Hospital Course

- Continued respiratory support
- No change in level of consciousness
- Grim prognosis
- Family discussion for further care
- Terminal extubation
- Died on Christmas Day
Physician Champion for Falls Reduction

- Awareness of falls as safety issue
- Identification of high risk (Morse scale)
- SBAR report includes fall risk
- Bed and chair alarms
- Hourly rounding
- Medication management (Ambien, Lasix)
- Falls debriefing
Why Falls are Problematic

High Volume:
  10% older adults in institutions
  2-10% of all inpatients

High Risk:
  Commonest injury is hip fracture

High Cost:
  No Medicare payment for preventable injuries
  Loss to families
Mean Annual Inpatient Fall Rates

- 2009: 3.1
- 2010: 2.7
- 2011: 3.1
- 2012: 2.54
- 2013 YTD: 1.3
- CalNOC low quartile: 1.7
- CalNOC Average: 2.55
Physician Champions at Methodist Hospital

CPOE (Dr. David Ratto)
Blood management program (Dr. Hani Sami)
SCIP (Dr. Kurt Neubauer, anesthesia)
Falls reduction (Dr. Chandrasekhar)
HAPU (Dr. Elizabeth Lee)
Orthopedic infections (Dr. Rishi Garg)
ICD-10 (Dr Steve Soldo, Dr. Rishi Garg)
Notable Successes

- CPOE: 80% medication orders by M.D.
- SCIP: 100% antibiotics within 1 hour
- HAPU: 50% reduction in Stage 3,4.
- Blood management: 95% compliance
Partnership for Patients
Healthcare without complications

Sustained improvement over 12 months in 7 of 10 HACS
- Falls
- Ventilator associated events
- Catheter associated urinary tract infections
- Early elective delivery
- Preventable readmissions AMI

Methodist Hospital

Commendation from CMS as one of top three hospitals in California
Why do we need Physician Champions?

“Physician led Process Redesign Creates Better Value”
What is value, anyway?

Value = Quality / Cost

Quality = Service + Outcome

Service = Patient satisfaction, Service delivery times
Outcome = Mortality, Complications, Length of Stay

Cost = Lab, Radiology, Pharmacy, LOS

75% of healthcare costs are controlled by doctors
Unsustainable Costs of Healthcare

Rising healthcare costs will put tremendous pressure on the federal budget in the next few decades and beyond. In the CBO’s judgment, the health legislation enacted does not substantially diminish that pressure.

Director, CBO
May, 2010
But why are our health care costs higher than other countries?

...Who said that?"
Fee For Service Has Created Our Tragedy

• FFS rewards throughput, ancillary utilization and radical autonomy
• Does not reward:
  
  Best measurable outcomes
  Cost effectiveness
  Coordination of care/team care
  Standardization around best science
  Participation in team initiatives
Government’s Response to Cost Escalation Under Fee For Service

IF it grows – Cut it.

IF it continues to grow – Cut it MORE
Changed Concept of Quality

Used to be individual outcomes
Now we add:
  Population outcomes assigned to a care system
  Customer satisfaction
  Meaningful access to care
  Shift to preventive care, early detection
Technical quality of care is still core
Safety in Healthcare

There is no quality without safety

Number of encounters for each fatality
Common Themes Resulting in Errors and Poor Outcomes

Huge variation in practice patterns:
- Underuse, overuse and misuse of services
- Disparities in quality between doctors
- Regional variations

Results:
- Medical errors
- Deaths
- High cost
- Dissatisfaction for patients and payers
Practice variations

Overuse:
- Low risk chest pain (unnecessary admissions)

Underuse:
- Beta-blockers for cardiac patients

Defective use:
- Medication errors
- Unnecessary hospital length of stay

Inefficient use:
- Variation in orthopedic implant usage
- Throughput on scanner usage in Radiology
Healthcare Reform Signals The End Of Business As Usual

What: Quality and cost must improve dramatically
How: Regulation and consequences
When: Over the next 5-7 years

The law creates the potential for consequences for providers, suppliers and payers who continue to embrace the traditional delivery model.
Key Drivers

New payment techniques (ACO, Bundled payments)
Business mindset
  Cost control
  Continuous Quality Improvement
  Customer Satisfaction
Public Reporting of Quality (Hospitals, Doctors)
Value Based Purchasing (Government, Businesses)

Businesses will purchase insurance from those who provide measured high quality
Key Drivers

Real Consumerism

Alternate options for care (Internet resources)
Variety of Providers (PA, NP, CRNA)
Alternate venues for care (e.g. Infusion centers)
Healthcare delivery
The new normal

• *Fee for service* will not be the primary payment mechanism for healthcare providers
• *Physician autonomy* and the private practice of medicine will not be rewarded
• There is no new money
• Providers who do not deliver value will fail
Where do we go from here?

- Healthcare delivery is fragmented and chaotic. We need a new breed of leaders to tame this chaos.

- These leaders must organize doctors into teams; measure their performance by outcomes; apply financial and behavioral incentives; improve processes; and dismantle dysfunctional cultures.

- By organizing care delivery around patients’ needs, these leaders will raise quality, efficiency and value of the services they provide.
How Can Physicians Impact Healthcare Delivery?

“Physician led Process Redesign Creates Better Value”
Physician Background

Primary focus in own practice (business model)
Traditions are deeply imbedded
Focus on individual patient, not the system
Value autonomy, protection and entitlement
The invisible hold of the status quo is very strong
Understanding Physician Values

Accountability/liability

Doctrine of “Captain of the ship”
Physician Champion Primary Role

“To serve in a leadership capacity promoting and implementing changes in healthcare delivery that create value and benefit their patients.”

Designer
Educator
Analyst
Liaison
Barriers to Physician Engagement

Time
Physician interest / denial
Lack of resources to support doctors
Physician knowledge in Quality Improvement
Difficulty with communicating message
Lack of urgency
Suspicion, concern for “critiquing”/“policing”
Barriers to Physician Engagement

- Burnout
- Culture of autonomy and individualism vs teamwork
- Lack of training in teamwork and systems thinking
- Lack of a *shared vision* for improvement
Lack of Shared Vision has Consequences for Change Implementation

- Self interest rules, especially when resources shrink
- Change initiatives seem disconnected or come out of the blue.
- Physicians and others do not engage if the destination isn’t one they aspire to…particularly if it means self sacrifice
Challenges To A Shared Vision

- Relationship between administration and physicians are strained
- Physicians do not readily acknowledge their interdependence
- Vision process is often superficial (eg., PR)
- No clear method to achieve vision
Investing in Shared Vision

• Helps reduce anxiety and bring focus to the work
• Meets the needs of the newer generation
• Responds to a hunger for a better life

PHYSICIAN CHAMPIONS need to connect the dots
Who are these Champions for change?

Usually, a minority of Medical Staff
Highly respected for clinical expertise
Willing to challenge the status quo
Capacity to command the attention of others
Ability to ignite passion in others for QI
“Always the same people”
Technology Adoption Curve

- Innovators: 2.5% gp
- Early adopters: 13.5%
- Early majority: 34%
- Late majority: 34%
- Laggards: 16%

Adoption gap
Where physician champions live

Where physician champions work
Approaching Potential Physician Leaders

Need a good response to the following:

Why me?
Why now?
Why should I care?
What is in it for me?
WHY ME?

Perceived as credible and respected
Highly knowledgeable in area of expertise
Willing to share knowledge with others
Willing to support and advocate for change
Good communicator
Leads by example
Unafraid to influence
Wide peer and social network
Able to defend self against aggressive incursions
“Establishing a sense of urgency is crucial to gaining needed cooperation. With complacency high, transformation usually fails because few people are even interested in working on the change problem….People will find a thousand ingenious ways to withhold cooperation from a process that they sincerely think is unnecessary or wrongheaded.”

-John Kotter, A Sense of Urgency
Why Now?

- Cost of doing nothing exceeds cost of change
- Cold, hard facts on performance and lack of sustainability
- Gap between aspiration and reality (where are we in relationship to stellar organizations)
- The personal impact of incidents (stories of near misses or complications)
Good data not enough to ensure quick adoption

Natural diffusion of new knowledge takes too long to reach general practice:

- Prevention of EED < 39 weeks (1998)
- VTE prophylaxis in ICU (1982, adopted 2001)
- IV antibiotics < 1 hour of cut time (1992, adopted 2005)

Champions will accelerate the rate of adoption, going further faster
Discover A Common Vision Or Purpose
What is in it for ME?

All human motivations can be placed into three categories after basic needs are met

Financial: Money, free time, avoidance of costs

Social: Peer pressure, prestige

Ethical: Respect for one’s self
Reframe values/beliefs

Communication of Vision and Goals

Physicians will embrace a vision when:
- They are at the table when vision is created
- It benefits them in a specific way
- Communication is delivered by respected leaders
- It is physician led
- Destination is irresistible
Physician Buy-In

Patient is at the center

- Improves patient compliance
- Improves clinical outcomes
- Improves patient satisfaction
- Increases growth and market share
- Reduces malpractice risk
- Improves physician satisfaction
Engaging Physicians in Quality Agenda

Common vision

- Adopt a collaborative Style
- Reframe values
- Plan of engagement

Physicians Engagement in Quality and Safety

- Provide actionable data
- Use ‘Engaging Improvement Methods’
Activate the Physician Champions

Engage early adopters
  Understand their motivation
  Assess readiness for change
  Assess their educational deficit
  Provide support (meetings, clerical, etc.)
Ask naysayers for their input early (could become early adopters)
Key administrative skills for Physician Champions

- Team building
- Conflict resolution/ negotiations
- Strategic and tactical planning
- Persuasive communication
  (One on one, no ppts)
- Financial decision making
Make it easy

• Provide good, actionable data
• Make it easy to understand
• Only measure what is important in real time
• For patient care, not for compliance/regulation

Beware: Head vs Heart
Use stories rather than data
## Hand Hygiene Submissions to Infection Control
### JUNE, 2013

### Overall Hand Hygiene Data

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<th></th>
<th>Before patient contact</th>
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<th>overall</th>
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<tr>
<td>Overall</td>
<td>45%</td>
<td>70%</td>
<td>58%</td>
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<tr>
<td>Physicians</td>
<td>20%</td>
<td>33%</td>
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<tr>
<td>RN/LVN</td>
<td>56%</td>
<td>85%</td>
<td>71%</td>
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### Detailed Data by Location

- **2T**: 60
- **3N**: 1
- **4N**: 27
- **4T**: 7
- **5N**: 9
- **5T**: 17
- **CCC**: 1
- **CCS**: 1
- **NICU**: 11
- **Rehab**: 2
- **TCU**: 5

### Actionable Data

*Hand Hygiene Submissions to Infection Control for JUNE, 2013.*
Explicit Goals and Work Plans

- Clearly defined activities and deliverables
- Identified Executive Sponsors
- Established Guidance Teams
- Well defined resources
- Well defined timelines that are realistic
- Measures of success
Communicate Often

Build trust at each step
  Transparency, share data, be consistent over time
Value physician time
Promote physician role in QI/safety
  Medical staff bulletins
  Doctors’ lounge
  Community newsletters
Encourage presentation to medical staff
  Explanation of rationale for final decision
  “New rules of the game” clearly articulated
CELEBRATE SUCCESS
Physician Champion Projects

Medical Staff Quality
  Credentials, Privileges, Peer Review
Clinical Pathways, Protocols
  (Joint replacement, CHF, DM)
Benchmarks for Physician Performance
  (OPPE, FPPE)
Mistake avoidance, Root Cause Analyses
Information Systems
  (CPOE, ICD-10)
Strategic planning, Budgets, Manpower
Final Thoughts

Every exceptional enterprise depends on self-managed, self-motivated people who accept responsibility to perform within the core values and demanding standards.

One notable distinction between “wrong” and “right” people is the former see themselves as “having a job” while the latter see themselves as having “responsibilities.”

-Jim Collins, How the Mighty Fall
Final Thoughts

• Great success comes to organizations that solve obvious problems that others take for granted.

• Healthcare is too expensive, poorly organized, uncoordinated, not accessible to many, wasteful, and produces mixed outcomes.

• Redesign using physician champions will be required to maintain and/or GROW income. The new winners will be:
  
• Coordinated TEAMS delivering evidence based, patient centered care
• Able to treat higher volumes of patients
• At a lower predictable cost per episode
• Demonstrating measurable higher quality
Thank you. Our patients are depending on us to do the right thing.