Recognize, Respond, and Resolve: A Proactive Approach to Addressing Clinical Performance Concerns

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Recognize, Respond, and Resolve:  
A Proactive Approach to Addressing Clinical Performance Concerns

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Objective

• Recognize red flags or performance patterns that can be early indicators of poor or declining clinical performance
• Identify approaches to respond to concerns and support early intervention
• Identify resources to resolve concerns and effectively support skill remediation or performance improvement

Defining Terms:

Remedial Education
Encompasses all education that is aimed at addressing gaps in knowledge, clinical skills, and other core competencies

Key points:
• Includes education designed for physicians who have been disciplined or had impairment
• Also refers to education addressing specific skills and educational needs
• Reentry education is considered remedial
What Hospitals Don’t Tell Patients

- The story of a patient who underwent hiatal hernia repair
- Returned to ER and soon had another surgery
- Doctor assured the family that the surgeries were a “success”
- Her condition worsened
- Chief of staff met with the family and suggested they could use another surgeon
- Patient underwent third surgery… ultimately died

What Hospitals Don’t Tell Patients

- Privileges at another hospital had been restricted and then reinstated with limitations
- Under review by the state medical board
- Multiple malpractice suit settlements

- Physician reached settlement with family
- Hospital sued for negligent credentialing
- Physician ultimately lost privileges and license
The greatest failure of all is failure to act when action is needed
Coach John Wooden

RECOGNIZE

Issues Hospitals Face
A cardiologist who falsified a letter, is suspended from hospital, then does not tell new hospital about the trouble at the previous one.
A surgeon who yells at OR doctors, nurses and staff whenever he is notified that a case is coming from the ER.
An ob-gyn who adopts baby he has just delivered and continues to serve as birth mother’s physician.
A neurosurgeon whose op note does not reflect error and return of patient to OR, and provides late responses to consultation requests.
A pediatrician with a longstanding history of shirking responsibilities, not following through with patients, and providing sub-standard care.
An ER doctor who prescribes more opioids and in higher amounts than all other doctors in ER rotation.
### Issues

#### Clinical Competence
- Substandard care
- Complication rates
- Poor outcomes
- Patient complaints
- Non-standard care
- Practice drift/change in scope of practice
- Competence following significant health issue

#### Absence from Practice
- Resuming patient care after an extended voluntary absence:
  - Caring for family members
  - Pursuing other careers
  - Recovering from medical event
  - Returning to practice after retirement

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#### Late Career Physician
- Actively practicing physicians who have reached advanced age where fitness to practice may be of concern

#### Clinical Competence
- Substandard care
- Complication rates
- Poor outcomes
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- Practice drift/change in scope of practice
- Competence following significant health issue
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More Issues!

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<td>Misrepresentation</td>
<td>Prescribing CS in large quantities</td>
<td>Communication that strains colleague or staff functions</td>
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<td>Delivery difficult or disappointing news</td>
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<td>license</td>
<td>To known or suspected drug abuser</td>
<td>Poor patient satisfaction ratings</td>
<td>Failure to explain clinical thinking</td>
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<td>To those likely to be diverting</td>
<td>Difficulty with new practice environment</td>
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<td>Financial impropriety</td>
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Increasing attention on clinician quality

- Focus on patient safety and quality
  - Expectation that clinicians be held accountable for quality of care
  - Risk of negligent credentialing
- Employed physicians
  - Increased liability risk for hospitals
  - Quality concerns with newly acquired practices
  - Ability for employers to require remediation
- Healthcare provider shortage
  - Need to retain doctors on staff
- FPPE/OPPE processes
  - Use of data and performance metrics to evaluate performance and identify outliers

Support retention/remediation vs. litigation/replacement

Underperforming Physicians

What does the literature say?

- U.S. study estimated that 6 – 12% of physicians were dyscompetent
- Canadian study of randomly selected physicians found 15% of FPs and 3% of specialists were practicing with considerable deficiencies

1) J Contin Educ Health Prof. 2006 Summer;26(3):173-9
2) Healthc Policy. 2009;42:141–160
3) CMAJ. 1990;143:1193–1199
4) JAMA. 2006;296:1035-1039
Predictors of Physician Performance on Competence Assessment

To identify factors associated with physician performance rating in a comprehensive competence assessment

Retrospective analysis
683 physicians assessed at CPEP
Evaluated as either safe or unsafe to practice
Multivariate logistic regression

Grace, ES; Wenghofer, EF; Korinek, EJ. Predictors of Physician Performance on Competence Assessment: Findings from CPEP. Acad Med. 2014 Jun;89(6):912-9

Variables

- Personal characteristics
  - Age
  - Specialty
  - Country of training

- Practice characteristics
  - Solo practice
  - Scope of practice match with training

- Referral factors
  - Previous discipline by medical licensing body (board)
  - Source of referral (hospital, licensing body)

Findings

- More likely to have unsafe outcome
  - For each year of increasing age
  - General practitioner (did not complete full residency)
  - In solo practice
  - Current or previous licensure action

- Less likely to have unsafe outcome
  - Board-certified
  - Practice scope matches training

Regression model accounted for 26% of variation
Conclusions

Majority either performed well or demonstrated potential to remediate
- 13% performed poorly

Confirmed previous associations
- Increasing age
- Lack of board certification
- Solo practice

Highlighted new, unrecognized factors
- Practice drift – practicing outside scope of training

Impact of aging on performance

US Physician Workforce is Aging
- 55% of US physicians are over 50; 30% are over 60
  FSMB Study of Licensed Physicians 2014

Studies have found skills deteriorate as physicians age
- Adults in 70s take twice as long to process mental task as those in 20s (JCEHP 2010)
- Patient mortality in some complex operations higher among physicians > 60 (Annals of Surgery 2006)
- Higher risk mortality and longer patient stay in inpatient care associated with older physicians (AJM 2011)

Poor patient communication

Intimidating and disruptive behavior on medical teams can
– Foster medical errors
– Contribute to poor patient satisfaction
– Lead to preventable adverse outcomes
– Increase the cost of care
– Lead to excessive staff turnover

Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment

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

Physician data increasingly sophisticated

• Available through software systems (CRIMSON, Midas)
• Flag outcomes
  – One concerning incident
  – Pattern of near misses
• Compare to peers or to national datasets
  – High blood loss
  – High infection rate
  – Accidental puncture
  – Medication errors (too high dose, contraindicated)

Don’t ignore patterns

• Studies have found that a small number of doctors account for the majority of complaints or claims1,2,3
• Those who have more than one claim/complaint are at higher risk of having another over time
  – In Australia study, doctors named in a third complaint had 38% chance of further complaints in a year and a 57% chance of another complaint within 2 years2

2Identification of doctors at risk for recurent complaints: a nation study of healthcare complaints in Australia. BMJ Qual Saf; published online April 10, 2012
3Prevalence and Characteristics of Physicians Prone to Malpractice Claims. 2016 Jan 28; NEJM374:4
Warning signs: When stakes are high

- Outside chart review identifies concerns
- Significant patient harm
- Fitness for duty (following health issue)
- Questions about procedural skills/decisions
- Returning to practice after absence

But what about these warning signs:

- On-going patient/staff complaints
- Trending data is outside norms
- Multiple malpractice suits
- Patterns of inadequate treatment
- Inadequate supervision of PAs or residents
- Failure to improve after FPPE
- Aging physician

RESPOND
**Peer review process...**

Before...

- Peer review relied primarily on patient or staff complaints
- Objectivity was difficult
  - “He’s ok, I play golf with him every Wednesday”
- Processes were variable
  - “It was a little messy” Medical Staff Professional

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**It was hard...**

“...Because of the link between peer review and disciplinary action, physicians generally are apprehensive about the process of peer review, whether as a recipient or as a reviewer.”

*Comprehensive Study of Peer Review in California: Final Report, July 31, 2008; Report prepared by Lumetra*
It’s still hard...

“Overall, physicians support the professional commitment to report … impaired or incompetent colleagues…; however, when faced with these situations, many do not report.”

Survey of 1891 physicians

- Reasons for not reporting
  - Someone else will take care of it
  - Nothing will happen if I do report it
  - Fear of retribution


It’s complicated!

Considering questionable care

Medical Executive Committee

- Care found appropriate?
- Restriction of privileges?
- Refer to outside resource?
- Termination/Suspension?

Peer Review Committee

- Conducts deeper review of the case
- Patient complaint
- Post-op infection
- Readmission <30 days
- Patient mortality

Medical QI Committee

- Looks for possible trends
- Conducts root-cause analysis

Care found appropriate
No further action

Medical Executive Committee
Results of peer review investigation

- Nothing
- Mandatory education or training
- Monitoring or proctoring procedures and practices
- Mandatory behavior counseling or some variant
- Change/restriction in privileges
- Summary suspension or termination

➢ Some may result in report to state or national agencies
➢ May impact physician’s livelihood and ability to work

Comprehensive Study of Peer Review in California: Final Report, July 31, 2008; Report prepared by Lumetra

Times are changing...

- Hospitals are implementing improved systems
  - Robust processes for making, tracking and responding to incident reports
  - Data mining programs provide trending and comparison data
  - Provide on-going feedback and comparison data
- Skills training of physician leaders
- Progressive levels of feedback and intervention
- Present peer review as an educational process rather than a punitive one

Striving to create a culture of trust and accountability

EARLY INTERVENTION
Create a culture of proactive intervention

• Have a defined process
  – Collegial Intervention Policy
  – Citizenship Committee

• Identify and train professionals to deliver the message
  – CMO/MDP/Quality Director
  – Peer messengers or coaches

• Data is your friend
  – Use trending data to compare to peers

Importance of early intervention

If addressed early and effectively
• Win-win situation for physician, medical staff and patients

If overlooked too long
• Possibility of significant patient harm
• Damaged relationships on staff
• Legal consequences for hospital and physician
• STRESS!

Ultimately, hospital could lose needed physician from staff and physician could lose career

Early intervention

Cup of Coffee Chat
Meeting with CMO
More Formal Process

Hospitals are striving to create uniform processes
Consider using outside expertise when...

- A department has trouble with unbiased peer review
- Medical staff are dissatisfied
- Patients are dissatisfied
- You are puzzled about clinical performance
- You have ‘near-miss’ errors
- You have a pattern of concerns

RESOLVE

“The first step is a talk with CMO and MSP (together) to bring issue to physician’s attention…

If it continues, they refer pretty quickly…

It is a change from prior years where the same issues drug on for years with no behavior change.”

Medical Staff Director
Resources for intervention

- FPPE process
  - Proctoring; chart reviews; consultations
- External peer review or consultant visit
- Health program evaluation
- Late career screening or evaluation
- Voluntary remedial agreement (formal or informal)
  - Self-education plan
  - Specific CME courses
  - Formal competence assessment/remedial education program

External Peer Review

- Used to provide objective expert review of one or more cases that have been identified by the facility
- Often used
  - To avoid perceptions of conflict of interest
  - When second opinion or outside expertise is needed
  - When there is a lack of qualified clinicians on staff for specific specialty
  - When new technology is being used
  - When there is a high likelihood of litigation

Physician Health Programs

- Provide peer assistance services
- Aid individuals who have health or mental health problems that could affect ability to practice
- Offer assessment, referral, monitoring and support services
- Non-disciplinary and confidential
- Most states have a PHP – scope of services provided varies

http://www.fsphp.org/State_Programs.html
Late Career Clinician

Age alone should not determine continuation in practice

Late Career Clinician
Screening or Evaluation

- Responsibility to determine impact of age on practice
- Screening: for everyone over a specific age
  - 10% of hospitals have implemented
- Evaluation: after lapses or when concerns arise
  - Health evaluation
  - Competence evaluation
  - Aging physician evaluation

Late Career Clinician Screening

- Decide age (65, 70, 72, 75)
- Decide frequency (annually, every 2 years)
- Decide elements
  - Cognitive function screen
  - Physical exam
    - By qualified, impartial evaluator
    - Evaluator should know physician’s specialty
  - Review of quality of care or charts
  - Other
Comprehensive Evaluation

Rigorous evaluation of lapses should be norm, regardless of age

– Consider health or skills evaluation
  • Detecting subtle cognitive or physical impairment difficult
  • Determine ability to practice with skill and safety
– Evaluation can help determine next steps
  • Further health evaluation
  • Educational intervention
  • Accommodation/limitation of practice
  • Permanent disability/retirement

Change is a Process not an Event!

What is effective CME?

CME leads to greater improvement in physician performance if it…

• Is interactive
• Uses a variety of methods
  – Simulation technology, standardized patients, immediate feedback, chart review
• Involves multiple exposures to content over longer duration
• Focuses on outcomes that are considered important by the clinician (contextually relevant)

Effectiveness of CME: Updated Synthesis of Systematic Reviews Cervero, et al; ACCME 2014
Remedial education for clinicians

- Intensive (2-3 days)
- Limited class size
- Use tools such as
  - Personal Improvement Plans
  - Chart Reviews
  - Feedback or Post-Program Report from Faculty
  - Follow-up or coaching option

Do your homework!
Look for practical, personalized educational options

Intensive, skill-building courses

- Medical Record Keeping (some with follow-up chart reviews)
- Professionalism/Ethics/Boundaries
- Communication (with peers or with patients)
- Disruptive Behavior
- Prescribing controlled drugs
- Specialty courses on specific procedural skills

“I was never taught this in medical school”

Case Study: Fretful Surgeon

- When notified of case coming from ER, yells at nurses, doctors, and staff to get ready!
- Had talk with CMO
  - “It won’t happen again…”
- Yelled at chair of Citizenship Committee
- Referred to course
  - Partners upset with referral
Case Study: Fretful Surgeon

- Inter-professional communication seminar
- Personality profile, emotional intelligence, stress management
- Personal improvement plan
- Report from faculty
- Follow-up coaching recommended

Doctor shared with CMO this his perspective had changed...
Partners called to say he was easier to work with...
Wife called to thank them!

Case Study: Duped doctor

Dr. Kay had two patient cases under review due to over-prescribing
Enrolled in 3-day Prescribing Course

Learned:
• How to identify and manage patients with chemical dependency or drug-seeking tendencies,
• Current information on state drug monitoring program, and
• Proper practices for prescribing and monitoring controlled substances.

Gained insight into what makes a clinician vulnerable to poor prescribing, and family systems and their impact on professional behavior.

Case Study: Duped doctor

Life-changing experience:
• “I gained increased confidence in my decision-making…”
• “I feel I’m making decisions out of integrity rather than fear…”
• “Helped me understand why I did what I did and gave me skills to change…”
COMPETENCE ASSESSMENT PROGRAMS

Competence Assessment Programs

✓ Focus on physicians whose clinical competence has been questioned
  – Referred by a regulatory agency
✓ Conduct comprehensive assessment
  – Relevant to core competencies
✓ Provide remedial education that identifies specific expected activities and goals

Help Hospitals

Address questions related to:
• Quality of care
• Reentry to practice
• Aging clinicians
• Changing scope of practice
• Ability to resume/remain on staff
Case Study: Missed management
- Internist
- New to small community hospital
- Moved after long career at academic medical center
- Nurses began complaining about care
- Patient death shortly after doctor saw the patient

Case Study: Shaky surgeon
- 56 year-old surgeon
- Hospital suspended due to possible health issue (slight tremor)
- Referred to PHP
  - Identified possible progressive disease
- Referred for competence assessment

Case Study: Concerning clinical care
- Pulmonologist/critical care doc
- In practice with father and brother
- Concerns
  - Lack of indications for procedures
  - Deficiencies in patient consents
  - Poor communication with nurses
  - Responds defensively and blames others
- Two prior outside reviews
- New CMO suggests competence assessment
Case Study: Helping hand

- 64 year-old Family Physician
- Left practice in good standing 2.5 years ago
  - Now wants to help out
- Recruited by small hospital to oversee PAs 2 weekends/month
- Seeking license in state where hospital is located

Not a PHP!

Physician Health Program

Assessment and Remediation Programs

Cognitive Concerns

Different from External Peer Review

**External Peer Review**

**Purpose:** Provide objective evaluation of patient care to determine if standard of care met

**Process:** External expert evaluation of patient charts identified by facility

*Usually does not provide recommendations for next steps*
Different from External Peer Review

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<td><strong>Purpose:</strong> Evaluate clinical competence and skills, and provide educational recommendations</td>
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<td><strong>Process:</strong> External expert evaluation of patient charts identified by facility</td>
<td><strong>Process:</strong> Objective, comprehensive assessment using multiple test modalities</td>
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Usually does not provide recommendations for next steps

Offers solutions to help address areas of need identified

When to consider a Competence Assessment...

- Self referral
- As part of credentialing process
- As part of a voluntary remedial agreement
- In anticipation of pending hospital review/investigation
- As a provision of a disciplinary agreement
- Prior to restoration of privileges

Confidential process – not reportable unless part of other reportable action

The Training Rule

It’s difficult to fix a problem unless you know what the problem is…

Diagnose first. . .

treat only when you have made the diagnosis
1) Conduct comprehensive clinical competence assessment
2) Design and implement educational intervention
3) Determine effectiveness

Patient Care

Knowledge and Judgment
Documentation Skills
Communication Skills
Ethics and Integrity
Competence programs are not the same...

- Assessment
  - Focus/scope of Assessment?
  - Location and length of process?
  - Sample report available?
  - Data on findings/outcomes?
- Education
  - Provide assistance in addressing educational needs?
  - Mini-residency? Community-based?
- Cost? (varies; $8,500 and up)

Educate yourself to make the best decisions

Assessment process

- Two-day evaluation
- Confidential and objective
- Tailored to specialty and practice
  - Includes focus on reasons prompting referral
- Evaluates competence within scope of practice
- Participant and referrer receive report of findings and recommendations

Assessment and Educational Intervention Program

Test modalities

- Clinical interviews by matched specialty consultants
- Patient records review
  - 20-40 patient charts selected from participant’s patient schedule
- Written tests (depending on specialty)
- Simulated patient encounters
- Cognitive function screen
- Review participant health information

Assessment and Educational Intervention Program
Educational intervention

- Activities, intensity and length
  - Determined by areas of educational need
  - Impacted by participant motivation
  - Focus on application of knowledge to actual practice

- Measurable performance objectives

  *Goal: Achieve and sustain improvements in practice*

Education process

- Structured education plan
  - Multiple educational strategies over time (6-12 months)

- Practice-based education
  - Uses resources in home/nearby community
  - Adapt to urban or rural practice

- Participant usually can maintain active practice

Benefits of Educational Intervention

- Provides structure to help physician focus on education in the midst of practice demands

- Receive support and guidance in completing educational objectives from education experts

- Best opportunity to make sustainable change in practice habits and patterns

- Encourages life-long learning and behavior change
Case Study: Missed management
Internist – moved to small community
- Knowledge and judgement deficits
  - Struggled with management of complicated cases
- Met with preceptor weekly for six months
  - Reviewed charts, discussed care
- Felt reconnected to medicine and rejuvenated in career

Case Study: Shaky Surgeon
Surgeon – health issue
Assessment findings
- Did well on Assessment
- Review of charts demonstrated good results from procedures
Recommendations
- Consider limiting procedures
- Continue with PHP
- Periodic observation in OR
Outcome
- Remained in practice

Case Study: Concerning clinical care
Pulmonologist – quality concerns
Assessment found:
- Fair knowledge but significant deficits in diagnostic imaging and mechanical ventilation
- Limited ability to reach correct diagnosis and assess acuity
- Marginal documentation
- Poor patient communication
**Case Study: Concerning clinical care**

Educational Recommendations:
- Intensive education including direct observation of specific procedures
- 6 months with preceptor
- Documentation course
- Communication courses
- Reduce practice volume

Physician refused to comply with recommendations; hospital moved forward to suspend privileges

**Case Study: Helping hand**

*Family Physician – returning to practice*

**Assessment findings**
- Inadequate knowledge/judgment
- Said she would ask PAs and pharmacists if he wasn’t sure what to do
- Cognitive function screen results poor
- Did not demonstrate ability to practice with skill and safety

**Outcome**
- Withdrew from hospital position

**Impact:**

**Competence Assessment Programs**

- Provide objective information to reach decisions about physician competence
- Identify solutions to effectively remediate competence concerns
- Focus on application of knowledge to practice and sustained improvement in care
Why we use a competence assessment program...

“[Program] provides experienced people to do a deep dive to figure out what is really going on with a physician… we are not going to find a colleague with the expertise or time to provide that kind of information.”

“We use these programs with the hope of saving a career and keeping a physician in our community…”

Lynn Stockton, former Director, Medical Staff Services
Medical Center of Aurora

Act before...

• Your heart sinks at the mention of a physician
• The physician’s file is too thick
• You are worried about changes in performance
• Quality of care concerns are overwhelming
• Institutional resources are stressed

Consider Proactive Intervention

Don’t wait until it’s too late
Directory of Assessment and Education Programs

FSMB Clinical Competence Assessment Resources
http://fsmb.org/licensure/spex_plas/plas_clinical

FSMB Directory of Physician Assessment and Remedial Education Programs
http://fsmb.org/Media/Default/PDF/USMLE/RMEdProg.pdf

THANK YOU

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