

HOSPITAL STRATEGIES TO ENGAGE PHYSICIANS IN QUALITY IMPROVEMENT

By Allison Liebhaber, Debra A. Draper
and Genna R. Cohen

In the last decade, growing evidence that the quality of U.S. health care is uneven at best has prompted greater attention to quality improvement, especially in the nation's hospitals. While physicians are integral to hospital quality improvement efforts, focusing physicians on these activities is challenging because of competing time and reimbursement pressures. To overcome these challenges, hospitals need to employ a variety of strategies, according to a Center for Studying Health System Change (HSC) study of four communities—Detroit, Memphis, Minneapolis-St. Paul and Seattle. Hospital strategies include employing physicians; using credible data to identify areas that need improvement; providing visible support through hospital leadership; identifying and nurturing physician champions to help engage physician peers; and communicating the importance of physicians' contributions. While hospitals are making gains in patient care quality, considerably more progress likely could be made through greater alignment of hospitals and physicians working together on quality improvement.

Physician Involvement Key to Hospital Quality Improvement

In recent years, such reports as the Institute of Medicine's *Crossing the Quality Chasm* have brought quality of care issues to the forefront. The dissonance between costs and outcomes has also heightened awareness about the need to improve health care quality, including the quality of care provided in the nation's hospitals. The United States spends about \$2.4 trillion on health care annually—nearly a third of which is for hospital care.¹ Yet, health outcomes in the U.S. are comparatively worse than those of many other developed countries that have lower spending.²

Although hospitals have long engaged in quality improvement (QI) activities, they continue to face escalating demands to participate in a wide range of quality improvement and reporting programs. Moreover, hospitals' financial and reputational interests are increasingly at stake to demonstrate high quality and to improve when weaknesses are identified. The Joint Commission, for example, requires hospitals seeking accreditation, which is often

required by payers for reimbursement, to demonstrate compliance with the National Patient Safety Goals—a set of standards focusing on the reduction of hospital-acquired infections and other patient safety issues. Additionally, the Centers for Medicare and Medicaid Services (CMS) collects data on a core set of quality measures from hospitals as part of its Reporting Hospital Quality Data for Annual Payment Update program. Hospitals that do not participate in the program or fail to meet CMS reporting requirements receive a 2-percentage-point reduction in their annual payment update. More recently, CMS also began disallowing payment to hospitals for so-called never events—medical errors such as foreign bodies left in surgical patients and preventable post-operative deaths.³

Given the increasing pressures on hospitals to improve the quality of patient care, the need to engage physicians in hospital quality improvement initiatives is critical. Physicians are the key decision makers

related to the care a hospitalized patient receives and are integral to hospitals' QI projects, ranging from improving hand-washing hygiene to reducing ventilator-associated pneumonia. Yet, hospitals' attempts to engage physicians in improving patient care come at a time when physicians face growing reimbursement and time pressures. Hospitals are using a variety of strategies to address these challenges and ensure physician involvement in QI, according to an HSC study examining physician involvement in hospital QI activities in four communities: Detroit, Memphis, Minneapolis-St. Paul and Seattle (see Data Source). These strategies include: employing physicians; using credible data to encourage physician involvement; demonstrating visible commitment to quality improvement through hospital leadership; identifying and nurturing physician champions; and communicating the importance of physicians' contributions.

Employment Engages Physicians

While there is wide acknowledgment that physician involvement is critical for hospital QI initiatives, hospitals face a major challenge in securing physicians' time to participate. Even some of the more straightforward activities associated with hospital quality improvement, such as attending meetings or reviewing proposed changes in hospital processes, are difficult for a physician with a large patient load. As one physician respondent lamented, "These things are terribly time consuming...and your patient responsibilities never go away." Nearly all respondents commented that the trade-offs for physicians—sacrificing either personal or billable time—are difficult to resolve.

Many hospitals have historically relied on the voluntary medical staff model to solicit physician participation—a model that is generally premised on a loose affiliation between hospitals and community-based physicians. However, as more services shift to outpatient settings and physicians confront quality-of-life issues and financial stresses, physicians increasingly feel less obligated to perform such functions as participating on hospital committees in exchange for hospital privileges. As a result, engaging loosely affiliated physicians in hospital QI projects can be particularly challenging because of competing priorities. Moreover, while respondents often described medical staff bylaws as encouraging physicians to "be good citizens" and participate in QI activities, bylaws often lack the specificity or accountability that clearly outline physicians' responsibilities.

Hospital employment of physicians is becoming more prevalent, often as part of a larger set of alignment strategies, such as securing emergency call coverage and initiating new service lines to attract more patients. For physicians, employment may be attractive because it eliminates the administrative burden of a private practice, secures a predictable income, offers relief from high malpractice premiums and allows for a better work-life balance. Typically, quality improvement is not the main reason driving tighter alignment of physicians and hospitals, but employment can create incentives for physician involvement in QI activities as one chief medical officer (CMO) described by "achieving economic alignment around the shared qual-

ity agenda." To ensure alignment, hospital executives reported increasing use of formal job descriptions and contractual arrangements that detail physician responsibilities to the hospital related to QI participation and increased accountability for results.

Employment of physicians can lessen competing pressures on physicians' time to participate in QI activities. Other benefits include increased physician accessibility and visibility, as well as a pool of potential champions to help garner support and engagement of physician peers. However, respondents frequently cautioned that employment alone is insufficient to gain and sustain physician involvement in the absence of other factors, including credible data to motivate engagement, personal interest, and other support and encouragement from the hospital.

Credible Data Motivates Improvement

Credible data to identify areas that need improvement and systematically assess progress are essential to securing physician participation in hospital quality improvement. As one hospital chief executive officer (CEO) said, "People rally toward data, toward measurement and toward evidence-based practice." Many respondents recounted how physicians assume they are providing good quality of care until they are shown data proving otherwise. For example, at one hospital, physicians had lower hand-washing rates than other caregivers. Only when the data were broken down by caregiver type were physicians able to see they were less compliant and begin to focus on improving.

Although hospitals' participation in CMS, Joint Commission and other programs has prompted increased data collection, many hospitals still report they are "starving" for good data. Many data sources are retrospective and administrative in nature (e.g. billing data), which makes physicians skeptical. Hospitals are trying to use other data sources, such as chart reviews, which are expensive. As a national hospital association representative stated, "I would first give a caveat that we are not lacking for data, we're lacking for useful information to make decisions. You can fall on your sword by giving physicians data that are not

reliable, not representative, or not useful."

Using external, risk-adjusted data is a way to improve data credibility. Several respondents noted the American College of Surgeons' National Surgical Quality Improvement Program⁴ (NSQIP) as a particularly useful data source for surgical specialties. Benchmarking data against other institutions is important as well. Academic medical centers placed high value on benchmarking against other University HealthSystem Consortium⁵ hospitals, and children's hospitals reported great value in benchmarking against other Child Health Corporation of America⁶ hospitals.

Although still a work in progress, some hospitals are moving toward using benchmarked data, when available, to provide feedback to physicians about their performance relative to their peers, either within the hospital or with physicians in similar care settings. Some hospitals give individual-level data to physicians, while others distribute aggregated quality scorecards. Hospital executives reported that this feedback appeals to the competitive nature of physicians. As one hospital director of quality improvement noted, "Helping them [physicians] understand goals and then providing them with information about how they're doing on those goals on an individual basis against one another is another tried and true strategy for gaining involvement."

Providing physicians with data support for QI—staff to collect and analyze the data—also is important. This is typically done by assigning hospital staff to serve as project managers for physician-led QI projects. Hospital executives emphasized the positive impact of quality departments taking more ownership of the data, collecting it, and making it accessible to physicians so physicians do not have to spend their limited time pulling information together.

The impact of information technology (IT) on quality improvement is "a mixed bag." Respondents acknowledged that it has provided access to more information in a timelier, more organized manner, allowing hospitals to improve reporting of individual physician and department performance. IT also has enhanced hospitals' ability to communicate with physicians by posting messages related to QI or performance results on a Web site or through physician portals. In

some ways, however, IT also reportedly makes it more difficult and complex to get information. Common complaints about IT were the lack of interoperability or uniformity across inpatient and outpatient settings and across different hospitals campuses, which means collecting comprehensive data is still cumbersome. Many hospital executives reported they were in the early stages of implementing an electronic medical record (EMR) system and were not yet at the point where they could use it to its full potential for QI.

Committed Hospital Leadership Engenders Physician Support

Visible commitment by hospital leadership can foster physician involvement in quality improvement activities. For example, several respondents noted how helpful it was when hospital boards became involved in the hospital QI agenda. As one respondent observed, “We’re seeing a growing interest at the board level in hospitals around quality...that connection between the board and medical staff seems to be one where there’s also a good potential for support. If the board is supportive of quality endeavors and they’re more engaged, that sets the tone.”

An important role of hospital leadership is creating a strong quality culture by publicly demonstrating that QI is important, supported and encouraged. Respondents from several hospitals noted that leadership turnover often created changes in QI priorities and methods, but hospitals with a well-established QI culture were better able to keep physicians involved despite the changes. As one hospital chief nursing officer (CNO) said, it’s an environment where “you get on the boat or the boat’s going without you.” This is reportedly achieved by providing clarity about what’s expected in terms of QI, establishing the appropriate infrastructure and institutionalizing that direction from an organizational perspective.

Respondents praised senior leaders who go out on patient floors to talk with patients and staff to see for themselves the quality challenges and issues the hospital faces. Some noted how useful it was to have senior leadership accompany physicians on patient

care rounds, which enables some of the quality discussion to occur in real time.

QI also needs adequate resources, which is challenging for hospitals as QI demands continue to increase. As one CMO noted, “If they’re [physicians] going to get engaged in quality projects, they want to be sure the hospital is going to back them up. Once they’ve done a project they need to be sure the hospital has the will to maintain the gains.” However, several respondents noted that after implementing initiatives mandated by external organizations, they often were left with limited, if any, resources to pursue other activities of interest to hospital staff.

Physician Champions Foster Broader Participation

Physician involvement in hospital QI is reportedly often limited to a fraction of the active medical staff. While respondents were generally favorable when describing the efforts of these physicians, they were frustrated that it was “always the same people.” Finding ways to engage more physicians is critical to QI, which ultimately requires all members of the medical staff to adopt process and practice changes. Respondents cautioned that continued reliance on the same set of individuals can lead to burnout and also limit the number of QI activities that can reasonably be pursued.

Hospitals often look to physician champions to help promote their quality agendas and elicit broader physician participation. Respondents emphasized the importance of physician champions being highly respected in their area of clinical expertise. Most respondents also noted that physicians who have emerged as champions appear to possess certain personality traits, such as a willingness to challenge the status quo, a capacity to command the attention of others and an ability to ignite passion in others. As one CEO described a physician champion in his hospital, “Every thought process he has always has a filter of ‘what is this going to do to quality?’”

To nurture physician champions, hospitals often provide support for leadership training or attendance at national quality meetings, which helps to broaden perspectives and heighten awareness in areas such as systems and change management. Physician

respondents spoke of the importance of hospitals investing in training physicians through courses and seminars to create “true believers” in quality improvement. The more forward-thinking hospitals have a succession plan in place for their quality leaders to identify young physicians who need to be exposed and educated on QI to ultimately assume the quality mantle.

Several respondents had experience with successfully converting naysayers—physicians who initially criticized the purpose and methodology of QI initiatives—into champions. Strategies included bringing naysayers into the process early and asking for their input. For example, one CNO recounted an experience where hospital staff worked with a physician who was critical of the Joint Commission’s National Safety Patient Goals and the hospital’s EMR to make sure he was fully trained and could see the benefit. Now that physician, who was initially a naysayer, reportedly “beats the drum for the thing.” However, at some point, as one CMO stated, “You have to keep marching on and not fret a lot about them [naysayers].”

Effective Communication Spurs Involvement

In soliciting physician involvement in hospital quality improvement, it is important to have clear communications and effective messaging. Many hospital executives found they were often dealing with an “educational deficit”—that many physicians did not understand QI and its importance, contributing to their reluctance to participate. Strategies that hospitals have used to communicate to physicians about QI include one-on-one meetings, newsletters, posters and e-mails.

A particularly effective message frames quality improvement as advantageous for patients. If hospitals can demonstrate to physicians that QI activities result in better patient outcomes, respondents believed that participation was appealing to physicians. As one respondent noted, “If physicians understand that it’s not for a regulatory or administrative requirement, but...it’s about the care they’re providing patients, they’re all over it, they’re very enthusiastic.” Other effective messages include how QI will ultimately protect physicians’ time by improving efficiency and how poor quality costs money and



Data Source

To examine physician participation in hospitals' quality improvement activities, information was collected from hospitals in four of the communities in the Robert Wood Johnson Foundation's Aligning Forces for Quality Program—a program focused on performance reporting, quality improvement by health care providers and engagement of consumers on health care quality issues. The four communities are Detroit, Memphis, Minneapolis-St. Paul and Seattle. In each community, up to four of the larger hospitals were selected to conduct interviews, for a total of 13 hospitals. To provide a range of perspectives, chief executive officers, chief nursing officers, chief medical officers and the directors of quality improvement were interviewed. Physicians identified by hospital leadership as quality improvement champions were also interviewed, as well as respondents representing relevant national and state organizations knowledgeable about the issues. The findings are based on semi-structured phone interviews conducted by two-person interview teams between September and December 2008. A total of 53 interviews were conducted, and Atlas.ti, a qualitative software package, was used to analyze the interview data.

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600 Maryland Avenue, SW, Suite 550
Washington, DC 20024-2512
Tel: (202) 484-5261
Fax: (202) 484-9258
www.hschange.org

President: Paul B. Ginsburg



impacts the reputation of the hospital, which could also affect physicians' reputations and bottom lines.

Hospital staff can also maximize physician involvement by recognizing that physicians have a limited amount of time to devote to QI and being strategic about using that time. Strategies to achieve this include inviting physicians to meetings that result in concrete decision making and scheduling meetings far in advance and for times early in the morning or in the evenings to accommodate physicians' clinical responsibilities.

Once physicians do agree to participate, respondents reported the importance of hospital leadership providing recognition and positive feedback, an area where several respondents believed their hospitals were lacking. For physicians to participate in QI, it often means voluntarily contributing their time and forgoing compensation; they want to be recognized by hospital leadership for that sacrifice. To achieve this goal, some hospitals have employed strategies such as publicly posting performance data, holding poster sessions to provide visibility and encouraging physicians to present their work to the broader staff.

Implications

While hospitals are working to improve their quality of care and are making incremental gains, considerably more progress can be made. Recognizing that physicians are essential to hospitals' quality improvement efforts, it is unlikely that significant progress can be achieved unless physicians are more effectively integrated into the process. Because many physicians are spending less time in the hospital and are increasingly reticent about voluntarily giving their time to hospitals, finding effective strategies to engage physicians in QI activities will become even more important.

To identify and promote policies and practices that encourage hospitals and physicians to work together to achieve results, it is important for policy makers driving the nation's health care quality improvement agenda to focus on:

- Rationalizing the demands placed on hospitals and physicians, focusing on a limited number of QI initiatives that demonstrate the most promise for significant improvement and striving for consistency across programs;

- Creating mechanisms to facilitate hospitals' efforts to use data to improve patient care quality, such as centralized data repositories; and
- Establishing financial and other incentives that best support hospital quality improvement while also examining state and federal regulations, such as gainsharing prohibitions, that may impede hospitals' engagement of physicians in quality improvement. ■

Notes

1. Centers for Medicare and Medicaid Services (CMS), *National Health Expenditure Projections, 2008-2018*, Washington, D.C.
2. Kaiser Family Foundation, *Health Care Spending in the United States and OECD Countries (Snapshots: Health Care Costs)*, Menlo Park, Calif. (January 2007).
3. CMS, *Eliminating Serious, Preventable, and Costly Medical Errors – Never Events*, News Release, Washington, D.C. (July 31, 2008).
4. NSQIP is a nationally validated, risk-adjusted, outcomes-based program to measure and improve the quality of surgical care. The program employs a prospective, peer-controlled, validated database to quantify 30-day risk-adjusted surgical outcomes, which allows comparison of outcomes among all hospitals in the program.
5. The University HealthSystem Consortium is an alliance of 103 academic medical centers and 210 affiliated hospitals. The consortium offers databases that provide comparative data in clinical, operational, faculty practice management, financial, patient safety and supply chain areas.
6. Child Health Corporation of America is a business alliance of 38 children's hospitals. The alliance provides a range of programs and services, including group purchasing and supply chain management; pediatric data management; performance improvement and patient safety initiatives; and Web-based training programs and strategic planning.

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