The Joint Commission
General Competencies: Setting expectations and measuring competency with perception data

Presented by

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Mark A. Smith, MD, MBA
Target Audience:
- Members of the Greeley Medical Staff Institute
- Medical staff officers
- Medical staff department chairs
- Medical executive committee members
- Developing medical staff leaders
- Senior hospital managers
- Governing board members
- Medical staff professionals
- Credentials Committee Chairs
- Credentials committee members
- Medical staff quality committee members
- Vice presidents for medical affairs/Chief medical officers
- CEO’s
- COO’s
- Governing Board Members

Statement of Need:
This audioconference program is to educate and train members of The Greeley Medical Staff Institute, physicians and administrative healthcare leaders to learn how to prepare for The Joint Commission’s increased focus on measuring physician competence beyond the technical aspects of care.

Educational Objectives:
At the conclusion of this audioconference, participants will be able to:
- Explain the impact of the Joint Commission adoption of the ACGME General Competencies on your medical quality measures.
- Define specific physician performance expectations for the non-technical competencies
- Describe the use of perception data to measure non-technical competencies
- Develop strategies to explore the use of perception data with your medical staff
The "The Joint Commission General Competencies: Setting expectations and measuring competency with perception data" audioconference materials package is published by The Greeley Medical Staff Institute, 200 Hoods Lane, P.O. Box 1168, Marblehead, MA 01945.

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Agenda

I. Overview of the General Competency categories and measurement challenges

II. What are your medical staffs expectations for the non-technical competencies

III. Understanding perception data tools and how it can be used fairly to measure physician competency

IV. Engaging your medical staff in the use of perception data: Do’s and don’ts

V. Q and A
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About The Greeley Medical Staff Institute

The Greeley Medical Staff Institute is a unique membership organization dedicated to serving the needs of hospital and medical staff leaders who recognize the importance of effective physician relationships to their hospital’s success. Members of the institute receive exclusive access to high-level, nationally renowned consulting experts—all physicians and former hospital leaders—who work closely with you and members of your staff to develop and implement a multifaceted relationship-building program. Each customized program is designed to reduce hospital costs, build effective medical staff leadership, develop a succession strategy, comply with regulatory requirements, meet public accountability for quality, and train staff to practice safe and effective medicine.
Dr. Marder is vice president at The Greeley Company. He brings over 25 years of healthcare leadership and management experience to his work with physicians, hospitals, and healthcare organizations nationwide.

Dr. Marder’s wide-ranging experience in senior hospital medical administration and operations management in academic and community hospital settings makes him uniquely qualified to assist physicians and hospitals in developing solutions for complex medical staff and hospital performance issues. He has consulted, authored, and presented on a wide array of healthcare leadership issues, such as physician performance measurement and improvement, hospital quality measurement systems, peer review management and improvement, hospital performance improvement, patient safety/error reduction, case management, and utilization management. Dr. Marder is also a member of the faculty of the American College of Physician Executives.

Prior to joining The Greeley Company, Marder held executive positions as assistant vice president for quality management at Rush-Presbyterian-St. Luke’s Medical Center in Chicago and vice president for medical affairs at Holy Cross Hospital in Chicago. He also served as the national project director for indicator development and use at the Joint Commission on Accreditation of Healthcare Organizations from 1988 to 1991. He is a board-certified pathologist and previously held positions as director of laboratories and director of clinical immunology at Northwestern Memorial Hospital in Chicago and as associate professor at Northwestern University Medical School in Chicago.

Dr. Marder is a graduate of Rush Medical College in Chicago. He received his residency training in pathology, with a fellowship in microbiology/immunology, at Rush-Presbyterian-St. Luke’s Medical Center.
Speaker profiles

Mark A. Smith, MD, MBA

Dr. Smith serves as the director of credentialing and privileging services and a senior consultant for The Greeley Company. He brings 25 years of clinical practice and hospital management experiences to his work with physicians and hospitals across the United States.

Dr. Smith’s clinical practice as a surgeon and multiple roles in senior hospital administration make him uniquely qualified to assist Greeley clients develop solutions to their complex staffing and managerial problems. Dr. Smith has an expertise in peer review and focused professional practice evaluation.

He is a fellow of the American College of Surgeons, Southwest Surgical Society, International Society of Endovascular Surgeons, and the American Board Quality Assurances and Utilization Review Physicians. He is a member of the American College of Physician Executives and the American College of Healthcare Executives.

Dr. Smith is a board-certified surgeon. He practiced as a vascular and general surgeon in Palm Springs, California, but is now a part time Vascular Surgery faculty member at University of California Irvine. Dr. Smith’s previous positions included president, chief of surgery, chairman of peer review committee, and medical director of cardiac surgery at Desert Regional Medical Center.

Dr. Smith is a graduate of Jefferson Medical College. He received his residency training at the University of Kansas Medical Center and had a fellowship at the Hospital of the University of Pennsylvania. Dr. Smith holds an M.B.A. from the University of Phoenix.
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Exhibit A

presentation by
Robert J. Marder, MD, and
Mark A. Smith, MD, MBA
The Greeley Medical Staff Institute

The Joint Commission General Competencies:
Setting expectations and measuring competency with perception data

Three Steps for Measuring Physician Competence

• Select a competency framework
• Set specific competency expectations
• Define measures for competency based on the expectations
Physician Performance Pyramid Dimensions

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

Joint Commission 2007 General Competencies Framework

- Patient care
- Medical/clinical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice
Comparison of the 2007 Joint Commission General Physician Competencies with the Physician Performance Pyramid dimensions

<table>
<thead>
<tr>
<th>JC. PYRAMID</th>
<th>Patient Care</th>
<th>Medical Knowledge</th>
<th>Practice Based Learning</th>
<th>Interpersonal/Communication Skills</th>
<th>Professionalism</th>
<th>Systems Based Practice</th>
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Step 2: Set Specific Competency Expectations

- What’s missing from the Joint Commission General Competencies?
  - Specific expectations that provide the basis to measure competency

- Why?
  - Because the Joint Commission adopted the framework from the ACGME but left the field to build the house
ACGME Competency Framework and Expectations

- See Attachment

Making the framework fit: Examples of attending physician expectations

- 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 at the end of life as evidenced by the following:
  - Achieve patient outcomes that consistently meet or exceed generally accepted medical staff standards.
  - Demonstrate caring and respectful behaviors when interacting with patients and their families
  - Counsel and educate patients and their families
Making the framework fit: Examples of attending physician expectations

- Medical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others as evidenced by the following:
  - Maintain ongoing medical education and board certification as appropriate for each specialty
  - Use evidence-based guidelines when available in selecting the most effective and appropriate approaches to diagnosis and treatment

Making the framework fit: Examples of attending physician expectations

- Practice-Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care as evidenced by the following:
  - Review your individual and specialty data for all dimensions of performance and utilize this data to for self improvement to continuously improve patient care.
  - Respond in the spirit of continuous improvement when contacted regarding concerns about patient care.
Making the framework fit: Examples of attending physician expectations

• 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 health care teams as evidenced by the following:
  • Communicate effectively with other physicians and caregivers, patients and their families through appropriate oral and written methods to ensure accurate transfer of information according to hospital policies.
  • Work effectively with others as a member or leader of a health care team or other professional group.

Making the framework fit: Examples of attending physician expectations

• Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society as evidenced by the following:
  • Act in a professional, respectful manner at all times and adhere to the Medical Staff Code of Conduct.
  • Respond promptly to requests for patient care needs.
  • Utilize sensitivity and responsiveness to culture, age, gender, and disabilities for patients and staff.
Making the framework fit: Examples of attending physician expectations

- Systems-Based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize healthcare as evidenced by the following:
  - Comply with hospital efforts and policies to maintain a patient safety culture, reduce medical errors, meet national patient safety goals and improve quality.
  - Provide quality patient care that is cost effective by cooperating with efforts to appropriately manage the use of valuable patient care resources.

Step 3: Define measures for competency based on the expectations

- Sources of competency measures
  - Current Measures
  - New Measures

Going beyond clinical data:
  The Brave New World of physician performance measurement
Types of Data for Measuring Competency

- Outcomes data (case reviews and rates)
- Resource use data
- Clinical process compliance data (chart abstraction)
- Documentation compliance
- Incident reports
- Perception surveys (patient satisfaction, peer and staff evaluations)
- Educational evaluation data
- Improvement data
- Patient Safety observation data

What is perception data?

- Views of others regarding our performance
  - Peers
  - Co-workers
  - Supervisor
  - Patients
Types of Perception Data

- Passive
  - Incident Reports
  - Complaints and Compliments

- Active
  - Evaluation Forms
  - Focus Groups
  - Surveys Forms
  - Interactive Surveys

- Is peer review of individual cases perception data?

Advantages of Aggregate Perception Data Tools

- Minimizes personal bias

- Allows for normative interpretation
Why have we minimally used perception data for physician performance?

- Lack of a comprehensive definition of physician competence
- Professional bias regarding value of opinions outside our profession
- Concerns about validity and attribution of tools
- Lack of administrative support

When should you use perception data?

- To evaluate performance related expectations:
  - when objective data is not available
  - for social interactions or interpersonal skills
    - Communication
  - not related to specific clinical privileges or well defined behaviors
    - Professionalism
### When is perception data a valid form of evaluation?

- When the perceiver is asked a question that they can have the ability to evaluate
  - Technical skills vs communication skills
- When the perceiver has a reasonable opportunity to observe performance
  - OR Nursing director vs Chief of Surgery

### What tools are available to obtain and use perception data?

- Department Chair evaluations
- Rule indicators for incident reports/complaints
- Patient satisfaction survey physician questions
- Teaching hospital student and resident evaluations of attending physicians
- Staff surveys based on ACGME resident evaluations
- Internal surveys of physicians and staff
ACGME-Based Professionalism Survey

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<th>1 poor</th>
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<td>is approachable</td>
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<td>Takes a genuine interest in the patient’s health</td>
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<td>Explains patient’s needs and concerns</td>
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<td>5</td>
<td>Answers questions from patients and families</td>
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<td>6</td>
<td>Communicates clearly and effectively</td>
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<td>7</td>
<td>Maintains patient’s privacy during exams</td>
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<td>8</td>
<td>Shows compassion and care</td>
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<td>2</td>
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<td>9</td>
<td>Shows respect for patients and families</td>
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<td>2</td>
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<td>10</td>
<td>Involves patient and/or family in decision making process</td>
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<td>11</td>
<td>Maintains appropriate behavior with patients and families</td>
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<td>Has good hygiene (e.g., washes hands, wears clean clothes)</td>
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Which Expectations Lend Themselves Best to Using Perception Data?

- Patient care:
  - Compassion
  - Education and Counseling

- Interpersonal and Communication Skills:
  - Clarity
  - Collegiality
  - Cooperation

- Professionalism
  - Behavior
  - Responsiveness
  - Sensitivity to diversity
Potential Expectations and Measures Needing Perception Data: Patient Care

- Expectation: **Demonstrate caring and respectful behaviors when interacting with patients and their families**
  - Patient satisfaction questions regarding physician bedside manner
  - Nursing survey questions regarding observations of physician-patient interactions
  - Incident reports/letters of complaints or complements regarding physician-patient

- Expectation: **Counsel and educate patients and their families**
  - Patient satisfaction questions regarding effectiveness of physician explanation of treatment

Potential Expectations and Measures Needing Perception Data: Communication

- Expectation: **Communicate clearly through appropriate oral and written methods.**
  - Patient satisfaction questions regarding physician communication
  - Nursing survey questions regarding clarity of physician communication (oral vs written)
  - Incident reports of illegible orders

- Expectation: **Work effectively with others as a member or leader of a health care team or other professional group.**
  - Nursing perception survey questions regarding of physician cooperation and collegiality
  - Incident reports of non-cooperation in healthcare team activities/policies
Potential Expectations and Measures Needing Perception Data: Professionalism

- Expectation: Act in a professional, respectful manner at all times and adhere to the Medical Staff Code of Conduct.
  - Incident reports of inappropriate physician behavior
  - Nursing and physician staff survey questions regarding physician professional demeanor

- Expectation: Respond promptly to requests for patient care needs.
  - Incident reports of non-availability when on call
  - Nursing and physician staff survey questions regarding physician responsiveness

- Expectation: Utilize sensitivity and responsiveness to culture, age, gender, and disabilities for patients and staff.
  - Nursing staff survey questions regarding physician sensitivity to diversity

Five Questions to Ask Before Getting Perception Data

- Who should you ask?
- How should you ask?
- How often should you ask?
- How will you interpret the data?
- How will you use the results?
Four Steps to Implement Use of Perception Data for Your Medical Staff

- Engage medical staff leaders in a discussion about perception data to obtain buy-in
- Involve physicians in the design by answering the 5 questions
- Pilot test any new approaches
- Educate the medical staff prior to roll-out
Joint Commission/ACGME General Competencies with ACGME Expectations

PATIENT CARE
Joint Commission: 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 at the end of life.

ACGME: Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:
• communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families
• gather essential and accurate information about their patients
• make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
• develop and carry out patient management plans
• counsel and educate patients and their families
• use information technology to support patient care decisions and patient education
• perform competently all medical and invasive procedures considered essential for the area of practice
• provide health care services aimed at preventing health problems or maintaining health
• work with health care professionals, including those from other disciplines, to provide patient-focused care

MEDICAL KNOWLEDGE
Joint Commission: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others

ACGME: Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:
• demonstrate an investigatory and analytic thinking approach to clinical situations
• know and apply the basic and clinically supportive sciences which are appropriate to their discipline

PRACTICE-BASED LEARNING AND IMPROVEMENT
Joint Commission: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care.

ACGME: Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:
• analyze practice experience and perform practice-based improvement activities using a systematic methodology
• locate, appraise, and assimilate evidence from scientific studies related to their patients’ health problems
• obtain and use information about their own population of patients and the larger population from which their patients are drawn
• apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness
• use information technology to manage information, access on-line medical information; and support their own education
• facilitate the learning of students and other health care professionals
INTERPERSONAL AND COMMUNICATION SKILLS
Joint Commission: 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 health care teams.

ACGME: Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates. Residents are expected to:
• create and sustain a therapeutic and ethically sound relationship with patients
• use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
• work effectively with others as a member or leader of a health care team or other professional group

PROFESSIONALISM
Joint Commission: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.

ACGME: Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:
• demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
• demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
• demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

SYSTEMS-BASED PRACTICE
Joint Commission: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize healthcare

ACGME: Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:
• understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
• know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
• practice cost-effective health care and resource allocation that does not compromise quality of care
• advocate for quality patient care and assist patients in dealing with system complexities
• know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance
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a 60-minute audioconference

Rick Sheff
Chairman and Executive Director
The Greeley Company