

# Management/Relationship Issues Impact Patient Safety Efforts

By Diane Shannon, MD

## In this article...

Examine strategies used by Controlled Risk Insurance Company, LTD/Risk Management Foundation of the Harvard Medical Institutions, Inc., to engage doctors in patient safety efforts.

Patient safety initiatives have become a top priority for health care organizations across the country. The effective implementation and ultimate success of these initiatives depend on the active involvement of front-line physicians.

As The Joint Commission phrases it, “No matter how many health care professionals become involved in an individual case, the ‘flight plan’ or course of clinical tests, treatment, and services is generally guided by a physician.” Experts in organizational change in health care settings assert that active participation of the individuals who provide direct care in implementing the change is a critical element for success.

Mandating physician involvement has historically resulted in abject failure, less-than-optimal hospital/physician relations, or both. By nature and training, physicians tend to be independently minded and resistant to surrendering what they perceive as control over practice decisions.

Given the importance of patient safety in the current landscape, physician involvement in these activities is essential. To achieve the desired shifts in culture and clinical outcomes, health care leaders must ensure not only that physicians participate in patient safety initiatives but also that they own and champion these endeavors.

## Focus on patient safety

The Controlled Risk Insurance Company, LTD/Risk Management Foundation of the Harvard Medical Institutions, Inc. (CRICO/RMF), is the medical malpractice company that serves the Harvard-affiliated hospitals.

Founded in 1976 to offer an alternative to the 10- to 20-fold increase in malpractice premiums in Massachusetts, the not-for-profit insurer provides malpractice coverage to 11,440 physicians at 220 Harvard-affiliated hospitals and health care organizations in the greater Boston area. A captive insurance company, the organization is owned by the hospitals it serves and governed by a board of directors that includes executives from its owner institutions.

In the early decades after its founding, CRICO/RMF applied a traditional risk management approach. CRICO/RMF loss prevention staff, many of whom had nursing experience, worked with risk managers within the owner institutions to avoid the recurrence of adverse events.

However, the heightened focus on patient safety in the last decade prompted CRICO/RMF executives to steer the organization toward a preventive approach. The shift in focus led to internal changes at CRICO/RMF as program leaders began to work with a new constituency—physicians.

Because improvements in patient safety depend so heavily on changes in physician practice, they require the cooperation and active involvement of physicians and physician leaders. In short, they require physician engagement.

Not only has the change in focus aligned the organization with national priorities to improve patient care, it also has resulted in improved outcomes in the metric most relevant to a malpractice carrier: in the years since the organizational shift, the insurer has witnessed a substantial reduction in claims. As a captive insurance malpractice carrier, the organization returns these funds to its Harvard-affiliated owners in the form of grants and lower premiums—premiums that now average among the lowest in the country.

How has an organization that lacks the carrot of profit sharing and the stick of restricted privileges managed to engage physicians in patient safety initiatives? The organization has applied three interwoven strategies to engage front-line physicians:

- Building relationships
- Attending to data quality and presentation



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- Providing meaningful incentives

Leaders throughout the health care system can adapt these strategies to successfully engage physicians in patient safety programs within their organizations.

### Strong working relationships

Although CRICO/RMF is intimately tied to its owner hospitals, the organization is not in close proximity to the hospitals' front-line health care providers. Because the insurer must influence physician practice from a distance, CRICO/RMF leaders emphasize strong working relationships with leaders at many levels within each institution.

Jack Mc Carthy, president of CRICO/RMF, has developed connections with trustees and members of the hospitals' board. Other senior executives have developed solid ties

with their counterparts at the owner hospitals, many of whom have served on the CRICO/RMF board of directors.

Luke Sato, MD, CRICO/RMF chief medical officer, has built relationships with senior physician executives, while program directors have fostered relationships with risk managers at the Harvard affiliates.



Sato

Relationship building is time-consuming. It also requires persistent effort—the tortoise rather than the hare approach. Yet the commitment of CRICO/RMF staff and leaders to nurture and sustain these relationships translates into an ability to effect practice change from a distance.

When the organization's claims analysts identified an increased number of claims in ambulatory care, CRICO/RMF leaders and program

directors were able to quickly and effectively communicate that risk to hospital leaders with decision-making power and to the front-line providers who could effect change. CRICO/RMF executives consider these relationships to be priceless.



Hanscom

According to Robert Hanscom, JD, vice president of loss prevention and patient safety at CRICO/RMF, "At every level, we employ a strategy of connecting. We don't want any of those healthy contact channels that we've formed to weaken. Each one of them allows us to talk to various people within the owner organizations, which is very important to our ability to convene and pull together consensus."

The organization also has stepped into the role of convener, fostering relationships among the leaders of

# Specific data can have a galvanizing effect on physicians.

Harvard-affiliated hospitals, who in the past were cast as competitors.

In 2005, CRICO/RMF invited the chiefs of the departments of surgery of the Harvard teaching hospitals—Children’s Hospital Boston, Brigham and Women’s Hospital, Massachusetts General Hospital, and Beth Israel Deaconess Medical Center—to discuss over dinner recent data on surgical errors in their institutions.

Atul Gawande, MD, associate professor of surgery at Harvard Medical School and the Harvard School of Public Health, facilitated a discussion among the surgical chiefs that resulted in a collaborative effort to improve communication between attending surgeons and surgical residents, which claims data highlighted as problematic. The cooperative effort resulted in a shift in culture about communication at all involved hospitals.

## Data quality and presentation

Experts in the field of hospital/physician relations recognize the importance of data quality and presentation when attempting to increase physician involvement in any quality or improvement program.



According to Michael Guthrie, MD, MBA, FACPE, who is executive in residence at the School of Business, Program in Health Administration, at University of Colorado—Denver, “Because of their training and education, physicians are comfortable and adept with the interpretation of data. For this reason, they are quick to identify and focus on any sketchiness or incompleteness in the presentation of data.”

By the same token, articulate presentation of relevant, actionable data is one of the most effective means for garnering physician support.

CRICO/RMF risk analysts scour the organization’s database—filled with 33 years’ worth of highly detailed, carefully categorized claims data—to identify specific areas of potential risk. CRICO/RMF program leaders then approach hospital leaders and department heads—a process made possible because of the strong relationships between the leaders of the insurer and the owner hospitals—to arrange opportunities to present the data to physician leaders and front-line clinicians.

During the presentations, CRICO/RMF program directors ask physicians to consider whether the data do in fact reveal an area of potential risk. If so, they invite physicians to help craft tools, practice guidelines, or process changes to address the problem areas.

Rather than telling physicians how to solve the identified issue, CRICO/RMF staff simply provides an opportunity for physicians to apply their innate ability to problem-solve. Not only do physicians become more actively involved in the process, but also they craft solutions that are based on their intimate knowledge of the front-lines of care—and thus more likely to be effective.

CRICO/RMF staff strives to present data to physicians that are credible, relevant, and actionable. Rather than providing feedback that is imprecise, CRICO/RMF program directors identify specific problem areas.

It’s the difference between “Your department had an increased number of claims for wrong site surgery this year,” and “Our claims file suggest that large blood loss tends to occur on weekends, especially when a new

surgical resident opens the case.”

Such specific data can have a



galvanizing effect on physicians. Kenneth Sands, MD, senior vice president of quality at Beth Israel Deaconess Medical Center in Boston, witnessed such an effect when CRICO/RMF conducted a hospital-wide risk assessment several years ago.

“They brought the information back to us and said, ‘Here are your strengths, here are your blind spots, here are your weaknesses, and here’s what we can do to help support you in some of those areas.’ That was very helpful in creating a level of engagement with physicians—for them to see well-collected, rigorous information specifically about our institution—and it allowed for a powerful change effort.”

Indeed, providing data to physicians in a clinically relevant, actionable state is more likely to motivate them to action. For example, CRICO/RMF staff presents hospital leaders, department chiefs, and frontline physicians with information about the phases within a clinical process at which vulnerabilities exist. Physicians shown such specific data are more likely to understand the necessity of changes than those given less specific feedback.

## Meaningful incentives

The third strategy that CRICO/RMF employs to engage physicians is providing meaningful incentives. After careful consideration of the practice behavior they wish to shift, CRICO/RMF program directors design incentive programs that provide a premium reduction or award grants to eligible institutions or individual physicians.

For example, in January 2010 CRICO/RMF program directors will be launching a surgical team training program with simulation. Participating surgeons will receive a 10 percent

rebate on their individual premium. To encourage participation of non-physician health care providers, CRICO/RMF also will be providing educational grants to the institutions to cover the cost of missed staff time.

Not only do the incentive programs encourage change in physician practice, they also provide CRICO/RMF with data that are used to promote the participation of other physicians.

For example, actuary data showed that anesthesiologists who participated in a CRICO/RMF simulation-based incentive program had a significantly lower error rate. CRICO/RMF program leaders shared these data with the department chiefs, who then made the simulation program a requirement for privileging and credentialing. Health care leaders should consider whether similar financial incentives—in the form of capital for new equipment, for example—might be effective in their institutions.

With the budgetary constraints that exist in most health care organizations these days, financial incentives for engaging physicians may not be feasible. Nonfinancial rewards can be a strong lever to encourage physician involvement in patient safety efforts.

Paul Levy, CEO of Beth Israel Deaconess Medical Center, encourages physician involvement in patient safety initiatives with several nonfinancial incentives. The leader leverages the organization's well-publicized commitment to data transparency to foster greater physician participation.

"Because we're very transparent with regard to clinical outcomes, we can show progress in terms of saving lives. When we publicize that, the people working on those projects feel proud, and are further stimulated to do more. And their colleagues say, 'Oh, that's great. We should do more.'"

Levy also ensures that mentoring is available to young academic

physicians interested in patient safety or performance improvement work. Helping a physician write and publish a paper helps him or her move ahead in an academic career. It also builds a cadre of individuals within the organization who have skills relevant to patient safety work.

According to Guthrie, health care organizations that effectively work with physicians to improve patient safety commonly use indirect benefits to incentivize greater involvement. For example, these organizations may encourage surgeons to engage in quality and safety programs by streamlining paperwork, employing dedicated nurses in the operating suite, and exchanging block time in the OR.

Health care leaders can explore the use of several types of incentives to encourage physicians to collaborate and "own" patient safety initiatives. They can try financial incentives, as CRICO/RMF employs, or one or more nonfinancial rewards. An important caveat is that incentives may encourage unexpected or undesired consequences.

For example, providing a financial reward to physicians only, when multidisciplinary efforts are needed for change, may erode rather than strengthen teamwork and communication. For this reason, organizational and program leaders must regularly assess whether the incentives are aligned to encourage the desired changes in physician practice. By tracking relevant metrics, health care leaders can ensure that their ship is heading in the right direction and their physicians are fully on board.

## Conclusion

Active physician involvement is essential to the success of patient safety initiatives. CRICO/RMF leaders have used a three-pronged approach to encourage physician participation and ownership.

By focusing on building relationships, attending to data quality and presentation, and providing meaningful

incentives, the organization has at a distance effectively engaged physicians in patient safety work. Health care leaders would do well to consider these strategies when faced with physicians who are less than enthusiastic about jumping into a patient safety initiative.

What's the downside if hospital



leaders fail to engage their physicians in patient safety activities? As M<sup>c</sup> Carthy puts it, "If you don't engage physicians, you're not going to get much

change. Physicians are swamped with work and with information. Regulators and non-physician third parties are all over the health care system, demanding data and new rules.

"Weekly, I see references to new initiatives that don't really speak to improving care but add to overhead and the physician's time. Programs that throw more work at physicians rather than trying to gain their active support are highly likely to fail."

In other words, if you want to reach your patient safety goals, make sure your physicians stand fully behind you.



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## Resources

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2. Ramanujam R Keyser DJ, Sirio CA. Making a case for organizational change in patient safety initiatives. *Advances in Patient Safety: From Research to Implementation.* Vol 2. Agency for Healthcare Research and Quality. Available at: <http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=aps.section.3580>. Accessed September 25, 2009.