

Medical Executive Committee Institute

Essential Training for All Medical
Staff Leaders

Greeley
+HCPRO

Making Peer Review Fair and Effective



**How do you feel when asked to
peer review the chart of
a colleague?**

Ecstatic ...



... or trapped?



What is peer review?

- **Traditional definition:**
 - The evaluation of patient charts to determine the quality of care provided by individual physicians
- **Contemporary definition:**
 - The evaluation of an individual physician's professional performance for all relevant performance dimensions using multiple sources of performance data

Sham peer review vs. effective peer review

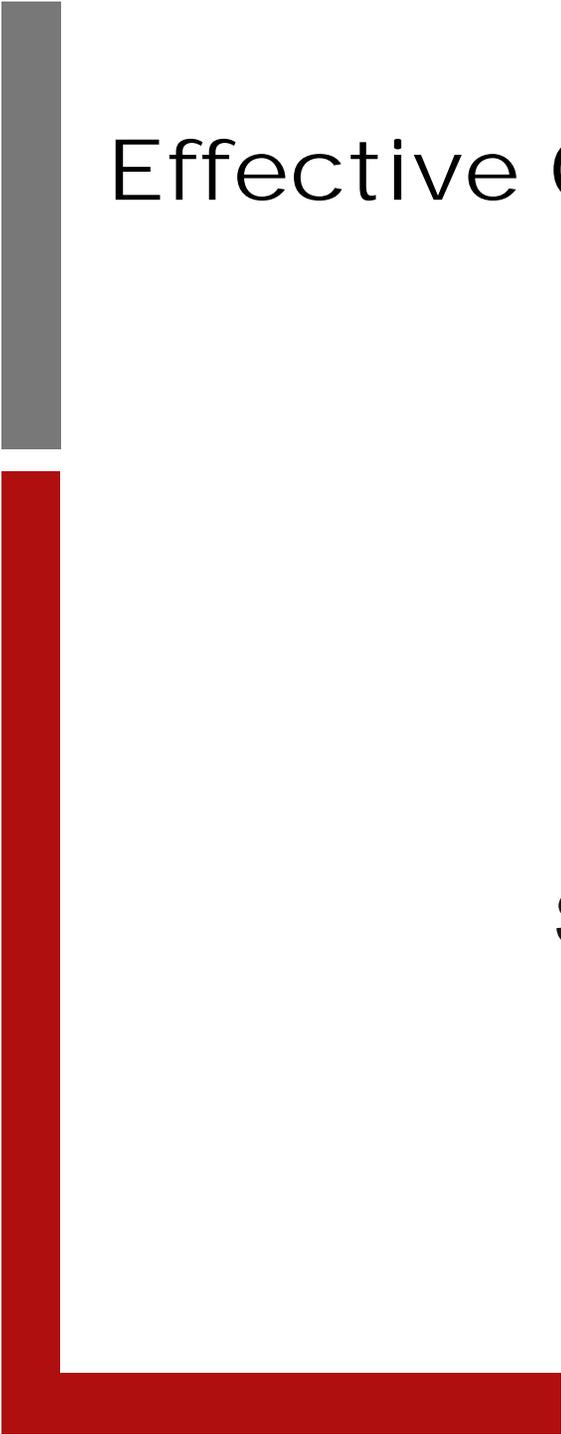
Sham peer review	Effective peer review
“Gotcha!”	Clear performance expectations
Rumor-, accusation-, and innuendo-driven	Data-driven
Biased and in bad faith	High integrity
Variation in the process	Consistency in the process
Little ongoing feedback	Timely, periodic feedback
Jump to corrective action	Progressive interventions to manage poor performance
Failure to hold peers accountable	Peer-to-peer accountability

What are the goals of a great peer review program?

- Nonpunitive culture that results in real physician improvement
- Valid and accurate physician performance measures
- Timely and useful physician performance feedback
- Well-designed and collegial physician improvement strategies
- Effective and efficient committee structure and processes
- Valuable, accurate data for reappointment

First, some Joint Commission terms

- Ongoing professional practice evaluation (OPPE):
 - Routine monitoring of current competency for current medical staff members (peer review)
- Focused professional practice evaluation (FPPE):
 - Confirming current competency for new medical staff members, new privileges, and/or concerns from OPPE (proctoring or focused review)



Effective OPPE =

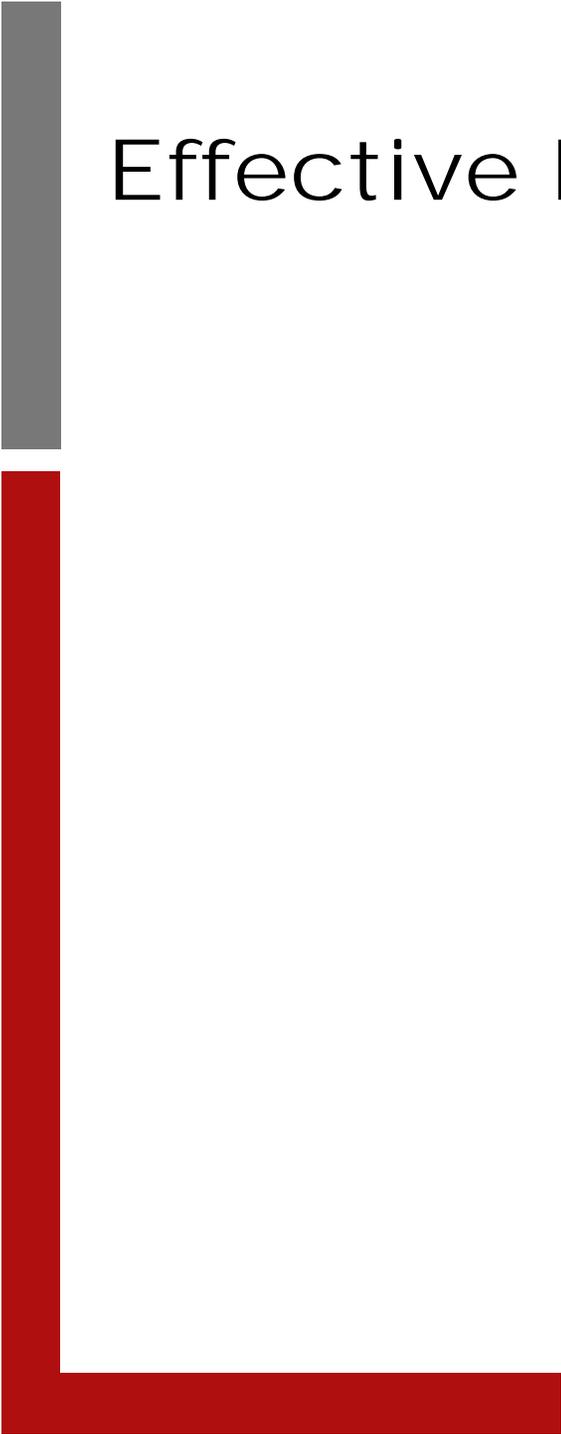
Systematic measurement

+

Systematic evaluation

+

Systematic follow-through



Effective FPPE =

Timely measurement

+

Timely evaluation

+

Timely follow-through

Four steps to make peer review effective

1. Select the right indicators and targets
2. Standardize the case review process
3. Provide timely and useful feedback
4. Simplify the committee structure



Select the right indicators and
targets=

The Greeley
Measurement Method

Classify all indicators

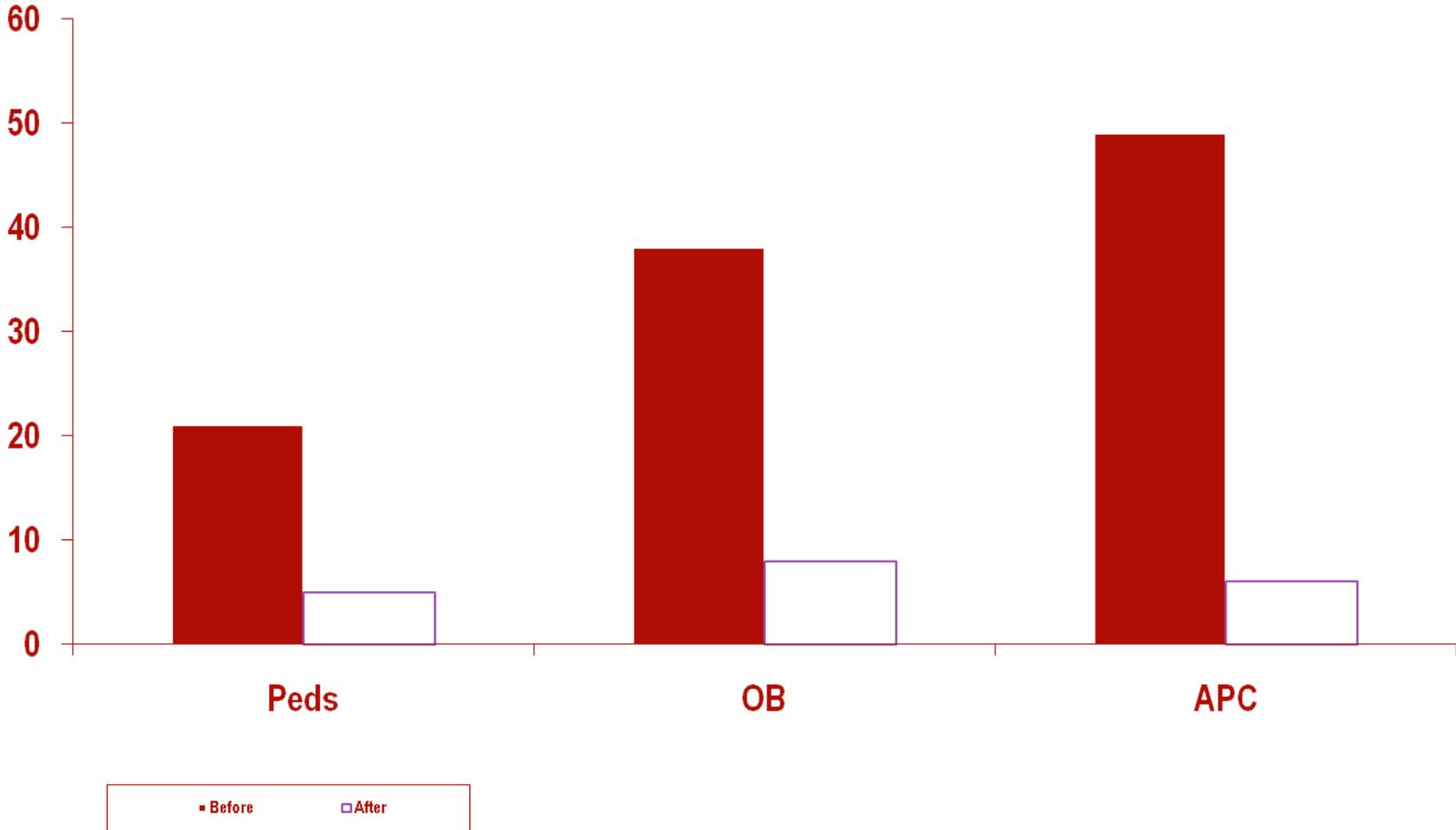
- Rules
- Rates
- Reviews

Response to findings

- Broken rules:
 - Automatic feedback and trend
- Rates and trends:
 - Evaluate and refer
- Unusual events:
 - Review immediately and act, if necessary

What difference would it make?

Comparison of charts actually reviewed to those reviewed with the three-category system



Source: Faith Regional Health Services–Norfolk, NE

Create indicators for each category of your competency framework

Technical quality

Patient care

Service quality

Medical knowledge

Patient safety/
rights

Practiced-based learning

Resource use

Communication skills

Relationships

Professionalism

Citizenship

Systems-based practice

The brave new world of physician performance measurement

- Several dimensions of physician performance can only be measured through the perceptions of others
- Corollary: Effective peer review today requires physicians to accept and use perception data, including perceptions of non-physicians

Types of perception data

- Passive
 - Incident Reports
 - Complaints and Compliments
- Active
 - Evaluation Forms
 - Surveys Forms
- Is peer review of individual cases perception data?

How many targets? Effect on your medical staff culture

One target = Two performance levels



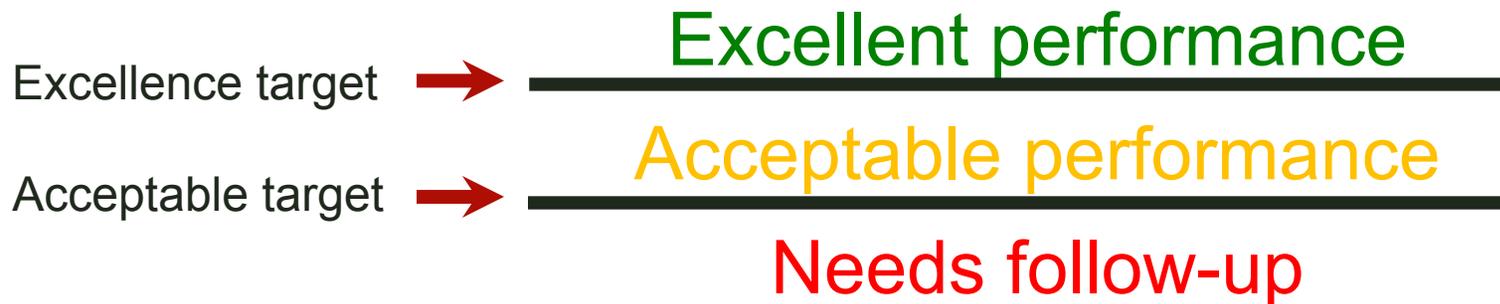
Cultural effect: Bad apples approach

- Focus on poor performance
- Assumes everyone else is the same

How many targets?

Effect on your medical staff culture

Two targets = Three performance levels



Cultural effect: Drives physician improvement

- Recognizes top performers
- Stimulates self-improvement of the middle
- Addresses potentially poor performance

Step 2: Standardize the case review process

- Goals:
 - Improve accuracy
 - Reduce inter-rater variation
 - Improve efficiency

Standardize each step in the case review process

- Case identification
- Pre-reviewer screening
- Physician review
- Committee discussion
- Reviewed physician input
- Committee decision
- Improvement plan

Case Identification:

- External Peer Review: lack of expertise, irreconcilable conflict or difference, potential litigation or fair hearing
- Internal Peer Review: approved medical staff indicators and targets, department and medical staff aggregate data based upon pre-determined rules and rates

Pre-Reviewer Screening

No criteria= No review, Committee discussion for possible inclusion of new criteria

Meets criteria= Referral for physician review

Physician Review (anonymous to physician under review, qualified, no irreconcilable conflict):

- Exemplary (ratified by committee)
- Appropriate (ratified by committee)
- Questionable or controversial (goes to committee)
- Inappropriate (goes to committee)

Something different....

- Most reviews will meet professional standard
- Some will receive exemplary care nominations towards commendation by the board
- Most reviews will result in a letter of appreciation from the committee

Participation of practitioners

- Won't be necessary for satisfactory or exemplary reviews (majority)
- Will always be solicited prior to full committee decision
- Practitioner may comment on any finding by the committee

Committee Discussion (Appropriate)

- May disagree with initial findings= Thank you note to physician
- Exemplary and appropriate assessments ratified by committee with letter of appreciation sent to physician
- Focused physician input
- Final scoring after physician input and consideration of outside reviewers if necessary

Committee Decision (Controversial or Inappropriate)

- Refer to department chair or MEC for improvement plan and follow up
- Refer to system quality committee
- Refer to nursing management
- Refer to medical staff or department for M&M

Improvement Plan

- Educational
- Self-acknowledged voluntary improvement plan
- Department generated improvement plan
- MEC generated improvement plan

Standardize the scoring system

- Identify all physician performance issues
- Determine effect on care (harm and potential for harm)
- Overall assessment of care:
 - Exemplary
 - Appropriate
 - Controversial
 - Inappropriate
 - Uncertain (needs committee discussion)
- System/process issues

Standardize the peer review process

- Train all reviewers in the process and scoring system
- Provide oversight to ensure reviews are performed consistently, accurately, and timely

Step 3: Provide timely and useful feedback

- Case review:
 - Exemplary care
 - Appropriate care
 - Controversial or inappropriate care
- Rule indicator occurrences
- Aggregate data:
 - Reappointment profile vs. performance feedback report

Why use physician performance feedback reports?

- To set expectations of performance
- To recognize good performance
- To identify opportunities for improving individual physician performance
- To allow physicians the opportunity to self-correct
- To provide a basis for dialog
- To provide a basis for managing poor performance
- For reappointment

Physician Profile Report

Provider: John Smith, MD

Dept: Medicine

Period: Jan. 2005-Dec. 2005

Activity Data

Admissions 200
 Consults 12
 Procedures 80
 Total encounters 250
 Transfusions (episodes) 100

Performance Data

Clinical Quality:

Indicator Type	Phys Volume	Phys Data	Excellence Performance Target	Acceptable Performance Target	Target Source	Current Rating	Previous Rating
Risk Adj. Mortality Index: All DRGs	Rate	200	0.95	0.85	1.25	IS	
Risk Adj. Complication Index	Rate	200	1	0.85	1.25	IS	
Peer Review Results: Cases rated 3	Review	10	2	0	2	PRC	
Blood Use Not Meeting Criteria	Rule	N/A	0	1	4	PRC	
Pharm. Recommendations Accepted	Rate	20	90%	90	75%	P&T	
Risk Adj. Mortality Index: DRG 89	Rate	20	1.3	0.85	1.25	IS	
Risk Adj. Complication Index: DRG89	Rate	20	1.1	0.85	1.25	IS	
CHF Patients on ACEI at D/C	Rate	25	85%	95%	85%	P&T	
AMI Patients on ACEI at D/C	Rate	15	90%	95%	85%	P&T	

Service Quality

ED page response w/in 30 minutes	Rule	N/A	0	1	4	PRC	
Incidents of delayed consultation	Rule	N/A	1	0	2	PRC	
Patient satisfaction with physician	Rate	50	65%	75%	50%	PRC	
Validated patient complaints on MD communication/responsiveness	Rule	N/A	0	0	3	PRC	

Patient Safety

Compliance with Med abbreviations	Rate	20	80%	95%	85%	P&T	
Incidents of illegible medication orders	Rule	N/A	1	2	4	P&T	
Incidents of non-participation in pre-procedure timeouts	Rule	N/A	0	0	1	OR	
H&P report not dictated w/in 24 hrs	Rule	N/A	0	0	2	MEC	
H&P/OP report elements	Rate	20	100%	95%	85%	MEC	

Resource Utilization: General

Severity Adj. LOS Index: All DRGS	Rate	200	0.9	0.85	1.25	UM	
Severity Adj. Cost Index: All DRGS	Rate	200	1.1	0.85	1.25	UM	
Delayed Starts in OR/Procedure Area	Rule	N/A	1	1	4	OR	
Sev. Adj. LOS Index: DRG 89	Rate	20	0.85	1.0	1.25	UM	
Sev. Adj. Pharm Cost Index: DRG 89	Rate	20	0.85	1.0	1.25	UM	

Peer and Coworker Relationships

Validated physician behavior incidents	Rule	N/A	2	0	3	MEC	
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Citizenship

Medical Records Suspensions	Rule	280	0	0	3	MEC	
Meeting Attendance	Rate	8	75%	>70%	>50	MEC	



Step 4: Simplify the committee structure

- Option 1: Continue department/section peer review with centralized committee oversight
- Option 2: Perform all peer review through a centralized peer review committee

Centralized peer review committee

- Performs all case reviews
- Periodically reviews, selects, and deselects indicators
- Monitors aggregate data
- Determines when a trend or event is significant enough to warrant an improvement process
- Assigns responsibility and ensures accountability for improvement
- Replaces medical records, tissue and transfusion, P and T, and UM committees



**Don't forget to address your
medical staff culture!**

Medical staff culture

- Collegiality *and* excellence
- Freedom *and* commitment
- Appropriate independence *and* mutual accountability
- Appreciation *and* continuous performance improvement
- Stability *and* change

Healthcare law: What medical staff leaders must know

Healthcare law:

Health Care Quality Improvement Act (HCQIA)

- Passed in 1996 in order to provide civil immunity to individuals, entities, and authorized agents from being held liable for reports made to the National Practitioner Data Bank
- Congress wanted to encourage good faith for professional review activities in order to restrict the ability of incompetent physicians from moving from state to state without disclosure or discovery of the physician's previous damaging or incompetent performance
- It was felt that such effective peer review efforts would not occur if physicians felt threatened by private money damage claims under federal antitrust and other civil claims
- Immunity protections apply to almost all civil allegations except federal civil rights actions.

Healthcare law: HCQIA (cont.)

- The protections are afforded to:
 - The professional review body
 - Any person acting as a member or staff to the body
 - Any person under a contract or other formal agreement with the body
 - Any person who participates with or assists the body with respect to the action
 - Any person or witness providing information to the body, unless such information is false and the person providing it knew the information to be false

Healthcare law: HCQIA (cont.)

- Most states opted in under the HCQIA protections and can therefore take advantage of HCQIA and any state immunities.
- The protections only apply if the professional review action was taken:
 - In the reasonable belief that the action was in furtherance of quality healthcare
 - After a reasonable effort to obtain the facts of the matter

Healthcare law: HCQIA (cont.)

- After adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances
- In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain the facts and after meeting the required notice and hearing procedures
- A professional review action shall be presumed to have met these standards for purposes of HCQIA protections, unless the presumption is rebutted by a preponderance of the evidence

Healthcare law: HCQIA (cont.)

- Notice and hearing requirements:
 - Physician must receive notice that a professional review action has been proposed, the reasons for the proposed action, that the physician has a right to request a hearing within a time frame of not less than thirty days after receipt of the request, as well as a summary of hearing rights
 - Once a hearing is requested, the physician must be told of the place, time, and date of the hearing, which cannot be scheduled less than thirty days after the date of the notice, along with a list of witnesses expected to testify

Healthcare law: HCQIA (cont.)

- A hearing can be held before an arbitrator mutually acceptable to the physician and healthcare entities; a hearing office who is appointed by the hospital but is not in direct competition with the physician; or before a panel of individuals appointed by the hospital who are not in direct competition with the physician
- The physician has the following hearing rights:
 - Representation by an attorney or another person of physician's choice
 - A record of the proceedings
 - To call, examine, and cross-examine witnesses

Healthcare law: HCQIA (cont.)

- Present evidence deemed relevant by the hearing officer, regardless of admissibility in a court of law
- To submit a written statement at the close of the hearing
- Upon completion of a hearing, the physician has the right:
 - To receive a written recommendation, including a statement of the basis for the recommendations
 - To receive a written decision by the healthcare entity, including a statement of the basis for the decision
 - Failure to meet the conditions shall not, in itself, constitute failure to meet the notice and hearing standards

Healthcare law: HCQIA (cont.)

- HCQIA does not require these procedures if no adverse professional review action is taken or where there is a suspension of less than fourteen days, during which an investigation is being conducted to determine the need for a professional review action
- HCQIA also allows the imposition of an immediate suspension, subject to the notice and hearing requirements, with the failure to take such action resulting in an imminent danger to the health of any individual

Healthcare law: National Practitioner Data Bank reporting

- Required reporters include:
 - Medical malpractice payers. Payments from settlements or judgments
 - State licensing boards. Licensure disciplinary action based on reasons related to professional competence or conduct
 - Hospitals and other healthcare entities. Professional review action based on reasons related to professional competence or conduct adversely affecting clinical privileges for a period longer than 30 days; or voluntary surrender or rejection of privileges while under, or to avoid, investigation

Healthcare law: National Practitioner Data Bank reporting (cont.)

- Professional societies: Professional review actions based on reasons relating to professional competence or conduct, adversely affecting membership
- HHS Office of Inspector General: Exclusion from Medicare/Medicaid and other federal programs
- Hospitals and healthcare entities must query the Data Bank at time of appointment, reappointment, and when physicians seek new privileges

Healthcare law: National Practitioner Data Bank reporting (cont.)

- Healthcare entity must report to the Data Bank when a physician's practice or conduct has or may have an adverse impact on patient care
- Reportable events include:
 - Summary suspensions greater than 30 days
 - Terminations
 - Nonreappointment
 - Involuntary reductions in clinical privileges

Healthcare law: National Practitioner Data Bank reporting (cont.)

- Mandatory consultations requiring prior approval
- Resignations in lieu of corrective action after investigation has been initiated
- Are reportable when there has been a final decision by the Board of Directors, except summary suspensions, which must be reported once they exceed thirty days
- Report must be factual and should be specific enough to identify the reasons for the report

Healthcare law: National Practitioner Data Bank reporting (cont.)

- Physician gets a copy of the report and can challenge factual accuracy and also submit his or her own version— inquiring hospital will get both versions
- Nonreportable events:
 - Probation
 - Letter of reprimand
 - Monitoring
 - Proctoring

Healthcare law: National Practitioner Data Bank reporting (cont.)

- Continuing education
- Leave of absence as a result of impairment
- Concurrent and retrospective reviews
- Voluntary relinquishment of certain clinical privileges at time of reappointment
- Administrative/automatic suspensions for failure to pay dues, maintain insurance, complete records, and other similar actions

Healthcare law: National Practitioner Data Bank reporting (cont.)

- Mandatory consultations which do not require prior approval
- Goal should be to identify nonreportable remedial measures to get physicians back on track and to use reportable events as a last measure option
- Bylaws should generally limit hearings to Data Bank or state reportable events

Healthcare law: Corporate negligence

- Hospitals have an obligation to make sure that physicians are qualified for membership and have demonstrated current competency to exercise each and every clinical privilege given to them. If a hospital knew or should have known that the physician was unqualified or did not meet established criteria and a patient is injured as a result of the physician's negligence, the hospital can be held independently liable for any injury suffered by the patient.
- This is a common law doctrine which has been adopted in one form or another in almost every single state.

Healthcare law: Corporate negligence (cont.)

- Breach of this duty can be established through proof that a hospital, through its medical staff, has failed to follow:
 - Medical staff bylaws, rules, or regulations
 - The hospital licensing requirements
 - Joint Commission or other accreditation standards—
OPPE/FPPE
 - Established delineated criteria for issuing clinical privileges
 - Reasonable standards in the request, collection, and review of relevant information at time of appointment and reappointment

Healthcare law: Corporate negligence (cont.)

- Recent court decisions:
 - Frigo vs. Silver Cross Hospital
 - Jury found in favor of patient who obtained an \$8,000,000 verdict against a hospital that had granted surgical privileges to a podiatrist even though he did not meet the established eligibility criteria.
 - The podiatrist had performed a bunionectomy, despite the presence of an infected ulcer near the surgical site
 - The patient had a postop infection, coupled with poor management, which ultimately lead to amputation of patient's foot

Healthcare law: Corporate negligence (cont.)

- The court determined that the hospital's criteria established the standard which the hospital violated when the podiatrist was appointed and subsequently reappointed
- The hospital attempted to establish that it met its burden under the Doctrine of Corporate Negligence through introduction of the peer review record, but because this information was privileged and confidential, the information was neither discoverable nor admissible into evidence
- The case was affirmed on appeal

Healthcare law: Corporate negligence (cont.)

- Anderson vs. Loyola Medical Center
 - The jury found Loyola “institutionally negligent” because it failed to adequately train the procuring transplant surgeon, who was a member of the Loyola transplant team, when he did not evaluate whether the heart, which he harvested from the donor, was suitable for transplantation.
 - Procuring surgeons simply removed the heart and advised the transplant surgeon that it was ready for transplant. After transplant surgeon removed recipient’s heart, he realized that the donor heart, which was subsequently delivered wholly inadequate.

Healthcare law: Corporate negligence (cont.)

- Because transplant surgeon had no alternative, the heart was transplanted, but the patient died within one week.
- The case was affirmed on appeal and currently is on appeal to the Illinois Supreme Court.

Healthcare law: Exclusive contracting

- Exclusive contracts describe a contractual agreement between a hospital and a physician and/or group giving the physicians the exclusive authority and responsibility to provide identified medical services.
- Examples include:
 - Anesthesiology
 - Radiology
 - Pathology
 - Emergency care

Healthcare law: Exclusive contracting (cont.)

- Hospitals have started to extend these arrangements to other services:
 - Cardiac testing
 - CU surgery
 - ICU coverage
 - ED call

Healthcare law: Exclusive contracting (cont.)

- Courts almost universally uphold a hospital's right to enter into exclusive contracts because of the quality-of-care benefits associated with these agreements:
 - 24/7 coverage
 - Ease of scheduling
 - No cherry-picking
 - Greater continuity of care and efficient use of supplies and equipment

Healthcare law: Exclusive contracting (cont.)

- Legal issues:
 - What do bylaws say about exclusive contracts or if there is a conflict between bylaws and contract
 - Is there a “clean sweep” provision whereby physicians waive hearing rights?
 - Has each physician signed a separate attestation agreeing to waiver?
 - Kadlec implications of allowing impaired physician to walk away but no hearing and no report

Healthcare law: Exclusive contracting (cont.)

- What is the impact on physicians who lose privileges as a result of the exclusive contract?
- Are the terms covering space, equipment, supplies, and personnel limited to what is only necessary to provide the exclusive services?
- Beware apparent agency argument (i.e., hospital held responsible for independent negligence of the group physicians because patients believe that they are employed by the hospital)

Healthcare law: Exclusive contracting (cont.)

- Are exclusive providers treated as business associates or as part of the hospital's organized Health Care Arrangement under HIPAA?
- Does medical staff leadership have any role in consulting with the hospital before entering into replacing or terminating the exclusive group?

Healthcare law: Legal status of bylaws

- Medical staff bylaws is the most important document for medical staff because it describes the manner in which it governs itself and how it inter-relates to the hospital management and board
 - Neither the board nor the medical staff may unilaterally amend the bylaws nor can they conflict under Joint Commission Standards
 - At a minimum, all parties are required to “substantially comply” with the bylaws and the bylaws must comply with licensure, accreditation, the Medicare *Conditions of Participation* and other legal requirements
 - But, are bylaws a contract between the hospital and the medical staff?

Healthcare law: Legal status of bylaws (cont.)

- Medical staffs usually argue that bylaws are a contract because of the view that this treatment or characterization provides them greater group and individual protection
- There is a split in the jurisdictions on this question
- If viewed as a contract, physicians and/or medical staff might be able to obtain injunctive relief and/or compensatory damages, which may not be an available remedy in a jurisdiction where bylaws are not a contract

Healthcare law: Legal status of bylaws (cont.)

- Bylaws as a contract can be a two-way sword
 - Medical staff leaders, committee members, and others could be on the receiving end of these claims by disgruntled physicians if bylaws are not followed exactly
 - Breach of contract claims are usually not covered by insurance
 - Are technical violations a breach of contract or is there a “materiality” requirement?

Healthcare law: Legal status of bylaws (cont.)

- Are rules, regs, and policies considered part of the bylaws and, therefore, part of a contract as well?
 - Can the hospital bring breach of contract claims against physicians who violate the bylaws?
- Keep in mind that medical staff bylaws will be treated as a standard in the context of negligent credentialing, accreditation, licensure and compliance with Medicare *Conditions of Participation*

Healthcare law: Stark and anti-kickback statute

- The Federal Self-Referral Statute, commonly referred to as the “Stark Law,” provides that a physician cannot:
 - Refer Medicare patients to an entity
 - For the furnishing of designated health services (DHS)
 - If there is a financial relationship between the referring physician or an immediate family member and the entity, unless an exception applies
 - Stark prohibits an entity from presenting a Medicare claim for a DHS that has been rendered pursuant to a prohibited referral

Healthcare law: Stark and anti-kickback statute (cont.)

- Stark I effective 1/92
- Stark II effective 1/95
- Stark III effective 12/07

Healthcare law: Stark and anti-kickback statute (cont.)

- Penalties for violating Stark include:
 - Denial of claims
 - Monetary penalties of up to \$15,000 for each claim submitted as a result of a prohibited referral
 - A fine of up to twice the amount paid for the service
 - Exclusion from Medicare/Medicaid programs

Healthcare law: Stark and anti-kickback statute (cont.)

- “Financial relationship” includes four different types of relationships between a physician and an entity furnishing DHS:
 - Direct ownership or investment interest
 - Indirect ownership or investment interest
 - Direct compensation arrangement
 - Indirect compensation arrangement
- A physician who has any of the foregoing relationships with a DHS provider cannot refer Medicare or Medicaid patients, unless an exception applies.

Healthcare law: Stark and anti-kickback statute (cont.)

- The Federal anti-kickback statute, which is intent-based, makes it illegal to knowingly and willfully offer, pay, solicit, or receive any remuneration, directly or indirectly, in return for the referral of a patient or in exchange for arranging for an item or service payable, in whole or in part, under a federal healthcare program except through a “safe harbor” arrangement
- Violations are punishable by imprisonment, treble damages, and fines of up to \$50,000

Healthcare law: Stark and anti-kickback statute (cont.)

- Employment relationships
- Equipment leases
- Fair market value compensation
- Obstetrical malpractice insurance subsidies in rural areas
- Personal services and management contracts
- Practitioner recruitment
- Space leases

Healthcare law: Stark and anti-kickback statute (cont.)

- What does this really mean?
 - Avoid all arrangements based upon referrals to the hospital
 - Compensate physicians at fair market value
 - Memorialize compensation through written agreements for at least one year
 - Set compensation amounts in advance
 - Physician employment creates the greatest protections
 - When in doubt, consult an attorney

Healthcare law: EMTALA

- EMTALA, the patient anti-dumping statute, ensures that patients with emergency medical conditions receive treatment in emergencies, regardless of their ability to pay and requires a hospital with a dedicated emergency department to perform a medical screening examination on presenting individuals to determine whether the individual has an emergency medical condition
- If the individual has an emergency medical condition, the hospital must stabilize or appropriately transfer the individual to another facility

Healthcare law: EMTALA (cont.)

- The Medicare *Conditions of Participation* for hospitals at 42 *CFR* § 489.20(r)(2) require that transferring and receiving hospitals covered by EMTALA maintain:
 - An on-call list of physicians who are on the hospital's medical staff or who have privileges at the hospital, or who are on the staff or have privileges at another hospital participating in a formal community call plan, in accordance with § 489.24(j)(2)(iii), available to provide treatment necessary after the initial examination to stabilize individuals with emergency medical conditions, who are receiving services required under § 489.24, in accordance with the resources available to the hospital

Healthcare law: EMTALA (cont.)

- The EMTALA interpretive guidelines in State Operations Manual, Appendix V, clarify that physician group names are not acceptable for identifying the on-call physician. Individual physician names must be identified on the on-call list.
- 42 CFR § 489.24(j) addresses the availability of on-call physicians, clarifying and explaining the statutory and regulatory requirements described above as follows:
 - In accordance with the on-call list requirements specified in § 489(r)(2), a hospital must have written policies and procedures in place:

Healthcare law: EMTALA (cont.)

- To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control
- To provide emergency services that are available to meet the needs of individuals with emergency medical conditions if a hospital elects to:
 - Permit on-call physicians to schedule elective surgery during the time that they are on call.
 - Permit on-call physicians to have simultaneous on-call duties.

Healthcare law: EMTALA (cont.)

- Participate in a formal community call plan. Notwithstanding participation in a community call plan, hospitals are still required to perform medical screening examinations on individuals who present seeking treatment and to conduct appropriate transfers.
- When requested to attend patients, on-call physicians must respond to the hospital in a timely manner to provide treatment after the medical screening examination in order to stabilize an individual's emergency medical condition

Healthcare law: EMTALA (cont.)

- Failure of an on-call physician to respond to call or to appear within a reasonable time subjects the physician and the hospital to liability for an EMTALA violation under 42 USC § 1395(d)(1)(C)
- The hospital must forward to a receiving hospital the name and address of any on-call physician who refuses to respond or fails to make a timely response, along with the transfer records of any patient transferred as a result of that refusal or lack of timely response

How to manage poor and marginal performance, disruptive behavior, and impairment

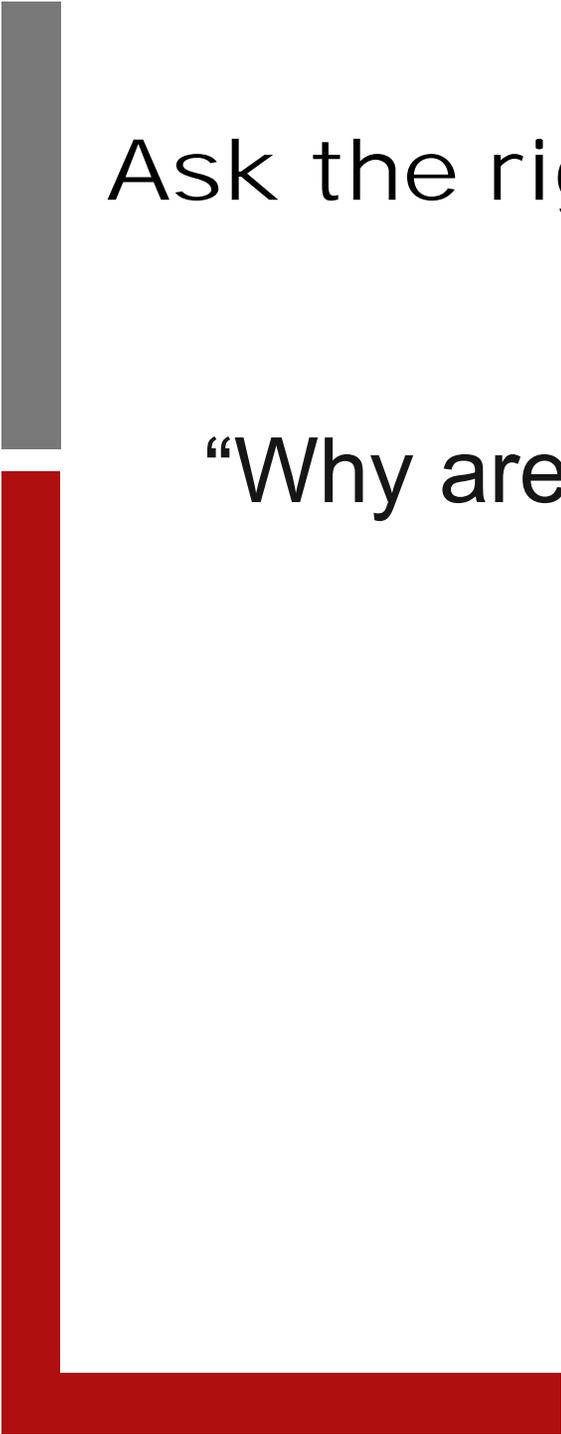
The Power of the Pyramid

Achieving great physician performance



Manage poor performance

- A series of carefully crafted, escalating interventions designed to decrease variation from expectations



Ask the right first question

“Why are you different?”

not

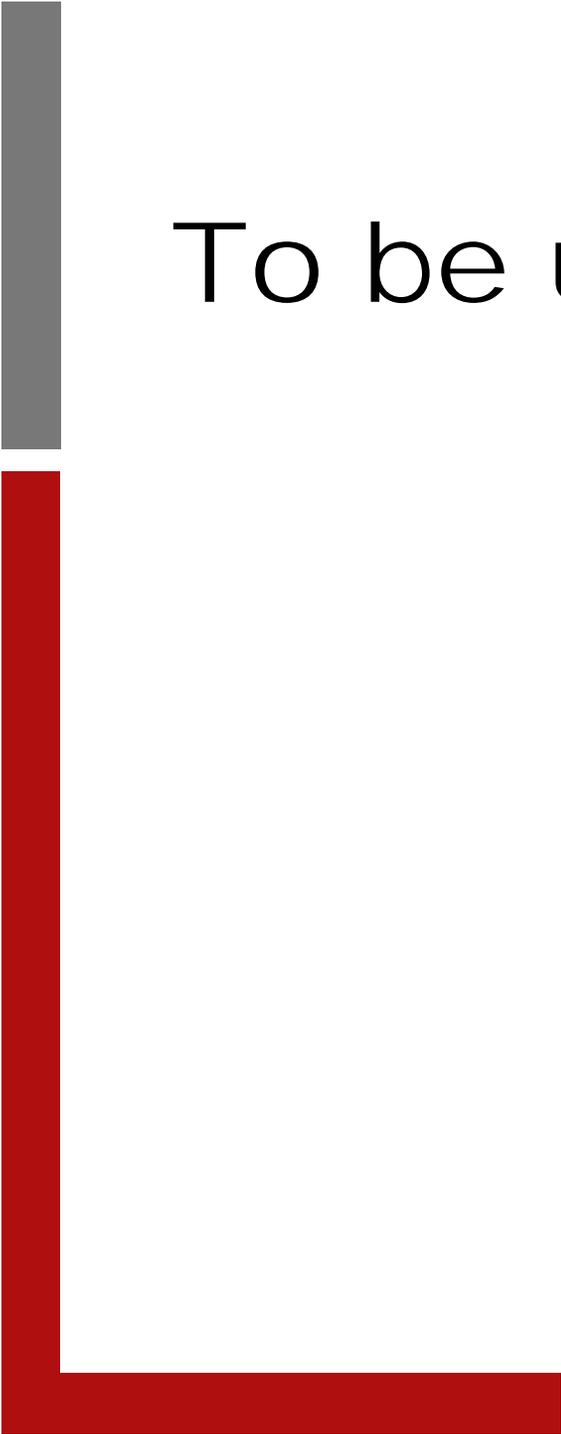
“Why are you bad?”

A step-by-step approach to managing problem physician performance

- Step 1: Plan your intervention
- Step 2: Practice your intervention
- Step 3: Carry out your intervention

Plan your intervention

- Treat every physician as you would want to be treated



To be understood ...

**Seek first
to understand.**

—Stephen Covey
and Saint Francis of Assisi

The source of power and influence

Never expect anyone to engage in behavior that serves your values until you have given that person adequate reason to do so.

—Charles Dwyer



Plan your BATNA*

*Best alternative to a
negotiated agreement
(Plan "B")

Plan your intervention: What are your goals?

- Specific goal behaviors:
 - Reiteration of the problem or concern
 - Acceptance of responsibility for the problem
 - Commitment to address the problem
 - Commitment to an action plan and goal(s)
 - Agreement on how you will both know whether the goal(s) are met
 - Commitment to meet again in the near future

Plan your intervention (cont.)

- What is an ideal outcome?
- What would be a good enough outcome?

Plan your intervention (cont.)

- Who?
- Where?
- When?

Practice your intervention

- Reference your role
- Acknowledge discomfort (optional)
- Name the concern in a nonjudgmental manner
- Reference the obligation of your role
- State your intended goal

Practice your intervention (cont.)

- Reference mutually agreed-upon expectations
- Be specific
- Consistently refer to data
- Focus on behavior, not the person
- Be persistent
- Time-limited
- Anticipate and prepare for resistance

Dealing with difficult people

- Gorilla
- Lion
- Sherman tank
- Denier
- Passive–aggressive
- Passive–indifferent
- Smoke screener

Managing poor performance

- Initial intervention: Collegial dialogue
- Second intervention: Develop an action plan (less collegial)
- Third intervention: Enforce an action plan with consequences (little discussion)
- Fourth intervention: Final warning (no discussion)

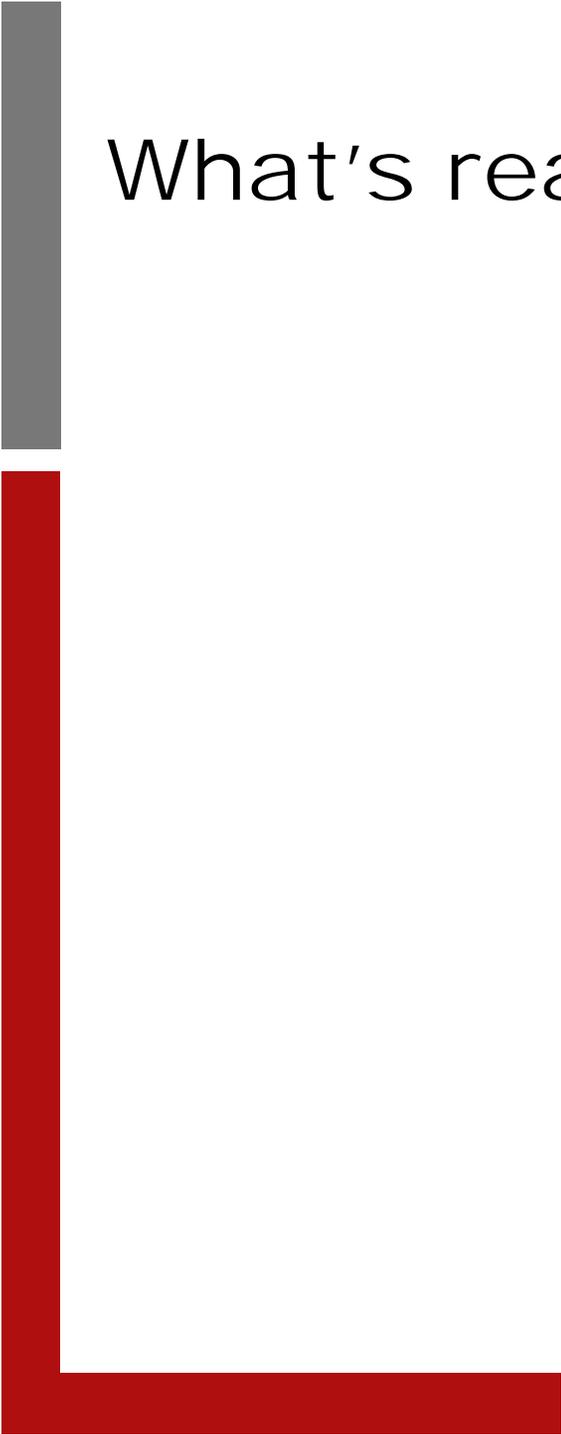
Dealing with disruptive physician behavior and impairment

Why is physician behavior such a problem? (The physicians' view)

- Physicians have a lot to be angry about
- Patient outcomes are at stake
- Physicians care deeply about their patients
- Physician liability is at stake
- Hospital systems are inefficient and poorly designed
- Hospital requirements slow physicians down
- Hospital requirements don't make any sense

Why is physician behavior such a problem? (hospital's view)

- Physicians don't respect policies and rules
- Physicians think they can boss around nurses
- Physicians think hospitals are still the “physician’s workshop”
- Physicians aren't team players
- Physicians are immature
- Some physicians have true character disorders
- Some physicians are bullies
- And the peer review process does nothing about it



What's really going on?

The problem of
character and fit!

Problem physician

- AMA: A physician who manifests behavior which directly interferes with or has the significant potential to undermine patient care and cause harm

Dysfunctional behavior

Sexual harassment

- Discrimination under Title VII of the Civil Rights Act of 1964
- Quid pro quo harassment
- Hostile environment
- Affirmative duty to seek out and eradicate

Disruptive behavior

- AMA: A style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care





“The impaired physician is a labor
of love; the disruptive physician is
a labor of law.”

—Spence Meaghan, MD

Impaired physician

- AMA: A physician who is unable to perform granted clinical privileges because of physical, emotional, mental, and personality issues, including deterioration through the aging process, loss of motor skills, and excessive use or abuse of drugs, including alcohol

Joint Commission (Rationale for MS.11.01.01)

- An organization has an obligation to ***protect patients from harm*** ... design a process that provides education about physician health, addresses prevention of psychiatric, physical, or emotional illness, and facilitates confidential diagnosis, treatment, and rehabilitation ... the purpose of the process is ***assistance and rehabilitation rather than discipline*** to aid a physician in retaining or regaining optimal functioning consistent with protection of patients.

Federal law

- Title VII of the Civil Rights Act as amended in 1991:
 - “Treating an individual in a demeaning, disrespectful manner in the workplace may support a claim of discrimination.”
(compensatory and punitive damages)

Joint Commission Leadership Standard 03.01.01

- Create and maintain a culture of safety and quality
- Support teamwork and respect for other people, regardless of their position
- Avoid behavior that intimidates, affects morale/turnover, and can be harmful to patients
- Address disruptive behaviors at all levels of the organization (management, staff, LIPs, and board)

New Leadership Standard

- EP4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behavior
- EP5: Leaders create and implement a process for managing disruptive and inappropriate behaviors

Sentinel Event Alert #40: Intimidating and disruptive behaviors cause

- Medical errors/deaths
- Increased costs (complications, re-work, liability, staff turnover, loss of confidence)
- Breakdown in communication/teamwork (leading cause of sentinel events)

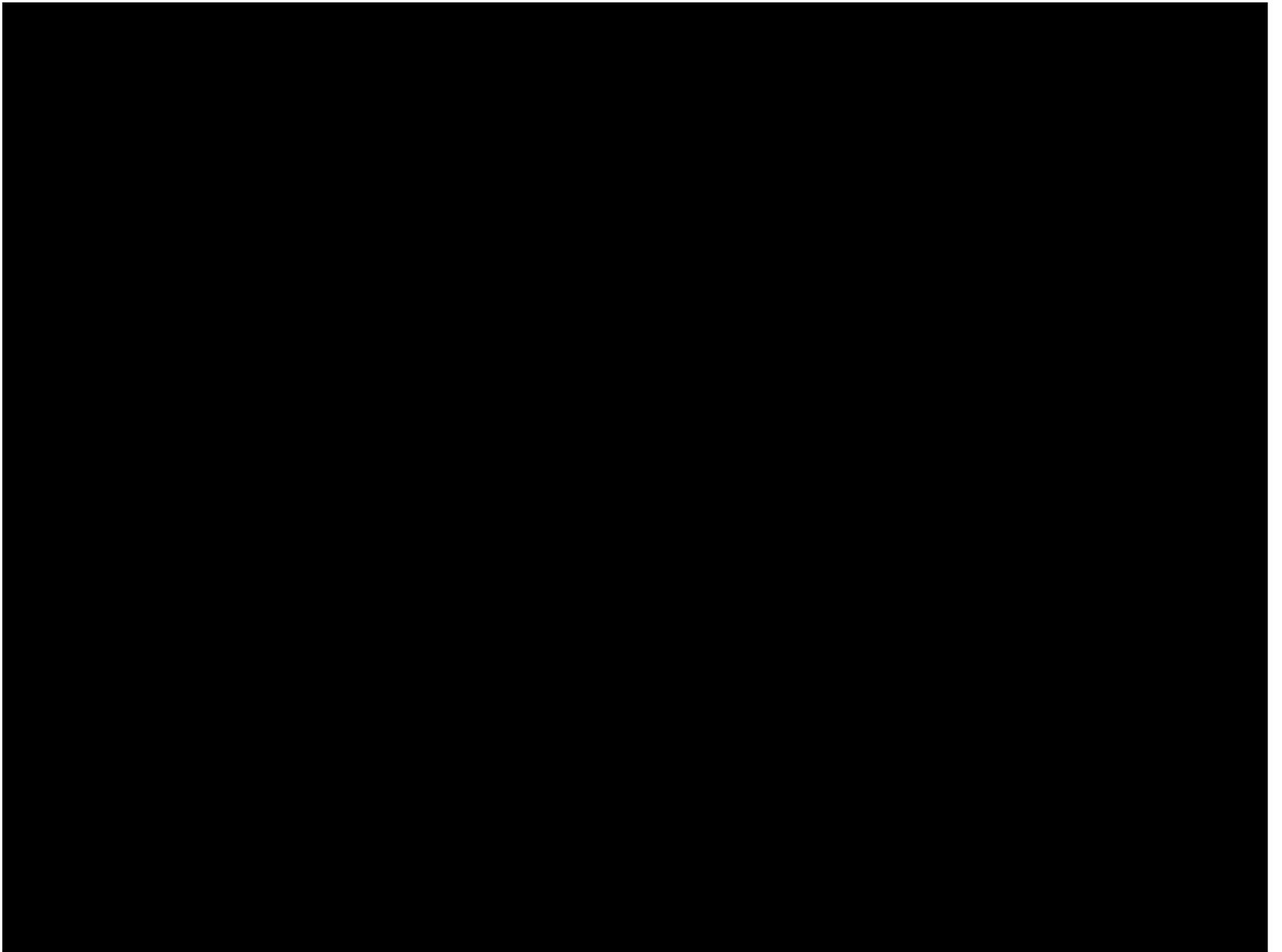
So what's the problem?

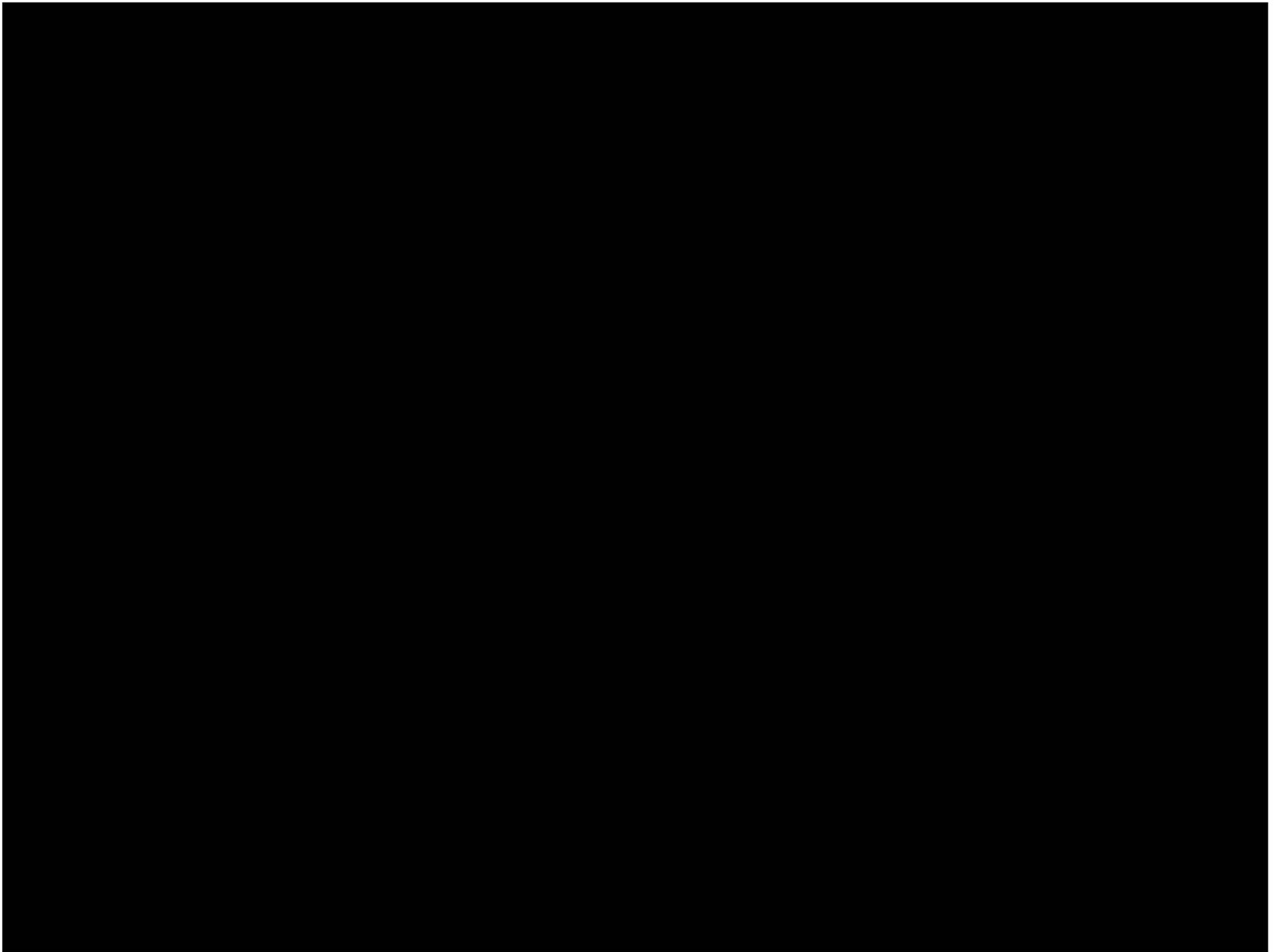
- History of tolerance and indifference
- Fear of retaliation (financial and legal)
- Fear of confrontation and conflict
- Professional and social stigma
- Some physicians are “more equal” than others

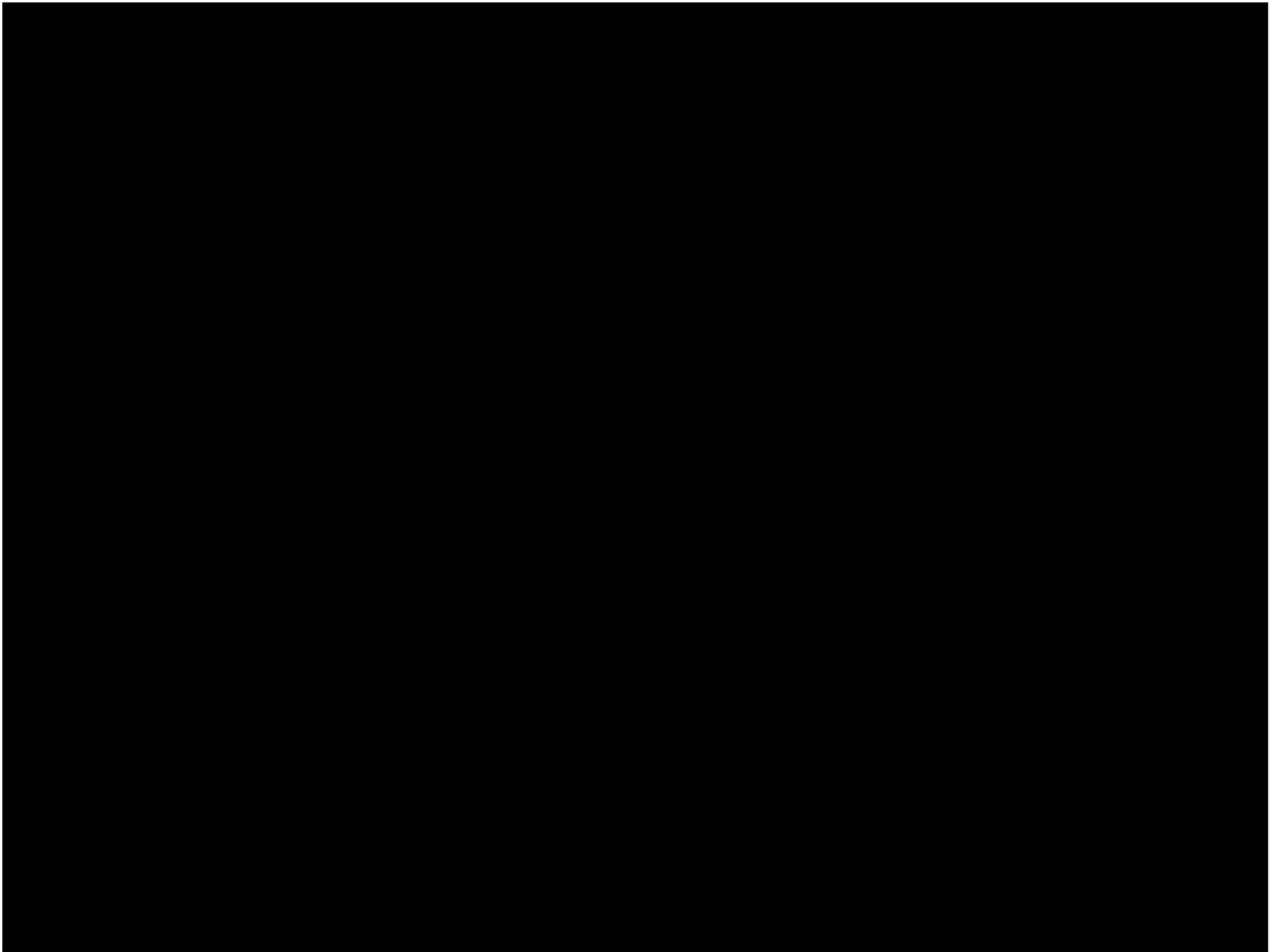
In other words: inadvertent and indirect promotion

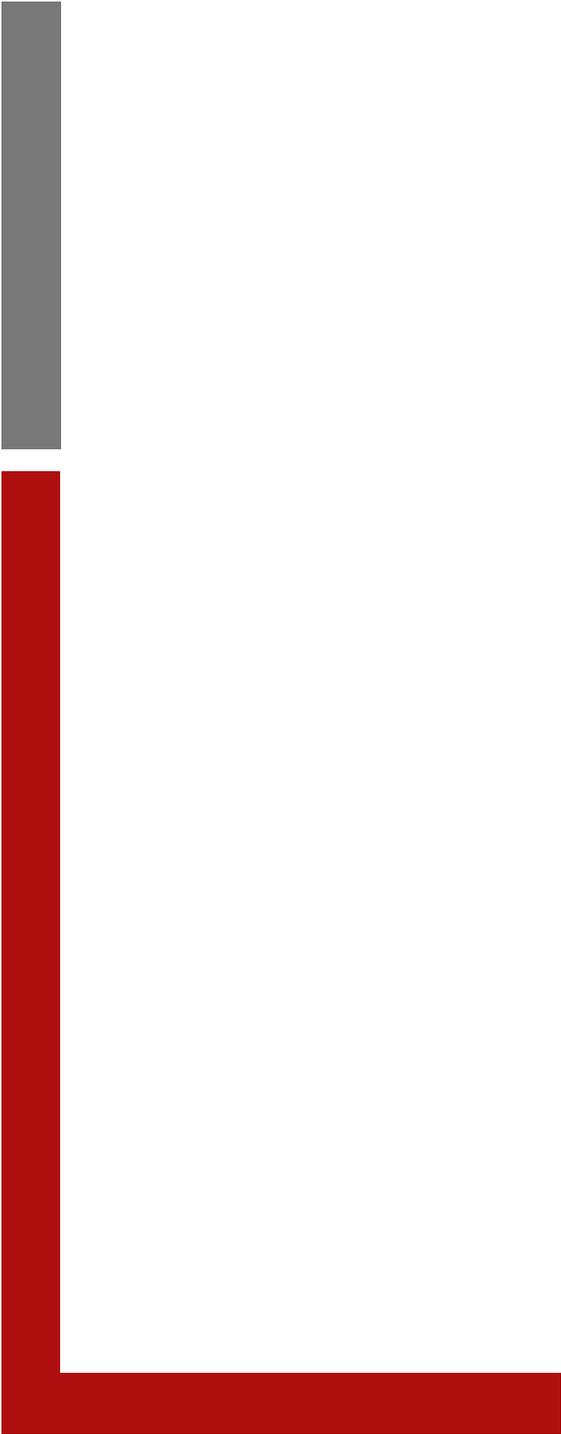
Common challenges

- Whistleblower
- Discrimination
- Libel
- Antitrust
- Mixed picture of competence and behavior issues
- Mixed picture of disruption and impairment







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Let's practice ...

How to manage an investigation and fair hearing

- Do's and don'ts of effective investigations and corrective action:
 - “Investigations” connote the need to review cases, a pattern of care, or unacceptable behavior in more depth because identified issues were not sufficiently addressed or resolved through the normal process
 - Keep in mind that under Data Bank reporting obligations, a physician who resigns or relinquishes privileges while “under investigation” or “in lieu of corrective action” must be reported to the Data Bank

How to manage an investigation and fair hearing (cont.)

- An investigation is not terminated until final action is taken. Therefore, bylaws should clearly describe what is truly considered an investigation as opposed to normal, preliminary peer review.
- Better to use an independent or ad hoc investigating committee when corrective action is requested, instead of the full MEC, that can be appointed by either the department chair or the MEC.
 - Need at least one or more members on the committee who are of the same specialty and, ideally, are not a direct competitor □
 - Use physicians who are knowledgeable, respected, and who will “do the job”

How to manage an investigation and fair hearing (cont.)

- Prior to the committee's recommendation, all relevant information should be shared with the physician and he or she should have the right to an informal meeting with the committee to discuss identified problems
 - Meetings are informal—attorneys are not allowed
 - The committee should prepare a report with findings to support recommendation to the MEC—the physician's comments should be reflected in the report
 - If some kind of remedial action is recommended, try to find a balance between protecting patients, while avoiding decisions that will trigger hearing rights
- If using outside reviewers, make sure you develop a paper trail to maximize confidentiality protections under state peer review statutes. Also, reviewers should not make any recommendations on what remedial action, if any, to take.
 - Should attempt to perfectly comply with bylaw procedures, although only “substantial compliance” is required.

How to manage an investigation and fair hearing (cont.)

- Evaluation of the physician should be based on existing policies, criteria, and other known and communicated standards.
- Investigation and recommendations need to be fair, reasonable, and consistent. Questions to ask include, “How did we handle these issues or problems in the past?” and “Do we have enough information on which to base an informed decision?”
- Some hospitals and medical staffs attempt to get the adversely effected physician to come up with an acceptable action plan, which he or she must follow.
- Strategies for avoiding the need for a hearing
 - Become familiar with what recommendations do and don’t trigger a physician’s hearing rights under the bylaws.
 - As a general matter, try and limit hearings to decisions which, if final, require a report to Data Bank or to the State (i.e., summary suspensions, terminations, involuntary reductions in clinical privileges, and mandatory consultations requiring prior approval.)

How to manage an investigation and fair hearing (cont.)

- Bylaws should identify what kinds of remedial measures can be taken, such as monitoring, proctoring, re-education, OPPE, FPPE, probation, that will not result in a hearing
- These lesser remedial measures should be widely used and encouraged as a means of working with a physician to get him or her back on track
 - Authority to utilize these measures should be vested in department and committee chairs as a way to avoid formal investigations or requests for corrective action
 - Sends a more positive message to the medical staff and is more consistent with the “just culture” approach under Patient Safety Act and Patient Safety Organizations

How to manage an investigation and fair hearing (cont.)

- Consider informal one-on-one discussion with physician.
 - Utilization of these measures will improve quality, limit denials of responsibility and finger-pointing and will limit the need for hearings.
 - “Doing nothing” is not a proper response. Doing something also will help defend against corporate negligence claims.
 - If efforts to work with a physician ultimately fail, you will have an excellent paper trail of being reasonable in the event there is a hearing and subsequent litigation.
- If you expect that an investigation is likely to lead to some reportable action, but an investigation or corrective action has not yet been requested, consider approaching the physician about this possibility as a professional courtesy. Resignation at this point in time is not reportable.
- Keys to an effective fair hearing
 - Remember, your ultimate audience may be a judge. The hearing procedures and administrative record should be clear enough for board members and judges to understand.

How to manage an investigation and fair hearing (cont.)

- Follow your bylaw and hearing procedures.
- Make an extra effort to reasonably accommodate the physician, even if this means giving him or her more rights than is provided under the bylaws.
 - Scope of court's jurisdiction generally is whether a hospital has substantially complied with its bylaws and if the proceedings were fair
- Make sure that the physician is given copies of all minutes, records, and documentation on which the adverse decision is based.
 - You are not required to respond to interrogatories or a request to produce documents; this is not a court hearing
 - Do not provide confidential peer review information about other physicians

How to manage an investigation and fair hearing (cont.)

- Make sure you have a well-qualified physician representative to present the case on behalf of the medical staff:
 - It is preferable to have someone who has been actively involved in the investigation and is of the same or similar specialty
 - Person should be well qualified, respected, and able to engage with the physician and the hearing committee
- Another key issue is the composition of the hearing committee:
 - No direct competitors
 - Try to get at least one member in same or similar specialty
 - Try to avoid members who are employed by or have a contract with the hospital in order to avoid allegation of conflict of interest

How to manage an investigation and fair hearing (cont.)

- Consider adding someone who might be seen as friendly to or supportive of the physician
 - Give the physician an opportunity to object to the hearing committee members, but only consider removal if based on credible information identifying a conflict or other reasonable basis for removal
- Identify key witnesses who can:
- Explain procedures followed in reaching the adverse recommendation and how these steps complied with bylaws and related policies.
 - If hospital varied from these procedures, explain why
 - Make sure to utilize documents in the administrative record

How to manage an investigation and fair hearing (cont.)

- Review the medical records/policies at issue to explain the substantive basis for the adverse recommendation
 - Explain the nature of the discussions during the relevant department and/or committee meetings where the recommendation was made, so that the hearing committee can understand the rationale
- Role of presenter/legal counsel:
- Must review bylaws to decide whether legal counsel for the medical staff and the physician is limited to acting as an advisor or if they will be allowed to ask direct and cross-examination questions of the witnesses

How to manage an investigation and fair hearing (cont.)

- Hearings should be treated as an intraprofessional conference and not a three-ring adversarial circus and, therefore, you should consider limiting the role of counsel with the option of expanding, based on the hearing committee's discretion.
 - The less expansive the role given to legal counsel, the more time needs to be spent preparing the presenter and scripting opening and closing statements and direct and cross-examination questions.
 - Outside counsel should represent the medical staff. In-house counsel should represent the hearing committee on procedural issues.
- Bylaw procedures need to follow HCQIA and state requirements

How to manage an investigation and fair hearing (cont.)

- Need to make sure the administrative record is complete and includes all relevant information that has been collected and introduced as part of the investigation, corrective action, and hearing process.
 - Goal should be to introduce record as the only document that the court needs to review in order to determine whether the bylaws were followed and the proceedings were fair
 - Should have court reporter transcribe the hearing
- Consider use of independent hearing officer to run the meeting and make procedural rulings; officer is not typically a decision-maker.
 - Needs to have healthcare experience, as well as having served as a hearing officer in other matters
 - Avoid arbitrations

How to manage an investigation and fair hearing (cont.)

- All procedural issues or disputes should be addressed and ruled on prior to commencement of hearing; helps hearing to proceed more smoothly
- Should allow each side to submit a pre-hearing and/or post-hearing memo in support of their respective arguments and positions
- Should impress on the hearing committee members the need to read materials in advance
- The hearing committee can ask questions during the proceedings, but should avoid comments or criticisms that reflect opinion or position about the merits of either party

How to manage an investigation and fair hearing (cont.)

- The hearing committee should meet in executive session to deliberate and then prepare a report, which reviews the requested corrective action. They must decide whether to affirm, modify, or reject the recommendation. The report should include findings to support the recommendation.

Hippocratic Oath

- To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art— if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

Prayer of St. Francis

Lord, make me an instrument of your peace.

Where there is hatred, let me sow love;

where there is injury, pardon;

where there is doubt, faith;

where there is despair, hope;

where there is darkness, light;

and where there is sadness, joy.