

Improving Care for British Columbians: The Critical Role of Physician Engagement

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Abstract

Canadian provinces are addressing quality of care and patient safety in a systemic way, but obtaining physician involvement in system improvement continues to be a challenge. To address this issue, individual physicians, physician groups, the British Columbia Medical Association, the health authorities, the BC Patient Safety & Quality Council (BCPSQC) and the Ministry of Health have come together to support physician involvement and foster physician satisfaction. Building on earlier work on patient safety, in 2010 the ministry developed a comprehensive strategy for system-wide improvement, focusing on achieving critical population, patient and sustainability outcomes. Central to this plan is the acknowledged need to involve healthcare providers of all disciplines, in particular physicians.

Today, BC physicians are leading large-scale provincial clinical improvement in three interdependent areas: Clinical Care Management, Integrated Primary and Community Care, and the National Surgical Quality Improvement Program. To further physicians' key contributions to BC's healthcare system, the BCPSQC, physician-ministry committees, health authorities and the Ministry will continue to engage physicians through practice support, feedback, financial recognition and information exchange, and by supporting improvements in the care provided to patients.

Organizations that are highly successful in achieving local and system-wide improvement in patient care and health service delivery have achieved their successes in large part because clinicians (most notably physicians) played an integral part in shaping clinical services (Mountford and Web 2009; Snell et al. 2011). Canadian provinces are addressing quality of care and patient safety in a systemic way, but obtaining physician involvement in system improvement, whether at the level of their clinical practice, healthcare facility or health authority, continues to be a challenge.

To address this issue, individual physicians, physician groups, the British Columbia Medical Association (BCMA), the health authorities, the BC Patient Safety & Quality Council (BCPSQC) and the Ministry of Health have come together to support physician involvement and foster physician satisfaction. Efforts to date have been based on a renewed provincial focus on individual and population health. To achieve improvements in care, physician leaders are needed in health system design as well as delivery, and impediments to their participation must be resolved. Neither strategy is sufficient in itself; individual and population health are interdependent, and both must be addressed to achieve the quality of care that British Columbians deserve.

Physicians as Leaders in Clinical Care Improvement

British Columbia (BC) has been proactive in recognizing the critical role of physicians in health system improvement. Steps have been taken over the last decade to involve physicians as leaders for clinical improvement and to address barriers (Mountford and Webb 2009) by recognizing their unique contributions, creating educational opportunities, removing financial barriers and by mentorship.

In 2003, the BC Ministry of Health created the BC Patient Safety Taskforce and, through its leadership, BC became an early adopter of Safer Healthcare Now!, a national quality improvement campaign that launched in 2005. The ministry also supported focused clinical improvement efforts for sepsis and patient flow through Evidence to Excellence,¹ and for access to primary care through the General Practice Services Committee (GPSC).² Critical to the success of these efforts were the physicians recruited to lead these initiatives.

Building on this work, in 2010 the ministry developed a comprehensive strategy for system-wide improvement, known as the Innovation and Change Agenda. This strategy focuses on system improvements to achieve critical population, patient and sustainability outcomes. It is underpinned by aggressive health promotion, integrated primary and community care delivery, improvements in the quality of clinical care, and in the productivity and efficiency of health services delivery. Central to this plan is the acknowledged need to involve healthcare providers of all disciplines, in particular physicians.

To undertake this ambitious plan, linkages have been formed with communities, health authorities, the ministry and professional associations such as the BCMA. In developing these relationships, several strategies have been used to encourage collaborative physician participation. These include the provision of the following:

- Improvement training for physicians through the BCMA and the Divisions of Family Practice
- Quality improvement expertise to support divisions and practices in their improvement efforts
- Opportunities for peer-to-peer interaction and sharing through collaboratives, webinars and workshops that are focused on improving the clinical care of patients with sepsis, cardiac and surgical diseases, and those needing intensive care
- Clinically relevant indicators and measurement systems that directly support physicians' clinical practice and their efforts for improvement
- Opportunities to recognize teams who have achieved sustained improvements through the BCPSQC awards program and, of key importance

- The deliberate recruitment of physician leaders to develop, guide and drive clinical improvement

Today, physicians are leading large-scale provincial clinical improvement in three interdependent areas: Clinical Care Management (CCM), Integrated Primary and Community Care, and the National Surgical Quality Improvement Program “(NSQIP)” in BC.

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Clinical Care Management

Clinical Care Management (<http://www.bcpsqc.ca/quality/clinical-care-management.html>) is BC's province-wide effort to improve care through the application of evidence-based clinical guidelines. CCM engages the health system at multiple levels, from clinicians to senior leadership in the health authorities. Currently, CCM is working to improve care in the following areas: care of critically ill patients, hand hygiene, heart failure, medication reconciliation, sepsis, stroke and transient ischemic attack, and surgical checklist and surgical site infections and venous thromboembolism. Programs are being developed for antimicrobial stewardship and the care of the frail elderly.

Fundamental to the success of CCM has been the incorporation of practising physicians with expertise in the clinical area through Clinical Expert Groups (CEGs) and as provincial Clinical Leads for each topic. The CEGs are topic specific, have developed clinically relevant indicators, and assess improvement progress as well as providing feedback and clinical leadership. CEG members are clinical and operational leaders from health authorities, physicians working in the community, the BCPSQC and the Ministry of Health; they serve as a direct connection to the multi-disciplinary teams working to improve care. The BCPSQC funds the provincial Clinical Lead positions and provides a Quality Lead for each clinical area to support improvement in partnership with the Clinical Lead. Beyond the formal leadership positions for physicians in CCM, practitioner involvement varies with the stage of the initiative. For example, in sepsis improvement, each health authority has a physician champion who is working with improvement teams at the facility level, whereas the care of the frail elderly has yet to be implemented at the front line.

Integrated Primary and Community Care

The creation of a system of care that integrates services delivered by community physicians with services in health authority facilities and other community organizations is a crucial improve-

ment goal. Physicians, health authorities and non-governmental organizations work to improve access and the availability of programs to help keep individuals out of hospital. However, these improvements are often undertaken within one area of care and are not always coordinated with the rest of the community services available. Work is under way to incorporate efforts into an aligned system-wide transformation.

The Divisions of Family Practice are foundational to addressing the complexity and coordination of patient care in their communities as they assume responsibility for the health of their patient population. Physicians working in collaboration with their geographic health authority have addressed many issues, including sharing patient information across practices with the health authority and with the patient, automated primary care and specialist communications, measurement of the quality of practices in key clinical areas (see CCM above), and provision of urgent access and primary care attachment.

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National Surgical Quality Improvement Program

The BCPSQC, in collaboration with the BC Health Services Purchasing Organization, has brought the American College of Surgeon's NSQIP (<http://www.bcpsqc.ca/quality/bcnsqip.html>) to 24 BC surgical centres. Together, these facilities perform 90% of the surgical procedures in the province. NSQIP is a clinical measurement system that provides risk-adjusted 30-day surgical outcomes for operations performed at participating facilities. These data allow comparison of outcomes with peers so that areas of improvement and leadership can be recognized. In addition, NSQIP provides advice on quality improvement strategies, on-site peer assessment and clinical quality evaluation. This approach is dependent on surgeon engagement and leadership, and has been highly successful in improving surgical care in the United States.

This is the first time that BC surgical programs will have accurate, rigorous and valid outcome data. Each site has organized a NSQIP team led by a surgeon champion, anesthesiologist, surgical clinical reviewer, quality improvement specialist and an administrative leader. NSQIP teams guide local improvement using the outcome data and multi-disciplinary "action teams."

NSQIP sites in BC have come together and formed the Surgical Quality Action Network (SQAN) (www.bcpsqc.ca/quality/surgical-quality.html) to provide a provincial vision and learning coalition for surgical quality improvement. Through the Surgical Quality Action Network, NSQIP sites receive non-risk adjusted reports based on their NSQIP data submissions, data they use to guide their own improvement initiatives.

The vision is "top enabled," and the improvement in care is "bottom driven." The SQAN's immediate goal is to accelerate improvement for all NSQIP sites while demonstrating local improvements in surgical outcomes by November 2012.

Helping Clinicians Lead

To build the capabilities of physicians to engage productively in quality assessment and improvement, several formal initiatives are under way to support education for medical leaders and to expand the efforts of the Practice Support Program. BCPSQC offers the Quality Academy, a project-based, mentored education program designed for professionals who learn the principles of quality improvement including: process and systems thinking; personal and organizational development; involving patients, users, carers, staff and the public; making improvement a habit: initiating, sustaining and spreading change; delivering on cost and quality; problem solving/internal consultancy skills; and innovation for improvement (Bevan, 2011) and undertake projects. Vancouver Coastal Health Authority is also working with the University of British Columbia's Sauder School of Business and the BCPSQC to build a leadership program for department, program and division heads. Similarly, the General Practice Services Committee and Simon Fraser University have developed a leadership training program to support physician leaders involved in the Divisions of Family Practice.

The conscious effort to support physicians in the evolving healthcare system has resulted in satisfaction rates that parallel those seen across the country (National Physician Survey 2010). Surveys, monitoring retention patterns and interest in physician leadership roles can be used to assess the engagement fostered by the initiatives and should be a focus of future research.

Supporting Individual Physicians in Practice

Physicians in individual or group practices face a number of pressures that limit their ability to engage with the larger health system. Changing societal expectations; pressures to serve patients in the face of limited numbers of physicians, in particular in rural areas; limited availability of locum services; low reimbursement; antiquated or non-existent information systems; and ongoing system re-organization have all added to the stress of practice (Thommasen et al. 2002). In BC, some of these factors have been addressed through expansion of University of British Columbia Faculty of Medicine enrolment, through payment changes and by the strategies implemented by the General Practitioner Services Committee, Shared Care Committee and Specialist Services Committee – all of which have implemented deliberate strategies to foster physician leadership and involvement in efforts to improve care. In addition, efforts have been focused on building the relationships with health authorities and supporting individual practice.



Relationships with Health Authorities

With the consolidation of hospitals in BC in the late 1990s, an unintended consequence was a sense of individual alienation and a polarization of care into community and health authority/regional spheres. Many physicians disengaged from the health system, with the result that the anticipated clinical efficiency and economies of scale did not occur. It was apparent that the relationships between physicians, the new health system and their communities had to be rebuilt. Rebuilding these relationships has taken a decade and has been based on two strategies: development of the Divisions of Family Practice and creation of compacts between the health authorities and physicians.

Divisions of Family Practice are community-based groups of family physicians working with their health authority, the General Practitioner Services Committee and the ministry toward common healthcare goals (<https://www.divisionsbc.ca/provincial/home>). The divisions provide physicians with a stronger collective voice in their community while supporting them to improve their clinical practice, offer comprehensive patient services and influence health service decision making. Divisions have been instrumental in building effective information systems for care and evaluation, designing service delivery, ensuring patient attachment and supporting colleagues. They have formalized the clear role for division members as leaders in guiding healthcare in their communities and health authority.

To bring physicians and organizations to a common understanding of goals and strategies, newly created compacts – written or unwritten descriptions of what an organization and those who work for it owe one another – have been of value. Compacts specify the responsibilities and mutual interdependencies of partners (Edwards et al. 2002). The process of creating such an agreement acknowledges and defines the goals, aspirations and expectations of all parties, and provides a common

framework for the requisite inter-professional and inter-organizational relationships. Perhaps, more significantly, the process fosters mutual respect and trust (Edwards et al. 2002; Liebhaber et al. 2009; Reinertsen et al. 2007; Sears 2011). Compact development has been successfully used at the BC Women's Hospital and Health Centre.

Physicians play a critical role in the design and delivery of healthcare for British Columbians. Many are engaged in these efforts and yet many are not.

Supporting Office Practice

Regardless of the type of practice, its location or the method of payment for services, the importance of helping to make the physician's job easier through system design has been long recognized in BC. At the practice level, optimizing care and access and office efficiency through advanced access and group visits has been a focus of the Practice Support Program, an initiative of the General Practitioner Services Committee (<http://www.gpsc.bc.ca/psp/practice-support-program>). The program provides self-assessment modules and learning sessions on a variety of topics relevant to primary care. Physicians' time while attending the learning sessions is also funded. In conjunction with ministry-supported information technology deployment into physician offices (<http://www.pito.bc.ca/>) and the Divisions of Family Practice, physicians are now better connected, can operate more efficiently and have a clear role as leaders in guiding healthcare in their communities and health authority. The successes achieved to date are detailed on the Practice Support Program website.

Physicians play a critical role in the design and delivery of healthcare for British Columbians. Many are engaged in these efforts and yet many are not. What can be done to further the key contributions of physicians to our healthcare system? In BC, the efforts of the BCPSQC, the physician–ministry committees (General Practitioner Services Committee, Shared Care Committee and Specialist Services Committee), the health authorities and the ministry will continue to make doing the right thing easy through practice support, feedback, financial recognition and information exchange, and by supporting improvements in the care provided to patients. The quality of clinical care is the fundamental contributor to system sustainability and patient/client experience. In this context, the leadership needed to transform the performance of hospitals and health systems must come primarily from doctors and other clinicians (Mountford and Webb, 2009). We must support physicians to make this so. **HQ**

About the Authors

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Peter Doris led the drive to bring the National Surgical Quality Improvement Program (NSQIP) to British Columbia. His passion for recognizing the value of physician leadership in driving improvements in care is demonstrated in his work as the physician champion of NSQIP at Surrey Memorial Hospital since 2006. Together with a team at the BC Patient Safety and Quality Council he is now guiding the implementation of NSQIP across 24 hospitals in BC.

Christina Krause brings a variety of health care experience to her role as executive director with the BC Patient Safety & Quality Council. Her passion and interests include the use of social change models and network theory in efforts to engage and mobilize stakeholders to improve quality of care. More recently, this has expanded to include social media to create enhanced connections and shared learning.

Doug Cochrane is the chair and provincial patient safety & quality officer of the BC Patient Safety & Quality Council, and Past Chair of the Canadian Patient Safety Institute. Dr. Cochrane is a professor at the University of British Columbia in neurosurgery, a certificant of the American Board of Pediatric Neurological Surgery.

Notes

- ¹ Evidence to Excellence is an academic organization established to improve clinical and operational outcomes for Emergency Departments across British Columbia (www.evidence2excellence.ca).
- ² The General Practice Services Committee (GPSC) is a joint Ministry of Health and BC Medical Association committee that is responsible for developing and implementing strategies that allow for optimum use resources allocated in the Physician Master Agreement to support improvements in primary care. The Divisions of Primary Care, based on the experiences in Australia and New Zealand, are an initiative of the GPSC (<https://www.divisionsbc.ca/provincial/home>).

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