# Quality and Safety Series, Season 1, Episode 1:
# The Challenge of Buy-In

The speaker is Christine Bailey, Quality Improvement Organization Executive Director, HSAG.

Speaker 1 (00:02):

Today, our objectives are to really define what buy-in is. Discuss the importance of buy-in and identify some methods for achieving buy-in. So, what is buy-in? You know, we use the term to really describe active support, belief, and enthusiasm for an initiative. And without that buy-in from key persons within your hospital, a project is destined to fail. It is so important to get that buy-in before you really launch a full-scale project. So, what are the keys to successful buy-in? Engage frontline staff, visible C-suite, reinforcement, and physician or provider support. I like to use the term with them: what's in it for me? What is important to them to make something sustained? Well, the same thing when you are trying to get buy-in. You have to know your audience and answer that question, what's in it for them? Why should they do this?

Speaker 1 (01:06):

To know your audience, when you have to appeal to your audience based on what motivates them. If I know I'm presenting something and trying to get buy-in from C-Suite, I'm going to look at patient safety, financial satisfaction, and employee retention. For my frontline staff, I'm going to talk about improved workflows, easier automatic processes, and improve patient outcomes. Same things for the physicians and providers. You know, data speaks so much to them. The evidence-based practice, improve patient outcomes, improved workflows, and I use patient stories a lot for any of these, but it really, really motivates the frontline staff and physicians. If you can find a true patient story of something that happened to a patient. One thing I learned with my Lean Six Sigma certification, you have a project charter and there always should be a C-suite sponsor. They can help you navigate some of the barriers and make decisions that sometimes stall a project.

Speaker 1 (02:16):

Getting that provider, a physician champion get them on board so they can have some of those difficult peer-to-peer conversations, especially when it's around changing practice. And then frontline staff. I know one of the things that I do frequently is I get my naysayers on the team. There's a reason, there's a reason that they are against an initiative. And once they see that their opinion's important to you, and then you start getting that buy-in from them and staff, other frontline staff will start to listen. So, other sources of pushback, you've probably all heard this because we've always done it that way. I worked in my early quality improvement days with a director and she was around for a very long time and was just a wealth of knowledge. And we would be in her office and talking about an initiative and she would open this massive cabinet she had and reach in and blow dust off of a notebook and say, oh, we did that in 1998.

Speaker 1 (03:28):

Oh, we did that in in 2000. So, sometimes it's hard to get past what we've always done it that way. And, and that also ties into the flavor of the month. So, you know, you have today or this month or this quarter, something's a big initiative. We push, we push, we make those achievements, and then we forget about it and move on to the next thing. So, you know, that is a big turn-off, and we really lose credibility as quality professionals. Sometimes,

as a part of quality improvement, you need to change your workflows for non-value-added steps. But a lot of times, a part of our work needs to make it less work for the caregivers. And you hear a lot of providers and physicians, you know, "this is cookbook medicine." And my response to that is, no, this is, you know, standards of care.

Speaker 1 (04:27):

These are our best practices, evidence-based practices. And if you think it's not right for your patient, just document that for us. We're, we're not telling you, you know, you have to do something one way if you don't feel it's right for your patient. So, buy-in strategies, there's various levels of resistance. Resistance Level One is: I don't get it. These folks need data. They need the literature behind those evidence-based interventions. Level Two: I don't like it. This group needs to feel some sort of emotional connection. And again, that's why those patient stories are so powerful, you know, to see how not doing the evidence-based practice or the right thing can hurt our patients unwillingly, but it still can have negative outcomes. And, and also these are the folks that you get on your change teams. Level Three: I don't like you and it's not so much you, it's just, I don't trust you.

Speaker 1 (05:37):

I don't trust what you're trying to do. And again, giving them data, showing them the evidence, and then making 'em feel a part of things so that they have a voice and they feel like they're heard. Include patient and family advisors or patient and family advisory councils. Again, that patient story and that voice of the patient and family is so important. And again, buy-in strategy concepts. So, providing provider championing champions, working with other providers. I can't tell you how important this is. If you don't get input from the providers and get buy-in and have that, have someone to have those peer-to-peer conversations, it is a lot harder. So, I mentioned "the elevator speech." When we are trying to propose something, we know people's time is very short. Your elevator speech should be no more than a minute, two at the most, or you start losing attention.

Speaker 1 (06:41):

It needs to be a very short, concise synopsis and persuasive. So, you need to have the intro, who you are, who your team is, and include a couple credentials, like, I am a registered nurse that has worked in the emergency department for 15 years and I have, you know, five years of experience really working with those that come in with opioid use disorder and overdoses. The next is your problem, who experiences the problem and the pain point. So, you know, we make referrals, but we lose patients because they go back and use because they fear the feelings and the side effects of withdrawal. You know, so that may be and this is where you want to briefly show, you know, our data shows we have 10 overdoses a month and five of them return either readmitting, re-overdose, or die due to overdose.

Speaker 1 (07:48):

So, real quickly, frame, frame that problem. If you know a business case and there's dollars attached to it, such as every central-line infection costs our hospital "X" amount of dollars that also can be worked in there. Again, very quick blurbs. Your solution and that's your hypothesis. So, this is how we want to change things to solve the problem. And then most importantly, what you want that person to do? Do you want them to be on all the team meetings or are you just going to meet with them monthly to debrief? What is the ask from them? So, again, organize it: the intro; the problem; the solution or your hypothesis; and what you want that person to do. So, our takeaways: prepare for those pushback pitfalls, prepare for the "we've always done it that way." And then,

obtain that key personnel buy-in [from] your C-suite, your providers, and physicians, and your frontline staff. Clear communication. And that includes listening to what they're saying when you're trying to find, you know, root causes of things and leverage your patient and family advisors. Again, those patient stories are so powerful.

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