

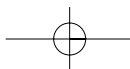
## Chapter 3

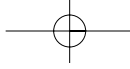
# How proctoring fits into current physician performance improvement models

---

As discussed in Chapter 1, proctoring has been used to both measure and improve physician performance. JCAHO's 2007 medical staff standards reflect a movement to place the proctoring activities of the medical staff into this context. In this chapter, we discuss these standards regarding physician performance and the performance improvement frameworks that can make them effective.

As noted in the Introduction, two new changes to the 2007 JCAHO medical staff standards affect physician performance measurement. The first change is the adoption of a comprehensive framework that defines the dimensions of physician performance for which medical staff physicians with clinical privileges should be held accountable. These privileges are called the General Competency Expectations for Physicians. The second change is JCAHO's reclassification of the measurement approaches for determining whether physicians on your medical staff meet these expectations. These approaches are now labeled Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE). Let's begin with the General Competency framework.





## Chapter 3

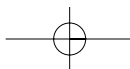
### The two changes

#### Defining your physician performance framework

The first questions you might ask with regard to proctoring are, “Why does our medical staff even need a comprehensive framework for physician performance? Haven’t we done just fine using traditional peer review of physician quality?” The answers lie in the definition of quality. For any product or service, quality generally has more than one dimension. For example, a quality car combines its mechanical features with its aesthetics, comfort, and service. But what about physician quality?

In the past, physician quality has been defined almost exclusively by its technical aspects. For example, a surgeon would be assessed on how well he or she performed a given procedure, or an internist would be judged by whether he or she prescribed the appropriate medications. Today, we recognize that, with the complexities of patient care, multiple dimensions of physician performance collectively define an excellent physician. Although each of us has a mental picture of what those dimensions are, using a mutually agreed upon, comprehensive framework for physician quality helps create a consistent and fair approach to evaluating physicians in the context of the organized medical staff.

Is having a comprehensive physician performance framework a new concept? The answer is clearly no. The Greeley Company has adopted a framework taught for years by the American College of Physician Executives (ACPE) for managing physicians’ performance in group practices and has applied it to hospital medical staffs. Based on Greeley instruction at national seminars, in publications, and through direct consulting, we are aware of hundreds of contemporary medical staff peer review programs that have used this framework to set expectations for physician performance and guide how those expectations should be measured.



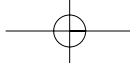
#### HOW PROCTORING FITS INTO CURRENT PHYSICIAN PERFORMANCE IMPROVEMENT MODELS

The six performance dimensions for this framework are based on the following sound human resource management principles:

1. Technical quality: Skill and judgment related to effectiveness and appropriateness in performing the clinical privileges granted
2. Service quality: Ability to meet the customer service needs of patients and other caregivers
3. Patient safety/patient rights: Cooperation with patient safety and patient rights, rules, and procedures
4. Resource use: Effective and efficient use of hospital clinical resources
5. Relations: Interpersonal interactions with colleagues, hospital staff, and patients
6. Citizenship: Participation in and cooperation with medical staff responsibilities

As noted, in its 2007 medical staff standards, the JCAHO provides a comprehensive framework for what is expected of physicians in an effort to guide medical staffs in developing their own performance measurement processes (i.e., the General Competency Expectations for Physicians). Instituting a comprehensive framework for measuring physician performance is fair to physicians and helps hold individuals accountable for their performance. This approach is not new to many medical staff leaders; the difference is the framework that the JCAHO chose.

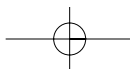
Notably, the JCAHO did not attempt to create its own physician performance framework. The General Competency expectations are identical to those implemented by

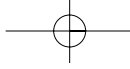


## Chapter 3

the Accreditation Council for Graduate Medical Education (ACGME) in 2002 for defining physician performance in residency training programs. The ACGME developed the model in conjunction with the American Board of Medical Specialties (ABMS) through the Outcome Project initiated in 1999, which held training programs and residents accountable by defining what they were expected to know and how they were expected to act as a result of their training. The resulting framework sets six performance dimensions and associated expectations, as follows:

1. **Patient care:** Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
2. **Medical/clinical knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, as well as the application of their knowledge to patient care and the education of others.
3. **Practice-based learning and improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care.
4. **Interpersonal and communication skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams.
5. **Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding of and sensitivity to diversity, and a responsible attitude toward patients, the medical profession, and society.

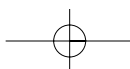
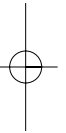
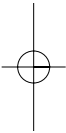




#### HOW PROCTORING FITS INTO CURRENT PHYSICIAN PERFORMANCE IMPROVEMENT MODELS

6. Systems-based practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided and the ability to apply this knowledge to improve and optimize healthcare.

As one can see, the JCAHO's General Competencies have somewhat different categories than does the Greeley framework for medical staffs outlined in this chapter. Although the framework has been useful with regard to residency training—and the specific elements that comprise these expectations are all relevant to practicing physicians—it is debatable whether the ACGME's categories or dimensions make sense when applied to physicians who have completed their medical training. The good news, however, is that both the ACGME and the JCAHO's frameworks are comprehensive, so medical staffs can easily choose the one that best suits their needs without fear of regulatory non-compliance. The crosswalk in Figure 3.1 compares the two frameworks.



## Chapter 3

Figure 3.1		JCAHO/AGME competency crosswalk				
JCAHO PYRAMID	Patient care	Medical knowledge	Practice- based learning	Interpersonal/ communication skills	Professionalism	Systems- based practice
Technical quality	X	X	X			
Service quality	X			X		X
Patient safety/rights	X		X		X	X
Resource use	X	X	X			X
Relationships				X	X	
Citizenship					X	X

### The second change: 2007 JCAHO standards for measuring physician performance

The goal for the JCAHO and ACGME frameworks and related expectations is to serve as a guide for medical staffs in measuring physician performance. The second change in the JCAHO standards is in how to classify physician performance measures.

As noted in the Introduction, the JCAHO's revisions to the medical staff standards for 2007 have increased the need for hospitals to focus on establishing physician competency through data. The goal is to have medical staffs use the General

## HOW PROCTORING FITS INTO CURRENT PHYSICIAN PERFORMANCE IMPROVEMENT MODELS

Competency expectations to evaluate physician performance. The JCAHO also has redefined the two types of physician performance evaluation it would like to see: Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE), both of which we discuss below.

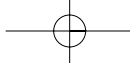
### Ongoing Professional Practice Evaluation (OPPE)

OPPE is the JCAHO's new term for the component of a medical staff peer review program that establishes routine measures or indicators of physician performance for current medical staff members. It includes individual cases identified for peer review through review screening criteria, as well as referrals for adverse events or aggregate performance measures such as rate, rule, or review indicators.

### The Greeley Company quality indicator classification categories

**Rate indicators:** This type of indicator identifies causes or events that are aggregated for statistical analysis before review by the appropriate committee or administrative function. This indicator may be expressed as a percentage, average, percentile rank, or ratio. Establish a target range for each rate indicator. Base it on best practices from benchmark data, statistical variation from the average, or internal targets.

**Rule indicators:** This type of indicator represents a general rule, standard, generally recognized professional guideline, or accepted practice of medicine in which individual variation does not directly cause adverse patient outcomes. Ideally, there should always be compliance, although rare or isolated deviations usually represent only a minor problem.



### Chapter 3

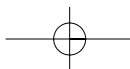
#### The Greeley Company quality indicator classification categories (cont.)

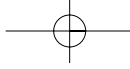
Review indicators: This type of indicator identifies a significant event that would ordinarily require analysis by physician peers to determine cause, effect, and severity.

*For more information on rate, rule, or review indicator, refer to Effective Peer Review: A Practical Guide to Contemporary Design, HCPPro, Inc., 2005.*

The first goal of OPPE is to obtain data for all six of the General Competencies, not just information on technical outcomes. This process requires a significant change for medical staffs that have not previously used some type of comprehensive framework for assessing physician competence. The second goal of OPPE is to make the evaluation of physician performance more timely so that identifying performance trends of current medical staff members is an ongoing activity, not just one that occurs every two years at reappointment. This allows for the opportunity to improve the individual performance prior to the reappointment decision.

OPPE is not the focus of this book. *Effective Peer Review: A Practical Guide to Contemporary Design* (referenced in the box earlier) addresses the methods needed to create an OPPE system that applies a comprehensive framework and has a real impact on improving physician performance on an ongoing basis. However, if the OPPE process results in the need for more specific evaluation beyond the routine measures after a potential trend is evaluated, then the organization moves to FPPE.





## HOW PROCTORING FITS INTO CURRENT PHYSICIAN PERFORMANCE IMPROVEMENT MODELS

### Focused Professional Practice Evaluation (FPPE)

FPPE is required when an organization lacks information regarding physician performance, and it generally occurs under three circumstances:

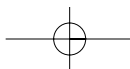
- The practitioner is not yet a medical staff member
- The practitioner has not yet performed the procedure for which he or she seeks privileges at your organization in the past
- There is a concern regarding the practitioner's current competency, either due to data from OPPE or because the practitioner has not used the privilege for an extend period of time

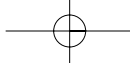
Proctoring, in its multiple forms described in the ensuing chapters, is one of the key methods of performing FPPE for all three of these circumstances. Our goal in this book is to help medical staff leaders and professionals understand and apply contemporary approaches to proctoring that make FPPE meaningful, effective, efficient, and fair.

### Making the new standards work for your medical staff

Once you have chosen how your organization will define and measure physician performance, the next step is to select the method that you will use in applying this data to actually improve physician performance. Note that this process does not depend on the JCAHO standards. In fact, it will depend greatly on your medical staff culture.

There are two approaches to dealing with physician performance: the “bad apple” approach and the performance improvement approach. The bad apple approach starts with the assumption that the only reason problems exist with physician performance



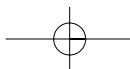


### Chapter 3

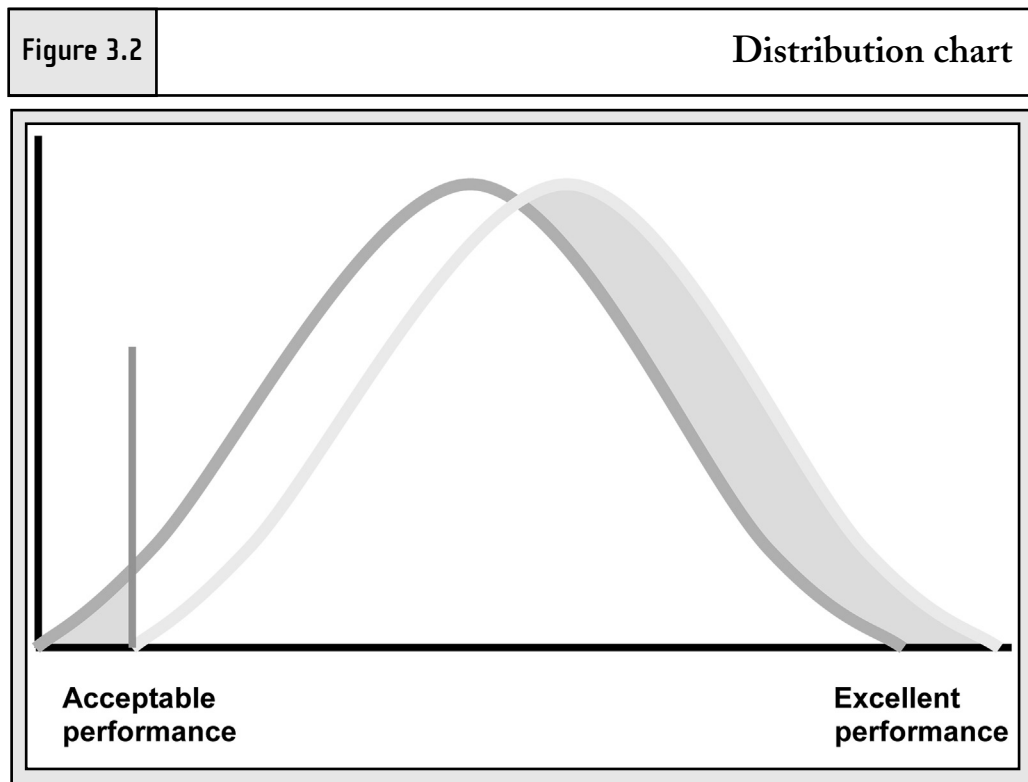
is that the few bad apples on the medical staff spoil the whole barrel. Conventional wisdom says that if you remove the bad apples, all the remaining apples will be fine. This approach assumes that the remaining apples are equally ripe, equally appealing, and equally delicious—something we all know is not true for apples. In fact, the quality of the remaining apples ranges from barely acceptable to superb.

Unfortunately, this truth also applies to physician performance. There is a range in individual skill, judgment, knowledge, and communication ability among practitioners. For that reason, simply focusing on improving (or removing) the poorest-performing physicians may mean that the rest of the medical staff is ignored. Nevertheless, many medical staff peer review programs continue to focus only on the bad apples. Under such a system, the overall care provided by the medical staff does not improve, and there is no opportunity to recognize the superior performers.

There is a better way. The chart in Figure 3.2 depicts the normal distribution of performance among practitioners on a medical staff. On the left side of the graph, the gray area under the curve shows the effect of eliminating only the bad apples. On the right side, the grey area shows the far greater effect of a performance improvement culture, which shifts the whole curve to the right. This approach helps marginal performers become good, good performers to become better, and better performers to become excellent. But how can your medical staff accomplish this goal?

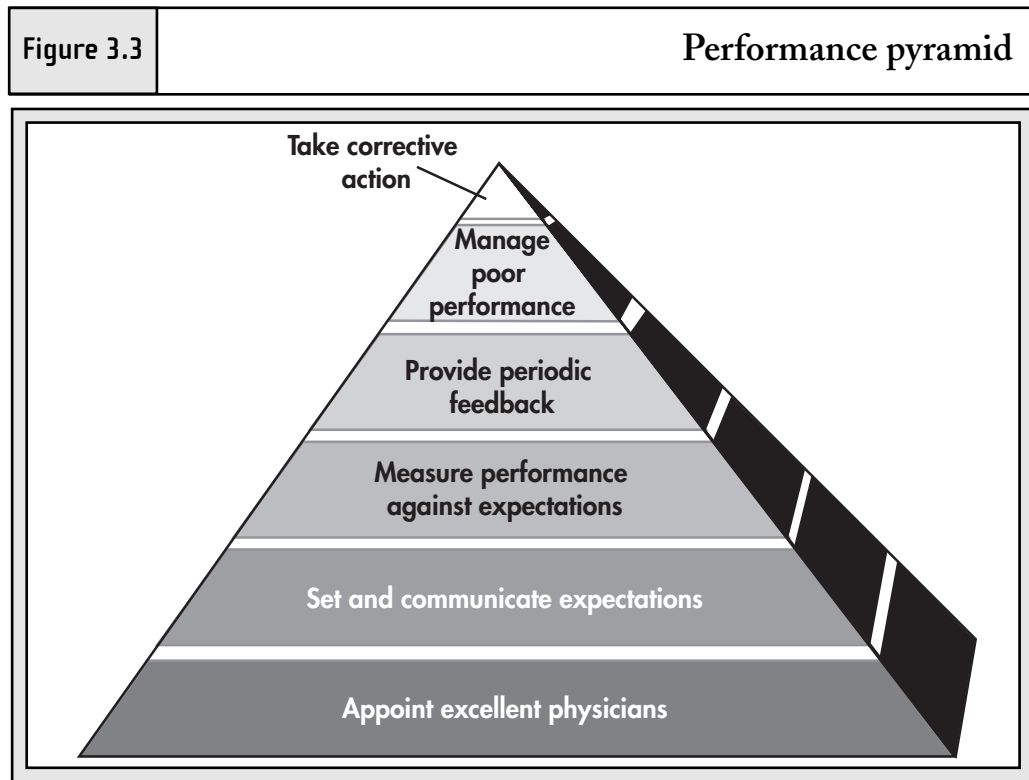


## HOW PROCTORING FITS INTO CURRENT PHYSICIAN PERFORMANCE IMPROVEMENT MODELS

**The performance pyramid model: a common-sense approach for creating a physician performance improvement culture**

The approach we recommend for creating a culture of performance improvement begins with the performance pyramid, shown in Figure 3.3. At its core, this approach is a basic human resource management tool. This model has been taught for years by the ACPE, and The Greeley Company has successfully pioneered applying this model to hospital medical staffs.

## Chapter 3



The pyramid is built of layers. Each layer represents an essential responsibility that physician leaders should carry out to optimize physician performance. The model is designed in the shape of a pyramid because the more time leaders spend on the base layers, the less time they will need to spend on the upper layers, especially on the disruptive and distasteful tasks of managing poor performers and taking corrective action. The following sections introduce the six layers of the pyramid and the role of each layer in improving physician performance.

## HOW PROCTORING FITS INTO CURRENT PHYSICIAN PERFORMANCE IMPROVEMENT MODELS

### **The first layer: Appoint excellent physicians**

If you start by bringing onto the medical staff practitioners who are well qualified and appropriate for your organization in the first place, you improve your ability to achieve the level of excellence in your staff that you desire. This layer involves adopting solid credentialing and privileging systems. However, don't just do the minimum required by regulations. Create and maintain the highest possible standards for medical staff appointment by requiring applicants to demonstrate excellence in all performance dimensions.

### **The second layer: Set and communicate expectations**

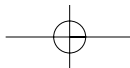
When a physician joins a medical staff, the medical staff leadership should tell the physician, in writing, what is expected of practitioners to achieve excellence at the hospital. Leadership should make clear what routines and protocols are used and are acceptable at the hospital. This one- to two-page document is a statement of the culture of the medical staff or, in simpler terms, a guideline of "how we do things here." Again, it should include expectations of all physician performance dimensions.

### **The third layer: Measure performance against expectations**

Once a hospital has established and properly communicated expectations to the medical staff, it must measure each physician's performance against those expectations. The basic premise—that measurement drives improvement—is the foundation of any successful quality program. Therefore, once these indicators are established, medical staff leaders must ensure that all physicians know that their performance will be measured, how it will be measured, and how it will be compared to that of their peers.

### **The fourth layer: Provide periodic feedback**

Nobody really knows whether they are meeting expectations unless they get periodic feedback on their performance. Therefore, provide timely and easy-to-follow feedback



## Chapter 3

to allow physicians to use this data for self-improvement. Also note that physicians must receive feedback when they perform well, not just when they perform badly. Remember, the goal is not to weed out the bad apples but rather to give all physicians the opportunity to improve.

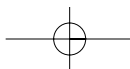
### **The fifth layer: Manage poor performance**

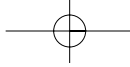
If a feedback report shows that a physician is not meeting performance expectations and the physician does not self-correct, appropriate leaders or mentors should meet with him or her to discuss self-improvement strategies. The leaders or mentors should help motivate the physician to change or eliminate unacceptable performance and should monitor the physician's progress. Medical staff leaders should not wait until a physician is up for reappointment to address performance issues—they should discuss such issues with appropriate physician as soon as concerns arise.

Managing poor performance is not the same as taking corrective action. It consists of a series of well-designed and well-executed interventions designed to help the physician improve. The first of these interventions should be collegial. If the physician does not improve his or her practices following an initial intervention, ensuing interventions should be progressively less collegial. The goal of these interventions is to help the physician be the practitioner best he or she can be.

### **The sixth layer: Take corrective action**

When all of the previous steps have been taken and a physician still fails to self-improve and his or her poor performance threatens quality of patient care, medical staff leaders must act. Corrective action is a formal process that involves loss of membership or privileges. Legal counsel should become involved at the first sign that a formal corrective action is or is likely to become necessary. In extreme situations,





#### HOW PROCTORING FITS INTO CURRENT PHYSICIAN PERFORMANCE IMPROVEMENT MODELS

complete termination of medical staff membership and privileges might be required. However, sometimes it is possible to change or limit the scope of a physician's practice to correct the situation.

With this background on the new JCAHO medical staff standards and a basic framework in place to apply them, let's move on to the specific details of proctoring and how to create an effective proctoring program.

