



On Demand Joint Commission Accelerate PI: Physicians Engagement in Quality Improvement

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The learning objectives for this session are: Describe the role of physician quality leaders in quality improvement initiatives. Recognize approaches that promote engagement versus approaches that may cause physician leaders to withdraw. And identify strategies to counter resistance.

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These staff and speakers have disclosed that they do not have any conflicts of interest. For example, financial arrangements, affiliations with or ownership of organizations that provide grants, consultancies, honoraria, travel, or other benefits that would impact the presentation of today's webinar content.

Myself [Susan Funk], Brandi Wamhoff, and Dr. Bobby Redwood.

00:05:10

I will now turn it over to Brandi to begin your presentation. Brandi, please take it away.

00:05:17

Good morning and good afternoon, everyone. Thank you, Susan, for that great introduction.

00:05:26

So, I'd like to welcome everyone as Susan mentioned to our webinar focused on physician engagement and quality improvement. My name is Brandi Wamhoff and I'm an Assistant Project Director at The Joint Commission. Before I turn things over to our presenter today, I'd like to take just a few minutes to provide some background for our call today and share some resources to support your organization in their Quality Improvement journey.

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As part of our mission and vision at The Joint Commission, we are committed to advancing safety and quality, and part of that is supporting organizations to embrace Quality Improvement. Customer feedback is a crucial part of learning what organizations need from us, and to that point, learning how to better engage physician leaders in QI has been a highly requested topic. We hope that the presentation from Dr. Redwood today helps to meet this need.

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Rather than thinking about Quality Improvement as an end to a mean, it's helpful to think about it throughout the journey from beginning to end. That's exactly why Quality Improvement is ingrained throughout all parts of the accreditation process, including standards and quality measurement. To help demonstrate this, I've highlighted a few of applicable standards for you to consider during the presentation. The Performance Improvement Chapter Standards require that an organization collect and monitor data, create a plan, compile, and analyze the data, and subsequently improve its performance. As we move throughout our presentation, perhaps take a moment to stop and ask yourself how physician engagement in QI can help demonstrate that your organization is meeting some of these requirements.

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Last but not least included on this slide are a few of the resources available on our website to support your organization and their Quality Improvement journey. The first resource consists of a short video in which we demonstrate live navigation to a suite of resources that exist on Joint Commission Connect and The Joint Commission website. The second and third resources are recorded webinars. One is for hospital settings, and one is for post-acute care settings. These webinars are geared toward basic performance improvement principles and methodology at a beginner level, and setting specific examples are provided to enhance understanding.

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So, at this time, I'd like to go ahead and introduce our presenter for today, Dr. Bobby Redwood. Dr. Redwood is a Physician Improvement Advisor with the Wisconsin Hospital Association and he's also the Faculty Advisor for the Wisconsin Hospital Association Physician Quality Academy. And Dr. Redwood, thanks for being with us today. I'll turn things over to you when you're ready.

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Great, thank you Susan and Brandi for that warm introduction. And thank you for The Joint Commission for putting on this content. I think we can all agree that Quality Improvement is significantly better when physicians are involved. Not to minimize any other role group of course, but physicians have such a key role in having a bird's eye view of the care plan, putting in orders, coming up with care plans in general. And so really bringing us into the fold early in the process is just so critical. And I wanted to thank all of you for attending today. I know we're all real busy and to take time out of your day, your pre-lunch hour, or your lunch hour on this important topic is just so critical. So, I thank you all.

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As mentioned, I am a Physician Improvement Advisor with the Wisconsin Hospital Association, and so I work a ton with Quality Improvement professionals, and I wanted to give a shout out to all our Quality Improvement professionals out there because the work that you're doing is really just incredible and so instrumental to healthcare. I call it implementation science. I really think of you as scientists and the quality role is a scientific role where we have all these best practices in medicine that we just need to bring to the bedside. And traditionally, physicians haven't been great at that, at bringing best practices to the bedside. There's a lag of 10 or 20 years sometimes before a best practice that's based on scientific evidence and meta-analysis, et cetera, finally gets to the point where we're applying it to patients. It's really astounding. I do work with Antimicrobial Stewardship and the literature is just so strong in how to prevent multi-drug resistant organisms. And then when you actually get there and look at clinical practice, we are decades behind. And so, this implementation science is just so key.

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And that's going to be a theme throughout our entire presentation today, is the idea of Quality Improvement as population health and implementation science, and making the sell to physicians is often bridging from the individual patient argument to the population health argument. And I think that's really been kind of a transformational thing going on over the past two decades. Is the idea of improving the health of populations, whether it's in your hospital, your patient panel, your region, your entire state. And that's really trickled down into med schools and residency programs. And I think we're in a different place now than we were 10 years ago where a lot of physicians are really understanding that conceptual leap.

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Now, I myself I'm an emergency physician as well as a preventive medicine physician. So, I'm dual trained. Preventive medicine is the medical specialty of public health, and it sounds like an odd combination at first, but my personal tagline is every emergency is a failure prevention. And so, as we get into this webinar today, we'll talk about best practices and evidence-based processes for getting physicians engaged in Quality Improvement. But we'll also just talk a lot about personal experience and anecdote because we're really talking about personalities, right? We are talking about actual people who are living their stressful lives just like the rest of us, and how to make the case for incorporating Quality Improvement into their workflow.

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And so, when I go to work as an emergency physician in the trenches, I'm seeing a stroke, I'm thinking about that stroke patient in front of me. When I see a trauma, I'm thinking about that trauma patient in front of me. But when I get home and I look at my data sets and I look at my dashboards, I'm thinking about process evaluation, I'm thinking about door to balloon time, I'm thinking about door to CT time, I'm thinking about, seatbelt wearing and alcohol prevention, these kind of things that would prevent that patient from arriving in the emergency department in the first place.

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So, me personally, when I think about what motivates me, it's seeing that emergency, seeing that failure prevention, that end stage clinical outcome and wondering how we can save the next stroke. How we can save the next car crash, those kind of things. And I think that's one of the key when we will talk a lot about the roles of the Physician Champion, but the question is, your individual physician, if you need to engage someone, how do you engage that person? What really makes them tick? What will lift the veil of your work beyond all the other clinical obligations and production pressures that are on that person? So that they really say, hey, this is work that's worth investing in. And so, I'll go ahead and share a lot of anecdotes throughout this presentation. I have held a lot of leadership roles as well. Everything from in the trenches emergency physician, to emergency department director, to hospital quality director and Chief Medical Officer. And we start off the presentation with the description of those roles. And so, I'll try to fill in some personal anecdotes on just what the role entails, because it really is different depending on what level of engagement you're looking for, whether it's an entire department or an individual.

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This is a brief course outline here, I'll let you read it. But what I really want to emphasize is, I know we have a mixed audience today. These types of presentations always draw a mixed audience. And I think the bulk is typically Quality Improvement professionals. We obviously have administrators in the audience. We obviously have frontline providers, physicians, nurse practitioners, PAs, clinical nurses, nurse managers. And so, when you have a mixed audience, the challenge is how do you tailor the content to everyone? And because we're talking about physician engagement today, there is a lot of content that centers around physician workflow, but I try to frame it for the entire audience. I would say the opportunity here, we always talk about change not challenges, but opportunities and Quality Improvement. The opportunity is to walk in someone else's shoes. So, if I'm speaking about content that's specific for a Quality Improvement professional, that's specific for a CEO, that's specific for an in the trenches position, try to put yourself in that person's shoes. Try to imagine what their life is like. And I hope that elucidates something for you because we are all on the same team here. And everyone who works in healthcare knows that when the hospital is really on the same page, when the strategic vision of the C-suite is in line with the Departmental Directors division is in line with the clinical care, and the EHRs is in line as well, then that's when things go best. And that's pie in the sky is all the arrows are never pointing in the same direction, but we can really work towards that. And putting ourselves in each other's shoes is a big part of that.

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I also have these slides throughout the presentation that are called clinical pearls. The clinical pearls are questions that are... They're kind of hypothetical questions posed to you, but if everybody could get out a pen and a piece of paper, or if you have your notepad up on your computer and actually try to write something down for these, you don't have to share it with anyone, nobody will be called out. But I find this as a way to stay engaged with the content and then have a takeaway after you've clicked exit the webinar. And this one hour is over. Have something that you've thought about in your own world, your own Quality Improvement journey, and maybe you'll have your own pearl to apply to your workflow.

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So, for physician quality roles, I don't want to belabor this too much, but as a Quality Improvement professional, if you are trying to bring someone into the fold, it's really important that you actually ask at the right level. Because if you go to a general workforce clinician and ask them to do the role of a Director of Quality, you're going to get like a deer in the headlights stare. What are you talking about? Quality Improvement is not yet ingrained in medical training. Definitely it's starting to be, but definitely not. And a Director of Quality is going to know everything you're talking about. They're going to know about your PDSA cycle, and your priority matrix, a general clinical workforce, probably not. And so, I just want to go through this so the attendees know kind of who you're dealing with if you have a specific ask for a physician in your hospital.

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So, the requirements of the general clinical workforce for Quality Improvement are actually pretty low. It's basic adulting, basic professionalism. And I think that'll change, I think that'll evolve as we get Quality Improvement into the medical school curriculum as a standard. But really, we ask our general clinical workforce to just kind of be aware, be aware of clinical guidelines, recommendations, know your department's quality initiatives. That sounds so funny. Well, maybe it doesn't sound funny, but so you'd be surprised how many people do not know the quality initiatives their department's working on. And then essentially support leadership. So, you don't want to be a naysayer, we want to have robust clinical discussion, but we don't want someone throwing bombs and poisoning the well and saying, oh, this is all bogus. Those would be kind of the basic requirements of the clinical workforce. And we'll talk about strategies for confronting physician resistance, when somebody's poisoning the well, if they're ghosting you not reporting to emails, a lot of that falls into the Medical Director realm, not really the Quality Improvement professional realm, which is a great reason to be engaged with your Medical Director and really be on a wonderful working relationship with that person.

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If you have a QI project team member, a lot of my examples, by the way, are rooted in emergency medicine just so they're rooted in kind of my truth. But you could apply this to every specialty of course. But let's say in emergency medicine, you're working on a new restraint protocol for agitated delirium for psychotic patients. You want to have somebody with a deep knowledge of that subject. So, you're probably going to get someone in emergency medicine who deals with behavioral health and that's their specialty, their kind of clinical niche. They probably don't know Quality Improvement though unless they've had that specialized training. And so, this is really a subject matter expert. When you have someone on a Quality Improvement team, you're having them there for a short amount of time to bang out a protocol, to work the policy, maybe talk about order sets to build into the EHR, but you probably don't have the full expectation of the strategic vision of the organization or Quality Improvement methodology. So, you just want to understand that these are really your Subject Matter Experts and try to use them strategically. If you're having a one-hour meeting and the first hour is running all the data, or the first half hour is running all the data, maybe they want to be there for that, but maybe not. Maybe you want to respect their clinical time, try to keep it focused, give them some homework before the meeting and say, why didn't you log on for the last 15 minutes? Something like that. And these QI project team members are pretty instrumental because they are Subject Matter Experts. They can go back to their clinical group and really walk the walk and talk the talk and say, hey, I've heard what the quality team has to say, this is really important stuff. I think they're on the right track here. It's in line with the medical evidence. I think we should go forward with this.

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And likewise, if they think your off track, that is really, really critical that you explore why they think your off track. Any project that gets started on the wrong foot has the ability to get derailed and never really come to fruition and you've just wasted a bunch of time. And so having those Subject Medical Experts chime in on the pros but also the cons of the approach early on is critical to having a successful launch.

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A lot of this presentation is talking about the Physician Quality Champion. So, with the Wisconsin Hospital Association, we've done a ton of work to curate Physician Champions. And the Physician Champion role is one that I don't think is actually super well-defined. It is largely uncompensated role. It is a role that I think is almost like a politician. These are like your cheerleaders. These are the people who are going to go in and grease the wheels and work the individual laggards and work the Medical Director and get this project done. And it has to be a passion project. Your Physician Quality Champion has usually had some sort of quality training. Maybe it was a clinical track and residency, maybe they did some Lean six sigma work, but someone who kind of understands quality work and is the ambassador for the QI team.

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And so, I find myself being a Physician Quality Champion on a variety of projects. It's usually something I'm interested in. It's something like antimicrobial stewardship or infection prevention, something related to opioids. Those are kind of my clinical niches. And whenever there's a project, I engage the QI team really early and say, "Ooh, okay, I think this is on track. I think this is off track. Have you considered this?" I try to fill them in on their blind points to say, "Oh, you know, physician X, Y, Z is not going to like this for these reasons. Have we thought about this approach? Oh, this is so many clicks in the EHR. Is there a way we could decrease some of these clicks. This is something that people are already banging their head against the keyboard on." I'm always willing to go first as a Physician Champion. And so, if there's a project where they say, "Ooh, this might be clunky, let's see how it works in real time." I'll say, "Hey, I'm on shift Monday, why don't we go live briefly on Monday? I'll give it a try, give you some feedback." The quality team has my cell phone, I'm texting them back and forth. It's kind of that in the trenches physician who's giving them that ground level view and helping build the project right the first time and setting good expectations.

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So, this is one where I think people actually sometimes go astray. You think the Medical Director, oh, they are the point person, they're going to say jump. All the physicians are going to say how high the Medical Director's the person who can get everything done. Sure. But the Medical Director has a lot of competing priorities. And the number one, if you think about Maslow's Hierarchy of Needs, the foundation of your needs pyramid as a Medical Director is keeping the place staffed. You need to keep the clinical work going. And to keep the place staffed, you have to have a good budget, you have to have a full cohort of physicians and you have to have happy physicians who show up to work, who don't call in sick, who don't take too much vacation, who share the workload, who cover for each other. It's a really big ask and it's a big body of work. And if you've got people who are already grumbling because their pay is too low, or they don't have enough CME, or et cetera, et cetera, making the quality ask is actually sometimes kind of difficult. It's not as easy as you would think having been a Medical Director. And it can sometimes poison the well in some of your other efforts.

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And so, on the one hand, Medical Director, fundamental, very important person, they're going to be the one who makes sure that the budget will actually support Quality Improvement work. They're going to make sure that the staffing supports Quality Improvement work. They're going to keep everyone in the department abreast of new projects that are being rolled out. They're going to be the ones who can share the data, especially if you have less than stellar data that you want to share with the group. But you can't lean on your Medical Director too hard because they just have a lot of competing priorities. And if you try to make them sort of an impromptu quality director, it's, I don't know it has the ability to backfire. And so obviously it's individual situations, you have to know your Medical Director, but I would say that's maybe a common pitfall is leaning too heavily on the Medical Director. You want to look for other allies in that group with the approval of course, of the Medical Director. Everything's done above board. But sometimes the Medical Director is not actually the best person to make the pitch. Sometimes it is that Subject Matter Expert or the Quality Champion as we'll talk more about.

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Oh, and I think I forgot to mention on the Medical Director. The Medical Director obviously has a lot to do with policies and procedures and that is really critical. So, we do alternatives to opioids in my emergency department, and we needed to get Nitrous Oxide. You can't get Nitrous Oxide without changing some policies and procedures. You got to get your Medical Director on board. And the Medical Director is often in a closed room. They're there with the medical staff where if emergency department and anesthesia have to hash it out over who has privileges for Nitrous Oxide, your Medical Director's going to be the one making that compelling argument. And so, I think that is one of the key areas to engage your Medical Director is policies and procedures.

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Now, if your organization is lucky enough to have a Director of Quality, this is again, a really key role that can actually offload the Medical Director. Sometimes your Medical Director is pulling their hair out, right? They have 10 hours of funded clinical time for week and 40 hours of work. I know during COVID, my Medical Director time essentially doubled, my administrative time... And the pay didn't double, right? So, I'm trying to get all this done.

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If you're lucky enough to have a Director of Quality, they can do things like just give the Medical Director the slide they need for their PowerPoint presentation or have the entire policy written and say, "Hey, can you just sign off on this?" And so that's a really powerful role if you have it. I've obviously worked critical access. I know there are a lot of you out there in the critical access world where you're wearing five or six hats, and you are not only the Director of Quality, but also the Director of Infection Prevention and also the Director of Clinical Nurse Managing, everything else. So, these competing demands can sometimes spread us thin. But if you're the Director of Quality, you're setting quality goals and timelines that are in line with the strategic mission. And it really is about setting goals and timelines. If we try to do everything, we get nothing done. And so most organizations have a strategic plan every one or two years. I kind of always have a priority matrix going where I say, there's so many things I want to get done, but what can I do realistically? And is this the right year for it? Hand hygiene, such a tough one, right? Well, COVID was a great time for hand hygiene. It was something that we all needed to focus on, and people really got it at that time. I know a lot of hospitals made strides and hand hygiene during that time because there were so many other synergistic things going on.

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The Director of Quality is going to be reviewing all the performance data for all departments. And I love this bird's eye view for this role because they can kind of see if departments are working against each other. Maybe for example, you're working on some process improvement for stroke, door to CT sign for stroke, but your transporters are getting dinged for transport time in other departments. And they say, oh, it's because we're always running down to ED to bring the stroke patients. And so sometimes you can see potential conflicts and actually think of a, instead of a plan A and plan B, think about plan C that works for everyone. And then identify new needs for improvements. So, the Quality Director can actually go and take the pulse of a department, can take polls of Medical Directors, kind of see what everybody needs. And sometimes there are synergistic needs. There are things where everyone says, "Hey, we really need a case manager. We could do so much with the case manager." Well, suddenly, when seven or eight departments say they need a case manager, that might be a time to work on a lot of small Quality Improvement projects that you've had on the back burner and actually get a funded FTE position, for example.

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The other thing the Director of Quality does is the actual nuts and bolts of Lean Six Sigma QI work. So, your Models for Improvement, your Workflow Mapping, your Assessments. I think this is part of the fun of the role and really some of the teamwork building. So, when you get these small nimble groups together, the Director of Quality can get Subject Matter Experts, they can get Physician Champions, obviously other clinical team members together and say, "Hey, what really happens in oncology? Hey, what really happens when a patient walks into a clinic? They do this and then this and then this. And sometimes these one-off creative meetings where you really get an idea of what's going on in the department are just so critical. And so, if you have a physician in this director of quality role, this is usually larger organizations or academic organizations, but if you have a physician di Director of Quality, it really is just a kind of a powerful position to know what physicians are really thinking, how their workflow is and set yourself up for success for QI projects that really compliment the nursing and physician workload.

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When you get to the C-suite, when you get to the Chief Medical Officer, CEO, the COO, I actually think these roles are largely hands-off. You're obviously looking at your overall strategic vision, you're obviously looking at budgets, budgets are key and how much you want to invest in quality I think is a very philosophical conversation to have. I would love to see a future world where we really bake quality work into the budget. Where you're not kind of having to ask for line items on every quality project, but there really is an investment in continuous Quality Improvement, but you're not typically participating on a daily basis. The Chief Medical Officer is often getting involved when there's different departments involved. And those Quality Improvement works are sometimes at odds with each other. So, if the radiologists are trying to really increase their outpatient reads and the ED needs a lot more emergent reads on CTs and they feel like there are these competing demands, and there's competing metrics, and oh, if we invest more in the outpatient, then our reads go down in the ED and vice versa. Sometimes that's where the CMO can come in and yeah, just really build that trust, build that benefit of the doubt and show the teams the overall strategy and try to look for that plan C.

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When I was Chief Medical Officer, a lot of it was honestly just giving praise where praise was due. So, you've got these high-flying Medical Directors or Physician Champions who are doing great work and you're in all these different hospital meetings and you share, hey, Oncology is doing this, the Orthopedists are doing this, GI is doing this, Dr so-and-so is doing this. And singing the praise for all that hard work that people are doing and letting other areas of the hospital know that department X, Y or Z is committed to quality.

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Sometimes in the world of doctoring quality really comes up in the old school days it came up as peer review or like a M&M conference, right? There's something bad happened. And I think that's a lot of our experience as physicians in the QI world is we come to the table when there was a bad outcome, and we want to justify our clinical decisions or talk about what happened and how we could work better in the future. And so, the Chief Medical Officer can kind of break that paradigm and talk about us in a positive light and talk about all the amazing things your department is doing 364 days out of the year. So, when there is an M&M conference, everybody knows that hey, OB is really committed to quality. They've been working on their mass transfusion protocol; they've been working on decreasing their C-section rate. And sure, they had this bad outcome that probably would've happened in any hospital around the us, but this is all the work they've been doing on an ongoing basis. It really builds a lot of trust so that when that Medical Director or physician is in a less pleasant meeting, people really give them the benefit of the doubt.

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So, here's my first physician engagement pearl is to clearly define your physician QI expectations. And so, scope creep is where Dr. Redwood helped you out with this project, and then the next one, suddenly he's signed on for five. Some of them are month long projects, some of them are yearlong projects. And I get home, after my clinical shift after working 12 hours and I'm like, wow, I feel like I have a quality role that I didn't really sign up for. And that's a way that you can kind of burn someone out without meaning to. And so, when you make a Quality Improvement objective, we often talk about the SMART Mnemonic, a Specific Objective, Measurable, Achievable, Relevant, and bound by Timelines. I would make the same recommendation when you're engaging a physician. If they have a quality role, if they're the Quality Director, sure, use that time. You might want to ask them, "Hey, how many hours do you actually have dedicated to this?" As a Quality Improvement professional, you might be 9 to 5 and have 40 hours, but as an employee physician for a private group, my quality role might be 5 hours a week. I might be getting paid five hours a week. And so, you might want to actually ask, how much bandwidth do you actually have? And then say, hey, I've got a specific project. We're working on a new BPA for Sepsis, we're going to spend three months on it. We want to increase blood culture use by 20%. And this is going to be relevant because the ED had so many, 13 multi-drug resistant organisms last year where we didn't have blood cultures and weren't able to choose the right antibiotic until later. And I think this is going to take about 10 hours out of your time in total. If it looks like you're getting to 10 hours really quick, please let me know and we can wrap it up. That would be a great conversation. I would say, oh, okay, this sounds like a worthwhile project. There're some nice boundaries around it. The person's respecting my time, let's get going. You know. And if it really is a big and ongoing role, if you're asking someone to be the ED liaison for stroke in your organization, you might want to actually talk about a job title, a compensated role because you get what you pay for. And if you ask for volunteer work for a big ongoing role, it's likely that clinical production pressures are going to get high, and your work might get tabled, and you'll just get a less valuable project.

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I know as a clinical physician, I get about 25 emails a day from work. As a Medical Director, I got about a 100. And as a CMO, I got about 300 emails per day, and only at the CMO level did I have an administrative assistant who could kind of help me screen emails and go through that. And I got recommendations. Again, I'm lifting the veil here, I'm trying to share personal experience. That doesn't mean this is a best practice, but I got recommendations from physician colleagues to only read emails that were directly to you, not to read any CC'd emails because when you're a Chief Medical Officer, for example, or even Medical Director, you're on so many committees that you're kind of CC'd on these chains of emails and each one has a PowerPoint and an agenda attached to it. You can't actually get it done. You can't do it. It's not enough time in the day to get it all done. And so, people will kind of come up with these workarounds and yeah, I think that's our role as quality provision professionals is to what level do we want to engage our physicians? How do we want to do it strategically? If we have something that they really need to read, how do we get to the front of their queue? How do we get them to actually read that email or show up to that meeting? And behind closed doors, Quality Improvement professionals are frustrated sometimes they say, wow, where's the professionalism from our physician workforce? They're not showing up to these meetings. And as emergency physician, I can just tell you, we don't work on a nine to five schedule. We don't work Monday through Friday. We don't have dedicated sit-down email time and trying to build these two worlds together can sometimes feel like it's in conflict. So, we'll get a little more into that.

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If you have your sketchpad ready, I want you to write down your pearls, what physician QI roles have been successful in your hospital? So, think of sometimes where it's went well, where Dr. X, Y or Z was engaged, where the project went off without a hitch. And then the next level question is, why did that go well? Was it all personality or was there something about the structure of that position engagement that set you up for success?

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Alright, so we're going to get a little bit philosophical here. I think it's no surprise to you that some physicians are suspicious of QI work. And you've probably heard some of these. I hope you haven't heard them in the halls of your hospital, but you probably have that, oh, this is coming from the Suits, or the Bean Counters, or the MBAs. This is corporate medicine this is moral insults. These are all kind of words that stressed out physicians use to describe work that detracts from their clinical work. And I don't think it's appropriate to say that, oh, these are bad doctors, right? I think we want to unpack this a little bit. And so, I'm going to share with you my personal journey going to become a physician.

00:35:29

So being a doctor is amazing job. I love my job. And it may sound like I'm playing the world's smallest violin here, but when I talk with my physician colleagues, this is stuff we talk about. So, our physicians entitled, I've heard that from a lot of clinical nurse managers is like, oh my gosh, the docs don't show up. They don't read their email. Basic professionalism issues. We would get fired if we were acting this way. And it's kind of framed as these docs are entitled, right? They're not doing the work that they're supposed to be doing. It's a long road to be a doctor. It's 12 years. I remember in undergrad, I was in the library all the time watching the people play Frisbee on the lawn. I wasn't out there playing Frisbee. I did not have a lot of life balance. I had two majors and pre-med. Four years of medical school your relationships are really on hold. You do not get the time with your friends that you want. Your work colleagues and your medical colleagues feel like, I've spoken with people in the military, and it almost feels like that in the trenches experience, the fog of war and the brother that you get during battle, there are no weekends. You age faster than your non-medical peers. I can't remember seeing more hair in the shower drain than during medical school. And it rolls right into residency, which is just, they're working on these work hour roles, supposedly 80 hours. A lot of us did. A lot of us said, it's still not a reality, even though they tell us to tell the world it is. And it's a life of sleep deprivation. It's very hierarchical, very again, military-like where they say jump, you say how high. Every day you're reminded of your incompetence. It's built into the model. And again, I hope that the compassion is increasing as we learn more about just being human in medicine. But for a lot of us it's not. And when you finish it all your 30,000 to 500,00 K in debt, your friends have kids in houses, you feel like you lost 10 years of your life, honestly. And this is all rooted in the individual clinical experience.

00:37:25

And here's where I hope the paradigm is changing, because what I'd love to see is this whole experience be looking more at population health in the future. But before doing my public health training, I had great mentors, people I really respected saying public health is a volunteer thing. It is not something you can build your career on. You have to think about your individual patients. When you're in residency, it's so focused on that patient, on that single interaction. You're logging all the things that happen for that individual patient. And then you get out in the workforce, and you start talking about quality. And we are essentially trying to break that paradigm. People have for 12 years been emphasizing the individual patient experience. And I'll give you an example.

00:38:06

If we're choosing something to treat a bacterial sinus infection, Augmentin works 94% of the time, Amoxicillin works 90% of the time. If you're looking at the individual patient, you would choose Augmentin. But we can't lose Augmentin. We need Augmentin. We need to use the smaller antibiotic. So, we don't get multi-drug resistant organisms or else we won't be doing surgeries in 50 years because everything will be resistant to that. And so, we should be choosing Amoxicillin, we should be accepting 10 treatment failures per a hundred patients instead of six treatment failures. And then if there's a treatment failure, bump it up to Augmentin. That's a hard argument to make to a lot of doctors. They say, what? Why wouldn't I just use the better drug? Well, the evidence shows Augmentin works better. And so, snapping people out of that mindset is the important way to get people engaged in Quality Improvement.

00:39:00

So, is your physician entitled? Maybe, but maybe they're burnt out. Maybe they are overworked. Maybe their clinical production pressures are paid for, but their administrative ones aren't. Maybe they just have 100 emails a day and they're having trouble sorting through it all and they don't want to miss their kids' soccer games. And so, the question is, how do you tap into that really engaged physician? I talk about my higher self and my lower self. My lower self-day, I might be grumpy and cut the conversation short and put the phone down. And on my higher self, when I'm having a day where my empathy tank is full, I have a bird's eye view of the care plan. I'm detail oriented. I'm careful about my patient care. The main thing I want is time with my patients. I think that's a lot of people don't understand that physicians actually are jealous of our nurse colleagues a lot of the time. When I went into medicine, I didn't realize I'd be spending so much time with the computer and so little time with the patients. My nurses are my eyes and ears. They get 20, 25 minutes with my patients where I get 3 to 5 minutes. And if you can tap into this person who really just wants to do the right thing, this person who really cares about good clinical outcomes, you'll find an amazing amount of dedication. And that's what it's all about, is finding out what makes each of us tick as an individual physician. And that's not all on you as a Quality Improvement professional. That's for our physician colleagues, for our Medical Directors. But again, at the end of the day, physicians are people. And if you want to engage in that expertise and tap into that expertise, it's about finding the argument that works for that person.

00:40:39

So, another pearl here. Most QI work is designed to benefit the population, but there's always a way to work in the individual patient argument. And so that's what I want you to all think about and jot down in your post is if you are making the case for a broad population let's use C-sections again. If we're trying to decrease our C-section rate, what is the individual patient argument there as well as the population health argument? And when you're talking to your docs, know your audience. If it seems like the population health argument is hitting, that's great, that means you're already there. And if it doesn't, if it feels like it's kind of falling flat or they're saying, well what about this case? What about this case it happened 10 years ago? Then try to bring in that individual patient argument where, hey, we had this amazing outcome two months ago where we followed the protocol, this happened, we had a great outcome. The patient wrote back giving us all compliments, their baby's healthy, et cetera, et cetera. But you want to have those, whatever projects you're doing, you want to have those in your back pocket and be ready to toggle between population health and individual patient argument. And they are sometimes in conflict like the antibiotics decision that I just gave you. Someone might say, well, Mr. Jones is going to have a better outcome if I choose Augmentin. And you say, well, does Mr. Jones have a kid? Is Mr. Jones going to have a grandkid? Because Mr. Jones's grandkid might not have any options when he or she gets a sinus infection 50 years from now if all of the strep-pneumo is resistant to Augmentin. How about you talk to Mr. Jones about that? We'll give you a 6% less chance of getting better with this drug, but it means your grandkids will live in a better world where we still have drugs that work against common bacterial infections. And maybe the argument won't work if it doesn't work, you back off and regroup later. We'll talk about that as well.

00:42:29

I am keeping an eye on the time here. I'm going to start cruising, because I do want to have time for a few of your questions at the end. And I think we have a lot of rich discussions when we have questions. So, let's talk about finding that ideal Physician Champion.

00:42:47

So, when you're looking for a Physician Champion, you are looking like we said, for a little bit of a politician. One of my colleagues called me the mayor, he is like, you're like the mayor, you're going around all the other departments, you're chatting up the techs and you're and the cafeteria workers. And I think that is part of spreading the gospel of good QI work. This is implementation science, but we're working with people. We need people to actually agree with the work that we're doing. So, you want someone who's respected as a physician. If they're not a good clinical physician, it's going to fall flat. A good communicator, someone with a backbone, they have the courage to stand up and really say, well, that you make a good point, however, if we look at the evidence, good social skills and relationships in the hospital are key. And so sometimes that is someone who's been there longer, but it can also be an eager beaver who's willing to make those good relationships, who wants to step outside and meet some new colleagues. And then I it could be any specialty, but really these primary care and team-based specialties like family medicine, like internal medicine, like emergency medicine, these specialties do tend to have people who touch different clinicians in different clinical environments and often just have that built in network in the hospital to be really effective in this role. Not to say it couldn't be any role.

00:44:06

The way we keep our Physician Champions engaged is, I do think it's important to compensate them. Ideally, I would hope it's built into your system, but if it's not built into your system, you want to think of those ways without a budget you can do it.

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So, I've done this so many times, worked in so many quality roles where this project doesn't have a budget. The main way you can compensate them is honestly with their time. You want to respect the person's time and be strategic about their involvement. I think we talked about that already, but it's not always a one-hour weekly meeting, right? You might meet them at shift huddle, you might pop by next to our work environment, say, hey, can I grab you for a minute? Instead of a one-hour regular meeting, have a five-minute Zoom with them before the meeting and you can represent them at the meeting. Any way you can do to get them back to their kids' soccer practice is appreciated. And then these are some ways that I've been compensated, or I've compensated others that really take very little money and go a really long way. So, I love coffee, everybody knows it. I always show up to my shift. I've got my coffee here. And so, a coffee card at the hospital's coffee shop that was like, oh, wonderful. Oh, you're keeping me awake. That's great. Maybe game tipping. Maybe somebody in the C-suite has season tickets and you can get a few game tickets to give away to your high performing Physician Champions. It's a memorable experience. It makes them think fondly on their QI work. Somebody gave flowers to my wife once on our anniversary. They said, hey, when's your wedding anniversary. I told them, and this big thing of flowers showed up for my wife. I was like, oh my gosh. Nobody's a prophet in your own land when we get home none of us are doctors at home. Our spouses rolled their eyes at us and at our medical degree. So, to know that somebody at the hospital thinks we're cool, thinks we're effective, things we're doing good work is just, it went so far.

00:45:43

Does your doctor have small kids? Maybe some babysitting vouchers, right? Maybe some sort of childcare option or a date night. I can't tell you that would stick out in my head for years if somebody did that. And again, it's all about time. Can they block one appointment in their day? Maybe you don't have extra money to give this person, but if you can block one appointment in their day, they'll actually read the minutes from your quality meeting. They'll actually weigh in instead of just kind of showing up in Zoom at the last minute and blinking out without having their camera on. If someone doesn't have their camera on, there's a pretty good chance they're working on their clinical notes right then.

00:46:21

And then it's essentially the converse. How do you lose your Physician Champion? Too many meetings. Meetings during clinical time where they feel flustered because they can't do two things at once, where they're trying to log in on shift. Interventions that are overly burdensome to that clinical workflow. Like if I designed that Sepsis BPA and it takes another six clicks per patient to get through it, oh my goodness, you just shot me in the foot as your Physician Champion. Anything that puts me in an adversarial position with my peers. So, if you know your emergency medicine group doesn't believe the medical literature on TPA and thinks that the harm outweighs the benefit, and then you throw me in as a Physician Champion, as a cheerleader for more TPA, I mean, goodness gracious, I'm just going to get devoured at our meetings, right? So, you got to talk beforehand and say, okay, our group isn't into this, but we need to be into this for our patient's sake. What is our strategic approach to chip away at them and to really win their trust and benefit of the doubt? Is it journal clubs? Like what are we going to do here?

00:47:19

And then drifting too far from the science. So, we talked about the importance of patient anecdotes. But in quality work we often kind of advertise our work to nonclinical people. So, we're telling the community about all the amazing stuff we're doing and then we have all this promotional material, and we bring it back to the doctors and try to sell it to the doctors and it looks like corporate window dressing or something like that. It falls a little bit flat. And so, you want to really keep it in the individual or in the real patient experience. I remember, like I've done a lot of Sepsis work and there was this big Sepsis campaign about a totally healthy, amazing young person who got Sepsis and unfortunately died. And if we had done all this stuff, it would've saved their life. And it fell a little bit flat on clinicians, because your average Septic patient is like, MI, diabetes, hypertension, lives in a nursing home, already has multiple amputations. That is our real clinical experience. And this one young healthy person out of a thousand other cases, while real didn't feel that real, it felt a little like we were overstating the success of our work or something like that. And so again, you just want to kind of keep it based in real clinical world and be a little bit cautious about using hospital level advertising material on your physician workforce.

00:48:43

And so, these are the pearls: Is you want some high yield interventions. If you're looking for interventions, something that's where it's really, you get a lot of bang for your buck. I use a model here, or the example here of Aspirin for acute Myocardial Infarction. The number needed to treat is 20. If we give 20 Aspirins to people with acute MI, we save a life. That's an amazing intervention. You want to help us like choose metrics that do things that we actually want to do. So again, I go back to blood cultures. I always want to order blood cultures when somebody's Septic. But it's just like one of these extra things and it's a pain in the butt for the nurses, and it's easy to forget. And so yeah, an intervention that would help me forget something that's very critically important for my colleagues down the line but not super relevant to my work would be a very high yield one to work with.

00:49:40

And then sometimes we get frustrated with metrics that actually work against clinical care obviously. So, there's a lot of issues with the pain scale being associated with the opioid epidemic. Patient satisfaction is wonderful worth talking about, worth doing, but we can't overemphasize patient satisfaction to the point where it becomes truly a customer service role. And we give people anything they want, even if it's not in the best interest of their health. And then obviously we don't want to push any interventions that aren't based on solid evidence. And I think the Quality Improvement world has really moved past that. But there are so many emergency physicians out there who still feel burnt about blood cultures for pneumonia, it was just rolled out too early, the evidence wasn't solid enough. So, when we talk about best practices, they really should be best practices. And if they're not, if it's COVID and we need to roll something out fast, then we just need to acknowledge that, hey, we don't know if this is a best practice yet. The best available evidence suggests that we need to be moving forward with this and the harm is so great, I think we need to go for it. I mean that's an argument I could get behind.

00:50:35

And so, if you have your notepad there, what metrics have physicians responded well to at your organization? And what have they not responded well to? And for those ones that they responded well to, I'd just be curious for you to write down, why do you think that metric was good? So again, keeping us on task here.

00:50:55

If your physicians aren't engaged, they might actually feel like they're engaged. We do a lot of stuff that isn't traditional Quality Improvement, like quality professionals think about. So, we're doing credentialing, we're doing peer review, we're doing patient complaints. There's all these meetings that physicians go to that I'm not sure the rest of the hospital knows that we're doing all the time. And so, a lot of physicians actually regard that as Quality Improvement work, even though it isn't data-driven implementation science. And so, you might want to start by just thanking them for the quality work they're already doing. You might not even know what they're doing, but you can thank them for the quality work they're already doing. Because every patient complaint I get, I've got to respond to, every patient question I get, I have to respond to. And that often feels like quality work, even though I don't think the quality department would necessarily regard it as such.

00:51:42

And when we talk about getting people to change behaviors, we talk about the stages of change. It's a scientific thing that we think about. So, if you're trying to get someone to quit smoking, you say what phase are they in? Are they Pre-contemplation? Are they in Contemplation? If you're having a physician who's not engaged, I would recommend applying this model. Where are they at? Is Dr. Redwood in Pre-contemplation phase? I don't even know we had a quality department. Am I in the Contemplation phase? Oh sure, yeah. We have a stroke thing going on. Yeah, I haven't read the emails yet. That's where you want to say, oh well, we have so much mortality from stroke, and we have this much room for improvement here.

00:52:18

Am I in the Preparation phase? Okay, I've read your email. No, I didn't totally get it. Oh, I think there's an order set coming out. Could you tell me more about it? Maybe I need some handholding. Maybe print out the email and bring it in front of me with the right things highlighted. I know it sounds like spoon feeding, but this is how real quality work gets done as you find where the rub is and get it done.

00:52:37

When someone's in Action phase, that's usually when the Medical Director can take charge there. Okay, I'm using the order set. All right, I'm aware of the quality metric and the Medical Director can kind of bring in cases that fell out or give me a pat on the back when I've done something well. And then when I'm fully engaged, when I'm your Physician Champion, again, I'm singing the gospel, I'm telling all my colleagues, hey, the stroke order set is great. Have you tried it yet? We're doing shoulder to shoulder learning. At that point you just stand back and let me do my work, praise me at departmental meetings, that kind of thing.

00:53:10

And then you will meet resistance. And maybe Dr. Redwood was just having a lower self-day. Maybe a patient died right before you came and talked to me. I'm not going to drop that on you, I'm not going to tell you about that. But it could have been some... There's maybe something weighing heavy on me. Maybe I bit off more than I can chew and I'm 20 charts deep and I'm missing my kids' soccer game already and I know it and this is one more thing and I snap at you. Back off in regroup is usually just kind of a happy warrior approach. But definitely stay committed, keep coming back. But if you get like initial brush reaction, I would just say like any human being, give them some space, empathy, back off. Add some levity, the request. I think self-deprecation goes a really far long way and it's important to take ourselves seriously in the clinical space, but when we talk about Quality Improvement work and we're looking at graphs, I think it's okay to have some levity, and yeah, just find out what that physician responds well to. There is a lot of like gallows humor in medicine and this is a space where sometimes that's successful if you're meeting some initial resistance. Use our peers to our advantage.

00:54:17

If you're not getting through to Dr. Redwood, but you're getting through to Dr. Jones, and we play golf every Saturday, I don't think that's inappropriate at all to say, "Hey Dr. Jones, what do you think about Dr. Redwood's involvement in this? Can you be an ambassador for me? Don't overstep your bounds, of course. But when you have that Physician Champion relationship, I think that's the type of conversation you could have.

00:54:36

And then definitely what you don't do is blame, shame, intimidate or nag us. If I just get 10 emails and everything's bolded and everything's cap lock, if you CC the CEO on the emails, I mean you, you're just burning the bridge. And so, it really is one of these catch more flies with honey than with vinegar and physicians are, we are essential to the organization. You have to be pretty unprofessional to get fired as a physician. And so not showing up for quality meetings or not getting quality metrics done, probably doesn't meet that bar. And just kind of shaming somebody in front of their boss isn't going to get you very far. They're probably going to keep their job and they're probably going to poison the well with the quality department. And so, it might work with other role groups. I don't think it works great with docs and I would recommend more of a kill them with kindness approach.

00:55:24

And so, if you could all jot down what strategies work well when you meet resistance, yeah, I'd be interested in in your thoughts.

00:55:37

So, we're wrapping up here with a few time for question, but when I think about the future of Quality Improvement work, what I really think about is full integration. And so, if you look on the left-hand column, as physicians, we need dual tracks in medicine for not only a medical doctor but a master of clinical implementation science, where you can have your dual credentials, bump some money off your loans, spend an extra year and really be an expert in the field.

00:56:02

Our professional societies have to integrate this. So, in emergency medicine, I have to do a QI project every five years. Now that probably sounds funny to you, it's only five years. Maybe we'll get to the point where it's one every year, but I think this needs to be ingrained in the DNA of our credentialing process as well. We have to have budgeted time. There's so many production pressures on physicians, if we don't have the time to do it and we have to be realistic about it, it's not going to happen. So, if it takes us four hours to read our quality emails every week, you either pay for those four hours or you expect those emails to not to be read unfortunately. And so, a lot of that is the strategic engagement piece.

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And then engage our physicians with things besides dangling money in front of their faces. There's this conversation about tipping nationwide going and there was a restaurant owner who said, tips are rewards, rewards are for children and dogs. And that really stuck out in my mind because what rewards me as a physician is good clinical outcomes, amazing care, the workflow going well, these are the things that really make me feel wonderful and a little bonus is nice, but it's not the reason I'm showing up to your quality meeting. And so, think of ways to really make sure that this improves our life and our clinical outcomes.

00:57:14

And then on the other side, for Quality Improvement professionals, we want infrastructure to support QI work in the EHR, especially. So, we're not doing individual chart grabs and running around kind of doing a lot of drone work for this. It needs to be just seamless and built into our EHR. We want to better define QI job descriptions and healthcare and actually fund those positions. And eventually I'd like to see QI professionals in med schools and residencies as well. And then the center column here is the integration of these two things. And so, this is when Quality Improvement, implementation science and medical assignments become the same thing. And when you're talking about clinical care, you're talking about individual care but also patient health, population health, looking at individual outcomes, also looking at your dashboards, et cetera, et cetera.

00:58:01

And so, the final pearl here is that at the end of the day don't be afraid to show us your true self. If you are in Quality Improvement work, there's a pretty good chance you're a data nerd, there's a pretty good chance that you love implementation science and bringing best practices to the bedside, that Lean Six Sigma makes you excited, that when you see a Gantt chart you get excited for all the good things you can do. Just show us, show us your expertise, show us your clinical science background. And I think you'll find that physicians respond really well to that. You can use technical jargon, you can talk about incidents, prevalence rates, all of these things. And as more and more physicians are trained in implementation science and Quality Improvement work, these conversations will become more natural.

00:58:45

All right, so to our facilitators, I don't know how time bound we are, but you have my whole day of course. And if we do have time for a few questions, I'd love to answer.

00:58:53

Thanks Dr. Redwood. I'm not going to read off everything on this slide and we already do have some questions coming in, so you can see on the slide how to submit your questions. And Brandi, I'll turn it over to you. I did also chat out to the audience that any questions that we don't answer today live will be posted in a written follow-up document on our website in a couple weeks.

So, Brandi, I'll turn it over to you to facilitate the couple questions we've received so far. Thanks.

00:59:21

Sounds good. Thank you so much. Alright, so rapid fire here. The first one that we got to live today is, "How often should the quality director meet with the med staff committee?"

00:59:36

Once a month. If you have something that you're really working on, like your hospital had some bad outcome and everybody's looking at it and you need to do it more frequently, that makes sense. But I think once a month it's totally appropriate. It's really more of a report out meeting and then to get feedback from the medical staff if they're off course.

00:59:54

Great, thank you. Next question. "Any suggestions on how to provide quality training to providers, whether that's resources or online courses?"

1:00:06

Sure, there's a lot of online content now that I think is excellent and a lot of that is through CMS or Joint Commission. And then what people really respond to well is our individual professional societies. And so, you could just ask the next time you go to your professional society meeting, could all of the docs in your group go to some sort of quality relevant training session or you could even design a bonus for that. Like the group gets a bonus if you do so many CME hours. Just make it open, CME hours. But I usually do things within my specialty within emergency medicine. So, it really is a good point. I recommend getting away from compensating people, like giving bonuses for performance on metrics and actually giving more bonuses for engagement and Quality Improvement work. I think we should be rewarding engagement. And so, the more that you do CME-related to Quality Improvement, the more you're going to understand the hospital's goals and you'll probably see those metrics improve just because people are more engaged.

1:01:06

Okay. And how about in your opinion, I know you mentioned a little bit about this in your presentation with the SMART metric, but "What's the best way to engage private physicians that are not employed by the hospital?"

1:01:22

Oh, that's a great question. So, I'm actually in a private group right now. I'm not engaged with my hospitals. Is the first time I've been in this situation. You can feel like you're on an island sometime, like it's a pain to get into the hospital's email system. And so, the first thing I would do is make sure that your tech works. Make sure that people... That it's not five jumps to get the same information that the hospital employed physicians are getting. And it really can be challenging because one place is using Teams and one place is using Zoom or whatever. But if you want your private groups involved, it does have to be easy for them. And I think it's often quite clunky to be honest. The other thing, I guess I'd go back to that quality bonuses for physician engagement rather than hard metrics. I think a lot of groups, you don't want to feel like you're just gaming the system and you're just trying to meet the metric. And so, private groups get bonuses based on their performance, but I would like to see a bonus for physician engagement there.

1:02:19

And then is there any hospital resource that you could share with the group? I mean, these are small businesses, right? So, they don't have a lot of support staff, we don't actually have a full-time secretary for our private group. And so maybe it's QI data, maybe you can give us graphs where we can put on our website or tell our patients how amazing we're doing, or maybe there's an award, maybe you're getting a Coverdale Award, and the emergency physicians played a role in it, and you can give us that award so we can, again, share with our patients to tell us what a great group we have, what a strong group we have.

1:02:47

If the hospital is kind of getting praise or preparing public facing documents anyways and there's any opportunity to share, let the private group kind of bask in that glory, I think that would actually go a long way because private groups don't always have the infrastructure to do that kind of thing.

1:03:03

Great. Thank you so much and we really appreciate you sharing the breadth of your content with us today. And we're actually at 12:03 now. So, there's a couple more questions here and I want to assure our attendees that these questions will be answered in a document that we will post to our website in the follow up. And over to you, Susan. Thanks.

1:03:24

Great. Just a few last closing remarks and it essentially just goes to how you find the recording afterwards, after the live event. You can find the recording, the slides, the transcript, and that Q&A document we've mentioned a couple times at the link shown on this slide. It's the Continuous Customer Engagement page.

1:03:43

The original broadcast included a live Q&A segment, which is included in this recording. To ask questions regarding the On Demand webinar operations or CE-related inquiries, send them to tjcwebinarnotifications@jointcommission.org.

1:04:06

Before this webinar concludes a few reminders about the CE survey. We use your feedback to inform future content and assess the quality of our educational programs. As explained earlier in the webinar, you can access the survey link in 1 of 3 ways.

See the next slide for the QR code to complete the survey via your mobile device. Stay tuned a few more moments after the recording completes, and a popup window will include the link to the survey. Just cut and paste that link into your Internet browser. Finally, if you miss the QR code or the popup screen, you will also receive an automated e-mail tomorrow that includes the survey link.

After you click Submit, at the end of the survey, you will be redirected to a URL from which you can print Or download and save a PDF CE certificate. An automated e-mail will also deliver the same PDF certificate.

1:05:11

Thank you for your participation on this On Demand webinar. Use the QR code shown on this slide with your mobile device or wait a few seconds for the popup message with the survey link.