So how does an eight-hospital system decide to move its organization under HFAP’s accreditation process?

“We should start at the beginning,” says Christina L. Turner, MBA, MS, RN, NEA-BC, CPHQ, chief quality officer for Kettering Health Network in Dayton, Ohio. “Over the course of the last 12 years we have grown from two hospitals to eight. As we’ve added them, each hospital has come with different approaches to accreditation and different accrediting bodies.”

Until recently, accreditation has been handled individually by each hospital. As the processes already in place worked adequately, there was not an immediate need for change.

But about two years ago, one of Kettering’s board members called attention to a particularly discouraging survey one hospital had undergone.

“This was not because the hospital wasn’t prepared as far as that accrediting body’s standards were concerned, but because that individual hospital struggled somewhat with the CMS Conditions of Participation [CoP] validation survey,” says Turner.

After this particular survey, the board member suggested a more standard approach to accreditation across the system.

“We are an organization that subscribes to the Baldrige framework for management processes,” says Turner. “One of the key concepts is you take best practices to drive improvement efforts. You learn from those efforts, pilot small tests of change, standardize...
what works, and spread those improvements across the organization. This allows us to expedite our improvement and standardize what works well.

One area to which Kettering had not yet applied that process was accreditation.

“We pulled together an interdisciplinary group with representatives from all of our hospitals. Included in this group were the individuals who were campus leaders for accreditation,” says Turner.

The group, chartered by Turner and comprising several nurses, a few physicians, and various accreditation professionals, fell under the purview of quality.

“We came together and talked about the different pros and cons of each accreditation organization,” says Turner. They created a decision grid, which looked at such concepts as:

- Survey cycles
- Cost
- Available resources
- Educational opportunity
- Alignment with CMS CoPs

The group explored the three approved accrediting bodies at the time, The Joint Commission, HFAP, and Det Norske Veritas, Inc. (DNV), and weighed the advantages and disadvantages—their philosophies, their survey processes, and more.

Note: As of April, the Accreditation Association for Ambulatory Health Care has launched an accreditation organization for hospitals.

“One of the drivers we looked at was cost,” says Turner. “We saw this as an opportunity to look at where we had each hospital with its own process and create a centralized function and knowledge sharing across the system. In a time where reimbursement is changing and the public is asking us to be more accountable for the money we spend, sharing resources, expediting improvement, and standardizing our approach were all of huge importance.”

Alignment with the CoPs

The next focus area for the group was how each hospital aligned with the CoPs.

“One of the biggest surprises came when we started looking at the standards and how they were measured, and how far off from the CoPs they were, or how many extra or additional things that were not related to patient safety, quality initiatives, or the CoPs that were included in the standards,” says Turner. “When you start looking at value-added work, there seemed to be a lot of things that weren’t related to those areas.”

The number of accreditation body-specific standards that couldn’t be tied back to those additional areas was surprising, she says.
“Those are the things when you look at preparing for survey that take extra time,” says Turner. “It’s hard to explain to staff why they are important. The purpose of accreditation is to demonstrate that the organization has met the requirements to provide safe care. When you get criteria that aren’t tied to that, it becomes bureaucratic.”

The surprise move

At the time, Kettering consisted of six Joint Commission–accredited facilities and two HFAP-accredited facilities. Several had been exploring moving to DNV and had begun the research process, but none had yet made the jump.

“It would seem like the preconceived notion of people who knew we were embarking on this process was that we would move to The Joint Commission,” says Turner. “The majority of our facilities were already Joint Commission accredited and the biggest two hospitals among the eight were with The Joint Commission. It would have been easier to move two hospitals to The Joint Commission.”

Or so one might think.

But the Kettering system did something unexpected: It resolved to shift all eight hospitals under the HFAP umbrella.

“The biggest factor overall was alignment to the CoPs,” says Turner.

When looking at the standards as they existed in 2009, she says, The Joint Commission’s standards were derived from the CoPs (i.e., they could be connected back to the CoPs), but the accreditor also had standards that were not directly tied back in this fashion. HFAP’s standards were laid out in the same format as the CoPs and were simpler to trace back to the source.

“They used the exact same language as CMS,” says Turner. “There was no room for interpretation or finessing the standard back to the CoP it related to.”

The team was also impressed with how HFAP explained what it was looking for, laying out evidence of compliance in a road map for the survey itself.

“It’s very easy for us to have our accreditation team go through the organization, through the standards, and tell exactly the best practice to get us to compliance and where we are not meeting the standard and why,” says Turner.

Turner and her team also identified HFAP’s nod to the National Quality Forum’s recommendations.

“It makes it very easy when you’re trying to connect the dots, explaining why it is important to us and our patients,” she says.

Bringing in the accreditors

Kettering’s decision was nearly final when it reached out to HFAP directly. The system sat down with leaders from the accrediting body and discussed where it was in its decision process.

One of the trickiest parts of changing accrediting bodies—whether DNV to Joint Commission, Joint Commission to HFAP, or any other combination of moves—is timing the transfer.

“We wanted to make sure we didn’t have any more overlapping time than we had to,” says Turner. “We tried to time it so that we would know what our accreditation status was and if we were terminating with The Joint Commission we could serve the proper 90-day notice and not pay for the next survey.”

Kettering did not, however, reach out to The Joint Commission until it had all of its plans in place.

“We’d talked to other organizations who had moved away from The Joint Commission and we had a lot of feedback from them to delay that notification as long as possible. The feedback was that early notification could create a lot of additional and unnecessary work,” notes Turner.

“It’s not punitive, and because it connects back to the CoPs, it’s not an interpretation, it’s exactly what you need to comply. It’s been a really positive experience.”

—Christina L. Turner, MBA, MS, RN, NEA-BC, CPHQ
Organizations must have a plan in place to address any deficiencies in their last survey, and Kettering didn’t want to have to manage a correction with The Joint Commission while simultaneously transitioning to HFAP. That being said, however, Turner notes that The Joint Commission’s reaction to Kettering’s decision was gracious and involved none of the problems other organizations had mentioned.

“Maybe it was urban myth, but once they knew we were leaving we didn’t have any of the problems other organizations had talked about,” says Turner. “We did have a phone call with them, and they wanted to know if there was anything they could do to change our minds, and what they could do better, as well as what it might take for us to come back.”

Prior to the phone call with Joint Commission representatives, though, the organization was concerned about drawing undue attention to itself and the switch.

“We struggled with that. We wanted to be very transparent and have very open conversations with our staff and leadership, but we were concerned that information would get back to The Joint Commission and out in the community and open us up to an increased level of scrutiny,” says Turner.

Resistance, or lack thereof

It was interesting, says Turner, that the mandate to investigate a move to one accrediting body for the network didn’t spur a lot of resistance.

“We kept everyone involved all along the way,” she says. “We let them know what the comparisons were telling us, where we had risks.”

Of course there must have been grumblings somewhere in the organization, but there was no public outcry or active resistance to the move.

“I’m sure there were people who were upset. Most people don’t like change,” says Turner. “But I think we did a really good job of demonstrating why we made this decision.”

One challenge Turner did find in advocating the transition was HFAP’s lack of public notoriety.

“HFAP has been around a long time, but by and large we’ve found lots of places aren’t aware of who they are or that they’ve been around so long,” she says.

The Joint Commission and DNV have a higher level of visibility for a variety of reasons, Turner notes.

“It was something I wasn’t prepared for,” she says.

“We were aware of them, but it’s been surprising how few people are familiar with HFAP.”

Another matter of confusion is HFAP’s connection to the American Osteopathic Association (AOA). “Those who were somewhat familiar with HFAP still associated them with osteopathic hospitals,” says Turner.

While HFAP falls under the AOA as a business, it is not an osteopathic-specific accreditor or survey process. The vast majority of its physician surveyors are, in fact, MDs rather than DOs.

Since making the transition, Kettering has seen one particular improvement that has left leadership very pleased: a better understanding among staff regarding the CoPs.

“We had had other hospitals go through successful surveys with other accrediting bodies who weren’t able to speak well to the CoPs during a CMS survey,” says Turner. “They could speak to the standards, but weren’t able to trace it back.” A particular hospital would perform impressively during the accreditation survey, but during its CMS validation survey, that same facility would struggle.

This has improved since bringing all facilities under HFAP. In addition, Kettering has seen the benefits it hoped to see. The knowledge gained from each survey was evident because changes from previous survey recommendations were incorporated across the system.

“I have to tell you, having gone through different surveys—they’re never fun. You are descended upon by surveyors and they look in every nook and cranny. But [the HFAP process] is truly an educative process,” says Turner. “It’s not punitive, and because it connects back to the CoPs, it’s not an interpretation, it’s exactly what you need to comply. It’s been a really positive experience.”
You might even go one step further by stressing to the medical staff the pressure on healthcare organizations to “objectify” quality, he says.

To that end, Sbardella says, the medical staff is responsible for policing itself. “We have to show people on paper that we’re doing that,” he says. “We need to show that we’re watching, and what outcomes we’re looking for, as opposed to saying we’re doing a good job.”

The other challenge in communicating this still-new concept to the medical staff world is closing the feedback loop. Even for those physicians currently undergoing FPPE, it needs to be clear that the process exists to improve the overall system and benefits quality of care in the long run, both for the individual practitioner and the organization as a whole.

And all of this must happen without appearing punitive, Sbardella says. “If we’re using the FPPE process to oversee a quality concern, there is a punitive aspect to that,” he says. “Physicians get defensive.”

To circumvent that, Hallmark Health’s approach has been a mantra of making the FPPE process about overall improvement of care—looking for ways to improve the process rather than lay blame.

**Tactics for implementation**

FPPE comes into play when evaluating new medical staff applicants, as well as current practitioners applying for new or additional privileges at the organization, for credentialing purposes. It allows the receiving organization to evaluate competency when it does not have firsthand evidence of that practitioner’s competence in a given area.

FPPE may also be used to evaluate a performance issue. This is where physicians most often sense a punitive aspect to the approach.

Lastly, FPPE can be used in cases where the physician may have less than the minimum recommended number of cases per year to maintain competency.
Obviously, these different uses present different levels of difficulty.

“The new appointee aspect is pretty straightforward,” says Sbardella. “It involved spending a lot of time with medical chiefs educating them with respect to the need to validate the quality of their new hires. That was the easy piece. We said, ‘We want you to show the medical staff how wonderful this new person is.’”

New procedure FPPE was similarly an easy sell. “Someone wants to get privileged for a new procedure—how do we know they can do it?” says Sbardella.

Proctoring and monitoring was not a new concept to the staff, either. “We spent a lot of time going through the professional review process and building a case of quality trends,” says Sbardella. “If there was an issue that was trending, it was something we needed to address and oversee.”

Because of this shift in perspective—objectifying quality—explaining how this would be addressed took the most work drawing medical staff members’ support.

“They asked the question, ‘Well, how are we going to know we’re getting better?’” says Sbardella.

First and foremost, the organization immediately made it clear that FPPE could only be recommended by a small group of people—the chiefs of service, with the support of the professional review committee and the medical council—and those people would be bound by a series of checks and balances.

“We make sure the issues we need to watch over have been vetted before we institute this,” says Sbardella. “It can’t be handled willy-nilly.”

The practitioner then signs on to the process as if he or she is signing a contract. He or she knows what’s going on, what’s being looked for, what’s going to happen, and whom the outcomes will be reported to.

“They get a sense that their peers are participating in the process,” says Sbardella.

It has taken a while for medical staff leaders to feel comfortable watching over their colleagues. “It took a lot of legwork,” says Sbardella.

A culture shift

FPPE and objectifying quality make logical sense, but what must be taken into account in every case is how much of a culture shift these processes mean for physicians. A core change in relationship building is required.

“You want to be confident that your colleagues can do what you trust they can do, so when issues come up we don’t present them in a negative way,” says Sbardella.

“There’s a trend here—let’s figure out why. Maybe it’s something around the practitioner, not the physician himself. It’s not a punitive process. It’s a process to make something better.”

That kind of relationship building is the culture shift in a nutshell. Everyone believes they are good at what they do, and everyone says they are good at what they do, but they are now required to identify and fix issues as they arise.

“We’re still trying to sell this,” says Sbardella. “It’s getting physicians to commit the time and effort to try to help one of their own and move forward. That’s the

A goal of self-reporting

While the existing FPPE process is successful, Steven P. Sbardella, MD, FACEP, FABC, and his team have an even bigger goal for the future. “My goal is to have people self-involve and self-report, to become part of the solution,” he says.

A new physician might walk in thinking, “I’m new to your staff. Let me show you what I can do.”

“It’s an opportunity to highlight themselves, as opposed to becoming defensive,” says Sbardella, medical director of quality and chairman of emergency medicine at Hallmark Health System. “I would love to see people be a part of the design process so they know, at the tail end, that they will be better. That’s the golden fleece.”

And Hallmark Health is close, he says. Feedback from physicians has been mostly positive. “If the end game is people are going to think better of you and have more confidence in you, if you go through the FPPE process and you come out glowing—why wouldn’t you want that?” he says.

FPPE is here to stay, after all. Why not embrace it?
focus of this. Sometimes it's very successful. Sometimes you find things that won't get better and you have to deal with it.”

The latter, though, is very uncommon, he says. In almost all cases, any issue that arises can be addressed and resolved.

“This is our family. We all practice together. Let me help you get better,” says Sbardella. “We’re very protective, and we want this process to be done in a respectful manner and done with dignity.”

Accusatory words are never used, and the organization does not permit hallway conversations—the process must be handled with the utmost professionalism.

One physician’s reaction to watching the FPPE process unfold firsthand was very telling. “I had one physician say that if this situation ever happens to me, I hope you treat me the same way you treated this person,” says Sbardella. “That tells me we do have a relatively clean, dignified process.”

A labor-intensive process

Despite having achieved a great deal of success with the FPPE process, Sbardella identified one facet of the development process he wished he’d known from the start. “If I knew how labor-intensive this was, I would have spent more time trying to educate the leaders of the medical staff that this was important,” he says. “I’ve found out in terms of time commitment that there is no easy technological way to do this. It’s all people power.”

It’s also easy to be confident of your process on paper, but you need to be prepared to quickly correct any design flaws, he says.

“We came out of the gate thinking we had a great product, and it looks good on paper, but when you try to implement it” you can see the design flaws, Sbardella says.

Another challenge is that physicians rarely practice at only one hospital.

“It’s person to person and institution to institution,” says Sbardella. “You assume what we are doing is being done at another institution, but it may not be. Everyone is not at the same point. It makes it difficult. You count on people giving you information and not having to reinvent the wheel.”

Sbardella says if he could wave a magic wand to make the process easier, he would create a base standard that every hospital must meet.

“I think [the regulatory bodies] are as close as they’re going to get to that,” he says. “I want something to be standardized, and then let an institution expand on the concept if they want to.”

The community hospital challenge

Developing FPPE for a community hospital comes with a unique set of pros and cons, Sbardella notes.

“You can’t hide among the thousands” as you could at a large teaching hospital, he says.

“It’s more difficult to implement because there isn’t a constant influx of new blood to help the culture change quickly.”

But this can also work in a community hospital’s favor, with more direct access, more face-to-face interaction, and closer professional relationships.

Sbardella points out that all hospitals are in this together.

“I would have no problem with anyone coming in here and asking what we’re doing,” he says. “We’re sometimes afraid to talk to each other. It’s not rocket science. It’s not proprietary. It’s just process.”

This sort of sharing is most helpful given how often facilities are trying to comply with FPPE on limited resources.

Scarcity is a particular challenge in community hospitals. Without the richer resources of an academic institution or tertiary hospital, implementing a process like this can be quite a hill to climb.

“One piece that’s difficult, I think, is determining how to get physicians who are in an unfunded leadership
role to want to do this,” Sbardella says. “That’s the key. A lot of hospitals have unfunded leadership, with physician leaders who enjoy the role” but are not financially rewarded for the additional time and energy.

And then there’s balancing time and efficiency. It isn’t sufficient to merely demonstrate that your organization has put in the man hours and ticked off the right boxes—you also need to show that you’re doing it right. This means not just working hours, but cerebral hours brainstorming the process.

FPPE is fundamentally an organic process. Each new experience adds to the pastiche and helps grow the process.

“We’ve been doing this for five years,” says Sbardella. “We haven’t done it the same way twice. We keep modifying and improving it.”

While the process itself is forever a work in progress, Sbardella says that it grows less complex rather than more so—his organization is striving to make the FPPE process efficient and simple.

Having a core team of four to five people work on this ongoing project has been instrumental in keeping it simple. New voices are added regularly to bring in fresh ideas, but the same team has been involved from day one.

This combination of perspectives continues to work.

“You have to have the willingness to look at it with open eyes, a willingness to say this could be better,” says Sbardella. “It’s more of an art than a science. Medicine is an art as well, but it’s data driven—it’s hard to tell someone it’s a work in progress.”

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**Questions? Comments? Ideas?**

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**Emergency hospitalization for ADE**

Two U.S. senators have called for the Department of Health and Human Services to convene a task force to develop strategies to reduce unnecessary hospitalization related to adverse drug events.

CMS recently amended tag number 508 in the hospital Condition of Participation (CoP), which sets forth the standards for hospitals on adverse drug events (ADE). This memo was issued May 20, 2011, and is contained in the updated hospital CoP manual that was released December 22, 2011. It requires hospitals to have a national definition of what constitutes an adverse event. CMS discusses the definition developed by the American Society of Health-System Pharmacists. Any ADE must be documented in the hospital medical record and the attending physician must be notified.

Sens. Michael Bennet (D-Colo.) and Olympia Snowe (R-Maine) cited a recent study that was reported in the *New England Journal of Medicine*. The study found that two-thirds of hospitalizations due to ADEs were related to four common medications: warfarin, insulin, oral antiplatelet agents, and oral hypoglycemic agents. The study suggested that many of these ADEs are preventable.

Recommendations included developing easier-to-understand patient medication guides. This could include the provision of the transition of care to help coordinate medications. Two-thirds of the admissions were due to unintentional overdose. Half of the hospitalizations were among adults aged 80 and older.

Strategies for increasing physician engagement

After reading this article, you will be able to:

➤ Describe methods for alleviating physician concerns when addressing Joint Commission standards
➤ Identify specific Joint Commission standards where problems of timing and dating of medical records is addressed

Editor's note: Guest columnist Kate Smith, RN, is director of quality improvement at Newton Medical Center in Covington, Ga.

In the quest to meet Joint Commission standards, it is very helpful to have a highly engaged medical staff. While usually not employed by the hospital, the medical staff is key to the hospital's success in meeting many of the Joint Commission standards. But how does a healthcare facility get physicians to care about the success of a hospital?

There are some strategies that a hospital can utilize to increase the collaboration and level of participation of the medical staff. Some hospitals have tried forcing the issue through requiring attendance at all meetings, and making in-services and workshops mandatory. But does this really engage the medical staff? Or does it create resentment?

This article will focus on positive strategies to help a hospital create a collaborative, supportive, and symbiotic relationship with the medical staff. As Henry Ford said, “Coming together is the beginning, keeping together is progress, working together is success.”

Consider the physicians’ concerns

One of the most effective strategies for successful physician engagement may also be one of the simplest: Take a step back and listen to what physicians are saying. This helps build trust, which is the foundation for any productive partnership. Avoid focusing your first conversation with a physician on what he or she can do for you. Instead, get the physician’s input on where he or she sees opportunities to improve processes and performance, and put yourself in a position to deliver something from that conversation.

These early conversations with physicians can also provide insight into the quality of communication within an organization, and whether the goals of physicians and hospital administration are aligned or contentious.

When good interpersonal dynamics exist, it is often easy to determine expectations from both sides as well as predict the level of cooperation expected at the outset. In situations where relationships could be strained, one-on-one meetings with physicians will yield details on the issues that present challenges, the roadblocks to navigate, and the potential solutions.

Cardiologist Mark Hanson, MD, chief of staff at Newton Medical Center, says, “Whether or not I’m going to agree, I appreciate that I understand what the hospital is doing and why. Transparency builds trust and will go a long way toward resolving any conflicts with medical staff.”

Once the concerns of the physicians are known, hospitals and physicians can find ways to resolve issues and broker deals that focus attention on the true problems at hand, such as how to decrease the cost of physician preference items while preserving the quality of care, or how...

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to gain physician support in meeting new or particularly challenging standards.

When trust is established and communication issues are resolved, the concept of physician engagement can become a reality. If physicians have an issue regarding one of their areas of practice, it is most beneficial to get their input first and ask for their guidance in how to respond. In turn, a hospital can expect that the physicians will help manage any changes and improvements needed to deal with the issue or standard.

**Identify physician champions**

A critical step in establishing the level of trust necessary for effective collaboration is identifying champions among the medical staff who will serve as liaisons to the hospital and administration and provide leadership, accountability, and clinical oversight for initiatives intended to meet standards or improve processes. Having point-of-contact physicians who can take issues back to other members of the medical staff will provide the best framework for ensuring targeted, efficient communication.

Another benefit of physician champions is that they are usually willing to help. Physicians can offer a unique viewpoint that may not have been considered within the organization. “Who else knows the view of the physician, if not the physician?” says hospitalist Josh King, MD.

The process of engaging physician champions can vary. Selecting physicians who are stakeholders in a particular process is a way to respect the preferences of physician leaders and obtain needed insight and support for hospital-led initiatives. An informal process is often effective, with the hospital acknowledging the value and expertise the physician brings to the table in making any changes.

If the process is formal, the expectations of the physician leader and of the hospital must be clearly defined. This helps avoid role confusion and the impression that the physician is “taking the hospital’s side” when working through a challenging initiative. Keep in mind that the expectations of both parties are usually higher in a formal process, and the collaborative relationship may be damaged if the initiative is not as successful as either party believes it should be.

**Watch practice patterns**

When it comes to Joint Commission compliance, most compliance officers are all too familiar with RC.01.01.01: “The hospital maintains complete and accurate medical records for each individual patient.”

The reason this standard is so familiar is that currently, The Joint Commission lists it as the standard with the most compliance issues. Almost all hospitals have had challenges with physicians signing, dating, and timing orders and other documentation in a timely manner.

It is important for documentation and medical records compliance to be part of physicians’ ongoing professional practice evaluation (OPPE). If a physician has a track record of stellar compliance with documentation...
The medical executive committee can help facilitate collaboration between the hospital and medical staff. The committee can go on record in support of policies and processes that comply with Joint Commission standards. Department chairs can work with peers to monitor compliance and cooperation. It is important that a medical staff OPPE program is set up to reflect physicians’ individual rate of compliance with standards.

Feedback on compliance and resources for assistance can be provided to physicians as part of their OPPE program. Medical staff leaders, if knowledgeable and engaged about compliance with regulatory agencies, will be valuable champions for hospital processes.

**Use data to support changes in behavior**

Positive results of physician engagement efforts are not earned on the basis of goodwill alone. For physicians, data is a critical component in making decisions that could benefit them and the hospital.

Physicians are not likely to simply accept the word of hospital administration at face value when being asked to make a change. When administration can present physicians with benchmark data, regardless of the clinical indicator, it makes the task easier.

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**Involve physicians in monitoring**

When it comes to understanding standards put forth by The Joint Commission, physicians don’t have to fall back on “we do this because The Joint Commission says we have to.” Instead, they can gain the upper hand. If physicians are part of the process of the hospital adopting processes and policies in alignment with Joint Commission standards, they are more likely to understand the rationale behind the standards.

If physicians are able to attain a better understanding of why certain standards are created, they may become more interested in monitoring other physicians for compliance. In this era of healthcare reform, physicians realize that it is important for hospitals to be successful and preserve high-quality patient care.

If a standard is particularly challenging to a hospital, engaging physicians in creating processes and monitoring the standard can be helpful. Physicians can bring some processes to their own practices, or integrate hospital practices for better continuity of care and a feeling of cooperation.

Newton Medical Center in Covington, Ga., created a strategy to keep all preprinted order sets in a software program accessible throughout the hospital. The order sets could be customized if the physician requested it, and could be printed with patient information included. To bring physicians further into the process of using the order sets, the hospital is setting up a physician portal for admitting physicians, so the same order sets available in the hospital will also be available in offices.

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“Most of us are data driven, and do things in response to data and studies,” says Hanson. Physicians are scientists, he adds, and will respond to objective data presented along with workable solutions.

Data is an effective tool for driving changes in physician behavior and practices. King notes, “Physicians may initially be resistant to anything that is presented as a critique, but may end up being surprised at what the data shows. It levels the playing field since it is fact, not driven by the goals of the hospital or regulatory agency.”

Hanson agrees. “If you showed me that I was the most expensive physician in the hospital, I would reevaluate how I practice,” he says.

The same could be said for compliance with regulations. A physician may think he or she is doing well with Joint Commission standards, and may resist any suggestions for improvement. Presentation of data can eliminate opinion and room for disagreement. Physicians are scientists, and they are more receptive to change if detailed information is provided while processes are being constructed. Diligent tracking is also important to keep physicians current on the results of practice changes. Ensuring physicians are up to date on progress made and providing them with feedback will help maintain positive behaviors and compliance.

**Build momentum for success**

Physician engagement strategies require a unique mix of people skills, process maneuvering, technological and clinical expertise, and careful follow-up. Providing physicians with the data they need to make informed decisions is a key component of engaging physicians in improving processes and meeting standards. Success creates its own momentum, and the more positive outcomes are achieved, the more likely physicians will trust the processes and agree to become part of them. The benefit of successful physician engagement can be realized by the hospital, the physicians, and the community as a whole.

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