Integrating Care for Populations & Communities Aim

National Coordinating Center (ICPCA NCC)

Engaging Physicians in Improving Care Transitions and Reducing Readmissions

A Practical Guide for QIOs

Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

ICPC Integrating Care for Populations & Communities

This material was prepared by CFMC the Medicare Quality Improvement Organization for Colorado, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the United States Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. PM-4010-146 CO 2012

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Introduction

Several QIOs and community coalitions have identified “engaging physicians” as a challenging area in your efforts to mobilize key stakeholders to support community-based efforts to improve care transitions and reduce avoidable rehospitalizations. Physicians can be critically important allies in efforts to lead, facilitate, and participate in a range of activities and practice changes that will improve transitions in care and reduce rehospitalizations.

This guide was developed by the Integrating Care for Populations & Communities (ICPC) National Coordinating Center (NCC) and physician consultants to provide some practical strategies to engage physicians. The physician insight included here will give you varied approaches when engaging physicians; this document is intended as a guide and not as a set of recommendations by the NCC.

Special thanks to Jane Brock, MD, Amy Boutwell, MD and Jay Want, MD for their contributions.

Key Points to Consider:

1. **You are asking for a donation.** For non-salaried physicians (many in out-patient practice) ask for his/her time as if you are asking for a money donation, because you are, unless you can pay for that time at the rate the physician would otherwise be earning during that interval. Physician offices primarily bill for physician time and cognitive effort given during direct interaction with patients, and that income supports the physician, their staff and the operation. Most people feel positively about donating to causes they believe in, so physicians will typically participate in important work without requiring up front reimbursement. However respecting this premise is of utmost importance and all other points below are what you need to do to honor this constraint. Read *Some thoughtful reflections from our NCC consultant*: found on page 9.

2. **Be very clear in your planning and in your interactions about why you are engaging him/her/them.**
   - Are you seeking to engage with physicians by educating them about the essential data and evidence-based models of care to first introduce the work of your community coalition to them?
   - If so, what do you want to accomplish by doing this?
   - Are you seeking a champion to lead a community coalition?
   - Are you seeking a physician who will influence her colleagues to change specific aspects of their practice?
   - Are you seeking input from the physician community to identify drivers of readmissions and opportunities for improvement?

3. **What do you mean by 'physicians'?** The roles for primary care physicians, hospital-based physicians, specialists and physicians associated with corporate operations will likely be different within a project. Keep in mind which physician group(s) you are trying to engage and what you would like each to do.

4. **Be prepared to make a clearly stated 'ask'.** See *List of Potential "Asks"*, found on page 11. We suggest and encourage all QIOs to use the Organizing for Health 1:1 framework for developing relationships with physicians. When you have shared purpose and values, it is much easier to make "the ask". People are the essential resource in organizing and by developing relationships; communities can drive volunteer commitment and inspire creativity to engage diverse social networks and the broader community.

5. **Liability exposure drives behavior.** Physicians are individually and personally liable for every element of clinical care, and change often feels like potential exposure. Be patient with initial resistance against suggestions that imply changing the nature of interactions with patients. Although lawsuits are fairly rare, every physician is somewhat disproportionately aware of this risk. Participation with a quality improvement initiative does not convey protection against legal action.

Why Engage Physicians?

Below we outline some of the possible purposes of engaging physicians, and some suggested methods suited to each purpose.

1. **Raise awareness and solicit ideas from within the community**

   Methods:

   1. Educational face-to-face presentations
      a. Local professional society dinners
      b. Noon conference/ lunchtime office in-service
      c. Hospital grand rounds
      d. Local and regional professional society meetings
      e. Engage APN and PA professional organizations--they are most likely doing the CT work for their physicians
      f. Always solicit suggestions from the physicians—nobody wants to be told what to do
   2. Educational webinars
      a. Host in the early morning (7am) or evening (8pm), an engagement strategy used by Doctors for America
   3. Articles in local professional publications
      a. State chapter of professional organization bulletins/e-newsletters
   4. Social Media
      a. Short series You tube videos, such as Dr Joanne Lynn's series on http://medicaring.org/ or even a low technology version of audio recordings such as the "Change Starts Here" series from the National Coordinating Center which is located at: http://www.cfmc.org/integratingcare/qios_reference.htm

2. **Identify and mobilize physician champions**

   Methods:

   1. Identify possible motivating interests why a physician would commit time and effort to the coalition, such as:
      a. personal story
      b. patient story
      c. research interest, publication motivation
      d. professional advancement, such as administrative leadership or academic promotion
      e. volunteerism ethic
      f. teaching/mentoring students, trainees
   2. Identify local/regional publication opportunities for physicians to publish editorials, improvement projects, research efforts
   3. Mobilize local press to cover leadership of physician champions
   4. Contact medical schools in your area—academic physicians from medical centers may be engaged in quality improvement endeavors
   5. Be prepared to make a specific "ask". See list of *suggestions* on page 11.

3. **Seeking participation in cross-setting workgroups**

Methods:

1. Establish MD-MD cross-setting workgroups
    a. Focus on reviewing MD-MD communication norms and methods
    b. Focus on reviewing standing MD orders for home health
2. Include MD relevant /actionable issues on cross-setting workgroup action list
    a. Cross-setting readmission diagnostic reviews
    b. Understanding the decision to hospitalize
    c. Improving timely discharge summaries
    d. Developing patient-centered care plans
3. Consider co-chairing workgroups with MD and other profession as co-leads
    a. MD-RN
    b. Inpatient MD-outpatient MD
    c. Generalist MD-specialist MD
    d. MD-Administrator
    e. MD-SW/CM
4. Encourage hospitalist group/practice to recognize workgroup time as part of administrative duties
    a. Some physicians are expected to spend a small percentage of time on hospital-based committees, or on quality improvement committees, etc.
    b. Ensure that where that is the practice, your community care transitions coalition is visible to leaders who can give credit to MDs for service on your committee
5. Offer custom analysis

4. **Facilitate practice or policy change in the organization**

Methods:

1. Provide specific, actionable requests for tests of change
    a. Complete the next 10 discharge summaries at the time of discharge
    b. Provide a pager/phone number to allow for clarification or further coordination to receiving provider for next 10 discharges
    c. Contact the outpatient providers 100% of the time when re-admitting a patient to gain a deeper understanding of the factors leading to a recurrent rehospitalization
    d. Test a standing order to ask the unit secretary to make a follow up appointment within 3-5 days for high risk patient
    e. Test a standing order set to titrate Lasix for home health patients
    f. Can be useful to demand change in hospitals
2. Outline practical uses of data to demonstrate performance and change over time
    a. Provide hospital, service line, practice readmission rates
    b. Provide group-level and individual performance data on:
        i. Discharge summary completeness (e.g., 4/4 key essential elements)
        ii. Arrange follow up appointment prior to discharge
        iii. 30-day readmission rates

5. **Solicit periodic input or involvement in an ongoing broader effort**

   Methods:

   1. Develop a specific list describing what physicians could do to contribute to the coalition's change efforts within a short timeframe (2 hrs.)
      a. Review best practice toolkit
      b. Review own performance data
      c. Attend cross-continuum team meeting
      d. Prepare and give housestaff noon conference
      e. Lead an eight-physician focus group for the coalition on a specific topic

Resources:

1. Boutwell, Calderon, Khan. STAAR Issue Brief: "Reducing Barriers to Care Across the Continuum: Engaging Physicians," available at: http://www.ihi.org/offerings/Initiatives/STAAR/Documents/STAAR%20Issue%20Brief%20-%20Engaging%20Physicians.pdf

2. Boutwell, A. "Engaging Physicians in Improving Care Transitions," North Carolina Partnership for Patients Summit, pre-summit dinner session. January 2012. www.collaborativehealthcarestrategies.com

The 10 Essential Steps to Effectively Engaging Physicians

1. Set a tone of collaboration – Make the time convenient for the practitioner, go to his/her practice/ bring food, know something that the physician excels at or is proud of. Open the conversation with, "I appreciate your visiting with us today. I've heard you trained at UCLA, did you know Dennis Cope?" Or "I see you have original photographs in your office. They are great. Who is the photographer?"

2. Explain the purpose of the project. "Our IPA has decided to focus some attention on the variation we see in patient's use of emergency department services. It's important because it has a big impact on patient's care but also because it is an important contributor to our financial performance. My visit here today is part of that effort".

3. Be non-judgmental, allowing the practitioner to become part of the solution. "As we have explored how patients use ED services, we noted that patients of some physicians seem to use the ED more than others. We are very interested in understanding why that happens. I'm hoping you can contribute to that understanding."

4. Present ONLY enough data to inform the discussion and explain why you are talking to him or her. "I'd like to show you this chart. It shows the variation we see in the frequency with which patients of different doctors use ED services. You are this point on the chart. Can you tell me a bit about how your practice uses the ED?" "Why do you think the rate is different from others in your community?"

5. Listen carefully to his or her responses. Demonstrate you want to understand without judging. "So, it sounds like from your point of view opening the practice at night has safety issues? Can you tell me more about what has happened?" or "I can understand how difficult recruiting physicians can be and opening at night is what young physicians are interested in. What do you think others have done?"

6. Engage other staff that might be present. "What do you folks hear from patients as you work with them?"

7. Offer praise whenever possible. "It seems like you are really trying to get folks in whenever possible. That's great because our patient feedback says they would rather come to the office than have to travel to the ED."

8. Encourage staff to consider solutions to problems identified so the physician won't have to be the solution to each problem. "Can you folks think of ways to respond to patient's needs before the doctor is involved? Have you talked to staff in other practices?"

9. Conclude by asking if the provider rep that has joined you can follow up on any questions emerging from the visit or provide additional information.

10. Send a follow up thank you note summarizing the results of the meeting and reemphasizing that the IPA is really interested in reducing the frequency of ED visits, especially for symptoms that can be managed in the office.

By Dr. Howard Beckman

http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20CINworkshopMay2010_TechniquesEngagePhysicians.pdf

Some thoughtful reflections from our NCC consultant:

First, people living far above the poverty line generally only do things requiring sustained effort for their own reasons. I might be willing to take a survey, fill out a form, etc. once because someone else asks me to, but I'm not going to take an hour a week for purely another person's purposes. This implies that you have to start with people's own motivations in engaging them, and not your own. This sounds simple and obvious, but it's actually neither. Most often in the authoritarian culture we are raised in medicine, we think people do things because we tell them to. Not so much. *So the first thing I think any of these QIOs need to do is discover what might be those motivations for the physicians they are trying to recruit.* If they haven't the foggiest, they should ask. In LEAN, this is called listening to the Voice of the Customer, and it's what I recommend anytime anyone has no clue about what they are building, how to proceed, etc.

Second, a smart doc in one of the IPAs I used to work with told me that all human motivation can be boiled down to three big buckets: financial, social, and ethical. The ratio between the buckets is different for each individual, but usually a person has all three in some proportion. Here's how each of the buckets work.

Financial is anything related to a material reward or penalty. This can be money, but also increased leisure resulting from greater efficiency, or avoidance of costs through in kind services. These motivations work on a short-term basis, and can be quite powerful. Big effect, gone as soon as the money is gone. So ideally these are used upfront to engage people, and are not a core strategy for long-term engagement.

Social is how others view me. These are longer lasting, but dependent on having a community whose respect I want to earn. Peer pressure, being number one on a quality graph, enhanced prestige in a practice community all fall into this category. These incentives are magnified by the strength and tightness of a community. The more people feel a part of such communities, the less willing they are to be thought of as a laggard, or a drag on performance. Public disclosure of performance very much depends on this effect.

Finally ethical is how I view myself. Social is *other people's* respect for me, ethical is *my* respect for me. This one may the most powerful one for long-term change, but also the most difficult to access in people.

This result from people buying into a vision of a world they personally would like to live in many times. To do that, you have to speak pretty clearly and compellingly about that better world; repeat often. In the best of organizations and/or efforts, this is what sustains people through frustration and discouragement. It helps where the other two buckets can't. This is kind of the mirror image of financial, in fact. Not as powerful in the beginning, but with a lot more staying power in the long run.

So if I'm a QIO looking for physician engagement, what should I do? I think understanding for each physician you approach what they'd like out of interacting with the QIO would be a good place to start. Is it because they'll get paid somehow? Is it because they like being known as a forward thinker? Is it because they know readmissions are bad care, and they want to do something about it? If you can't find a hook in any of these buckets despite understanding that doc's motivations well, I'd move on. They fundamentally will not do this difficult work so the QIO meets its contract. They just won't.

If it's financial (and it's unlikely you'll be able to pay them), can they somehow gain other ways? For example, would a hospital partner be willing to give a small honorarium for working on a readmissions protocol? It doesn't have to be a lot, but zero pay feels like exploitation to many people, especially if the hospital is using the effort to make their finances look better.

If it's social, is there a way to engage the physician community in some way so that there's recognition among peers that matter to a particular physician? Showing people readmission rates so they have some cognitive dissonance that their reputation might be tarnished?

If it's ethical, not only do you have to say the obvious "it's the right thing to do", but you have to help them understand there's a good chance they'll feel their time and effort was worthwhile, that because of them the ball will actually move in the right direction, and they'll be able to look back with satisfaction that they made a difference. This part requires considerably more time than the other two buckets, because it involves a deeper part of their psyches than the other two.

This in a nutshell is what I know from my career to date. I hope you get the flavor that I don't believe in quick fixes, at least ones that last. You can't gin up physician engagement on a short-term basis like a commodity except for very brief periods using cash (think drug companies paying docs to come to a dinner on Whizbang new drug x), and it'll go away after the last dollar is paid. Long-term sustainable change comes from the building of relationships by understanding people in the textured, nuanced ways we actually exist. People only do hard things for their own reasons.

Jay Want, MD, MPH