

Engaging Physicians to Improve Quality

Jane Coutts

Saskatchewan's Health Quality Council (HQC) was launched in 2003 with a mandate to not only measure and report on healthcare but also work with a range of partners to improve the province's health system. In late 2007, HQC's board decided it was time for Saskatchewan to reinvent its healthcare system, using the highest-performing systems in the world as its model. And in 2008, HQC launched Accelerating Excellence, a multi-level program to rethink, redesign and renew healthcare.

To help maintain momentum and show other provinces whether high-performing healthcare can be achieved in Canada, HQC is documenting its journey toward high-performing healthcare. This third article in this series discusses the challenge of physician engagement.

The doctor, when he gets to sit down, perches on a bar-height chair in the corner, his laptop with the electronic records sharing space on a narrow counter with a jar of lollipops. Across the room, the big desk Dr. Mark Brown used to occupy has been given over to his medical office assistant. This unconventional arrangement saves Dr. Brown running to the back of the building every time he wants a word with his assistant, and keeps both of them just steps from the waiting and treatment rooms. It's part of Dr. Brown's "continuous quality improvement" efforts to run his family practice more efficiently and effectively.

"My involvement in improving quality came about through my own interest in my own practice," he says in an interview in the small, crowded office in Moose Jaw. "It wasn't, 'Let's change the world.' It was more a question of things being too busy and too chaotic ... I had to use my time better and learn to work smarter."

A dawning realization that there must be better ways to practise medicine is a typical experience for the relatively few physicians already involved in Saskatchewan's efforts to transform the quality of healthcare in the province. The program, called Accelerating Excellence, is run by the Health Quality Council (HQC). It's a multi-level effort to rethink and renew healthcare through system-wide change, and includes Quality as a Business Strategy, a rigorous program for administrators

and board members, and Releasing Time to Care™, a new approach to hospital care that's spreading ward by ward around the province.

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Getting the province's 2,300 physicians to participate in Accelerating Excellence may be its biggest challenge, and under the guidance of a committee called Champions for Quality Improvement, that work is just getting under way. "Involving physicians is essential because so much of the system revolves around physician control of resources and the pace of change," says Ross Baker, an HQC board member and University of Toronto professor who specializes in quality issues. Every one of the high-performing healthcare systems he has studied – which are the models for what Saskatchewan is doing – has had strong physician leadership, usually just one dedicated, long-serving visionary person.

There are quality visionaries in Saskatchewan. Dr. Kishore Visvanathan is one. Since he launched efforts to overcome the waiting list in his urology practice, he's become HQC's poster doctor for quality improvement. He and his partners at Saskatoon Urology Associates tackled unacceptably long waits in their practice with advanced access scheduling – first cutting working extra hours to reduce their backlog, then keeping the majority of office appointments open for same-day visits, so patients are seen fast, when they need to be. They also pooled referrals and joined HQC's Clinical Practice Redesign program (Institute of Health Improvement n.d). Dr. Visvanathan speaks to conferences and colleagues about quality improvement and documents the effort to eliminate the waiting list on his blog, *Adventures in Improving Access* (Visvanathan n.d.).

Unfortunately, he says, nobody reads the blog who doesn't already think quality improvement programs are a good idea.

“There are many, many times I have thought, ‘Why do I keep writing this?’” Dr. Visvanathan admits in an interview in his office. He says physicians lack incentive even to learn about quality improvement. “We doctors are very comfortable doing what we have always done. We make a good living, we are boss of everything. Why would we change?” he asks.

Dr. Mark Wahba, an emergency physician in Saskatoon, was one who saw little need to worry about quality – he thought his one lecture on the topic in medical school was a waste of time. But the lack of planning and continuity and a string of mistakes during his father’s final illness showed him the human cost of poor quality care and made him realize how readily, in many cases, it could be improved. He had read about HQC’s work and got in touch; the council – in collaboration with the Saskatchewan Medical Association and College of Physicians and Surgeons of Saskatchewan – sent him to an Institute for Healthcare Improvement (IHI) conference in the United States. It was an eye-opener.

“At work, everyone is so negative. They say, ‘We can’t do that; we don’t have the money.’ But you go to an IHI forum and everyone is there with the same goal, trying to do a better job.” Dr. Wahba came home and soon had a list of about 30 ideas for improvements in emergency. The first one he tackled was the process for handing a patient from one physician to the next at shift changes. Evidence shows that this is a time when a lot of mistakes get made. He designed a simple one-page form to ensure that key information passes from one doctor to the next. He and his colleagues tried it, modified it and found it works well.

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Dr. Wahba is now working his way through his list, where ideas range from developing protocols for several common conditions to providing physicians with business cards to give patients, who often don’t know their doctor’s name. For most items on the list, the estimated cost is either nothing or “time.” A few are priced at \$50 or \$500. The challenge is obtaining buy-in. “You have to show [physicians] what some small changes can mean directly to the patients,” Dr. Wahba explains. “If you want to make an impact, you have to show how it will affect the patients in the room. They don’t care about the system.”

In Regina, advanced access scheduling has cut the waiting list for an initial consultation with sleep disorder expert Dr. Guruswamy Shridhar from 54 weeks to three. Having his patients fill out questionnaires before they come in and getting their data entered in the computer can cut five minutes from

each visit, giving Dr. Shridhar an extra 90 minutes a day and, more to the point, more time during each visit to focus on the patients’ problem. He notes, however, that while he is seeing patients faster, they still wait – only now they wait for tests or treatment; the bottleneck has been moved, not eliminated.

Dr. Dennis Kendel, registrar of the College of Physicians and Surgeons of Saskatchewan, calls these examples of leadership “pockets of excellence in a sea of mediocrity.” And together with the other members of the Champions for Quality Improvement committee, he realizes leadership cannot be left to the chance of a medical Napoleon emerging from the ranks to lead fellow physicians in building a quality empire. That’s why, through a methodical mix of training, support, role models and incentives, the committee members are hoping to construct an environment in which leadership can grow and quality, with careful tending, can flourish.

Baker and others believe that Saskatchewan has a huge advantage over other systems looking to reform – an almost unprecedented level of co-operation among several key groups. In Saskatoon, the Saskatchewan Medical Association (SMA) and the College of Physicians and Surgeons actually share office space, which would be unimaginable in many provinces. When they work together to promote quality, it means it doesn’t come across as either self-interest on the part of physicians or a threat of punishment from the college. Working with other groups, including the College of Medicine and HQC, and having close ties to the Ministry of Health broaden the approach even more.

HQC is mapping out a framework for achieving the Champions committee’s goal of building quality leadership over the next three years. The framework says the group is aiming to develop 280 “early adopters,” who will incorporate quality improvement methods or tools into their practices. According to theory, that number (13.5% of all physicians registered with the College of Physicians and Surgeons) will produce enough “opinion leaders” to start an overall shift toward integrating quality improvement methods (Rogers 1962). They are also looking for the square root of that number – 16 physicians – to be “champions” of the idea, credible resources other physicians will turn to for inspiration and guidance.

For the past several years, the different groups have been working on developing early adopters by sending Saskatchewan physicians to learn about quality improvement and leadership. With funding from the province, HQC, the college and the medical association, several dozen physicians have been to workshops and other events put on by IHI. SMA has 40 doctors moving into the advanced level of the Canadian Medical Association’s Physician Management Institute. A total of 103 practices have participated in one or both of HQC’s Chronic Disease Management Collaboratives. Through them, many practices have started clinical practice redesign programs. “We are developing a base of docs with some form of formal

training in quality,” explains the SMA’s executive director, Dr. Martin Vogel.

The next step, he says, is to give those physicians the opportunity to exercise leadership and apply what they’ve learned. The Champions’ framework calls for every region to have a dedicated, full-time physician quality improvement leader by 2013 (and lays out the steps for getting to that point).

Other objectives in the framework, also for 2013, include ensuring “engaged” physicians have the knowledge and skill to implement quality improvement science in clinical settings, and that they will all be collaborating and sharing tools and resources. Dr. Vogel thinks that medical leadership is ahead of the membership in its support for Accelerating Excellence, and it will take intensive work over the next three years to gain acceptance. That echoes a frequently repeated message from people working on Releasing Time to Care™: you can never do too much education about your program.

Dr. Kendel, who persuaded his council to free up money for quality improvement training, says the jury is out on how worthwhile the investment is in training programs. Some doctors will be inspired but not manage to incorporate change in busy practices. Others will do a few things; some at least will return as full-fledged advocates. However, “in the absence of any more effective strategy anywhere else, I am going to be optimistic about it working,” he states.

Those physicians who do come back from their training anxious to introduce quality improvement changes face multiple barriers. Improvement initiatives need goals and measures based on data, but the time to collect, analyze and interpret these data is hard to find. The same health system that demands improvements may get in the way of them: Dr. Jason Hosain works in West Winds Primary Health Care Centre in Saskatoon, part of the University of Saskatchewan’s medical school. He finds the requirements for setting up research projects can slow down his efforts to introduce innovations at the clinic. Other doctors sent on courses by HQC have reported that their health regions lack the funding or the information technology needed for changes,

or complain that they don’t have the authority or support to try their ideas.

And there is always the struggle between time and money. Right now, there is no mechanism to pay doctors for quality improvement projects. Some people say quality reform can’t happen as long as doctors are paid by fee for service, which puts the emphasis on volume and action rather than managing health. But Bonnie Brossart, chief executive officer of HQC, says how doctors are paid is not the issue. Rather, she explains, the problem is that physicians don’t know how to respond when they’re asked to improve quality because the demand is too abstract.

“You need to start by defining what you want to accomplish, by setting expectations, using targets or goals, like, ‘We expect this proportion of people to wait no longer than this long to see their practitioner,’” she asserts. Clear goals, from shorter waits to achieving set blood-sugar levels in a certain percentage of diabetics, are known to be essential for quality improvement. The province’s Patient First Review and Saskatchewan Surgical Initiative are steps toward establishing those sorts of goals. “If physicians knew there were expectations of the system, that there was a requirement for a certain level of access, and that we would help them deliver that, I think you would get a groundswell of appetite for change,” continues Brossart.

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