Questions-and-Answers from "Introduction to the Evidence" Webinar
Presentations by: Elizabeth Bradley, PhD, and Henry Ting, MD, FACC

Q: Are the strategies mentioned in this webinar ways of practicing better culture, team work, and communication? Or do you first need a foundation of better culture, team work, and communication before being able to work on the strategies?
A: Having these strategies as goals to achieve and working on them together can help build a stronger culture, team, and communication. It is very hard to sit in front of a group of people and tell them they need to communicate better. Instead, have the group identify a problem they all agree on that is important for clinical care and work towards solving that problem. That alone will start to build culture and make an enormous difference.

Q: How long does it take to change culture and achieve these goals?
A: It takes a long time. You will see some real shifts after a year, with more momentum building in a couple of years.

Q: When you take on a project like this, what level of support do you need (i.e. Board of Trustees or Governors, CEO, COO, CMO, department or division chair, nursing leader, pharmacy or ED director, front line staff)? Who do you really have to have on board and how much time should you spend getting those people on board vs. jumping in and trying something?
A: It depends on who will have a different role after the change has been implemented. For example, if the front line staff will have different roles, then they are the most fundamental group to have on board and be engaged. There may be instances in which the front line staff will not have to change their roles, because they're already doing exactly what needs to be done and communication is great at the front line. However, communication gets mucked as it travels up the hierarchy and sometimes what gets reported to the Board of Trustees is not what is really going on. In this case, you must get the top engaged by getting inside their heads and finding out what motivates them and what allows them to accomplish their goals.

Q: How do you recommend that we engage physicians, i.e. physicians that are not employed by the hospital or multiple competing physicians?
A: This has to be a multi-prong strategy. The first way is with science and data. As scientists, physicians like data. As competitors, even though it can make people uncomfortable, seeing how they are doing compared to their colleagues is very motivating. Of course the science has to be good and compelling; that is the way to make change. The second way is through determining what the physician needs to feel comfortable and good about his/her own identity as a physician, and goals as a business man or woman and as a professional. There is no one recipe because everyone is different, but the science alone will not do it. The third way is to reduce the bureaucracy and administrative work.

Q: Our hospital networks are getting bigger, so if we are to embark on a project like this one, how do you recommend we carry it out? Do we do it in all of our sites at the same time, or just in a lead hospital?

A: There are different approaches to making changes in an entire system. It depends on how individualistic the solutions have to be and how homogenous the network is. In heterogeneous systems, starting in the node can demonstrate to and inspire others to make a change. Selecting a set of lead hospitals that are well connected and able to provide adequate resources is a tremendous way to spread ideas and change because the interaction is peer to peer.

Q: You mentioned that how we work together should lead to the creation of the checklist, not the other way around. What is actually happening when the pharmacist rounds with the team, or during the monthly meetings with EMS, that leads to the creation of the checklists?

A: The recurrent theme is close contact between different people on the same team. What happens in the monthly meetings that is the most effective is people meeting each other and building a personal connection. Establishing this relationship creates trust and makes communication faster.

Q: Sounds like you are a big advocate of creating real, functional, effective teams across boundaries and silos that are virtual, not real. If we do this kind of work (none of the strategies are intended to decrease readmissions), do you think it can have an impact beyond mortality for acute MI?

A: Absolutely, if you can start to work towards developing this type of culture and adopt some of the approaches mentioned, the relationship that is built becomes the fabric that allows hospitals to either sustain high quality or innovate quality in a new place.