LEARNING FROM OTHERS:

A Case Study From the Anesthesia Quality Institute

Collection of data is all well and good, but improvement in patient outcomes requires the ability to turn information into action. The AQI Practice Quality Improvement Committee (PQIC) will collect and present examples of this principle so that all of us can learn from those who are doing it well. Learn more about quality improvement at **www.aqihq.org/quality.aspx**.

Physician Leadership and Quality: Getting Buy-in for Your Quality Program

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With the rapid shift in medicine toward value-based care and patient-centered outcomes, physician leadership at all levels of an anesthesia practice has never been more important. Paired with new performance reporting requirements for quality measures, anesthesia practices are facing a perfect storm of threats to traditional payment models. Providers can face negative reimbursement penalties ranging from 2-4 percent for non-compliance with reporting of quality measures. It is imperative to have buy-in to quality initiatives from every provider within your practice, whether you are in a large academic institution, are contract providers within a health system, or work in a small private practice. For the majority of anesthesia providers, the quest to continually improve patient outcomes is nothing new. Physicians have the clinical skills to constantly examine and evolve their individual patient care, but may lack the "softer" skills necessary to move a practice toward achieving better health, better care and lower costs, the "Triple Aim" advocated by Dr. Donald Berwick as the leader of the Centers for Medicare & Medicaid Services (CMS) (Angood P. and Birk S, 2014).

To drive change within a practice or organization, physician leaders need to possess the tools for effective leadership. Leaders need to have an understanding of how quality, patient-centered care looks. According to Angood and Birk, there are nine elements to consider: "quality-centered, safe, streamlined, measured, evidence-based, value-driven, innovative, fair and equitable, and physician-led" (page 6). Currently, health care providers swim in a sea of data, but much of what we see is inconsistent and unreliable because of conflicting definitions, variable methods for collection and reporting and limited analytic capability. Quality and patient safety advances have lagged behind evidence-based best practice, and often initiatives are reactionary to regulatory requirements or patient complaints rather than proactive efforts to improve care (Pronovost, Miller, Wachter and Meyer, 2009). So how can physician leaders influence and drive quality initiatives and patient-centered care within their organizations?

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Physician anesthesiologists within an organization may be expected to assume a leadership role at some point in their tenure. This may be serving as the department chair, as medical director for a specialty team or unit, or as chair of an internal practice or hospital committee. Often, there is inadequate time for these providers to perform effectively in their added roles due to clinical practice obligations or lack of recognition by their peers of the need to allocate time and money to these activities. Quality and patient safety (QPS) departments in the hospital system exist to help physician leaders by gathering data and providing reports, but they are usually understaffed compared to demands and excessively focused on regulatory requirements. Further, anesthesia is not usually the biggest problem on their radar. As within the practice, hospital system leadership needs to recognize the importance of investing in physician leaders and empowering them to drive quality and patient safety from the bedside.

Anesthesia practice leaders need to engage their peers in specific quality improvement projects. One key component is understanding how data are collected, analyzed and reported so as to be consistent and reliable. Leadership must have confidence that the data they share are trustworthy and can be

used to drive quality initiatives. In addition, they must understand and use feedback from patients and other stakeholders (e.g., surgeons) to improve the overall perception of the department. In these situations, the "softer" skills of team building and emotional intelligence are needed. Team members need to have their questions and concerns addressed in a manner that validates them so they will continue to look for opportunities to improve patient care and quality outcomes. They should expect the leader to present evidence that supports initiatives while being able to balance other points of view, not just the practice's or practitioner's perspective. This delicate balance will eventually provide more sustainable results and buy-in from team members and will move the practice toward a "culture of safety" (Angood and Birk, 2014).

Lack of resources, both human and analytical, will continue to plague anesthesia practices as reporting and regulatory requirements for quality measures move to the forefront of patient care. Anesthesia leadership can help with this problem by advocating for the practice to receive its fair share of quality management attention, information technology support and decision-making capacity from the hospital, and by working internally to ensure that time spent on essential administrative activities is appropriately acknowledged and compensated by the practice.

Regardless of group size or the model of care delivery, every anesthesiologist must understand the threats posed by recent rapid changes in health care delivery and payment and the part they must play in meeting these challenges. Anesthesia leaders have the additional responsibility of representing their peers in group and system-wide discussions, while at the same time mentoring colleagues to become more involved. The most successful practices in the next era of health care will be those in which every provider understands the goals of the group and the hospital, the steps needed to meet those goals and their own contribution to the effort.

Bibliography:

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