“I used to speak only to engineers or safety people,” says Salamone. “Now I do a lot more presenting and educating to administrators and healthcare executives.”

Before this recent growth in interest from the executive level, he found that middle management understood the process and the need to ensure a successful survey, but getting support at the upper tiers was difficult due to a lack of understanding. Obtaining the budget, staff, or assistance needed to make improvements was difficult when leadership did not see the pivotal importance of compliance.

“Now when you talk to leaders, they are interested. They go back to their facilities and call in the department directors and managers,” says Salamone. “They ask, ‘Are we compliant? Do we have the capability to ensure compliance? How comfortable are you with the necessary existing resources?’ And leadership is now leading the talk. They’re in the room and they need to know that they’re not out of the woods.”

The Joint Commission’s decision to cite the leadership standards for noncompliance has been a game changer in this area.

Despite economic downturns in recent years, Salamone still sees a focus on survey readiness, particularly in the engineering/facilities side of healthcare.

“The economy is hurting, but healthcare is still growing,” says Salamone. “More renovations, more construction, more design work.”

And that means more of the tactics we as accreditation professionals have become accustomed to.

“I think facilities need to not only be proactive but to really keep that full court press on,” says Salamone. “Just because the survey is over doesn’t mean everything goes back to normal. We can’t get complacent, and I think that is our goal in healthcare and the message that we’ve needed to get to leadership.”

FPPE, OPPE, and physician involvement

Communication key to developing optimal practices

Every hospital faces unique challenges, and devises unique solutions, when looking for the best way to manage focused professional practice evaluation (FPPE). For example, Longmont (Colo.) United Hospital has implemented a singularly effective form for tracking FPPE within its radiology unit. In describing how that form was developed, AHAP Insider’s sister publication Medical Staff Briefing had the chance to hear about the bigger picture of not only the organization’s FPPE policy development and improvement, but also how it maximized physician involvement in the ongoing professional practice evaluation (OPPE) process.

“When we implemented FPPE in our facility, we involved the physicians in that process,” says Dana Crowell, CPMSM, director of medical staff services for Longmont United Hospital. Crowell is also president of the Colorado Association for Medical Staff Services.

Getting active participation from physicians wasn’t just a matter of rubber-stamp involvement, Crowell points out. “You can say you involved them if they approve certain things, but that doesn’t mean they were involved in the development phase. We wanted them to have ownership in the process,” she says, adding that any time a new requirement is handed down from an accrediting or regulatory agency, physicians appreciate being asked to help rather than having policy forced on them without their input.

When it came time to create the radiology form, for example, the organization reached out to its exclusively contracted group of radiologists.

“When we needed this to happen, we sat down with the president of that group and said, ‘Here is what we need—can you help us determine what appropriate things we would want to have reviewed?’ ” says Crowell.

The lead physician drafted a set of key components, and the form was created based on those.

“It was all rather painless,” says Crowell. “Had we had multiple groups, it might not have been so easy to accomplish.”
Longmont United Hospital has always had a radiologist as a member of its medical executive committee—radiology being one of its clinical service areas. Chairmanship of the committee rotates between radiology and pathology, with the representative from the other unit acting as a vice chair. Longmont also almost always has a radiologist on the credentials committee to keep that specialty directly involved in its decisions.

Crowell notes that this kind of direct physician involvement has been applied across the board.

“They know they have a key stake in what you’re trying to develop,” she says.

In addition to FPPE and OPPE, this physician involvement has been useful for focused chart reviews when the peer review committee identifies potential issues.

OPPE by any other name
While the healthcare community still struggles with the requirements of OPPE and FPPE, the former really is not a new concept.

“I’ve been here six years, and this facility has been doing OPPE for a long time—they were not necessarily calling it OPPE, but prior to the Joint Commission requirement a lot of facilities could probably say the same thing, doing the equivalent by gathering and evaluating performance data.”

That being said, when she first arrived Crowell found the forms in use somewhat generic.

“A generic form is okay if you’re looking at a medicine specialty. We had a generic medicine form, a generic surgery form, but nothing for pathology or radiology, radiation oncology, or emergency services,” she says.

The existing forms weren’t really appropriate to evaluate those areas because they weren’t asking the right questions to drill down into physician performance.

“We met with the leaders of those specialties to create forms specifically for them,” says Crowell. They worked on all the forms simultaneously, with Crowell explaining why it was important for each one to include specialty-specific data requirements.

“I think physicians were not aware that this data was being collected on them for years,” says Crowell. “They didn’t understand the importance of this data, that the data is relevant and will speak to whether your privileges are maintained, modified, or reduced.” Because of those facts, she explained, the information provided on the form has to be pertinent to physicians’ specialties.

Having exclusive contracts for some of these specialties made it easier to establish data requirements and get everyone on board.

“For other specialties like surgical and medical subspecialties, we have what I would call a generic form—we have a diagnostic and a procedural form, and although I call them generic, they are pertinent to any procedure,” she says. “Depending on what is being evaluated, we choose an appropriate physician to perform the analysis.”

This settled the issue of updating OPPE processes, but FPPE—as many organizations find—was a slightly more difficult challenge.

“It’s more difficult because it’s harder to understand,” says Crowell. “It’s one of those standards you can read the language and try to wrap your brain around, but it’s a tough sell to physicians because they feel we do our job at the credentialing and privileging process with the data we collect.”

FPPE from the standpoint of peer review might seem like a normal part of a facility’s practice, but it can be more difficult to gain acceptance for when done elsewhere—such as when it’s part of adding new privileges.

“I’ve actually had this conversation with a Joint Commission surveyor,” says Crowell. “It is sometimes perceived as a slap in the face to do FPPE for adding privileges, because we have a very strenuous credentialing and privileging process—we feel we go above and beyond the requirements to do best practices.”

FPPE’s requirement to collect additional data and evaluate every procedure performed, especially in an area like family medicine or general surgery, can seem an impossible burden.

“Fortunately, they said we could bundle procedures,” says Crowell. “But that’s why so many hospitals are still struggling. The expectation in the standards are very difficult to meet if you take them literally.”

Would it be more beneficial if The Joint Commission were more prescriptive? “Part of me would love it if they would...
be more prescriptive and say, 'Here's the requirement, here is how we want you to do it.' But by the same token they want to give us the freedom to manage the hospital the way we see fit," says Crowell. "That's part of the struggle, particularly for newer MSPs, as they work their way through Joint Commission and CMS requirements."

In any event, Crowell and her organization have done something right with FPPE—at their last survey, the Joint Commission surveyors asked to take copies of Longmont’s FPPE documents with them to pass along as best practices for other facilities.

"That makes you feel good at the end of the day," she says. "When the people who really count want to share your story with other hospitals, that's when you want to give kudos to everyone involved in the development process."

Age makes a difference
Among the struggles to implement FPPE and the ongoing difficulties related to getting physicians on board with the concept, there has been a very noticeable pattern of which physicians are having an easier time.

"I've found that younger doctors who are coming out of training or recent graduates have much less trouble embracing FPPE and OPPE than those who have been practicing for many years," says Crowell. "The residency and fellowship training programs are talking to them more and more about how you are not the captain of the ship, but rather part of a team." When she works with younger physicians in an orientation setting, they are much more likely to make immediate sense out of the organization’s FPPE processes. More worrisome, she finds, is a particular trend with physicians who have been practicing at other organizations.

"It's a bit disturbing—a lot of physicians who have been practicing in other facilities for a number of years, whether it was a practice in another area or a locum tenens, I get the deer in the headlights look," says Crowell. "It appears that there are hospitals out there that are collecting this data without the physicians knowing!"

In some cases, it seems that the only time the data is made available to the physician is when there is an outlier. In other cases, physicians may actually be receiving the data but are simply too busy to notice its arrival. Regardless, the physicians have a right to this data, Crowell notes. "How will you hold them accountable for data they don't know about?"

In cases where the data is being provided but possibly overlooked, how can you ensure physicians will review the information your department gives them? The answer is physician involvement, says Crowell.

“There are a number of ways to involve your physicians—the standards require involvement, but there are different levels to meet that standard,” she says.

Best practice would involve the specialties in the process, giving them a say in how the data is used and ensuring the data arrives in a useful format. “This data needs to be useful and meaningful,” says Crowell. “I'm not a believer in gathering data just because we have to. It's not just the physician, but the hospital you're affecting!”

Crowell’s organization does OPPE reports every six months, although her office works on those reports on a daily basis. “I have almost 400 reports to do, and one of the things we have been sensing is that perhaps the physicians are not getting as much out of them as we’d like,” says Crowell.

In working with the medical executive committee, she and her office have tried to avoid making OPPE “busy work”—which brings us back to meaningful data collection. To get a better handle on how the physicians were perceiving and using the OPPE reports, Crowell’s office issued a series of questions to gauge their involvement.

“We had some preconceived notions of what the answers would be. We were right on some and wrong on others," says Crowell. “We thought based on previous feedback that we'd have a large number of practitioners who had no idea what OPPE was, but the majority knew exactly what we were talking about.”

Unsurprisingly, though, there was some confusion about what was being done with the data. “A fairly large percentage didn't know what we were doing with this information, so we needed to include more information on the cover letter for their reports,” says Crowell. They also received a fair amount of feedback asking for a different, more usable data format.

“I would encourage other hospitals who have been doing OPPE to take the time to do a self-check, and the best way to do a self-check is to ask your physicians!” says Crowell.

It's easy once the process is in place and functioning well to overlook the necessity of self-diagnosis. "It's human nature,
Hospital presented to its medical staff as a check-in on the effectiveness of the hospital’s OPPE process:

1. Are you aware of the OPPE measures that are being used to evaluate your practice at Longmont?
2. Are you aware of how the data collected is used by the credentials committee, medical executive committee, and board?
3. Is the data provided in the OPPE reports useful to you in guiding practice improvement?
4. Do you feel the OPPE measures used are an effective tool to measure the quality of your hospital practice?
5. Are the OPPE reports easy to read and interpret?
6. What measures would you suggest be added or removed from the OPPE reports?
7. What other OPPE process changes would you suggest?
8. If you would like to discuss your suggestions with the credentials committee chair, please provide your name and preferred contact.

Survey your physicians
To ensure the data you are collecting for OPPE reports is of value to your medical staff, be sure to check in with them. The following are the questions Longmont United

Salary growth still limited for survey coordinators

Accreditation specialists see low or no increases to pay in past 12 months

In the 2012 AHAP Salary Survey, just over a third (34%) of respondents reported receiving no pay increase in the previous 12 months, and of those who did, 31% received 2% or less. How did the profession fare in the 2013 survey? It could be argued accreditation professionals had an even worse year, according to the results, as the most significant responses still come from the low- to no-increase categories.

Respondents to this year’s survey reported a small uptick in going a year without a salary increase (35%), with a heavy 39% reporting a small increase of 2% or less. This number clocked in at 31% last year, so there has been some improvement there.

However, for the more respectable 3%–4% raise category, we saw a decrease from 27% in 2012 to 21% in 2013.

Increases higher than 4% this year were almost nonexistent, according to respondents:

- 5%–6%: 1%, compared to 3% last year
- 7%–8%: Unchanged at 1%
- 9%–10%: No responses, compared to 2% last year
- Over 10%: 1%, a slight drop from 2% last year

But salary increases are not the only form of compensation, so we asked our respondents whether they received bonuses as part of their pay. The numbers barely moved from last year’s survey, showing that bonuses remain uncommon among accreditation specialists:

- An annual bonus based on performance of organization: 23%, up from 22% last year
- An annual bonus based on individual performance: 11%, up from 10% last year
- A bonus based on achieving department goals of efficiency or productivity: 9%, down from 11% last year
- No bonuses: 65% receive no bonuses (compared to 69% last year)