Washington Association of Medical Staff Services
Lake Chelan, Washington

How to Manage Physician Performance: Case Studies and Lessons Learned

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Performance Management General Principles:

1. When is the best time to address a performance issue?
2. When do we typically address performance issues?
3. How do we move the process ‘upstream’ so that there is less conflict, less pain, and greater benefit to everyone?
Case Study #1: I heard it through the grapevine

A highly qualified neurosurgeon has been recruited to your organization. She has excellent standard references, no outstanding malpractice cases, and excellent credentials. Through the grapevine you heard that she has chronic issues with communication, responsiveness while on call, completion of medical records and unwillingness to adapt to new evidence based practices. You are under pressure to get her on staff quickly so that she can take call. What should you do?
Discussion Points:

1. Is the medical staff and board responsible for important information that is not on the application? (Nork v. Mercy/Gonzales, 1984)
2. Which is more common: Information or decision errors?
3. Why is it important to gather as much information as possible ‘at the door’?
Case Study #2: You can’t make me!

The OBGYN Department has begun an initiative per ACOG to eliminate all unnecessary elective inductions under the age of 39 weeks gestation. Everyone is ‘on board’ except for an older OBGYN who asserts that he knows what is best for his patients and the department has no authority or right to tell him how to practice medicine.

What should the department chair and the medical staff do?
Discussion Points:

1. Does the organized medical staff have the legal right to determine what the standard approach to care practices will be?
2. Does the staff have the legal authority to require others on staff to practice in a particular way?
3. What are top performing organizations doing today?
Case Study #3: It’s not in my contract!

The medical staff is working on improving their HCAHPS scores to help drive growth/market share in their respective departments. A highly productive employed physician states that making patients ‘feel good’ is not her job, and besides, she is paid on a work RVU basis that has nothing to do with making people happy.

What should the medical staff and management do?
Example of a management contract (ED):

- 50% base pay (5\text{th} tile MGMA compensation)
- 10% quality program and performance (2% bonus for every 20% departmental compliance with agreed upon quality targets)
- 10% patient satisfaction (2% for each 10\text{th} tile above 30\text{th} tile Press-Ganey departmental scores)
- 10% physician satisfaction (2% for each 10\text{th} tile above 40\text{th} tile for hospital survey of physicians)
- 10% corporate compliance (e.g. medical records) (2% for every 10% compliance over 50\text{th} tile)
- 10% evaluation by President MS and CEO (top potential pay – (95\text{th} tile MGMA compensation))
Discussion Points:

1. When performance expectations are in a contract and there are performance issues, who is responsible and to whom?
2. How should the MEC and management coordinate its oversight responsibilities?
3. Who should generally handle the peer review evaluation?
4. Who should handle ‘corrective action’ if it becomes necessary?
Case Study #4: Garbage in, garbage out

The medical staff would like to raise the bar to encourage a high level of professional conduct. Unfortunately, conduct issues are tracked through an anonymous incident reporting system that pits doctors and against nurses against staff and the result has been poor professional relations, poor trust, and poor communications.

What should the medical staff and management do?
Validation ("Rashomon")

- Individual filing the complaint
- Practitioner in question
- Patient
- First hand eye witnesses

Can an anonymous incident report be part of a ‘peer review’ process?
How to Use a Rule Indicator: # validated behavior incidents/year

0 = commendation
1 = constructive feedback (documented)
2 = meeting with department chair (documented and voluntary improvement plan)
3 = meeting with peer review committee/BERC committee/medical staff healthcare/wellness committee and mandatory improvement plan (chronic pattern)
4 = meeting with MEC (final warning)
5 = BOT corrective action
6 = BOT more significant corrective action
7 = BOT most significant corrective action
Case Study #5: No news is good news

Management has begun to share cost data with the medical staff in the hopes of working with them to achieve more cost-effective care. Two doctors on staff have risk and severity adjusted average lengths of stay that are 3 days longer than everyone else’s and nobody on the medical staff wants to ‘confront’ them since these physicians wield significant influence and referrals.

What should the medical staff do?
What is the Hawthorne Effect?

• Individuals do not want to be perceived as ‘outliers’
• Self-reflection far more powerful than ‘corrective action’
• Individuals will generally ‘self-correct’ when given credible data
• Leverage the individual’s motivation for self-respect and self-esteem
How to Use a Rate Indicator: %tile
Risk/Severity Adjusted LOS

<50% tile = commendation
51%tile-60%tile = constructive feedback (documented)
61%tile-70%tile = meeting with department chair (documented and voluntary improvement plan)
71%tile-80%tile = meeting with peer review (mandatory PIP)
81%tile-90%tile = meeting with MEC (final warning)
91%tile-95%tile = BOT corrective action
96%tile-98%tile = BOT more significant corrective action
99%tile-100%tile = BOT most significant corrective action
One physician has multiple performance issues that the medical staff has worked on for years including: lack of compliance with evidence based practices, poor communications, poor handoffs, poor medical records, and poor responsiveness when on call. He has been tolerated and enabled for many years due the staff’s sympathy with his years of service and their reticence to ‘rock the boat.’

What should the medical staff do?
High, Middle and Low Performer
The Gap becomes more evident

Hoping that:
More time will help
More attention will help
More focus will help
A transfer will help
They will leave
The Gap is Intolerable
Results Decline (look familiar?)

The Wall

Gap is uncomfortable

Gap is intolerable

Results Decline
Over the Wall

Gap is uncomfortable

Gap is intolerable

The Wall
Manage Poor/Marginal Performance:

1. Initial intervention (collegial and supportive)
2. Second intervention with creation of a voluntary improvement plan (collegial)
3. Third intervention with creation of a obligatory improvement plan (less collegial)
4. Fourth intervention with a final warning and little discussion
5. Fifth intervention with some form of corrective action (loss of membership and privileges)
Case Study #7: Imminent danger

A long standing internist has been going through a tough time in her personal life with divorce and a child going through drug rehabilitation treatment. She comes into the ICU to manage a critically ill patient with an acute MI while intoxicated and high. The Chief of Staff is notified.

What should she do?
Discussion Points:

1. If a practitioner is having a ‘breakdown’ what is more collegial, an intervention or ‘looking the other way’?
2. Is there such a thing as protecting a good person from him or herself?
3. At the end of the day, what must come first—the needs of physicians or the needs of patients?
Conclusions:

1. Address issues at ‘the door’ for both appointment and reappointment
2. Negotiate expectations with all practitioners and help them to understand the consequences in a ‘pay for value’ world
3. Memorialize expectations in all contracts
4. Create fair and transparent performance measures and targets
5. Provide timely and constructive feedback
6. Manage poor/marginal performance in a timely way
7. Take corrective action as a last resort to protect patients from potential harm
Thank You for Joining Us!

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