

CULTIVATING PHYSICIAN ENGAGEMENT

in Performance Improvement



American Board
of Internal Medicine®



November 1–2, 2016
Meeting Report

The American Board of Internal Medicine and the ABIM Foundation convened a group of stakeholders, including both physicians from varying practice settings and other opinion leaders for a two-day meeting to discuss what physicians need to know and do to improve quality and how certifying boards, specialty societies and other organizations could foster physician engagement and skills development in performance improvement.

The meeting began with remarks from Richard Baron, MD, the President and CEO of the ABIM and the ABIM Foundation. He suggested that the quality improvement field is one where there is broad agreement about the end (improved quality and safety) but significant differences about the means (e.g., How important is the role played by individual physicians? How do they play that role within systems? Should quality improvement be the exclusive province of systems?). He termed this state of affairs an “incompletely theorized agreement,” borrowing a concept from legal theory.

Indeed, Dr. Baron said that some had told him that the meeting was fundamentally misguided, because quality improvement is purely a systemic issue. However, he referenced the processes that systems have installed to ensure that heart attack sufferers receive treatment within two hours, and argued that patient outcomes are nonetheless ultimately dependent upon a qualified physician being present when patients arrive. In other words, there is a critical role for individual physicians in the quality and safety mission, and boards certifying individual physicians thus have an important role to play.

“Individual physicians have to ask themselves if there are ways to do things better,” said Dr. Braddock.

Clarence Braddock, MD, Professor of Medicine at UCLA and the chair of ABIM’s Board of Directors, discussed the Physician Charter, which includes a “commitment to improving quality of care” as an essential commitment of medical professionalism. He illustrated how this element can be fulfilled through two stories of residents who were frustrated with aspects of care delivery at their institutions and worked with stakeholders to better understand the causes of the problems and implement solutions. “Individual physicians have to ask themselves if there are ways to do things better,” Dr. Braddock said. “There’s something to the expertise of systems, but there has to be more than that.”



PATIENT PERSPECTIVES

A panel of patient advocates followed these introductory remarks by shedding light on what matters to patient advocates in the quality improvement discussion. Patricia Skolnik, MSW, the Founder and Executive Director of Citizens for Patient Safety, shared the story of her son's death at age 22. She cited a lack of communication from her son's physicians, and described the neurosurgeon who performed unnecessary surgery on her son as "inexperienced, incompetent and arrogant."

"Communication is the biggest thing in any business," Ms. Skolnik said. "There was no one to tell us what the big issues were. We didn't really have conversations." She described communications as an essential element of improving quality, and said that younger physicians were more skilled at and more open to communicating with patients.

Diane Blum, MSW, the Senior Vice President at the National Executive Service Corps and a cancer care advocate, agreed with this, but also noted that there has been an evolution over 40 years in employing shared decision making and eliciting and respecting patients' values and preferences.

Moderator Jackie Judd, a health care journalist and consultant and Trustee of the ABIM Foundation, asked Ms. Skolnik and Ms. Blum how to make the case to physicians about the importance of quality improvement. Ms. Skolnik said that the story of her son's care takes physicians "back to why they wanted to be a doctor in the first place." Ms. Blum said that when physicians elicit patients' personal concerns, the information the health care team learns helps create an appropriate treatment plan. She talked about the importance of having senior physicians champion the importance of the physician's role in improving quality.

Audience members asked a number of questions about measures. One asked the panelists if they believed patient surveys were helpful in driving quality improvement. Ms. Skolnik said she thought Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores were not very helpful, but that other ways to solicit patient opinion, such as having "patient ambassadors" interview patients about their care, could improve quality. Another asked whether patients should care which measures are used to assess physician performance. Ms. Skolnik said that the measures are ideally designed to improve patient care and did matter. "We want to reassure people that someone is looking at what kind of care is being offered," she said. Ms. Blum was more equivocal, saying views among patient advocates differed. The panelists also responded favorably to the concept of mandating CME on communications.



KEYNOTE ADDRESS

Jeff Wiese, MD, the Senior Associate Dean for Graduate Medical Education at Tulane and Chair of the ABIM Internal Medicine Specialty Board, gave a keynote address tracing the modern history of the intersection between payment and

quality. He described the transition from cost-based reimbursement to fee-based reimbursement to the launch of the Relative Value Unit concept, and detailed how quality issues came to the forefront with the release of the Institute of Medicine's seminal reports on patient safety and the enactment of the Affordable Care Act and the Medicare Access and CHIP Reauthorization Act (MACRA). He posed the question whether, with the federal government and other payers poised to tie compensation and quality together more closely than ever, there is still a role for certifying boards or professional societies to focus on quality.

Dr. Wiese discussed ABIM's attempts to drive quality improvement through Practice Improvement Modules (PIMs), which he said became onerous and may have inadvertently communicated that quality improvement is a perfunctory task. Despite their flaws, he described two positive aspects of the PIMs. First, he reminded the group that competence, by Bloom's Taxonomy, is contingent upon knowledge, skills and attitudes. Assessing attitudes is deeply challenging, and the surrogate measure of an attitude is assessing a behavior. Even though they were required, he said, the behavior of completing PIMs could be considered the manifestation of the attitude central to competence in internal medicine. "It's easier to act your way into new beliefs than it is to believe yourself into new actions," he said. "The mere act of participating in quality improvement moves people into a new belief that no matter how good you are, you could be better."

Secondly, he praised PIMs for requiring physicians to reflect on their practice patterns. He described the "adaptive unconscious," in which your mind goes on auto-pilot while you perform routine tasks. "The big mistakes my residents and faculty make don't scare me," he said. "What scares me are the wrong things they do and patients live anyway; if they do these wrong things enough times, these wrong actions will seep into their adaptive unconscious, and there they will sit for the rest of their careers. In short, practice does not make perfect—perfect practice makes perfect. And perfect practice is defined by reflection. It is the only way to inspect and correct the adaptive unconscious. But if there is no structured way to make you reflect, you won't. And the busier you are, the less likely it is that you will take time to reflect on your practice. What you might say is that if you think you're too busy to do MOC and reflect, you really need the MOC to force that reflection."

"It's easier to act your way into new beliefs than it is to believe yourself into new actions," said Dr. Wiese.



Dr. Wiese then described and differentiated between finite and infinite games, drawing on the work of religion scholar James Carse. He said finite games have defined beginnings and endings, and that people within the game are abstractions of themselves, merely playing a role. The singular goal in a finite game is to win; the value of any action is measured solely by its utility in winning. Equally important, any action that is not explicitly prohibited is implicitly allowed. In infinite games, people are people, not roles; the utility of any action is the implicit value of that action; and the goal is simply to keep playing, for the love of the game.

Dr. Wiese was quick to add that there is nothing wrong with finite games. “Finite games motivate people to achieve higher performance levels,” he said. “Where the finite game goes astray is when it compromises the infinite game.” For example, he described how hospitals, faced with the finite game of satisfying the core measure of time to antibiotics, began giving all ER patients antibiotics. “This action naturally compromised the infinite game’s purpose of improving quality of care, but the action was not explicitly prohibited, so it was implicitly allowed,” he said. “It helped win the finite game, so we did it.” This was a great success in the finite game of meeting the measure, but a defeat in ensuring quality.

Dr. Wiese noted that once you measure an action and attach stakes to it, it transforms the infinite game to a finite game. He pointed out that MACRA and core measures, described by many as quality solutions, are all finite games, and that we shouldn’t be surprised if the health care community responds in exactly the way that it did with time-to-antibiotics. “For over a decade and a half, health care providers have been socialized into thinking through finite games: semesters in college, blocks and clerkships in medical school, and rotations in residency...these are all finite games,” he noted. “People in the health care community are not just good at winning finite games; they are the Jedis of finite games. They had to win all these games to get to be a practicing physician. It should not surprise us, then, that if we roll out another finite game, they will respond with the finite game mentality and do whatever is not explicitly prohibited to win that game, even if it compromises the infinite game of improving quality.”

Dr. Wiese finished the keynote by proposing that there might be other ways to improve quality and patient safety outside of the traditional Plan-Do-Study-Act (PDSA) cycle. As an example, he stressed the importance of “flow” (undisturbed concentration on a task) and suggested that a lack of physician mental bandwidth is a major barrier to improving quality. He noted that mistakes come when you do not have the time and mental bandwidth to concentrate on decisions and their potential consequences. Engagement in activities to optimize the system’s efficiency, such as Lean Theory, might then be construed as meaningful participation in improving quality.



Dr. Wiese also discussed physician burnout and how this could compromise quality. He noted that burnout is not a product of too much physician work *per se*, but work out of proportion to fulfillment, which he defined as connections to other people. He said that he could tell within 15 minutes of visiting a hospital whether it delivers high quality. “I’d walk with the person showing me around, and see if he or she interacted with people of different levels in the hospital, like nurses, or clerks, or janitors, on a first-name basis,” he said. “If they did, then I would know that they saw their fellow team-members as people, completely outside of their role. If that is the case, then you are in an environment where anyone, regardless of role, could raise their hand and say ‘Is what we are doing for the patient safe?’ And everyone would listen...because you listen to a person, you do not listen to a role. That’s a place where people have had time for connectivity. It protects against burnout, but it also ensures safety.” He said that ABIM’s teamwork module was on-target with this idea and represented an area where “ABIM got it right” in advancing quality outside of the PDSA.

Dr. Wiese closed with a story about quality pioneer Avedis Donabedian. He said when Donabedian was asked for the secret of quality at the end of his life, he replied that it was love: for your system and the people in it. Dr. Wiese said he understood that physicians usually say, “But I don’t love my system...I hate my system!” but he returned to the idea that it is easier to act one’s way into new beliefs than to believe oneself into new actions. “Do everything that would be consistent with loving your system, and eventually you will find yourself in that new belief that you do,” he said. “That’s where participation in quality improvement, PDSA or otherwise, gets us closer.” Dr. Wiese concluded with two truisms: “We can’t become who we want to be if we continue to be who we are,” he said. “And the same minds that created the problem can’t be the ones to correct it. The same people can, but we have to change our minds.”

A REPORT FROM ABMS

Tom Granatir, Senior Vice President for Policy and External Relations at the American Board of Medical Specialties (ABMS), then updated the group on the ABMS’ recent report of a Board Task Force on Improvement in Medical Practice. He said that after significant consultation with specialty societies, experts in measurement science, hospitals, health plans and consumers, the ABMS Board of Directors has affirmed that improvement in medical practice should remain an element of MOC.



As elaborated in the final Task Force report, the keys to ABMS' recommended approach will be:

- **Consistency:** adopt a common statement of purpose and common expectations for physicians to engage in personal or system improvement activities;
- **Alignment:** align with other professional assessment activities and provide flexibility to clinicians to choose practice-relevant activities available in their clinical environment; and
- **Support:** prioritize learning about quality and safety and providing tools or system support for reflection and improvement.

ENGAGING PHYSICIANS: DRIVERS, BARRIERS AND SOLUTIONS

During the next session, participants discussed drivers, barriers and solutions related to physician engagement at their tables. Suggested solutions from this discussion could apply to certifying boards, hospitals and health systems, specialty societies and others.

They included:

- Placing a greater emphasis on practicing in teams, which can potentially provide physicians and other team members with “less of a treadmill approach to their practice”
- Creating a user-friendly module to teach physicians performance improvement skills
- Providing credit to physicians for quality improvement work they are already doing
- Leading a mindset shift for physicians, in which they see themselves not as guests who provide services at hospitals and systems (akin to a golfer visiting a country club) but as leaders with critical roles in improving the quality and safety of those institutions
- Focusing on helping physicians recapture the enthusiasm and altruism from when they started in the profession, such as through stories and narratives
- Ensuring that physicians have access to granular data about their and their colleagues' performance, and receive suggested performance improvement solutions with the data
- Prioritizing measures with greatest clinical relevance

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- Highlighting models of good quality care
- Better integrating peer review as a non-threatening way to engage with peers
- Clarifying financial and workflow incentives for performance improvement activities
- Ensuring the relevance and achievability of performance improvement activities
- Taking steps in the training sphere to reinforce personal relationships with patients

MEANINGFUL QUALITY IMPROVEMENT FROM DIFFERENT PERSPECTIVES

A panel discussion followed, which featured Leah Binder, MA, the President and CEO of the Leapfrog Group, Yul Ejnes, MD, the Founding Partner of Coastal Medical in Rhode Island and a member of the ABIM Board of Directors, and Philip Stauffer, an aviation safety inspector at the Federal Aviation Administration and public member of the ABIM Cardiovascular Specialty Board.

Ms. Binder spoke about employers' roles in improving quality. She said employers are becoming frustrated because they do not believe they can trust the quality information they receive, and that many now view price as the only meaningful metric in choosing providers. She said Leapfrog believes this is a troubling pattern, and that the physician community needs to determine how to create a more nuanced understanding of quality and of the importance of quality improvement. She pointed to Wal-Mart's effort to provide significant incentives to their employees to receive care at nationally-recognized institutions like the Cleveland Clinic as an example of employers' receptivity to quality arguments.

Mr. Stauffer described how aviation, like medicine, faces both challenges related to its professionals' competence and current knowledge and an expectation of safety. When he looks at medicine, he said he looks for "hallmarks of a well-functioning system – professionalism, teamwork, and clear communication." He said that he strongly supports any automation or system enhancement that can "wash out the failures of humans," but noted as a danger that people are prone to become "passive observers" when they are placed in large systems. He also stressed the importance of having a standard such as board certification to demonstrate that physicians are current in their knowledge.

Mr. Stauffer described how aviation has a strong model for sharing safety lessons within the industry, including a longstanding program of de-identified voluntary disclosures. He echoed Dr. Wiese's concern about repeated mistakes becoming ingrained when they do not lead to harm. As an example, he shared a personal story of having been removed from telemetry against his physician's orders; no harm was done, but he questioned how the system could allow it to happen and saw a need for feedback. He suggested that health care systems should look carefully at the aviation industry's creation of an environment in which all flight crew members have the responsibility to speak up if they see a threat to safety, and are protected from consequences if they are wrong.

Dr. Ejnes spoke about how his medical group engaged practice colleagues (including about 100 physicians and a few dozen nurse practitioners) in quality improvement efforts. Their work followed a decision to embrace alternative payment models, which required critical infrastructure investments to give physicians the resources to do their work well. He said it was also critical, however, for physicians to empower other team members, citing his practice's team-based success in reducing A1C levels through staff outreach to patients at home.

"You don't want to carve physicians out, but sometimes we are our biggest enemies," he said. "When they get notifications related to quality, physicians' first reaction is they don't have time to address them. Convincing them that we can do better without their doing more (and maybe even doing less) was great." Dr. Ejnes conceded that the measures they were trying to meet through their shared savings model were imperfect. "A lot of these measures aren't terribly relevant or meaningful, and sadly physicians played a role in creating them," he said. "Sometimes we have to swallow that as a bitter pill." He said that his practice's focus on quality has extended beyond those measures covered by the shared savings program, however, such as reducing antibiotic use for respiratory infections.

Dr. Baron, who moderated the session, asked Mr. Stauffer what advice he would give to medical practices to aid their quality improvement efforts. He stressed coaching and practicing to improve areas where performance is weaker. "There's lots of practicing in the airline industry," he said.

Dr. Baron then asked Dr. Ejnes for his perspective on how Leapfrog and employers should aid physicians working on performance improvement. He talked about supporting physicians' intrinsic motivation and desire to take the best care of their patients by prioritizing measures that aid in day-to-day practice and diminishing the degree to which less relevant measures

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become coercive tools. Ms. Binder said Leapfrog is trying to harness intrinsic motivation, but also believes outcome measures are very important. “We recognize the limitations of measurement,” she said. “We need to look at peer review and culture of safety assessments of hospitals. We also need to look at whole new ways of measuring performance.”

ATTRIBUTES OF MEANINGFUL ACTIVITIES

After hearing from the panel, participants met again in small groups to try to define the attributes of meaningful activities in performance improvement. Suggested attributes included:

- Relevant to physicians’ particular practice and the size of the organizations where they work, so that they have personally meaningful options for engagement
- Educational and engaging for physicians and encouraging of reflection
- Beneficial to patient outcomes and experience
- Helpful to work-life balance
- Workable and transferable to other institutions
- Conducive to teamwork and collaboration, within and potentially beyond an institution
- Organic: activities developed from the bottom up, including possibly with patient involvement, that promote a feeling of engagement
- Conducive to multiple avenues of contributions (as physician, scientist, systems expert, etc.)
- Quantifiable through particular outcomes

SKILLS AND COMPETENCIES

The next section of the meeting was devoted to the skills and competencies physicians need to engage in performance improvement activities. Chuck Kilo, MD, Vice President and Chief Medical Officer at Oregon Health & Science University, introduced the topic by talking about how the “establishment of deep trust-based relationships” is an overriding determinant of the quality of health outcomes. Yet our medical education system—aside from limited efforts to provide communications training that have not yielded significant results—does not train physicians how to create those relationships.

He argued that the performance improvement movement, which began around 1990, has thus far failed to meet expectations. He traced this failure to health leaders' failure to employ a scientific approach to performance improvement, which he called the "science of systems." For example, he cited the persistence of grand rounds despite "decades of data" showing that our current educational practices do not work. "There's a science around education and we're mostly not using it," he said. He also said the medical educational system needs to do a better job in teaching systems-based practice and basic statistical concepts that are necessary to measure system performance.

Dr. Kilo suggested that current improvement efforts are largely "project-based and not very strategic." "We should be using industrial strength performance improvement approaches," he said. He said some organizations have engaged in strategic improvement efforts, and listed five determinants that help organizations make this move: leadership, culture, infrastructure, methods and methodology. He argued that the Lean approach supplies the methodology and can be an effective tool to drive change, and that organizations that have distinguished themselves in this area have taken the method seriously. However, he said Lean in and of itself is not the answer—a complete organizational shift is required.

"We should be using industrial strength performance improvement approaches," said Dr.Kilo.

Dr. Kilo suggested that meaningful engagement for individual physicians requires the development of competencies they could transfer to a new working environment. He suggested a "starter list" of these competencies would include the ability to:

- Articulate the central role of systems knowledge and change management in improving outcomes
- Define "system," explain variation, and employ statistical process control
- Teach the science of safety to learners and staff, and participate in safety report submission, event reviews, and root cause analyses
- Explain the elements of a culture of safety and the needed organizational and leadership attitudes and behaviors necessary to put it in place
- Use data and databases to drive improvement and identify appropriate metrics, measurement systems, and measurement vendors for performance improvement
- Participate productively in institutional improvement activities

In response to comments from participants about the practicality of this approach, Dr. Kilo agreed that the average physician would be “put over the edge by this” because the system has not supported this kind of learning. “We have an industry-wide change management problem,” he said.

The participants returned to their groups to discuss the competencies they believe physicians need to participate in meaningful performance improvement activities. Although some embraced the competencies suggested by Dr. Kilo, others believed they were unrealistic. Some suggested that this was an appropriate area for physician specialization, pointing to the recent recognition of medical informatics as a specialty. Suggested competencies from the group included the ability to:

- Use data to drive improvement
- Participate productively in improvement activities
- Be wise consumers of performance improvement research
- Understand terminology and measurement approaches

SUMMARIZING DAY ONE

Dr. Braddock closed the first day by recalling the ABIM’s 2014 decision to “hold harmless” diplomates who did not complete performance improvement activities, and how some observers drew the incorrect conclusion that ABIM no longer believed such activities were important. He said the correct conclusion was that ABIM believed its approach was not having a meaningful impact on quality. Dr. Braddock said the most important element of ABIM’s review of its MOC program has been asking physicians across the country why doctors should want to do any continuing assessment activities. “All of them aspired to be a doctor who was current in knowledge for patients,” he said. He said the day’s discussion was similarly useful, and allowed ABIM to better understand physicians’ views about the place of quality improvement in assessment.

He characterized the first part of the day as being about “what’s in our hearts as physicians that makes us concerned about quality.” During the second half of the day, participants were able to consider what “dose of knowledge, skills, and attitudes each physician needs” to put that desire to care into practice. He closed by asking participants to consider whether and how boards and other entities can contribute to implementing that vision of touching hearts and moving minds.





DAY TWO

Three clinicians offered reflections on the first day's discussions to begin the meeting's second day.

Barbara Spivak, MD, an internist at Mount Auburn Medical Associates in Massachusetts, said she was interested by how much participants had talked about quality improvement as a means for payment and credentialing. She also spoke about how administrative burdens, including having no control over what they're measured on, have diminished the joy physicians take in their profession, and said that those who want to measure and improve quality need to reckon with how to do so without exacerbating that.

David Price, MD, Senior Vice President at ABMS, said the discussions about intrinsic and extrinsic motivation had resonated with him. He stressed the difference between mere compliance and commitment, which he called slower to build but more enduring. He also said he was pleased to hear broad agreement that the dichotomy between whether individuals or systems are responsible for quality improvement is a false one. "Quality improvement won't happen without physicians," he said.

Susan Edgman-Levitan, PA, Executive Director of the Stoeckle Center for Primary Care Innovation at Massachusetts General Hospital (MGH) and an Interprofessional Member of the ABIM Council, said the first day impressed upon her the need to talk about quality improvement in simple jargon-free language, as she recognized that many dedicated practicing physicians

were unfamiliar with current quality improvement tools and terms. She embraced the view that physicians are eager for community and collaborative improvement activities and that they need regular data to motivate them. She said that physicians at primary care practices at MGH are viewing and using an internal physician-level quality dashboard that reports on their quality metrics and outcomes, with steady improvements documented.

Jackie Judd, who moderated the session, said a key takeaway for her was the theme of physician leadership, and how it is "as much a mindset as a skill set." She noted that culture change can take a generation but there is urgency to improve care, and asked the panelists about the time frame for change. "Patients need us to do better and not just wait for the next generation to come up with solutions," Dr. Price said, calling for the development and utilization of patient-oriented metrics to emphasize improvements in areas that patients value.

Dr. Price emphasized the need to balance the tension in making improvement activities rigorous without being burdensome.

Ms. Edgman-Levitan said her system identified urgent priorities for improvement by asking clinicians and staff about the “rocks in their shoes;” she said that physician engagement in quality improvement required signaling that “we’re hearing what’s driving you crazy.” She said that many of the practices also included patients on quality improvement teams. “If you take people like us and redesign processes with no patients, we will come up with interventions that are too complicated, expensive and wrong,” she said. “Patients often cut through all the turf issues and devise simple and elegant solutions that are easy to put into place and that work.”

Ms. Judd asked panelists what made them uneasy from the first day. Dr. Price emphasized the need to balance the tension in making improvement activities rigorous without being burdensome. Dr. Spivak discussed the challenge of aligning credentialing requirements with what physicians are already doing to avoid redundancy. Ms. Edgman-Levitan talked about the need for the boards and other actors to synchronize their requirements with the requirements ultimately imposed under MACRA and commonly used by multiple payers.

THE ROLE OF CERTIFYING BOARDS

The next panel focused on how certifying boards can promote and recognize performance improvement. Dr. Baron, serving as moderator, asked panelists Daniel Cole, MD, the Vice Chair of the Department of Anesthesiology and Perioperative Medicine at UCLA, and Michael Hagen, MD, Senior Vice President at the American Board of Family Medicine, for their takeaways from the meeting. Dr. Cole said he was surprised by the frequency with which alignment with MACRA arose during discussions. He also said he was struggling with Dr. Kilo’s comments about the difficulty of training people in quality improvement techniques; Dr. Cole suggested we need 2-, 5- and 10-year plans to train the workforce. Dr. Hagen said he was taken by the need to educate the workforce and help diplomates become comfortable with the relevant vocabulary.

To provide an example of the kind of program that could build performance improvement skills, Carolyn Hendricks, MD, a medical oncologist at Maryland Oncology Hematology PA, spoke about the Quality Oncology Practice Initiative (QOPI), which is sponsored by the American Society of Clinical Oncology (ASCO). Through QOPI, oncology practices submit charts and receive feedback comparing their performance to their peers on a series of measures. Dr. Hendricks began participating in the program as a solo practitioner eight years ago, and reported that about 50 percent of ASCO members have participated in the program, demonstrating the demand for effective quality improvement offerings. She said QOPI’s “core strength” was that it is physician-driven, created by medical oncologists who wanted something specialty-specific, and also had strong commitment from ASCO.





Dr. Baron asked Dr. Cole how boards can learn from the QOPI experience, and whether there is a way for them to promote, engage, and incentivize participation rather than requiring it. Dr. Cole discussed the importance of connecting with physicians' desire for professional fulfillment, which he said certifying boards have "done less than a great job of doing." He told a personal story of how he and a cardiologist had helped save the life of a passenger on a plane, and suggested that the more boards can do to connect MOC with moments such as that, the more successful they'll be.

Dr. Baron discussed how patient outcomes have appropriately become the major focus for those evaluating the health care system, but that we know that those outcomes are produced by complex interactions of teams and systems. In light of that, he asked how we define the physician's role and contributions to achieving desired outcomes. Dr. Cole said every physician needs to take leadership responsibility for delivering these outcomes. Dr. Hagen said leadership requires developing a familiarity with change management skills and the vocabulary of performance improvement. Dr. Hendricks said an asset of the QOPI program is that it requires physician leadership.

During the discussion period, Dr. Kilo stressed the need to define the competencies physicians need to be effective in quality improvement, saying there is currently "no textbook for quality improvement that you can master." Dr. Baron said he hoped that "the table of contents for that textbook would come out of this meeting."

Dr. Braddock commented that when new areas of knowledge or changed understandings of medical conditions emerge, boards update their assessments to assure that physicians grasp fundamental concepts. He suggested that if we believe there's a fundamental core of knowledge about the science of improvement, it should be part of assessments. Dr. Baron questioned whether the issue is "something you know or something you do," and said that ambiguity has made it challenging to create programs in this area. Dr. Braddock suggested this sort of tension can be found throughout the assessment portfolio, such as discrepancies between physicians' knowledge of the evidence for breast cancer treatment and the treatments they actually offer. He agreed that ABIM has been more comfortable assessing knowledge, but that it could also measure core competencies in quality improvement.

DEVELOPMENT OF CRITERIA

The participants spent the next portion of the meeting working in small groups to develop proposed criteria for defining meaningful performance improvement; meaningful participation in performance improvement for individual physicians; and the minimum set of competencies for physicians in the performance improvement area.

Suggestions that received the most support from participants included:

Meaningful Performance Improvement

- Matters to physicians/patients/other stakeholders
- Supported by evidence
- Predicated on system and organizational change, with resources for infrastructure
- Shareable: can be learned and reproduced by other groups
- Aligned to support multiple requirements

Meaningful Participation in Performance Improvement

- Reflection should be key to the process
- Valuable to clinicians: not busywork and related directly to practice
- Includes feedback
- Clinicians actively participate in plan development and implementation
- Physicians share learnings from activities
- Includes appropriate credit mechanisms

Minimum Set of Physician Competencies

- Engage and participate in practice/team based improvement
- Demonstrate knowledge of systems
- Model culture of safety
- Ability to identify performance gaps
- Show familiarity with common forms of quality improvement data and change management strategies
- Ability to apply scientific method to evaluate practice



HOW TO GET TO BETTER QUALITY

After this defining of criteria, participants met again in small groups to consider what knowledge, skills and attitudes of physicians can help move the health system toward a more coherent quality improvement strategy, and how to appeal to physicians' sense of professionalism in this effort. Suggestions for important knowledge, skills and attitudes included patient-centeredness, humility, empathy, love, respect for other team members, an ability to synthesize information, and commitment to excellence and professional development. Proposals for appealing to physicians included:

- Encourage physicians to engage in mentoring and teaching to connect with others, rekindle their passion, and reflect
- Ensure that leaders demonstrate that they recognize the importance of quality improvement
- Frame certifying board efforts in this area as helping physicians comply with existing and forthcoming requirements (e.g., MACRA)
- Employ inspirational examples of quality improvement projects and their impact on patients and increasing joy in practice
- Appeal to their desire to be respected by their peers
- Present quality improvement as an opportunity to create a community
- Recognize and celebrate quality improvement through designations/awards



CONCLUSION

Dr. Baron closed the meeting by thanking the attendees for their contributions to achieving ABIM's goal for the meeting: to receive guidance about the appropriate role for ABIM in the quality improvement field and how it could best play that role. Dr. Baron said he believes individual physicians have a critical role to play. "When I hear people say we want physicians to get out of the way and have systems do it all, it kind of makes me want to cry because we would lose all their contributions," he said.

"I commit that we will not go forward in a passion-killing way and that we will try to make this an exercise in professionalism, pride and self-actualization," said Dr. Baron.

Dr. Baron said that the meeting had contributed greatly to defining what success looks like. He reflected on the numerous comments about the importance of physicians' individual emotional engagement in making care better, and about how ABIM and other certifying boards were not taking advantage of that engagement. "We were leading people to box-checking and not true engagement, and we want to fix that," he said. "I commit that we will not go forward in a passion-killing way and that we will try to make this an exercise in professionalism, pride and self-actualization."

Dr. Braddock said the meeting had confirmed for him that individual physicians bear responsibilities that are distinct from system responsibilities: "love for our work, and bringing particular knowledge and skills to the table." He said the ideas put forward for the roles and contributions of individual physicians would "galvanize" ABIM's continuing conversation about its role in performance improvement, and urged the participants to continue to think about the issue and share their thoughts with ABIM.

