Mitigating Risk

Addressing Clinical Performance Concerns in a Distracted World

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FORMERLY KNOWN AS THE GREELEY COMPANY

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Disclosure Statement

Beth Korinek and Sally Pelletier
have no financial relationships to disclose.

Learning Objectives

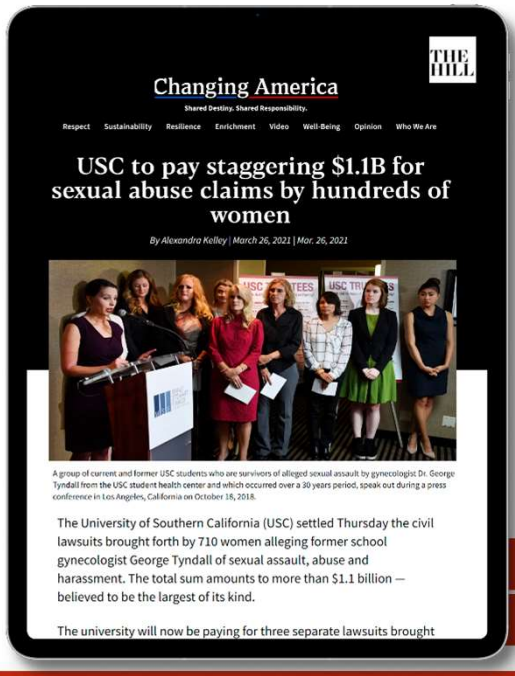
At the end of this session, participants will be able to:

SUMMARIZE
important implications for bylaws and medical staff policies and processes that support remediation or intervention.

IDENTIFY
available remedial training resources and explain how these services have been transformed in response to the pandemic.

LEARN
the basic elements needed to design a consistent, effective approach to guide remediation processes that support behavior change and skill enhancement.

The Importance of Intervention



THE HILL

Changing America

Shared Destiny. Shared Responsibility.

Respect Sustainability Resilience Enrichment Video Well-Being Opinion Who We Are

USC to pay staggering $1.1B for sexual abuse claims by hundreds of women

By Alexandra Kelley | March 26, 2021 | Mar. 26, 2021

A group of current and former USC students who are survivors of alleged sexual assault by gynecologist Dr. George Tyndall from the USC student health center and which occurred over a 30 years period, speak out during a press conference in Los Angeles, California on October 18, 2018.

The University of Southern California (USC) settled Thursday the civil lawsuits brought forth by 710 women alleging former school gynecologist George Tyndall of sexual assault, abuse and harassment. The total sum amounts to more than $1.1 billion — believed to be the largest of its kind.

The university will now be paying for three separate lawsuits brought

Case brought by **710** PATIENTS seen by George Tyndally, M.D., **over 30 years.**

Complaints from patients and colleagues **began within years of his hiring.**

Evidence that the university officials knew **for decades** of problems and failed to remove him. Complaints ignored **"again and again"**

Finally suspended in **2016** when a nurse reported him to the campus rape crisis center.

University allowed him to **resign with a payout.**

Never alerted the Medical Board until reporters started asking questions

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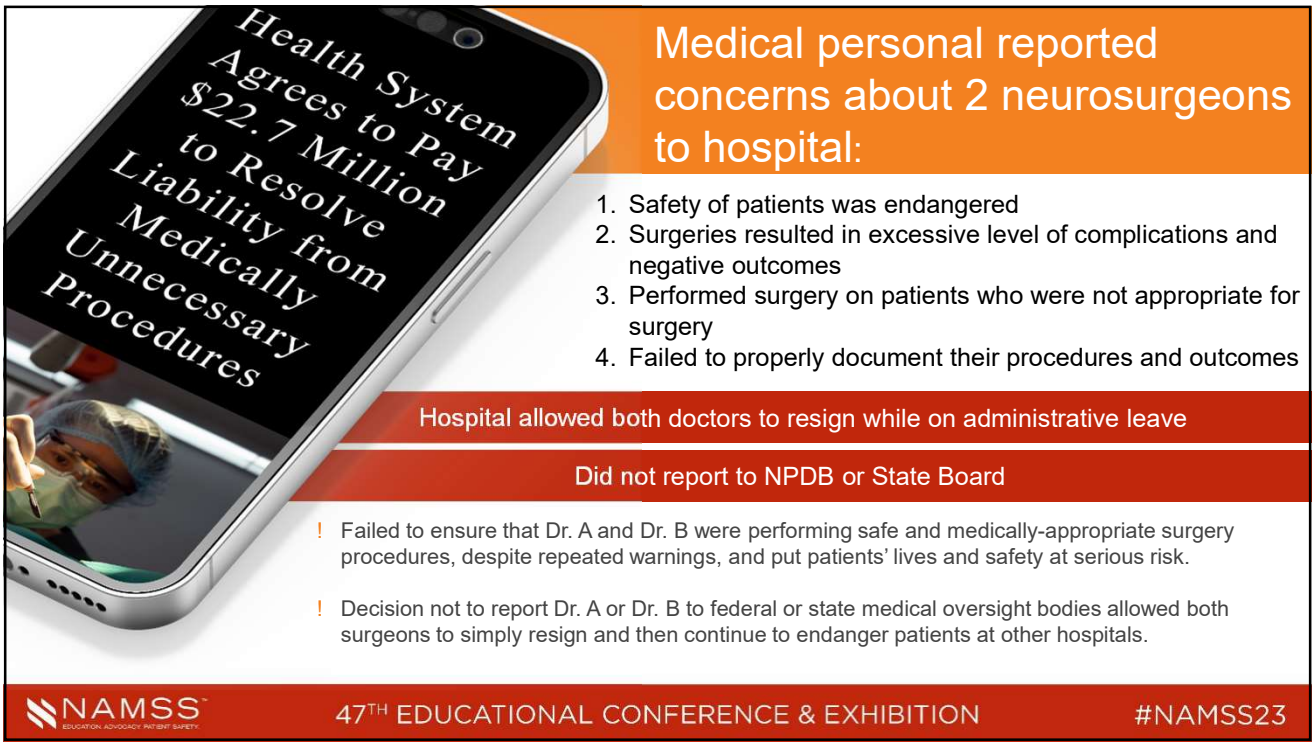
Health System Agrees to Pay $22.7 Million to Resolve Liability from Medically Unnecessary Procedures
Medical personal reported concerns about 2 neurosurgeons to hospital:
1. Safety of patients was endangered
2. Surgeries resulted in excessive level of complications and negative outcomes
3. Performed surgery on patients who were not appropriate for surgery
4. Failed to properly document their procedures and outcomes
Hospital allowed both doctors to resign while on administrative leave
Did not report to NPDB or State Board
! Failed to ensure that Dr. A and Dr. B were performing safe and medically-appropriate surgery procedures, despite repeated warnings, and put patients' lives and safety at serious risk.
! Decision not to report Dr. A or Dr. B to federal or state medical oversight bodies allowed both surgeons to simply resign and then continue to endanger patients at other hospitals.
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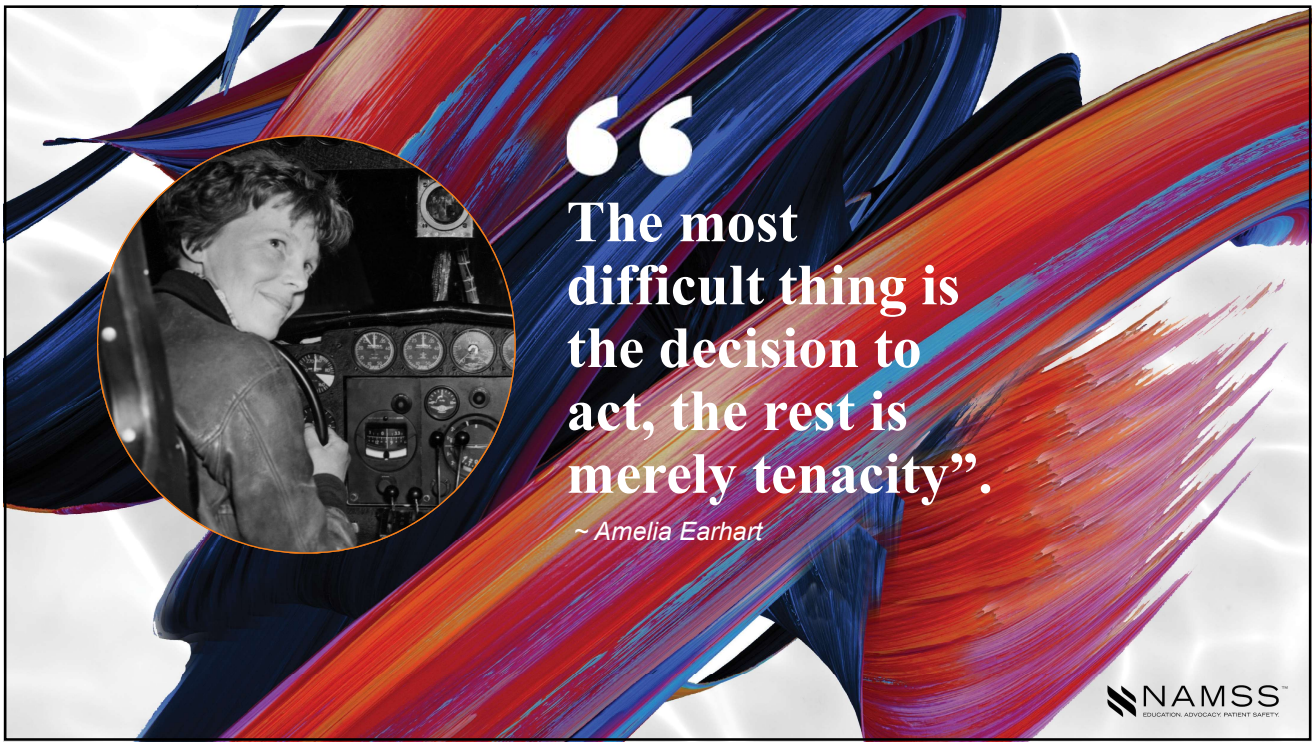
"The most difficult thing is the decision to act, the rest is merely tenacity".
~ Amelia Earhart
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PERFORMANCE CONCERNS

Do These Sound Familiar?

Clinical Performance

- Significant patient harm
- Multiple malpractice suits
- On-going patient/staff complaints
- Outside chart review identifies concerns
- Failure to improve after FPPE
- Questions about procedural skills/decisions
- Trending data is outside norms
- Patterns of inadequate treatment
- Unusually high patient volume

Aging or Reentering Practice

- Cognitive or physical decline in late career clinicians
- Reentry to practice after an absence

Communication with Team …

- "Belittling, demeaning or unfairly critical comments"
- "Yells at residents in front of patients, 'makes them feel inept'"
- "Gender-charged and racially insensitive comments"
- "Communications were 'intimidating', 'bullying', 'harassing', 'condescending' 'belittling', 'nasty'"

… with Patients

- "Physician does a poor job involving patients in shared decision making"
- "Doesn't seem to listen to patients or understand their point of view"
- "Often does not explain procedures and any expected pain or discomfort"
- "Does a poor job demonstrating any kind of empathy with patients"

Professionalism, Ethics & Boundaries

- Physician sent unwanted texts of flirtatious and sexual content to a resident
- Surgeon prescribed a benzodiazepine to spouse on several occasions
- Accessing the EMR without authorization to check whether an employee was being treated for a heath issue (or just missing work)
- Surgeon unable to arrive in a timely manner for urgent procedure because she was taking call from outside the agreed-upon range
- Pattern of "cutting corners", not taking responsibility for mistakes, unprofessional behavior in front of subordinates
- Falsely reported that she was board certified on recredentialing when she had failed to pass recertification exam

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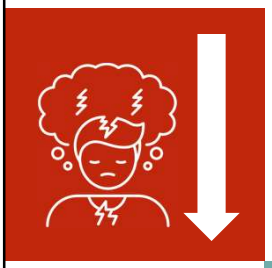
What are the Potential Consequences

of Unaddressed Performance Concerns in the Healthcare Setting?



RISK
of poor clinical outcomes or patient harm

INCREASED
staff turnover

Poor **MORALE**

LAW-SUITS

Perpetuation of a culture of **TOLERANCE**

Introductory Concepts


Dunning-Kruger Effect
People who are incompetent at something are unable to recognize their incompetence
AND
Not only do they fail to recognize their incompetence, they're also likely to feel confident that they actually are competent
Source: https://www.forbes.com/sites/markmurphy/2017/01/24/the-dunning-kruger-effect-shows-why-some-people-think-theyre-great-even-when-their-work-is-terrible/#16a1db2c5d7c
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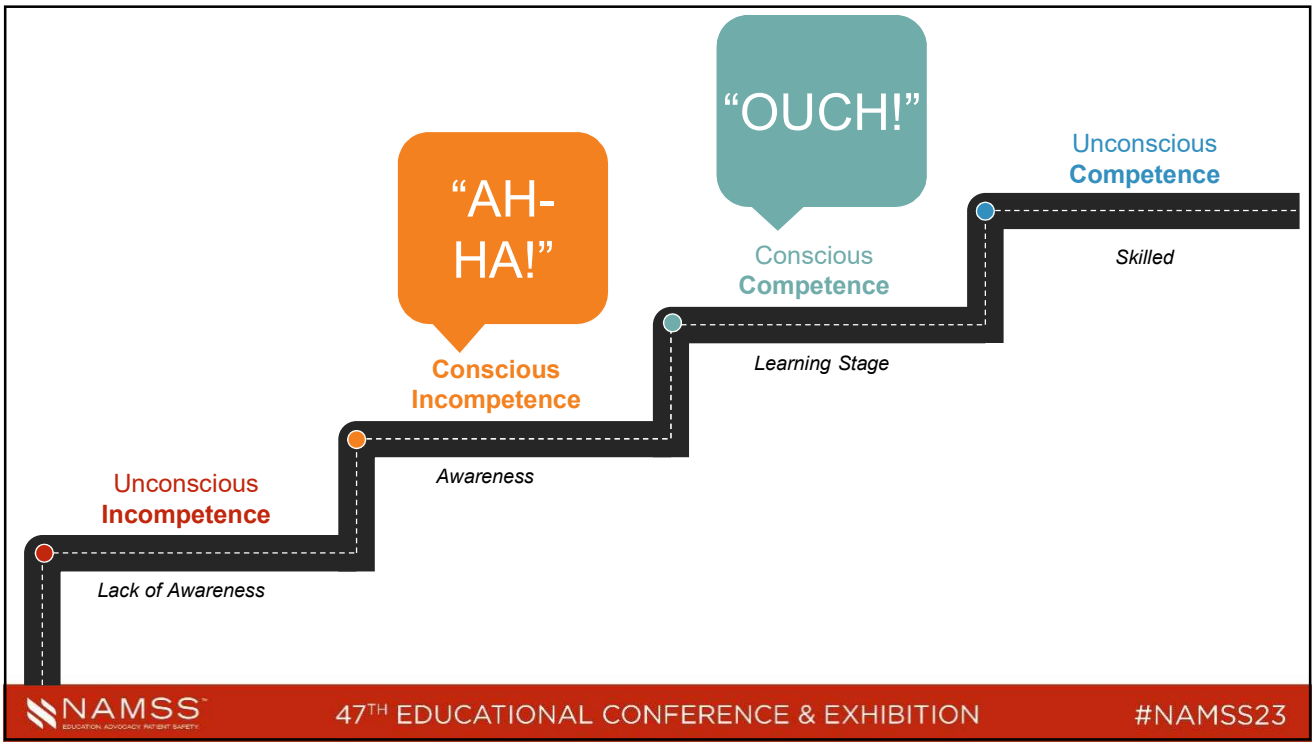
"OUCH!"
"AH-HA!"
Unconscious Competence
Skilled
Conscious Competence
Learning Stage
Conscious Incompetence
Awareness
Unconscious Incompetence
Lack of Awareness
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The MSP's Role in Supporting a Truly Accountable Medical Staff

The Chartis Clinical Quality Solutions Performance Pyramid

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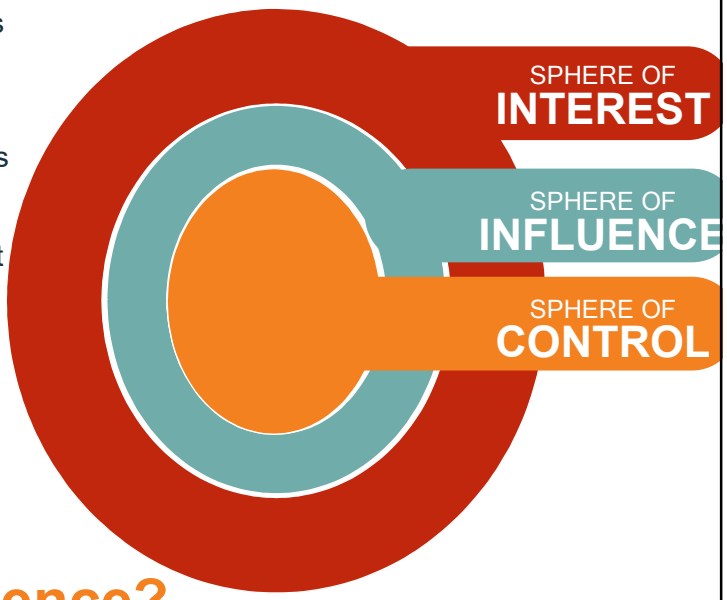
- Well trained, effective physician leaders
- Well designed, efficient, and consistently followed governance documents and policies and procedures
- Effective, efficient processes (OPPE, FPPE, case review, indicator and target design, etc.)
- Effective, efficient tools (privilege delineation forms, feedback reports, etc.)
- Medical staff culture of measurement, excellence, and accountability



What Can You Influence?

Clearly Define Practitioner Care Issues

- ☐ DIAGNOSIS
- ☐ CLINICAL JUDGEMENT
- ☐ TECHNIQUE/ SKILLS
- ☐ KNOWLEDGE
- ☐ COMMUNICATION
- ☐ PLANNING
- ☐ FOLLOW-UP
- ☐ POLICY COMPLIANCE
- ☐ SUPERVISION
- ☐ OTHERS

Leadership Pearls

When mentoring your physician leaders surrounding these challenges, MSPs should guide them as follows:

- Ask and answer the following question, and the appropriate course of action will become clear: "What layer of pyramid are we dealing with?"
- **Intervene early** – by driving issues as low down on the pyramid as possible, the results will be greater effectiveness and more collegiality.

21ST CENTURY PEER REVIEW HAS EVOLVED RESULTING IN GREATER ACCOUNTABILITIES

Ongoing Professional Practice Evaluation (OPPE)

- ✓ Systematic data collection and evaluation
- ✓ More frequent periodic evaluation

Focused Professional Practice Evaluation (FPPE)

- ✓ Follow-up to address performance issues
- ✓ Improvement plan design and monitoring

The Goal of Privileging…

To match **privileges** granted with **demonstrated practitioner competence**

…and the Competency Equation

Current Competency = Evidence You've Done It Recently + Evidence that When You Did It, You Did It Well

The COVID and Great Resignation Impact

- **What if…**
  you were informed by HR that they had just hired an anesthesiologist who had been out of patient care for six years due to a serious health issue?
- **What if…**
  the medical staff decides that laborists are fine to perform gynecological surgeries after a multiple-year hiatus?

Additional Tips for Bylaws and Policies

- ✓ Multispecialty peer review committees
- ✓ Changing landscape of performance measures
- ✓ Formalizing reentry pathways
- ✓ Mandatory appearance policy
- ✓ External peer review policy
- ✓ Practitioner behavior policy – let's explore further

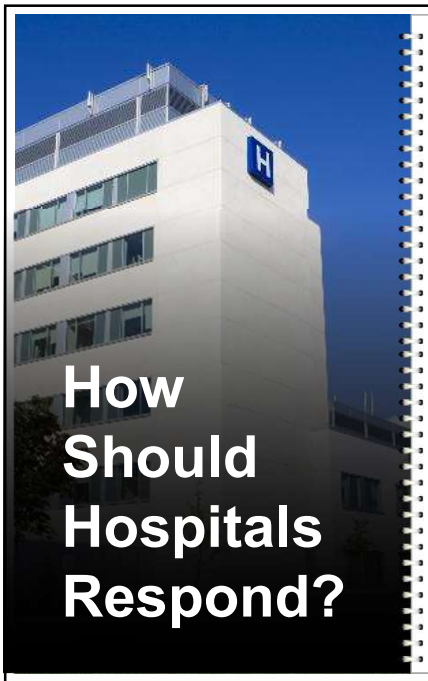
Why is Physician Behavior Such a Problem?

Among physicians over age 50, disenchantment with their chosen profession continues to grow

Physicians who **REPORT BURNOUT**: **47%**

General population who **REPORTED JOB BURNOUT**: **10.1%**

What Should Be in Your Practitioner Behavior Policy?



How Should Hospitals Respond?

- **Goal**
  to arrive at an outcome that prioritizes patient and staff safety while recognizing the rights of the clinician involved
- **Considerations**
  - Egregiousness of the behavior
  - Potential impact of the behavior
  - One-time or repetitive conduct
  - Prior intervention and outcome

Accountability Conversations Follow an Escalating Trajectory

Types of Interventions

INITIAL INTERVENTION:
COLLEGIAL DIALOGUE

1 Cup of Coffee Chat

- An informal conversation can help address problematic behavior
- Goal is to deliver a single "story" or observation and let the physician know what was observed
- Bring issue to the physician's attention so they can reflect on their behavior
  - Not to "fix" the situation or place blame
- Not having the conversation may imply endorsement of the behavior and may risk its repetition
- Promotes accountability for what appears to be a non-egregious unprofessional conduct

Conversation should be documented in physician's peer review file

DEVELOP AN ACTION PLAN

2 Written Remediation Plan

(Less collegial)

- Sets specific and measurable goals
- Provides clear plan and expectations
  - For all involved: Practitioner, CMO, MSSD, department chair, preceptor or proctor
- Helps clinician
  - Understand expectations and focus on educational requirements
  - Develop consulting relationships
  - Restore trust among colleagues and staff
- Helps ensure patient safety

DEVELOP AN ACTION PLAN: WRITTEN REMEDIATION PLAN

Hospital-Guided Plan Resources

- **Education/CME**
- **FPPE Processes**
  - ✓Observation/Proctoring
  - ✓Retrospective Chart Review
  - ✓Prospective Case Approval
- **Coaching/ Mentoring**
- **Practitioner Well Being Committee**

DEVELOP AN ACTION PLAN: WRITTEN REMEDIATION PLAN

External Peer Review

Provides objective expert review of one or more patient charts that have been identified by the facility

Lack of internal expertise	Ambiguity	Credibility	Legal concerns	Benchmarking: Especially for single specialty	Lack of internal resources

DEVELOP AN ACTION PLAN: WRITTEN REMEDIATION PLAN

2

Clinical Competence Assessment Programs

Confidential Process – not reportable unless part of other reportable action

- Assess knowledge, judgement, communication and documentation
- Conduct an in-depth evaluation of the clinician's clinical skills
- Report findings and educational recommendations
- Develop and oversee a structured education plan

DEVELOP AN ACTION PLAN: WRITTEN REMEDIATION PLAN

2

Clinical Competence Assessment Programs

Aging Practitioner

- Designed for situations when there are performance concerns related to aging or health
- Combines elements of competency assessment and health evaluations
- Elements customized based on needs of referring organization
- Identify education or health needs and recommend next steps

Reentry to Practice

- For practitioners returning to practice after an absence
- Informs hospital about the practitioner's current competence
- Provides education plan and concrete steps for resuming practice
- Assists the practitioner in preparing for transition to practice
- Provides documentation of evaluation and training process

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DEVELOP AN ACTION PLAN: WRITTEN REMEDIATION PLAN

Clinical Competence Assessment: Test Modalities

Interviews		Written Tests		Simulated Patient Encounters		Review Participant Health Info
	20-40 Patient Record Reviews		Simulation Technology Test		Cognitive Function Screen	

DEVELOP AN ACTION PLAN: WRITTEN REMEDIATION PLAN

Education Plan Following an Assessment

Plan components may include:

- **Preceptorship**
  - Retrospective chart reviews
  - Clinical discussions
  - Observation (shadowing) in clinical setting
  - Supervised patient care
- **CME: online; home study; in-person classes**
- **Intensive seminars**

Oversight by educational experts

Regular Reports by educational experts

2

DEVELOP AN ACTION PLAN: WRITTEN REMEDIATION PLAN

Intensive Skill-Building Seminars

- Medical Record Keeping *(with follow-up chart reviews)*
- Professionalism Ethics Boundaries
- Communication *(with peers or patients)*
- Disruptive Behavior
- Prescribing Controlled Drugs
- Specialty courses on specific procedural skills

"I was never taught this in medical school".

2

DEVELOP AN ACTION PLAN: WRITTEN REMEDIATION PLAN

Intensive Skill-Building Seminars

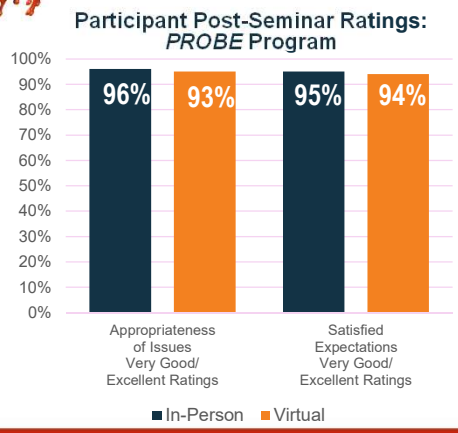
- Intensive (2+ days)
- 2-3 expert faculty per session
- Limited class size
- Use tools such as:
  - Personal improvement plans
  - Chart reviews
  - Simulated patients
  - Feedback or post-program report from faculty
  - Follow-up or coaching option

2

DEVELOP AN ACTION PLAN: WRITTEN REMEDIATION PLAN

Pandemic Pivot: The Leap to Virtual Interventions

- Assessment and education programs transitioned to virtual programming
- Use live, interactive video-conference technology for assessments and seminars
- Maintain the same quality, faculty and CME credit
- Maintain the same limits on enrollment
- Removes barriers and increases access and convenience for participants



When and How Do You Document?

First,

COLLEGIAL INTERVENTION

Documentation is *optional but highly recommended*

All

OTHER INTERVENTIONS:

- ✓ At the conclusion of the intervention, inform the physician you'll send him/her a letter summarizing the discussion and agreed-upon action plan
- ✓ File the documentation in the practitioner's peer review file
- ✓ You may allow the practitioner to submit a "rebuttal," but it does not negate the data or the import of the intervention

3

ENFORCE THE ACTION PLAN

Consequences

(Less discussion)

What If They Don't Comply?

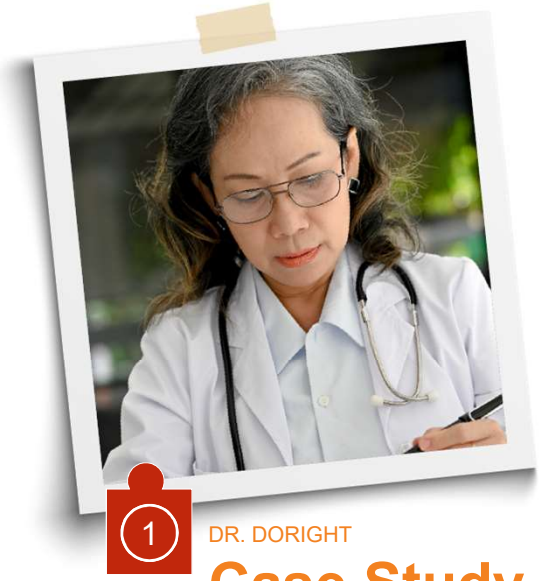
Look at Your Medical Staff Bylaws

- Determine that no action is justified
- Issue a letter of guidance, counsel, warning, or reprimand
- Impose conditions for continued Membership and Clinical Privileges
- Require monitoring, proctoring or consultation
- Require additional training or education
- Recommend reduction or restriction of Clinical Privileges
- Recommend suspension of Clinical Privileges for a specified period of time
- Recommend revocation of Membership or Clinical Privileges
- Make any other recommendation that is deemed necessary or appropriate

1

INITIAL INTERVENTION:
COLLEGIAL DIALOGUE

Cup of Coffee Chat



1

DR. DORIGHT

Case Study

There have been a number of complaints about Dr. DoRight. She berates nurses and colleagues when they are not providing care in the way she thinks is best.

The Department Chair set up a meeting with Dr. DoRight to relay the concerns.

Dr. DoRight began by saying that she is always striving to make sure that patients get the best care. She said she would work on improving her communication.

1

DR. LETSGO

Case Study

- Family physician, 5 years out of training, who is well liked by colleagues and patients
- Over the past year, several cases have come to the MEC. There was no clear pattern of concern, and none were egregious.
- Noted that documentation was completed weeks after the encounters, so it was difficult to determine accuracy of what was recorded.
- The Department Chair met with Dr. Letsgo to discuss the concerns.
- Dr. Letsgo demonstrated appropriate concern about the feedback and indicated that he would work to improve his documentation timeliness and his attention to patient care.

DEVELOP AN ACTION PLAN

Written Remediation Plan

DR. DORIGHT

Case Study

Two staff members reported that Dr. DoRight yelled at a nurse in the hallway after seeing an inpatient.

Chief of Staff and Department Chair met with her to discuss the incident. Dr. DoRight acknowledged the incident and explained that she felt the nurse's care of the patient had been inadequate.

An action plan was developed requiring her to meet every other week with the head of nursing to discuss any concerns she had about patient care and to receive feedback on her communication for 2 months.

Dr. DoRight agreed to and signed the plan.

2

DR. LETSGO

Case Study

- A case was reviewed by the MEC in which Dr. Letsgo attended to a patient who presented with possible early signs of a cardiac arrest.
- The patient was sent home but admitted the next day in cardiac arrest.
- During the review it was noted that Dr. Letsgo's charting were still late.
- The case was sent to outside peer review. The review found some concerns about the care provided but did not find it to be substandard.
- Dr. Letsgo entered an agreement to:
  - Have retroactive chart reviews of 30 cases.
  - Complete a 10-hour documentation seminar.

3

ENFORCE THE ACTION PLAN

Consequences

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3

DR. DORIGHT

Case Study

Two months after signing the action plan, Dr. DoRight made a nasty comment to a resident that was witnessed by the nursing staff.

The MEC created a written voluntary agreement that was signed by Dr. DoRight.

The agreement required:

- Completion of an intensive inter-professional communication course and 6 session coaching program
- Mandatory bi-weekly meetings with the Nursing Director for 6 months

Included CONSEQUENCE AND FINAL WARNING: Suspension if the behavior continued.

3

DR. DORIGHT

Case Study

Attended a 3-day inter-professional communication seminar

- Learned about personality profiles, emotional intelligence, team dynamics, stress management
- Developed personal action plan
- Faculty provided report and recommendations

Completed coaching to support accountability to maintain changes

Met with Nursing Director to receive immediate feedback regarding any perceived slips in communication

Both Dr. DoRight and Chair noted sustained improvements in how she communicated with other staff and handled frustration

> “Dr. DoRight realized she had many fences to mend and burned bridges to repair and she has worked diligently to do so.” ~ CMO

3

DR. LETSGO

Case Study

- Dr. Letsgo saw an obstetrics patient at 34 weeks gestation. The patient presented with significant swelling and high blood pressure.
- He sent the patient home and said he would follow-up in a week.
- The mother was rushed to the emergency room that evening. Mother and baby died.
- The hospital skipped FINAL WARNING and moved directly to suspension of Dr. Letsgo.
- The case was reported to the medical board.

3

DR. LETSGO

Case Study

- Required Dr. Letsgo to complete a competence assessment before they would consider reinstatement of privileges. The assessment found:
  - Dr. Letsgo had a tendency to rush through cases and had a very low index of suspicion for acute presentations
  - Patient volume was high; communication with patients was hurried
  - Documentation quality and timeliness had improved
- Action Plan required Dr. Letsgo to complete a 9-month education plan that included:
  - CME courses on enhanced history taking, actionable risk assessment
  - Retrospective chart reviews
  - Weekly meetings with a preceptor to review and discuss cases and apply new history taking skills
  - Communication seminar to improve patient interactions

Voluntarily continued meetings with preceptor for another 6 months to ensure he was providing appropriate care


Change is a Process
Not an Event
Photo by Suzanne D. Williams on Unspla
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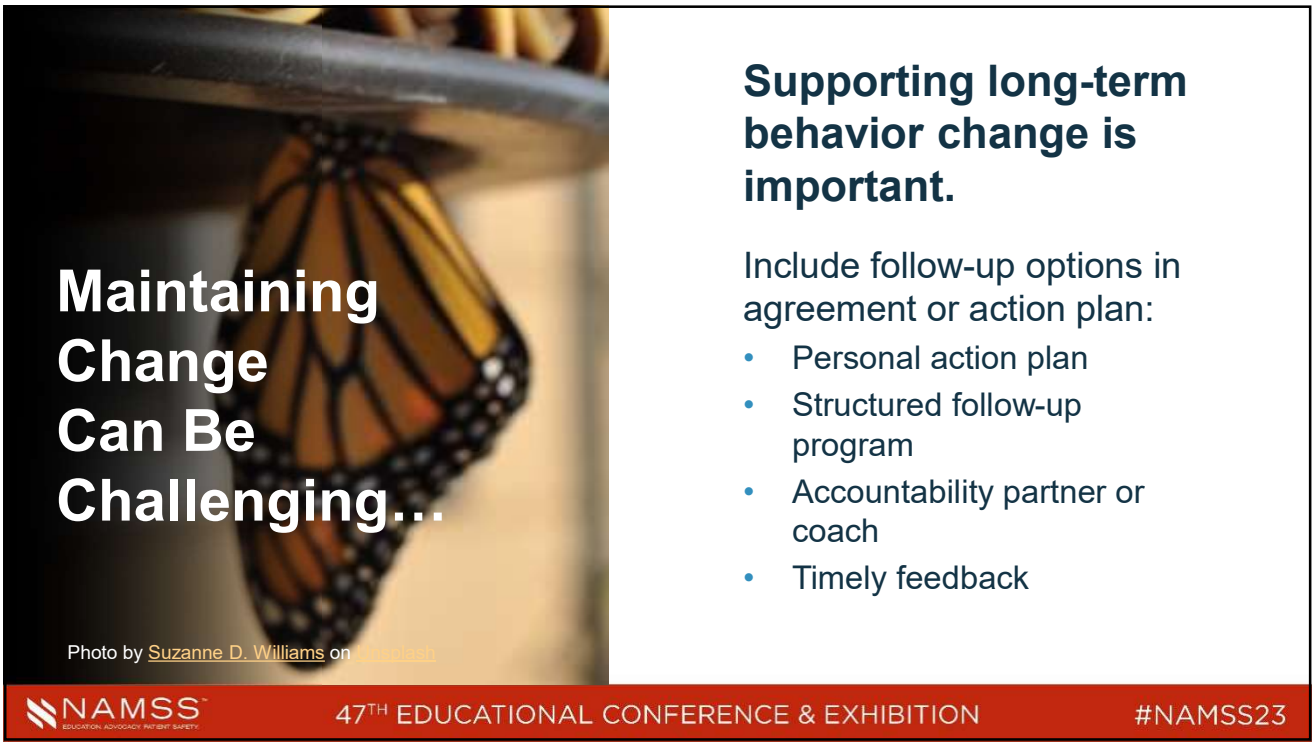
Maintaining Change Can Be Challenging…
Photo by Suzanne D. Williams on Unsplash
Supporting long-term behavior change is important.
Include follow-up options in agreement or action plan:
• Personal action plan
• Structured follow-up program
• Accountability partner or coach
• Timely feedback
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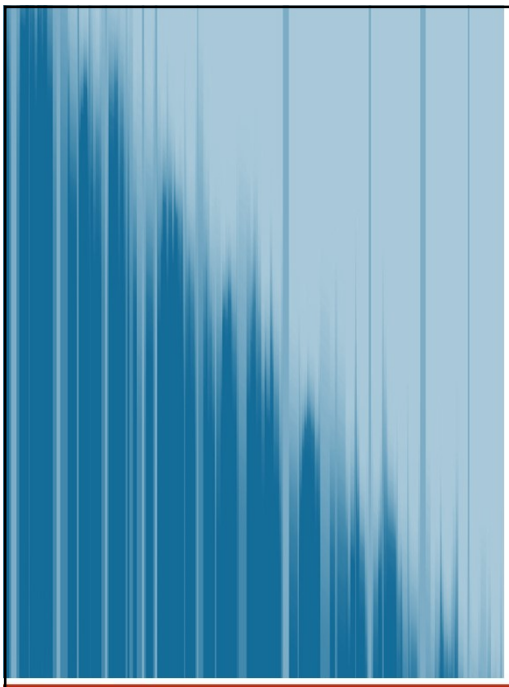

Stump the Experts

Let's discuss the issues that you are struggling with now…

Disclaimer: Our responses are not meant to be considered formal or legal advice… and we don't guarantee we will have the answer!

Summary

Consistently follow policies	Remember the Pyramid	Don't rely on self-assessment	Identify the problem	Create an effective plan and follow-up

Consider proactive intervention — don't wait until it's too late!

2 Resources

FEDERATION OF STATE MEDICAL BOARDS

Directory of Physician Assessment And Remedial Education Programs

http://fsmb.org/Media/Default/PDF/USMLE/RemEdProg

CPE

Coalition For Physician Enhancement Organizational Member Directory

http://cpe.memberlodge.org

Questions

Feel free to contact us if you have any questions!

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