Inside The Physician Mind

ENGAGING THE PHYSICIAN IN QUALITY AND PATIENT SAFETY

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Assumption
“We have absolute mutual interdependency.”

Joseph Bujak

Clark S, Creating a Culture of We, Healthcare Executive, 2014:25(1), 11
Rural Physician Engagement
A Strategic Imperative for a Value-Based World

• Integration of care within the community
• Key community member and advocate
• Motivation for being a primary care rural provider
• Making a Positive Difference = Retention
Key Elements of Increased Physician Engagement

• Define Quality and Safety
• Cultivate the Relationships
• Persuade with Data
• Leadership
Define Quality and Safety

FIND THE COMMON LANGUAGE
Defining Quality That Engages

**DISENGAGES**
- “CMS Says we....”
- “The Joint Commission says we....”
- “Administration says we....”
- “To meet the Core Measure we have to...”

**ENGAGES**
- “The AHA/ACC suggests that....”
- “The ACP is promoting...”
- “How can we always achieve the best outcome for your patients?”
Example

**Conclusions**: Current heart failure performance measures, ...., have little relationship to patient mortality and combined mortality/rehospitalization in the first 60 to 90 days after discharge.”
Key Thought

“Don’t confuse regulatory performance with clinical performance.”
Who’s Agenda?

“Physician, please join us in our quality agenda”

Physician, what is your quality agenda and how can we help you achieve it?

“Pizza Methodology”

“Winning Methodology”
Cultivate Relationship

TRUST IS THE COMMODITY OF EXCHANGE
Relationship Building - 101

- Communicate Effectively
- Demonstrate Competency
- Be Professional
- Empathy
- Listen to Understand
- Follow Through – *Always*
- Respect
- Dignity
- Be Available & Responsive
A Few More Thoughts
A Few More Thoughts
Key Thought

“Good Leaders Already Know How.”
The Data

TELL THE STORY WELL
The Must Haves:

- Data that Illuminates as Opposed to Causing Heat
  - Engages: Variation between Facilities looking at clinically ‘meaningful’ outcomes.
  - Disengages: Physician-specific performance metrics with questionable quality or quantity of data
- Reasonably accurate and verifiable to the patient
- Timely
- Clinically meaningful
Use Data to Create Knowledge

Data | Information | Knowledge
Overall Complications – Key Metrics

### Complications

<table>
<thead>
<tr>
<th></th>
<th>O/E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline (CY 13) Rate</td>
<td>1.20</td>
</tr>
<tr>
<td>Rolling 12 month (Jul13-Jun14) Rate</td>
<td>1.09</td>
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</tbody>
</table>

Data Source: Premier, Jan12-Jun14, Vineeth Y, 07/19
Center for Clinical Care Excellence

OR 1st Case Late Starts

Data Source: Manual Data Collection, Jan13-Jun14, Brenda B, 07/24

1st Case Late Starts = Cases Starting on or after 0740

Interventions Implemented

Trend Line
Suggestions for Engaging Around the Data

• Do your homework – where are the ‘best’ opportunities?

• Where are the ‘pain-points’ for physicians?
  • Things that directly harm patients – complications
  • Things that consume too much time, inconvenient

• Pick your first project thoughtfully
  • Right Scope
  • Right Resources
  • Right Physician Champion
  • High Likelihood of Success

• Present a compelling story with the Data
Key Thought

“Use Good Data, Presented Well, like a Professional ….”
Physicians and Leadership

CLINICAL LEADERSHIP DOES NOT EQUATE TO LEADERSHIP
Our Future

The Demands of Integration, High Performance, and Efficiency

- Team-based Care Culture
- Care Continuum
  - Ambulatory, Acute, Post-Acute
- Team-based Leadership Culture
- Patient (Consumer) – Driven Decisions
- Transparent Cost and Quality
- Shrinking Inpatient
- Growing Chronic Disease Burden
- Reduced Volume-Base Reimbursement
Physicians who become Leaders

- Integrator across the continuum
- Quality driver
- Liaison
- Patient-centered advocate
- Journey from clinician to leader
- Partner with administrative and nursing leaders
Key Thought

“Clinical Leadership does not Equate to Leadership.”
Summary
Key Elements of Increased Physician Engagement

- Define Quality and Safety
- Cultivate the Relationships
- Persuade with Data
- Advocate and support Physician Leaders as Partners
Questions and/or Comments
Bonus Slides
The National Context

UNSUSTAINABLE COSTS, INEXPICABLE VARIATION
National Health Expenditures per Capita
1960-2010

Notes: According to CMS, population is the U.S. Bureau of the Census resident-based population, less armed forces overseas.

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2010; file nhegdp10.zip).
Cumulative Increases in Health Insurance Premiums, Workers’ Contributions to Premiums, Inflation, and Workers’ Earnings, 2000-2010

Notes: Health insurance premiums and worker contributions are for family premiums based on a family of four.

Inexplicable Price Variation

Total Rates of Reimbursement for Noncapitated Medicare per Enrollee

http://www.dartmouthatlas.org/downloads/reports/Spending_Brief_022709.pdf
Wide Variation in Quality

Even with access to care, quality is not consistent
Exhibit 10. Five-Year Survival Rate for Select Cancers, 2004–2009

Note: Breast and cervical cancer rates are age-standardized; colorectal cancer rates are age–sex standardized.

* 2003–08.
** 2002–07.
Source: OECD Health Data 2011 (Nov. 2011).