Engaging Physicians in a Shared Quality Agenda

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Institute for Healthcare Improvement, 20 University Road, 7th Floor, Cambridge, MA 02138 Telephone (617) 301-4800, or visit our website at www.ihi.org

INSTITUTE FOR HEALTHCARE IMPROVEMENT

Engaging Physicians in a Shared Quality Agenda

Authors:

James L. Reinertsen, MD: *President, The Reinertsen Group; IHI Senior Fellow*
Alice G. Gosfield, JD: *Principal, Alice G. Gosfield and Associates PC*
William Rupp, MD: *President and CEO, Immanuel St. Joseph's – Mayo Health System*
John W. Whittington, MD: *Patient Safety Officer and Medical Director of Knowledge Management, OSF Healthcare System; IHI Senior Faculty*

Context and Background

The unique relationship between physicians and the American hospitals in which they practice arose historically when lay board members recognized their need to draw on the expertise of physicians to fulfill the board's fiduciary responsibility for quality. This led to the concept of the "organized medical staff"[1]—a vehicle through which otherwise unrelated physicians would come together to participate in ensuring the quality of care in the facility, and most particularly the quality of care provided by their peers. The importance of this mechanism has long been supported by state hospital licensure regulation, the Medicare program in conditions of participation for hospitals, and The Joint Commission,[2] which recently reaffirmed this view in the statement, "The importance of the medical staff bylaws cannot be overstated."[3]

But the context for this traditional relationship has radically changed in the last few years. Hospitals and their physicians are increasingly in competition with each other. For example, many hospitals have begun to employ various types of physicians whom independent medical staff members fear will steal their business, while the independent physicians themselves build and develop rival surgi-centers, imaging facilities, and even whole hospitals.[4,5] In some communities the tensions are so high that they have generated high-profile articles in the popular media, with both sides claiming quality of care both as a primary motivation and support for their position.[6] And the hospitals' "organized medical staffs" often have trouble generating much enthusiasm from their membership, who are challenged by the demands of their daily professional and business lives, including onerous administrative burdens, lowered reimbursement, escalating malpractice premiums, and overall decreased satisfaction with their roles as physicians.[7]

As a result, the medical staff organization is seen by many as an obsolete and moribund structure, incapable of fulfilling its purposes of overseeing quality,[8] at precisely the time that hospitals and physicians are coming under intense pressure to produce measurable quality and safety results.

Some hospitals are making dramatic improvements in quality, despite the difficulties they face with the organized medical staff, even while many others struggle to implement evidence-based protocols and rigorous safety practices. Yet even in the most advanced hospitals, one of the most common questions raised is, "How can we do an even better job of engaging our physicians in the quality and safety agenda?" This question arises today because of several overlapping realities:

- Physicians' primary professional and business focus is their own practice—the quality of care they personally deliver, and the economics of their own professional microsystems (a five-physician practice, for example). In many instances, these priorities for physicians seem out of alignment with the quality issues faced by the larger system in which they work. At best, physicians have little time to spare for the organization's quality agenda, whether that

organization is a hospital or other delivery system. At worst, relationships get strained because the physicians' quality and business agendas appear to be in conflict with those of the hospitals and other institutions which they staff. For example, in one hospital the administrator wished to standardize hip prostheses, both to obtain better pricing and to reduce costly and hazardous variation in the process of hip replacement. An orthopedist on staff responded, "What? I've just become really comfortable with the prosthesis I'm using. I'm getting great results, and it's efficient for me. Now you want me to take the time to learn a whole new prosthesis? That's risky for my patients. How is that an improvement?"

- A critical fact about hospitals is that very little happens in the health care system without a physician's order. By virtue of physicians' plenary legal authority, which is broader than that of any other actor on the health care scene, almost all actions in health care are derivative of their decisions and recommendations. Therefore, any changes in the way care is designed and delivered require physician acceptance, either as individuals or as a professional body (e.g., the Medical Staff Executive Committee).

- A belief in personal responsibility for quality is powerfully engrained in the physician professional culture—and is largely responsible for physicians' fierce attachment to individual autonomy. This cultural element puts physicians in conflict with a core tenet of improvement theory: a systems view of quality and safety. It also leads naturally to a blaming culture. Physicians are taught that "If we work and study hard enough, we won't make a mistake." This leads them to believe that if a mistake does happen, then someone (a physician, in this instance) didn't work hard enough or study hard enough. Both of these effects—lack of a systems perspective, and a tendency to blame individuals when things go wrong—arise from the same basic belief in personal responsibility.

Given the deep-seated nature of these realities, and the importance of physician engagement to achieving quality results, it is surprising that so few hospitals have actually articulated a plan to improve the engagement of their physicians. The primary purpose of this white paper is to provide a framework, a sort of scaffold, on which hospital leaders might build a written plan for physician engagement in quality and safety. While the principal focus of the paper is on American hospitals and their organized medical staffs, we believe that the framework might also be applied to many other types of health care systems and in settings outside the United States.

Sources of Knowledge:
"Best-in-the-World Laboratories" for Learning about Physician Engagement

The measure of effective leadership is results. While we do not know of every organization that has effectively engaged physicians to get results in quality and safety, we are aware of several excellent examples, from which we've drawn the lessons and ideas that make up the core elements of the IHI Framework for Engaging Physicians in Quality and Safety. These ideas come from organizations such as Virginia Mason Medical Center, McLeod Regional Medical Center, Hackensack University Medical Center, Immanuel St. Joseph's – Mayo Health System, and Tallahassee Memorial Hospital, along with many others in a variety of settings ranging from multispecialty group practices to independent medical staffs to the British National Health Service. None of them claims to have the answer to physician engagement in quality. But many of them have achieved stunning results. For example, Tallahassee Memorial Hospital[9] and Immanuel St. Joseph's – Mayo Health System have reduced mortality rates 30-40 percent. Hackensack and McLeod are now capable of delivering "perfect care scores" on evidence-based care at levels of only 1 or 2 defects per 100, for all Centers for Medicare & Medicaid Services (CMS) Core Measure sets.[10] McLeod has gone seven straight months without a single adverse drug event,[11] as measured with the IHI Trigger Tool methodology[12] (an objective count of medication-caused harm which does not depend on incident reports or other self-reporting systems). These results could not have been achieved without significant engagement on the part of the physicians on the organized medical staff.

We have also tried to notice what doesn't work, because we learn as much or more from failure as from success. The path to more and better physician collaboration is not always smooth. So in addition to extracting lessons about what leaders should do to improve physician engagement in quality, we have also attempted to address some things that leaders should *not* do. We hope that the IHI Framework for Engaging Physicians in Quality and Safety, built from elements learned from "best-in-the-world laboratories," will encourage hospital leaders to develop and execute a written plan to improve physician engagement in these sorts of quality and safety initiatives.

IHI Framework for Engaging Physicians in Quality and Safety

The IHI Framework for Engaging Physicians in Quality and Safety comprises six primary elements, as shown in Figure 1. Each framework element and its components are described in detail in this white paper.

Figure 1. IHI Framework for Engaging Physicians in Quality and Safety

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

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

2. Reframe Values and Beliefs:

2.1 Make physicians partners, not customers
2.2 Promote both system and individual responsibility for quality

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5. Show Courage:

5.1 Provide backup all the way to the board

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

Framework Element 1. Discover Common Purpose

Link the Hospital Quality Agenda to the Physician Quality Agenda

The first element of the framework requires a mind shift on the part of hospital administrators. It suggests that the question we have been asking—"How can we engage physicians in the *hospital's* quality agenda?"—could also be rephrased as "How can the hospital engage in the *physicians'* quality agenda?" This question forces hospital administrators to recognize that physicians *are* interested in quality—in particular, two attributes of quality: patient outcomes and personal *muda* (waste), especially wasted time. Interestingly, these two quality concerns of physicians—outcomes and time—are not independent variables. They are strongly linked.

1.1 Improve Patient Outcomes

1.2 Reduce Hassles and Wasted Time

Giving physicians more time in their day is neither simply an issue of personal satisfaction with the quality of their professional lives, nor merely an opportunity for them to generate more revenues. Rather, the issue of time is one which itself has a significant impact on quality and outcomes. The Institute of Medicine has stated, "The transfer of knowledge is care."[13] Whether that transfer occurs through dialogue, the writing of a prescription, the interpretation of a study, or the performance of a procedure, in order to optimize that knowledge transfer the physician must apply the best science available to the specific patient, taking into account not only the patient's drug allergies, laboratory test results, social, family, and medical history, but also the patient's fears, beliefs, socioeconomic status—in essence, everything that makes the patient unique. To do this effectively requires time: time to listen, time to examine, time to think, time to explain, time to operate, time to interpret, time to comfort.

The lack of time to do a good job is a particularly strong driver of primary care unhappiness,[14] but all physicians feel these pressures to some degree. Hospitals can help by changing the way work gets done, and improving flow of work processes, so as to remove time stealers and improve patient outcomes. In essence, this reframes the quality agenda so that the physicians' needs for fewer hassles in daily work, and better outcomes for their patients, are harnessed to the hospital's need for things like better patient throughput and improved CMS Core Measure scores.

Hospital work includes many activities that are time stealers for physicians: documenting care, finding results of studies, waiting for delays and backups in patient flow, serving on hospital committees. These are in addition to the demands physicians face in their offices: justifying care to managed care plans for prior authorizations; documenting medical necessity and the CPT and ICD-9 codes for services for which they seek payment; responding to the demands of other providers for certificates of medical necessity for equipment and ambulances; managing patients'

pharmaceutical needs with prescription renewals; interacting with pharmacy benefit managers, case managers, and more. All of these activities can potentially steal time from the value-added aspects of their relationships with their patients.[15,16]

Physician engagement in the hard work of quality improvement is much more likely to occur if hospital leaders remember John Gardner's teaching that one of the key tasks of leadership is to explain "why," in personally meaningful terms.[17] What could be more meaningful for physicians than "Our aim in quality is to eliminate those things that waste everyone's time, so that you and the entire team can have more time to do the important things that really determine patient outcomes"?

1.3 Understand the Organization's Culture

An essential first step to finding common purpose is to be abundantly clear about the place from which you are starting your physician engagement endeavors. Here, the point is to be brutally realistic and not unduly rosy-eyed about the real work at hand. If physicians hold grudges from past tensions and battles, they will carry the scars of those skirmishes into the context of any new initiative, including quality. The physician memory of difficult hospital interactions is often very long. And whatever the problems might have been, the fact that they have nothing to do with the current proposal, or even the current administrators, is often irrelevant. More to the point, different segments of the hospital medical staff will view the same issues quite differently.

In today's hospital environment, within a single medical staff some physicians might be employed directly by the hospital, while other physicians might be employed by an affiliated but separate entity (e.g., a faculty practice plan or a primary care entity). Still other members of the staff practice as completely independent physicians in solo practice, single specialty groups, and large multi-specialty groups. Some of those physicians admit solely to one hospital, while others have divided loyalties. Some have academic affiliations and career goals; others do not. The perceptions of each of these types of physicians regarding their position in the facility and their roles in hospital quality and safety initiatives are likely to be quite different.

A complex mix of factors influences any one hospital's degree of difficulty in moving from a defined starting point toward higher levels of physician engagement in quality and safety. Some factors are structural, such as the various employment arrangements described above. Others are historical—the memory and residual effects of relationships and events in the institution's past. But the most powerful factor of all is *culture*—the beliefs, norms, and values—spoken or unspoken—that form the basis for the patterns of behaviors of the medical staff. Understanding the existing culture is critical to changing to a new one.

Patterns of behavior provide the primary window into the culture of any given hospital. It's important to note that a hospital medical staff does not have a single culture; rather, it contains multiple "microcultures," corresponding to departments, medical groups, subspecialties, and so forth. To illustrate, what pattern of behaviors might you expect if an improvement team recommends the adoption of a standardized method for all physicians' insulin orders? Is the pattern of behaviors the same across all departments, medical groups, and units? What underlying beliefs support these various patterns of behavior? If hospital leaders don't have a good understanding of the beliefs, norms, and values that are driving these behaviors, they are unlikely to bring about successful engagement at a higher level.

The issue of culture becomes particularly difficult when two hospitals merge, or enter a joint venture, requiring medical staffs in different cultures to work together. For example, if one of the hospitals is a large teaching institution with multiple residency programs and the other is a community-based hospital with a private-practice-driven medical staff, the patterns of behavior and the underlying beliefs around topics such as physician autonomy, partnership with administration, relationship to the board of directors, and customer service are likely to be substantially different—and will constitute a significant challenge to physician engagement in quality.

The Physician Engagement Difficulty Assessment

For the purposes of developing a strong plan for improved physician engagement in quality and safety, it is not necessary to define every aspect of the medical staff culture and microcultures. But it is important to assess those aspects of the various cultures that will predictably thwart (or enhance) physician engagement. The Physician Engagement Difficulty Assessment (see Appendix A) is intended to provide a rough assessment of the cultural and historical factors that need to be taken into account when building a physician engagement plan. (Note: The suggested scoring system is *not* intended to be rigidly used; there are undoubtedly many nuances to any hospital's answers to any of the items in the assessment. For example, physicians employed by the hospital may be just as resistant to change as a completely independent medical staff. Or, the medical staff may be highly functional in reality even though its bylaws are obsolete and essentially irrelevant.)

The historic cultural factors (see assessment item 7 in Appendix A) deserve additional explanation, since these sorts of issues play such a prominent role in many medical staff cultures. Some examples include:
- A recent battle over taking a department into exclusive contract status or terminating an exclusive contract approach might have been a very defining moment in medical staff history.
- A recent quality initiative might have started badly, and left a sour taste in everyone's mouth. Further efforts will be tainted by this experience.

• Failed managed care contracting strategies can haunt the medical staff long after the contracts are terminated.
• Successful hospital-physician joint ventures can provide part of a foundation on which to build quality engagement.

These examples, and the self-assessment in Appendix A, surface an important point regarding building plans to engage physicians in quality and safety: sometimes, in some stages of a hospital's history, you might have to re-engage the physicians much more broadly on a variety of administrative and strategic issues, before taking on the quality and safety agenda. On the other hand, when relationships between physicians and the hospital are rocky because of issues such as those noted above, the quality and safety agenda can function extraordinarily well as a bridge-builder because it appeals to the deep professional aspirations of physicians and hospital administrators alike.

The Physician Engagement Difficulty Assessment is designed to prompt hospital leaders to think carefully about the structural and historical factors present in their current context that will inform the degree of difficulty that any hospital might have in moving together with the medical staff to a higher level of partnership for quality and safety.

The "best" total score on the Physician Engagement Difficulty Assessment is 7. At this level, physician engagement is not necessarily assured, but it is a lot easier to get to a real integrated, clinically collaborative, sustainable, quality-driven culture than at the "most difficult" score of 25. That is a hard row to hoe, and might require a very different approach.

The total score is not determinative of what might happen, but in essence is a taking of the organization's temperature. Completing the self-assessment, and discussing its implications among your medical staff and administrative leaders, is an important early step in understanding, prioritizing, and sequencing the hard work you will need to do in order to develop and execute a plan for physician engagement in quality and safety (see Appendices B and C).

This assessment is a relatively gross way of thinking about and querying the medical staff about their views of their circumstances. Whatever the responses, the process of going through an honest self-examination of where your organization is starting from 1) can be useful to custom tailor your efforts toward any engagement moving forward, and 2) will point, in some measure, to the attention that will have to be paid to certain overarching principles of engagement that are useful in winning the hearts and minds of the physicians for quality improvement (see Framework Element 6).

The key to changing a culture is to first write down a non-judgmental, specific description of the current culture, and to develop a shared picture of the patterns of behavior driven by that culture. Only when everything about the starting point is on the table can a group have deep discussions

about what changes in culture will be necessary to accomplish the hospital's aims in the future. Two successful methods to accomplish such a change have been advocated by Dr. Jack Silversin and his work with "compacts,"[18] and by Dr. Marc Bard and his development of a tool called "simple rules."[19] Both methods define the current state of the culture, then define the desired culture needed to support the achievement of specific organizational aims.

1.4 Understand the Legal Opportunities and Barriers

Physicians are the lifeblood of the hospital. They admit patients, order services, and decide when to discharge patients. They personally perform many of the most critical and intimate procedures in the care of patients. In the course of all these activities, they generate revenue for the hospital (as well as the great majority of the operating costs—which they seldom if ever recognize).

This role as revenue generator and referrer for services is recognized in the many legal barriers designed to prevent a hospital from inappropriately currying favor and garnering patients from those physicians. Yet, there are significant mythologies about the limitations imposed by the Stark and anti-kickback statutes.[20] It is *not* true that a hospital cannot engage financially with its referring physicians. For example, to the extent a hospital needs time from physicians to be spent in services that improve quality, that hospital *can* pay physicians. For example, this applies to paying for physicians' time and service in developing hospital computerized physician order entry (CPOE) initiatives, which will not succeed without physician acceptance,[21] for working on quality improvement teams, and many other activities that are intended to improve quality and safety.

Does this mean physicians will not engage in quality work without pay? It does not. In fact, many organizations are finding that physicians have a deep need to contribute to improving the situation—to be part of what's right, rather than what's wrong, with the health care system. Alva Whitehead, MD, Vice President of Medical Services at McLeod Health (Florence, South Carolina), which has worked with its physicians to achieve 99 percent "perfect care" scores for virtually all CMS Core Measures, dramatic reductions in mortality rates for acute myocardial infarction, and extraordinary improvement in medication safety (two orders of magnitude reduction in harm events), articulates this as follows:

> "If we have a secret, it is that we have become a 'learning organization' and that appeals to life-long learners, which physicians are. We like to say that our improvement work is 'Physician-Led, Evidence-Based, Data-Driven,' but what we're really saying is that we believe that physicians have a deep-seated need to learn together, with evidence and data at the foundation of the learning. Moreover, we've found that it's important to broaden the group doing the work beyond physicians. This team learning, done across disciplines, increases respect and communication. We showcase the physicians and staff, implement

their efforts, and give ownership of success to them. This gives them the relatedness necessary for personal growth, and it gives them real self-esteem."[22]

Note that Dr. Whitehead never mentions money.

Nevertheless, there are creative ways in which the hospital can help physicians meet their needs with direct financial benefit to them, while furthering quality—without running afoul of the law. For example, many physicians would like to use mid-level practitioners in their offices. These highly trained individuals do not come cheap, and physicians are often fearful that they will not be able to afford full-time salary and benefits for them. Hospitals are uniquely situated to become staffing agencies in effect: to hire physician assistants and nurse practitioners to be employed full-time by the hospital, but leased on a fair market value hourly basis to physicians to use part-time in their offices for purposes of quality improvement. These clinicians can save physicians in private practice for their highest and best use. If these mid-level practitioners were trained to develop and support the Chronic Care Model developed by Ed Wagner and colleagues at the MacColl Institute,[23] for example, they could help physicians in many different practices improve their delivery of evidence-based care. The physicians could bill to Medicare for many services rendered by these leased independent contractors at 85 percent of the physician fee schedule.

While a hospital has no business without the patients the physicians bring to it, in many ways physicians operate businesses that are competitive with the very institutions they staff. As more technologies once relegated only to acute inpatient care can safely be provided in physician offices, more physicians do exactly that. The resulting legal entanglements and competitive battles that swirl around the medical staff/administration front constitute a significant barrier to the "common purpose" agenda. These sorts of problems strain relationships between physicians and administrators, and a significant part of the task of uncovering common purpose requires that leaders first rebuild damaged relationships, which are often the elephant in the room in conversations about engaging physicians in quality. Finding ways to support each other's business success by improving quality and safety is a primary route to rebuilding those relationships and therefore has a prominent place in this framework.

Framework Element 2. Reframe Values and Beliefs

Two major cultural changes—re-framings of deep-seated values and beliefs—need to occur in order for physicians to engage fully in the organizational quality agenda. First, hospital administrators need to stop regarding physicians as customers and start treating them as partners in the delivery of care. Second, physicians need to stop seeing their care responsibilities as narrowly focused on the patient in front of them, and start seeing their responsibility for the performance of the hospital as a system. Neither of these changes is easy.

2.1 Make Physicians Partners, Not Customers

Hospitals have historically regarded physicians as customers. This is obvious from the language used in many hospital documents. It is even more powerfully demonstrated in the actions taken (or not taken) when hospitals face the choice between enforcing a safety policy such as mandatory "time-outs" before surgery, on the one hand, and offending a surgeon who is a major source of admissions and revenue, on the other. Leading-edge hospitals and care systems have recast the relationship between physicians and the institution, and consider each other partners in the delivery of services to the only customer—the patient. This "remaking of the physician compact" requires a dramatic shift in viewpoint from both the physicians' and the administrators' perspectives, and seems to be a marker of many organizations that have achieved dramatic new levels of meaningful engagement of physicians in quality and safety. Characteristics of this new relationship include:

- Physicians are asked to lead and partner with administrators to do real work to improve the system.
- Information, resources, and responsibility are shared openly among administrators and physicians.
- New recruits are clearly advised as to "what the deal is" and are encouraged *not* to join the organization if they do not want a real partnership on behalf of patients.
- There is a system for allowing physicians to opt out or to be asked out of this "new deal," and it is used when necessary.

Perhaps the most powerful example of this idea at work is the statement found at the top of virtually every quality agenda and performance report at Park Nicollet Health Services (Minneapolis, Minnesota): *"The patient is the only customer."*

2.2 Promote Both System and Individual Responsibility for Quality

The other major cultural shift needs to be brought about within the profession of medicine itself. Physicians are imbued with a deep sense of personal responsibility for the outcomes of their patients—their own patients—and for that portion of the patient's care that involves their own decisions and actions. This professional value, which is the primary driver of the physicians' fierce

attachment to individual autonomy ("If I'm personally responsible, then I must have complete control and autonomy in the decisions about care"), stands in direct contrast to the central idea of quality improvement—the nature of a system, and the recognition that most quality outcomes are system attributes, rather than individual provider attributes. In many ways, coming to a different place on this issue begins with the physicians giving up their personal autonomy to a broader view of professional control,[24] and with their understanding that an entire field of science—systems science—exists, and that physicians know little about it.

For example, Hackensack University Medical Center (HUMC) in New Jersey set out to improve cardiac care, and in particular, their scores on evidence-based care measures for acute myocardial infarction and congestive heart failure. In their "old" method, physician autonomy held sway, which meant that whenever issues regarding heart disease patients arose, physicians were called in their offices, disrupting the flow of their work. So the physicians worked with the unit nurses to develop protocols to handle common problems immediately,[25] and authorized nurses in the cardiology unit to take on functions that had previously remained within the purview of physicians. By sharing autonomy with each other (designing a common system for all physicians to use) and sharing some responsibility with the clinical nurse specialists, HUMC was able to achieve spectacular improvements in virtually all measures of care, while simultaneously freeing physicians from many disruptive telephone calls. Care improved and physicians gained precious time. In the process, physicians began to see these outputs (e.g., improved patient outcomes, CMS Core Measure scores) as a product of their new cardiology "system" rather than as attributes of each of their individual practices.

To get physicians to see the system in which they work as part of their professional responsibility, leaders must use practices that encourage a systems view, and allow physicians to make a profound shift in mindset, framed as follows: "As a leader in this system of care, I share responsibility for the outcomes of all the patients in the system, regardless of whether I was personally involved in their care."

Hospital leaders might consider any of the following specific suggestions for encouraging physicians to adopt a systems view:
- Start every Medical Executive Committee meeting with a specific story about a serious, recent harm event in the hospital, along with an analysis of the systems issues (e.g., handoffs, teamwork, poor system design) that contributed to the event.
- Gather the medical staff leadership annually and provide a detailed, candid assessment of the performance of the system, and the interactions among the parts of the system (e.g., discuss in detail the relationship between something that distresses physicians greatly such as diversions from the emergency department and something they don't want to change, like the elective surgical schedule).

- Use "Morbidity and Mortality" reviews to broaden the discussion from "Was there an error of judgment or an error of technique by an individual physician?" to "How did the system of care fail this patient, and what could we do to reduce that risk in the future?"
- Provide opportunities for medical staff leaders to track an individual patient for a day or two through all the various interactions, waits, and other experiences that typify a hospital stay, and report his/her observations to the rest of the medical staff.
- Have a physician track medication orders from the moment they are written until they are executed, and report to the medical staff.
- Use medical staff meetings to expose interesting variation in common practices and the effects it has on the system of care. For example, ask the physicians present at a meeting to respond on a "multivote" electronic system to questions such as "I wish to be called for a post-op temperature of…" and then display and discuss the variation among staff. (Physicians tend to be curious, and nothing provokes curiosity like unexplained variation.)
- Show the system's results on quality and safety measures at each medical staff meeting, and also send these results to the entire medical staff, regardless of whether that individual staff member has a logical relationship to any particular quality measure (e.g., send surgical site infection rates to cardiologists, not just to surgeons, and send "door-to-PTCA" times to surgeons, not just to cardiologists).

Framework Element 3. Segment the Engagement Plan

Joseph Juran emphasized that there is really "no such thing as improvement in general."[26] Similarly, there is no such thing as "physician engagement in general." Both improvement and engagement take place at finely granular levels, with specific changes in processes and designs, in the case of improvement, and within individual physicians, in the case of engagement. One of the most practical ideas for developing a plan to engage physicians in quality and safety is to *segment the plan:* identify specific roles that need to be played by physicians, and develop a detailed plan to prepare individual physicians to play these specific roles.

Prioritizing and Sequencing

The first task in segmenting the engagement plan is to review what your organization is trying to accomplish. Hospitals are complex organizations that are usually working on dozens of initiatives at any one time. Physician engagement at the highest levels is critical to some of those initiatives; for other initiatives, physicians do not really need to be engaged at all. For example:

- Physician engagement is *imperative* for activities such as physician credentialing, privileging, monitoring, and corrective action. It is also required for choosing and applying clinical practice guidelines, planning for physician recruitment, and many quality of care and patient safety initiatives.

- Physician involvement is *important* for activities such as strategic planning, maintaining and managing relationships with payers, workforce planning and allocation decisions, risk management, and compliance education.

- Physician involvement is *useful* when making marketing plans, especially if the plans touch on physician services or attributes, directly or indirectly.

- Physician involvement is typically ***not a priority*** in setting up a materials management plan, or selecting a vendor for the maintenance of the parking ramp.

So the first task in developing a segmented plan for physician engagement in quality is for the hospital leadership team to get clarity about *what specifically* they need to engage physicians in.

Sequencing is also important. For some organizations, at certain stages of their organizational life cycle, the path to physician engagement in key quality or safety work might be indirect—a sort of "bank shot." For example, a hospital that has had a bad managed care contracting experience that did not work out well for their primary care physicians might choose as a first step to build bridges with these physicians—for example, by leasing nurse practitioners to support physicians in their offices, thereby giving them an immediate opportunity to improve revenues. Later, when the relationships are better, the hospital might start to work with the physicians and the nurse practitioners to implement the Chronic Care Model—a proposal that would have fallen on deaf ears if it had been the initial effort.

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"

The second task in developing a segmented plan is to examine the quality and safety workplan itself, and ask a more focused set of four questions that follow.

1. What are the projects and initiatives in which we most need physician engagement?

Within the broad quality and safety arena, projects differ in the level of requirement for physician leadership and engagement. As a general rule, physician engagement in efforts to improve reliability of evidence-based care delivery, reduce risk of nosocomial infection, and

other projects aimed directly at clinical outcomes need a great deal of leadership, input, and support from physicians. On the other hand, initiatives focused on improving the quality of front-line supervision of nursing personnel, or reducing times to answer nurse call lights, might require physician awareness, but far less direct engagement than for clinical projects. *As a general rule, if a project is going to require physicians to change the orders they write, to adopt new clinical policies and "rules," or to alter their daily workflow, their engagement at a very high level is necessary for success.*

2. *What specific roles are we looking for physicians to play in each initiative?*

For many projects, it is important for at least one physician to play the role of a *champion.* Within the same project, it might be critical for key *structural leaders* such as department chairs, Medical Executive Committee members, and medical directors to play other important roles. For some projects, a physician is needed as the *project leader,* a role distinct from champion or structural leader. Almost all clinical projects ask some physicians to implement the project's recommendations in their practices—the role of *adopter,* if you will. And finally, in many clinical projects, the engagement plan needs to identify and work with the *"cautious laggards,"* that is, those physicians who require extremely strong evidence before making any changes in their practices, and who are adept at finding flaws in proposed designs for improvement. To build a segmented plan for physician engagement, it is important to understand each of these roles a bit further.

- **Champion:** A strong champion can make a critical difference in many clinical projects. The key test of a champion comes at any point when the project faces a challenge—usually from another physician—for example, "The proposed change doesn't rest on strong enough evidence. We should continue with our current methods. Change is too risky. I'm not going to go along with this." There are many ways in which a champion might respond to such a challenge in order to keep the project moving forward. But there are two ways that an effective champion will *not* respond: either with silence, or with an offensive attack on the individual objecting to the initiative. This leads to the identification of the two key attributes of an effective champion: *courage* and *social skills.*

  Certainly, other attributes are also highly desirable in a champion. Effective champions are often highly respected clinicians and, ideally, have experience in a specialty relevant to the initiative under consideration. A good champion has "professional gravitas," not necessarily "organizational gravitas" (i.e., a champion need not be a structural leader, and in some instances, participation as a structural leader might actually diminish the credibility of a champion). *But no personal characteristics are more important than both the courage to speak up when the project is about to be paralyzed by one physician's objections, and the social skill to be*

able to use one's voice effectively. For example, a courageous, useful response to the objection cited above might be: "I understand you feel that way, Bob; the evidence isn't perfect. But it never is, is it? And the leading minds in our specialty, plus the CDC and the specialty society itself, have all recommended that we make this change. I don't think we're going to reinvent the science here in our hospital, and I think we should adopt these changes. Sure, there might be risk in making the change. But we've seen the evidence of the harm that's occurring to our patients with our current approach. What is the risk to our patients of *not* making the change?"

That's a champion at work.

Here is a specific example of one champion's effectiveness: OSF Healthcare System, a seven-hospital, 2,000-physician care system in Illinois, was experiencing difficulty getting full support from all physicians in reducing central line infections. Because it was following the full set of the Center for Disease Control's (CDC) recommendations, one of OSF's intensive care units (ICUs) had dramatically decreased its line infection rates while the other ICUs in the system were reporting much higher rates of infections. A champion with courage and social skills stepped forward and shared the data on all ICUs with a group of surgeons who had been resisting some of the recommendations for decreasing central line infections. When confronted with evidence on the effectiveness of the changes, the surgeons agreed to abide by the recommendations. At the same time, the champion encouraged the Medical Executive Committee to pass a "red rule" that required anyone placing a central line in a non-emergent situation to follow the CDC guidelines for using maximal sterile barrier precautions. (A "red rule" must be followed. If it is not, a physician will be called before several members of the Medical Executive Committee and the CEO of the hospital. This was another idea that the safety champion had encouraged.) This action led to a 37 percent reduction in central line infection rates for the OSF system overall.

- **Project Leader:** It is not necessary in every instance for an improvement project—even a clinical project—to have a physician as project leader. This role—to bring together the project team, to organize and execute the project plan, to lead the various meetings and other activities—is often extremely time-consuming, and requires specific project management and other skills that are not commonly present among practicing physicians.

  For this reason, when it is important symbolically to have a physician identified as the leader of the initiative, many organizations also identify a key administrative co-leader who can do much of the time-consuming background work to allow the physician project leader's time to be used most effectively. Even with this sort of administrative support, physician project leaders should at a minimum be effective communicators who understand good meeting

management skills, and who can articulate the rationale for the project ("explain why") in terms that are credible and engaging to physicians.

- **Structural Leaders:** In most instances, structural leaders are already in place and the issue isn't "Who should be the structural leaders for this initiative?" but rather "How should we best use the structural leaders that are in place in order to achieve the needed improvements?" Within the organized medical staff, structural leaders such as committee chairs, department chairs, and MEC members might be particularly important when quality initiatives require adoption of new policies (e.g., "All non-emergency central lines will be inserted using full barrier precautions"). After all, these are the individuals who will vote on these changes to formal organizational policies, and therefore, hospital leaders need to make a specific plan to work through the organizational "politics" of such decisions. This is a very different plan from that required to support champions, or to train and equip project leaders.

- **Adopters:** Every initiative needs adopters—those physicians who can take the initial work of others, see the evidence that it might benefit patients and their own practices, and apply the new method in their work. A thoughtful physician engagement plan will stratify the physicians into "early adopters," "early majority," "late majority," "late adopters," and so forth, and will map out a strategy to allow the early adopters to pave the way for more widespread, full-scale application of the changes. The plan will also take into account more than just the characteristics of the individual physicians. A good plan will reflect the nature of each proposed change (e.g., how easy it is to try the change, how risky the change appears to be, etc.), as well as numerous other factors that will influence any individual physician's attraction to the innovation.[27]

- **Cautious Laggards:** Physicians' primary mode of thinking is "logical negative." Every day, for patient after patient, their job is to think through "What is wrong with this picture?" They are good at it (for which all of us as patients should be grateful), and they fall naturally into this mode of thinking when confronted with new ideas (which causes anyone who is advocating change some heartburn). Some physicians are particularly good at noting the flaws in proposed changes, and it is important for the physician engagement plan to have a method for listening carefully to these "cautious laggards." Yes, they are often overly cautious or excessively negative; but sometimes, they are right.

  One interesting method for listening to these physicians is employed by McLeod Regional Medical Center, where a committee is convened on an ad hoc basis when initiatives have had some early testing and are ready for wider deployment. This committee has been *intentionally* populated with the physicians (and nurses and other professionals) who have historically been the most vocally critical and negative about new programs and changes. The job of this

committee is clear. They are told: "You are good at seeing what's wrong with things. So tell us—what's wrong with what we're planning to do?" Then the leaders of the initiative listen. A large proportion of what they hear comes under the category of "We've never seen a change we like and this is no exception." But they almost always hear something else as well— observations about real flaws in the proposed change. The committee is thanked for their input and, if indicated, the proposed changes are modified accordingly. The results, when the change is finally implemented on a broad scale, are noteworthy: the members of the committee don't necessarily embrace the change, but generally they go along with it and don't undermine the process.
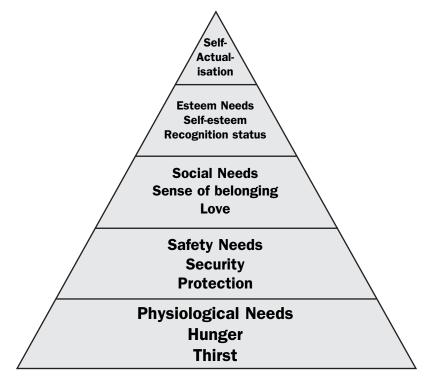
3. *Which physicians are candidates for which roles?*

An effective plan to engage physicians will examine the roster of potential candidates (e.g., the entire list of active medical staff members) and will first separate out the smaller list of the physicians that actually have any direct involvement in the care of patients affected by the initiative. The "20/80 rule" generally applies here; that is, only 20 percent of your medical staff usually performs the vast majority (80 percent) of the clinical services in the institution.

From this list, leaders of an initiative should identify the best initial candidates for roles such as champion, early adopter, and so forth. In order to "screen" the list for the final candidates, the best strategy is simply to have a brief face-to-face conversation with the physician in which you describe the initiative, what it might do for patients and for the daily work of physicians, and the physician's potential role in the initiative. While describing the project, watch their body language. If the physician's eyes light up, you have identified a champion or a project leader. If the physician starts working his or her Blackberry, you should move on to another candidate on the list. This isn't a perfect method for identifying which physicians are candidates for which roles, but it is practical, quick, and reasonably effective. It should be noted that physicians whose eyes don't light up aren't necessarily bad candidates for future projects; it may well be that other factors are interfering with their ability to get excited about this particular project at this particular time.

Maslow's Hierarchy of Needs (see Figure 2) provides a useful framework for thinking about how to approach individual physicians (or even physician groups) in these conversations about potential leadership roles in quality and safety.

Figure 2. Maslow's Hierarchy of Needs

Abraham Maslow, *Motivation and Personality,* 2nd ed., Harper & Row, 1970

The idea is that physicians are unlikely to work at the highest levels of this pyramid (e.g., using creativity and innovation to improve safety and care for patients and to contribute to the design and development of a better health system) if their most basic needs are not being met. For example, real-life barriers to physiologic needs (air, food, sleep, sex) are rampant in hospital work (frequent calls at night, absence of hospitalists, backups in flow that cause late admissions and surgical cases). Examples of barriers to safety needs include malpractice risks, distrust of administration, burden of debt, and unavailable information on lab results. Barriers to belonging and love are legion: working in professional isolation (even in "group practices"), lack of real relationships with administrators, lack of family time. So those who wish to engage physicians in common purpose around quality, at the top of the pyramid, often must first deal with some of the more basic problems that doctors face.[28] The ultimate aim, however, is to engage physicians in at the highest levels of self-actualization, as described by George Bernard Shaw:

> "This is the true joy in life, the being used for a purpose recognized by yourself as a mighty one… the being a force of nature instead of a feverish selfish clod of ailments and grievances complaining that the world will not devote itself to making you happy."

4. What is our plan to equip and support those physicians, in each role?

Finally, once the leadership team has identified the specific initiatives needing physician engagement, the roles to be filled, and the individuals to fill those roles, the team must also put together a specific plan to support them effectively. While this support plan will necessarily be highly specific to any individual organization, initiative, and set of physicians, some common questions will need to be addressed in any effective support plan:

- How can we maximize the effective use of this physician's time and avoid wasting it?
- How will we provide the physicians with timely, credible data?
- What training and development is needed if this physician is to be effective in this specific role?
- What communication system will be necessary in order to keep all stakeholders informed and build trust throughout the initiative?

The planning template "checklist" in Appendix C further lays out an approach to segmenting a plan for engaging physicians. What is clear, however, is that it is absolutely essential to think through this challenge carefully at a very fine-grained level. Juran was right; there is no such thing as "physician engagement in general."

Framework Element 4. Use "Engaging" Improvement Methods

Some approaches to improvement can be extremely attractive to physicians—to the ways in which they naturally think, to their curiosity, and to their desire to learn. Other approaches can be toxic to their engagement, and will leave a lasting "bad taste in the mouth" about quality improvement for almost all physicians. This aspect of the IHI Framework for Engaging Physicians in Quality and Safety proposes that when working with physicians on improvement, leaders should be careful to use "physician-engaging" improvement methods. Some examples follow.

4.1 Standardize What Is Standardizable, No More

Hospital leaders often complain that "our physicians won't accept any standardization of practices." But when you look at what the hospital is trying to get physicians to do, you find that they're being asked to follow detailed protocols with multiple branching logic trees covering every aspect of care for stroke patients, or other complex, extended standardized "pathways." These pathways attempt to standardize too much, are too complicated, and are legitimately resisted by physicians as "cookbook medicine" in many instances.

It is much more engaging to physicians to begin at the other end of the spectrum—with creation of standard work around common practices and procedures such as "start heparin" and "initiate the surgical site infection intervention." It is *much* more difficult, and perhaps not worth the effort at this stage of improvement, to standardize the decision whether to start a patient on heparin, or to take the patient to surgery. Some best practices in deciding *what* to standardize include the following:

- The evidence-based "goal posts" are often quite wide. It is useful to pick a specific goal within the parameters and to standardize to that goal; being inside the parameters isn't enough. A recent lesson in control of blood glucose levels in cardiac surgery provides an example. Each surgeon in an academic program was using a protocol that fit within the evidence-based parameters (ranging from "start insulin for any blood sugar over 110" to "start insulin for any blood sugar over 160, but only for diabetic patients"). Hypoglycemia was common, and deep sternal wound infection rates were 1.4 percent. When the surgeons all agreed to use one method within the parameters, and then conducted successive improvement cycles, becoming more and more aggressive, they eventually all were starting insulin at a blood sugar of 110, using an identical protocol, with stunning results: no deep sternal wound infections for 19 months, and very low hypoglycemia rates.[29]

- Start with something a few key physicians can agree to standardize, and move onward from there. For example, start with something simple and local like "a standard protocol for starting heparin in our stroke unit if you choose to start heparin."

- Measure and communicate the benefits of standardization in physician-relevant terms (better patient outcomes and less wasted time for physicians) rather than "reduced supply costs" and "decreased LOS."

But it's not enough to decide the "what" of standardization. Successful organizations have learned to standardize many other aspects of critical care processes such as who, when, where, and how. Standardizing the "what" requires understanding of the evidence. Standardizing who, when, where, and how requires understanding of how the organization's system of care operates on a daily basis.

The "old way" and the "new way" of standardization can be contrasted as follows.

Old Way:
- Experts design a comprehensive protocol using evidence-based medicine over months of meetings, focusing on the "what" of standardization.
- The result of the expert meetings is a protocol considered by the team as a finished product.
- Subsequent changes to the protocol are discouraged.

- The compliance strategy is to educate, expect vigilance and hard work, then report miscreants.
- No expectations are expressed by leadership regarding reliability of the standardization process.

New Way:
- Standardize how, what, where, who, and when.
- The "what" is based on medical evidence.
- The "how" does not need medical evidence, but rather knowledge of how your system works!
- Very little expert time is invested in the initial protocol.
- Initial protocols are tested on a very small scale.
- Changes to the protocol in the initial stages are required and encouraged.
- Defects are studied and used to redesign the protocol.

The new way of standardization is far more engaging to physicians, and should be part of any written engagement plan.

One very powerful effect of the new way of standardization results from the use of rapid tests of change. When physicians realize that the process is going to test many ideas, they tend to become less vested in their own ideas and more receptive to others. They know that their idea is going to get a chance to be tested, and that only the ideas that work, in real-life applications in their own setting, are going to be adopted.

4.2 Generate Light, Not Heat, with Data (Use Data Sensibly)

There is a paradox embedded in physicians' attachment to individual responsibility, on the one hand, and their sensitivity to individually attributed data on quality and safety, on the other. Far too much heat is generated by physicians (and quality staff!) on arguments about "the data aren't right, aren't properly adjusted, aren't relevant to my patients' outcomes," etc. Much of this wasted energy is caused by physicians' intuitive recognition that many quality and safety data elements are *not* attributes of individual performance, but rather are attributes of the system.

We create even more heat when we generate data for purposes of comparison to others, as opposed to generating data for improvement. And we approach explosive levels of heat when we use these sorts of comparative, physician-specific quality data for profiling and credentialing individual physicians. Two general categories of best practices fall under this element of the framework:

- Revise reports on quality so that they report system attributes as system attributes, not as individual physician attributes. For example, show the CMS Core Measures for AMI patients, or for surgical site infections, for the hospital as a whole, not for individual physicians or departments. Once the whole system is performing at 95 percent or better, then deal with the

few physicians who seem to be performing as individual statistical outliers. (Note: If your cultural assessment indicates that physicians and administrators are capable of using individual physician data for learning rather than for judgment, then it is possible to use individual physician performance reports to accelerate improvement before the overall performance of the system reaches 95 percent reliability. But the ability to learn, rather than to judge, from individual data is not a common cultural attribute of most health care systems.)

- Revise reports on quality so that they are framed in reference to the theoretical ideal, rather than in reference to comparative benchmarks. (To the extent possible, remove the denominators.) For example, instead of reporting only "Central Line Infections per 1,000 Line Days," simply show a run chart of "Number of Central Line Infections per Month," or "Number of Days Since the Last Central Line Infection." Your data will be more timely, less "abstract," and much more engaging to physicians. Most important, you won't be lulled into complacency because you're "better than the 50th percentile of the NNIS benchmark."

A good example of a practice that uses data in a "light-generating" way, while simultaneously encouraging physicians to take a systems view (Framework Element 2), is the mortality analysis process at OSF Healthcare System. OSF hospitals review *all* deaths, using a team of physicians whose specific task is to look for and make recommendations on patterns of process and system issues possibly underlying in-hospital mortality. These mortality review committees at OSF have uncovered a number of important system factors in mortality rates for the hospitals: end-of-life planning, getting patients to the right unit on admission, a high rate of diabetes in some populations, etc. Typically, the discussions about the systemic improvement opportunities surrounding each death are so rich that the teams have a difficult time moving from case to case. During the time since this process has been implemented, risk adjusted mortality at OSF has fallen by 30 percent. (Note: This committee of physicians (in some instances, joined by nurses and administrators—an excellent design) occasionally *does* uncover an individual physician "peer review" issue, in which case the matter is referred to a different committee. This is a good example of separating the use of data for learning, as opposed to using data for judgment.)

4.3 Make the Right Thing Easy to Try

Physicians often see a proposed change as risky. The logic goes something like this: "What's being done now can't be bad, or else we wouldn't be doing it, right? Any change has the potential to make things worse. So we should be absolutely certain that the change is the right thing to do before we make the change." Physicians will debate endlessly about the merits of this paper or that article, rather than getting on with trying things that might make the system better. The result is paralysis by analysis. Or better said, "paralysis by needing to determine what the *best* idea is, before you'll try *any* idea."

The best antidote to this stalemate is to make sure that when physicians are considering ideas that might improve performance, they understand that trying out an idea is not the same thing as full-bore, everybody-will-do-it-this-way-forever implementation. It is simply a test of the change. It is time-limited, and on a small scale. For example, "What if three of us who insert a lot of lines tested this new idea for reducing risk of infection over the next week? We'll keep a simple log of each procedure and give you all a report on how it goes…whether it slows us down too much, whether the nurses have the right training and equipment to support us, and so forth. We'll bring back a report to the full department meeting, with some suggestions for any improvements. Then we'll test out the improvements, and once it seems to be working well, then we'll bring it back to the department for more general adoption as a policy."

This approach has proved successful over and over, in almost every type of improvement project. It doesn't ensure success, but it makes it far more likely that a solid majority of the physicians will be willing to "have a go," as the British would say, than would be the case if the change were debated endlessly, without testing in the real world, and then brought to the full department for "implementation for ever and ever."

4.4 Make the Right Thing Easy to Do

When changes are being tested on a small scale, it isn't enough to test whether the change is associated with improved outcomes, or reduced harm, or whatever the outcome of interest is. Particularly where physicians are concerned, it is vitally important that the small-scale tests are also designed to study "implementability," particularly the question, "Does the new way require more physician time and effort than the old way?" If the answer to this question is "Yes, it's more cumbersome to do it this way," then it's important to conduct additional small-scale tests to find out ways to make it easier to do the process right (the new way) than to do it wrong (the old way). Far too few tests of change measure the impact of the change on physicians' and nurses' time in the process, for example, and it's not a surprise that front-line staff react negatively to the change when it's finally rolled out.

Framework Element 5. Show Courage

5.1 Provide Backup All the Way to the Board

Hospitals have historically sent mixed signals to the medical staff on quality. Hospital leaders, including Medical Executive Committee (MEC) members, have talked about their commitment to quality, but when a prominent member of the medical staff ignores the policies and procedures that are recommended by the leadership, no one takes action. For example, medical records are a chronic problem for many hospitals. It's a requirement that the records be timely and complete, including having a History and Physical on the chart when the patient goes into surgery, and a discharge

summary available to others who might need to care for the patient within a reasonable time after discharge. Many hospitals struggle with this requirement, and the MEC and board repeatedly forgive or otherwise "bend the policy" for physicians, especially those who are big admitters. The signal that's read by the quality staff, physician champions, and many of the rank and file members of the medical staff, who are all aware of the medical records situation, is: "They're not really serious about quality. If we can't execute the policies we have in place on something as simple as History and Physical information in the chart, how can those who are working to adopt policies on vital safety processes such as mandatory timeouts before surgery, and full barrier precautions for all central line insertions, believe that the hospital leadership and board will behave any differently?" This leaves the quality staff, nursing leaders, and many physician champions feeling very vulnerable, and uncertain, when they anticipate or counter physician opposition to an important policy.

An essential component of the IHI Framework for Engaging Physicians in Quality and Safety is "demonstrate backbone." All who work in the hospital system need to know that the hospital is willing to take action to protect its patients from harm, and to drive significant improvements in quality. In the words of Donna Isgett of McLeod Regional Medical Center (Florence, South Carolina), everyone working on quality "needs to know that they have backup, all the way to the board."

A vice president of medical affairs of a 450-bed medical center described an example:

> "We had a chronic problem with timely medical records completion by a few physicians, including our most prominent trauma surgeon. We had to ask ourselves whether we were serious about this quality policy, and we decided we were. We suspended the trauma surgeon for two weeks, causing significant disruption in our trauma service (and our revenues), but two important things happened: our physicians, including the trauma surgeon, immediately began dictating their op notes and discharge summaries in a much more timely fashion, and we also noted a significant improvement in compliance with many other policies, some of which might be of far greater significance for safety such as mandatory timeouts and full barrier precautions for central line insertions. I think it's important to send a signal that says, 'We're serious about patient safety and quality practices.'"

The importance of the board's support for demonstrating backbone cannot be overemphasized. See IHI's "How-to Guide" for the 5 Million Lives Campaign on engaging the board.[30] By the same token, though, where a medical staff is trying to change its culture to one of real physician engagement in quality, the courage of the physician quality leaders within the medical staff organization is also important, especially when they are not the structural leaders. Courage comes

up against a core value of the medical profession—collegiality, and a requirement for consensus decision making and universal agreement before change is adopted.

"Organizational silence"[31]—the reluctance to confront problems that need to be addressed—is toxic to improving quality. Several versions of this kind of silence have been observed. "Cultural censorship" occurs where untoward events or problems are recognized but covered up as "expected medical variation." Similarly, "consensual neglect" occurs where the decision makers tacitly ignore problems that are discovered so as to maintain the superficial appearance of unity of purpose and harmony.

Physicians do not accept criticism of their own performance easily. Moreover, quality problems are, as noted above, criticisms of some physician in their midst. So it takes courage to speak about these problems. The good news, though, is that research suggests that once a single person visibly breaks conformity and offers an alternative point of view, others are far more likely to follow. Clear support within the medical staff organization for the hard work of quality change is also essential. Physicians typically regard "grand rounds" as their model for intellectual engagement; yet most who participate in grand rounds know that there is rarely any real criticism or intellectual engagement in these settings where, typically, a renowned expert presents recent information that the assembled doctors may find interesting. To the extent that physicians in such conversations engage around the matters presented, the debate is often conducted at a fairly intellectual and abstract level. This is not a model for working on real problems at home in their own house, so to speak. So while support all the way to the board will be fundamental to real cultural change, support within the medical staff culture for the physician champions and others who raise difficult issues—sometimes requiring real courage—is also important.

Framework Element 6. Adopt an Engaging Style [32]

Physicians do not engage around business or management methods like business people or even other professionals. Their mechanisms for hearing, processing, and responding to data are driven by how they are trained and what they do in their professional lives. Their training ingrains in them hard-won, immutable values they will bring to bear in their work with the hospital. This is not merely a cocktail party truism. It is important to understand the physician mindset in order to engender successful physician engagement around any endeavor. The following six observations about the physician mindset are directly relevant to engaging physicians in quality:

1. Physicians treat patients one patient at a time. To help them do that in a way that takes into account a broader context of care in the hospital will depend, in part, on how data regarding a desired quality change is presented to them. Several of the principles in this framework reflect the particular data management issues associated with physician behavior.
2. At some point in training or practice, it has entered the consciousness of all physicians that they

bear a searing, daunting, life-changing, personal accountability for the life and death of the human beings whom they treat. They are acutely aware of their vulnerability to making poor decisions, based on imperfect information and human frailties in complex circumstances. Most doctors, no matter how long they've been practicing, can tell you—by name—every patient whom they believe was harmed or killed by their actions. They must gird themselves against this risk every day in order to do what they do. For this reason, they feel separated from, and superior to, those who do not understand this powerful reality. As a result, they see information provided to them by others in light of whether the source has shared this experience. Importantly, they do not view all physicians as co-equal on this point and ascribe credibility more to those whose experience is closer to theirs in terms of this risk. Thus they differentiate the credibility of the source of information based on experience as well as specialty.

3. Physicians vastly overestimate their risk of malpractice liability, in most data by about three times their actual risk,[33] so they filter potential action through the lens of how it will impact their malpractice exposure. This issue is best confronted directly regardless of the initiative under consideration, but it also raises the issue that they live with a certain level of paranoia that guides their responses to change. They are very concerned about how change will impact their liability, in addition to what demand it will place on their time.

4. Physicians have a strong sense of collegiality. During training, physicians learn to share their intellectual capital with each other. The consultant is called in to give her views of how to treat the patient. She may participate directly in the care, but at a minimum she shares her expertise and opinion with her colleagues. While physicians are fiercely individualistic in their management of what they do (in part because of their perceived individual accountability for that patient), this tradition of collegiality can be called on to support quality initiatives.

5. Although in practice they are supreme empiricists—physicians believe what they have seen or experienced themselves before almost any more formally gathered data—they do see themselves as science based. Consequently, evidence they consider credible does influence their thinking.

6. They place very strong faith on "due process," which they take to be a fairly elaborate series of steps to ensure that physician "rights" are safeguarded when their competence or professional quality is questioned. This reflects their concern that "there but for the grace of God go I," which relates to their sense of their own vulnerability. As a result, quality initiatives with potential negative consequences to physicians must take this value into account. For example, a hospital administrator, doing a review of serious quality deficiencies of a particular surgeon, privately asked every other physician on staff, "Would you allow this surgeon to operate on you or a member of your family?" The unanimous answer was a loud, "NO!" But when the

administrator acted on that information and suspended surgical privileges for that surgeon, the medical staff reacted in an uproar. "Where was the due process?" was the concern.

Understanding these values of physicians leads to seven simple principles of engagement that comprise Framework Element 6 and can support collaboration between physicians and hospitals regarding quality. These principles of engagement based on physician mindset are in the nature of the "quality initiative checklist," similar to an airline pilot's checklist. To facilitate the likelihood of a successful project, the list should be reviewed before launch of each project and from time to time throughout its implementation.

6.1 Involve Physicians from the Beginning

Physicians are often suspicious of initiatives that are handed to them partially developed, even when they are asked to participate in bringing them to fruition, and they are far more suspicious of programs that they are asked to accept when delivered to them full-grown.

6.2 Work with the Real Leaders, Early Adopters

Leaders of improvement are not necessarily the titled "leaders" in the medical staff organization. The real leaders have earned respect in their peer culture as magnanimous representatives who can advocate for physician concerns and communicate effectively back to their constituency, avoiding an emphasis on a personal agenda. But they do have to be given the opportunity to fulfill this function as well. Stemming from their collegiality, physicians will expect to be kept informed about the activities that will affect their lives. Depending on the specific institutional culture, this may require formal reports from leaders to constituents. Although these can be inefficient and time-consuming to some, sometimes they are necessary.

In addition to identifying the "real leaders," it is critical to know and work with the "early adopters." Everett Rogers has developed the concept of innovators, early adopters, early majority, late majority, and laggards.[27] This stratification can be applied to almost any group of physicians, whether a department, medical staff, etc. The early adopter group is most forgiving of the inevitable imperfections in any change concept. They will work with and modify a concept to a working reality and will, in fact, embrace and enjoy the process of change. Focusing on this group is most likely to produce the critical mass for change, "the square root of *n*." Trying to institute a change across the organization at one moment is probably doomed to failure because the initial versions cannot be perfect and the late majority and laggards will not be forgiving of early imperfections.

6.3 Choose Messages and Messengers Carefully

Because physicians ascribe credibility in part to who delivers the message, it is important to plan how and by whom the engagement is initiated and who is involved from the hospital as the quality initiative unfolds. Who invites participation, who reports ongoing progress, and how the message is conveyed and communicated are especially important early in quality efforts, and become less critical as more trust is built. Similarly, it is important to choose words carefully in communications about the project. Terms such as "accountability" and "performance reports" can be loaded with unintended meaning, and so it is important to regularly audit your communications to make sure that your language is engaging and not inflammatory.

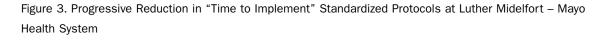### 6.4 Make Physician Involvement Visible

Not all physicians need be involved at all stages, but if they do not know some physicians have been part of the process from the beginning, they will not be as accommodating to the proposal presented to them.
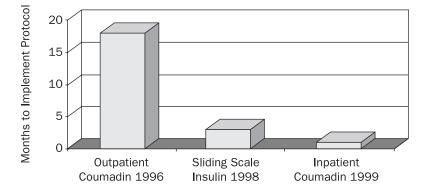
6.5 Build Trust Within Each Quality Initiative

Whether or not past grudges still live in the present, trust is a vital dynamic in the hospital-physician relationship, and it is earned from both sides of the partnership. But it is earned over time and the same way for both parties: "Do what you say. Say what you do…consistently over time." For example, at Luther Midelfort – Mayo Health System (Eau Claire, Wisconsin), one of the early improvement projects was development of a standardized outpatient coumadin protocol run by nurses. It took almost 18 months and many one-on-one conversations to get all physicians engaged and using the protocol. Data was repeatedly shown regarding the decrease in INR variance, in clots and in bleeds—thus documenting improvement in patient care. The key for physicians was to see data on improved outcomes. Once the physicians learned that these sorts of protocols were *not* just "cookbook medicine" and actually could produce better results for patients, each subsequent standardized protocol has taken less time than the last (see Figure 3), as data is shown to prove the improvement in care and the medical staff's trust in standardization increases. At Luther Midelfort – Mayo Health System, many standardized protocols can now be widely disseminated in a matter of weeks because of the overall trust level of the medical staff. This principle relates directly to the next.

6.6 Communicate Candidly, Often

Engage in open, frequent, candid communication, even when the matters at hand are difficult, sensitive, and strategic. Physicians are trained not to trust interpreted data. It is always better to provide the raw data supporting the asserted analysis, even though the physicians might not have time to actually evaluate it. It is the withholding of raw data that they will find troublesome. Giving physicians data helps them believe in the value of the undertaking. For example, when IHI's 100,000

Figure 3. Progressive Reduction in "Time to Implement" Standardized Protocols at Luther Midelfort – Mayo Health System

Lives Campaign was announced in December 2004, a presentation was made to Immanuel St. Joseph's Medical Center (ISJ) medical staff indicating that hospital leaders had signed up for the Campaign and, based upon their size and number of discharges, leadership estimated that ISJ could expect a saving of 40 to 80 lives by implementing all of the Campaign interventions. Initial reaction from the medical staff was outrage and insult: "You cannot tell us that we are needlessly allowing 40 to 80 patients a year to die at ISJ." But two years later, after persistent candid communication, including widespread display of credible, unedited data on deaths, hospital-acquired infections, and other measures, Mayo estimated it has saved nearly 100 lives per year, and the medical staff is proud of its accomplishment and publicly touts the results.

6.7 Value Physicians' Time with Your Time

Show physicians that you value the process enough to spend *your* time on it. When physicians are engaged in collaboration with the hospital, and they take time from their professional lives to assist the hospital with what it needs, administrators must consistently attend quality initiative meetings and respond to requests made of them in a timely manner. Doing otherwise can undermine the potential for the program by seeming to devalue physician input. Similarly, if you ask for physicians' engagement, expect to support those efforts administratively with clerical help (e.g., typing, photo-copying, taking meeting minutes) so that you draw the most efficient level of effort from physicians at their highest and best use in the engagement itself.

These principles, as well as concomitant expectations of the physicians who are participating, are worth articulating. Developing a written document of principles, a new manifesto to which the

parties can refer, is in some settings a useful way of reframing the new approach. Such a document also serves as a statement to others in the hospital community—for example, nurses, technicians, pharmacists—about the expected changes.

A Commentary on Responsible Engagement

Most of the discussion in this framework has been about ideas for how hospital leaders might engage physicians in the organization's quality agenda. But creation of a new relationship—a real partnership—raises serious expectations and responsibilities for the physician partners as well. To engage effectively, physicians must overcome the challenges that lurk in some common physician behaviors and take on their new responsibilities responsibly.

Some useful principles that can help to guide physicians (whether leaders or followers) in responsible engagement are described below.

Engage Responsibly, or Support Those Who Do

Consistent physician involvement is often difficult to achieve. Patient demands hold trump and make it difficult for physicians to attend meetings consistently or on time. When physicians agree to participate in defining the environment in which their patients will receive safer, better quality care, they and their practice colleagues should recognize the value to all from physician engagement. When physicians are not seen as active participants in the projects that affect them, one of their first complaints is, "Why weren't the doctors involved in designing this?" Yet they will also argue that their partners won't let them participate. This issue is directly related to how much they see the initiative as benefiting them. To engage responsibly, when physicians in private practice agree to participate in hospital-based initiatives, their colleagues should recognize and provide coverage for them so that patient demands do not call them away from the quality initiative commitments they have made.

Maintain Confidentiality

In significant quality improvement (and other governance-related) projects, physicians may gain access to sensitive and strategic information. There is a need to maintain confidentiality, both of data and of the process itself, until it is ready for prime time. Adopting a communication strategy that will enhance the project can help. Mutually determined principles of communication and confidentiality are an essential part of all quality initiatives.

Trust Your Leaders

Stemming from their issues with respect to control of the processes that affect them, and their tradition of collegiality, physicians tend to have a town meeting culture (i.e., all should participate at all times). Often, the introduction of a new idea will be met with a response such as, "Let's get all the cardiologists involved." This is inefficient, but those who are excluded from the work may be resentful. In addition, if the champion of the project is not the titular leader, steps will have to be taken to make sure that the nominal leader does not feel disenfranchised and therefore entitled to undermine the process. Drawing on the involved few to inform the affected many is a significant path to success, but it can be laden with barriers. For the followers to trust them, the leaders must "do what they say, say what they do… consistently over time," *and* they must keep the followers informed without breaching confidentiality. This is a challenge, but it can be accomplished.

Support the Process You've Agreed To

Failure to honor this principle is usually manifested in two ways:

1. A physician who is participating in developing the project will revisit his particular concern about the process design over and over. Because physicians tend to be consensus decision makers, reflecting their collegiality, they often are willing to listen to one loud negative voice until that physician is satisfied. Here, "majority rules" may solve the problem. Although it is not necessary to be unduly formalistic in the meetings or mechanisms by which quality improvement projects are designed and implemented, sometimes taking votes and keeping minutes that document that decisions have been made and will not be revisited are important techniques for continuing to move the work forward.

2. When the decisions have been made, some participating physicians may publicly, or "behind the back" of the project, air their grievances and attempt to get the decisions undone. If physicians understand, at least initially, that new ideas will be tried and tested before any mandates or policies are created, the likelihood of this problem occurring can be reduced.

Value Process More Than Structure, but…

Physicians often focus on the formal structure of the mechanism creating an improvement project: "How many physicians were on the committee? Are they employed by the system or independent? Who else is involved? Are we outnumbered?" These questions reflect both physicians' need for control and their anxiety that others cannot share their perspectives or speak for them. Physician quality leaders, whether titular or champions, should be prepared to address these concerns with a communication plan that speaks to the extent of physician participation. Assuring ongoing communication to garner and sustain the credibility of the work is also important. Although

the process of engagement and its substantive output is always more important than the structure that created it, when the culture has in fact changed, it is a good idea to formalize the changes in writing.

If Structure Is an Impediment, Change It

For hospitals, the medical staff bylaws are the Constitution of the medical staff. They define the environment within which collaboration of the hospital and physicians occurs. The Joint Commission as well as the physicians place enormous faith in the power of what the bylaws describe. They are the document that binds the physicians together and orders their relationships in common cause for quality pursuant to their delegated authority in the hospital governance structure. As the new environment unfolds, it is useful to revisit the bylaws, rules and regulations, policies, and procedures that define the medical staff culture.

When real cultural change has been accomplished, the standard off-the-shelf bylaws are no longer reflective of the reality of the environment. Some medical staffs, for example, are moving to avoid the rigidity of a strict departmental model in favor of a clinical service model, which can permit physicians from multiple departments to coalesce on an ad hoc basis to address specific issues. These less formal aggregations can be allowed to remain in effect to manage specific quality problems more effectively or to sunset when they are no longer needed. In those contexts, for example, to confront the typical endovascular disagreements in which physicians in radiology, cardiology, vascular surgery, and general surgery may be struggling over common clinical turf, the quality issues surrounding this conflict can be best handled outside of any one department.

While legal requirements do define some boundaries for medical staff bylaws, what has evolved over the last ten years from The Joint Commission, which very much influences medical staff bylaws, defines an environment in which far greater flexibility is available than has often been perceived. The medical staff bylaws are an ideal place to document change when it has permeated the hospital culture.

Conclusion

Today's confluence of demands for both demonstrably safe, high-quality hospital care *and* physician performance offers an unprecedented opportunity in health care organizations to redesign the essential partnership between hospitals and physicians. Many hospitals and other health care institutions are making improvements without significant physician engagement. IHI believes, though, that optimal hospital quality will only be achieved when the hearts and minds of the medical staff members are engaged in common cause for quality with the hospital. The IHI Framework for Engaging Physicians in Quality and Safety sets forth our current view of ideas, principles, and techniques by which this engagement may be more widely achieved. We look forward to opportunities to test and improve these concepts as all of us continue the work to enhance the health care of the patients we serve.

Appendix A. Physician Engagement Difficulty Assessment

The Physician Engagement Difficulty Assessment is designed to prompt hospital leaders to think carefully about the current structural and historical factors in the organization that will inform the degree of difficulty the hospital might have in moving together with the medical staff to a higher level of partnership for quality and safety.

Score your hospital on each of the seven dimensions. Lower scores indicate an easier environment in which to engage physicians; higher scores indicate a more difficult environment in which to engage physicians. The lowest possible total score is 7; the highest possible total score is 25.

1. **Physician connectedness** . . . . Score: _____
    The majority of active staff physicians are:
    ☐ Employed: **score 1**
    ☐ Affiliated (e.g., part-time with the faculty practice plan; in the
      system network or PPO): **score 2**
    ☐ Independent: **score 3**

2. **Physician loyalty** . . . . Score: _____
    The majority of active staff physicians:
    ☐ Are employed by the hospital: **score 1**
    ☐ Admit primarily to this hospital: **score 2**
    ☐ Are splitters (e.g., go to multiple hospitals): **score 3**

3. **Stability of medical staff structures, mergers, and relationships** . . . . . . Score: _____
    ☐ The medical staff culture has been stable for years: **score 1**
    ☐ The medical staff was merged from more than one facility some
      years ago and most of the disagreements are over, although there
      are still some bruised feelings in a few departments: **score 2**
    ☐ The medical staff includes a recent merger, and the wounds are
      still raw: **score 3**

4. **Currency of medical staff bylaws** . . . . Score: _____
    The medical staff bylaws reflect current reality:
    ☐ The medical staff bylaws are dynamic, up-to-date, and reflect
      the current reality: **score 1**
    ☐ The medical staff bylaws were revised in some substantial measure
      within the last few years to reflect current reality: **score 2**
    ☐ The medical staff bylaws have not been amended or revised
      in years: **score 3**

5. **Medical Executive Committee (MEC) authority** . . . . Score: _____
   - ☐ Balanced: The MEC functions effectively as the "Supreme Court" for the staff, and resolves inter-departmental feuds. There is a procedural assumption by the medical staff that the MEC acts fairly and wisely: **score 1**
   - ☐ The MEC "represents" the medical staff. The board of directors and administration are wary of ceding too much power to the MEC, so the board has the power (occasionally used) to approve/disapprove medical staff officers and department chairs. The Credentials Committee reports to the board and not to the MEC: **score 2**
   - ☐ Civil libertarian: The emphasis of the MEC is on protecting individual physician rights and maintaining high levels of due process even for minor disciplinary actions. Reactive and formalistic, the MEC rarely initiates any actions that would impinge on the autonomy of individual medical staff members: **score 3**

6. **Board engagement with medical staff in quality initiatives** . . . . Score: _____
   - ☐ The board engages directly with medical staff, actively seeks staff input, and involves them in all quality initiatives at the earliest stages: **score 1**
   - ☐ The board watches quality from a distance and depends on administration's reports for monitoring and surveillance of the medical staff: **score 2**
   - ☐ The board thinks quality of care is purely a medical staff responsibility. There is no real will, no real engagement on the part of the board: **score 3**

7. **Historic cultural engagement** . . . . Score: _____
   The culture of engagement for physicians is best described as:
   - ☐ Full engagement: Most of the active staff involved in inpatient work participate in initiating, implementing, and improving quality initiatives. The community-based physicians who never come to the hospital are engaged in hospital quality initiatives as they relate to the continuum of care (e.g., appropriateness of admissions, presentation to ER, etc.). The administration is seen as a helpmate and assists in responding to medical staff programs. Interdisciplinary team projects are the norm; the CEO's salary and/or bonus depends on quality results; the board supports physician engagement with resources and education: **score 1**

☐ Good engagement: Many medical staff members participate in design and implementation of quality initiatives. The MEC is convener, arbiter, and communication conduit throughout the medical staff organization, with and to administration and the board. There is a clear recognition of "highest and best use" of clinical personnel, with nursing having more clinical authority, responsibility, and perception of teamwork with physicians than in traditional settings: **score 2**

☐ OK engagement: Medical staff members participate in cross-departmental quality projects and work across boundaries on them with nursing, administration, quality staff, and/or finance. The board has expressed an interest in quality, but relies on administration to manage processes and report results: **score 3**

☐ Some engagement: Some medical staff leaders/members identify and champion small departmental-based projects; some inter-disciplinary team efforts have been initiated within isolated units; the board does not make quality a priority: **score 4**

☐ Minimal engagement: Medical staff leaders respond to some hospital initiatives through traditional structures only, sometimes more in response to departmental projects (e.g., laminated cards to help the medical staff members remember how to document for payment; hospital provides lunch to medical staff members to finish charts). There is little cross-departmental interaction on quality: **score 5**

☐ Mutual détente: Separate spheres of influence; medical staff focuses only on credentials, some privileging, rare corrective action; privileges reside in departments with little overlap or interaction with other departments; no cross-departmental resolutions of problems; there are struggles between physicians and the nursing staff over a range of issues: **score 6**

☐ Openly hostile: Mutual suspicion; loss of trust; past grievances won't die; big emphasis on medical staff competitive challenges (economic credentialing, loyalty oaths, financial disclosures). The board and administration focus entirely on the bottom line and financial results; current strategies of the hospital are suspect and challenged (e.g., recent mergers or acquisitions): **score 7**
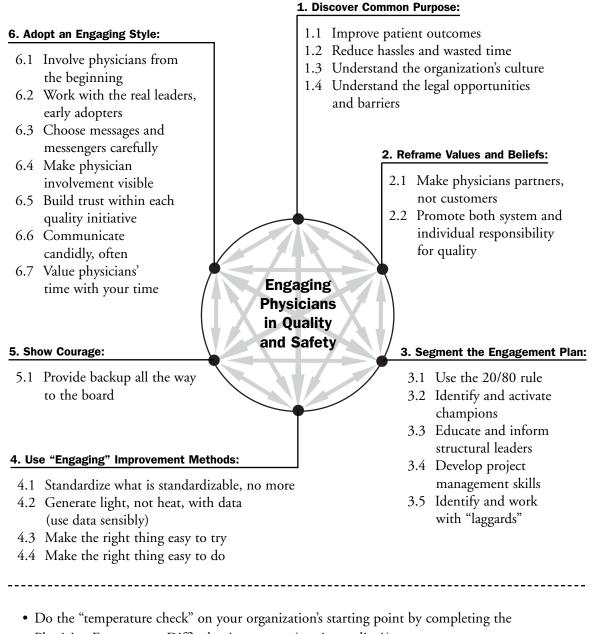
Add up scores for all seven questions . . . . **Total Score:**_____

Appendix B. Using the IHI Framework for Engaging Physicians in Quality and Safety to Build a Written Physician Engagement Plan

The following sequential steps are suggested for hospital leaders who wish to design and execute a plan for improved engagement of physicians in quality and safety initiatives.

1. Assess your starting point, using the Physician Engagement Difficulty Assessment (see Appendix A). This will give you a good sense of how high your aims for physician engagement might be, and the kinds of tactics you might need to consider in your engagement plan.

2. Prioritize your needs for physician engagement based on your strategic plan and your understanding of the critical initiatives in which physicians must be engaged. This will give a good sense of which hospital initiatives your engagement plan must address, and which initiatives have the most dependence on physician engagement.

3. With your self-assessment in hand, and your priorities clear, state the aims for a few (no more than three) key initiatives during the next year for which you are going to build a detailed plan for improved physician engagement. Write these aims down as "how good, by when" statements using specific measures of performance (Example: *Reduce total number of nosocomial infections by 50 percent within 12 months as measured by the sum of CLABS, SSIs, MRSA, C. difficile infections, and VAPs*).

4. For each of the three key initiatives, work through the IHI Framework for Engaging Physicians in Quality and Safety and address the questions that arise from each element of the framework. Use the checklist in Appendix C to create your plan for each initiative. Your answers to these questions will form your first draft of a written plan to improve physician engagement in your organization, and can then be more broadly shared for revision and improvement by your leadership team.

5. Execute the plan, and steer any modifications to the plan using data based on two types of questions:

    • Are your measured quality and safety aims being achieved? (Is the plan working, as indicated by results?)

    • Is physician engagement improving? (The answer to this question will depend on a variety of inputs, but the best indicators are what you hear in ongoing informal conversations with physicians, and asking the nurses and quality initiative leaders for feedback on the level of physician engagement.)

Appendix C. Checklist for Building a Written Physician Engagement Plan Using the IHI Framework for Engaging Physicians in Quality and Safety

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

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

2. Reframe Values and Beliefs:

2.1 Make physicians partners, not customers
2.2 Promote both system and individual responsibility for quality

Engaging Physicians in Quality and Safety

5. Show Courage:

5.1 Provide backup all the way to the board

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

- Do the "temperature check" on your organization's starting point by completing the Physician Engagement Difficulty Assessment (see Appendix A).
- Prioritize initiatives needing physician engagement.
- Establish aims for three important initiatives requiring physician engagement.
- Then complete the checklist that follows…

Initiative: (Include a statement that describes the specific quality initiative and its aim. Example: *Reduce total number of nosocomial infections by 50 percent within 12 months as measured by the sum of CLABS, SSIs, MRSA, C. difficile infections, and VAPs.*)

Framework Element	Specific Questions to Assess Current Status of Element	Specific Action Plan to Use This Element (Who, What, Where, When, How)
1.1 Improve patient outcomes	Is this initiative's aim framed and communicated to physicians so that it's clear we're aiming to improve patient outcomes?	
1.2 Reduce hassles and wasted time	How will specific aspects of this initiative reduce hassles and wasted time for physicians? How will we measure that improvement in ways that are credible to them?	
1.3 Understand the organization's culture	What cultural attributes will this initiative come up against? What "simple rules" do we need to establish in order to succeed in this initiative?	

Framework Element	Specific Questions to Assess Current Status of Element	Specific Action Plan to Use This Element (Who, What, Where, When, How)
1.4 Understand the legal opportunities and barriers	Are there any legal and "shared business" opportunities to reinforce the common agenda in this initiative?	
2.1 Make physicians partners, not customers	Are we as administrators ready to share information, power, and resources with physician leaders in this initiative? Are physician leaders ready to be responsible partners? How will treating physicians as customers inhibit this initiative?	
2.2 Promote both system and individual responsibility for quality	How will we get physicians to see the "balcony view" of this initiative?	
3.1 Use the 20/80 rule	Which physicians must ultimately be engaged in this initiative if it is to succeed (and which physicians are not relevant to this initiative)?	

Framework Element	Specific Questions to Assess Current Status of Element	Specific Action Plan to Use This Element (Who, What, Where, When, How)
3.2 Identify and activate champions	Which physicians are on our short list of potential champions for this initiative? How will we select one or two champions? What is our plan to support them?	
3.3 Educate and inform structural leaders	What will be the role of the Medical Executive Committee (MEC), department chairs, committee chairs, and medical directors in this initiative? What data will be presented, and when, to the MEC and other structural leaders?	
3.4 Develop project management skills	Does a physician need to be the project leader for this initiative? If so, how will we train and support that physician so that the project will be led effectively?	
3.5 Identify and work with "laggards"	Which physicians are likely to vocally oppose and potentially derail this initiative? How could we mitigate that risk?	

Framework Element	Specific Questions to Assess Current Status of Element	Specific Action Plan to Use This Element (Who, What, Where, When, How)
4.1 Standardize what is standardizable, and no more	What standard protocols will be necessary to adopt in this initiative? Do we have a plan to use the "new way" of standardization for these protocols?	
4.2 Generate light, not heat, with data (use data sensibly)	What is our plan for use of individual physician performance measures in this initiative? Are we ready to use them (i.e., already at 95 percent reliability, or have a culture capable of learning rather than judging)?	
4.3 Make the right thing easy to try	Is the "project set-up" for this initiative based on lengthy design of a big change to be implemented all at once, or is it a series of multiple small tests of change?	
4.4 Make the right thing easy to do	How could this initiative move to implementation in a way that fits easily into the daily workflow of physicians?	
5.1 Provide backup all the way to the board	Are there any policies related to this initiative where we can anticipate needing to "take a stand"? How could we send the signal in advance that we will support the physician leaders who champion that stand?	

Framework Element	Specific Questions to Assess Current Status of Element	Specific Action Plan to Use This Element (Who, What, Where, When, How)
6.1 Involve physicians from the beginning	Were physicians involved in choosing this initiative? How will we open our process and data to physicians in this initiative at the outset?	
6.2 Work with the real leaders, early adopters	Who are the critical physicians most relevant to this initiative? How can we involve them? Who are the physicians that are already doing most of what is needed for this initiative, and are always receptive to trying new things? How are we going to work with them for maximum effect?	
6.3 Choose messages and messengers carefully	Who is the best person to speak about this initiative? What language should we avoid in communications about this initiative?	

Framework Element	Specific Questions to Assess Current Status of Element	Specific Action Plan to Use This Element (Who, What, Where, When, How)
6.4 Make physician involvement visible	As this initiative progresses, what could we do to highlight individual physicians' involvement, as an example to their peers?	
6.5 Build trust within each quality initiative	How will we as administrative leaders make sure that we say what we do, and do what we say, consistently throughout this initiative?	
6.6 Communicate candidly, often	What results from this initiative are we planning to measure and communicate; to whom, and how often?	
6.7 Value physicians' time with your time	What is the plan for senior executives to channel attention to this initiative by being personally engaged in much of the work alongside the physicians we're hoping to keep engaged?	

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INSTITUTE FOR HEALTHCARE IMPROVEMENT

20 University Road, 7th Floor

Cambridge, MA 02138

(617) 301-4800

www.ihi.org