American College of Emergency Physicians
Emergency Department Directors Academy

Rewarding Champions & Corralling Stragglers: Improving Peer Review & Performance Through Mutual Accountability

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The Most Important Slide?

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Rewarding the Champions Corraling the Stragglers

- What Gets Rewarded Gets Repeated
- What You Permit You Promote
- Lots of Rewards
- Defining "Good Docs"
- Clarity and Concision

- Separate them out-No 2 sets of rules
- They can't be allowed to pull the team down
- "Thinning the herd"
- Specific Strategies to Change Behavior

Let's Start with a Little Perspective

- This isn't a "Deal with the Outliers" System
- It is a system of iterative excellence based on mutual accountability
- A Team vs. B Team (Hint: No one is always one or the other…)
- Rewarding the Champions, Corralling the Stragglers
- "Corral" = Perimeters within Parameters
- "The job you were hired for is almost undoubtedly not the job you are currently doing."
- "I was hired to teach/ save lives/ move freight…not kiss butts!"
- "The job has evolved-so must you."
- What you permit you promote, what you repeat you become.

…opportunity

Engaging Doctors = Engaging People
What Do **We** Want?

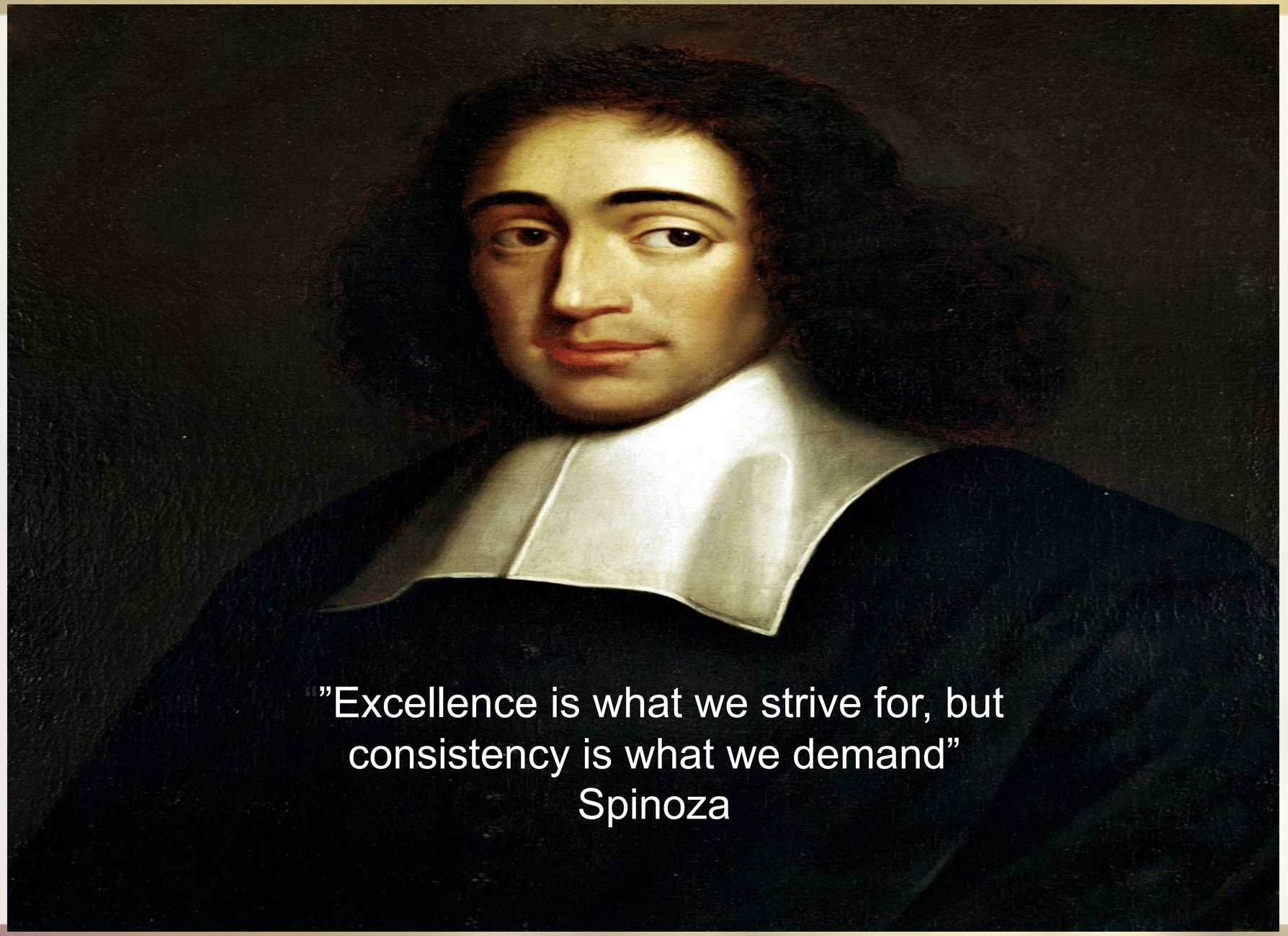
What is our **true goal?**

What is our **true role?**

The **joy** of *creating, sustaining and constantly innovating a* **system** which…

Makes our patients' lives better, while

Making our lives easier

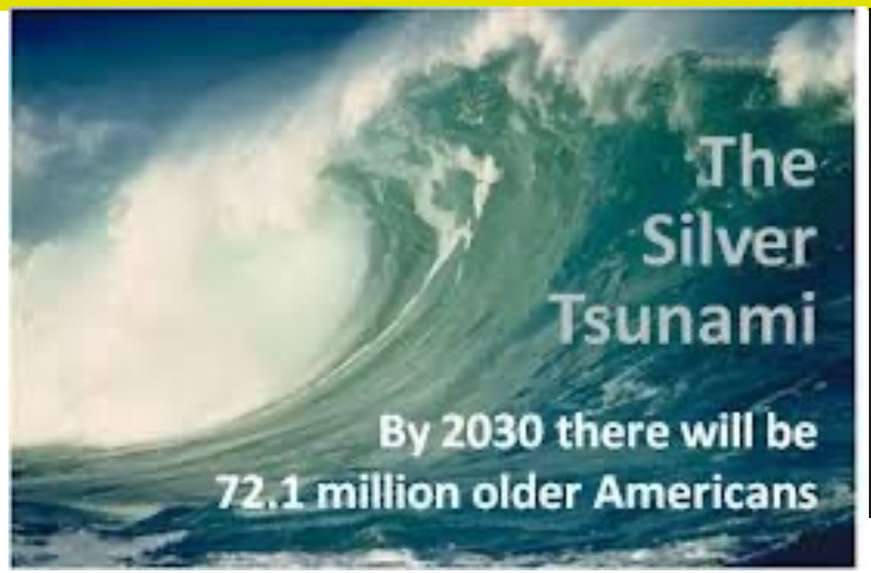

”Excellence is what we strive for, but
consistency is what we demand”
Spinoza

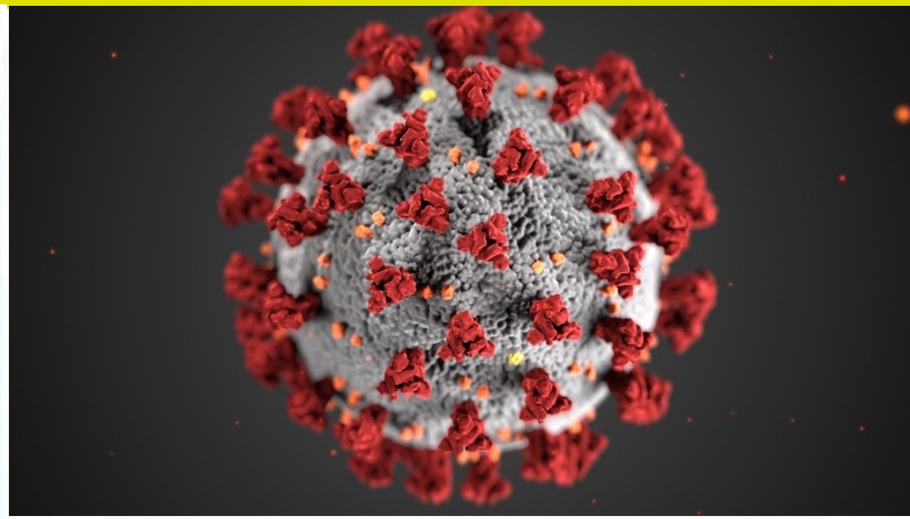
“After further review…”

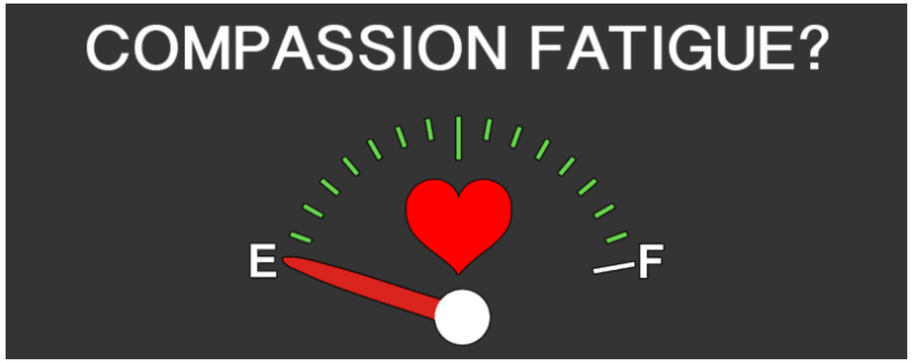
- Failure to hold people accountable is **deceptive** and **dishonest**..
- Because telling people “It’s OK” when it is **decidedly not OK**…
- Will cost **them** their job eventually and..
- It will cost **you** your job…or your sanity

All of this in the midst of…

Burned







Is There a "**Right Way**"?

Getting the 'Why' Right Before the 'How'

1. • **Science** of Clinical Excellence
2. • **Art** of Customer Service
3. • **Business** of Execution


ER
RX
RX
H
A
Q

What Do Our Patients **Want**?

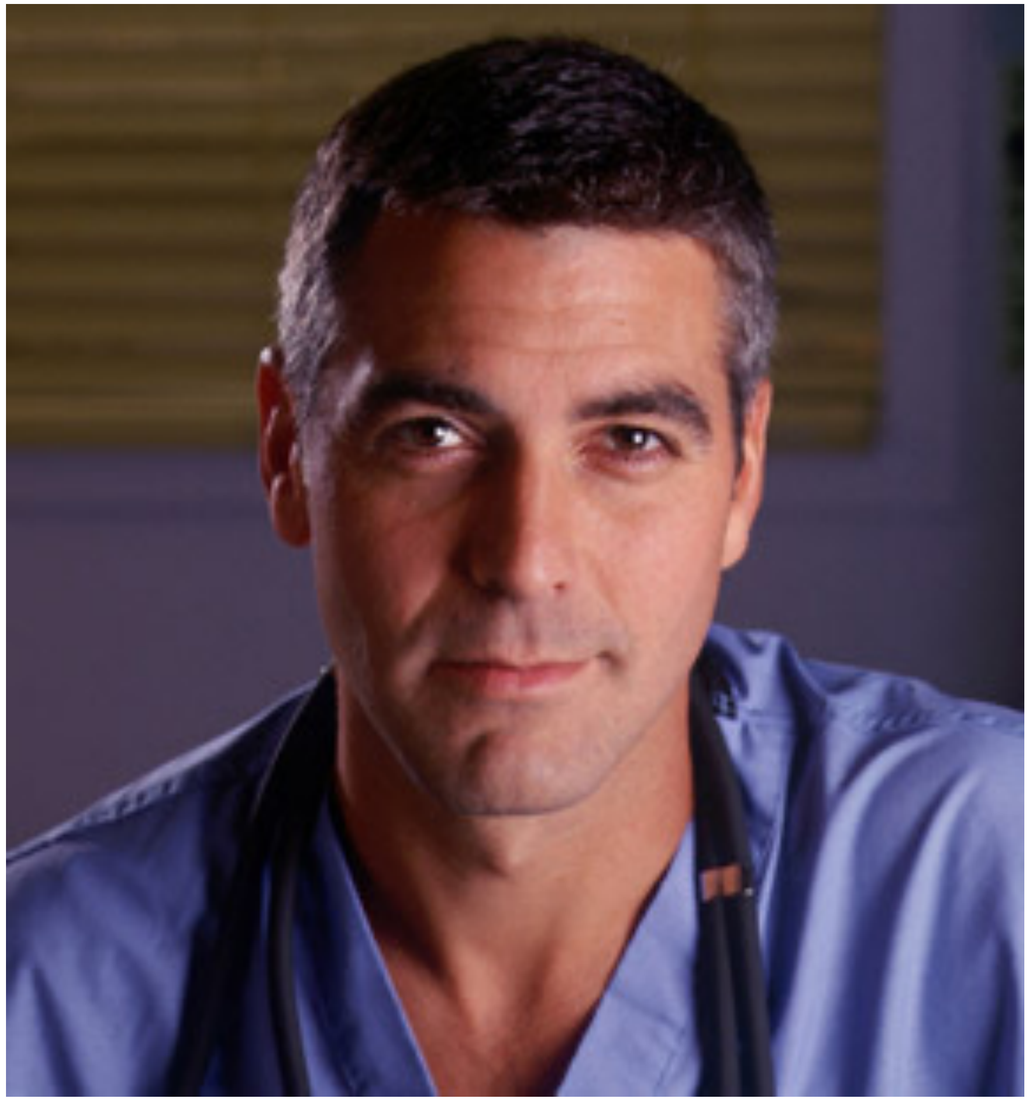
GB3

Get Back!

Get Better!

Get Boogying!

What do **We** Want?
Accentuate the A Team
Eliminate the B Team



How Do You Deal with…

Changing Performance Evaluations

- Neo-Colonialism
  - "Here are your deficiencies."
  - "Here are the deficiedata supporting your ncies (which you had no voice in generating…)"
  - "Here's the timeline for reassessing your deficient performance."
  - Metrics mania without means
  - "Fix it!"
  - "Oh, by the way, I basically own you…"

- Best Practices
  - From "Who screwed up?" to "What happened?"
  - Data, Delta, Decision
  - Coaching specifics
  - "Whose job is it to improve?" "Yes!! And here's how to make your job easier."
  - "Here's what I've been working on…"
  - How is the job performing for you?

Measurement "DO's"

- Focus on A Team behaviors … not the measurement itself
- Use as a tool, not a club!
- Connect the measure to purpose
- Put the data to use quickly
- Share it!
- Push for results – no excuses
- It makes your job easier!

Measurement "DON'Ts"

- Get carried away with validity and reliability
- Use as a club
- Keep data a secret
- Make this into rocket science
- Tolerate B Team behaviors

Free Form Evaluations

- “I would not allow this employee to breed.”
- “Since the last report, this guy has hit rock bottom and started to dig.”
- “Works well under constant supervision and when cornered like a rat.”
- “Has delusions of adequacy”
- “This employee is depriving an unfortunate village of an idiot”
- “Got the full six pack but lacks the little plastic thing to hold it all together.”
- “I would like to go hunting with him soon.”
- “Has an IQ that, if squared, results in a smaller number instead of a larger number”

Holding Professionals Accountable
Mutual Accountability

- This is sometimes *difficult* to do…
- But it's really not *complicated*

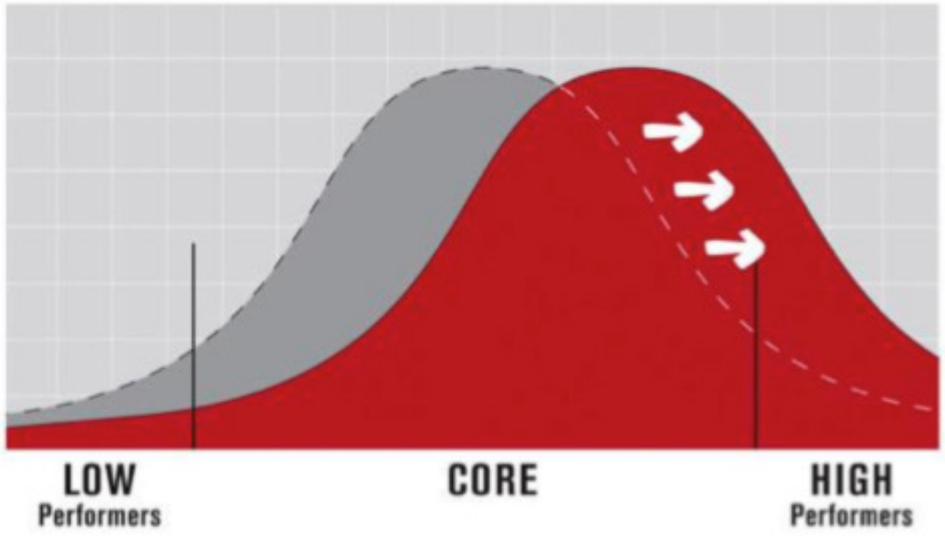
1. Powered by Data as a Tool, Not a Club
2. A Culture of Team Accountability, Coaching, & Mei
3. A Theory of Intrinsic Motivation-Makes the Job Easier
4. Aligned Strategic Incentives-Connect the Gears
5. The Tools of Rewarding the Champions
6. The Tools of Corralling the Stragglers

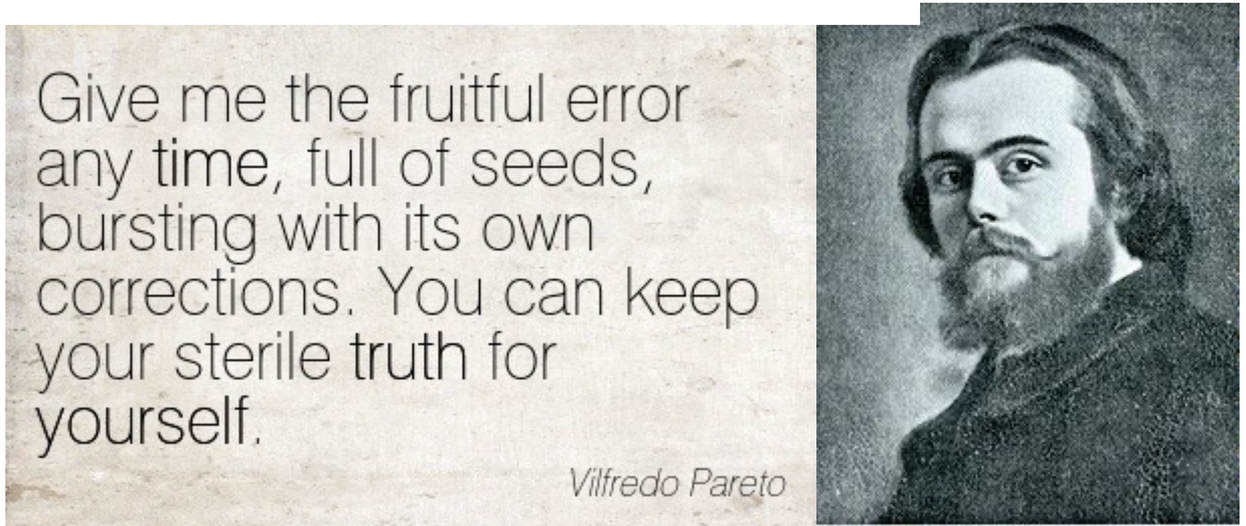
#1 Powered by Data-Metrics *With* Means

1. **Only use data tied to the M/V/V of the team**
2. No one wants to be in the bottom third
3. Data drives the train-Docs are scientists
4. Make data transparent, simple & accessible
5. Accentuate A Team Members and Behaviors
6. Take-Off, Landing!
7. Fix the System-Stop Stupid Stuff, Start Smart Stuff

#2-Changing the Culture
Words on Walls Vs. Happenings in Halls

- Pareto's Paradox-80% of leaders time is spent with 20% of the people
- Move the entire curve!
- It's not **your** job…
- It's **everyone's** job!
- Decrease variation that doesn't add value
- Coaching and mentoring are essential skills for EM





A Few Thoughts on Mentoring

- Usually assumed…wrong!
- It has to be taught, cultivated and mentored
- There's science to the art
- "Do" ≠ "Show"
- Never send a Man to do a job a Woman can do Better
- You can choose one mentor…but they had better know **everything!**

What Do You Want to See More Of?
What Do You Want to Less Of?

"Why" Before "How"

But there must always be a "How!"

Coach and Mentor Details

2 Hire Right! Culture and Mutual Accountability The Talent Arbitrage Business!

You are the Chief Talent Officer !

Screen for the mutual accountability gene

“Coaching and mentoring is our culture. Don’t come here if you disagree!”

Surround yourself with talent-any 1 of which can outperform you

Hire Right!
Because the Biggest Reward is…

- Don't hire **smart** people and try to **motivate** them
- You can train "Smart"
- Hire **motivated** people and let **passion** (yours and theirs) **inspire** them!

 # 3-All meaningful and lasting change is driven by INTRINSIC motivation…

German Coast Guard

“Mandatory” Extrinsic Motivators

- Organization
  - The Joint Commission
  - Det Norske Veritas (DNV)
  - American College of Emergency Physicians
  - American College of Surgeons
  - American Heart Association
- Motivation
  - CMS Accreditation
  - CMS Accreditation
  - Geriatric EDs
  - Opioid-Lite EDs
  - Trauma Center
  - Cancer Center
  - Stroke Center

6 Steps to Mutual Accountability for Docs and Nurses

1. Clearly state what the group values. (What is the ideal emergency physician?)
2. Make the generation of what the group values a team-oriented process (including patients, nurses, and the medical staff).
3. What the group values must be clear, measurable and succinctly-stated. (Elevator Speech)
4. Make the results transparent and easily-available.
5. The results must be actionable and capable of "fixing."
6. The group must be open to coaching and mentoring when results are below target levels.

What's the Ideal Emergency Doc?

One View

- Buys donuts
- Show up early
- Says “Leave those charts-I’ll bang ‘em out”
- Does what the nurses tell him
- Loves holiday shifts
- No sign-outs at shift change
- Has 23 kids (needs the shifts!)

What's the Ideal Emergency Doc?

- Clinical acumen (Always right)
- Great service (Can sell grenades to Gandhi)
- Speed (Moves the meat!)
- Multi-tasking Leadership (Able to juggle)

Fundamentally, What Does Your Organization VALUE?

- Quality of Care
- Volume (Moves the Meat!) Key Concept: Patient (Asset) Velocity and Revenue Velocity
- Teamwork
- Customer Service
- Risk Management/Risk Reduction
- Citizenship
- Enterprise Value

    EMS, Disaster Medicine, Peds EM, Sports Medicine

What Do We Value? What Do We Measure?

- *Value*

  Speed

  Revenue

  Customer Service

  Patient Safety

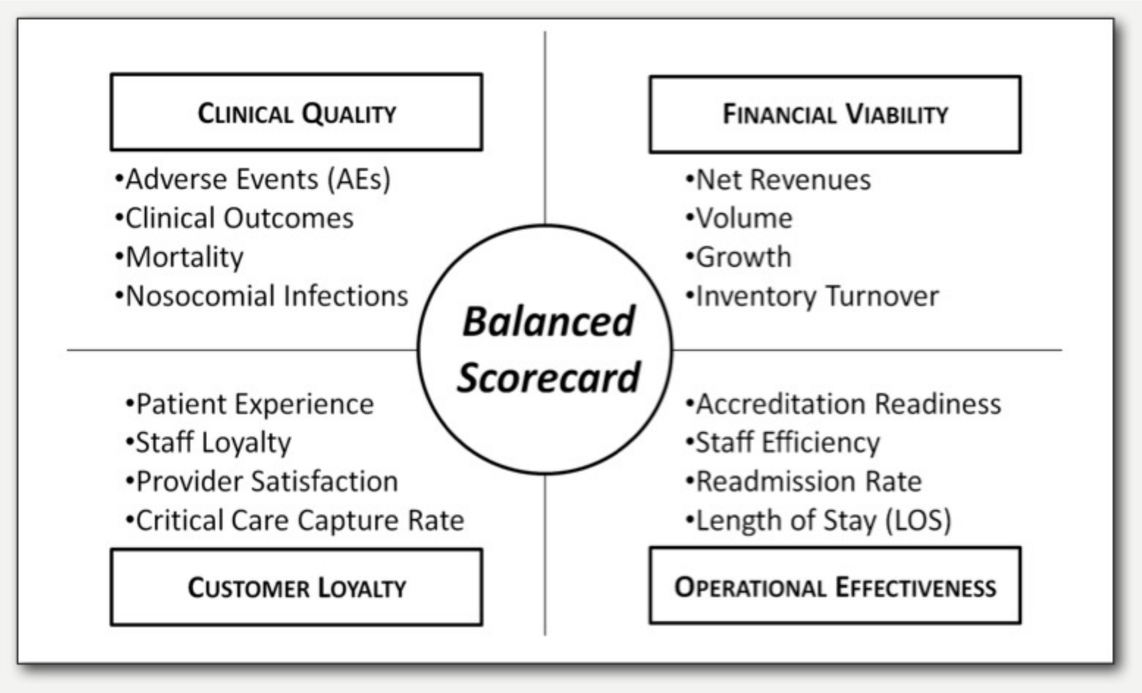
  Risk Reduction

  Process improvement

  Citizenship

  Enterprise Value

#4-Aligning Strategic Incentives With Our Partners



Emergency Departments are…**Complex Adaptive Systems**
Connect the Gears…and Adapt!

Clinical Effectiveness

Safety

Patient Experience

Hardwiring

Flow

#5 The Tools of Rewarding the Champions

Battle Burnout-Restore Resiliency
Coaching and Mentoring
Hire Right!
Pragmatic, real-time feedback
Make it easy to compliment
Say “Thanks” 50 times a day
Harvest Compliments Aggressively
Caught Caring
Be Like Praveen!

THOM MAYER, M.D.

Make Harvesting Compliments Easy

- Make compliments a part of the culture
- Say “Thank You” 50 Times a Day
- Hardwire Flow-Change the System-Stop Stupid, Start Smart
- Caught Caring, Catch a Star
- “Great job!”
- “You just saved this guy’s life.”
- Which file is thicker?

Something to Keep in Mind…

- 85 year old lady from assisted living
- “Food poisoning”
- “They got me back to Winchester, which is all I wanted.”
- “I am forever grateful!”
- “Dr. Kache Praveen”

6-The Tools for Corralling Stragglers

1. Tie it to Making the Job Easier-Why Before How
2. Pragmatic and Real Time Feedback
3. Deal with the Myths of Impossibility and Autonomy
4. Focused Coaching and Mentoring Culture
5. Rogers' Theory of Diffusion
6. Hold the Mirror Up-The Gordon Method
7. Brutal Optimism-Stockdale Paradox
8. Shadow Shifting
9. After Action Reports and Evidence-Based "Flight Plans"


We are the hollow men
We are the stuffed men
Leaning together
Headpiece filled with straw. Alas
Our dried voices, when
We whisper together
Are quiet and meaningless
As wind in dry grass
Or rats' feet over broken glass
In our dry cellar

Shape without form, shade without colour,
Paralysed force, gesture without motion

Those who have crossed
With direct eyes, to death's other Kingdom
Remember us - if at all - not as lost
Violent souls, but only
As the hollow men
The stuffed men.

This is the way the world ends
This is the way the world ends
This is the way the world ends
Not with a bang but a whimper.

T. S. Eliot

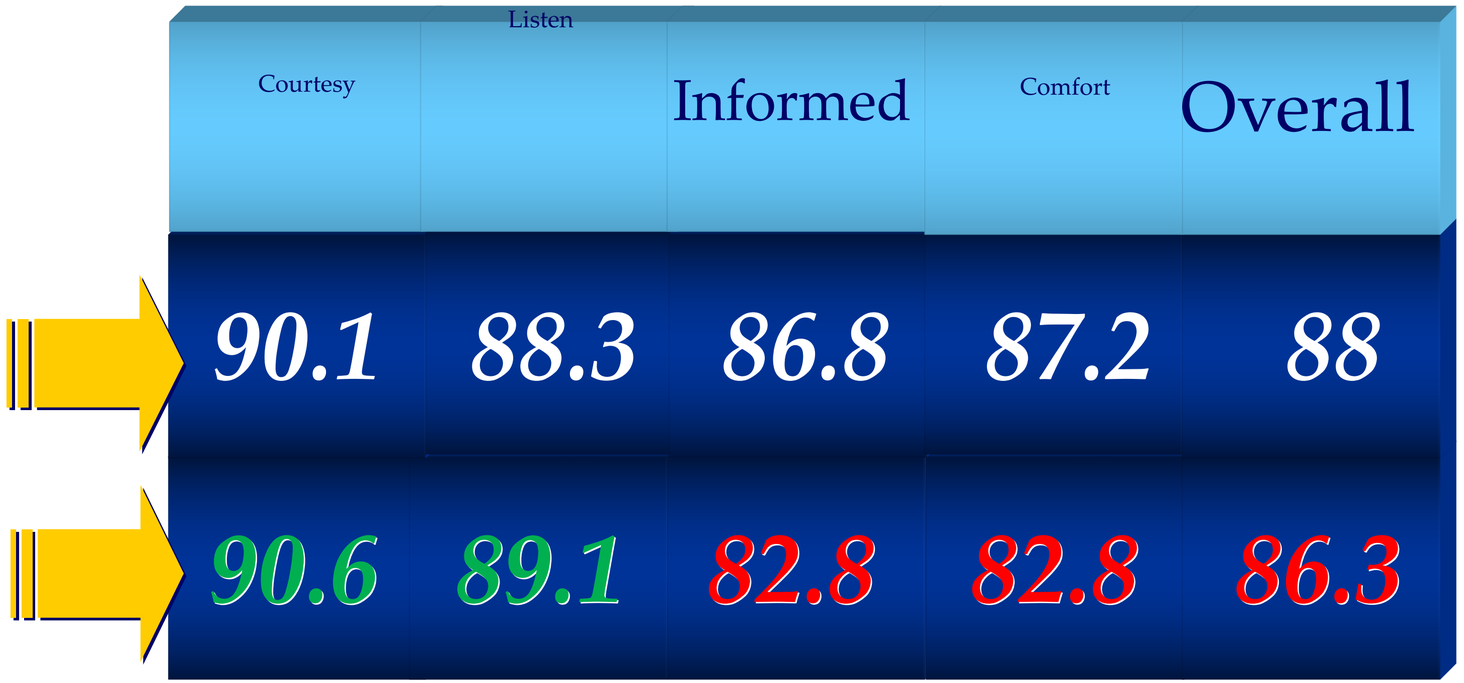
It Can't Be Done **Here!**
The Myths of "Impossibility" & Autonomy

- In fact, it can be done *here*…
- Because it's already being done *here*…
- It just isn't being done *by you!*
- Or at least not consistently enough to produce traction around *results*
- "That's not how I practice…"
- "Where should I send your letter of reference?"

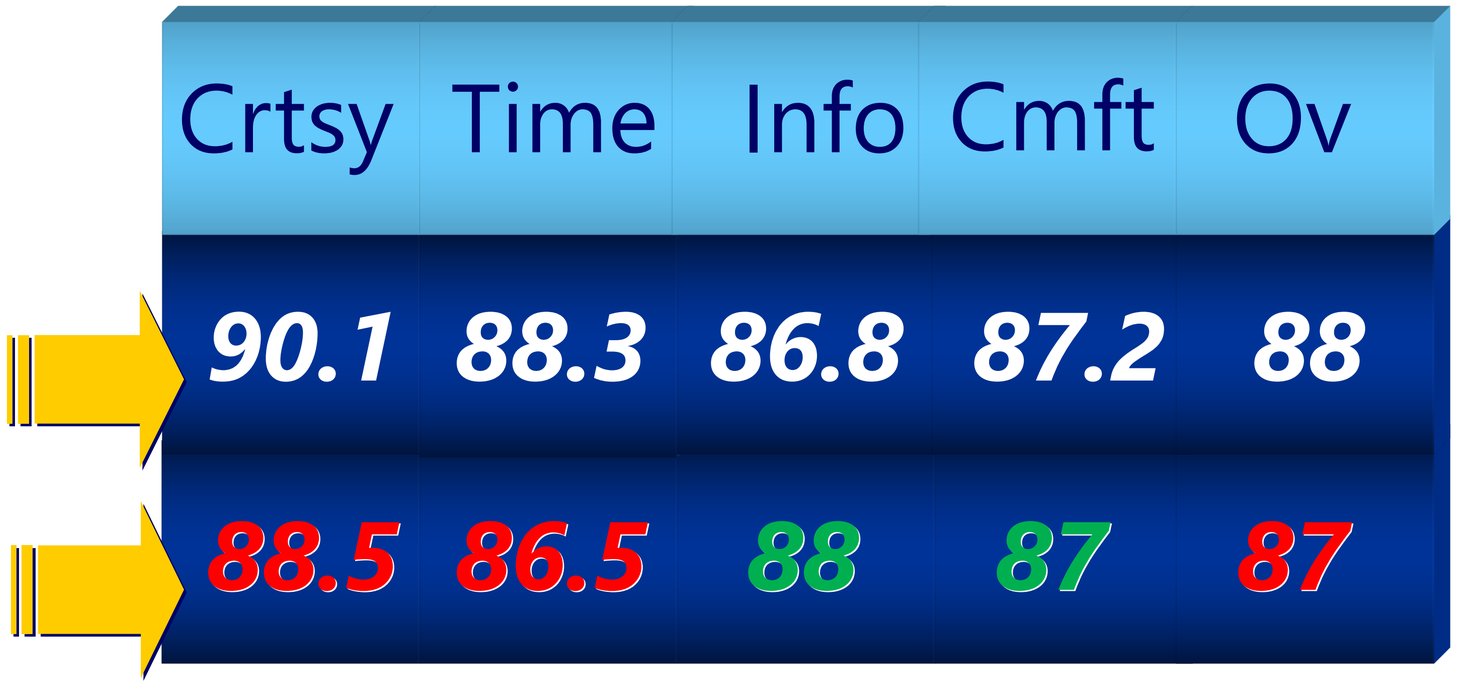
Focused Coaching and Mentoring

$$\frac{66 + 77}{2} = 95$$

Focused Patient Satisfaction Coaching Doctor Smith

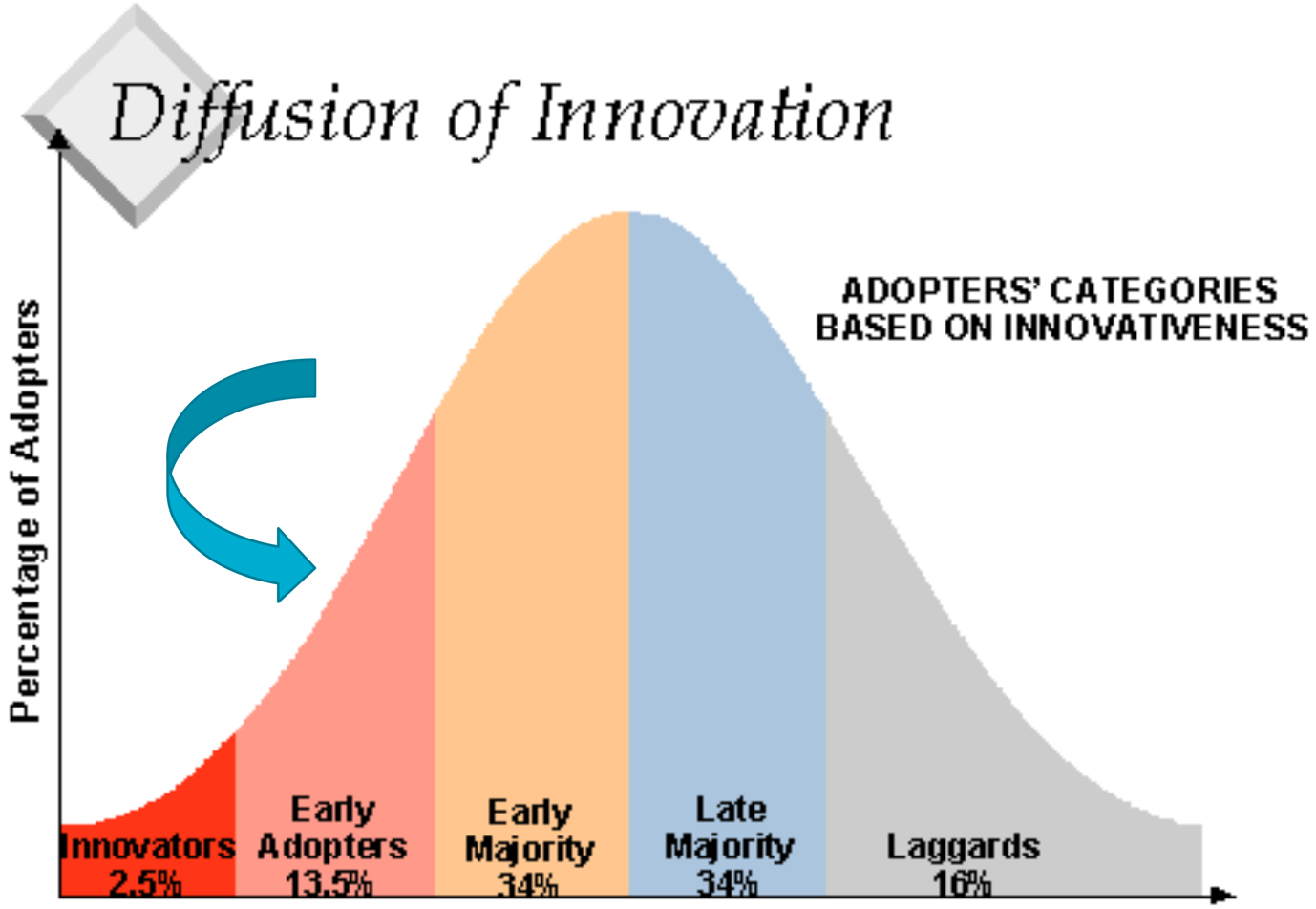


Focused Patient Satisfaction Coaching Dr. Jones



Focused Patient Satisfaction Coaching
A Team Behaviors Shared **66+77/2=95!**

Rogers' Theory of Diffusion



Dealing With The B-Team Employee
The Gordon Model (Rob Strauss, MD)

- "When you do __X____, it makes others feel ___Y____. Try ____Z_____.
- "When you do 'B-team behavior', it has this effect. Try this A-team behavior."
- "When you show up *late* (a clear and common B Team behavior), it makes others *feel angry* (the effect of the B Team on the A Team). Try doing *3 less tasks before coming to work* (the A Team Behavior)."
- Where would they rather be? *Anywhere!*

Mutual Accountability
Confront The Brutal Facts

- Brutal optimism-be your own worst critic
- When tortured, the optimists die first. (Stockdale, McCain, Epictetus, Frankl…)
- Strategic Optimism-You should know the worst about your ED before someone else points it out to you
- Invest your Optimism Wisely and for ROI

The Stockdale Paradox

“I never lost faith in the end of the story. I never doubted not only that I would get out, but also that I would prevail in the end, and turn the experience into the defining event of my life. This is a very important lesson. You must never confuse the faith that you will prevail in the end with the discipline to confront the most brutal facts of your current reality.”

Peer Review-The Stockdale Paradox

- Your group is a democratic, open-books, ‘We few, we happy few, we band of brothers’ group.’ You believe this is the only real practice model.”
- However, your CEO has insisted on a performance clause in your contract tied to customer satisfaction scores.
- Despite an aggressive CS focus, two of your eight partners have basement-dwelling scores…and they are getting worse !
- What’s at risk here?

Shadow Shifting-The Most Powerful Tool

- An extraordinarily high-leverage tool, but…
- One which both the A Team and B Team resist
- A change in culture…
- Docs don't like being watched
- No competitive team would resist coaching from high-performers
- "I'm working with Dr. Smith today."
- "Here's what's worked for me…"

After Action Review

1. What results did we intend to achieve in this case?
2. What measures can we use to assess results?
3. What challenges might we have expected beforehand that affect the future?
4. What lessons did we learn from our actions and their consequences?
5. How can we succeed better in the future?
6. How (specifically) can we implement?

AAR's and Accountability

1. What results did we intend to achieve in this case?
2. What measures can we use to assess results?
3. What challenges might we have expected beforehand that affect the future?
4. What lessons did we learn from our actions and their consequences?
5. How can we succeed better in the future?
6. How (specifically) can we implement?

Mentoring Millennials

- **Boomers**
  - "It's true because it's 'tried and true,' peer-reviewed…"
  - Pyramidal, Hierarchical Structure & Information Flow
  - Direct report, 1 on 1, siloed
  - Evidence-based progress
  - Limited definition of diversity

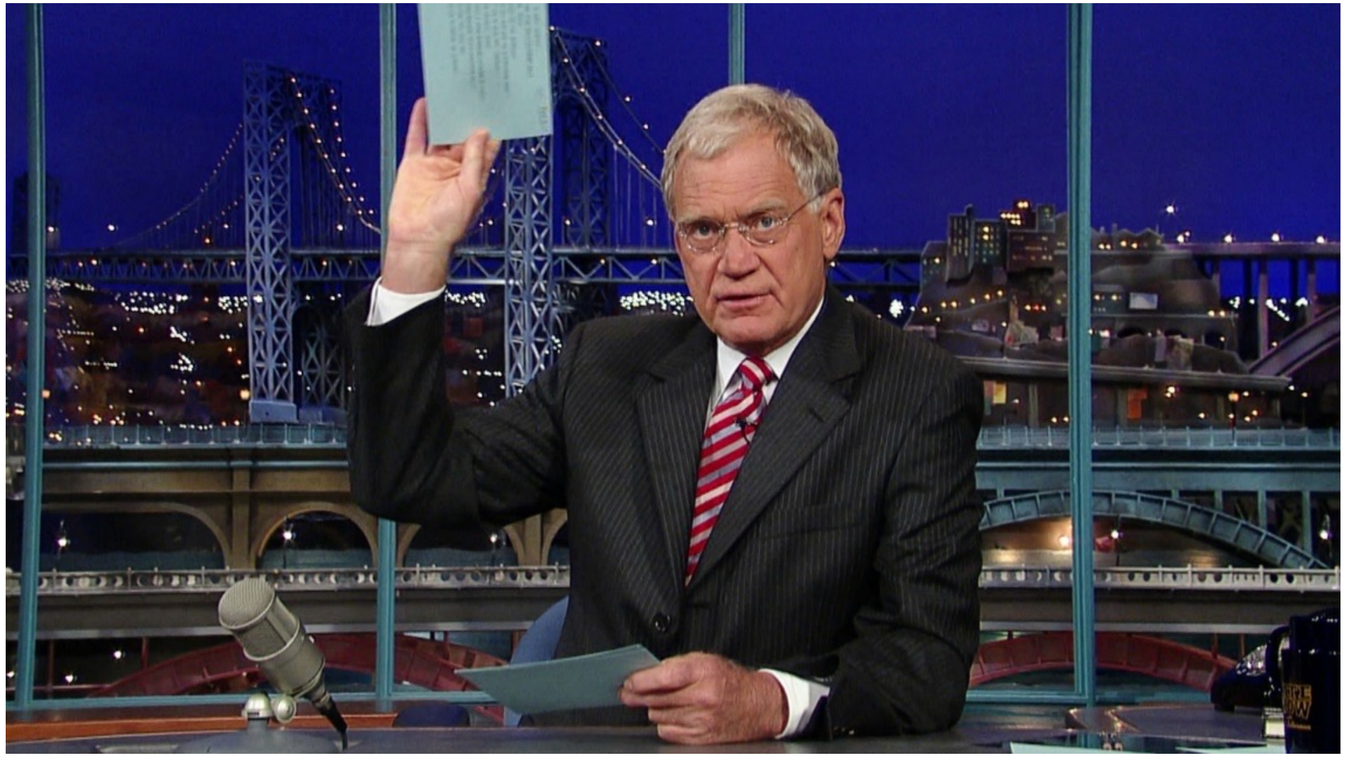
- **Millenials**
  - "It's true because it works and I like it & so do my friends"
  - Flat, pragmatic structure, speed of electrons/light
  - Snowflake relationships, cross-functional, 1 on many
  - Innovation requires failure
  - Diversity of thought, ideas, approaches

Key Issue-360 Degree Feedback

- Great idea-you go first!
- Making the Job Easier
- Do you value nursing?
- Will you have nurses evaluate you?
- Do you get to evaluate them?
- Does it make us better clinicians?
- Quality of the feedback
- Ability to integrate

David Letterman Presents…

- Acute Myocardial Infarction
- Appendicitis
- Meningitis
- Chest Pain (ACS and Non-ACS)
- Open Wounds
- Abdominal/pelvic pain
- Pneumonia
- Spinal Fracture
- Aortic Aneurysm
- Acute Testicular Torsion



Imaging Studies Evolving in EDs

- More Diagnostic Ultrasounds and MRIs
- EKG used 26 times per 100 patients seen
- MRI scans 1.1-2.0 per 100 patients seen
- CT scans 20-25 procedures per 100 patients
- Ultrasound 5.5 per 100 patients
- Plain films 48 per 100 patients

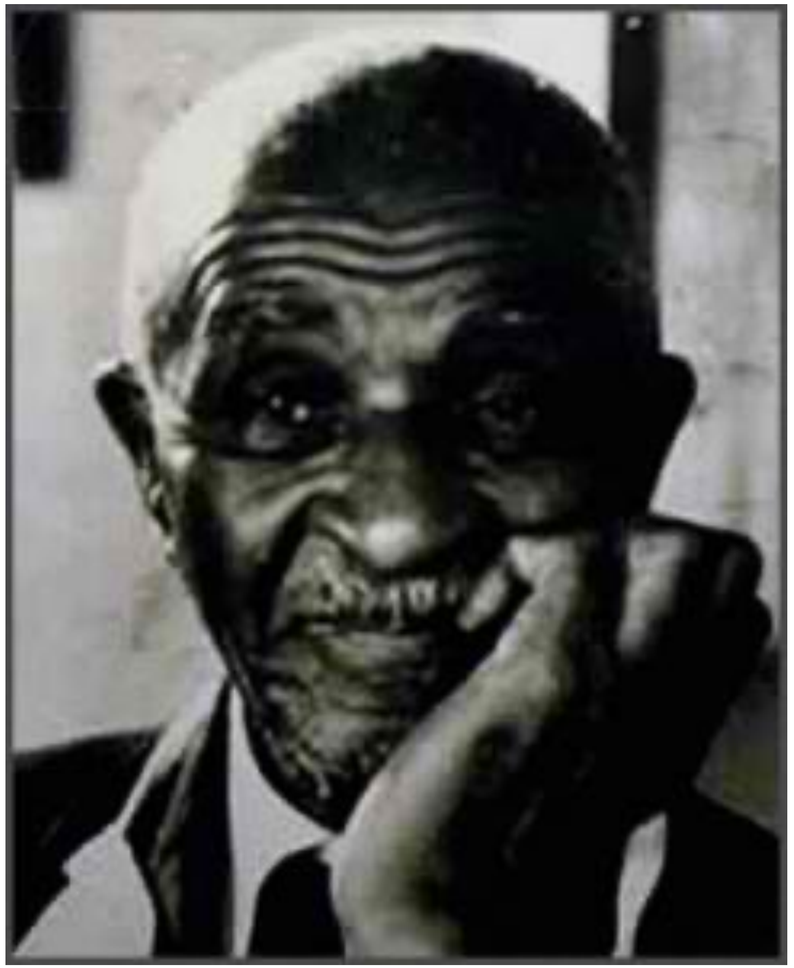
Dr. Glow in the Dark-CTs/100 Patients

1. Increasing reliability by reducing variation
2. High of 36 per 100
3. Low of 19 per 100
4. Pushing group and individual performance to the Clinicians

							Total Patient Vol	Total Occurances of an Ordered CT	Total Sum of % Utilized
tilized 00908		200909	200910	200911	200912				
24%		21%	21%	21%	21%		1468	325	22%
			0%		33%		4	1	25%
29%		24%	26%	24%	24%		1536	393	26%
33%		24%	19%	21%	22%		1294	318	25%
		100%					1	1	100%
16%		26%					390	76	19%
		31%	20%	26%	33%		393	105	27%
31%		36%	25%	33%	38%		266	86	32%
33%		31%	31%	27%	35%		941	276	29%
22%							322	79	25%
33%		37%	36%	29%	24%		1353	427	32%
24%		21%	23%	16%	20%		1263	266	21%
			22%	23%	24%		615	141	23%
, MD	27%	8%		25%	14%		49	9	18%
n, NP	24%	19%	23%				358	79	22%
MD	31%	34%	35%	40%	38%	39%	667	239	36%
DO					20%		15	3	20%
, MD	19%	23%	23%	25%	17%	13%	808	159	20%
ahue, MD	24%	24%	22%	20%	21%	22%	1382	306	22%
en, MD	34%	25%	29%	24%	28%	22%	1264	344	27%
ell, MD				0%			1	0	0%
NP			24%				33	8	24%
el, MD	36%	27%	28%	31%	28%	47%	721	230	32%
h, MD						19%	63	12	19%
Grand Total	**28%**	**27%**	**28%**	**27%**	**24%**	**26%**	**28905**	**7679**	**27%**

Timing is Everything…

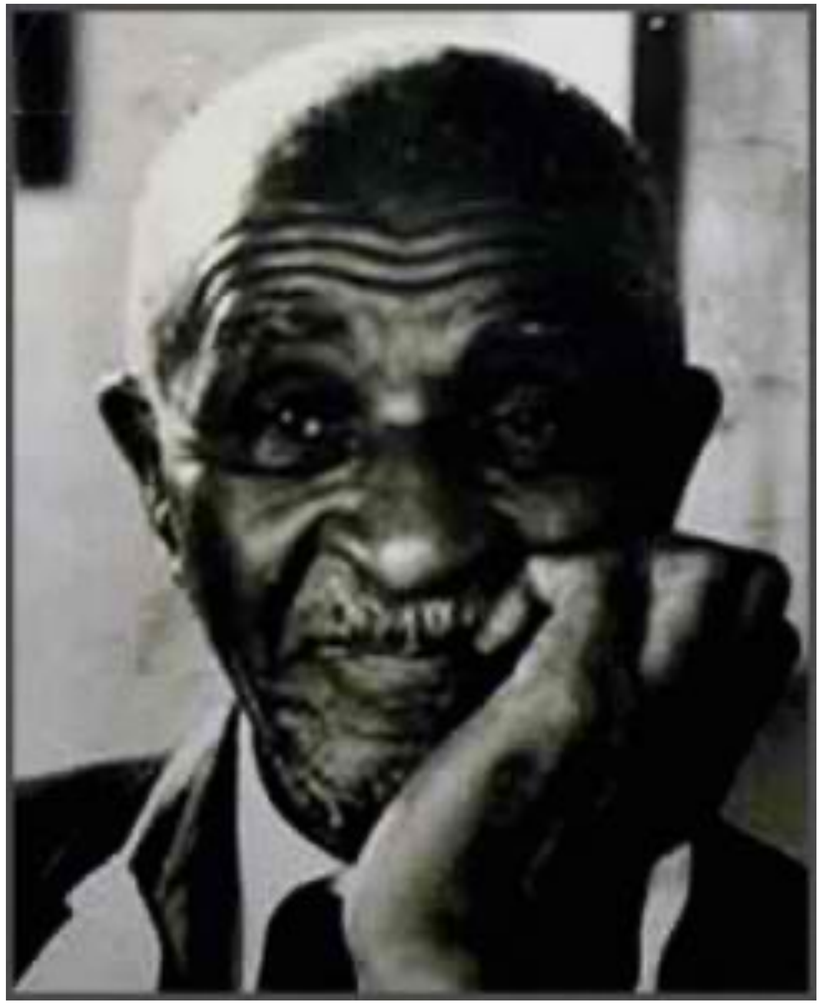
George Washington Carver



How far you go in life depends upon …

Courtesy Chuck Stokes, FACHE

George Washington Carver



- How far you go in life depends upon your being-
- Tender with the young
- Compassionate with the aged
- Sympathetic with the striving
- And tolerant of the weak and strong
- Because someday in your life
- You will have been all of these things

Courtesy Chuck Stokes, FACHE

CEDR - Clinical Emergency Data Registry

Overview | Advantages | FAQs | Resources | Measures

Welcome to ACEP's New Clinical Emergency Data Registry

As part of its ongoing commitment to providing the highest quality of emergency care, ACEP has developed the CEDR registry. This is the first Emergency Medicine specialty-wide registry at a national level, designed to measure and report healthcare quality and outcomes. It will also provide data to identify practice patterns, trends and outcomes in emergency care. CEDR is an evolving

The 1st Tier of Peer Review/PI

- LWBS (Target <1, 2, 4, 5 %?)
- Returns within 48, 72 hours
  - Change in Diagnosis
  - Admission
  - Change in therapy
- Radiology over-reads
- EKG over-reads
- Condition on discharge
- ASA in AMI
- Beta-blockers in AMI ???
- Press-Ganey Scores

2nd Tier Peer Review/PI-1st Tier Plus:

- Time Indicators - Door-Doc, Doc-Decision, Decision-D/C
  - Total TAT
  - Admissions
  - Discharges
  - Fast Track
- "Quality"/ Time Indicators
  - Time to Abx in CAP (oops!)
  - O2 Sat, MS, VS in CAP
  - Door to Cath Lab/Open artery
  - Sepsis Bundles
  - CHF Bundles
  - Trauma indicators
  - EKG for Non-traumatic CP, Syncope >40

3rd Tier Peer Review/PI-2nd Tier Plus:

- Discharge summaries on all admitted patients
- Copy of ED medical record to personal physicians
- Downcoding/incomplete chart reports
- Complaints/compliments analysis
- Team time indicators
- Boarder Hours (Reasons?)
- Meaningful data trending
- All of which lead to “So What?”

RVUs Per Hour Ranges

- Broad range of 4-10 RVUs per hour
- Heavily skewed to EDs in the 6.5-8.5 RVUs per hour
- Productive ED Docs can hit 7-9.5 RVUs/hr
- Can be seasonal
- Effected by pediatric, geriatric mix
- Nights are slower (or at least they used to be)
- The mix of E/M codes is critical to RVUs per hour
- TC/CC high RVUs per patient but low PAVs and RVs

Let's Look at the Specifics

- Fast Track

PV =3.5

Assume all 99283 (1.73)

RVU's/Hour =

PV X RVU's/pt =

6.05 RVU's/Hr

- Critical Care

PV = 2.4

Assume an equal blend of 99284 and 99285

RVU's/Hour=

PV Times RVU/ pt =

9.49 RVU's/Hr

Creating the Risk Free ED

Protect Your Patient
Protect Your Practice

- ✓ **Best Practice #1**

  Ensure any patient with acute onset of testicular pain and clinical findings of torsion has:
  - **IMMEDIATE call to Urologist**
  - **Attempted manual detorsion**

  Treatment is immediate surgery

  WHY?

  Testicular torsion CAN be ruled in, definitively, on a clinical basis.

Testicular Torsion

Protect Your Patient

Protect Your Practice

- ✓ **Best Practice #2**

  Every patient with acute onset of testicular pain, <u>but</u> with equivocal findings of testicular torsion receives a color flow Doppler ultrasound

WHY?

Because torsion CANNOT, definitively and reproducibly, be ruled out on clinical grounds.

Testicular Torsion

Protect Your Patient

Protect Your Practice

- ✓ **Best Practice #3**

  Ensure any patient with acute scrotal pain and negative imaging study receives:

  - **Urologic consultation**
  - **Admission, placement in observation unit OR follow-up with urologist in AM**
  - **Careful discharge instructions**

  - **WHY?**
  - **Because the Gold Standard, Color Doppler, only reliably assesses current blood flow-spontaneous partial detorsion**

Testicular Torsion

Protect Your Patient

Protect Your Practice

- ✓ **Best Practice #4**

  Ensure prospective, proactive discussion with both radiology and urology regarding the use of color flow Doppler ultrasound

WHY?

Let's decide these difficult issues at 3PM on a sunny day instead of 3AM on a stormy night

Thank you

Thom Mayer, MD, FACEP, FAAP, FACHE
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