There’s More to be Learned from Good Results than Bad—and Why It Matters

written by Thomas Dent, M.D. | December 20, 2018



Becoming a physician requires passing many tests, beginning

with premed studies, all the way through residency and, ultimately, board certification. You spend countless hours focused on passing examinations or rotations and learning to avoid pitfalls.

As a residency program director, I and my colleagues invested considerable effort to determine which residents were struggling and to develop strategies to help them. We focused on finding deficiencies that would impede them from being excellent physicians.

A fellow faculty member ran a Morbidity and Mortality conference that he nicknamed the “boo-boo” conference. This process of identifying and analyzing medical errors produced competitive physicians, but also ones who were tired and avoided the measurement process. Physicians who train this way are very attuned to looking for where things have gone wrong—an attitude also fostered by our medical-legal system, which focuses on avoiding mistakes. When lives are at risk, this is essential. A physician must “stand tall” and acknowledge a mistake in order to maintain professionalism and integrity. Mistakes are best addressed in the long run by creating a process of continuous improvement. This process requires physician buy-in and cooperation.

Now I work in a company that assists in measuring clinician performance. Most of the time this measurement is based on quality measures developed by different groups for CMS. Reimbursement is tied to these measures. Clinicians and organizations are scored and compared to others. Not surprisingly, physicians have reported concern and anxiety over being “dinged” by poor scores. Conditioned by competitive

medical training, they do not want to appear professionally inadequate and may focus disproportionate attention on those things that might contribute to an appearance of incompetence.

How Measurement Is Communicated and Evaluated Is as Important as the Data

All of this measuring in medicine is essential to evaluating outcomes and improving performance to achieve quality, affordable care. But how the measurements are communicated and interpreted makes all the difference in physicians' ability and willingness to lead and participate in needed change in our health care system.

Now the emphasis in performance measurement is shifting from quality outcomes to cost of care. Physicians will be measured and compared to their peers based on the cost of care for specific episodes of care. While this measurement isn't as threatening to professionalism, it can present an economic threat, particularly with the advent of narrow networks.

For example, there are many caveats to cost measures, based on differences in patients and resultant costs. But these costs may be beyond the purview of the physician. Although patients are "risk-adjusted" to make these measurements more meaningful, risk adjustment hasn't been as accurate at capturing causes of variance based on social or environmental factors, such as social support.

In working with providers to improve performance, it is neither inspiring nor helpful to focus on negative results. The response is often avoidance, hostility and hiding data. Who can blame them? Clinicians who perform procedures on or assume care

of high-risk patients should not be compared to clinicians caring for lower risk populations. Even when the data is correct, the denial process can be extreme enough to mirror the five stages of grief described by Kubler-Ross.

Appreciative Inquiry Shifts the Emphasis from Blame to What Works

I propose an alternative approach—a management tool called "appreciative inquiry". Rather than seeking to identify and correct or avoid unexpected poor results, appreciative inquiry explores positive outcomes to discover operational improvements. In so doing, this approach changes relationship dynamics among administrators, providers and office staff.

Punitive challenges are replaced by aspirational goals. This invites providers to study why some things work well and to identify existing best practices. Collaboration among providers is enhanced because it is much easier to share successes than failures.

To be of real value, appreciative inquiry must lead to measurable improvement. Rather than presenting actions and interventions that are part of improvement activities in the context of a negative situation, interventions are recommended based on success. This avoids stigmatizing the provider for not providing high quality and efficient care and places the emphasis on what works and has been done well.

An additional benefit: training in appreciative inquiry (along with mindfulness and narrative medicine) can help to prevent physician burnout.

Four Steps to a Positive Process of Performance Improvement

Here are four steps toward performance improvement actions and interventions that build off positive results (based on the Appreciative inquiry 4-D cycle of Discovery, Dream, Design, and Destiny):

1. Make it real. Use data and examples from the practice. Whatever is done must be measurable. Look for positive change. Good or even average results in challenging patients (because of multiple or serious co-morbidities, unhealthy lifestyles, or personal circumstances) are unexpectedly positive outcomes and need to be recognized and investigated.
2. Capture more information. Avoid the evasiveness of stressed and suspicious clinicians. This action is the antithesis of rolling out poor results and demanding plans for improvement. Hiding or just not reporting unfavorable results is human nature, especially when there may be liability associated with poor outcomes. When things go well, the default is to assume that's just how things should be, but root causes need to be explored (for which it's much easier to get buy-in). Specifically ask what went well and what the clinicians aspire to that will make them proud of their work.
3. Generate reasons (hypotheses) for what caused positive results. These reasons should be tested in applications with future patients. The practice will need to be creative and approach this evaluation process with curiosity and inspiration.
4. Implement or deploy actions or interventions based on the

hypotheses. Measure the impact and modify as needed.

Appreciative inquiry has been likened to an organizational placebo effect. A placebo is an intervention that produces positive results based upon the patient or physician believing it will. Appreciative inquiry builds on a solid research base and has been implemented in numerous organizations of all different sizes. Exploring why there is an unexpectedly good outcome creates energy and pride within the practice. It is best to take the high road to reach goals, a path that provides the greatest opportunity for inclusion and success.

Founded as ICLOPS in 2002, Roji Health Intelligence guides health care systems, providers and patients on the path to better health through Solutions that help providers improve their value and succeed in Risk. Roji Health Intelligence is a CMS Qualified Clinical Data Registry.

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