CHAPTER 9

Quality: A Cornerstone of Physician Engagement

John Byrnes

The process of creating healthy organization–physician relationships is critical to organizational success. Partnerships in process improvement can nurture these relationships and mitigate burnout by meeting physicians' psychological needs. To flourish, physicians need some degree of choice (control over their lives), camaraderie (social connectedness), and an opportunity for excellence (being part of something meaningful). Organizations can provide these opportunities by establishing constructive organization–physician relationships and developing physician leaders.

—Steven Swensen, Andrea Kabcenell, and Tait Shanafelt, "Physician–Organization Collaboration Reduces Physician Burnout and Promotes Engagement," 2016

Why address quality in a book on physician engagement? Consider this: Can a robust quality and safety program be the cornerstone of a successful physician engagement strategy? To what extent are physician engagement and quality related? Does one element drive the other?

Consider three facts. First, physicians ascribe to the Hippocratic Oath, which is often interpreted as "I will first do no harm." While these are not the exact words of the oath, the Greek translation is

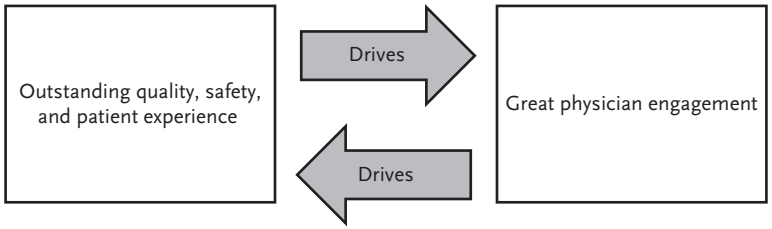
better phrased as, "Abstain from whatever is deleterious and mischievous." While this admonition may seem stale, it is nonetheless a part of every physician's foundation.

But then consider a second fact. Physicians are the people who make the majority of clinical decisions and guide practically all the actions that affect clinical quality. Physicians and clinical quality are as related as milk and cookies. Oshiro (2015) describes this relationship well: "Making significant improvements is not an achievement organizations can do without physician engagement, though. They need physicians to be on board. Why? The reality is that physicians play a large role in the complex mechanisms of healthcare delivery. From providing frontline care to filling leadership positions, physicians drive 75 to 85 percent of all quality and cost decisions. That's a mighty large percentage, which translates to significant financial losses if physicians are disengaged and don't participate in improvement initiatives." The relationship between physician engagement and clinical quality is clear-cut. It is strong; it is 100 percent correlated; it is critical.

And not only is quality directly correlated with physician engagement, but in light of the same logic, so are patient safety and patient experience. As Kramer (2019) explains, "An emotional connection with the patient can be just as important as an accurate diagnosis. Though individual providers take the Hippocratic Oath, its provisions on warmth, sympathy, and humanity are a road map for improving overall culture." Consider also the findings from Press Ganey, a firm that conducts thousands of surveys and is an expert voice on both physician engagement and patient satisfaction. In a white paper on engagement, the company writes, "Patients have front-row seats to an organization's cultural successes and failures. They can tell whether employees and physicians are engaged or would rather be working somewhere else. Being surrounded by engaged caregivers reinforces to patients that they are in a safe place and affects how they evaluate their care" (Press Ganey 2013).

Finally, a third fact that cannot be ignored is that physicians and institutions face the risk of medical malpractice suits. Although this risk presents a negative reason for equating physician engagement

Exhibit 9.1 Quality, Safety, and Patient Experience as Related to Physician Engagement



and quality, it is nonetheless an important factor. Low physician engagement can be related to stress, which can cause quality issues that expose both physicians and organizations to medical malpractice risks. Shanafelt and Noseworthy (2017) write that "physician distress has also been linked to physician prescribing habits, test ordering, the risk of malpractice suits, and whether or not patients adhere with physicians' medical recommendations."

To conclude, clinical quality and physician engagement are most likely closely related. The relationship is shown in exhibit 9.1.

The following case study illustrates the matter of driving physician engagement and quality simultaneously.

Case Study: Board Retreat

During a recent board retreat where the outside speaker was focusing on clinical quality improvement, many of the physicians in attendance seemed surprised at how much they as individual clinicians affected quality. They had mostly viewed quality as an organizational function, something that was relegated to the hospital quality committee and the quality officer. They had not fully reflected on how they as individual physicians drive quality. While the discussion continued, they began to recognize that their impact on quality came from

(continued)

(continued from previous page)

two basic mechanisms: the orders they write and the medical decisions they make. During a break at the retreat, two physicians approached the speaker, visibly troubled. They were concerned about how much effect they had on the outcomes of their patients and wanted to know what more they could do to learn about and improve their performance. Toward the end of the retreat, the speaker asked all the physicians if they believed that they could or would now play a larger leadership role in improving care for their patients. Hands raised around the room, showing 100 percent buy-in and the physicians' sincere willingness to help lead clinical projects in their organization. Moreover, they wanted to begin immediately!

Later that day, many of the physicians were asked what, among all the things they had heard during the retreat, motivated them to volunteer to now lead improvement projects in their organization. Unanimously, they indicated that it was the realization that they as individuals have an impact on nearly all the clinical outcomes. This new awareness clearly provided the motivation.

This case study should be an important wake-up call for all readers. This encounter (which is not fictitious) demonstrates physicians' passion for quality and, as a result, their zeal to be engaged. As noted, patient quality and physician engagement are tightly linked. The moral of this story is this: When physicians understand their impact on clinical quality, they will engage with and lead improvement projects. In this case, and in less than a day, an entire room of physician board members became highly engaged in their organization's journey toward better quality. Why? They understood that they are personally responsible for their patients' outcomes—through the orders they write and the medical decisions they make.

HOW PHYSICIAN CULTURE AND ATTRIBUTES DRIVE ENGAGEMENT AND QUALITY

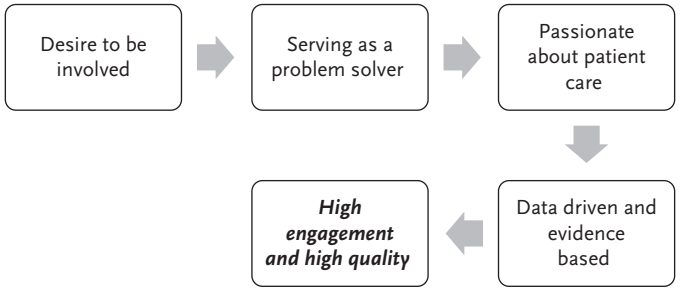
In designing physician engagement programs, healthcare leaders should consider the elements of physician culture and other physician characteristics that can help drive clinical quality and engagement. Exhibit 9.2 shows these key traits. We will next look at them in detail.

A Desire to Be Involved

Simply asking physicians to help is one of the best ways to put to good use their desire to be involved. One method a healthcare leader used was clear-cut. It went something like this: "Dr. Rodriguez [a surgeon], I need your help to lead an improvement team focused on reducing surgical infection rates. Your expertise will be essential to designing our care guidelines, and your standing with your peers will help a lot with collaboration among the docs. Can you help out?" As most readers know, the old adage of "Just ask; all they will do is say yes or no" can go far in leadership.

Asking for help also takes advantage of another key characteristic of physician culture: Physicians want to be involved in decisions that affect their practices, their patients, and their organizations.

Exhibit 9.2 Common Physician Culture and Attributes That Drive Engagement and Quality



This desire to have some influence in decisions lies at the core of physician culture. And nothing gets a physician closer to having some influence than does working on improvement teams to design evidence-based guidelines, order sets, and the clinical dashboards that physicians will use to improve their clinical outcomes.

But, the number one mistake that leaders can make is to engage physicians only *after* decisions that affect their practice have already been made. Like most people, physicians don't like when things are done to them without their input and involvement. To ensure greater physician engagement, always invite them to lead or at least participate in an improvement team from the beginning. They are busy professionals, but many will make time for this important work.

The number one mistake that leaders can make is to engage physicians *after* decisions that affect their practice have already been made.

A Problem-Solver Attitude

Another aspect of physician culture can be used to drive engagement on quality projects: Physicians are problem solvers. It is what they are trained to do, and it is what they do every day—with every patient they see. When physicians understand that the goals of a clinical project are to eliminate complications, mortality, and readmissions, they are ready to engage. To meet these goals, they will need their problem-solving skills. If every improvement project is clearly a problem-solving exercise, quality and physician culture will be fully aligned. And when these two are aligned, physician engagement is almost always guaranteed.

Physicians are problem solvers. It is what they are trained to do.

Compassion About Patient Care

Ritchie (2019) writes that "when health care providers take the time to make human connections that help end suffering, patient

outcomes improve and medical costs decrease. Among other benefits, compassion reduces pain, improves healing, lowers blood pressure and helps alleviate depression and anxiety." The benefit of physician compassion may be one of the strongest arguments for the link between physician engagement and patient quality. Rarely does any conversation with a physician not include the topic of patient care. And consider this side benefit, described by Emma Seppälä (2019): "Compassion for patients is associated with lower medical expenditures."

Physicians are compassionate about patient care.

A Data-Driven Mindset

Physicians are data driven. They use data every day to make decisions for every patient. They are trained in the scientific method and know how to analyze and interpret data. So when data sets and dashboards are used to drive clinical improvement, physicians are well suited for the task. But with this expertise comes the expectation that the data is accurate and that the quality department staff will be transparent and will disclose potential weaknesses inherent in a data set. Physicians do not expect perfection, but they will quickly identify the flaws in a dashboard, especially when the information is reported for a familiar medical condition or surgical procedure. We will next look at how data can be a tool that fosters fabulous engagement or, when things go wrong, disengagement and a loss of trust.

Data's Role in Engagement and Disengagement

Data can be the best or the worst tool to promote physician engagement. Key to its role with physicians is how organizations: (1) involve physicians in the design of data dashboards, (2) shift ownership of data and dashboards to physician leaders, (3) support physician leaders in the dashboard rollout, and (4) troubleshoot data integrity issues when they occur. Let's review this process in some detail, as the approach will determine how well it goes.

Involving Physicians in Dashboard Design

As discussed, physicians want to be involved in everything that affects their practice. For this reason, they must be included at the beginning of any dashboard design session. Here are some key steps to get off to a good start:

1. Assemble a physician-led dashboard design committee.
2. Ask the medical director or chair of a department to chair the committee.
3. Before the first meeting, (a) fully brief the physicians on the purpose of the project and (b) share several dashboard examples from other organizations and ask them to bring examples of their own.
4. For every meeting, always supply quality-improvement and analytic staff who are subject-matter experts in data sources, validation, and so forth.

The foregoing steps guarantee a good start to a data and dashboard development session. Following these steps will give physicians ownership of the dashboard and will instill a sense of trust between the quality department staff and physicians. Ownership and trust are key to the physicians' buy-in and ongoing support. Leaders make a common mistakes when they present a prototyped dashboard to the physicians as a completed design. This approach will fail every time and guarantees wholesale disengagement, as the physicians will be inclined to reject anything they had no part in developing.

Supporting Physician Leaders During Dashboard Rollout

After the dashboard prototype has been designed and the data validated by quality department analysts, the next step is the rollout. Keep in mind that the rollout reaches a broader group of physicians, those whose performance will be contained in the dashboards. Because of its wide reach, the rollout must be done correctly for positive engagement.

The rollout includes at least five goals. First, the physicians must fully understand the dashboard content, especially the definition of each measure. Because the definitions can be complicated, no one should rely solely on the measure's name. For instance, certain criteria must be met to code the record for "respiratory failure following surgery." Physicians need to understand when this complication is coded and reported on the dashboard. Because of the complexity, every physician dashboard meeting should always include a data analyst. They are the experts, so take full advantage of their support.

Second, the physicians need to understand how the dashboards will be used. When dashboards are used to drive improvement, track adherence to evidence-based practices, or educate physicians about their performance, then they will feel engaged. However, if dashboards are used in any punitive manner, such as for finger-pointing or "bad-apple chasing," then physicians will be disengaged.

Third, the physicians should understand when a *statistically significant* change in performance occurs. Month-to-month variation in performance is inherent in clinical care patterns. However, physicians do not want to react to every minor change in performance. *Statistical process control charts*, with their built-in rules for identifying significant changes, provide a ready-made solution.

Fourth, physicians must know how the dashboards will be used throughout their organization. For example, who will see physician level data? Administration? Other physicians? Nursing leaders and staff? The board of directors? The medical executive committee (MEC) or any of the various quality committees, including peer review committees? A policy that is approved by the MEC is a good safeguard. A good policy will state exactly who will see physician-level performance information and exactly how it will be used in the organization. A good rule to follow is this: Use data for measurement and learning *but not for judgment*.

Finally, leaders should limit access to physician-level data. Most organizations limit initial access to individual physician-level data to the physician or physicians listed on the report. The information

is usually blinded to the group, and only the individual physicians involved know their own personal performance. As improvements are implemented and performance improves, many physicians are usually comfortable unblinding the data to their peers and department chair. And given 12 months to see improvements, physicians may actually ask to have this "objective" performance data added to their peer-review file. After all, they did much of work to improve performance; why shouldn't it be used in credentialing and privileging?

In summary, if the leaders cover the following topics with the physicians in the dashboard rollout meetings, positive engagement will result (this list was adapted from Byrnes [2015]):

1. Introduce members of the design committee—always include physicians.
2. Review the development process for the prototype—it included physicians.
3. Discuss the sources used for the dashboard measures.
4. Explain how validation and audits are used to verify accuracy.
5. Explain the physicians' role in improving data accuracy throughout the next year.
6. Review the types of measures included—process versus outcome measures.
7. Review the definitions of the measures.
8. Proactively address common objections physicians usually voice about data integrity.
9. Introduce statistical process control (SPC) charts—how measures will be trended over time (e.g., 24 rolling months)—and how statistically significant changes will be determined.
10. Discuss common-cause and special-cause variation, that is, discuss how to determine when a change is significant.

11. Review the accepted uses for each level of dashboard (system rollup, hospital comparisons, and physician level) and which groups will have access to each.
12. Review the protection in place for physician peer-reviewed data.
13. Review how physician attribution is assigned—a formal MEC approved policy is a must.
14. Tell physicians that they may not like the initial results. If they have not measured their performance previously, it is unrealistic to expect great performance.
15. Seeing less-than-great performance means they should investigate the information (with quality department assistance to investigate), uncover any data errors, validate the performance, or take some or all of these actions.
16. Ask for the physicians' help in making the data more accurate with each monthly update.

The last point is particularly important, because 100 percent accuracy is impossible when a group is developing clinical dashboards. There are just too many variables that rely on human input, and humans are inherently error-prone. Transparency on this one issue will result in great engagement, probably more positive than most leaders could have imagined.

The following example script illustrates a successful approach to starting the discussion with physicians:

> Databases are dependent on humans to construct and maintain them. We've used the best data sources [name them—finance, cost accounting, coding, electronic health record, chart review] we have available. But no data set will ever be perfect. For quality improvement projects, we strive for 90 to 95 percent accuracy. The databases we are using, especially the administrative data, has been extensively validated. After all, our administrators use it to run the business side of our

> organization. But we *now need your help* to identify problems with the data (inaccuracies) that our teams did not catch. This step relies on your clinical expertise and the insight you have into your practice. When you identify a measure that seems out of line with your clinical experience, we will pull the charts, review the coding and database entries, and share the results with you and the team. Sometimes, it's a data issue, which we will correct, or it can be close to true performance. In that case, and in the spirit of *data for learning and not for judgment*, together we will help design new care processes to improve our performance. Sound good?

The rollout meeting can be an hour or two of discussion and clarification. Spend as much time as necessary, and be 100 percent transparent about the data sources and how the dashboard has been produced. When the physicians understand that the leaders and quality team are sincere and supportive and have no punitive intent, clinical dashboards will become the primary tool driving improvement. This is physician engagement at its best, but all these topics need to be addressed up front, with full transparency, and in a spirit of collaboration. With this collaborative, honest approach, true trust will start to emerge.

CELEBRATING SUCCESSES

Celebrating successes by recognizing the frontline physicians, advanced practice providers, nurses, and clinical support staff who have done all the work is not just the right thing to do; these demonstrations of gratitude and recognition are the *fuel of engagement*. In *The Quality Playbook* (Byrnes 2015), I express the importance of celebrating people's successes: "Demonstrations of gratitude—a pat on the back or verbal thank you—[are] potent energizers for your program. Over the years, the celebrations I've held have generated such enthusiasm and goodwill that they fueled individual and group

motivation for months (if not a full year) into the future. If I can say only one thing about this topic it's this: Always celebrate your [front lines'] successes in quality and safety, *always.*"

REWARDS AND RECOGNITION

The most successful healthcare leaders know that they should recognize their people for doing great things. But all recognition must be sincere, unique, and from the heart. It cannot be a cookie-cutter solution or feel forced or trivial. Actions reflected by comments like "Every leader sends out *x* number of thank you cards a week," or "We're doing rounds every Wednesday at 10 a.m. so that we can thank *a*, *b*, and *c*" are not the right approach. That is not how widely successful recognition programs are built. One book with many ideas for recognition is Bob Nelson's *1501 Ways to Reward Employees* (Nelson 2012). The book offers unique, heartfelt solutions to provide sincere recognition in a world where it can be very rare.

Award Ceremonies

Annual award ceremonies provide so much engagement and enthusiasm that one organization's executive team deemed these forums an essential element of its quality (and engagement) programs. In a few years, the organization's Annual Synergy Awards ceremony grew to seven hundred physicians, staff, and their spouses in attendance. The rules are simple. Anyone in the organization can nominate a quality or safety team for several categories of awards. But one requirement must be met: The team must demonstrate significant improvement in a set of clinical, safety, or experience measures over the past 12 months. For each award category, the nominated teams are introduced by video vignettes (professionally produced) that highlight their members and the improvements made. When the winning team is announced, the members come up on stage,

receive an elegant crystal award piece, and are personally thanked by members of the executive team, usually the CMO, CQO, and CNO.

What makes the Annual Synergy Awards even more special? At some point in the program, the spouses are invited to stand. They receive a heartfelt thank-you from the MC and then a standing ovation from the crowd. This organization has received much feedback since the ceremony was begun, but it can be summed up in the words of one attendee: "The awards are nice and the food great, but what makes the event so special to them is that they can share the evening (and their accomplishments) with a loved one and that their leaders are there as well."

Public Recognition

Public recognition for exemplary performance is a great way to thank those responsible, including physicians, clinicians, staff, and volunteers, and to further solidify the engagement of your physicians. For example, a hospital just received a Watson Health 100 Top Hospitals Award, which uses a balanced scorecard composed of clinical, operational, and financial metrics for 2,600 hospitals in the United States (IBM Watson Health 2020). This award places a hospital in the top 4 percent of those included in the study. Such an impressive accomplishment needs to be celebrated widely. The following sections present some ways to recognize those who contributed.

Sunday Newspaper

A full-page tribute placed in the Sunday newspaper has always been a crowd-pleaser. It must thank and congratulate all the physicians, staff, and hospital volunteers involved. However, don't make the mistake of turning it into an advertisement for the organization. The announcement has only two purposes: recognition of, and thanking, the front line. A good gesture is to place at the bottom

the signatures of the chair of the board, CEO, chief of staff, CMO, CNO, and CQO. A public tribute like this highlights the values of the organization and the importance of all the frontline caregivers, and it creates a tremendous sense of pride among everyone.

Personalized Letter from the Board Chair and CEO

Who can imagine getting a letter at home thanking them for their contributions at work? Can they further imagine that the letter details the patient outcomes they personally helped improve? And what if it is signed by the board chair, the CEO, the CMO, and the department chair? Such a letter says that their efforts have been recognized and that the highest organizational and physician leadership is grateful for the effort. Now *this* is guaranteed to make an impression.

To be successful with such an effort, leaders should ask everyone to personally sign the letters. Signature stamps send just the opposite message. And mail them to the recipient's home. Do not use interoffice mail. It's in the same category as signature stamps. There are many reports of these being shared with family and being hung on refrigerators at home.

When should these letters be sent? At the end of each calendar year, for every metric that has shown improvement, and to every team member responsible for making those improvements, leaders should send a letter.

Commendations from the Board of Directors

Commendations are reserved for truly spectacular quality or safety improvements. Examples include a children's hospital that reduced serious safety events by 90 percent, a department that achieves CABG (coronary artery bypass graft) surgery mortality rates that are 25 percent of the predicted rates, and a medical group that has 90 percent of its HEDIS (healthcare effectiveness data and information set)

measures in the top decile seven years in a row. These real examples from just one US healthcare system show, amazingly, exactly what is possible.

For extraordinary accomplishments like these, a formal resolution and commendation from the board of directors is appropriate and a powerful way to recognize excellence. It should be signed by the board chair and board quality committee chair. When the quality team coleads, both committees should receive the commendation, and after the update at the board of directors, the chair should reaffirm the resolution and present (the often surprised) leaders with the framed commendation. Word spreads like wildfire through the organization, the commendation is hung at the nursing station, and physician engagement is improved yet again.

Service-Line Annual Reports

Similar in size and quality to a corporate annual report, a service-line annual report is a document sent to an organization's surrounding communities. It highlights the services provided by the line and includes pictures of physicians, nursing leaders, and frontline staff. And of course, it includes a lot of information on the clinical outcomes (mortality, complication rates, costs, etc.) of the service line. Because of its wide distribution, this report is a powerful way to recognize everyone who contributed to the outstanding performance of the hospital or health system. Service-line annual reports are also distributed throughout the organization, helping drive pride in the organization and, of course, the engagement of all caregivers, including physicians.

A Simple Thank-You

A sincere thank-you is one of the nicest ways to recognize individuals. When a healthcare environment can be full of blame and

bad-apple chasing, this small act begins to turn the corner toward a new culture of appreciation and respect for hardworking caregivers. Many will say that a thank-you is just common sense, and that is true. But leaders often forget this simple but meaningful act during their busy days on the front line.

When delivered in person, a thank-you feels great. When it is written on a nice card with sincerity and not as an obligation, a thank-you certainly goes a long way to improve physician engagement.

But a word of caution: Thank-yous can be overused. Too many of them, in too many meetings, from too many leaders can have a detrimental effect. After a while, an excess of thanks starts to feel hollow—the words feel insincere and start to hurt reputations. The repetition can generate resentment and disengagement in staff and physicians. The bottom line? There should be no forced schedule for sending out thank-you cards. Only use them when they are well deserved. Sure, set a monthly goal, but don't overdo it. The same guidelines apply to thanking an entire group at the beginning or end of meetings. Just don't overdo it. And when making rounds, be sure your thanks are sincere, heartfelt, and well deserved. Find the right balance, and this recognition will be appreciated. It will move engagement one more step in the right direction.

CONCLUSION

The chapter began by asking, "Why address quality in a book on physician engagement?" It should be very clear that a robust quality and safety program can be the cornerstone of a physician engagement strategy. In fact, many of the most successful health systems have used quality as the primary strategy to begin or enhance physician engagement in their organizations. Properly designed quality programs appeal to the physician mindset—one that is involved, leadership-driven, compassionate about patients, problem-solving, and focused on data. When they are engaged at the beginning of

projects, physicians are happy to be involved and appreciate that their voices are heard. They believe they have a true position in the organization. They move from caring for one patient at a time to affecting the lives of thousands through their improvement work. When their efforts are recognized and celebrated through small and large events, physicians become loyal partners of the organization. In summary, quality fuels engagement and improves physician relations, and because of that engagement, quality moves organizations to levels of excellence they never thought possible.

REFERENCES

Byrnes, J. 2015. *The Quality Playbook: A Step-by-Step Guide for Healthcare Leaders*. Bozeman, MT: Second River Healthcare.

IBM Watson Health. 2020. "Watson 100 Top Hospitals Snapshot Report." Published April 21. www.ibm.com/downloads/cas/REAWOAOD.

Kramer, M. 2019. "7 Physician & Staff Engagement Strategies to Boost Patient Experience." *Calibrater Health*. Published December 2. www.calibrater.com/physician-engagement-strategies-patient-experience.

Nelson, B. 2012. *1501 Ways to Reward Employees*. New York: Workman.

Oshiro, B. 2015. "6 Proven Strategies for Engaging Physicians—and 4 Ways to Fail." *Health Catalyst*. Published March 5. www.healthcatalyst.com/proven-physician-engagement-strategies.

Press Ganey. 2013. "Every Voice Matters: The Bottom Line on Employee and Physician Engagement." Accessed February 11, 2021. http://images.healthcare.pressganey.com/Web/PressGaneyAssociatesInc/%7B605442db-1e4f-4d26-8e7f-5512e6f61bd3%7D_PI_Every_Voice_Matters.pdf.

Ritchie, L. C. 2019. "Does Taking Time for Compassion Make Doctors Better at Their Jobs?" NPR. Published April 26. www.npr.org/sections/health-shots/2019/04/26/717272708/does-taking-time-for-compassion-make-doctors-better-at-their-jobs.

Seppälä, E. 2019. "Doctors Who Are Kind Have Healthier Patients Who Heal Faster, According to New Book." *Washington Post*. Published April 29. www.washingtonpost.com/lifestyle/2019/04/29/doctors-who-show-compassion-have-healthier-patients-who-heal-faster-according-new-book.

Shanafelt, T. D., and J. H. Noseworthy. 2017. "Executive Leadership and Physician Well-Being: Nine Organizational Strategies to Promote Engagement and Reduce Burnout." *Mayo Clinic Proceedings* 92 (1): 129–46.

Swensen, S., A. Kabcenell, and T. Shanafelt. 2016. "Physician–Organization Collaboration Reduces Physician Burnout and Promotes Engagement: The Mayo Clinic Experience." *Journal of Healthcare Management* 61 (2): 105–27.