The Role of the Surgical Champion: Effective Engagement of Colleagues, Staff, and Institutional Leaders To Improve Patient Outcomes

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Objectives:

• Discuss characteristics and qualities of a Surgical Champion

• Examine the maturation of Quality Improvement in health care

• Review tactics for success as a Surgical Champion

• Test the strategy as a champion with a case study in process improvement.
THE ROLE OF THE SURGICAL CHAMPION

The Role of the Surgical Champion:
Effective Engagement of Colleagues, Staff, and Institutional Leaders
To Improve Patient Outcomes

A “Surgical Champion”
Need not be a Surgeon

Personal Traits:
• Engaging
• Collegial
• Inspired
• Committed

Colleagues, Staff, and Institutional Leaders
Effective Engagement
Improve Patient Outcomes

Who
What
Why
Every hospital should follow every patient it treats long enough to determine whether the treatment has been successful, and then to inquire “if not, why not?” with a view to preventing similar failures in the future.

Ernest Codman, M.D.

1914

End Result Idea

Data Collection

Peer Review

Clinical Analytics

Quality Improvement
Characteristics of a Champion

- Maintains a wide peer and social network, with extensive insight into how colleagues interact with each other.
- Credible and respected.
- Highly knowledgeable and current through a variety of sources.
- Shares knowledge generously with others.
- Supports and advocates for process changes.
- Engages new guidelines and serves as a resource for others.
- Welcomes contact and attends to issues.
- Demonstrates an interest in a spectrum of viewpoints.
- Flexible and controlled in the face of stress.
- Leads by example.
- Advocates for issues while respectful of other viewpoints.
How is a Champion successful?

- Establishes vision
- Engages support
- Asks questions
- Makes decisions
- Introduces skepticism
- Avoids foolishness
- Runs interference
- Encourages the troops
- Celebrates success
THE ROLE OF THE SURGICAL CHAMPION

1970

James Decker Munson Hospital
Traverse City, Michigan

Administrator

Assistant Administrator

Director of Nursing

Chief Engineer

Chief of Staff

Physicians

Surgical Quality – A Nursing Responsibility
The chief resident rotating on emergency surgery worked a night shift and was required to document all cases performed in the daily logbook.

An excerpt from the logbook records the cases performed on March 10, 1972.

- Gunshot wound to the neck with holes in the esophagus and thyroid cartilage
- Gunshot wound to the left femoral artery
- Perforated duodenal ulcer treated with a vagotomy and pyloroplasty
- Gunshot wound to the shoulder involving the veins and nerve

The staff that evening was Dr. J. C. Rosenberg, and he was in the hospital and available if needed.
The chief resident would also document in the logbook any problems. This included such items as:

- Suction in OR not working
- Pharmacy out of KCl times two days
- Bed check at 8 p.m. found five beds not on the admitting list
- There was no psych resident and ER filled with psych patients including the Governor’s son on drugs
- A third-year medical student on Medicine exhibited psychotic behavior. The surgery residents restrained, sedated and transferred him to the Detroit Psychiatric Institute.

Presidential Address – American Surgical Association
Surgeon as the “Captain of the Ship”

Physician is responsible for patient outcomes and quality

National Academy of Sciences Institute of Medicine

Non-Physician stakeholders define, measure, report Healthcare Quality
Surgical Quality – A Matrixed Responsibility

THE ROLE OF THE SURGICAL CHAMPION

Operational Platforms
- Inpatient Services
- Outpatient Services
- Perioperative Services
- Emergency Services

CEC (+MCP CEO) / FMCP Board (+FMCP President)
- Sr. VP Finance and Admin
- MCP Board Chair
- Dean
- FH President
- CFO
- CMO

Clinical Department Chairs
- MCP CEO
- FMCP President

SVP Service Line Development
- Hospital Presidents

Operational Platforms
- Cancer
- SOT
- Heart & Vascular
- Neurosciences
- Musculoskeletal
- Women’s Health

SL Vice President
- Cancer
- SOT
- Heart & Vascular
- Neurosciences
- Musculoskeletal
- Women’s Health

SL Director Physician
- Cancer
- SOT
- Heart & Vascular
- Neurosciences
- Musculoskeletal
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SL Director Admin
- Cancer
- SOT
- Heart & Vascular
- Neurosciences
- Musculoskeletal
- Women’s Health

Network Director Physician
- Cancer
- SOT
- Heart & Vascular
- Neurosciences
- Musculoskeletal
- Women’s Health

Network Director Admin
- Cancer
- SOT
- Heart & Vascular
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THE ROLE OF THE SURGICAL CHAMPION

Operational Excellence

Pillars:
- Knowledge
- Expertise
- Analytics
- Informatics

Foundation: Operational Leadership
THE ROLE OF THE SURGICAL CHAMPION

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Mission of Froedtert Surgical Services

We are committed to the highest standards of excellence to bring the value proposition to our patients:
Outstanding quality in patient care and safety, with reduced cost.
Core Values

**Patient Centered Care**
Thoughtful planning for every patient will be conducted so their experience and safety is optimized, including uncompromised care, pain management, protection of privacy, emotional support and alleviation of anxiety, empathy, technical excellence, and adherence to quality initiatives.

**Excellence**
We will strive to provide outcomes that meet or exceed national benchmarks with a continual commitment to quality improvement.

**Respect**
We will create and maintain an environment of care, where communication is highly valued; individual initiative is appreciated; resources are conserved; programs are created and administered with contributions and critiques welcomed from all participants; and all members of the patient care team are mutually respected and valued.
Safety
Because human life is fragile, we will create and maintain a workplace and systems of care to maximize the safety of our patients and health care workers. We will maintain a proactive reporting system for process improvement that encourages caregivers to provide information that will enhance our working environment.

Compassion
We will maintain the highest level of empathy for our patients, their families and loved ones. We will extend an equal level of concern to our colleagues and those with whom we collaborate to deliver patient care.

Stewardship
We will optimize use of resources and increase the value (quality/cost) of the care we provide.
Mission of Mortenson Construction

We are inspired by a compelling purpose: Building structures and facilities for the advancement of modern society.

Our purpose is fulfilled through our Mission: To create an exceptional customer experience.
Mortenson Values

**Trust**
We place trust at the center of every relationship—with customers, subcontractors, suppliers, architects, engineers and fellow team members.

**Teamwork**
People are our greatest strength. Mortenson people work with customers and business partners in a spirit of collaboration and trust to tackle the challenges of construction.

**Responsibility**
We are responsible to team members, customers, subcontractors, suppliers, architects, engineers and the communities in which we live and work.

**Safety**
We are committed to eliminating all worker injury. Every Mortenson team member and every customer, subcontractor, supplier, architect and engineer can expect that our work sites place their personal safety as our highest priority.

**Service**
We embrace a customer service culture. We believe our future is secured by advancing the interests and success of our customers.

**Stewardship**
We will perpetuate our business for future generations and support the communities in which we live and work.
### Froedtert Values vs. Mortenson Values

<table>
<thead>
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<th>Froedtert Values</th>
<th>Mortenson Values</th>
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Management by Walking Around (MBWA)

Popularized by Bill Hewlett and David Packard
Considered applicable to hospitals

• Stopping by to talk with people face-to-face
• Get a sense of how they think things are going
• Listen to whatever may be on their minds

Management by Walking Around (MBWA)

1. **Make MBWA part of your routine.**
   - Most effective if you don’t do it on any fixed schedule.
   - Do plan for MBWA on your own calendar.

2. **Don’t bring an entourage.**
   - MBWA works best as a continual stream of one-on-one conversations with individual employees.

3. **Visit everybody.**
   - Try to spend roughly the same amount of time – over the long run – with each person involved in the unit.
4. **Ask for suggestions, and recognize good ideas.**
   - Ask each employee for thoughts about how to improve processes or service.
   - Track suggestions to recognize contributors.

5. **Follow up with answers.**
   - Return with an answer.
   - Besides being common courtesy, it builds trust.

6. **Don’t criticize.**
   - You’re on a fact-finding mission.
   - The secondary purpose is building rapport.
   - Don’t attempt to solve problems on the spot.

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What are the most useful questions?

**Responsible**
- The person who actually carries out the process or task assignment
- Responsible to get the job done

**Accountable**
- The person who is ultimately accountable for process or task being completed appropriately
- Responsible person(s) are accountable to this person

**Consulted**
- People who are not directly involved with carrying out the task, but who are consulted
- May be stakeholder or subject matter expert

**Informed**
- Those who receive output from the process or task, or who have a need to stay informed
THE ROLE OF THE SURGICAL CHAMPION

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Makes Decisions
Making decisions requires a structured approach.
A Decision Diagnostic

Review a meaningful decision you’ve made.

Ask yourself the following questions:

1. Was the decision correct?
2. Was the decision based on appropriate facts?
3. Was it made with appropriate speed?
4. Was it communicated and executed well?
5. Were the right people involved, in the right way?
6. To the extent that there were divergent facts or opinions, was it clear how the decision was made?

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From The JAMA Network
Does Rigorous Quality Process Reporting Guarantee Superior-Quality Health Care?
Gary R. Selzner, MD

JAMA SURGERY
Timing of surgical Antibiotic Prophylaxis and the Risk of Surgical Site Infection

IMPORTANCE Timing of prophylactic antibiotic administration for surgical procedures is an area that is inadequately studied and publicly reported quality metrics are underused. The Veterans Affairs Surgical Quality Improvement Project (VASQIP) at the Veterans Affairs Medical Centers is associated with decreased surgical-site infection (SSI).

OBJECTIVE To determine whether prophylactic antibiotic administration is associated with SSI occurrence.

DESIGN Retrospective cohort study using medical records and data from Veterans Affairs Medical Centers' hospitals and medical centers from 2004 to 2005.

SETTING National Veterans Affairs Surgical Quality Improvement Project data from 62 Veterans Affairs Medical Centers' hospitals and 8 medical centers.

PATIENTS Patients undergoing open or laparoscopic, colorectal, gynecologic, vascular, and myocardial ischemia procedures from 2004 to 2005.

INTERVENTION Timing of prophylactic antibiotic administration with respect to surgical incision time.

MAIN OUTCOMES AND MEASURES Data for prophylactic antibiotic agent, prophylactic antibiotic administration with respect to surgeon's incision time, and patient and procedural risk variables were assessed for their relation with the occurrence of a composite superficial or deep incisional SSIs within 30 days after the procedure. Proportion generalized additive models were used to examine the associations between antibiotic timing and SSI.

RESULTS Of the 34,419 operations, prophylactic antibiotics were administered at a median of 38 minutes (interquartile range, 17-83 minutes) to surgical incision, and 1,047 cases (3.0%) developed SSI. Compared with procedures with antibiotic administration within 60 minutes prior to incision, higher SSI rates were observed for timing more than 60 minutes prior to incision (unadjusted odds ratio, 1.14; 95% confidence interval, 1.05-1.23). For inhaled general anesthetics, 1,474 (4.3%) developed SSI. For inhaled general anesthetics, 1,474 (4.3%) developed SSI. In unadjusted generalized additive models, we observed a significant association between prophylactic antibiotic administration and SSI at 1 hour following surgical incision (P < 0.05). In addition, in generalized additive models adjusted for patient, procedural, and antibiotic variables, no significant association between prophylactic antibiotic administration timing and SSI was observed. Vancomycin and hydrocortisone were associated with higher SSI occurrence for orthopedic procedures (adj OR, 1.75), followed by SSI occurrence for orthopedic procedures (adj OR, 1.75; 95% CI, 1.16-2.64). Cefazolin sodium and ciprofloxacin in combination with vancomycin were associated with lower SSI rates (adj OR, 0.46; 95% CI, 0.34-0.71; p=0.07; 95% CI, 0.35-0.87) for colorectal procedures.

CONCLUSIONS AND RELEVANCE The SSI risk varies by patient and procedural factors as well as antibiotic properties but is not significantly associated with prophylactic antibiotic administration. While there is no evidence that prophylactic antibiotic administration is not better care, there is little evidence to suggest that it is better care.

In a recent article in JAMA Surgery, Hwang and colleagues1 reported a focused and methodologically sound assessment of outcomes driven by measured metrics within the Surgical Excision Improvement Project (56). The retrospective cohort study used data from 32 Veterans Affairs Medical Centers' hospitals and medical centers to assess the risk factors associated with SSI in 35,878 patients. The study found that early administration of prophylactic antibiotics was associated with a lower risk of SSI, with a 41% decrease in the risk of SSI for patients who received prophylactic antibiotics within 30 minutes of incision compared to those who received antibiotics after 30 minutes. The study also found that the type of antibiotic used was associated with a lower risk of SSI, with vancomycin and the cephalosporin class of antibiotics associated with a lower risk of SSI compared to other antibiotics.

REFERENCE
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Parachute use to prevent death and major trauma related to gravitational challenge: Absence of randomised controlled trials

- As with many interventions intended to prevent ill health, the effectiveness of parachutes has not been subjected to rigorous evaluation by using randomised controlled trials.

- Advocates of evidence based medicine have criticised the adoption of interventions evaluated by using only observational data.

- We think that everyone might benefit if the most radical protagonists of evidence based medicine organised and participated in a double blind, randomised, placebo controlled, crossover trial of the parachute.

BMJ; 327:1459-60. December 2003
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The topic of “setting the tone” was not one that we originally set out to explore but arose during data analysis. Clinicians indicated that events in the preoperative phase of the case set the tone of the room for the rest of the case or even the rest of the day. Clinicians remarked that surgeons were key facilitators in setting the tone, as good communication led to an improved OR atmosphere. Conversely, early miscommunication or delays resulted in tension.

Greenberg, et al. JAMA Surgery
Online: September 28, 2016.
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Meaningfulness of Work

Coaching …

Praise, recognition, and acknowledgement matters a great deal.

But also consider …
that work is important when the results:

- are important to others. Transcendence
- have an emotional consequence. Poignant
- are focused at an event. Episodic
- are examined in perspective. Reflective
- are the result of a unique experience. Personal

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THE ROLE OF THE SURGICAL CHAMPION

Thank you
Your hospital identifies an increased incidence of surgical site infections for patients receiving total hip arthroplasty.

The infection prevention team is charged to investigate and create an action plan for process improvement.

Senior Leaders, Quality Improvement Staff
Champion, Content Experts
Project Sponsor, Process Experts
Team Leader, Stakeholders

What is the role of the Surgical Champion for this initiative?
**The Role of the Surgical Champion**

**Establishes Vision**

Because human life is fragile...
Provide clinical perspective on the implications of the pattern of infection.

**Engages Support**

Visit the clinic, day surgery, operating room, PACU, nursing unit, sterile processing department.
Initiate conversation with nurses, support staff, surgeons, pharmacy, EVS, managers, vendors.
Create project awareness outside of scheduled meetings.

**Asks Questions**

Instructions about pre-op shower?
Surgical skin prep?
Implant management / IUSS?
Peri-op antibiotics / timing?
Sequence of the operation?
Post-op wound care?
<table>
<thead>
<tr>
<th><strong>Makes Decisions</strong></th>
<th>Establish <strong>standard</strong> pre-op teaching. Add rigor to <strong>protocol</strong> for antibiotics. Introduce <strong>policy</strong> for dressing changes.</th>
</tr>
</thead>
</table>
| **Introduces Skepticism** | Suggest unlikely infection sources and vectors.  
If not lapses in skin prep or surgical technique, **why not?** What else? |
| **Avoids Foolishness** | Nix idea to culture every surgical wound every day.  
Balance against: *Introduces Skepticism*. |
THE ROLE OF THE SURGICAL CHAMPION

Runs Interference
- Provides updates for senior leaders.
- Escalates concerns.
- Secures resources.

Encourages the Troops
- Attends project updates.
- Supports individual initiative.
- Watches for frustration.
- Keeps attention focused on goals and the meaning of the work.

Celebrates Success
- Acknowledges individual efforts.
- Broadcasts details of project outcomes at leader forums.