

Towards Physician Acceptance, Trust and Collaboration: Incorporating Joint Commission OPPE into a Hospital-Wide Quality Improvement Program

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Abstract

The Ongoing Professional Practice Evaluation (OPPE) six general competencies have been part of The Joint Commission's evaluation standards since January 2008, but hospitals are experiencing various levels of success implementing quality-improvement programs that include OPPE. This paper recognizes the challenge of change that OPPE presents and the opportunities it provides for organizational performance improvement. It also highlights effective methods to gain physician acceptance, trust and collaboration to make OPPE and performance measurement in general an ingrained and welcome part of their practice and the quality-improvement culture of the entire healthcare organization.

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Whether they particularly like it or not, physicians are accustomed to having their actions judged — by their patients and their loved ones, other members of the care team, and the organized medical staff of the hospital(s) where they have privileges.

For many years, their evaluation by the hospital and its medical staff came at periodic reappointment (every one or two years), and was a somewhat basic — and often subjective — validation of their perceived competence, technical skill and judgment.

But more recently, The Joint Commission (TJC) and other accrediting bodies and payers have established more stringent guidelines for the *ongoing* evaluation of the professional practice quality of each medical staff member, across all departments and services. Called **Ongoing Professional Practice Evaluation (OPPE)**, the program features six core areas measuring a practitioner's clinical and behavioral competence. (*See the next page for overview of the six competencies.*) Evaluation is to be on a regular basis, such as every two, four or six months. This means more frequent scrutiny of their practice patterns — and the outcomes of their practice of medicine — than ever before.

Perfection and the Challenge of Change

Some physicians may not view this as a major change or reason for concern. Hospitals have already been delivering a variety of performance management data to them for some time. But as regulations and medical practice in general have become more complex — and data have become more plentiful — having a positive dialogue regarding the specifics of a physician's practice as part of the organization's quality-improvement program has become more challenging.

After all, by their very nature and the job they're challenged to perform, physicians want to be perfect - and don't generally like hearing when they're not. None of us enjoy criticism.

Also, being told that their method of practice is less than perfect means they have to experience *change*, which is typically a challenge for every human being. This is especially true for something as ingrained as an individual physician's (or a department's) daily practice of medicine.

Premier's QualityAdvisor™ and the Practitioner Profile

QualityAdvisor from Premier helps measure and report on metrics associated with most of the six OPPE categories, especially those around Patient Care and Systems-Based Practice.

But it's broader than just practitioner measurement; it helps identify drivers for outcomes improvement — benchmarking, trending and analyzing severity-adjusted performance.

- **Clinical outcomes** — Morbidity and mortality, readmissions, complications, hospital acquired conditions, patient safety indicators and inpatient quality indicators
- **Efficiency and cost analysis** — Opportunity analysis, length of stay patterns, cost per case, charge analysis
- **Resource utilization** — Quantities consumed (blood, pharmaceuticals), tests and procedures performed, population utilization, and variation in practice. Ties choices to outcomes
- **Other relevant criteria** as determined by the organized medical staff (for OPPE and FPPE) and other departments

QualityAdvisor can compare performance across several attributes — clinical population (DRG, diagnosis, procedure, etc.), physician, payer, resources, discharge status, patient demographics and more.

QualityAdvisor Practitioner Profile

- Supports regulatory requirements for re-appointment
- Familiarizes physicians with their data
- Identifies care practice variations
- Identifies opportunities to improve care processes
- Measures impact of improvement efforts
- Monitors ongoing quality and efficiency
- Reduces staff time for generating reports

The Practitioner Profile integrates CMS Core Measures compliance information for “one-stop” reporting. Outcomes are measured from industry-standard risk models, and data reliability is supported by more than 1,500 data validations.

QualityAdvisor is useful not only for the medical staff, but for executives, Pharmacy, Case Management, Quality, Finance and other departments across your organization in the joint quest to improve quality and decrease costs.

If you're the person tasked with sitting down with a physician to discuss practice variations as part of OPPE or any other performance-improvement initiative, you need to be prepared for the reactions you're likely to encounter. Thinking through the process ahead of time will help you move forward the conversation more quickly toward a positive dialogue and acceptance for implementing change — change designed to lead to broader implementation of best practices and achievement of improved outcomes.

Moving Through the Stages

An incredibly useful model for coping with all types of change — or any news people don't want to accept, for that matter — has proven to be one adapted from the [Elizabeth Kübler-Ross](#) model on the stages of grief (“On Death and Dying”), developed in 1969.

Remember that these stages are fluid; during the process, a person can go from a bargaining stage to denial and back again. So while predicting human behavior is not an exact science, the Kübler-Ross model *is* a useful foundation.

Stage 1: Denial. “This is not right! The data are incorrect!” In this initial stage, the data is in effect summarily dismissed. (Arguing that the risk-adjustment model is incorrect comes later, in the bargaining stage.)

The most common summary dismissal is this is *just* “administrative” data. In my mind, the term administrative is outmoded and relates to a former, less-complex time - when five or so discharge codes were applied only for the purposes of reimbursement. Today, a discharge abstract contains 36, 64 or even more ICD-9 codes so all comorbidities and complications can be effectively captured. Coders have long since learned that this data is being used for public reporting, quality improvement and many other purposes.

It's interesting to me that physicians who would expect and demand that data be captured in a codified way for use in a clinical trial will simultaneously dismiss the benefits of a coded discharge summary as “just administrative.”

Stage 2: Anger. “How dare you? Who are you to tell me this?” Don't be scared off of by this response. Expect it as a move in the right direction to the next stages. Remember...you may have to visit this (and other) stages more than once before positive and consistent forward movement is achieved.

Stage 3: Bargaining. You've reached the “Yes, but...” stage. “If you just had better data...if it were more clinical and less administrative...my patients are sicker and this doesn't take that into account...”

Here's where you can engage in a discussion of the validity of the data and the risk-adjustment model to help move the practitioner to the next stage.

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For example, Premier healthcare alliance member hospitals can point to the fact that they are using the largest clinical comparative database of its kind, used by more than 600 facilities in North America. It includes both inpatient and outpatient data, from all payers, representing one in every five discharges in the U.S.

The Premier risk-adjustment model itself has a solid foundation of reliability and credibility. Developed in conjunction with our members, it includes outcomes measures from industry-standard risk models, with more than 1,500 data validations.

Even that kind of evidence supporting the data you're presenting may not be enough. But you've reached a critical juncture in the road towards acceptance — you're now having a *dialogue* about the data instead of a total rejection of it.

Remember that you won't win every argument. You don't need to. But this is the perfect time to elevate the conversation: *"It's true; nothing's perfect. But wouldn't our time be of more value to our patients if we focus on what it can tell us, and what we can do about it?"* Keep the discussion about how — together — we can use the data to improve patient care quality and safety, as well as effective use of hospital resource - and the practitioner's time.

Stage 4: Depression. Practitioners don't typically spend much time at this stage, once they've gone through bargaining. They will either move on into the acceptance phase, realizing that they need to get on with the tasks at hand, or they will circle back immediately to anger and bargaining. Framing the exercise as one of quality improvement for the sake of providing exceptional patient care — rather than as an attack on professional competence — will hasten progression to the acceptance phase.

Stage 5: Acceptance. You made it! Now's the chance to move this practitioner and the entire medical staff in a more transparent process to not only satisfy the OPPE requirements, but more fully ingrain an organization-wide, ongoing professional performance improvement culture that they will support willingly.

How? Turning Data into Actionable Information... and Improved Outcomes

Data is necessary but not sufficient; to be useful it has to be transformed into *action*. To my knowledge, no one has ever *prevented* a hospital acquired condition (HAC) solely due to data in a report. Data have to be correctly presented, interpreted and put into consistent and best practice to positively impact outcomes throughout your organization.

Here are three thoughts as you prepare to turn your data into action:

Data for Judgment vs. Data for Improvement

The first step to making information actionable is determining how the data is to be used. Are we interested in using data only for judgment, or are we truly interested in finding opportunities for improvement? The first asks a rather narrow question: *"Is Provider/Department/Hospital A significantly better than Provider/Department/Hospital B?"* The second asks a broader question: *"Can we find an area where there is room for improvement?"* This certainly makes a huge difference in both practitioner acceptance and the overall value of the OPPE process and your performance improvement initiatives in general.

There's a significant danger in using data merely for judgment — you miss opportunities for real improvement. Because of the nature of the exercise, using data for judgment requires we minimize the number of false positives — instances in which we identify differences between practitioners, when in fact none exist. Finding true differences is often difficult, because we are often looking for small differences in practice patterns that, to a great extent, overlap. What's more, when you find and correct these differences, the overall impact to the organization is relatively small.

CASE STUDY: Linking Outcomes & Process

Scenario:

A hospital noted that a neurology practitioner's stroke patients had higher rates of aspiration pneumonia.

Finding:

Using QualityAdvisor from Premier, investigation into the stroke population found that aspiration pneumonia rates were higher in patients admitted on the weekend, as they had to wait longer for a speech and swallowing consultation.

Thus, study revealed not a practice variation, but a *process breakdown* causing decreased quality of care and increased length of stay and cost.

Opportunity:

The cost of care for each patient with aspiration pneumonia was ~\$5,000 greater than for those with no respiratory complications, an ~\$82,000 opportunity across the population.

But if you're truly using data for improvement, the task isn't to determine fine nuances of differences between practitioners. Instead, you should be asking: "If we see a group practicing on the far, high end of performance, why can't we shift the entire curve there? That is, why can't we move everyone up the performance scale?" Unlike using the data for judgment, here we're not very worried about false positives. In fact, just as with any screening exam, we can tolerate some false positives if it means not missing an opportunity.

So we must be very clear as we approach practitioners regarding OPPE that we are *not* in a "data for judgment" mindset. It's understandable they would think that we are; the word "evaluation" implies a judgment. Clearly, one small aspect of OPPE is to identify true performance outliers, but by definition these are few and far between.

If this is the only use of OPPE and the sole focus of the tools you're using, then the organization will miss out on a potentially large opportunity to make real strides in exploring special cause variation from a variety of viewpoints. The goal is to identify opportunities for improvement and "shifting the curve" not merely at the individual practitioner or departmental level, but at the system level.

So What IS 'Actionable' Information?

First, it's important to note that information will be actionable if it has a set of discrete characteristics; perfection does *not* happen to be one of these. In all of the characteristics that follow, a useful injunction might be "don't let the perfect be the enemy of the good." Find the balance between data that is good enough to accomplish the task at hand.

Information is actionable when it is:

- **Timely.** Reports that describe outcomes a year old won't be very useful for improvement purposes. On the other hand, "real-time" data isn't necessarily the goal either. Even with a sophisticated EHR, final diagnoses aren't usually assigned until discharge. Physicians don't change practice patterns all that quickly, so dismissing data barely a month old as "irrelevant" also isn't reasonable. Again, the concept of balance.
- **Accurate.** Obviously, reports riddled with mistakes will only serve to annoy, or as some have said will "generate heat rather than light." A best practice might be to "vet" a series of reports with a group of engaged physicians before a mass dissemination. However, there's a fine balance between justified concern with accuracy and the bargaining stage of grief previously described. If someone is seeking perfection where none can exist, perhaps this is a grief reaction rather than a response that will get the organization where it needs to be.
- **Relevant.** Nothing will generate "heat" quicker than cramming a report with irrelevant metrics. For example, displaying perinatal harm metrics to a cardiologist makes no sense. However, clinical leaders should remember that it's their role to work collaboratively with the hospital's analytic staff to determine a set of metrics that is relevant and practical.
- **Reconciled.** When information is reconciled, common definitions will be employed; that is, "variable cost" will be defined in the same manner for all reports. Nothing diminishes credibility more than a pair of reports

showing costs to be simultaneously too high and too low because the “cost” metric on each is defined in a slightly differently way.

- **Effectively presented.** Information must be displayed in a way that facilitates understanding. This is generally an overlooked aspect of reporting. Analysts composing the reports typically forget that not everyone will have seen it a thousand times and be able to overcome confusing jargon, abbreviations and a busy display of information.
- **Placed in context.** Too often, data is displayed without the proper context needed to give it meaning. For example, what does a single mortality statistic convey? Isn't it much more useful to see a trend of data points? If you're concerned with exploring length of stay, isn't it also necessary to simultaneously understand the readmission rate, the “observation” stay rate, and the severity of illness? Such “balancing” measures are often absent altogether, or placed so far away from the metric in question as to be useless.

The Power of a Physician Champion

Mindful of the fact that anger and bargaining are inherent parts of the change reaction — and also mindful that clinicians tend to let “the perfect be the enemy of the good” — you cannot underestimate the importance of a physician champion as an effective component of the improvement process.

The champion's role is very simple: to openly and constructively confront and diffuse the inevitable complaints and dismissals that will arise during the journey. In other words, the champion mustn't let others derail the organization's progress towards acceptance and true improvement. It isn't necessary for the champion to convert each and every “angry bargainer” to acceptance; this may be too large a task. The champion, however, cannot sit idly by as other clinicians — often senior ones — attempt to stall the process with a well-worn litany of complaints. Tact, diplomacy and a high degree of “emotional intelligence” are prerequisites for the role.

What Can be Achieved

Having an *operational* OPPE program has become a given. It's a Joint Commission standard for recertification and thus important to virtually every hospital. Having an *effective* OPPE program is another matter. Making your OPPE program truly effective requires framing it within the context of using information for improvement rather than judgment, and using “actionable” information to improve the lives of patients and staff alike.

More importantly, having a process and tools to effectively gain practitioner buy-in can and should lead to an organizational culture where physician performance reporting is part of a larger, transparent quality improvement process - where the organization can focus on delivering the highest level of care possible, rather than engaging in non-productive “grief” sessions.

By recognizing the inherent challenges of coping with change, understanding the Kübler-Ross model, providing “actionable information” and correctly framing the exercise in the context of institutional improvement, you'll be prepared to deal with roadblocks that will inevitably occur along the path towards improved performance and outcomes. And you'll be able to accelerate your organization's overall performance improvement initiatives and results.

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[View the video](#) highlighting a model for managing physician response to being measured, adapted from the Elizabeth Kübler-Ross model on grief.