Sutter East Bay Medical Group

Peer Review Training

March 1, 2025

Charles Chulack

Horty, Springer & Mattern, P.C.

Jointly sponsored by the University of Pittsburgh School of Medicine

Center for continuing education in the health and science and HortySpringer Seminars

AGENDA

8:30 to 9:30 a.m. **Introduction & The Basics of Outpatient Peer Review**

9:30 to 10:45 a.m. **Conducting an Effective Review of Clinical Concerns**

- Appropriate triggers and case review forms
- Individual reviewer documentation and reporting to the Peer Review Committee
- Tone and content of communication with practitioners being reviewed
- Tips and tools for collegial counseling

10:45 to 11:00 a.m. **BREAK**

11:00 a.m. to Noon **Addressing Health and Behavior in an Outpatient Setting**

- The scope of practitioner health issues
- Do we need to comply with employment laws (e.g., the Americans with Disabilities Act and the Age Discrimination in Employment Act) when addressing health issues?
- Classic characteristics of disruptive practitioners
- Examples of behaviors that undermine a culture of safety
- Best practices for addressing health and behavior concerns

Noon to 12:30 p.m. **Outpatient Peer Review Potpourri**

- Do we have any legal protections under state and federal law?
- Effectively sharing information with affiliated entities (e.g., hospitals) at which our employees provide clinical services
- Maintaining confidentiality
- Addressing issues through the peer review process vs. the employment process – pros and cons of each

Noon **Q&A and Adjournment**

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Accreditation Statement

In support of improving patient care, this activity has been planned and implemented by the University of Pittsburgh and Horty Springer 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 2.75 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

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CHARLES J. CHULACK is a partner with the law firm of Horty, Springer & Mattern, P.C. in Pittsburgh, Pennsylvania, where his work is devoted exclusively to advising hospitals and physician leaders on a wide range of topics, including medical staff issues, medical staff bylaws and associated documents, compliance with federal and state law and regulations and accreditation standards, and employment matters. In addition, he represents hospitals in litigation on topics such as contractual disputes, physician hearing and appeal rights, and immunity under state and federal law.

Mr. Chulack is currently a faculty member for the HortySpringer seminar *The Peer Review Clinic* and was previously a faculty member for *Credentialing for Excellence*. He frequently provides individualized on-site and virtual educational programs on credentialing, privileging, peer review, professionalism, practitioner health, investigations, and other medical staff topics for hospitals and medical staffs across the country. He has done numerous presentations for legal organizations including the American Health Law Association and the Pennsylvania Bar Institute.

Mr. Chulack is an editor of the firm's *Health Law Express*, a weekly e-newsletter on the latest health law developments. Mr. Chulack also served as an editor for the fourth and fifth editions of the American Health Law Association *Peer Review Guidebook* and the first edition of the American Health Law Association *The Complete Medical Staff*, *Peer Review*, and *Hearing Guidebook*. He has published articles in Bloomberg's *Health Law Reporter*, *Duquesne Law Review*, and Allegheny County Bar Association's *Lawyer's Journal*.

Mr. Chulack is a member of the Allegheny County Bar Association and the American Health Law Association and is admitted to practice in front of the Pennsylvania Supreme Court and the United States District Court for the Western District of Pennsylvania.

Conflict of Interest Disclosure

No 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 with any proprietary entity producing, marketing, re-selling, or distributing health care goods or services, used on, or consumed by, patients to disclose.

Disclaimer Statement

The information presented at this activity represents the views and opinions of the individual presenters, and does not constitute the opinion or endorsement of, or promotion by, the UPMC Center for Continuing Education in the Health Sciences, UPMC/University of Pittsburgh Medical Center or Affiliates and University of Pittsburgh School of Medicine. Reasonable efforts have been taken intending for educational subject matter to be presented in a balanced, unbiased fashion and in compliance with regulatory requirements. However, each program attendee must always use his/her own personal and professional judgment when considering further application of this information, particularly as it may relate to patient diagnostic or treatment decisions including, without limitation, FDA-approved uses and any off-label uses.

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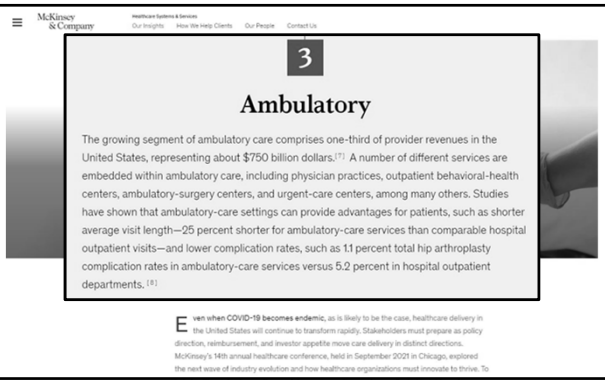
1

Welcome to the Brave New World!

Ambulatory
Peer Review

2



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Ambulatory care is one of the fastest-growing and highest-margin segments of the healthcare industry. Analyzing variations in Commercial claims data and doctor surveys shows that significant growth potential remains. While many health systems have benefited from investing ahead of this trend, significant opportunity remains to be captured.

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Why the Growth?

- **Innovation and technology**
- **Patient demand**
- **Payor pressure**
- **Provider opportunity for shared ownership models**

And this growth is just beginning.

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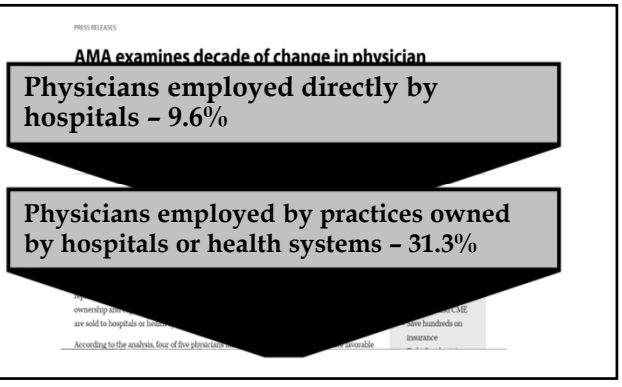

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Why Ambulatory Peer Review?

- More care is being provided in these settings
- You have no idea if it is good care!
- Allows for sharing of peer review information (check state law)

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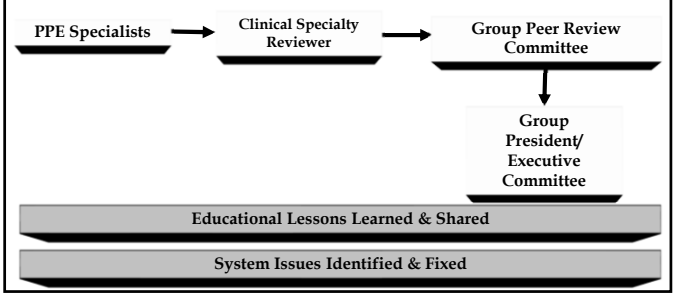
What does ambulatory peer review look like?

8

Ambulatory Peer Review



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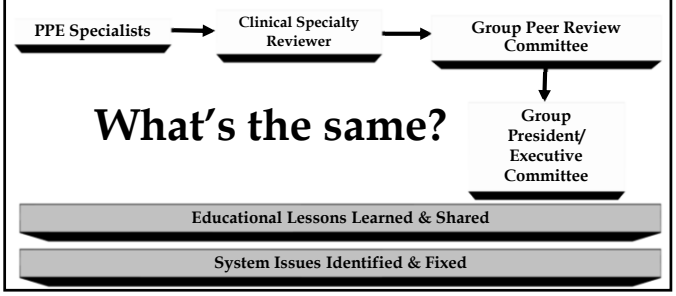
What is the same and what is different about this process in the ambulatory world?

10

Ambulatory Peer Review



11

PPE Specialists

Functions

- Log case in to "Central Repository"
- Initial review
  - Is physician review required?
- Close case, send "informational letter," or refer the case for further review

12

PPE Specialists

What's Different?

13

What Triggers a review?

- Less focus on reviewing "cases" and more focus on "outliers"
  - Admissions after office visit with same/similar diagnosis
  - Readmissions after discharge
  - Vaccination and screening rates
  - On-time case starts

14

Ambulatory Peer Review

PPE Specialists → Clinical Specialty Reviewer → Group Peer Review Committee

What's the same?

Group President/ Executive Committee

Educational Lessons Learned & Shared

System Issues Identified & Fixed

15

Clinical Specialty Reviewer

At this point in process

Need appropriate *specialty* review and expertise

16

Clinical Specialty Reviewer

What's Different?

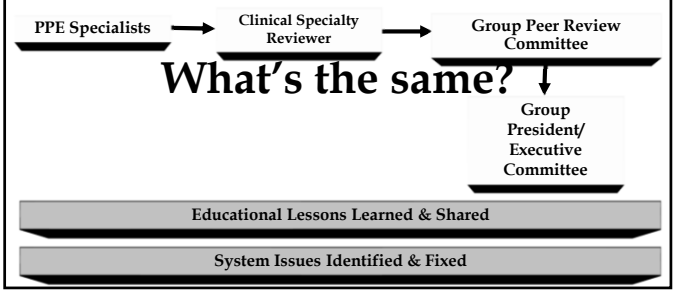
17

Clinical Specialty Reviewer Options

- **Less structural resources to support multiple specialty committees** *(may also not be a need if a single specialty group)*
  - **Likely going to be an individual member of the Group Peer Review Committee (with option to use Assigned Reviewer) acting on behalf of the Committee**
  - **Fact-finder only**
- **Is their work peer review protected?**

18

Ambulatory Peer Review



19

Group Peer Review Committee

Functions

- **Multi-Specialty (maybe)**
- **Review and assess cases/outliers**
- **Determine the appropriate intervention based on the nature of the concern**
- **On the look out for "system" issues and lessons learned**

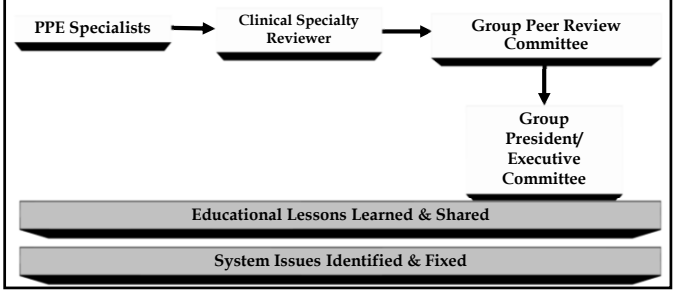
20

Group Peer Review Committee

What's Different?

21

Finally… Ambulatory Peer Review



22

Group President/ Executive Committee

- **This is *not* the Medical Staff**
- **Generally, no Hearings, no NPDB reports* (maybe state reporting obligations?)**
- **Group HR policies/contract will control**

** Technically, could qualify as a "health care entity" under the HCQIA*

23

Remember…

If the ambulatory setting is provider-based to the hospital, it will be overseen by the Medical Staff process.

24

Effective Peer Review of Clinical Concerns

25

The "peer review" world has changed dramatically —for the better!

Thinking!

Techniques!

Governing Documents!

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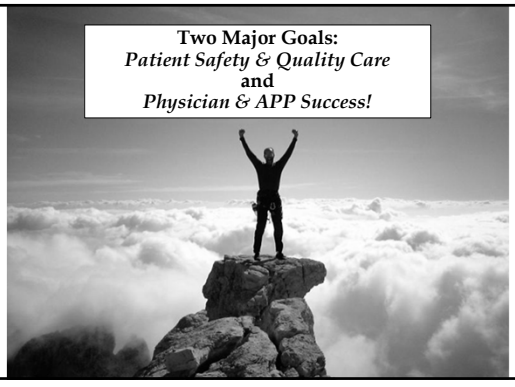

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Common Obstacles to Effective Peer Review

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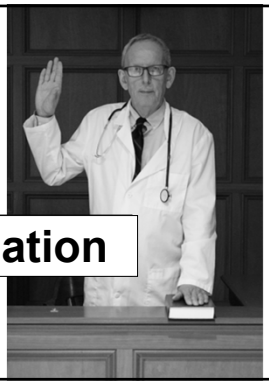

Fear of litigation

29

Legal Protections for Peer Reviewers

- **The Health Care Quality Improvement Act**
- **California State Peer Review Statute**

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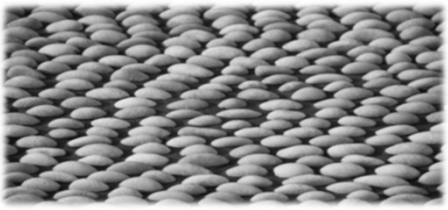
Inexperienced reviewers

31

Not Identifying Appropriate Cases for Review



32

Based on 20/20 hindsight

33

Not Being Aware of Options

34

Leaders lack of necessary tools.

35

No opportunity for meaningful input

36

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**
- **Leadership burnout**
- **Distraction from performance improvement activities**

37

So, What Works?

Clinical Quality Issues

38

#1

Constantly Reinforce the Three Main Goals of Modern Clinical Peer Review

39

Goal #1

Practitioner-Specific Reviews that Focus on Education and Improvement

- **Policy should emphasize input from colleagues, feedback, and practical, specific recommendations to promote improvement**
- **Many non-disciplinary tools available**

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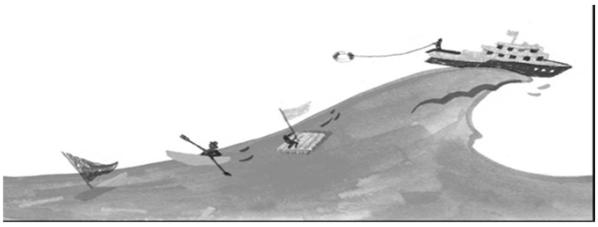
Goal #2
Elevate Performance of *EVERYONE* in Group



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Peer Review Should Be a Tool for the Best CME Ever

- **Policies should include practices to identify "lessons learned" from reviews**
- **Share with relevant specialties**

42

Goal #3
Improve "Systems" of Care

43

Fixing System/Process Issues

- Policies should include practices to identify "system/process" issues
- Issue referred to appropriate committee or person for resolution
- Issues stays on agenda of Peer Review Committee until notice of resolution is received

44

#2

Collegial Efforts and the Progressive Steps Continuum Will Successfully Resolve Almost All Issues!

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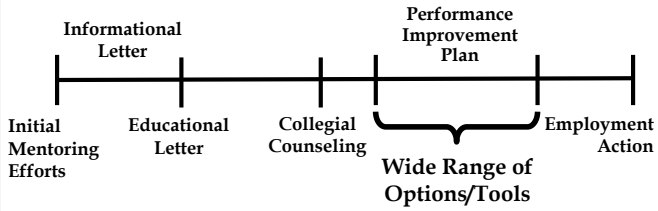
Use the
Least Restrictive Approach
That is Consistent With
Safe Care/Good Quality!

46

Progressive Steps Continuum



47

#3

Describe PIP Options in Policy – and Use Them!

48

Multi-Specialty Professional Practice Evaluation Committee

Improvement Tools

- **Educational letter**
- **Collegial Counseling**
- **Performance Improvement Plan**
- **Address through Employment Contract**

49

Performance Improvement Plans

(options used individually or in combination)

- **Additional education/CME**
- **Monitoring/retrospective chart review for the next X patients**
- **Procedure indications checklist**
- **Second opinions/consultations**
- **Concurrent proctoring**

50

Performance Improvement Plans

(options used individually or in combination)

- **Participation in formal evaluation and assessment program**
- **Additional training/simulation**
- ***"Other"***

51

#4

No Improvement Efforts…
Even Low Level Ones…
Without First Seeking Input!

52

General Rules

- **<u>*No improvement tool*</u> (Educational Letter, Collegial Counseling, PIP) until practitioner is notified of specific concerns and provides input**

53

How does the practitioner provide input?

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

54

Reviewing Concerns is an Acquired Skill – Empower Reviewers with Training and an Effective Review Form

55

But first…

56

What Triggers a review?

- **Less focus on reviewing "cases" and more focus on "outliers"**
  - **Admissions after office visit with same/similar diagnosis**
  - **Readmissions after discharge**
  - **Vaccination and screening rates**
  - **On-time case starts**

57

Reviewing concerns an acquired skill –
provide guidance and support to *all* clinical reviewers.

A little training goes a long way!

58

Reviewers

Training!

- **Role in the overall process**
- **How to obtain additional information or input from practitioner or others, if necessary**
- **How to appropriately characterize findings**
- **How to effectively present a case to the Peer Review Committee**
- **Time frames for review, confidentiality agreements and tips, etc.**

59

Empower Reviewers with
Effective Review Forms!

60

Reviewers

Review Form Best Practices

FOUNDATION:

- **Utilize a standardized, carefully-drafted *REVIEW FORM* for *ALL* reviews and fact-finding!**
- **Must be tailored to *YOUR* process!**

61

Case Review Form

- ***Instructions***
- ***Part 1:*** **Patient Demographics and Details**
- ***Part 2:*** **Obtaining Input from Practitioner**
- ***Part 3:*** **Assessment of Care and Determination**

62

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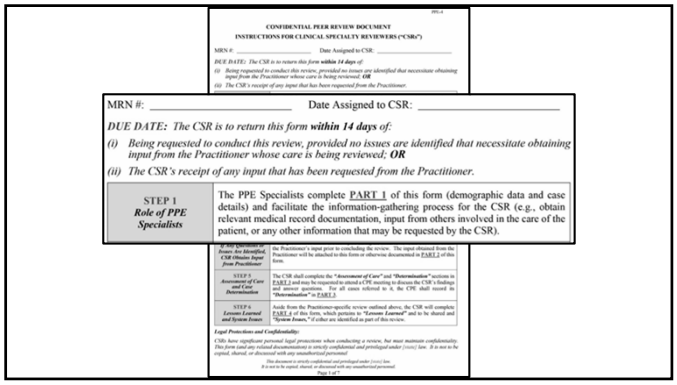

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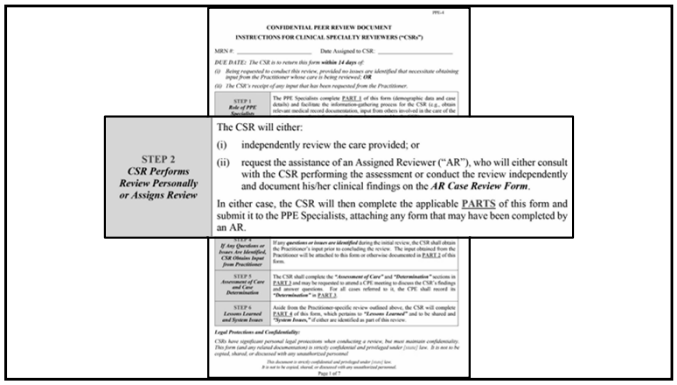

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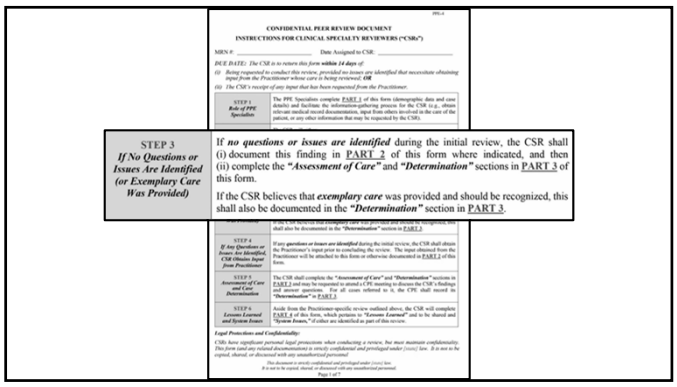

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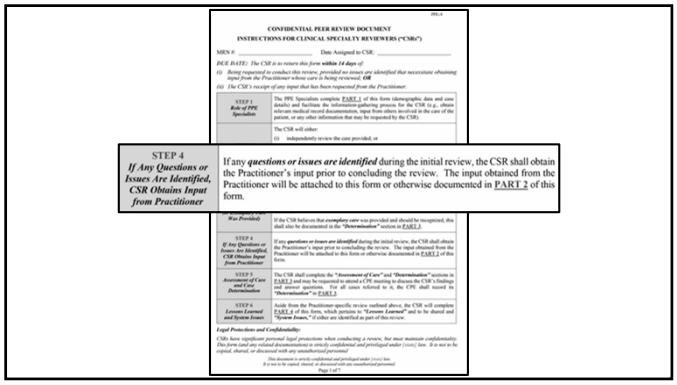
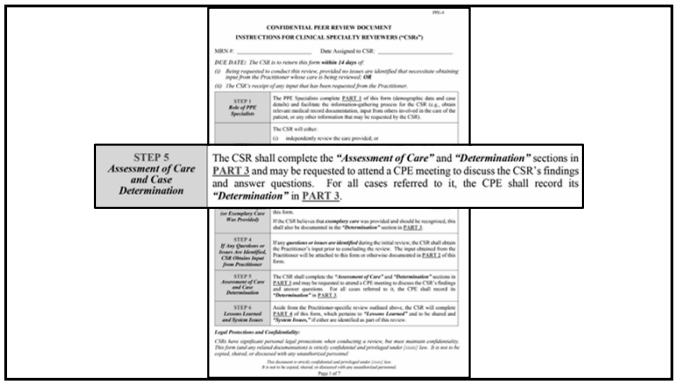
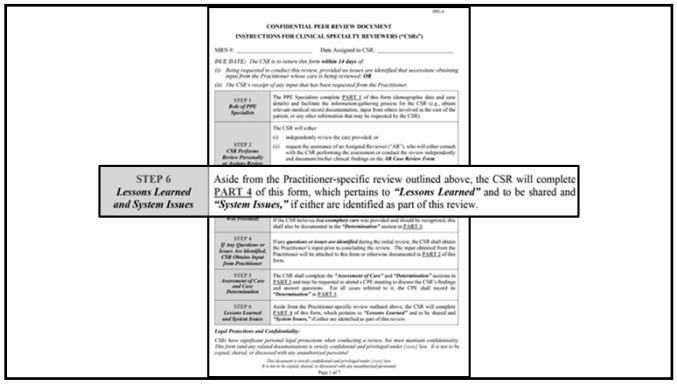

CONFIDENTIAL PEER REVIEW DOCUMENT
INSTRUCTIONS FOR CLINICAL SPECIALTY REVIEWERS ("CSRs")
STEP 4
If Any Questions or Issues Are Identified, CSR Obtains Input from Practitioner
If any questions or issues are identified during the initial review, the CSR shall obtain the Practitioner's input prior to concluding the review. The input obtained from the Practitioner will be attached to this form or otherwise documented in PART 2 of this form.

67


CONFIDENTIAL PEER REVIEW DOCUMENT
INSTRUCTIONS FOR CLINICAL SPECIALTY REVIEWERS ("CSRs")
STEP 5
Assessment of Care and Case Determination
The CSR shall complete the "Assessment of Care" and "Determination" sections in PART 3 and may be requested to attend a CPE meeting to discuss the CSR's findings and answer questions. For all cases referred to it, the CPE shall record its "Determination" in PART 3.

68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INSTRUCTIONS FOR CLINICAL SPECIALTY REVIEWERS ("CSRs")
STEP 6
Lessons Learned and System Issues
Aside from the Practitioner-specific review outlined above, the CSR will complete PART 4 of this form, which pertains to "Lessons Learned" and to be shared and "System Issues," if either are identified as part of this review.

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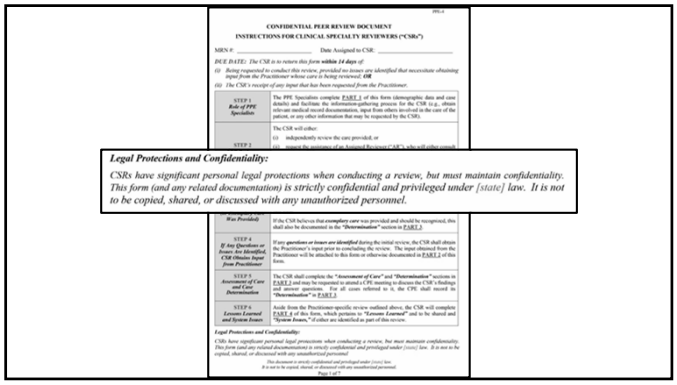

CONFIDENTIAL PEER REVIEW DOCUMENT
INSTRUCTIONS FOR CLINICAL SPECIALTY REVIEWERS ("CSRs")

MRN #: _____ Date Assigned to CSR: _____

DUE DATE: The CSR is to return this form ***within 14 days*** *of:*

(i) Being requested to conduct this review, provided no issues are identified that necessitate obtaining input from the Practitioner whose care is being reviewed; OR

(ii) The CSR's receipt of any input that has been requested from the Practitioner.

STEP 1 ***Role of PPE Specialists***	The PPE Specialists complete PART 1 of this form (demographic data and case details) and facilitate the information-gathering process for the CSR (e.g., obtain relevant medical record documentation, input from others involved in the care of the patient, or any other information that may be requested by the CSR).
STEP 2	The CSR will either: (i) independently review the care provided; or (ii) request the assistance of an Assigned Reviewer ("AR") who will either consult
Was Provided	If the CSR believes that ***exemplary care*** was provided and should be recognized, this shall also be documented in the ***"Determination"*** section in PART 3.
STEP 4 ***If Any Questions or Issues Are Identified, CSR Obtains Input from Practitioner***	If any ***questions or issues are identified*** during the initial review, the CSR shall obtain the Practitioner's input prior to concluding the review. The input obtained from the Practitioner will be attached to this form or otherwise documented in PART 2 of this form.
STEP 5 ***Assessment of Care and Determination***	The CSR shall complete the ***"Assessment of Care"*** and ***"Determination"*** sections in PART 3 and may be requested to attend a CPC meeting to discuss the CSR's findings and answer questions. For all cases referred to it, the CPC shall record its ***"Determination"*** in PART 3.
STEP 6 ***Lessons Learned and System Issues***	Aside from the Practitioner-specific review outlined above, the CSR will complete PART 4 of this form, which pertains to ***"Lessons Learned"*** and to be shared and ***"System Issues,"*** if either are identified as part of this review.

Legal Protections and Confidentiality:

CSRs have significant personal legal protections when conducting a review, but must maintain confidentiality. This form (and any related documentation) is strictly confidential and privileged under [state] law. It is not to be copied, shared, or discussed with any unauthorized personnel.

Page 1 of 7

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70

Case Review Form

- *Instructions*
- *Part 1:* **Patient Demographics and Details**
- *Part 2:* **Obtaining Input from Practitioner**
- *Part 3:* **Assessment of Care and Determination**
- *Part 4:* **"Lessons Learned" and "System Issues"**

71

Case Review Form

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- *Part 3:* **Assessment of Care and Determination**
- *Part 4:* **"Lessons Learned" and "System Issues"**

72

Obtaining Input from Practitioner

- *No questions or issues identified*, no need to obtain input – proceed to Assessment of Care and Determination
- *If any questions or issues identified*, provide details to and obtain input from Practitioner
- *Letter or e-mail* sent to Practitioner seeking written input
- In addition to written input, did reviewer speak with Practitioner? If so, record relevant details
- *After* input obtained, proceed to Assessment of Care and Determination

73

Case Review Form

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- *Part 1:* Patient Demographics and Details
- *Part 2:* Obtaining Input from Practitioner
- *Part 3:* Assessment of Care and Determination
- *Part 4:* "Lessons Learned" and "System Issues"

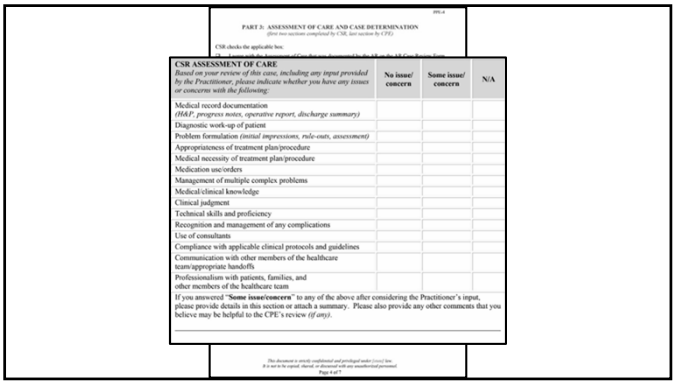
74

Assessment of Care and Determination

- List elements of care (e.g., judgment; technical skill), and then…

  "No Issue/Concern" or "Some Issue/Concern"
- Determination (*must match your process/option you choose*):
  - No issue
  - Exemplary care provided, inform Practitioner
  - Send Educational Letter
  - Conduct Collegial Counseling
  - Refer to Peer Review Committee

75



PART 3: ASSESSMENT OF CARE AND CASE DETERMINATION

CSR ASSESSMENT OF CARE *Based on your review of this case, including any input provided by the Practitioner, please indicate whether you have any issues or concerns with the following:*	No issue/ concern	Some issue/ concern	N/A
Medical record documentation *(H&P, progress notes, operative report, discharge summary)*			
Diagnostic work-up of patient			
Problem formulation *(initial impressions, rule-outs, assessment)*			
Appropriateness of treatment plan/procedure			
Medical necessity of treatment plan/procedure			
Medication use/orders			
Management of multiple complex problems			
Medical/clinical knowledge			
Clinical judgment			
Technical skills and proficiency			
Recognition and management of any complications			
Use of consultants			
Compliance with applicable clinical protocols and guidelines			
Communication with other members of the healthcare team/appropriate handoffs			
Professionalism with patients, families, and other members of the healthcare team			

If you answered "**Some issue/concern**" to any of the above after considering the Practitioner's input, please provide details in this section or attach a summary. Please also provide any other comments that you believe may be helpful to the CPE's review *(if any)*.

76

Case Review Form

- *Instructions*
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- *Part 3:* **Assessment of Care and Determination**
- *Part 4:* **"Lessons Learned" and "System Issues"**

77

"Lessons Learned" and "System Issues"

- **Once this review is concluded, would this patient scenario be of educational benefit to other group members?**

  Y/N?
- **Based on your review, are there any system process or policy changes that could improve patient safety and care?**

  Y/N?
  - **Recommendations (e.g., new policy or checklist; training for staff)?**
  - **Who should be involved to most effectively address the issue?**

78

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

79

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 has a concern about a case and input has not already been obtained**

80

How?

81

General Rules

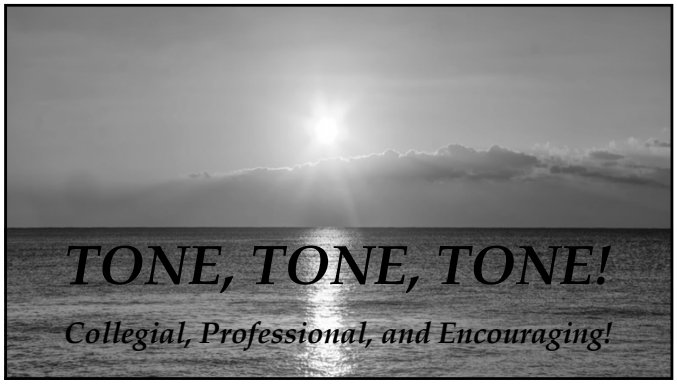
- *No improvement tool* **(Educational Letter, Collegial Counseling, Performance Improvement Plan) until practitioner is notified of specific concerns and provides input**
  - **Note: this does not apply to Informational Letters…but choose events that trigger an Informational Letter *carefully*!**

82

Keys to Successful Communication

- **You can't be nice enough!**

83



84

Keys to Successful Communication

- **You can't be nice enough!**
- **"Thank you for your cooperation and input to date"**
- **"We are conducting this review to successfully and constructively address any issues that are identified."**

85

Keys to Successful Communication

- **"Thank you for your cooperation and participation in the Group's ongoing efforts to improve the care that we provide."**

86

General Rules

Request should include time frame for practitioner's input

87

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)**

88

Four Steps for an *Effective Collegial Interventions*

89

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?**

90

Collegial Intervention

Step #2: Address administrative issues

- **Where and when are you going to meet?**
- **Who is going to meet (one-on-one or group)?**
- **How much time do we need? How much are we likely to get?**

91

Collegial Intervention

Step #3: Plan and Prepare!

- **What are your talking points?**
- **What reactions/responses can we anticipate… and be prepared to address?**
- **What is the desired outcome/objective?**

92

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**

93

Plan for the inevitable "what ifs"!!

94

What if?

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

95

Collegial Intervention

Step #4: Document!

96

Remember The Basics!!!

Talk to your colleague

97

Remember The Basics!!!

Last But Not Least…

Improves Legal Position –
Even if it Doesn't Work!

98

Practitioner Health and Professionalism

99

Part I:

Practitioner Health

(Helping Colleagues and Protecting Patients)

100

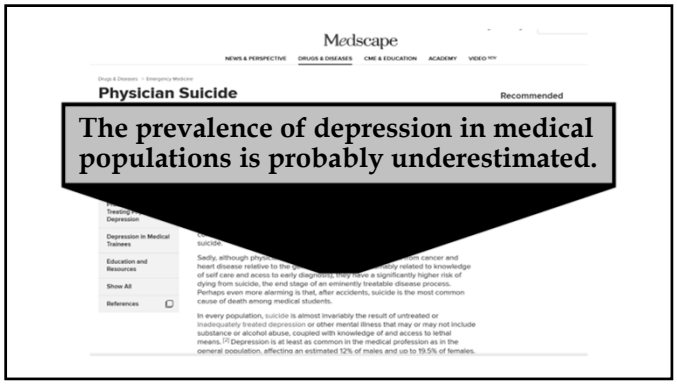
What's the Scope of the Problem?

101

Depression rate in physicians is similar to that in the general population:
12% of males
19.5% of females

But...

102



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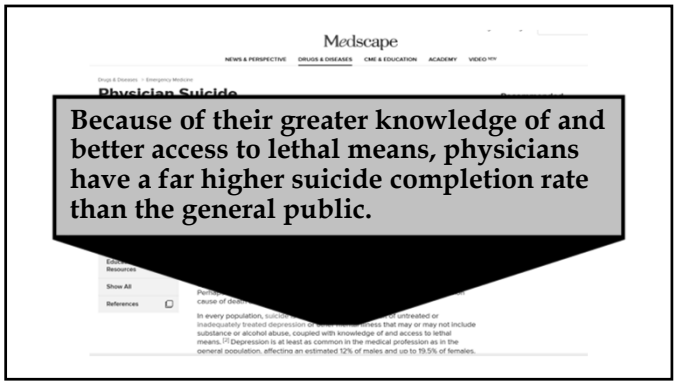

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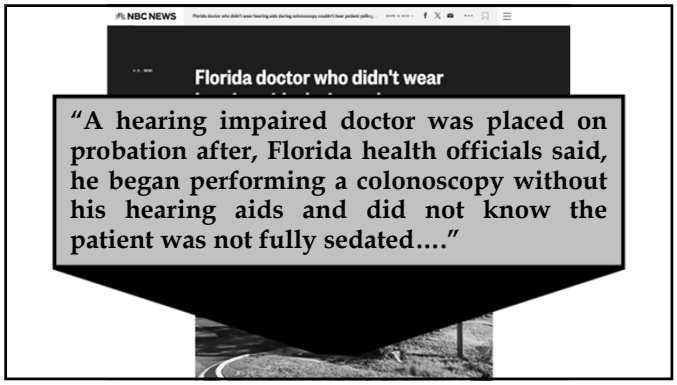
Physicians with a positive screening for depressive symptoms are at higher risk for medical errors.

- JAMA

105



106

Substance Abuse

10% – 14% of physicians may become chemically dependent (i.e., drugs or alcohol) at some point in their careers. This mirrors the general population.

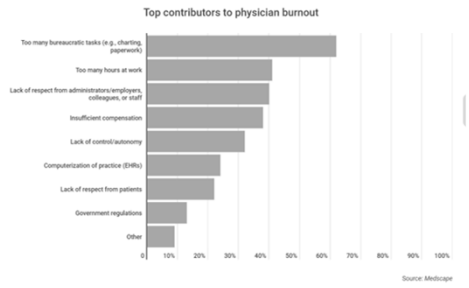
107

108

Physician Burnout

49% of physicians describe themselves as burned out, according to a 2023 Medscape Survey

109



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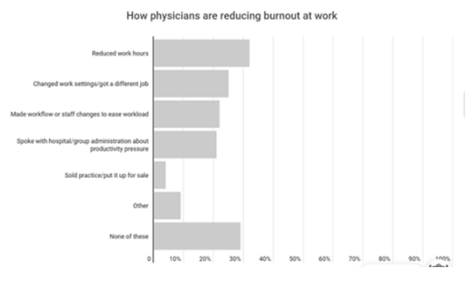

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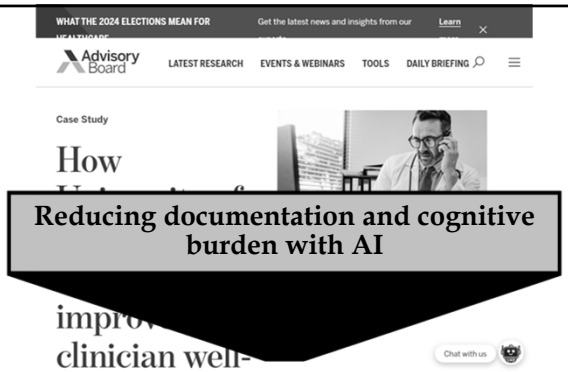
Physician Burnout

"I personally find a lot of wellness in running and doing yoga, but that doesn't address the root cause of sitting in front of a computer going mad trying to click all the boxes."

112



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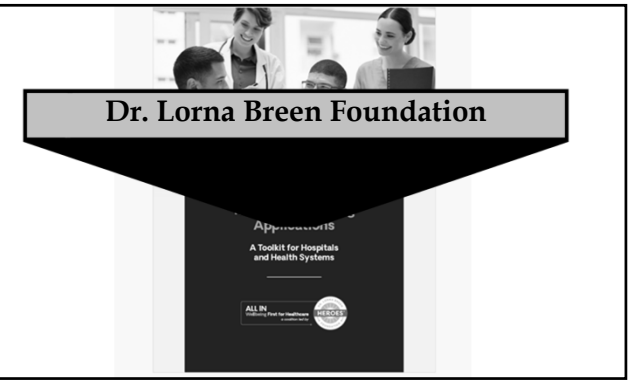

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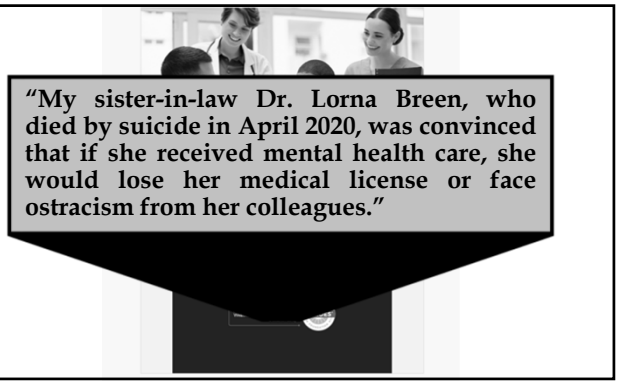

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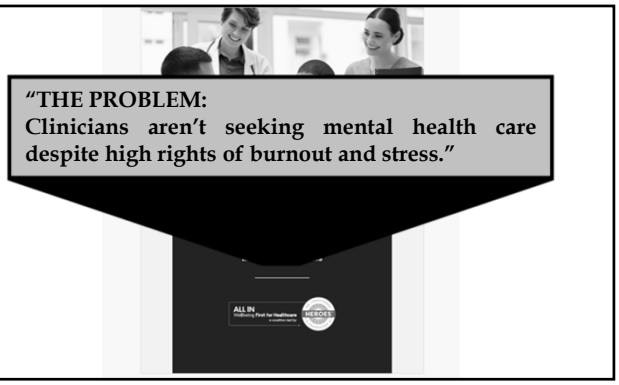


116

Kimberly Jones

117

Education:

- **Definition of a "Health Issue"**

118

The AMA defines physician impairment as "any physical, mental, or behavioral disorder that interferes with the ability to engage safely in professional activities."

119

Education:

- **Definition of a "Health Issue"**
- **Examples**
  - **Substance or alcohol abuse**
  - **Use of medication that affects alertness, judgment, or cognitive function**
  - **Mental health conditions**
  - **Infectious/contagious disease that could compromise patient safety**

120

Reporting:

- **Practitioner Health Committee?**
- **Outpatient Peer Review Committee?**

121

Reporting:

- **Duty to self-report**
- **Reports on suspected issues**
- **Confidentiality**
- **Response to immediate threats**
- **Warning signs**

122

Warning Signs of Substance Abuse

123

- Patients with pain out of proportion to charted narcotic dose
- Never returning waste drug at end of case

124

- Spending more hours at work than needed
- Odd behavior or personality change

125

- Intoxication at social events
- Arrest for DUI
- Increased quality problems

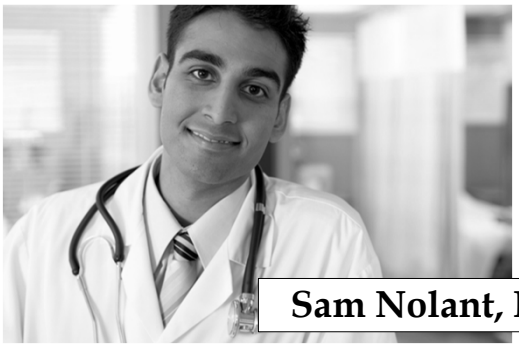
126

Assessment & Reinstatement

127

Dr. Sam Nolant

128



129

What are your options?

130

Voluntary Agreement to Refrain and Fitness for Practice Evaluation

131

Fitness for Practice Evaluation

Best practices:

- **Entity selected by, or acceptable to, the Practitioner Health Committee**
- **Authorization to permit communication**
- **Form of report (specify the questions you want answered)**

132

© HortySpringer Seminars

…Leave of Absence (if treatment program is warranted by the results of the Fitness for Practice Evaluation)

133

Fitness for practice evaluation should focus on whether Dr. Nolant is safe and competent to practice.

134

Reinstatement:

- **Conditions described in detail**
- **For substance abuse:**
  - **Coverage**
  - **Changes in practice**
  - **Ongoing monitoring**
  - **Periodic reports of health status**
  - **Random screens**

135

What information should the Practitioner Health Committee ask for in considering Dr. Nolant's request for reinstatement?

136

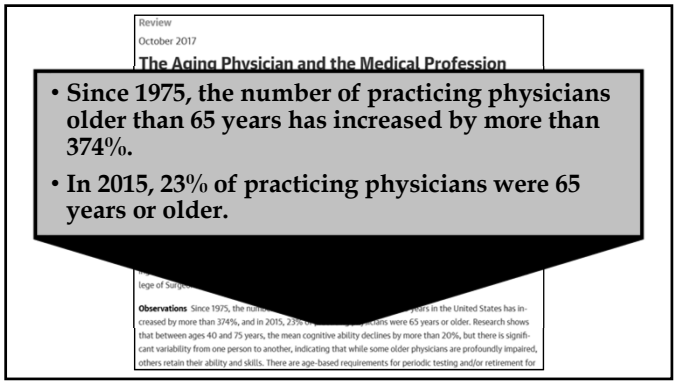
Evaluate reporting requirements:

- **Is a report to state Board of Medicine required?**
- **Is a report of theft of controlled substances to federal DEA required?**

137

Age-Related Concerns

138



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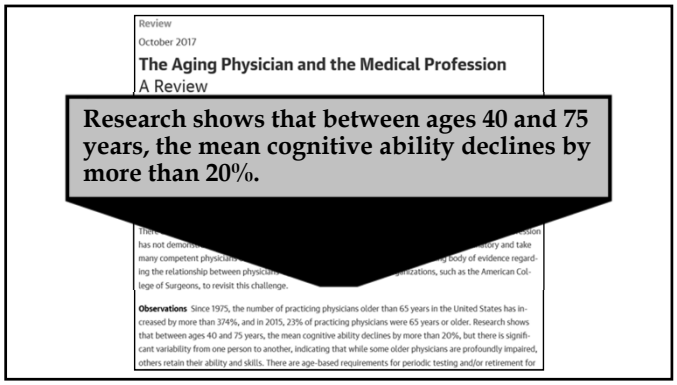


140

"For surgeons older than 60 years…significant differences in mortality rates were largely restricted to those with low procedure volumes... Among high-volume surgeons, however, there were no significant differences in mortality rates…."

— *Annals of Surgery*

141

Age Discrimination in Employment Act of 1967 (ADEA)

- **Applies to "employees" (though some courts are interpreting broadly) over age of 40**
- **Prohibits employment action based on age**
- **Applies to mandatory retirement, mandatory testing, etc.**

142

Options

143

This Issue Views 6,110 | Citations 0 | Altmetric 163

JAMA Performance Improvement

January 14, 2020

Cognitive Testing of Older Clinicians Prior to

Yale New Haven Hospital requires neuropsychological assessment for clinicians aged 70 years or older.

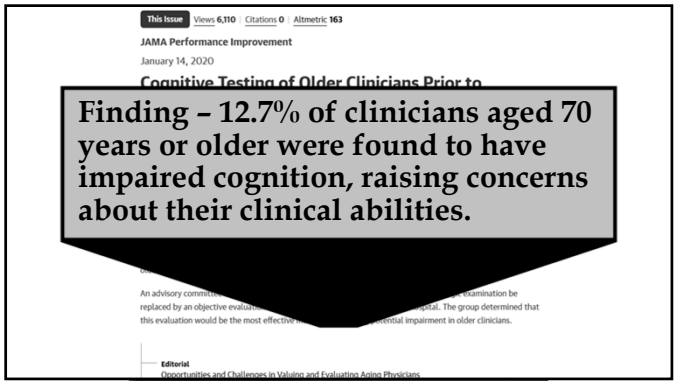
older.

An advisory committee of [illegible] neurologic examination be replaced by an objective evaluation of cog[illegible]y the hospital. The group determined that this evaluation would be the most effective method of assessing potential impairment in older clinicians.

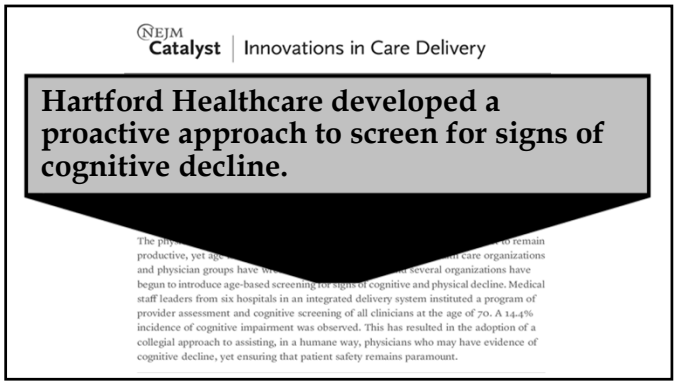
Editorial

Opportunities and Challenges in Valuing and Evaluating Aging Physicians

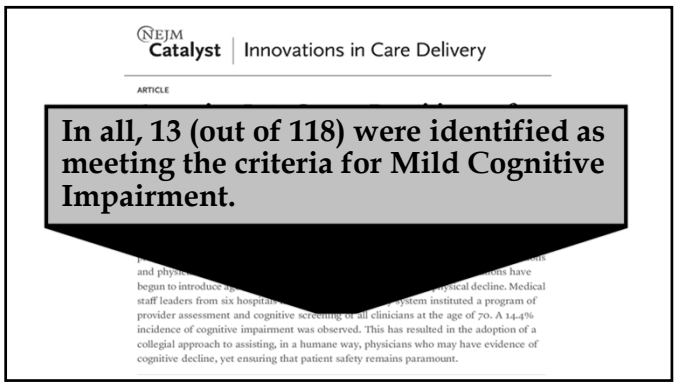
144


This Issue
Views 6,110 | Citations 0 | Altmetric 163
JAMA Performance Improvement
January 14, 2020
Cognitive Testing of Older Clinicians Prior to
Finding – 12.7% of clinicians aged 70 years or older were found to have impaired cognition, raising concerns about their clinical abilities.
Editorial
Opportunities and Challenges in Valuing and Evaluating Aging Physicians

145


NEJM Catalyst | Innovations in Care Delivery
Hartford Healthcare developed a proactive approach to screen for signs of cognitive decline.
productive, yet age
and physician groups have
began to introduce age-based screening
staff leaders from six hospitals in an integrated delivery system instituted a program of
provider assessment and cognitive screening of all clinicians at the age of 70. A 14.4%
incidence of cognitive impairment was observed. This has resulted in the adoption of a
collegial approach to assisting, in a humane way, physicians who may have evidence of
cognitive decline, yet ensuring that patient safety remains paramount.

146


NEJM Catalyst | Innovations in Care Delivery
ARTICLE
In all, 13 (out of 118) were identified as meeting the criteria for Mild Cognitive Impairment.
and physi
begun to introduce
staff leaders from six hospitals in an integrated delivery system instituted a program of
provider assessment and cognitive screening of all clinicians at the age of 70. A 14.4%
incidence of cognitive impairment was observed. This has resulted in the adoption of a
collegial approach to assisting, in a humane way, physicians who may have evidence of
cognitive decline, yet ensuring that patient safety remains paramount.

147

But…

148

EEOC v. Yale New Haven Hospital

Filed February 11, 2020

***Allegation* – Yale New Haven violated the ADEA by adopting the Policy and applying it to physicians over the age of 70.**

149

U.S. Equal Employment Opportunity Commission

Languages

Search terms... Search

January 7, 2021

The EEOC investigation determined that Hennepin Healthcare System's "Late Career Practitioner Policy" discriminated against practitioners age 70 and older.

150

151

152

Part II:

Professionalism

(Setting and Achieving High Standards)

153

Does "disruptive" conduct adversely affect patient care?

(as if you really need convincing!)

154

Data tells us "Yes, it does"

155

In a survey of 1,500 health care professionals, 17% reported knowing of adverse events related to disruptive conduct.

156

157

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

158

The courts tell us

"Yes, it does"

159

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

160

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.'"

161

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."

162

	According to the Hospital, Dr. Leal became so enraged he:	According to Dr. Leal's affidavits, he:
	1. broke a telephone	1. accidentally broke a telephone when he tripped on its cord
	2. shattered the glass on a copy machine	2. closed the lid of a copy machine with 'some force' and the glass cracked
	3. shoved a cart into the doors of the operating suite so hard that it damaged one of them	3. moved a cart that was blocking the doors of the operating suite
	4. flung a medical chart to the ground	4. was handed a chart and some of the loose papers fell to the floor
	5. threw jelly beans down the hallway in the surgical suite	5. ate jelly beans, some of which fell on the floor when he tried to throw away flavors he did not like

163

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."

164

The Court Said:

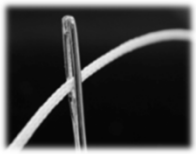
"The fact that no patients were hit by pieces of the broken telephone, or by the shattered copy machine glass, or by the careening metal cart, or by the flying jellybeans, or by the airborne medical chart, is not dispositive."

165

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."

166



The common thread is that this type of behavior interferes with the orderly operation of the hospital and has the potential to adversely affect care.

167

168

Incorporate Professionalism Standards into Your Peer Review Policy.

169

Professionalism Standards

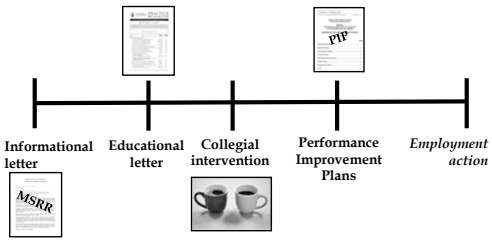
- **Identify acceptable and unacceptable behavior**
- **Define review process**
- **Provide for progressive steps**

170

Use Progressive Steps to address concerns early.

171

Progressive Steps Continuum



172

Be Shy –
The Meet & Greet.

173

- **Remember our Intervention steps**
  - **Breathe, Plan, and Prepare**
  - **Do we need to address confidentiality and retaliation?**

174

Ignore quality concerns.

175

Stay focused on the inappropriate behavior, not its cause.

176

Diagnose.

177

Psychiatric Evaluations?

- **Be careful! Generally not a good idea!**
- **Stay focused on inappropriate behavior, not possible causes!**

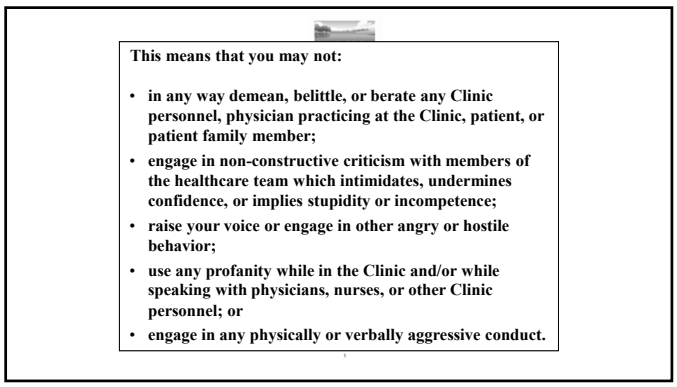
178

Document, document, document!!!

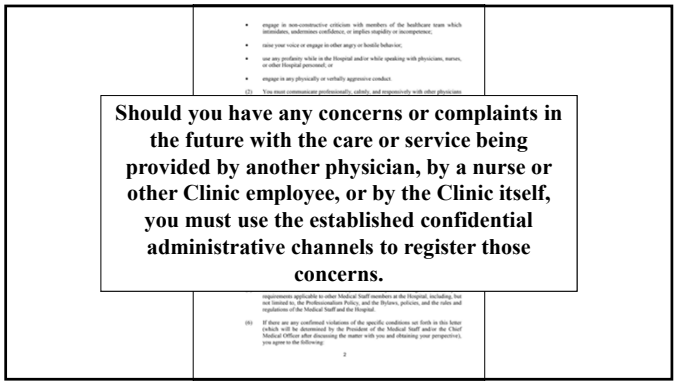
179

Consider a Personal Code of Conduct/Performance Improvement Plan.

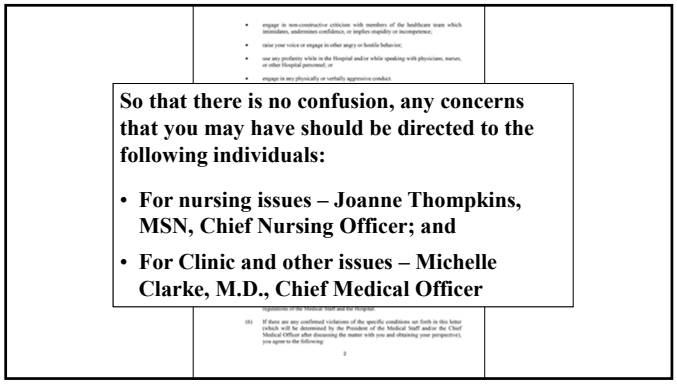
180


This means that you may not:
• in any way demean, belittle, or berate any Clinic personnel, physician practicing at the Clinic, patient, or patient family member;
• engage in non-constructive criticism with members of the healthcare team which intimidates, undermines confidence, or implies stupidity or incompetence;
• raise your voice or engage in other angry or hostile behavior;
• use any profanity while in the Clinic and/or while speaking with physicians, nurses, or other Clinic personnel; or
• engage in any physically or verbally aggressive conduct.

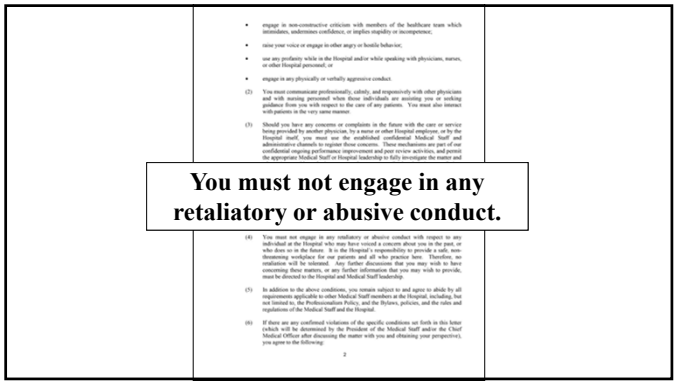
181


Should you have any concerns or complaints in the future with the care or service being provided by another physician, by a nurse or other Clinic employee, or by the Clinic itself, you must use the established confidential administrative channels to register those concerns.

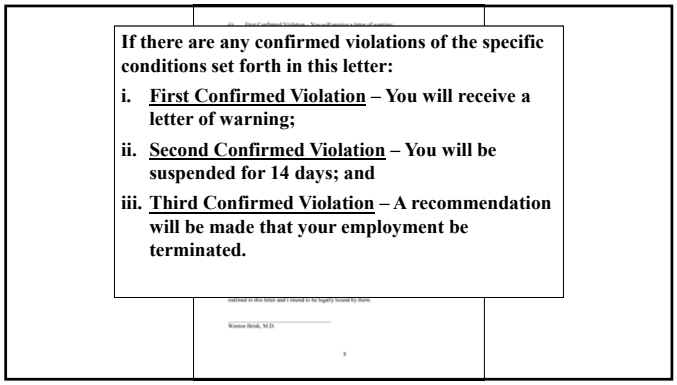
182


So that there is no confusion, any concerns that you may have should be directed to the following individuals:
• For nursing issues – Joanne Thompkins, MSN, Chief Nursing Officer; and
• For Clinic and other issues – Michelle Clarke, M.D., Chief Medical Officer

183


You must not engage in any retaliatory or abusive conduct.

184


If there are any confirmed violations of the specific conditions set forth in this letter:
i. First Confirmed Violation – You will receive a letter of warning;
ii. Second Confirmed Violation – You will be suspended for 14 days; and
iii. Third Confirmed Violation – A recommendation will be made that your employment be terminated.

185


Consider outside resources.

186

Ignore Harassment

187

Outpatient Peer Review Potpourri

(*aka* a lot of information in a short period of time)

188

Legal Protections

189

The Health Care Quality Improvement Act (HCQIA)

190

HCQIA
The Rundown:

1. **Federal law**
2. **Provides immunity from damages**
3. **Protects:**
   - **professional review bodies,**
   - **members of professional review bodies, and**
   - **those providing information**

191

HCQIA
The Rundown:

Applies to "health care entities":

- **Hospitals**
- **Entities that provide health care services and have a formal peer review process**

192

HCQIA
The Rundown:

Professional review bodies immune if action taken:

- **In reasonable belief in furtherance of quality care**
- **After reasonable investigation**
- **After notice of action and hearing***

193

State legal protections:

- **Peer review privilege**

194

Cal. Evid. Code § 1157(a)

The proceedings and records of a "peer review body" are not subject to discovery.

195

Cal. Bus. & Prof. Code § 805

A "peer review body" includes a committee organized by an entity consisting of or employing more than 25 licentiates (i.e., physicians).

196

Keys to *Confidentiality*

197

Teach confidentiality best practices…
and reinforce at every opportunity!

198

Confidentiality Statement

199

Confidentiality Statement

- **Made by physician leader at the beginning of every committee meeting**
- **Content is practical, "physician-speak," not threatening lawyer tone**

200

- ***Quick reminder:*** **Everything we discuss today is very sensitive and protected by state law**
- **Let's have robust and constructive discussions today, but remember everything is *strictly confidential***
- **Once you leave the meeting, no discussions *except* with another authorized individual *and* in private or we place everyone at risk**
- **Thanks for your *professionalism***

201

Confidentiality Agreements

- **"As a committee member, I recognize that I will have access to sensitive and confidential peer review information…."**
- **"I understand that all such information and any discussions regarding it are strictly confidential…."**
- **"I understand that breaches of confidentiality reflect a lack of professionalism and have multiple, serious consequences…."**
- **"Therefore, I agree to maintain the confidentiality of all peer review information…."**

202

Distribution of Documents

Consider...

203

- **Not providing "hard" copies of confidential documents in advance of meetings**
- **Numbering copies of any confidential documents that may be distributed before or at meeting**
- **Collecting and destroying copies after meetings/ instructions to delete e-mailed documents**
- **Secure e-mail/secure intranet**

204

Promote Information Sharing Through Formal Mechanisms

205

Formal Mechanisms for Information Sharing

- **Policy language**

206

Authorization to Share Information Among Affiliated Entities:

The individual authorizes Affiliated Entities to share information pertaining to the individual's clinical competence, professional conduct, and health.

"AFFILIATE" means an entity that controls, is controlled by, or is under common control with the Group.

207

Formal Mechanisms for Information Sharing

- **Policy language**
- **Employment contracts**
- **Information Sharing Policy**

208

Information Sharing Policy

Includes processes for:

- **Responding to "pull" requests**
- **Making "push" notifications (affirmative obligation to provide information in defined circumstances)**
- **Using consent forms for certain health information**

209

Final Tips

210

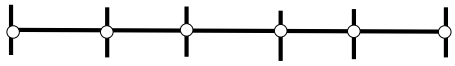
Final Tips

"Hire hard, manage easy"

211

Final Tips

Use collegial efforts and progressive steps!



212

Final Tips

Document, document, document!

213

Final Tips

Call counsel!

214

Final Tips

Take Care of Yourself

215

Thank You!

216

Thank you!

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