A Physician's Perspective on Quality & Patient Safety

Chatham Kent Health Alliance
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Overview

- Traditional healthcare delivery model
- Call for a new model
- Understanding the physician perspective
- Strategies for engagement
- Benefits of physician involvement

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The Traditional Model

- Healthcare professionals responsible for safe and quality care
- Focus on the needs of individual patients
- Doctors practice autonomously; not hospital employees
- Hospital provides infrastructure, support and resources to deliver patient care

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The Traditional Model

- Healthcare professionals responsible for safe and quality care
  - Undergo extensive training and evaluation
  - Evaluate new knowledge and adjust practice accordingly
  - Bound by oath, ethics – commitment to the patient good

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The Traditional Model

- Focus on the needs of individual patients
  - Unit of care is the provider-patient encounter
  - Trained using case-based examples
  - Provider-patient relationship paramount

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The Traditional Model

- Doctors practice autonomously; not system/ hospital employees
  - Historical relationship
    - hospitals restructured to a bureaucratic model
    - physicians responsible to patients; to a third-party would constitute conflict of interest
    - Thus relationship with institution – through the Medical Staff Organization
  - Felt to protect patient advocation
  - Practice in multiple locations

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The Traditional Model

- Hospital provides infrastructure, support and resources to deliver patient care
  - With formation of MSO – Doctors responsible for patient activity, safety, performance – oversight by MSO
  - Administration provided oversight of the plant, employees, finances, resources

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Sounds like a good model built on good intentions

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Does the model work?

What happens when you measure?

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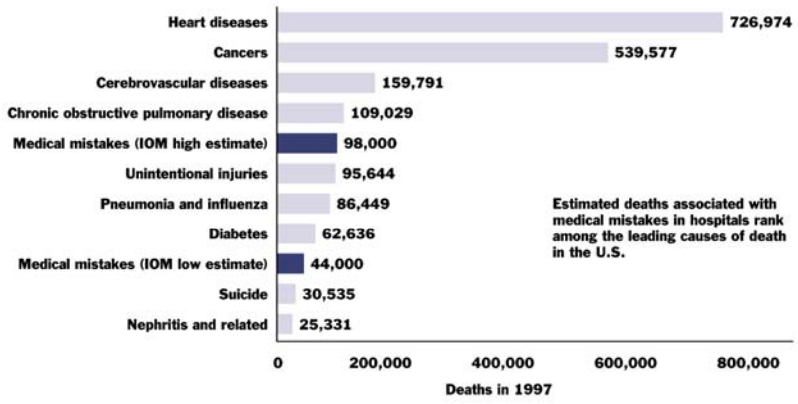
Chart 2–1

Estimated Deaths Associated with Medical Mistakes Compared to the Leading Causes of Death in the U.S.



Sources: IOM 2000; Kramarow et al. 1999 (deaths).

Table 3. Adherence to Quality Indicators, Overall and According to Type of Care and Function.

Variable	No. of Indicators	No. of Participants Eligible	Total No. of Times Indicator Eligibility Was Met	Percentage of Recommended Care Received (95% CI)*
Overall care	439	6712	98,649	54.9 (54.3–55.5)
Type of care				

Table 5. Adherence to Quality Indicators, According to Condition.*

Condition	No. of Indicators	No. of Participants Eligible	Total No. of Times Indicator Eligibility Was Met	Percentage of Recommended Care Received (95% CI)
Coronary artery disease	37	410	2083	68.0 (64.2–71.8)
Hypertension	27	1973	6643	64.7 (62.6–66.7)
Congestive heart failure	36	104	1438	63.9 (55.4–72.4)
Cerebrovascular disease	10	101	210	59.1 (49.7–68.4)
Chronic obstructive pulmonary disease	20	169	1340	58.0 (51.7–64.4)
Colorectal cancer	12	231	329	53.9 (47.5–60.4)
Asthma	25	260	2332	53.5 (50.0–57.0)

McGlynn EA. The Quality of Health Care Delivered to Adults in the United States. NEJM 2003.

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Why?

- Medical science and technology have advanced at an unprecedented rate
- Healthcare has become very complex
- The healthcare system assumes that well intentioned healthcare professionals will provide quality and safe care through hard work, vigilance and use of evidence

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A call for a new model

- "a higher level of quality cannot be achieved by further stressing current systems of care"
- "the courage, hard work, and commitment of the healthcare workforce are, today, the only real means we have of stemming the flood of errors

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A call for a new model

- The healthcare system needs to see the implementation of evidence-based, safe and quality medicine as an system responsibility, rather than the sole responsibility of individual clinicians
- Physicians are essential partners in system redesign – if true improvement is to be realized

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The Pressure to Change is On

- Growing attention to quality/ safety issues
- Era of accountability
  - To accreditors – safety/ quality ROPs
  - To government – public reporting
  - To public – access, wait-times
  - To patients – disclosure, apology
- Everyone must/ is get/ting in the new game

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"How do we get the physicians to be more interested/ involved in our safety and quality improvement plans/ initiatives?"

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A Physician's Perspective

- Safety and quality is at the core of physician practice
  - "Primum non nocere"
  - Striving to do their best for every individual patient they see
  - Hold accountability for life and death
  - Deeply rooted in medical education – perfection is the necessary goal

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A Physician's Perspective

- Different view of safety and quality
  - Individual outcomes over population
  - Clinical outcomes over administrative
  - Tension between patient-centred care and whole-system improvement

"I'm less concerned about the care of your last 9 patients; I am concerned about how well you will care for me and my kids"

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A Physician's Perspective

- Fiercely autonomous
  - Embedded in training, CME/ CPD
  - Duty to advocate for patients despite resources, financial pressures, politics
  - "Legal captain of the ship"
  - We've been given it = the traditional model

"If I'm personally responsible then I must have complete control and autonomy in the decisions about care"

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A Physician's Perspective

- Physician as personal identity
  - What we do is what we are
  - Mistakes are seen as personal failures
  - Fear of being shunned by community; need for belonging

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A Physician's Perspective

- Evidence and data driven
  - Trained to seek and use data
  - Show me the numbers; raw
  - Pressure to change practice – evidence from rigorously conducted research
  - BUT…discuss/ debate knowledge collaboratively; implement it individually
  - AND…essentially no training in QI methodology/ science

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A Physician's Perspective

- Time is limited and precious
  - Time devoted to patient care = better time spent
  - Administrative activities of less value
  - High demand for clinical time – no time for less valued activities
  - Frustrated by system inefficiencies

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Becoming More Involved

- Understanding the physician perspective
  - Enables physicians to seek/ create opportunities to become more involved
  - Enables staff/ administrators to design initiatives using strategies to attract/ engage physicians
- Understanding that physician culture is a barrier
  - Need to be more open to change

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INSTITUTE FOR HEALTHCARE IMPROVEMENT

Innovation Series 2007

Engaging Physicians in a Shared Quality Agenda

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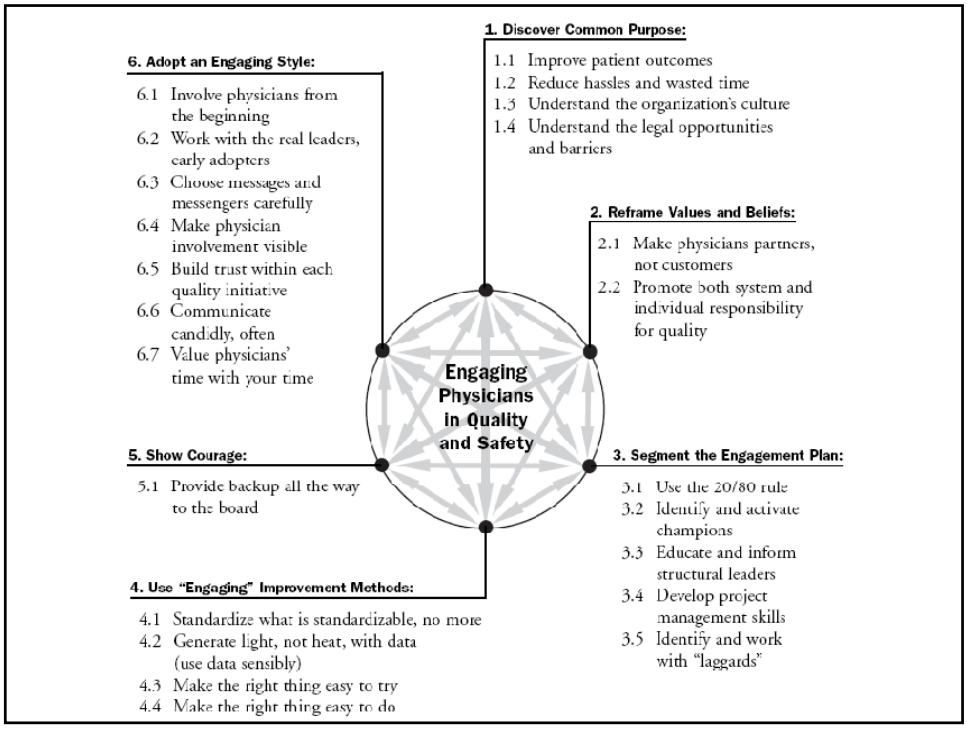

Engagement Strategies

- Discover common purpose
  improve patient outcomes, reduce hassle and wasted time
- Create partnerships
  Physician not contractor; hospital not supplier/controller
  Share responsibility with individual and system of patients
- Involve physicians early
- Work with medical leadership
  Division director, Chair MAC, Physician in chief
- Identify/ be a champion
  find/ be a vocal believer, consider making/ being project lead

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Engagement Strategies

- Standardize/ protocolize evidence
  Start with aspects that are agreed upon with evidence
- Use (local) data to drive change
  use aggregate data to show change is needed
  use meaningful/ agreed upon quality indicators
- Make the right thing easy to try
  involve MDs in PDSA/ reliability tests
- Make the right thing easy to do
  avoid plans that add more work for MDs or others
- Make physician involvement visible

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Does higher physician involvement improve quality?

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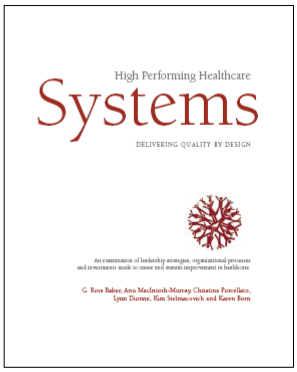
High Performing Healthcare Systems

DELIVERING QUALITY BY DESIGN

Chapter 1
Introduction



Citation Information

Baker, G.R., A. MacIntosh-Murray, C. Porcellato, L. Dionne, K. Stelmacovich and K. Born. 2008. "Learning from High-Performing Systems: Quality by Design." *High Performing Healthcare Systems: Delivering Quality by Design*. 11–26. Toronto: Longwoods Publishing.

Table 2. Attributes of successful improvement

Attribute	Elements
Culture	* Organization/leaders support and expect learning and innovation. * Organization/leaders value staff and empower all members to participate. * Organization/leaders focus on customers/patients. * Organization/leaders value collaboration and teamwork. * Organization/leaders are flexible.
Leadership	* Strong administrative leadership that provides role models for organizational values. * Leadership celebrates and even participates in improvement initiatives. * Emphasis on developing, fostering and inclusion in decision-making for clinical leadership and champions. * Board support: Board sets expectations by asking for reports on improvement initiatives and results. * Board provides continuity of expectations if administrative leadership changes.
Strategy and policy	* Leaders set clear priorities for improvement. * Improvement plans are integrated in the overall strategic plan as the means to achieve key strategic goals. * Leaders demonstrate both constancy of purpose and flexibility. * Operational policies and procedures, including human resources policies, provide incentives, rewards and recognition. * Incentives, rewards and recognition are aligned to support improvement work.
Structure	* Roles and responsibilities for improvement are clearly articulated. * Steering/oversight committees provide direction. * Teams and teamwork are part of structure.
Resources	* Organization provides time for staff members to learn skills and participate in improvement work. * Financial and material resources and human resources are available for improvement. * Quality improvement support/expertise: A core group of improvement experts is available to help teams and individuals. * Quality improvement department coordinates and supports initiatives.
Information	* Needed clinical and administrative data are readily available. * Information is available to support improvement.
Communication channels	* Organization has vehicles to communicate with stakeholders regarding priorities, initiatives, results and learning. * Ample forms of communication, including newsletters, forums, meetings and intranet sites.
Physician involvement	* Physicians are involved in planning improvement initiatives and participate as team members. * Opportunities for physician and clinical leadership of improvement. * Clinicians "own" improvement.

High performing organizations

- Quality by Design
  - Henry Ford, Jonkoping, Intermountain Health, National Health Service, Veterans Health, Calgary Health Region, Trillium Health Centre
- Baldridge Award Winners
- Pursuing Perfection Hospitals, IHI

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Can physicians benefit from being involved in quality improvement?

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Physician Benefits - Examples

- Professional Development/ Career Opportunities
  - Demand for physician leaders in QI/ patient safety
- Improvement in group practice
  - OR booking efficiency, orthopedics
- Improvement in own practice
  - Quality review of ENT procedures
  - Checklist reminders in office practice

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Summary

- The traditional medical model is failing to deliver the care that we and the public expect
- A new model is emerging which requires partnership, flexibility and change between all parties – including physicians

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Summary

- Physician professional culture important factor in level of involvement in quality improvement activities
- Opportunities to develop strategies for physicians to seek involvement and hospitals to gain engagement
- Higher quality is obtainable while maintaining our individual commitment to patient care

Thank you

- Questions??
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