
Abrazo Healthcare and Carondelet Facilities

Medical Staff Leadership Program

March 31 - April 1, 2023

Ian Donaldson
Horty, Springer & Mattern, P.C.

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CENTER FOR CONTINUING EDUCATION IN THE HEALTH SCIENCES AND HORTYSPRINGER SEMINARS

AGENDA - Day 1

- | | |
|-------------------|--|
| 1:00 to 1:45 p.m. | The Top Reasons Traditional Peer Review Doesn't Work...And What Does Work! <ul style="list-style-type: none">• Overview of an Effective Peer Review Process• Educational focus• Distinguishing role of Peer Review Committee from role of MEC• Sharing lessons learned and fixing system/process issues |
| 1:45 to 3:00 p.m. | Recommended Peer Review Process <ul style="list-style-type: none">• What Cases Get Reviewed?• Empowering "PPE Specialists" to support reviewers• Role of the Leadership Council in clinical reviews• Using Clinical Specialty Reviewers to obtain specialty expertise• Key role of multi-specialty Peer Review Committee |
| 3:00 to 3:15 p.m. | BREAK |
| 3:15 to 3:30 p.m. | A Key Step in the Process: Obtaining Input from Those Under Review |
| 3:30 to 5:00 p.m. | Using Collegial Interventions and Progress Steps <ul style="list-style-type: none">• Understanding the "progressive steps continuum"• How to conduct an effective collegial counseling session• Tips and tools for Performance Improvement Plans• Documentation – tone and content• Case study – Dr. Y. Buck, confident young surgeon |
| 5:00 p.m. | DAY 1 CONCLUDES |

AGENDA - Day 2

9:00 to 9:45 a.m.	Legal Protections for Medical Staff Leaders – The Law is on Your Side! <ul style="list-style-type: none">• HCQIA• Arizona Peer Review Statute• Protections in Bylaws
9:45 to 11:15 a.m.	Peer Review in Action – Dr. Earnest Case Study <ul style="list-style-type: none">• Voluntary agreements to refrain• NPDB reporting• Information sharing with employers• Conflicts of interest• Responding to reference requests
11:15 to 11:30 a.m.	BREAK
11:30 a.m. to 12:00 p.m.	Understanding the Behavior/Patient Safety Connection <ul style="list-style-type: none">• What do physicians, accrediting entities, and courts say about the connection between behavior and patient safety?• Tools that should be in your policy• Performance Improvement Plans for conduct
12:00 to 12:45 p.m.	Practitioner Health – Dealing with Impairment Issues on the Medical Staff <ul style="list-style-type: none">• How big is this problem?• Best practice tips for reviewing health issues• What about “Late career practitioners”?
12:45 to 1:00 p.m.	Attracting and Preparing Medical Staff Leaders
1:00 p.m.	DAY 2 CONCLUDES

ACCREDITATION STATEMENT

In support of improving patient care, this activity has been planned and implemented by the University of Pittsburgh and HartySpringer Seminars. The University of Pittsburgh is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

This activity is approved for the following credit: AMA PRA Category 1 Credit™. Other health care professionals will receive a certificate of attendance confirming the number of contact hours commensurate with the extent of participation in this activity.

The University of Pittsburgh designates this live activity for a maximum of 7.5 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

EDUCATIONAL INTENT

This program is designed for physicians who serve in Medical Staff leadership positions in hospitals. Upon completion of this program, participants should be able to identify common credentialing issues and develop best practices relating to initial appointment, reappointment, and clinical privileges. They should also be able to identify and manage the variety of peer review issues that confront them in their roles as physician leaders. Finally, participants should be able to define the legal responsibilities of Medical Staff leaders and the legal protections available to them.

TARGET AUDIENCE

- Medical Staff Officers
- Department Chiefs
- Credentials Committee Members
- MEC Members
- Bylaws Committee Members
- VPMAs, CMOs, and Medical Directors
- Medical Staff Services Professionals
- Quality/Performance Improvement Directors
- Hospital Management

IAN DONALDSON

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IAN DONALDSON is a partner with the law firm of Horty, Springer & Mattern, P.C. in Pittsburgh, Pennsylvania. He devotes his practice entirely to health care law, working extensively with hospital and physician leaders on various medical staff issues including credentialing and peer review matters. Ian is an Editor of the *Health Law Express*, a weekly e-newsletter on the latest health law developments. He previously served as a faculty member of the HortySpringer Seminars *The Credentialing Clinic* and *The Complete Course for Medical Staff Leaders* and is a current faculty member of *The Peer Review Clinic*. He has also served on the faculty of ACOG's (The American Congress of Obstetricians and Gynecologists) *Quality and Safety for Leaders in Women's Health Care* postgraduate course.

Ian earned his B.S. in Economics from Penn State University. He earned his J.D. and Certificate in Health Law from the University of Pittsburgh School of Law, where he served on the *Pittsburgh Tax Review*.

Conflict of Interest Disclosure

No planners, members of the planning committee, speakers, presenters, authors, content reviewers and/or anyone else in a position to control the content of this education activity have relevant financial relationships to disclose.

No relevant financial relationships with commercial entities were disclosed by:

Ian Donaldson, Partner
Horty, Springer & Mattern, P.C.

Disclaimer Statement

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Medical Staff Leadership Program

March 31-April 1, 2023

Ian Donaldson

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The “peer review” world has
changed *dramatically*
—and for the *better!*

Thinking!

Techniques!

Governing Documents!

2

Top 10 Reasons Why
Peer Review Generally
Doesn't Work



3

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All Too Common Language

After the case is reviewed and a score is assigned, practitioners shall be informed of the score by certified mail, return receipt requested, and notified of their right to appeal the assigned score.

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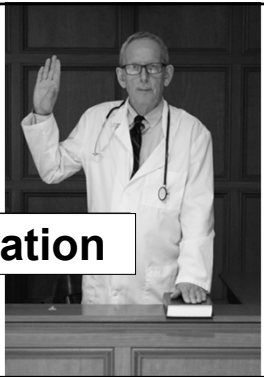
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First sentence in your Policy

Peer review is the responsibility of all appointees to the Medical Staff and failure to participate in a timely manner may be cause for suspension on recommendation of the MEC.

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Fear of litigation



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Inexperienced reviewers



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Lack of necessary tools.



**Rome wasn't built
in a day.**

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**Peer Review
Limited to Departments**

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**Based on 20/20
hindsight**



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“Many have found peer scoring to be a nonproductive aspect of traditional peer review because it tends to foster defensiveness, be extremely subjective and unreliable while giving a false impression of accuracy, and distract from the true objectives of individual and organizational improvement [1-3, 17-22].”

American Journal of Roentgenology, 210, March 2018, pg 578.

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What are the costs of not doing peer review well?

The Human Factors...

- Patient injury
- Physician careers jeopardized
- Reputation and trust of community
- Employee morale
- Medical staff leadership burnout
- Distraction from performance improvement activities

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What are the costs of not doing peer review well?

Regulatory and Legal Concerns...

- Compliance with accreditation standards (e.g., TJC's alphabet soup of PPE, FPPE, and OPPE!)
- Risk of medical malpractice lawsuits
- Risk of negligent credentialing claims
- Risk of litigation related to adverse professional review actions
- Dollars and cents!

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So, What Works?

Clinical Quality Issues



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Constantly Reinforce the Three Main Goals of Modern Clinical PPE



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Goal #1

Practitioner-Specific Reviews that Focus on Education and Improvement

- Emphasize input from colleagues, feedback, and practical, specific recommendations to promote improvement
- Many non-disciplinary tools available

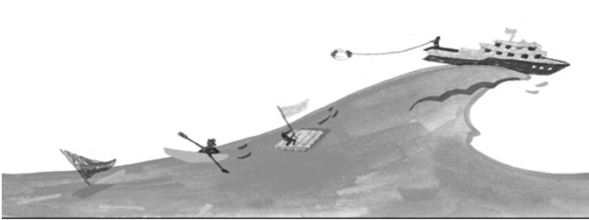
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A process that does not require MEC involvement in day-to-day reviews, and that does not require reports to government agencies, is more likely to be viewed as educational.

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Goal #2

Elevate Performance of ALL Physicians in Specialty



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Peer Review Should Be a Tool for the Best CME Ever

- Adopt practices to identify “lessons learned” from reviews (e.g., case review form, algorithm for committee review, meeting minutes)
- Share with relevant specialties

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Goal #3 Improve “Systems” of Care



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Fixing System/Process Issues

- Adopt practices to identify “system/process” issues (e.g., case review form, algorithm for committee review, meeting minutes)
- Issue referred to appropriate committee or person for resolution
- Issues stays on agenda of Professional Practitioner Evaluation Committee (PPEC) until notice of resolution is received

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How Are These Three Goals Constantly Reinforced?

1. One big thing
2. Lots of small things

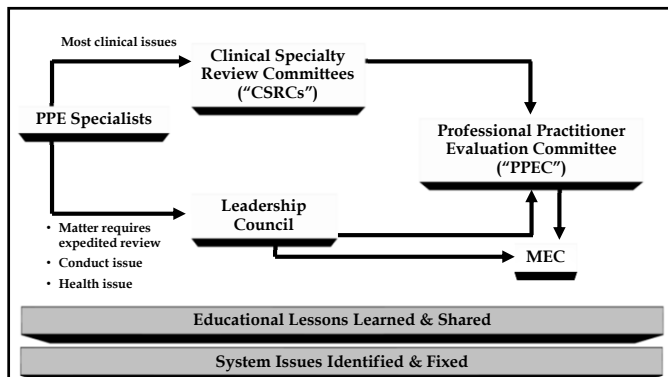


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The BIG thing: PPE Policy should state:

- Routine PPE is distinct from disciplinary action
- The Leadership Council and Professional Practitioner Evaluation Committee (PPEC):
 - Use performance improvement tools;
 - Have no disciplinary authority;
 - Seek voluntary agreement of practitioners
- Medical Executive Committee receives oversight reports but is not involved in day-to-day PPE

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Little details:

- Start with first paragraph of PPE Policy
- Every letter and e-mail (use templates)
- Case review forms
- Every meeting with practitioner (have talking points)
- Performance improvement options
- Committee minutes
- Periodic reports to Medical Staff

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GET THE WORD OUT TO THE MASSES!

1. *PPE Activity Report: Number of cases reviewed through the PPE process and the dispositions (in aggregate form)*
2. *Top 10 Lessons Learned...and Shared*
3. *System Issues Identified...and Fixed*

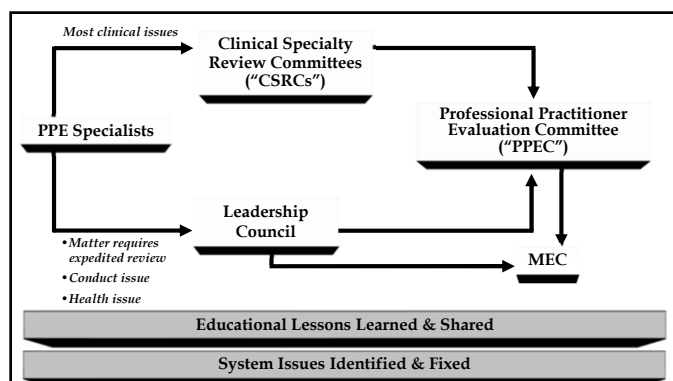
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Overview of Our Recommended Process

but first....

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But first, how are clinical concerns identified and reported to the PPE Specialists?

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How are clinical concerns identified?

- Reported concerns
- Serious safety events
- Patient complaints
- Protocol or policy not followed
- Litigation risks
- Medical necessity
- Specialty-specific indicators
- OPPE data requires review

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How are clinical concerns identified?

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Reported Concerns

Joint Commission Standard
MS.09.01.01, EOP 2

“Reported concerns regarding a privileged practitioner’s professional practice are uniformly investigated and addressed, as defined by the hospital and applicable law.”

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Reported Concerns

Practical Tips

- Don’t call them “incident reports” – keep them separate
 - Incident reports go to Risk Management
 - “Reported concerns” go to PPE Specialists
- If using a single electronic reporting system, ask reporter if issue pertains to practitioner’s competence or conduct, and route accordingly
- Educate Risk Management staff

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Respond to Those Who Report

- Thank you for reporting concern and participating in our culture of safety and quality care
- Medical Staff leaders are reviewing matter and may/may not need more information
- Due to confidentiality, can't provide specific outcome
- No retaliation is permitted; please report any incidents

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ACPE Quality of Care Survey

1,054 respondents (CMOs, VPMAs)

77%

Fear of reporting quality and safety problems is an obstacle to providing high-quality health care and patient safety initiatives

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How are clinical concerns identified?

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Serious Safety Events and PPE:

- “System” focus is commendable – goal is to avoid blame
- Unfortunately, this can result in “silos” or “blindness”

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Serious Safety Events and PPE:

Bottom line:
Practitioner-specific concerns cannot be ignored

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Practical Tips:

- Refer practitioner-specific issues to PPE process
- Coordinate SSE and PPE interviews to avoid duplication
- OK to share lessons learned and data among SSE and PPE processes (but be careful with practitioner-specific PPE information)

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Process Tips:

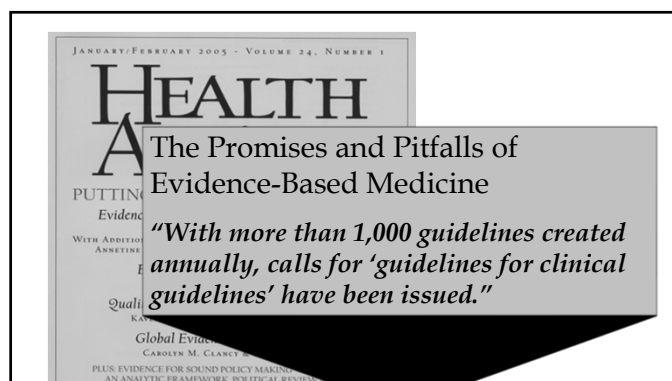
- Identify PPE/peer review purpose of root cause analyses in SSE Policy; use language from state peer review statute
- Treat SSEs as another form of PPE; educate staff about confidentiality, label documents, etc.
- Change perception of PPE (educational, not punitive)

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How are clinical concerns identified?

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Compliance With Protocols

- Survey of 1,534 ICUs by Columbia/CDC
- Most had protocols to prevent central line infections:
 - 37% - 71% compliance with protocols
- Most had protocols to prevent ventilator-assisted pneumonia
 - 45% - 55% compliance with protocols

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*Deya v. Hiawatha Hosp.
Ass'n, Inc.*

United States District Court Kansas

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Tips

- Start small
- Choose non-controversial, widely accepted protocols (look to payors)
- Choose high-volume procedures; get the “most bang for your buck”
- Use transparent process to approve protocol; invite input

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Tips

- If physician chooses not to follow protocol, must document rationale
- Identify method to monitor compliance
- Re-assess periodically

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How are clinical concerns identified?

- Reported concerns
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- OPPE data requires review

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Department of Surgery

Examples

- Ambulatory surgery patient admitted for complications of procedure
- Unplanned injury or removal of organ
- Retained foreign body
- Laceration/puncture of body part

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Department of Medicine

Examples

- Unplanned transfer to special care unit
- Adverse outcome unrelated to natural course of illness
- Death in low mortality DRG
- Critical/abnormal lab result unaddressed

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How are clinical concerns identified?

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- Medical necessity
- Specialty-specific indicators
- OPPE data requires review

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What is OPPE?

"OPPE is a screening tool to evaluate all practitioners who have been granted privileges and to identify those clinicians who might be delivering an unacceptable quality of care...."

As with all screening tests, a positive finding must be followed up with a more specific diagnostic test, one that should have high specificity for poor care."

Robert A. Wise, M.D.
Medical Advisor, TJC
August 21, 2013

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Department of Surgery

Specialty-Specific Indicator

- Ambulatory surgery patient admitted for complications of procedure
- Unplanned injury or removal of organ
- Retained foreign body
- Laceration/puncture of body part

OPPE Data Elements

- Unplanned return to surgery rate
- Surgical infection rate
- Complication rate
- Post-operative DVT rate or rate of compliance with DVT preventive measures
- Informational letters
 - Medical records
 - Clinical protocols
 - Other R&R

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Department of Medicine

Specialty-Specific Indicator

- Unplanned transfer to special care unit
- Adverse outcome unrelated to natural course of illness
- Death in low mortality DRG
- Critical/abnormal lab result unaddressed

OPPE Data Elements

- Pneumonia measures
- CHF measures
- Acute MI measures
- ALOS
- Informational letters
 - Medical records
 - Clinical protocols
 - Other R&R

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Adopt triggers for positive events!

Thank you letter for:

- OPPE data that demonstrates excellent care
- Positive patient comments
- Care that leads to new protocol

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PPE Specialists

Role of the PPE Specialists

- **Conserve physician time - empower staff to use their skills!**

Leading cause of physician burnout?

"Too many bureaucratic tasks (e.g., charting, paperwork)," according to 60% of survey respondents

("Lack of respect from administrators/employers, colleagues, or staff" a distant 2nd place at 39%)

2022 Medscape Survey

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PPE Specialists

Who Are PPE Specialists?

- Not necessarily a title; instead, an "umbrella" definition:
- Typically includes:
 - Quality Management Staff; and
 - Medical Staff Services

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PPE Specialists

Who Are PPE Specialists?

To maximize peer review protection, definition in PPE Policy should be even broader, and include others who may assist on occasional basis (such as Human Resources staff)

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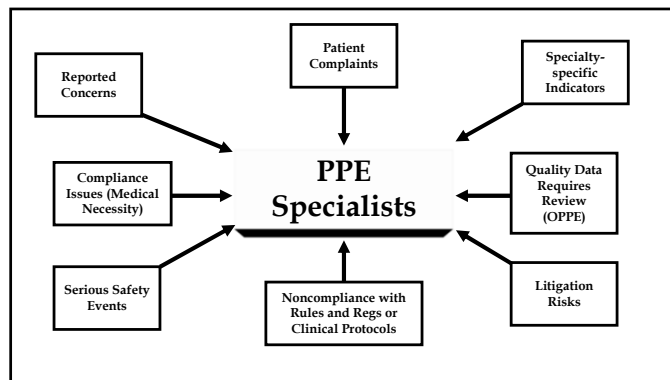
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PPE Specialists

Functions

- Log case into "Central Repository"

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CONFIDENTIAL PEER REVIEW DOCUMENT
PROFESSIONAL PRACTICE HISTORY REPORT
 PHYSICIAN: 123

DATE TO DATE

Medical Record #	Occurrence Date	Reason for Referral	Case Description	Disposition	Disposition By
238442	4/5/2022	FPPE Indicator	Bowel injury during laparoscopic colorectal resection	Educational letter enclosing article from Annals of Surgery	CSRC
239976	5/15/2022	FPPE Indicator	Perforation during laparoscopic procedure	Educational letter regarding patient selection/documentation	CSRC
236659	7/14/2022	FPPE Indicator	Small bowel perforation during laparoscopic hernia repair	Collegial counseling regarding patient selection for laparoscopic procedures	CSRC
237540	7/30/2022	FPPE Indicator	Complications during laparoscopic repair of para-esophageal hernia	Referred to CPE	CSRC

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PPE Specialists

Functions

- Log case in to “Central Repository”
- Initial review
 - Is physician review required?

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PPE Specialists

No Physician Review Required

(PPE Specialists with Medical Staff Leader)

- The case is unfounded or unrelated to a physician
 - Close case or forward appropriately
 - Include in periodic reports to PPEC

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PPE Specialists

No Physician Review Required – Prepare “Informational Letter”

- Objective circumstances chosen by PPEC (i.e., “black/white” “yes/no”)
 - Medical record deficiencies
 - Failure to follow Rules & Regulations
 - Failure to follow adopted protocol or document reason for not doing so
- Pre-drafted and tactfully worded – generated by PPE Specialists and sent by PPEC Chair
- Establish limits (e.g., third letter in “x” time frame triggers review)
- Include in periodic reports to PPEC

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TOP NOTCH HOSPITAL

As part of its ongoing and routine quality improvement efforts, the Professional Practitioner Evaluation Committee ("PPEC") has identified specific performance issues that can be successfully addressed solely by providing timely feedback to the Practitioners involved, rather than proceeding with a more formal review.

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MRN 13579

The purpose of this feedback is to increase your awareness of the rules governing Medical Staff members and to allow you to self-correct and improve. No response from you is required and no further review of this matter will be conducted unless a pattern is identified.

We hope that you will receive this letter in the spirit of continuous improvement and support our efforts to create a positive approach to our review processes. Thank you in advance for your cooperation. Please let me know if you have any questions or if I can provide any further assistance to you in addressing this matter.

Enclosure – Indicate care measures, policy, rule and resolution (clinical protocol, etc.)

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TOP NOTCH HOSPITAL

One such opportunity for improvement has been identified with respect to your compliance with Section 2.1 of our Medical Staff Rules and Regulations. Section 2.1 states "[i]f a full operative procedure report cannot be entered into the record immediately after the operation or procedure, a progress note must be entered by the Attending Physician in the medical record before the patient is transferred to the next level of care." No operative report or progress note was entered for MRN 13579.

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TOP NOTCH HOSPITAL
CARING FOR FAMILIES SINCE 1974

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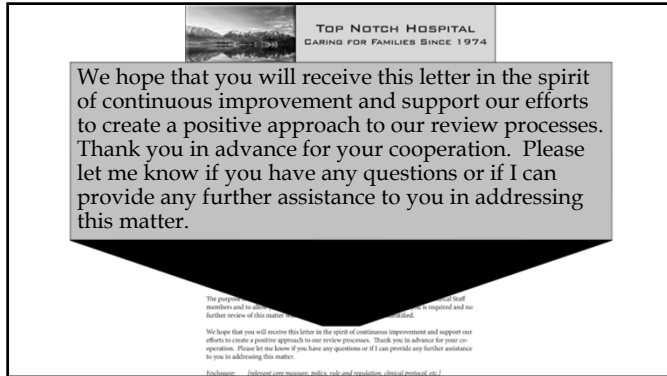
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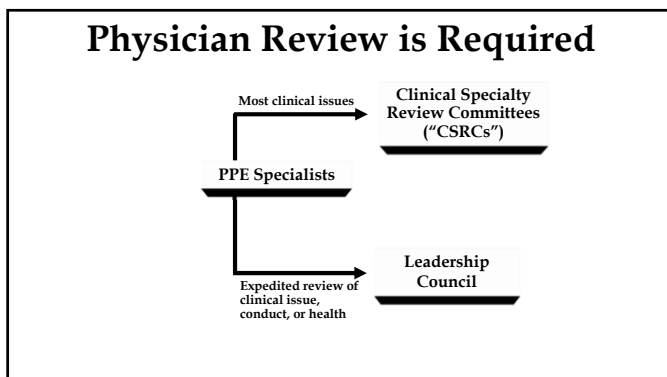
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PPE Specialists

Physician Review Is Required

- **Prepare Case for Review**
 - Obtain medical record
 - Summarize case
 - Interview witnesses and others
 - Pull applicable Rules and Regs, protocols and guidelines, etc.
 - Research medical literature

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What about cases involving:

- Practitioners from two or more specialties?
- Clinical Specialty Review Committee members?
- Specialties not otherwise available on the Medical Staff?



**PPE Specialists consult with a
Medical Staff Leader to route case**

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**Keystone of
Modern
Medical Staff
Governance!**

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**Not just
another layer
of
bureaucracy!**

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And not just another meeting!



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A key tool in addressing issues in an effective manner - *and you are probably already using one!*

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Primary Functions

- **"First responders"** when a matter requires *expedited review*



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Leadership Council

Matter requires expedited review

Takes initial steps (e.g., evaluates action that may be needed to protect patients during review; arranges external review) then refers case down the appropriate pathway.



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99.9% of you do this – so why is it important to formalize this body as a “committee?”



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Leadership Council

Benefits of Formalizing

- We want to make sure their discussions, work product, and deliberations are protected.
- We don't want to give a disgruntled colleague the ability to say “show me where!”



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Primary Functions

- “First responders” when a matter requires *expedited review*
- Responsible for *conduct* and *health* issues



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Why is this important?

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Real World Example

- OB/GYN is known for having a “difficult personality” but no formal complaints have ever been filed
- His Department Chair tries to have an informal “mentoring” conversation with him about inductions prior to 39 weeks
- OB/GYN “storms off” and leaves the chair with some unprofessional parting words on his way out (in front of nurses and visitors)

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Real World Example (con't)

- After storming off, OB/GYN locked himself in an office and refused to come out for an hour
- His employer has told the CMO that they have “taken care of it” by suspending him for a week for his conduct
- CMO then receives a note from OB/GYN stating he can’t come back to work for a medical reason

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Real World Example (con't)

- CMO reaches out and is informed OB/GYN is depressed and marriage is on the rocks
- However, he informs the CMO he will be ready to return after his week suspension is up

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*For these types of issues,
the focus is on
leadership expertise,
not clinical expertise*

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Leadership Council

Who Typically Serves?

- Medical Staff President (Chair)
- Medical Staff Vice President
- Chair, Professional Practitioner Evaluation Committee
- Credentials Chair (*or past President*)
- CMO
- PPE Specialists

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Leadership Council

Advantages of Leadership Council handling conduct and health issues

- Vis-à-vis Department Chair:
 - Consistency across departments



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Leadership Council

Advantages of Leadership Council handling conduct and health issues

- Vis-à-vis Department Chair:
 - Expertise through experience
 - Department Chair may be partner or competitor of physician
 - Help Department Chair preserve working relationship with practitioner under review
 - More than one set of eyes

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Leadership Council

Advantages of Leadership Council handling conduct and health issues

- Vis-à-vis Practitioner Health Committee:
 - See the “big picture”
 - Have sightlines to the credentialing and peer review processes
 - Meet regularly and are “current”

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Leadership Council

Advantages of Leadership Council handling conduct and health issues

- Vis-à-vis MEC:
 - Practical (e.g., scheduling meetings)
 - Confidentiality
 - Avoid perception of “punishment” that comes with MEC actions

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No Disciplinary Authority!

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Primary Functions

- “First responders” when a matter requires *expedited review*
- Responsible for *conduct* and *health* issues
- Only occasionally involved in *routine clinical* issues



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Leadership Council

When might they also be involved?

- PPEC or Clinical Specialty Review Committee requests assistance:
 - PPEC delegates monitoring of Performance Improvement Plan
 - Clinical Specialty Review Committee seeks assistance with Collegial Counseling

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Leadership Council

Other Possible Functions of Leadership Council

- Serves as a resource to Department Chairs and other Medical Staff Leaders dealing with performance issues
- Serve as Nominating/Leadership Development Committee for the Medical Staff
- Manage reinstatements from agreements to voluntarily refrain, automatic relinquishments, or LOAs

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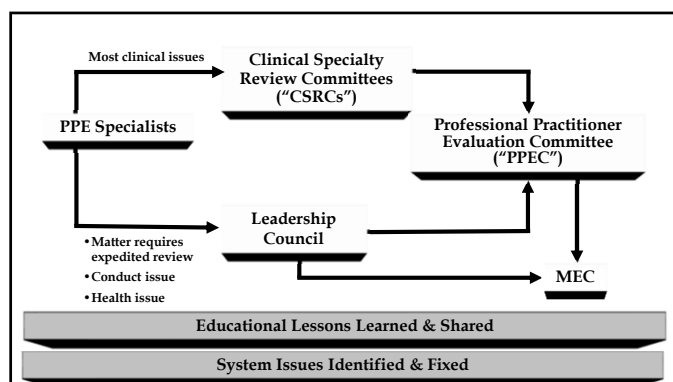
Abrazo Healthcare and Carondelet Facilities

Leadership Council

Meetings

- Special called meetings (on short notice) to address urgent clinical, behavior, or health concerns
- Scheduled meetings as needed to address routine business. Typically, every other week or monthly (and occasionally longer) depending on:
 - size of hospital/volume of cases
 - specific duties of Leadership Council

97



98

Clinical Specialty Review Committees "CSRCs"

At this point in process
↓
Need appropriate specialty expertise

99

Abrazo Healthcare and Carondelet Facilities

Clinical Specialty
Review Committees
("CSRCs")

Who are the CSRCs?

- Usually, one CSRC per department or specialty (e.g., CSRC for Medicine, CSRC for Surgery)
- May be pre-existing committee or newly appointed committee for this purpose
- Designated or appointed by Leadership Council

100

Clinical Specialty
Review Committees
("CSRCs")

Who serves in this role?

**Many Options...
All Can Work But One!**

101

Clinical Specialty
Review Committees
("CSRCs")

Who will serve in this role?

~~**Department Meeting
(or Specialty Meeting)
Peer Review**~~

**This would be challenging even in a perfect world
without egos, jealousy, fear, and anger!**

102

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Challenges/Weaknesses of Peer Review at Department Meetings

- “Inquisition” type setting for individual under review
- Lack of consistency/dependent on attendance
- More difficult to obtain individual’s input and share prior to meeting
- Time limitations may impede thoughtful review
- Less control over potential conflicts of interest
- Unnecessary use of resources – most reviews do not require a village!

103

Why use a “committee”? Is it because we like meetings?



104

Clinical Specialty
Review Committees
("CSRCs")

Why use committees?

- More effective reviews (more than one person’s perspective)
- More credibility if two individuals involved
- Eases pressure individual reviewers might feel
- Depending on state law, peer review privilege may apply only to committees
- There are ways to make the “committee” process less painful

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Clinical Specialty
Review Committees
("CSRCs")

Who are the CSRCs?

- Department Committees (e.g., Medicine, Surgery, etc.)
- Service Line Committees (e.g., Trauma, Stroke, etc.)

AND/OR

106

Clinical Specialty
Review Committees
("CSRCs")

Who are the CSRCs?

- One of the following individuals, working "asynchronously" with PPEC Chair or other PPEC member:
 - Department Chair
 - Department Vice Chair
 - "Physician Advisors" in each specialty/department
 - Applicable CPE member
 - Service Line Medical Director or Representative

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Clinical Specialty
Review Committees
("CSRCs")

Asynchronous Reviews

- Members of CSRCs may work independently, but must communicate about cases periodically
- Case review form may serve as "minutes" of CSRC

108

Clinical Specialty
Review Committees
("CSRCs")

Role of CSRCs

- Fact-finders only (reporting everything to the PPEC for its review and determination)
- OR
- Fact-finders PLUS lower-level performance improvement tools (e.g., Educational Letter; Collegial Counseling)

109

Clinical Specialty
Review Committees
("CSRCs")

Role of CSRCs?

- Choice depends on:
 - Volume of cases – can PPEC handle all? Or should it delegate authority for lower-level actions to CSRC?
 - “Maturity” of process – how experienced are CSRCs?
 - Benefits of multi-specialty review
- Oversight reports may promote comfort with more active role for CSRCs

110

Clinical Specialty
Review Committees
("CSRCs")

Training for CSRCs

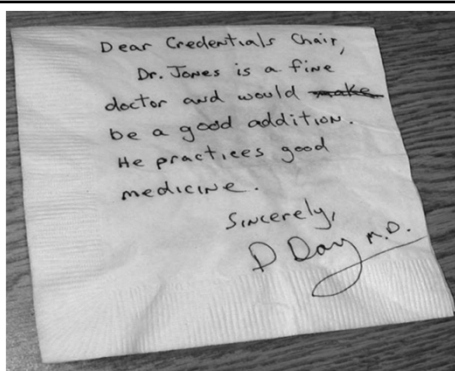
- Role in the overall PPE process
- How to obtain additional information or input from practitioner under review or others, if necessary
- How to appropriately characterize findings
- Time frames for review, confidentiality agreements and tips, legal protections, etc.
- Complete appropriate review form!

111

Clinical Specialty Reviewer Committees ("CSRCs")

Use
effective
review
forms!

112



113

Clinical Specialty Review Committees ("CSRCs")

Review Form Best Practices

FOUNDATION:

- Use a standard, carefully-drafted *CASE REVIEW FORM* for *ALL* case reviews and fact-finding
- Must be tailored to *YOUR* PPE process

114

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Assessment of Care

- No focus on patient outcomes
- No “scoring”
- Instructions to reviewer
- List elements of care (e.g., judgment; technical skill), and then “No issue” or “Some issue”
- Description of why concerns continue after input, if applicable

115

Lessons Learned and System Issues

- Once this review is concluded, would this patient scenario be of educational benefit to other members of the specialty or Medical Staff?
- Based on your review, are there any system process or policy changes that could improve patient safety and care?
 - Recommendations (e.g., new policy or checklist; handoff breakdown; training for staff)?
 - Who should be involved to most effectively address the issue?

116

Clinical Specialty
Review Committees
("CSRCs")

Should Identity of Practitioner be “Blinded” During Initial Review of Case?

- Creates legal risk in managing conflicts of interest
- Complicates process for obtaining input from practitioner
- Impossible to do consistently, so if required by policy violations will likely occur

117

**Clinical Specialty
Review Committees
("CSRCs")**

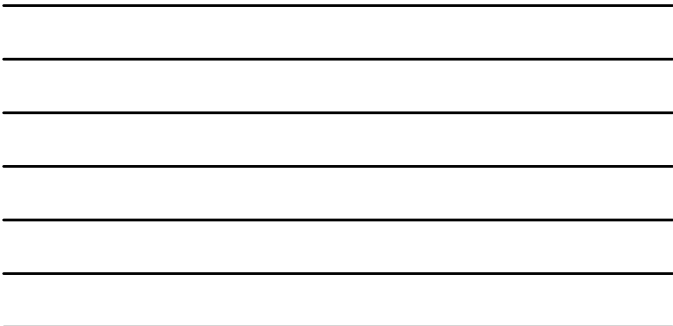
**What if CSRC needs assistance
(e.g., subspecialty expertise)?**

Assigned Reviewers

```
graph TD; CSRC[Clinical Specialty Review Committees (CSRCs)] --> AR[Assigned Reviewer]; AR --> CSRC;
```

- CSRC may obtain assistance from another Practitioner (an "Assigned Reviewer")
- Assigned Reviewer may simply serve as consultant to CSRC, or may complete a review form
- CSRC remains accountable for deciding what to do

-
-
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Foundation of an effective process!

121

Multi-Specialty "PPEC" is the Key to an Effective *Clinical* Review Process!



122

Professional Practitioner
Evaluation Committee ("PPEC")

Composition

- Who should serve?
 - "Up and Comers" along with some *adult supervision*
 - Broadly representative of clinical specialties
 - Review and accept duties prior to appointment
- Who should *NOT* serve?
 - Current MEC members!
(e.g., department chairs)

123

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Professional Practitioner
Evaluation Committee ("PPEC")

Why no Department Chairs/MEC members?

Remember our discussion of the Leadership Council ...

- Department Chair may be partner or competitor of physician
- Help Department Chair preserve working relationship with practitioner under review
- Avoid perception of "punishment" that comes with MEC actions and keep separation between levels of review within the process

124

Professional Practitioner
Evaluation Committee ("PPEC")

Composition

How about ...

- At least two experienced Medical Staff Leaders
- Physicians from a cross-section of the specialties on the Medical Staff
(*BEST PRACTICE TIP: efficient and effective if CSRC Chairs or members serve as CPE members!*)
- At least one Advanced Practice Professional (APP)
- CMO
- PPE Specialists

125

Professional Practitioner
Evaluation Committee ("PPEC")

Terms

- At least 3-5 year terms
- Staggered, so there is always expertise on the committee
- Educate and equip all new members!

126

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Professional Practitioner
Evaluation Committee ("PPEC")

Tools

Practical Tip — Create *tools* that continually reinforce the PPE process, educate the PPEC members, and promote consistency and effectiveness...

CONSIDER QUICK REFERENCE TOOLS!
(e.g., PPE process flowchart; Case Review Guidelines;
Listing of PIP options)

127

Professional Practitioner
Evaluation Committee ("PPEC")

What about Risk Management on the PPEC?

- Jeopardize Peer Review Protection?
 - Having nonphysicians on the committee generally does not increase risk; but ...
 - Having risk management on PPEC can blur the line between peer review activities and risk management activities
- Political issue?
 - Would presence of risk management impact candor of discussion at meetings?

128

What can the PPEC do when it identifies an issue or concern?

129

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**Remember, just like the
Leadership Council, the PPEC
has
*No Disciplinary Authority!***

130

Professional Practitioner
Evaluation Committee ("PPEC")

Improvement Tools

- Educational letter
- Collegial Counseling
- Performance Improvement Plan
- Refer to Employer
- Refer to MEC

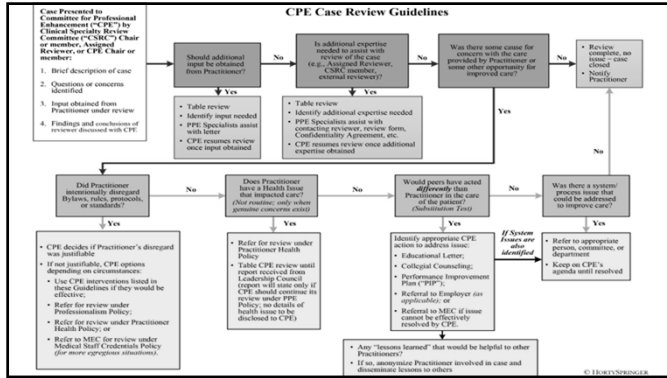
131

**What is the appropriate performance
improvement tool?**

- Based on:
 - Nature of concern AND
 - Practitioner's peer review history

132

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133

Final Practical Tips

134

Professional Practitioner Evaluation Committee ("PPEC")

Who will present the case?

- CSRC Chair or CSRC Member
- Assigned Reviewer
- PPEC Chair
- Appropriate PPEC Member

135

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Provide Guidelines to Those Presenting Cases to PPEC

1. Concise description of case
2. Questions or concerns identified
3. Input obtained from colleague whose care is under review
4. Present findings, conclusions, and recommendations

(Do you need to establish a time limit?)

136

Professional Practitioner
Evaluation Committee ("PPEC")

Don't forget "Loop Closure"

How will you monitor whether:

- Expectations were met or a plan of action was completed as designed?
- Improvement was obtained and sustained?

If improvement is not achieved, what's next?

137

Professional Practitioner
Evaluation Committee ("PPEC")

Don't forget these other Functions!

- Practitioner-Specific Reviews
- "Policy" Decisions
- Lessons Learned & Shared
- Monitoring "System" Fixes
- Public Relations!

138



When and how should you get input from the practitioner? (Clinical Issues)

139

When is input sought from practitioners?

- As soon as a potential concern is first identified (e.g., as a result of a trigger)?
- After a disturbing trend has developed?
- Any time a reviewer (i.e., a Clinical Specialty Review Committee, Assigned Reviewer, Leadership Council or PPEC) has a concern about a case and input has not already been obtained

140

General Rules

- No improvement tool (Educational Letter, Collegial Counseling, Performance Improvement Plan) until practitioner is notified of specific concerns and provides input
 - Note: this does not apply to Informational Letters...but choose events that trigger an Informational Letter *carefully!*

141

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General Rules

- Input can be sought at any time
- Multiple requests may be made
- Request can include office records



142

General Rules

- Identity of person who reported or provided information generally not disclosed
- Why? This is a collegial discussion, not an interrogation



143

General Rules

Request should include time frame for practitioner's input



144

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General Rules

- Decide whether initial request should notify practitioner of consequences of failure to provide input:
 - For most practitioners, first letter probably doesn't need to discuss consequences
 - For outliers, or for those who ignore first request, identify consequences

145

Options:

- Option 1: Review proceeds without practitioner input
 - Advantages: simple, non-threatening
 - Disadvantages: less effective reviews, may lead to a "re-do" later if practitioner doesn't like result of review
- Option 2: Report to MEC
- Option 3: "Automatic relinquishment" until input provided

146

Automatic Relinquishment

Clinical Specialty Review
Committees ("CSRCs")

Leadership
Council

Professional Practitioner
Evaluation Committee
("PPEC")

- Notice that input or meeting is mandatory
- Notice that automatic relinquishment will occur for failure to provide written input or attend meeting
- Not reportable to government agency, no hearing

147

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**Automatic
relinquishment**

**NOT
Automatic
suspension**

Define/explain in PPE Policy

148

What format is used for requesting input?

- **Written request:**
 - Promotes consistent message through use of standard language
 - Serves as documentation
- E-mail may be less threatening than letters
- Consider phone call as “heads up” (may reduce tension and avoids “I don’t check e-mail” problem)

149

**How does the practitioner
provide input?**

- **Written explanation of care, responding to specific questions**

150

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How does the practitioner provide input?

- In person, at request of person or committee conducting review, or at request of practitioner:
 - Committee decides – full committee or representatives

151

How does the practitioner provide input?

- No “button-holing” committee members (i.e., separate discussions) outside of committee meeting unless authorized by committee
- No providing verbal input to PPE Specialists with request that it be relayed to someone else

152

At CPE

- Can involve the practitioner in development of Performance Improvement Plan (PIP), if PPEC deems appropriate (recall that input on the care provided has already been obtained)
- Review elements of Performance Improvement Plan with practitioner in person

153

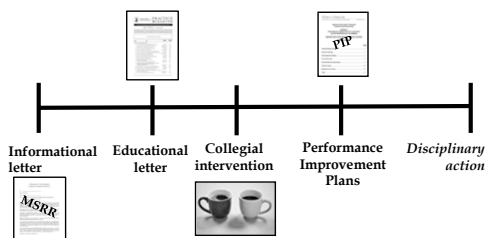
***“Stuff” Happens on
the Very Best of
Medical Staffs!***

154

***Using Initial Mentoring
Efforts and Progressive Steps
to address this “stuff”!***

155

Progressive Steps Continuum



156

Using *Initial Mentoring Efforts* and *Progressive Steps* to address this “stuff”!

157

Initial Mentoring Efforts

- Different than formal “collegial intervention,” which are formal, planned, face-to-face discussion between the Practitioner and one or more Medical Staff Leaders
- Informal discussions, mentoring, counseling, sharing of comparative data, and similar efforts
- No need for prior input from Practitioner
- Documentation optional (but a good idea)



158

Initial Mentoring Efforts Case Study

**Dr. Van Winkle:
Is he asleep at the switch?**

159


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Dr. Van Winkle
**Internist,
Solo practitioner**
Has one NP


Average inpatient census: 20+ patients
Recent OPPE Report:
ALOS 54% above expected
Data confirmed by Department Chair

160



- Dr. Van Winkle received 6-month OPPE report
- ALOS 54% higher than average
- Dr. Van Winkle doesn't see a problem; patients are doing well

161



Dr. Prompt offers suggestions:

- Round earlier, set priorities
- Have NP round
- Don't admit for non-staff physicians

162

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- Dr. Prompt asks about lack of documentation for patients in hospital six days or more
- Dr. Prompt suggests these patients could have been cared for in another setting

163



- Dr. Prompt closes by saying “let’s see how this length of stay looks on the next report”
- Dr. Prompt also says he will be putting a note in the file of Dr. Van Winkle about their conversation

164

What did Dr. Prompt do well?

- Respectful tone
- Well prepared
- Had his own talking points/suggestions
- Anticipated Dr. Van Winkle’s arguments

165

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What could Dr. Prompt have done better?

- Meeting rather than phone call
- Advance notice of call and issues
- Start by discussing positive aspects of OPPE report
- Encourage Dr. Van Winkle to take ownership (e.g., "what would you suggest?")

166

What could Dr. Prompt have done better?

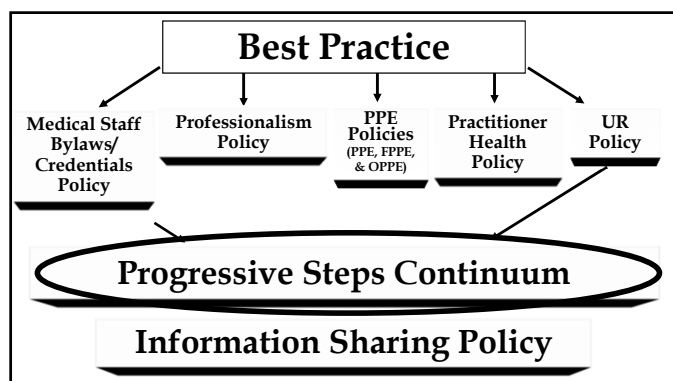
- Review sooner than next OPPE report
- Provide measurable, intermediate goals
- Discuss consequences of failure to improve?
- Follow-up e-mail to Dr. Van Winkle (as opposed to note in file)

167

Using *Initial Mentoring Efforts* and Progressive Steps to address this "stuff"!

168

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169

The Basics

- Be explicit and consistent about the "Progressive Steps Continuum" in your documents:
 - Medical Staff Bylaws documents
 - PPE Policy
 - Professionalism Policy
 - Practitioner Health Policy

170

The Basics

- Provides helpful guidance to leaders
- Important for peer review protection

171

The Basics

Use the *Least Restrictive Approach*
Consistent With *Good Quality!*

172

The “*RIGHT*” option/tool depends on:

- Assessment of the current issue
- Practitioner’s history
- *No requirement to proceed SEQUENTIALLY!*

173

The Basics

More flexibility to work without fear of:

- Hearings
- Data Bank Reports

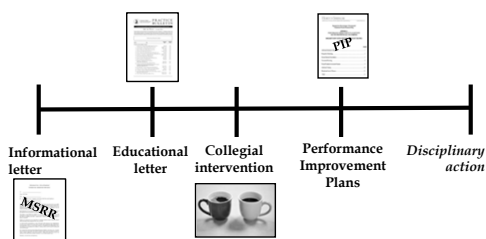
174

The Basics

**Last But Not Least...
Improves Legal Position —
Even if it Doesn't Work!**

175

Progressive Steps Continuum



176

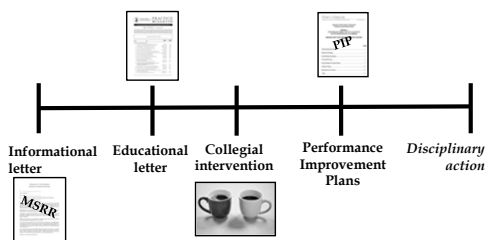
Informational Letters

- “Informational” letter based on objective circumstances chosen by Medical Staff leadership
- Medical record deficiencies
- Failure to follow Rules & Regulations
- Failure to follow protocols
- Pre-drafted and tactfully worded — generated by PPE Specialists and sent from Medical Staff leader
- Establish limitations (e.g., third letter triggers further review)
- Part of OPPE data

177

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Progressive Steps Continuum



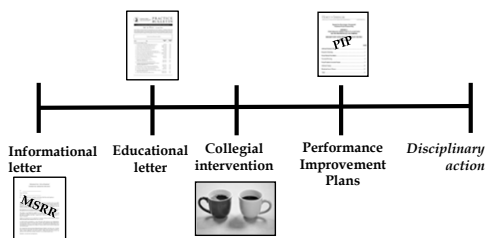
178

Educational Letters

- Informational *plus* more specific guidance/suggestions
 - Describe an opportunity for improvement that was identified in the case reviewed; and/or
 - Offer specific recommendations for future practice.
- "Enclosed is an article from the Green Journal on managing...."

179

Progressive Steps Continuum



180

*Can be the Most Effective
(But Most Difficult!) Step
on the Continuum!*

181

**Four Steps for an
Effective
Collegial Interventions**

182

Collegial Intervention

Step #1: Assess the situation – no zero to 100 reactions!

- How serious is the issue?
- Is there a past history of similar incidents?
- Where are we in the continuum?

183

Collegial Intervention

Step #2: Plan!

- Who is going to meet with the individual (one-on-one or group)?
- Where are you going to meet?
- What is personality of individual involved?
- How much time do we need? How much are we likely to get?

184

Collegial Intervention

Step #3: Prepare!

- What is the desired outcome/objective?
- What are your talking points?
- Who is going to address each talking point?
- What reactions/responses can we anticipate... and be prepared to address?

185

Talking Points

- Introduction
 - "Thank you for meeting with us"
 - "We are..."
 - "The purpose of this meeting is to..."
- Confidentiality/Retaliation
 - "This is a part of our peer review process."
 - "Thou shalt not retaliate"
- Issues/Questions

186

Plan for the inevitable “what ifs”!!

187

What if?

- The practitioner wants to record the meeting?
- The practitioner brings her lawyer?
- The practitioner doesn't show up?

188

Collegial Intervention

Step #4: Document!

189

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Remember The Basics!!!

**Last But Not Least...
Improves Legal Position —
Even if it Doesn't Work!**

190

*Catipay M.D. v. Humility of
Mary Health Partners
(Court of Appeals Ohio)*

191

Facts:

- OB on staff for 15 years with no issues.
- Then...
 - Posted "Kama Sutra Indian Sex Guide" on hospital bulletin board
 - After heated argument with a nurse, posted "Police Says Man Killed Wife" article in LDU, with note "This happens when wives talk too much."
 - Other NSFW incidents

192

Abrazo Healthcare and Carondelet Facilities

Facts:

- CMO and Chief of Staff meet with Dr. Catipay to discuss his conduct.
- Dr. Catipay signs a letter agreeing to knock it off, but...

193

Facts:

- Harasses pediatricians for what he perceived to be inadequate neonatal resuscitation coverage.
- Failed to notify the Hospital that his privileges had been revoked at a neighboring hospital.
- Later sends the CMO a “disturbing” letter with “bizarre” references to “The Godfather.”

194

Matter goes to the MEC...

- Request a psychiatric evaluation, but Dr. Catipay refuses
- Clinical privileges are suspended:
 - Inappropriate conduct towards staff
 - Inappropriate conduct towards CMO
 - Failure to disclose suspension
 - Refusal to obtain examination
- Informed of his right to a hearing

195

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Dr. Catipay sues...

196

Holding:
Case Dismissed!

197

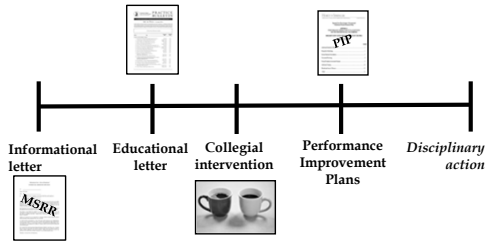
**HCQIA immunity applies
when action is taken:**

- in the reasonable belief it was in furtherance of quality care
- after an opportunity to obtain the facts
- after notice and hearing

198

Abrazo Healthcare and Carondelet Facilities

Progressive Steps Continuum



199

Performance Improvement Plans

(options used individually or in combination)

- Additional education/CME
- Monitoring/retrospective chart review of next X cases
- Procedure indications checklist
- Second opinions/consultations
- Concurrent proctoring/proctoring "lite" (review of videos)

200

Performance Improvement Plans

(options used individually or in combination)

- Participation in formal evaluation and assessment program
- Additional training/simulation
- Educational LOA/voluntary agreement to temporarily refrain from exercising privileges
- "Other"

201

Abrazo Healthcare and Carondelet Facilities

Key to PIP Success
The Devil is in the Details!

202

Additional Education/CME?

203

The screenshot shows the NetCE website with a special offer for 30 CME credits for \$69. The offer is for physicians and includes a list of topics such as Autoimmune Diseases, Diabetes, and Heart Disease. A box highlights the text "Is online CME sufficient?".

NetCE
Nurse Continuing Education

Questions?
Call us at 1-800-931-4335

Physicians:
Get 30 Credits for only \$69 - FAST!

- ACCME Accredited
- AMA PRA Category 1 Credits™
- Instant certificates - no waiting
- High-quality, evidence-based course material

30 AMA PRA Category 1 Credits™

Fast & Easy Credits:

1. Register & read the course you want.
2. Purchase & submit your test(s) and pass(es).
3. Print!

Did you know?
Our website and mobile app make it so easy to earn your credits. Get started today!

Is online CME sufficient?

SPECIAL OFFER (expires June 30, 2023)
30 CME Credits for only \$69

INCLUDES:

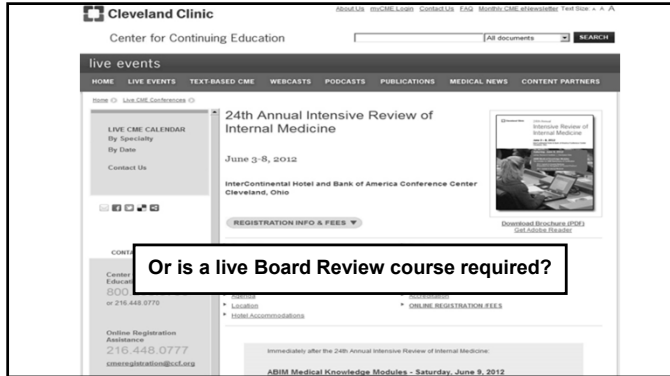
- #9452 Autoimmune Health Status
- #9445 Autoimmune Diseases

Register & Get Started

Course	Credits	Price
9407 Autoimmune Diseases	10	\$19
9410 Autoimmune Diseases	10	\$19
9417 Pathophysiology and Clinical Management of Autoimmune Diseases	10	\$19
9418 Pathophysiology and Clinical Management of Autoimmune Diseases	10	\$19
9419 Pathophysiology and Clinical Management of Autoimmune Diseases	10	\$19
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9479 Pathophysiology and Clinical Management of Autoimmune Diseases	10	\$19
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9481 Pathophysiology and Clinical Management of Autoimmune Diseases	10	\$19
9482 Pathophysiology and Clinical Management of Autoimmune Diseases	10	\$19
9483 Pathophysiology and Clinical Management of Autoimmune Diseases	10	\$19
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9500 Pathophysiology and Clinical Management of Autoimmune Diseases	10	\$19

204

Abrazo Healthcare and Carondelet Facilities



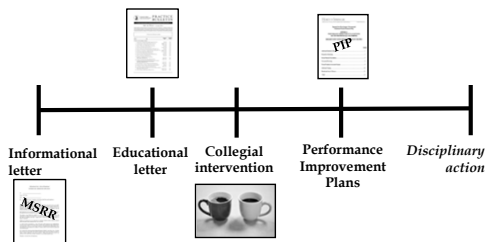
205

Additional Education/CME

- Be specific
- What type?
- Number of hours?
- Does Medical Staff leadership approve program *prior* to enrollment?

206

Progressive Steps Continuum



207

“Disciplinary Action”

- MEC level decisions
 - Formal Investigation?
 - Precautionary Suspension?
- This is where the outcome may trigger a hearing and reports (e.g., long term suspensions, revocation of appointment or clinical privileges)

208

Documenting Collegial Interventions (and Other Progressive Steps)

209

Best Practice? Document All “Formal” Counseling Interventions ... Constructively!!

210

Abrazo Healthcare and Carondelet Facilities

Document All Formal Sessions

- Fosters consistency and fairness
- Facilitates a central repository of knowledge (be careful of separate files)
- Aids education of new leaders
- Improves effectiveness of interventions

211

KEY: Tone is as Important as Content!

- Collegial, respectful, and empathetic (i.e., *nice*)
- Find a way to start with "Thank you"
- Exception? When necessary to reflect individual's failure to change ("we're disappointed..." "we regret you have chosen...")

212

Topics to Address in Follow-Up Letters

- Summarize background
 - describe incident
 - identify relevant Bylaws or policy provision
 - discuss history
- Describe expectations going forward
- Describe consequences of failing to meet expectations (as needed)
- Monitoring, non-retaliation (as needed)

213

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Remember Your Audiences

- Physician under review
- Physician's attorney
- Future physician leaders
- Hearing Panel
- Judge/Jury

Always come back to your main objective - protecting patients?

214

Whenever You Document...

- Individual given opportunity to respond in writing
- Response kept in file

215

Do physicians have a legal right to see everything in their Medical Staff files?

216

Abrazo Healthcare and Carondelet Facilities

- Right to access employment files often exists
- Typically, no legal right to access Medical Staff files
- Do you have a policy governing access?

217

Consider a Policy on Practitioner Access to Confidential Files!

218

General Rules

- Advanced notice/must schedule specific time for review
- CMO/VPMA-Type determines format of review (paper/electronic, location, etc.)
- Individual may review and take notes but no copies! (*and check cell phones at door?*)

219

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Special Rules for Accessing *Sensitive Documents*

- Documents redacted or summarized to remove the identity of those who filed complaints or provided information
- Must agree to confidentiality and non-retaliation (use form)

220

**Like any good rule, there is an
exception...**

**Practitioners do have a right to non-redacted
copies of documents used as basis for a
“Professional Review Action”**

221

**Can you ever expunge information
from a Medical Staff file?**

222

Abrazo Healthcare and Carondelet Facilities

- **Should not happen automatically**
 - Information may still be relevant if ongoing issues
 - Defending lawsuits
 - Insurance coverage
- **Have a process for corrections or deletions for any factually inaccurate information**
- **Can you meet them halfway?**

223

Performance Improvement Plan Options (“PIPs”)

Clinical Performance Issues

224

Performance Improvement Plans (options used individually or in combination)

- Additional education/CME
- Monitoring/retrospective chart review of next X cases
- Procedure indications checklist
- Second opinions/consultations
- Concurrent proctoring/proctoring “lite” (review of videos)

225

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Performance Improvement Plans (options used individually or in combination)

- Participation in formal evaluation and assessment program
- Additional training/simulation
- Voluntary agreement to temporarily refrain from exercising privileges/Educational LOA
- "Other"

226

Keys to PIP Success

- You can't be nice enough!

227



228

Abrazo Healthcare and Carondelet Facilities

Confidential Peer Review

Re: Performance Improvement Plan

- Thanks for cooperation and input to date
- CPE conducted review/developed voluntary PIP to successfully and constructively address issue
- PIP details
- Your voluntary agreement — not a “restriction” that requires hearing or reporting

229

Confidential Peer Review

Re: Performance Improvement Plan

- Demonstrate your commitment to work with us — sign and return within X days
- If you disagree with need for PIP, CPE has no further authority; matter will be referred to MEC for independent review
- Pleased to meet again if you have any questions or need any clarification

230

Confidential Peer Review

Re: Performance Improvement Plan

“Thank you for your cooperation and participation in the Medical Staff’s ongoing efforts to improve the care that we all provide.”

231

Abrazo Healthcare and Carondelet Facilities

Keys to PIP Success

- You can't be nice enough!
- Be explicit on details/expectations — develop and use a PIP checklist tool

232

The **DETAILS** matter!
Be **EXPLICIT**
on the Plan and Its
Implementation!

233

Develop A Checklist Tool!

PIP OPTION	IMPLEMENTATION ISSUES
Additional Education/CME <i>Wide range of options</i>	Scope of Requirement <input type="checkbox"/> Be specific - what type? <input type="checkbox"/> Acceptable programs include: <input type="checkbox"/> CPE approval required before practitioner enroll: <input type="checkbox"/> Program approved: _____ <input type="checkbox"/> Date of approval: _____ <input type="checkbox"/> Time frames: <input type="checkbox"/> Practitioner must enroll by: _____ <input type="checkbox"/> CME must be completed by: _____ <input type="checkbox"/> Who pays for the CME/course? <input type="checkbox"/> Practitioner subject to PIP <input type="checkbox"/> Medical Staff <input type="checkbox"/> Hospital <input type="checkbox"/> Combination <input type="checkbox"/> Specify documentation of completion that must be submitted to: <input type="checkbox"/> Date submitted: _____ Additional Subpoints <input type="checkbox"/> Will the individual be asked to voluntarily refrain from exercising the use of clinical privileges until completion of additional education? <input type="checkbox"/> Yes <input type="checkbox"/> No Follow-Up <input type="checkbox"/> After CME has been completed, how will monitoring be done to be sure that concerns have been addressed/practice has improved? (Personal perspective monitoring? Practicing?)

234

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Additional Education/CME

- Be specific – what type? Number of hours?
- PPEC approves program prior to enrollment

235

NetCE
Continuing Education Online

Physicians:
Get 30 Credits for only \$69 - FAST!

- ACCME Accredited
- AMA PRA Category 1 Credits™
- Instant certificates - no waiting
- High-quality, evidence-based course material

30 AMA PRA Category 1 Credits™

SPECIAL OFFER
30 CME Credits for only \$69 (Expires June 30, 2012)

Fast & Easy Credits:

1. Register & read the course you want.
2. Purchase & instant your credits and certificate.
3. Print certificate.

Did you know? Our easy and instant online CME education can save you time.

Is online CME sufficient?

Course Title	Credits	Price
#9402 Annual Related Health Risks	10	\$19
#9445 Autoimmune Diseases	10	\$19
#9407 Asthma: Review	10	\$19
#9415 Autoimmune Diseases	10	\$19
#9407 Asthma: Review	10	\$19
#9415 Autoimmune Diseases	10	\$19
#9407 Asthma: Review	10	\$19
#9415 Autoimmune Diseases	10	\$19
#9407 Asthma: Review	10	\$19
#9415 Autoimmune Diseases	10	\$19

Register & Get Started

236

Cleveland Clinic
Center for Continuing Education

live events

24th Annual Intensive Review of Internal Medicine
June 3-8, 2012
InterContinental Hotel and Bank of America Conference Center
Cleveland, Ohio

REGISTRATION INFO & FEES

Or is a live Board Review course required?

CONTACT INFO
Center for Continuing Education
800.238.2388
or 216.448.0776

Online Registration Assistance
216.448.0777

237

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Additional Education/CME

- Establish time frames (e.g., enroll by ____; complete by ____)
- Who pays?
- What documentation of completion must be provided to the PPEC?
- After CME completed, will monitoring be done to be sure that concerns have been addressed/practice has improved? (e.g., retrospective chart review, proctoring, etc.)

238

Keys to PIP Success

- You can't be nice enough!
- Be explicit on details/expectations – develop and utilize a PIP checklist tool!
- Personal meeting with colleague, be transparent and helpful – have a script!
- PIPs never leave PPEC's agenda until they are successfully completed!



239

OTHER



240

[illegible][illegible]



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	 Shady Oaks Memorial Hospital 2023 S. 25th Street Peasopville, OH 43429 Phone: 404-555-1202 www.shadyoaksmh.org
	<p>Thank you for providing written input regarding MR# 13579. I appreciate your constructive participation in our review process.</p>

244

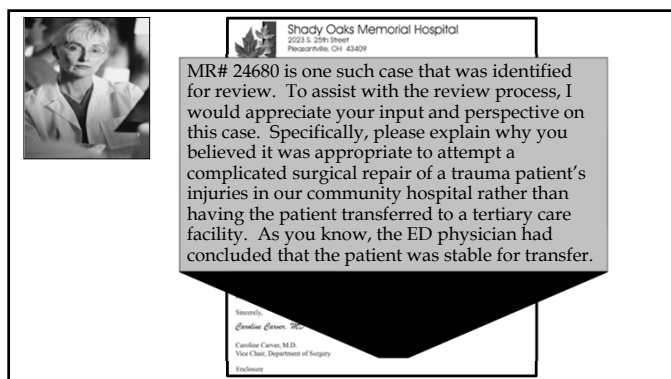
	 Shady Oaks Memorial Hospital 2023 S. 25th Street Peasopville, OH 43429
	<p>As you know, this case involved a scheduled abdominal surgery on an elderly patient with significant co-morbidities and several prior abdominal surgeries. The patient experienced significant bleeding during the procedure followed by a cardiac arrest. Fortunately, the patient was resuscitated and you got the bleeding under control.</p>

245

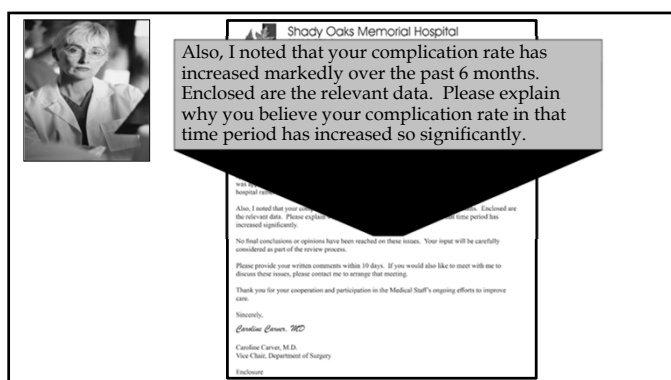
	 Shady Oaks Memorial Hospital 2023 S. 25th Street Peasopville, OH 43429
	<p>Your technical skills in addressing the patient's bleeding are not in dispute. However, the procedure likely would have had a different outcome if you had asked another surgeon to be present at the operation from the outset. In the future, please consider whether such difficult surgeries would benefit from the presence of another surgeon.</p>

246

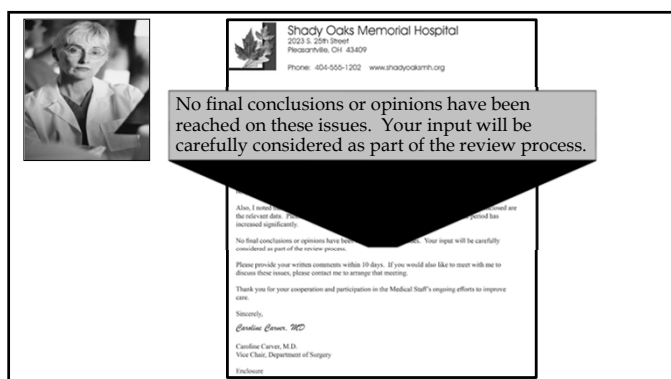
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250



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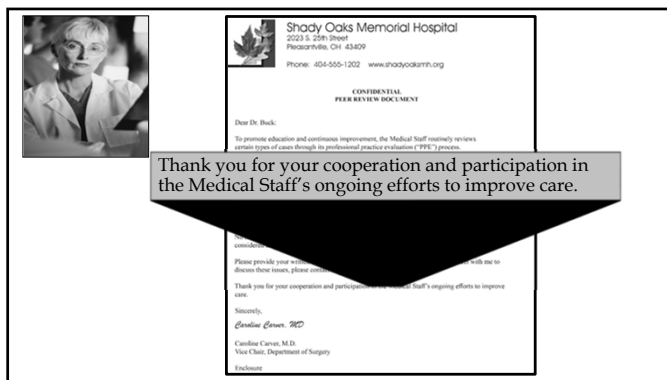


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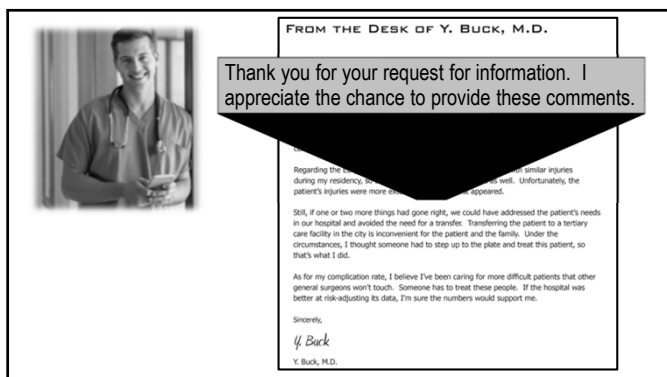
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253




254



255

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FROM THE DESK OF Y. BUCK, M.D.


Regarding the ED patient in MR# 24680, I operated on patients with similar injuries during my residency, so I felt qualified to treat this patient as well. Unfortunately, the patient's injuries were more extensive than they first appeared.

Still, if one or two more things had gone right, we could have addressed the patient's needs in our hospital and avoided the need for a transfer. Transferring the patient to a tertiary care facility in the city is inconvenient for the patient and family. Under the circumstances, I thought someone had to step up to the plate and treat this patient, so that's what I did.

As for my complication rate, I believe I've been caring for more difficult patients that other general surgeons won't touch. Someone has to treat these people. If the hospital was better at risk-adjusting its data, I'm sure the numbers would support me.

Sincerely,
Y. Buck
Y. Buck, M.D.

256




FROM THE DESK OF Y. BUCK, M.D.

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Y. Buck, M.D.

257



FROM THE DESK OF Y. BUCK, M.D.

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Sincerely,
Y. Buck
Y. Buck, M.D.

258

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What should the PPEC do?

1. Is there an issue or concern?
2. If so, what performance improvement tool can best help our colleague?

259

Issues to consider:

- What changes in circumstances?
- How to address those changes?
- What personality traits are relevant?
- Advice for Dr. Buck?



260

PIP Options

- Additional CME
- Monitoring/Retrospective Chart Review
- Procedure Indications Checklist
- Second Opinions/Consultations
- Concurrent Proctoring
- Formal Assessment Program
- Additional Training/Simulation
- Educational LOA/Voluntarily Refrain from Practice
- Other

261

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Abrazo Healthcare and Carondelet Facilities

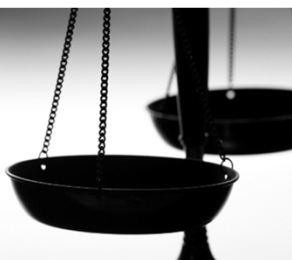
Medical Staff Leadership Program

March 31-April 1, 2023

Ian Donaldson

262

Legal Protections For
Medical Staff Leaders:
The Law Is on Your Side



263

Lawsuits by Physicians

- Fairness – Due Process
- Antitrust
- Whistleblowers
- “Employment” Discrimination

264

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Legal Protections for Physician Leaders



- Health Care Quality Improvement Act of 1986

265

Health Care Quality Improvement Act

Provides "immunity"

266

Health Care Quality Improvement Act

- Immunity for:
 - Those who provide information

267

Abrazo Healthcare and Carondelet Facilities

- **No liability UNLESS**
 - **Information false;**
AND
 - **Knew it was false**

268

Health Care Quality Improvement Act

- **Immunity for:**
 - **Those who provide information**
 - **Peer reviewers**

269

HCQIA immunity applies when action is taken:

- **in the reasonable belief it was in
furtherance of quality care**
- **after an opportunity to obtain the facts**
- **after notice and hearing**

270

Abrazo Healthcare and Carondelet Facilities

HCQIA immunity applies to a suspension:

- when failure to act may result in “imminent danger to the health of any individual”

271

Health Care Quality Improvement Act

- Immunity Applies to:
 - Federal antitrust actions
 - State law claims

272

HCQIA Protections Do Not Apply to:

- Civil rights actions
- Actions involving non-physician practitioners
- Policy decisions

273

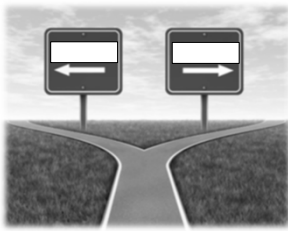
Abrazo Healthcare and Carondelet Facilities

Health Care Quality Improvement Act

- Case law under HCQIA – peer reviewers winning!

274

“Right way” vs. “wrong way”



275

The Right Way...

Cohlma v. St. John Medical Center
(10th Cir.)

276

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Facts:

- Cardiovascular and thoracic surgeon's privileges suspended based on two thoracotomies he performed on lung cancer patients.
- One patient died seven days after the procedure.
- A second was permanently disfigured.

277

Facts:

- VPMA reviews and determines "there was an inadequate workup...before [the patients] were operated on."
- VPMA and MEC then determine Dr. Cohlma's continued practice "posed potential harm to patients" and suspended his privileges.

278

Facts:

- Three external reviews confirm findings related to care.
- Hearing officer affirms findings that led to suspension and ultimately Dr. Cohlma's privileges are terminated.
- After termination, his privileges are not renewed at one sister hospital and he voluntarily resigns privileges at two other sister hospitals in the system.

279

Abrazo Healthcare and Carondelet Facilities

Facts:

Oh, by the way, two years prior to the suspension, Dr. Cohlmlia had explored opening his own competing specialty heart hospital.

280

Dr. Cohlmlia sues...

281

HCQIA immunity applies when action is taken:

- in the reasonable belief it was in furtherance of quality care
- after an opportunity to obtain the facts
- after notice and hearing

282

Abrazo Healthcare and Carondelet Facilities

**Holding:
Immunity Granted!**

283

**HCQIA immunity applies
when action is taken:**

- in the reasonable belief it was in
furtherance of quality care
- after an opportunity to obtain the facts
- after notice and hearing

284

The Wrong Way...

Poliner v. Texas Health Systems
(N.D. Tex.)

285

Abrazo Healthcare and Carondelet Facilities

Facts:

- During his first year on the staff, Dr. Poliner had:
 - three serious cases identified through the peer review process
 - a fourth case where he performed an angioplasty on the wrong artery

286

Facts:

- At 2:00 p.m.
 - Medical staff leaders asked Dr. Poliner to sign abeyance agreement

287

Facts:

- Dr. Poliner was told:
 - Agreement must be signed by 5:00 p.m.
 - Not to contact attorney
 - Failure to agree would result in suspension of all privileges
 - NEVER given opportunity to comment on cases

288

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**Dr. Poliner agrees to sign
the agreement.**

289

Dr. Poliner sues...

290

**HCQIA immunity applies
when action is taken:**

- in the reasonable belief it was in furtherance of quality care
- after an opportunity to obtain the facts
- after notice and hearing

291

Abrazo Healthcare and Carondelet Facilities

**Holding:
Immunity Denied!**

292

**HCQIA immunity applies
when action is taken:**

- in the reasonable belief it was in furtherance of quality care
- after an opportunity to obtain the facts
- after notice and hearing

293

**The jury awarded
Dr. Poliner ~~\$366~~ million.**

294

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The jury award was reduced to \$36 million.

295

Verdict overturned!!

296

HCQIA immunity applies when action is taken

- in the reasonable belief it is in furtherance of quality care
- after an opportunity to be heard on the facts
- after notice and hearing

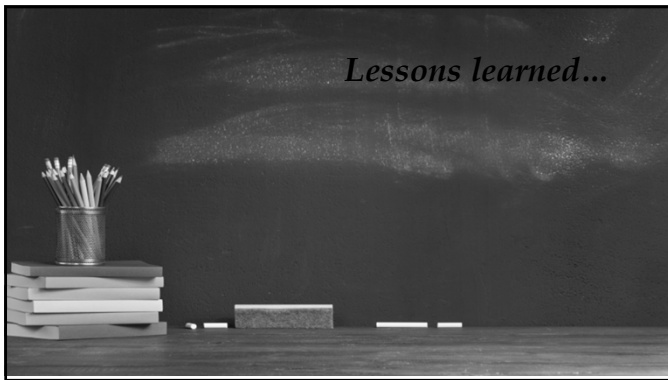
297

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HCQIA immunity applies
to a suspension:

- when failure to act may result in
"imminent danger to the health of
any individual"

298



299

Lesson 1

**Know why you are concerned -
and make sure you can articulate
those reasons.**

300

AND REMEMBER!

If you want protection under the HCQIA, there is only one reason to support the imposition of a precautionary suspension – imminent danger.

301

Lesson 2

Meet with the physician before imposing a suspension.

302

Lesson 3

Appearances Matter – Manage Them Carefully! (Conflicts of Interest and Otherwise)

303

Lesson 4

Protect Patients!
What is the least restrictive option
that will protect patients during the
investigation process?

304

Consider Your Options:

- Safeguards (e.g., Proctoring, 2nd opinion)
- Agreement to refrain some/all privileges
- Suspension of some/all privileges

305

Lesson 5

**Follow Your Policies
(and Document Variances)**



306

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Legal Protections

- Health Care Quality Improvement Act of 1986
- State peer review statutes

307

Arizona Peer Review Statute

"Any individual who, in connection with duties or functions of a hospital ... makes a decision or recommendation as a member, agent or employee of the medical or administrative staff of a hospital or center or of one of its review committees or related organizations or who furnishes any records, information, or assistance to such medical staff or review committee or related organization is not subject to liability for civil damages or legal action in consequence thereof."

Ariz. Rev. Stat. Ann. §36-445.02.

308

Arizona Peer Review Statute

"No hospital or outpatient surgical center and no individual involved in carrying out review or disciplinary duties or functions of a hospital or center pursuant to section 36-445 may be liable in damages to any person who is denied the privilege to practice in a hospital or center or whose privileges are suspended, limited or revoked.... If the record shows that the denial, revocation, limitation or suspension of membership or privileges is supported by substantial evidence, no injunction shall issue. In such actions, the prevailing party shall be awarded taxable costs, but no other monetary relief shall be awarded."

Ariz. Rev. Stat. Ann. §36-445.02.

309

Abrazo Healthcare and Carondelet Facilities

Arizona Peer Review Statute

"All proceedings, records and materials prepared in connection with the reviews provided for in section 36-445, including all peer reviews of individual health care providers practicing in and applying to practice in hospitals or outpatient surgical centers and the records of such reviews, are confidential and are not subject to discovery except in proceedings before the Arizona medical board, or the board of osteopathic examiners, or in actions by an individual health care provider against a hospital or center or its medical staff arising from discipline of such individual health care provider or refusal, termination, suspension or limitation of the health care provider's privileges."

Ariz. Rev. Stat. Ann. §36-445.01.

310

Arizona Peer Review Statute

"No member of a committee established under the provisions of section 36-445 or officer or other member of a hospital's or center's medical, administrative or nursing staff engaged in assisting the hospital or center to carry out functions in accordance with that section or any person furnishing information to a committee performing peer review may be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on those activities."

Ariz. Rev. Stat. Ann. §36-445.01.

311

Arizona Peer Review Statute

"This article does not affect any patient's claim to privilege or privacy or to prevent the subpoena of a patient's medical records if they are otherwise subject to discovery or to restrict the powers and duties of the director pursuant to this chapter, with respect to records and information that are not subject to this article. In any legal action brought against a hospital or outpatient surgical center licensed pursuant to this chapter claiming negligence for failure to adequately do peer review, representatives of the hospital or center are permitted to testify as to whether there was peer review as to the subject matter being litigated. The contents and records of the peer review proceedings are fully confidential and inadmissible as evidence in any court of law."

Ariz. Rev. Stat. Ann. §36-445.01.

312

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Limits on Privilege

- Federal courts DO NOT recognize:
 - Employment discrimination
 - Antitrust
 - False Claims Act

313

Legal Protections

- Health Care Quality Improvement Act of 1986
- State peer review statutes
- Release provisions in bylaws and application forms

314

B. Release and Immunity

By applying for appointment and clinical privileges, I accept the following conditions and intend to be legally bound by them, regardless of whether or not I am granted appointment and/or clinical privileges. These conditions shall remain in effect for the duration of any term of appointment that I am so granted, and, as applicable, in this and all subsequent appointments after I have been granted.

1. To the fullest extent permitted by law, I extend absolute immunity to, release from any and all liability, and agree not to sue the Hospital or the Board, any member of the medical staff or the Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or my qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken, or received by the Hospital, its authorized representatives, or third parties in the course of credentialing and peer review activities.

I authorize the Hospital, its medical staff, and their authorized representatives to release such information to other hospitals, health care facilities, managed care entities, and their agents, and any government or regulatory agencies, including licensure boards who solicit such information for the purpose of evaluating my qualifications pursuant to a request for appointment and clinical privileges, participating provider status, other credentialing matter, or licensure or regulatory matter.

3. I agree that the hearing and appeal procedures set forth in the Hospital's Credentialing Policy shall be my sole and exclusive remedy with respect to any professional review action taken at the Hospital.

4. I agree to reimburse the Hospital and any member of the medical staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorneys' fees and lost revenues.

DATE: Travis T. Skully, MD
Signature of Practitioner

315

Abrazo Healthcare and Carondelet Facilities

Legal Protections

- Health Care Quality Improvement Act of 1986
- State peer review statutes
- Release provisions in bylaws and application forms
- **Directors' and officers' insurance**

316

Legal Protections

- Health Care Quality Improvement Act of 1986
- State peer review statutes
- Release provisions in bylaws and application forms
- Directors' and officers' insurance
- **Indemnification policy**

317

Summary

- Concerns raised about Dr. Earnest at prior hospital
- Now employed by Bright Beginnings, independent 5-member OB/GYN group
- Appointment at New Horizons Medical Center subject to enhanced initial FPPE to confirm competence
- No problems identified during initial FPPE to confirm competence

318

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Summary

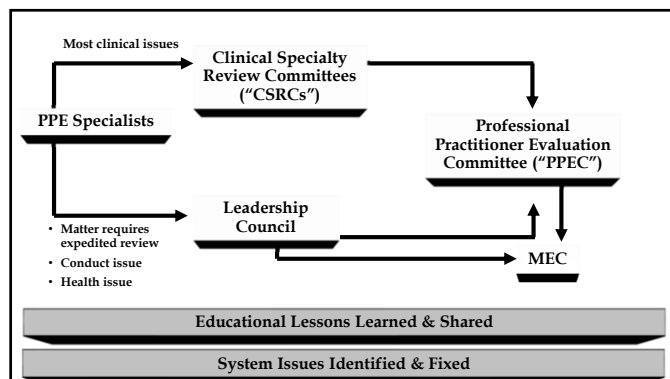
- Three recent complications:
 - Two weeks ago, ureter injury during hysterectomy
 - Last week, ureter injury during laparoscopic sling operation for stress incontinence
 - Next day, bowel and bladder perforation during an emergency peri-partum hysterectomy

319

What's the first step?

Keep patients safe!

320



321

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Leadership
Council

Matter requires expedited review

Leadership Council takes initial steps (e.g., evaluates action that may be needed to protect patients during review; arranges subsequent review) then refers case to Clinical Specialty Review Committee or PPEC

322

Fundamental Principle:

Always use the least restrictive action
needed to protect patients

Will practitioner agree to voluntarily refrain from exercising
relevant privileges while information is gathered?

323

5.N Agreement to Voluntarily Refrain from Exercising Clinical Privileges or Other Practice Conditions

- (1) At any point in the review process described in this Policy, the Leadership Council or CPE, or their representatives, may ask a Practitioner to voluntarily refrain from exercising clinical privileges while the review proceeds. As an alternative, Medical Staff Leaders and the Practitioner may also agree upon practice conditions that will protect the Practitioner, patients, and staff during the review process. Prior to any such action, the Practitioner shall be given the opportunity to discuss these issues with the Leadership Council or its representatives and provide written input regarding them.

324

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- (2) These actions are not considered to be disciplinary actions and do not imply any admission by the Practitioner or final finding of responsibility for the concerns that have been raised. They are temporary precautions and reflect professionalism and cooperation with the review process.

EVALUATION POLICY (PEER REVIEW)

325

Fundamental Principle: Always use the least restrictive action needed to protect patients

- Will practitioner agree to voluntarily refrain from exercising relevant privileges or take an LOA?
- Are other alternatives feasible (proctor for every case, second opinion prior to surgery, etc.?)
- If not, can only certain privileges be subject to precautionary suspension?

326

When Should a Precautionary Suspension Be Used?

- Only as a last resort; and
- Only when "failure to take action may result in imminent danger to the health and/or safety of any individual." (Per HCQIA)

327

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Calls can be okay:

- where little or no substance will be discussed
- where the relationship is still collegial
- where you don't need "evidence" of the invitation



328

Collegial Notice

"The Committee would like to meet with you in the next few days to discuss next steps.

Please contact the CMO at 555-5555 to arrange a mutually convenient time.

We do not anticipate the meeting taking longer than 30-60 minutes.

Thank you for your participation in the process. We look forward to talking with you soon."

329

More Formal Notice

"The Committee would like to meet with you to discuss next steps. The meeting has been scheduled for October 17 at 8:00 a.m. in the South Wing Board Room. Your attendance is mandatory.

If extenuating circumstances will prevent you from attending, please contact the CMO at 555-5555 to reschedule.

Thank you, in advance for your cooperation."

330

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"We've Had Enough" Notice

"...As you know, the Committee has rescheduled this meeting twice to accommodate your schedule and both times you have canceled at the last minute.

Therefore, the meeting has now been scheduled for October 17 at 8:00 a.m. in the South Wing Board Room. Your attendance is mandatory. Your failure to attend will result in your automatic relinquishment of appointment and clinical privileges pursuant to Section 6.D.3 of the Medical Staff Credentials Policy.


Thank you, in advance for your cooperation."

331

No Attorneys at Collegial Meetings

- This is part of collegial process – not a hearing
- Issues are more effectively addressed when physicians talk with physicians
- Attorneys create conflict
- Attorneys chill conversations and reduce candor
- Attorneys can provide counsel before and after meeting, but not during


332



To promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner shall generally involve only the Practitioner and the appropriate Medical Staff Leaders and Hospital personnel. No counsel representing the Practitioner or the Medical Staff or the Hospital shall attend any of these meetings.

333

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In their discretion, Medical Staff Leaders may permit a Practitioner to invite another Practitioner to the meeting. In such case, the invited Practitioner may not participate in the discussion or in any way serve as an advocate for the Practitioner under review, must sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

334

Dr. Halper spoke with Dr. Earnest:

- Explained policy language
- Encouraged her to consult with attorney before and after meeting

Dr. Earnest agreed to attend without her attorney.

335

How should the Leadership Council prepare for its meeting with Dr. Earnest?

336

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Preparation

- Review practitioner history
- Review current cases identified for review
- Read the relevant policies
- Consult with legal counsel

337

Purpose of Meeting

- Obtain agreement of Dr. Earnest to voluntarily refrain from exercising privileges while more information is gathered
- Listen to what Dr. Earnest has to say, but fact-finding and detailed input from Dr. Earnest will come later

338

What should be the tone of the meeting?

Collegial!

339

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Anticipate the practitioner's reaction:

- Embarrassment
- Defensiveness
- Reluctance to have partners find out
- Reluctance to take time off work

340

Anticipate the practitioner's concerns/reaction:

- Feeling unfairly targeted
- Feeling like you've already reached the conclusion that she's "guilty"

341

Anticipate the practitioner's perspective:

- Cares about her patients
- Cares about her reputation
- Wants to be successful
- Wants to resolve this matter

342

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What should be said?

- Thank you for meeting
- We know this must be difficult
- All cases with these indicators are reviewed (it's not personal!)

343

What should be said?

- No findings have been reached
- We are still at the beginning of the process
- We will include you in this process and keep you informed

344

What should be said?

- We want to ensure patient safety while the process takes place
- We know you share our concern for patient safety
- Our goal is to take the least restrictive steps consistent with keeping patients safe
- We want you to succeed

345

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What should be said?

- Have you considered taking a step back while we find out what's going on?
- Do you have any other ideas for maintaining patient safety while we look into this?
- Tell us your concerns

346

What should not be said?

- The word "Investigation"
- Precautionary suspension
- "If you don't, then..."

347

Don't go into the meeting with a precautionary suspension letter ready to deliver.

348

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Agreement to Voluntarily Refrain - Implementation Tips

- Notify relevant hospital staff as needed to ensure practitioner does not continue to practice
- Arrange for care of physician's patients (as needed)
 - Acceptable to work with physician to identify substitute (e.g., a partner)
 - Develop script to talk with patients

349

Agreement to Voluntarily Refrain - Implementation Tips

- Remove physician from on-call schedule
- Consult Bylaws/Credentials Policy for subsequent review requirements

350

Are we required to report Dr. Earnest to the NPDB?

1. Yes
2. No
3. Yes, if the agreement to refrain lasts more than 30 days
4. I have no idea - call legal

351

National Practitioner Data Bank (NPDB)

352

National Practitioner Data Bank (NPDB)

1. Report required when:

- Action "adversely affects" clinical privileges for more than 30 days
- Based on professional competence or conduct

353

Adversely Affects Clinical Privileges

- Reducing
- Suspending
- Revoking
- Denying
- Restricting

354

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What Is a “Restriction”?

“A ‘restriction’ is the result of a professional review action based on clinical competence or professional conduct that leads to the inability of a practitioner to exercise his or her own independent judgment in a professional setting.”

NPDB Guidebook

355

What Is a “Restriction”?

- Mandatory concurring consultation (i.e., can’t do unless another physician agrees)
- Other involuntary actions that prevent the independent exercise of privileges

356

NPDB

2. Reports also required for surrenders of clinical privileges:

- While under Investigation
- In return for not conducting Investigation or “proceeding” (i.e., hearing and appeal)

Have a bright line in Bylaws for when an “Investigation” starts!

357

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No NPDB Reports For:

- Suspensions for 30 days or less
- Commencement of Investigation
- Automatic relinquishment
- Loss of appointment and privileges due to "incident and coterminous" clause
- Any of the PIP options when properly implemented by the PPEC

358

Examples

359

If a peer review matter is referred to the PPEC and the physician resigns upon learning of the referral...

Is that reportable?

No.

360

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If a peer review matter is referred to the MEC and the physician resigns upon learning of the referral...

Is that reportable?

It depends on how the referral was made.

361

If a physician agrees to voluntarily refrain from exercising clinical privileges while a review by the PPEC is pending...

Is that reportable?

No.

362

If a physician agrees to voluntarily refrain from exercising clinical privileges while an Investigation by the MEC is pending...

Is that reportable?

Yes, if at MEC and voluntary agreement lasts longer than 30 days.

363

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**If a physician's privileges are
precautionarily suspended pending the
outcome of a review or an Investigation...**

Is that reportable?

**Yes, if the suspension lasts
longer than 30 days.**

364

**Is Dr. Earnest surrendering privileges
while under Investigation by agreeing
to Leadership Council request?**

365

**Use Your Documents to Help Provide
Clarity on Investigations**

- **Leadership Council and PPEC:**
 - Do not have "disciplinary authority"
 - Cannot compel a practitioner to do anything
 - Work with practitioners on a voluntary basis
- **Only the MEC or Board can begin investigation**

366

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Dr. Earnest

- The Leadership Council has no disciplinary authority
- The MEC and Board - which do have disciplinary authority - are not involved
- The cases are still within the collegial peer review process - not a precursor to professional review action
- No one has threatened Dr. Earnest with an investigation or adverse action

367

Don't forget to check state law!

368

What now, once Dr. Earnest has agreed to voluntarily refrain?

1. Call Dr. Earnest's senior partner to discuss

369

Can we do that????

370

Information Sharing Key Points

- Check state law
- Policy, Resolution, or Agreement
- Application Forms
- Bylaws/Credentials Policy
- Release & Confidentiality Agreement

371

“Best Practice”

Address information sharing in relevant Medical Staff policies, Bylaws, and consider adopting an Information Sharing Policy, to:

- Prevent waiver of peer review privilege
- Avoid allegations of “tortious interference”
- Be transparent and show commitment to confidentiality

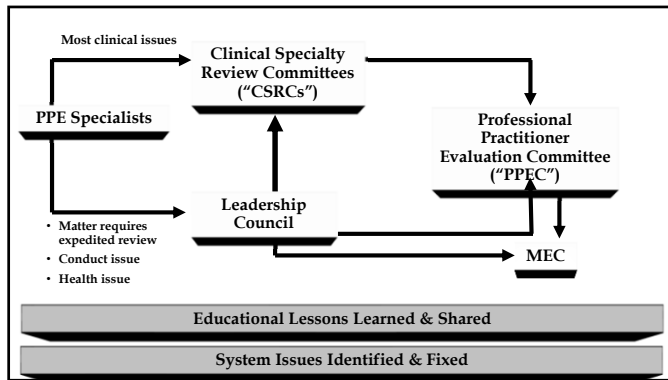
372

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What Now?

1. Call Dr. Earnest's senior partner to discuss
2. Refer for review by one of our OB/GYN?

373



374



Is it okay for Dr. Earnest's own group to review her case? What about a competing group?

375

Managing COIs is essential to:

- Be fair to the physician under review
- Protect integrity of the process
- Protect person with COI

376

The Problem?

377

Best Practice for Managing COIs

- Identify most common conflict situations
- Create specific guidelines for participation at the various Medical Staff committee levels
- Establish clear rules for recusal!

378

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CONFLICT OF INTEREST GUIDELINES									
Potential Conflicts	Provide Information	Levels of Participation							Board
		CSRC	Credentials Committee	Leadership Council	CPE	MEC	Investigating Committee	Hearing Panel	
Employment/contract relationship with Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	R	R	R	R	R	N	N	R
Relevant treatment relationship	Y	R	R	R	R	R	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Involvement in prior VIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R

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CONFLICT OF INTEREST GUIDELINES									
Potential Conflicts	Provide Information	Levels of Participation							Board
		CSRC	Credentials Committee	Leadership Council	CPE	MEC	Investigating Committee	Hearing Panel	
Employment/contract relationship with Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	R	R	R	R	R	N	N	R
Relevant treatment relationship	Y	R	R	R	R	R	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Involvement in prior VIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R

380

CONFLICT OF INTEREST GUIDELINES									
Potential Conflicts	Provide Information	Levels of Participation							Board
		CSRC	Credentials Committee	Leadership Council	CPE	MEC	Investigating Committee	Hearing Panel	
Employment/contract relationship with Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	R	R	R	R	R	N	N	R
Relevant treatment relationship	Y	R	R	R	R	R	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Involvement in prior VIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R

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CONFLICT OF INTEREST GUIDELINES									
Potential Conflicts	Provide Information	Levels of Participation						Hearing Panel	Board
		Committee Member					Investigating Committee		
		CSRC	Credentials Committee	Leadership Council	CPE	MEC			
Employment/contract relationship with Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	R	R	R	R	R	N	N	R
Relevant treatment relationship	Y	R	R	R	R	R	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Involvement in prior VEP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R

382

Rules for Recusal

- ✓ Can provide information and answer questions
- ✓ Must *leave meeting* prior to deliberation and decision-making
- ✓ Document recusal in minutes
- ✓ Whenever possible COI should be raised and resolved prior to meeting by committee chair

383

What Now?

1. Call Dr. Earnest's senior partner to discuss
2. Refer for review by one of our OB/GYNs
3. Obtain an external review?

384

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Consider an external review when:

- Conflicting internal reviews
- Lack clinical experience internally
- Concerns about bias
- Best interest of all involved to ensure a thorough, objective review

In this case...

385

Cooperation from a practitioner
does not negate the need to
follow your policies

386

Reasons

1. Internal review of cases not complete
 - Fact-finding not done
 - No report from Clinical Specialty Review Committee
 - Scope and nature of concerns not clear

387

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Reasons

2. Not following PPE policy could be viewed as an impermissible “shortcut” by a plaintiff’s attorney alleging negligent credentialing

388

Reasons

3. Leadership Council might not have authority under PPE Policy to approve a PIP (depending on how policy is drafted)

389

Summary

- Matter referred to PPEC
- Expediated review because Dr. Earnest voluntarily refraining
- PPEC reviewed all information (including input from Dr. Earnest) and had several concerns:
 - Knowledge gap
 - Technical skills
 - Self-confidence

390

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Options for PPEC

- No further review required
- Obtain additional input
- Educational Letter
- Collegial Counseling
- Performance Improvement Plan (PIP)
- Refer to MEC

391

PIP Options

- Additional CME
- Monitoring/Retrospective Chart Review
- Procedure Indications Checklist
- Second Opinions/Consultations
- Concurrent Proctoring
- Formal Assessment Program
- Additional Training/Simulation
- Educational LOA/Voluntarily Refrain from Practice
- Other

392

St. Mary's Regional Medical Center
1212 South 14th Street
Belle Vernon, Washington 98054
(206) 855-3400

Dr. Elaine Earnest is applying for privileges at St. Mary's Medical Center. She has indicated that she currently has privileges at your facility.

We would appreciate your candid assessment of Dr. Earnest. Please complete the attached form and return it to me at your earliest convenience.

Belle Vernon General.

While I certainly appreciate the confidential nature of such investigations, the members of the Medical Executive Committee here at St. Mary's are understandably concerned and would appreciate whatever information you can share with us.

Sincerely,

393

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**Could we just say all good things
about Dr. Earnest?**

394



395

***Kadlec Medical Center
v.
Lakeview Anesthesia Associates***

396

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**Dr. Berry was an anesthesiologist
practicing at LRMC -
but he had some issues....**

397

March 27

Dear Dr. Berry:

As we have discussed on several occasions, you have reported to work in an impaired physical, mental and emotional state. Your impaired condition has prevented you from properly performing your duties and puts our patients at significant risk.

Effective March 13, your employment with Lakeview Anesthesia Associates is terminated.

Sincerely,

Lakeview Anesthesia Associates

398

As we have discussed on several occasions, you have reported to work in an impaired physical, mental and emotional state. Your impaired condition has prevented you from properly performing your duties and puts our patients at significant risk.

Effective March 13, your employment is terminated.

Lakeview Anesthesia Associates

399

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**The group had an exclusive
contract with LRMC.**

400

**Later that year, Dr. Berry starts
practicing at Kadlec as a locums -
but the issues continue....**

401

**Lawsuit brought by patient's
family settles for \$8.5 million -
but we aren't done.**

402

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<p>October 26</p> <p>To: Kadlec Medical Center</p> <p>Dr. Berry was on the Active Staff in the field of anesthesiology from [This Date] to [That Date].</p> <p>No further information can be provided due to the large volume of inquiries received in the office.</p> <p>Sincerely,</p> <p>Chief Executive Officer</p>

403

<p>Dr. Berry was on the Active Staff in the field of anesthesiology from</p> <p>No further information can be provided due to the large volume of inquiries received in the office.</p> <p>Sincerely,</p> <p>Chief Executive Officer</p>
--

404

<p>Fall</p> <p>To: Kadlec Medical Center</p> <p>I have worked with Dr. Berry for four years. He is an excellent physician and will be an asset to any anesthesia service. I recommend him highly.</p> <p>Sincerely,</p> <p>Lakeview Anesthesia Associates</p>

405

Abrazo Healthcare and Carondelet Facilities

I have worked with Dr. Berry for four years. He is an excellent physician and will be an asset to any anesthesia service. I recommend him highly.

Sincerely,

406

Trial Court Ruled There Is a Duty:

- Not to misrepresent directly, and
- Not to omit “material” information

407

5th Cir. Appeals Court

Duty owed when responding to inquiries about a physician’s status at the hospital:

- Not to misrepresent directly, and
- ~~• Not to omit material information~~

408

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When You Are Contacted

If no significant concerns, respond if:

- ☒ Request in Writing
- ☒ Appropriate Purpose
- ☒ Signed Authorization & Release from Application Form

409

If significant concerns exist:



SEVERAL OPTIONS

410

Option 1

Ignore request or send "name, rank, and serial number."

But beware of problems with this approach

411

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Option 1 - Problems

- State law may impose affirmative duty to respond (e.g., California, New Hampshire, New Jersey, Michigan, Washington)
- Credentialing and peer review would break down if all hospitals used "name, rank and serial number" approach

412

Option 2

If significant concerns exist:

Then – No Response
UNLESS →

Specific Release

☐ _____

☐ _____

413

What if physician won't sign?

- No effect on hospital with information
- Incomplete application or automatic relinquishment at hospital seeking information

414

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Option 3 – Brief, Factual Statement

"Dr. B was appointed to the Medical Staff on [DATE]. His privileges expired on Sept. 4 and he did not seek reappointment. After concerns were raised, Dr. B did not exercise his privileges after March 13. If further information is requested, please have Dr. B sign the enclosed specific release."

415

When You Are Contacted

- Remember legal protections
 - HCQIA (immune from liability in defamation suit unless false information is knowingly provided)
 - State law protections
- Answer accurately and factually
- If discussing significant concerns, choose each word carefully; consider legal review (share file with counsel)
- Same rules for phone calls

416

Even if you get a release:

1. Don't spread rumors and don't guess
2. Share only what is relevant to job performance
3. Stay away from inflammatory remarks
4. Be sure reference response is consistent with actions at hospital
5. Mention positive information as well as negative

417

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Employed Physicians

Scenario:

- Physician employed by hospital-related group
- Employment termination leads to automatic loss of privileges ("incident and coterminous clause")
- Hospital not informed of cause for separation
- Settlement agreement between hospital-related group and physician includes negotiated reference language and non-disparagement clause

418

Employed Physicians

Result:

- Medical Staff should only describe first-hand, "official" knowledge about physician
- Refer requester to employer if lacking information: "Dr. Smith's privileges terminated automatically when his/her employment with the group ended. Please contract the group for additional information."

419

Dr. Earnest Reference Response:

- If the PIP is disclosed, how much detail should be provided?
- Should any other information be provided?

420

**The Connection Between
Physician Behavior
and
Patient Safety**

421

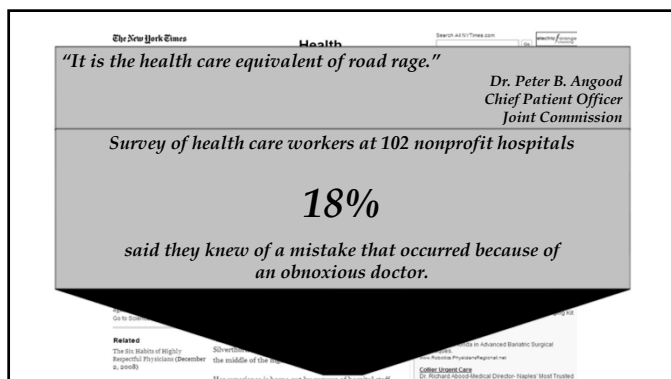
**Does “disruptive” conduct
adversely affect patient care?**
(as if you really need convincing!)

422

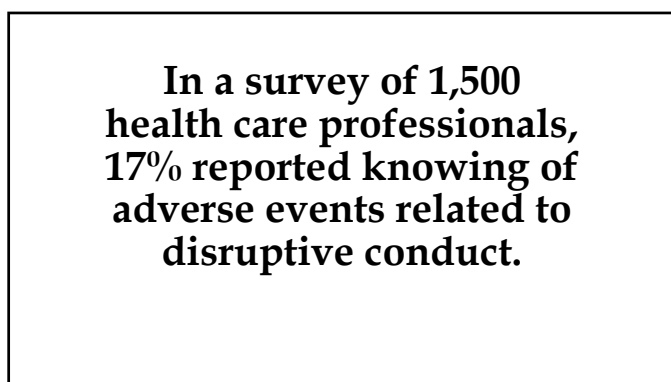
**The data tell us
“Yes, it does.”**

423

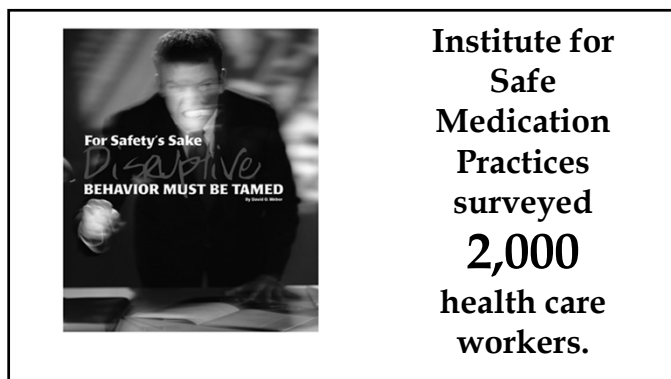
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424



425



426

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**2 out of 5
admitted they
held their
tongues rather
than risk
setting off a
known
intimidator.**

427

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After surgery, how patients fare may depend on how their doctor behaves, study says
By Christine Kimball, MD

After surgery, how patients fare may depend on how their doctor behaves, study says

NEW — Chronic patients have problems after surgery about double of their surgeon's behavior, a new study suggests.

The study, published Wednesday in the journal *Annals of Surgery*, found that patients were at higher risk of complications from surgery when their surgeon was more likely to be rated as "disruptive" or "intimidator" in the study.

"Having chronic things happen at the exact right time is an essential function for those teams," said study author Dr. William D. Stassen, director of the Center for Patient and Professional Assessment at Cleveland Clinic's Medical Center. "And to do that, people have to be able to talk with each other, share ideas and coordinate the care of which is going on around them."

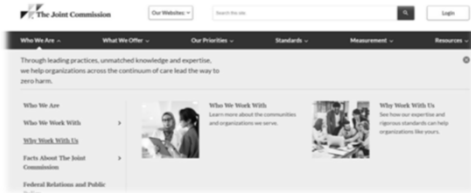
428

The patients of surgeons who were reported for behavioral issues were 12-14% more likely to experience complications after surgery.

429

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**Accrediting bodies tell us
"Yes, it does."**



430

**Joint Commission
Sentinel Event Alert
July 9, 2008**

**Behaviors that undermine
a culture of safety**

431

**Joint Commission 2009
L.D.03.01.01**

**"Leaders create and maintain a
culture of safety and quality
throughout the hospital."**

432

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**Rationale for
Joint Commission Standard
L.D.03.01.01**

"Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the organization."

433

LD.03.01.01

EOP 4

Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.

EOP 5

Leaders create and implement a process for managing behaviors that undermine a culture of safety.

EOP 8

All individuals who work in the hospital, including staff and licensed independent practitioners, are able to openly discuss issues of safety and quality.

434

DNV MS.14:

"...unprofessional demeanor and conduct and/or behavior is likely to be detrimental to patient safety or the delivery of quality care or is disruptive to organization operations."

435

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436

**The cases where
physicians won?**

437



Dr. Leal and
the
Terrible,
Horrible,
No Good,
Very Bad Day

438

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Leal v. Secretary, U.S. DHHS

"The plaintiff, Dr. Jorge J. Leal, was like Alexander in the classic children's book. He was having 'a terrible, horrible, no good, very bad day.'"



439



The Court Said:

"At the end of that day, when told that his use of an operating room was going to be delayed, he pitched a fit."

440

According to the Hospital, Dr. Leal became so enraged he:

1. broke a telephone
2. shattered the glass on a copy machine
3. shoved a cart into the doors of the operating suite so hard that it damaged one of them
4. flung a medical chart to the ground
5. threw jellybeans down the hallway in the surgical suite

According to Dr. Leal's affidavits, he:

1. accidentally broke a telephone when he tripped on its cord
2. closed the lid of a copy machine with 'some force' and the glass cracked
3. moved a cart that was blocking the doors of the operating suite
4. was handed a chart and some of the loose papers fell to the floor
5. ate jellybeans, some of which fell on the floor when he tried to throw away flavors he did not like

441

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The Court Said:

"In other words, this urological surgeon, who earns his living wielding a razor-sharp scalpel on some of the most delicate parts of the body, does not have a bad temper – he is just clumsy."

442



The Court Said:

"The fact that no patients were hit by pieces of the broken telephone, or by the shattered copy machine glass, or by the careening metal cart, or by the flying jellybeans, or by the airborne medical chart, is not dispositive."

443



The Court Said:

"The Hospital was required to report its disciplinary action to the Data Bank, even though its halls were not littered with injured patients."

444

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The Court Said:

"...Disruptive and abusive behavior by a physician, even if not resulting in actual or immediate harm to a patient, poses a serious threat to patient health or welfare. A physician must work collaboratively with other members of a medical staff in order to provide quality care to patients."

445



The Court Said:

"...A hospital is one place where no one can do his job alone, where better teamwork means better care, and where disruptive behavior threatens lives."

446

Best Practices for Addressing Behavior Issues

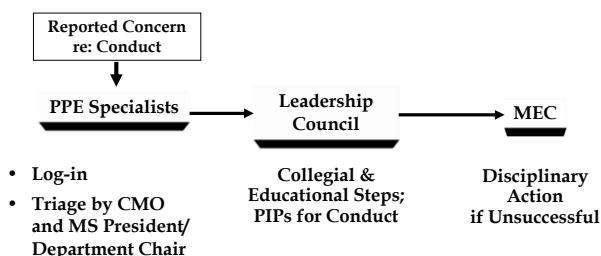
447

Professionalism Policy

**Most Effective Committee to
Address Behavioral Concerns?
Leadership Council!**

448

Professionalism Policy



449

Professionalism Policy

- Explain the “Why?” and promote a positive tone
“Communication, collegiality, and collaboration are essential for the provision of safe and competent care.”
- Part of attributes of the successful Medical Staff member/expectations for our “brand”

450

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Professionalism Policy

Provide specific examples of Inappropriate Conduct

- Educates all Medical Staff members and APPs
- Facilitates enforcement of Policy

451

Professionalism Policy

EXAMPLES OF INAPPROPRIATE CONDUCT

To aid in both the education of Medical Staff members and Allied Health Professionals and the enforcement of this Policy, examples of "inappropriate conduct" include, but are not limited to:

...abusive or threatening language directed at patients, nurses, students, volunteers, visitors, Hospital personnel, or Practitioners (e.g., belittling, berating, or non constructive criticism that intimidates, undermines confidence, or implies stupidity or incompetence);

452

Professionalism Policy

EXAMPLES OF INAPPROPRIATE CONDUCT

... unprofessional medical record entries impugning the quality of care being provided by the Hospital, Practitioners, or any other individual

453

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Professionalism Policy

EXAMPLES OF INAPPROPRIATE CONDUCT

...retaliation against any individual who reports a concern about a Medical Staff member or Advanced Practice Professional (this includes approaching and directly discussing the matter with the individual who reported the concern);

454

Respond to those who report!



455

Respond to Those Who Report

- ✓ Thank you for reporting concern and participating in our culture of safety and quality care
- ✓ Medical Staff leaders are reviewing matter and may/may not need more information
- ✓ No retaliation is permitted/please report any incidents
- ✓ Due to confidentiality, can't provide specific outcome

456

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Professionalism Policy

**Initial “Triage Process” by
MS President/Department Chair
and CMO to quickly resolve
minor concerns**

457

Initial Triage Process

- Low level concern/no pattern or history with colleague
- No fact-finding, no request for written input from colleague in advance
- Conduct brief and informal collegial discussion or send note so that colleague is aware
- Document with brief note to file or in electronic reporting system

458

Initial Triage Process

- Specify that allegations of “Identity-Based Harassment” will not be resolved through initial triage process
- Consider when Human Resources (“HR”) should be notified of behavioral concern:
 - Any allegation of Identity-Based Harassment involving hospital employees?
 - Any allegation of Identity-Based Harassment, to take advantage of HR expertise?

459

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Professionalism Policy

If complaint is more significant

OR

There is a pattern/history with your colleague...

460

Four Steps to Success



461

Professionalism Policy

STEP #1

Timely and brief preliminary call or personal discussion with the colleague involved

462

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Have a script for discussion

- Give a “heads up” that a concern has been raised and that more details soon to follow
- No fact-finding has yet occurred, “courtesy call”
- Briefly explain review process, including colleague’s involvement in process
- Set tone — “we look forward to your good faith participation in the review”
- Non-retaliation reminder/protects colleague

463

Professionalism Policy

STEP #2

Fact-find to determine if further review is required

464

Professionalism Policy

- Review documentation of concern and interview witnesses
- Use script to introduce interviews
- Have interviewee sign short confidentiality acknowledgement

465

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Professionalism Policy

STEP #3

If MS President/Department Chair and CMO determine that further review is required, share details with colleague for response, (but protect the individuals who reported!)

466

Provide enough detail so practitioner can respond to the concern.



467

Preventing Retaliation

- Cover letter approach (most common) or Confidentiality and Non-Retaliation Agreement
- Make the expectations clear when providing specifics to colleague — no retaliation can occur!
- Identity of individual who reported generally not disclosed

468

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What if the practitioner doesn't want to participate?

Leadership
Council

AUTOMATIC RELINQUISHMENT
of privileges if Practitioner fails to
provide input prior to meeting date
or attend meeting when requested

469

Professionalism Policy

STEP #4

Leadership Council reviews summary of
incident, input received from Practitioner,
Practitioner's history, and determines most
effective improvement tool if necessary

470

Leadership Council Options (outlined in Professionalism Policy)

- No further review or action required
- Educational Letter
- Collegial Counseling
- Performance Improvement Plan
- Refer to Employer
- Refer to MEC

471

Professionalism Policy

Stress Collegial and Educational Objectives!

472



**NO Counsel
at Meetings!**



**NO audio or
video recording!**

473

PIP Options for Conduct (used individually or in combination)

- CME courses/education (e.g., communication tools; anger management techniques)
- Review of literature regarding behavior/safety and report to Leadership Council

474

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PIP Options for Conduct (used individually or in combination)

- “Collegial Counseling on steroids” intervention meeting involving full Leadership Council or other designated group, which can include Board Chair or Member
- Periodic/scheduled meetings involving Medical Staff Leaders or mentors for feedback and reinforcement

475

PIP Options for Conduct (used individually or in combination)

- Behavior Coach or Behavior Modification Course
- Personal Code of Conduct
 - (Outlines specific expectations and specific consequences of further violations)
- Other

476



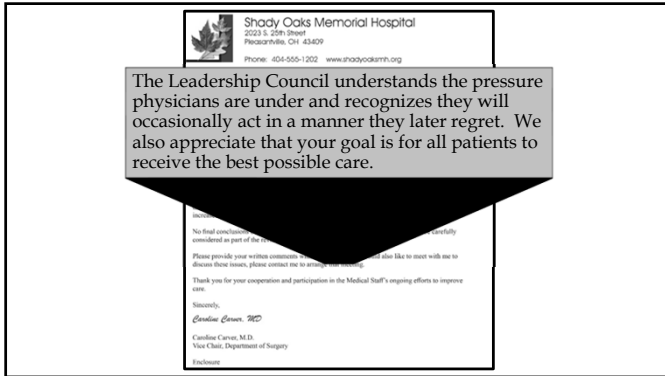
Shady Oaks Memorial Hospital
2023 S. 25th Street
Phoenix, AZ 85009
Phone: 404-555-1202 www.shadyoaks.org

Thank you for providing written input and speaking with the Leadership Council about concerns that have been raised about your interactions with others at the Hospital. We appreciate your professionalism in discussing these issues.

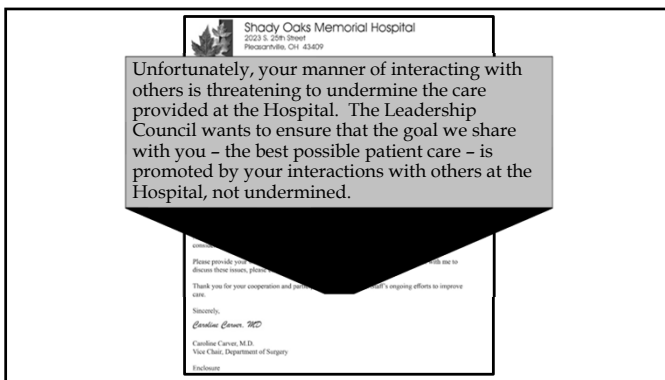
Comments:
Please provide your written input to the Leadership Council with me to discuss these issues, please.
Thank you for your cooperation and participation in our ongoing efforts to improve care.
Sincerely,
Caroline Curran, MD
Caroline Curran, M.D.
Vice Chair, Department of Surgery
Medicine

477

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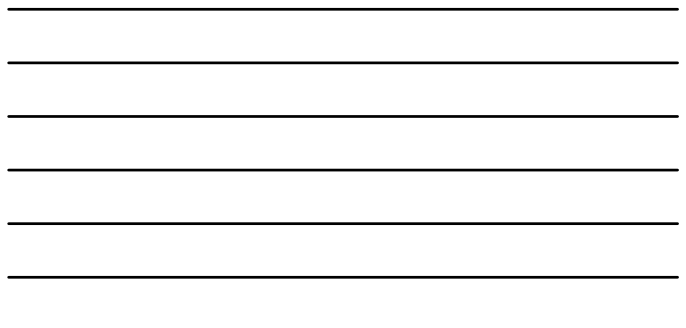
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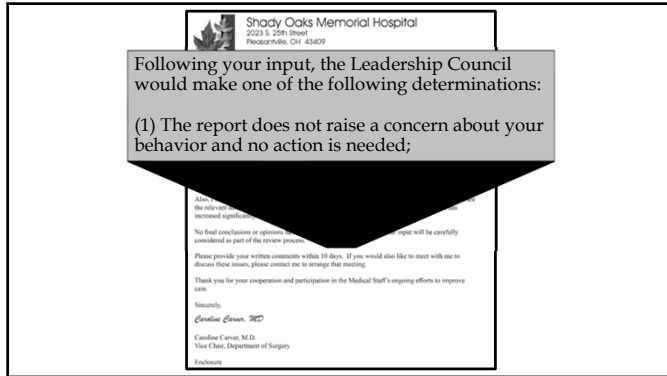
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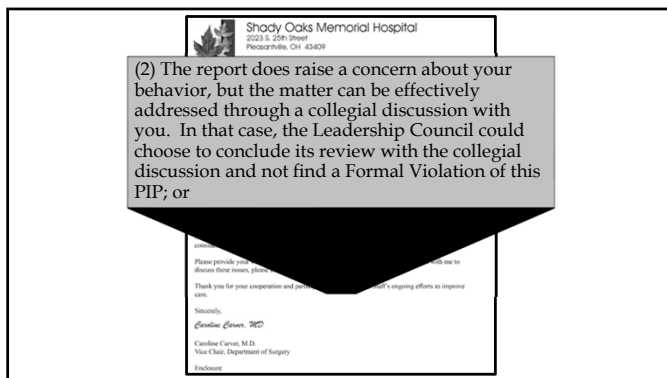
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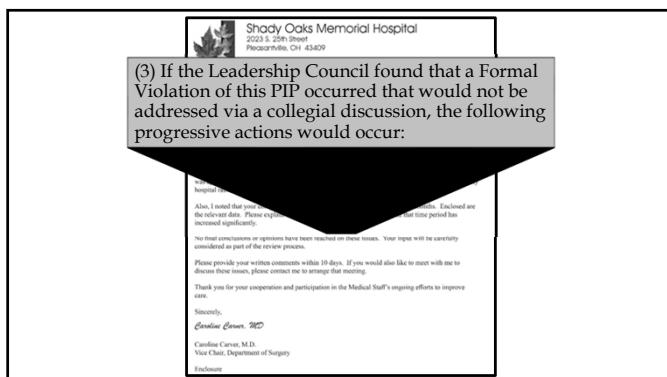
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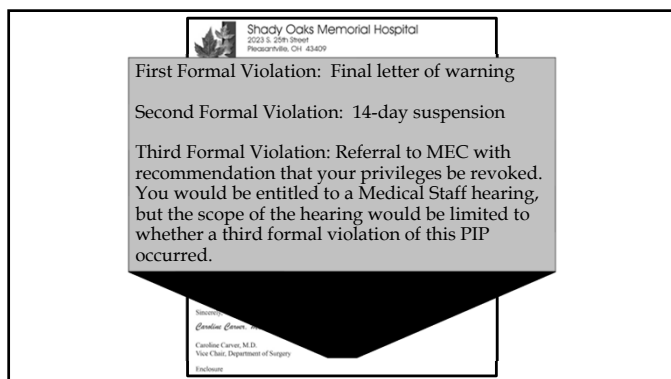
484



485



486



487

Psychiatric Evaluations?

- **Be careful! Not a good idea unless there's reason to believe a mental health concern exists**
- **Generally, focus on inappropriate behavior, not possible causes**

488

"Discipline" is a last resort

(But there is little doubt about how the courts feel if a matter ends up there!)

489

Practitioner Health: Impairment and Aging

490

Understanding the Nature of the Problem

491

Impairment Can Be Caused By:

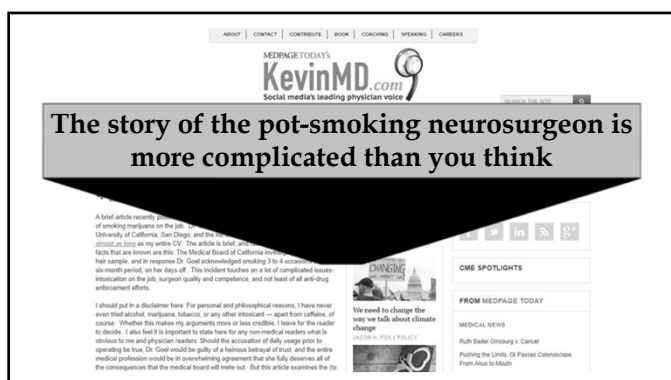
- Substance abuse (illicit drug use, alcoholism, misuse of prescription drugs)

492

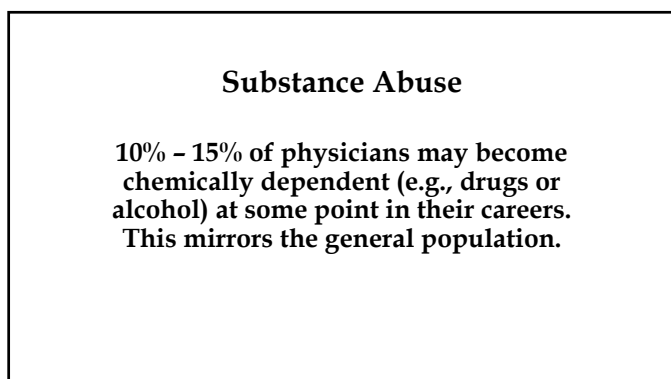
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493



494



495

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496

Impairment Can Be Caused By:

- Substance abuse (illicit drug use, alcoholism, misuse of prescription drugs)
- Mental health

497

Mental Health

- The lifetime prevalence of clinically significant depression in two studies was:
 - 12.8% of 1,300 male physicians
 - 19.5% of 4,500 female physicians

498

Physician Burnout



- 42% of physicians describe themselves as burned out, according to a 2018 Medscape Survey

499

Burnout is an official medical diagnosis, World Health Organization says

Burnout is an official medical diagnosis, World Health Organization says

By Rachel Wilson, CNN

20:30 GMT+10 (10:00 AM EDT) May 27, 2019



500

Impairment Can Be Caused By:

- Substance abuse (illicit drug use, alcoholism, misuse of prescription drugs)
- Mental health
- Physical limitation (stroke, heart attack, nerve damage, broken bones)

501

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Impairment Can Be Caused By:

- Substance abuse (illicit drug use, alcoholism, misuse of prescription drugs)
- Mental health
- Physical limitation (stroke, heart attack, nerve damage, broken bones)
- Disease (cancer, epilepsy, multiple sclerosis, Parkinson's, HIV, hepatitis)

502

Where do we begin?

503

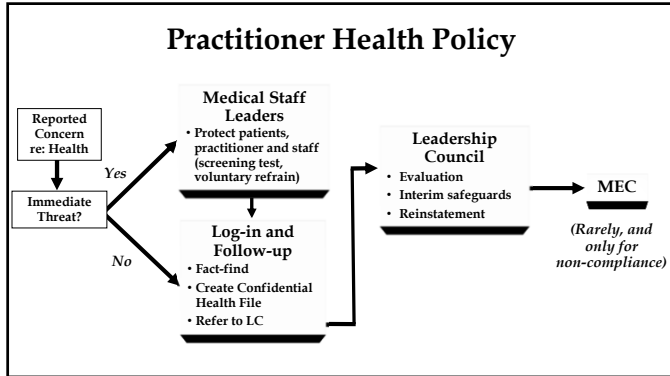
Your Guide – Practitioner Health Policy

Key Elements

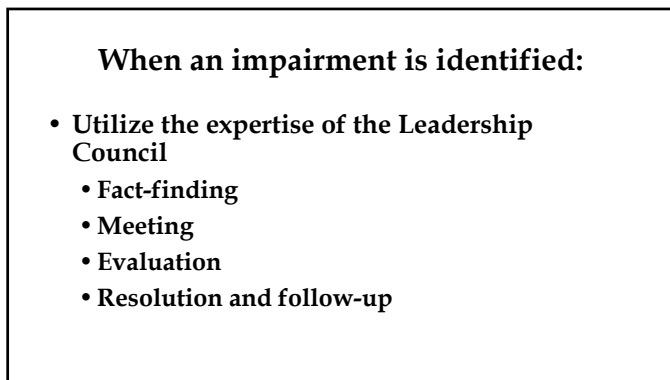
- Identifies reporting channels
- Provides for a fact-finding process (including an external assessment)
- Identifies options for managing and resolving the matter
- Stresses confidentiality

504

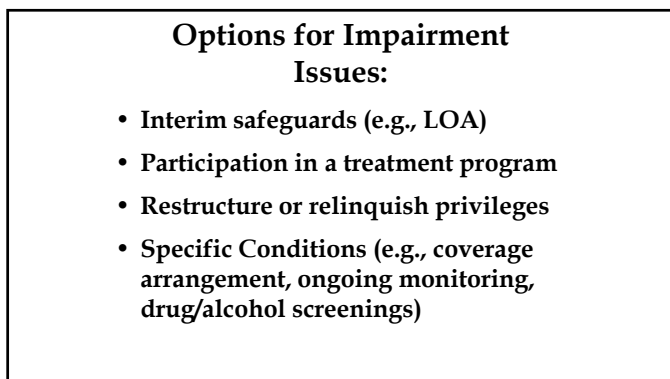
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505



506



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Policy should also anticipate when immediate action is needed

- E.g., Practitioner smells of alcohol while scrubbing for surgery, or seems disoriented while rounding
- No time for Leadership Council to meet, so identify who can act and the actions they can take

508

Education is a key component

509

**Education
CME Should Address:**

- Prevention, identification, diagnosis, and treatment of health issues
- Need to report and downside of "enabling"
- Recognizing warning signs

510

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Americans with Disabilities Act (ADA)

Does It Apply?

511

Under the ADA, *employees* are protected from disability discrimination in the workplace. However, the employee must be able to perform the *essential functions* of the job, with or without reasonable accommodation.

512

Examples of “Essential Functions”

- Safe, competent care
- Timely, complete medical records
- Communication skills, professional behavior
- ED call

513

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Professionalism Counts

"...the ADA provides no bar to discipline for misconduct...the ability to effectively communicate [and interact] with professional colleagues [and patients] is essential to safe patient care."

*Schwarz v. Loyola
University Medical Center*

514

In addition, an employer may exclude an applicant or employee with a disability from a particular position if that individual would pose a *direct threat* to health or safety.

515

While courts have generally deferred to hospitals in deciding if an impaired physician poses a "direct threat" to patients, this determination must be based on an individualized assessment supported by medical evidence.

516

What about Aging?

517

LIVE LONGER

At 106 (and 1/2), this doctor isn't slowing down

By Samantha Breanahan, CNN
Updated 4:54 PM EDT on October 5, 2016

At 106 (and 1/2), this doctor isn't slowing down



518

The "Greying" of the Medical Staff

- Since 1975, the number of practicing physicians 65 or older has increased by 374%
- 25% of practicing physicians are 65 or older
- 42% of practicing physicians are 55 or older

*"The Aging Physician and the Medical Profession: A Review" – JAMA
2016 Survey of Physicians 55 and Older – AMN Healthcare*

519

The “Greying” of the Medical Staff

- 12,000 surgeons older than 70 years practicing in the U.S. (10%)
- 50,000 surgeons who are 55 to 69 years of age “who will soon enter senior status.”

*“Transition Planning for the Senior Surgeon” – JAMA Surgery
May 15, 2019*

520

The “Greying” of the Medical Staff

- Studies exploring proficiency of “late career” physicians have varying results

521

“Physicians who have been in practice longer may be at risk for providing lower-quality care. Therefore, this subgroup of physicians may need quality improvement interventions.”

*– Annals of Internal Medicine,
2005; 142:260-273*

522

The “Greying” of the Medical Staff

- Studies exploring proficiency of “late career” physicians have varying results
- Age affects everyone - eventually

523

Possible Causes Stemming from the Effects of Aging

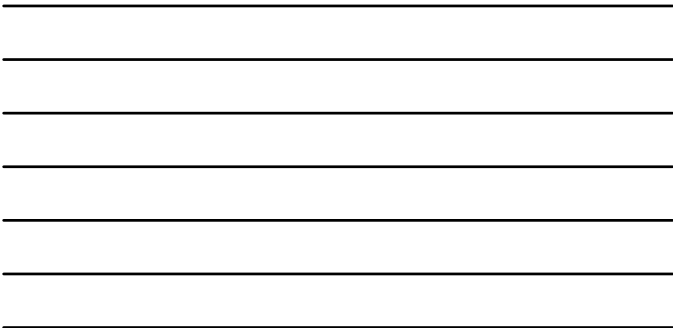
- Deterioration of cognitive skills or physical dexterity
- Memory loss
- Decreased reaction time
- Increased difficulty in staying focused on task in highly stressful situations
- Hearing loss and visual impairment

524

The “Greying” of the Medical Staff

- Studies exploring proficiency of “late career” physicians have varying results
- Age affects everyone - eventually
- How do you identify the subset of physicians who don’t know when to stop?

525



-
-
-
-
-
-

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Benefits to Establishing a Rule

- Protects patients
- Treats all physicians the same (thus reducing risk of discrimination claims)
- Depersonalizes issue

529

Drawbacks of a Rule

- Overly inclusive
- Difficulty interpreting test results
- Unnecessary if peer review process is working properly
- Controversial and inconvenient

530

And, There Are Some Legal Risks...



531

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Age Discrimination in Employment Act (ADEA)

532

ADEA

- Federal civil rights statute designed to protect "employees."
- Makes it unlawful "to discriminate against any individual with respect to his compensation, terms, conditions, or privileges of employment because of such individual's age."

533



534

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Exceptions Do Apply

- ADEA exempts fire fighters and law enforcement officers
- ADEA also allows other exceptions for “*bona fide occupational qualifications*” or a “*BFOQ*”
 - Examples include mandatory retirement for airline pilots

535

BFOQ is a Narrow Exception:

Age limit must be “reasonably necessary” for the operation of the business, and either:

- “all or substantially all” of the disqualified members are unable to perform duties, or
- impractical to deal with the older employee on an individual basis

536

**What about physicians
and other practitioners?**

537

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538

Higher Level of Legal Risk

- Policies triggered by age (e.g., Stanford, etc.)
- Annual reappointment at a certain age
 - Focused review of a stated number of cases
 - Additional CME for older physicians
 - Comprehensive physical and psychological evaluations
- "Mandatory Retirement"

539

Minimize Legal Risk

- No Focus on Age
 - Rely on improved peer review processes

540

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Treat Like Any Other Health Issue

- Substance abuse
- Physical limitation
- Disease
- Stress, mental illness, burnout
- **Aging**

541

Minimize Legal Risk

- No Focus on Age
 - Rely on improved peer review processes
 - Utilize your Practitioner Health Policy

542

Also Consider

- Collegial discussions
- Goal: voluntary responsive steps
 - Agree to conditions
 - Modify or relinquish privileges
 - Take an LOA

543



544

Attracting and Preparing Medical Staff Leaders

545

Leadership

"....The meeting to discuss the clinical concerns regarding case 12345 will take place in the Medical Staff conference room at 6:00 a.m. this Friday...."

546

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Leadership

"....Review sessions for proposed updates to the Medical Staff Bylaws and Peer Review Policy will take place each Tuesday in October from 6:00 - 9:00 p.m. Please mark your calendars."

547

Leadership

"....This entire review is clearly a conspiracy orchestrated by [the physician leadership]. You wanted a fight, you got it. The gloves are off. You think I've been a problem up to this point? You haven't seen anything yet...."

E-mail from physician under review to Medical Staff leadership

548

Leadership

"Excuse me while I go over to the corner and throw up."

Dr. S, Medical Staff President

549

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Why would anyone do this?!?!?!

550

**You know the difference
leaders can make.**

551

**What are the core
responsibilities of the
Medical Staff?**

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1916

553

American College of Surgeons 1916-1919

- First survey of 2,700 hospitals
- 89 hospitals passed

554

National Program for the "Standardization" of Hospitals 1919

- "Minimum Standard" for hospitals
- One page
- Precursor of Joint Commission standards, state hospital licensing laws and Medicare CoPs

555

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Medical Staff

- Consists of licensed medical graduates who are competent and worthy in character and matters of ethics
- With the Board, the Medical Staff will adopt and approve rules, regulations, and policies

556

Medical Staff

- Reviews clinical work
- Review based on medical records
- Medical records must be accurate and complete

557

Joint Commission 1952

With the support of

- American College of Surgeons
- American College of Physicians
- American Hospital Association
- American Medical Association

558

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Joint Commission 1952

Medical Staff must be “responsible to the patient and to the governing body of the hospital for the quality of all medical care provided patients in the hospital and for the ethical and professional practices of its members.”

559

Condition of Participation §482.22

The hospital must have an organized medical staff that operates under bylaws... and which is responsible for the quality of medical care provided to patients by the hospital.

560

Condition of Participation

- The medical staff must examine the credentials of candidates for membership and make recommendations to the governing body
- The medical staff must periodically conduct appraisals of its members.

561

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**Where did you learn how to run a meeting?
Or negotiate? Or resolve conflicts?**

562

Keys to Developing Medical Staff Leaders

- Select the right people
- Equip them for success
- Celebrate their good work

563

**Start with the right
people.**

564

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I bet someone told you:

- "You'd be great at...."; or
- "Your skills would really help us...."; or
- "You are so well-respected by your peers, you'd make a terrific...."; or
- "Please help me out by reviewing these cases and...."

565

**Identify and Nurture
Leadership Pool.**

566

**Evaluate your
nomination/appointment processes.**

567

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The Medical Staff Farm System!

- **Physician Leadership/ Nominating Committee**
- **Nominates Officers and Chairs**
- **Appoints members of committees**
- **Succession planning!**

568

What Qualifications Does a Physician Leader Need?

- **Respected clinicians**
- **Effective communicators**
- **Trustworthy – understand confidentiality**
- **Rhino skin**
- **Take on second full-time job**

569

Equip them for Success!

570

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Equip for Success

- Orientation
- Staff support
- Letter to each new leader
- Leadership Handbook
- Mentoring by experienced leaders

571

Letter to each new leader

- Leadership responsibilities
- Orientation and evaluation
- Benefits and prerogatives
- Legal protections

572

Leadership Handbook

- Survival tips for leaders
- Department/committee policies
- Tips for effective meetings
- Confidentiality Policy

573

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**Last But Not Least,
Celebrate good work!**



574

**How do we get physicians to
participate in the medical staff?**

Wrong question.



575

**Better question:
What can the medical staff do to bring value
to the life/practice of physician leaders?**



576

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It Depends!

- "Thank you!"
- Skills and Professional Development
- Financial Benefits
- Other (e.g., no call? parking spot?)

577

Thank you.

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www.hortyspringer.com

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