Clinical departments: Is more always better?

As one facility reduces its number of departments, another looks to expand its roster

It’s hard to ignore the role medical staff culture plays in most medical staff–related decisions at an organization. Politics, whether good or bad, tend to dominate the how and why votes are taken to make changes to the medical staff, and the dissolution or formation of clinical departments is no exception.

“The changes we have seen here are heavily driven by politics, but politics don’t always have to be mutually exclusive—politics can either hurt [medical staff members] or put them in a spot of accountability,” says Keith Justice, MD, past chief of staff at Flagler Hospital in St. Augustine, Florida.

At Flagler Hospital, the politics that led to the creation of two new departments—orthopedics and cardiology—have made the members of those departments more accountable.

“Across the board, you have a captive audience who is interested in just what you are talking about. If I am the hospital administration, I am thinking, ‘Okay, I have one group of people to negotiate with to get these things done.’ If I am the orthopedic group, maybe they think they can get themselves into stronger numbers in that group to influence things, they would also be reckoning for professional existence in the hospital by trying to influence the hospital to do the things they want,” says Justice. “They have to get involved in the ballgame and negotiate for what they want. They have to answer for the accountability of the department. So I think it is helping because if you are going to have a cooperative agreement, you have established the lines and put the arena out there where this has to occur.”

It also helps with attendance at department meetings because physicians don’t have to sit through hours of information when maybe only 10% of that information applies to them, adds Terry Wilson, CPMSM, CPCS, director of medical staff services at Flagler Hospital. For a general department like medicine, there could be 15 different specialties in attendance.

“Orthopedic physicians are now attending department meetings, where before, we would have one
show up at a surgery department meeting,” says Wilson. “And they are a big moneymaker, so it is important for them to get their job done and [work] with administration to keep prices down. Those conversations cannot take place in a big forum.”

On the flip side, Tonya Pratt, RN, associate director of medical staff services and quality management for the Regional Medical Center of Orangeburg, South Carolina, anticipates that meeting attendance and sharing of opinions will increase at her organization by having fewer clinical departments. In a small town, the issue with having a department with only one specialty or a handful of members is that often there are two competing groups. If it is just one group against another, they may not be able to agree on decisions for the department, or, in a more extreme case, the physicians do not want to sit in the same room as their competitors, so they don’t even attend department meetings. Pratt says by having a department not comprised solely of competitors, a physician should feel more compelled to voice his or her opinion.

“By having a larger department, they are more likely to have a voice and speak their needs because they are not looking at their competitors to assist them or approve their needs,” she says.

On February 1, the Regional Medical Center of Orangeburg amended its medical staff bylaws, which included the dissolution of several clinical departments. The hospital now has only six departments (medicine, specialty medicine, surgery, mother-child, radiology, and emergency department) with individual “sections” for specialties. Physicians can meet as a specialty independent of their department meeting, however it is not considered a formal medical staff meeting. That means the medical staff services department (MSSD) is not responsible for meeting coordination and minutes, and any decisions made by the specialty must be forwarded up the chain of command to the department. According to Pratt, one of the issues with so many departments was the amount of work it created for the MSSD.

The suggestion to reduce the number of departments came from a consultant hired to review the Regional Medical Center of Orangeburg’s medical
staff bylaws. He also suggested having the chair from each old department (before the revisions) serve on the subcommittee to help develop the new bylaws. Pratt says this helped make the process go smoother and helped the physicians to accept the new bylaws. The new bylaws were approved by a 92% vote.

“We didn’t get much pushback at all and I really think it was because of the way it was handled from the beginning: we asked for feedback from each department, and not just about the [restructuring] of departments; we went through every section of the bylaws,” she says.

Sections and temporary status

As mentioned above, specialty-specific sections or divisions are a good alternative to formal departments. Along with reducing the extra administrative burden on MSPs, it can also be a good test to see if the section would be able to function as its own department. Flagler Hospital has disbanded divisions for not meeting requirements such as holding meetings, keeping meeting minutes, or meeting performance requirements. If these divisions were departments, it would have required a bylaws revision to form and disband the group. It also threatens the functionality of the medical executive committee (MEC).

“By definition, the department chair has a seat on the MEC and the MEC is concerned that if we have too many departments, it will become unmanageable,” says Wilson. “If the department doesn’t work, and it is in name only, we have an additional person on the MEC. Multiply that by five, six, or seven departments that want to form, and now you have an MEC that isn’t working, and neither are the departments.”

Divisions that do get voted into departments at Flagler are put on a one-year provisional status. Before the department is formed, it must present its goals and reasons for wanting an independent department. During the one-year provisional period, the department must show that it is meeting its goals and functioning as a group (i.e., holding regular meetings, having a quorum, keeping meeting minutes).

“Part of this provisional status is to make sure we don’t paint ourselves into a corner,” says Justice. “If a new department isn’t working, we have a strategy. The MEC can say, ‘Okay, this department is disbanded,’ or ‘Show us your own remedy on how you are going to repair this problem and you will continue on provisional status.’ ”

Changing bylaws, privileges, and performance reports

It doesn’t necessarily take a formal bylaws revision to see that a department is no longer necessary or when a new one is needed.

“We were sitting in a [family medicine] department meeting three or four years ago, and it was time to elect a new chief,” explains Nancy Griffin, CPMSM, manager of medical staff services for Jupiter (Florida) Medical Center. “We were sitting there with seven or eight doctors, the current chief of family medicine had termed out, and everyone else was saying that they didn’t want to do it. So we decided to get rid of the department. They closed their meeting, went downstairs to the department of medicine and introduced themselves, and that’s how [easily] that happened.”

The formal disbandment of the department did require a vote by the general medical staff and approval by the board of trustees to amend the bylaws. However, the medical staff was ready to handle this because it already had a process in place. You should be prepared for a similar situation at your institution by making sure your bylaws contain language that lays out the process for forming or dissolving a department. Most bylaws require a vote by the general medical staff or MEC.

At Jupiter Medical Center, a physician can request a change to the bylaws regarding a department. The draft revision language is written by a member of the bylaws committee, read at the next general medical staff meeting, and then voted on at the meeting after that. Then it goes to the governing board for final approval. The whole process takes about a year. At the Regional Medical Center of Orangeburg, the process recently changed as part of the bylaws revision. The general medical staff no longer gets a vote. The bylaws language reads:

“The hospital board, contingent on a recommendation endorsed by three-quarters of the members of the MEC, may eliminate, consolidate, or create additional medical staff departments where this would improve the effectiveness of the medical staff in carrying out its responsibilities.”
Changing your departments should not affect delineation of privileges or OPPE and FPPE measures for specialties because these should all be specialty-specific regardless of how your medical staff is departmentalized. What may change is how requests for privileges or OPPE/FPPE reports are reviewed.

“The department chair will still be responsible for signing off on [OPPE and FPPE reports], but in the department meetings we have conducted so far, there was a verbal understanding that if [department chairs] have any questions about performance, they will go to the senior member of that specialty for guidance before they sign off on anything,” says Pratt.

Having more departments could eliminate the need to have a second person review a request for privileges or a performance evaluation. On the other hand, it could create a situation where a department chair does not feel comfortable disparaging a direct competitor or a practice group member.

Matching the needs of your medical staff

There is no perfect number of clinical departments. This number will be specific to the needs of your medical staff, hospital, and community. You also have to be prepared to change departments based on need, including disbanding then reforming the same department.

Jupiter Medical Center disbanded its pediatrics department because it was no longer offering pediatric services. Then the hospital received a donation to open a pediatric unit.

“We are in the process of putting the department of pediatrics back in because we are bringing in more and more specialists,” says Griffin. “They were rolled into the department of obstetrics, but [obstetricians] don’t feel like they understand enough about pediatrics to be able to do peer review and interviews, and be responsible for them. So we are in the process of breaking [the department of pediatrics] back out.

“Things might change down the road. You might think you won’t have pediatrics and then things change,” adds Griffin. “The department of family practice was created in the ’80s when a lot of people were in family practice. They really pushed for it, and eventually, it kind of died off. In this area of Florida, there are not a lot of general practitioners. They are more specialized.”

Justice says medicine is becoming more functional and service-line oriented, and organization systems should change to mirror that approach when it comes to the business of medicine (i.e., budgetary concerns, utilization, credentialing and privileging, public contact, and marketing).

“If I had carte blanche to reform any medical staff, I would want to have the medical staff on a functional basis, so everyone goes to a meeting and they look around the room and see people doing the same thing they are doing. That is your best chance to have an effective medical staff. If I was the hospital, I would be wanting that too. Why waste time talking to psychiatrists about what cardiologists want,” says Justice.

Medical staff structure: Should the medical staff be departmentalized?

CMS's CoPs state that medical staff bylaws must “describe the organization of the medical staff” (42 CFR § 482.22(c)). Likewise, The Joint Commission’s accreditation standards require that medical staff bylaws include a “definition of the medical staff structure” (MS.01.01.01 EP 6). So, what should a medical staff consider as it develops this section of its bylaws?

Medical staffs have historically organized themselves around clinical departments. This was initially a relatively simple structure composed of a few key departments representing major specialties, including medicine, surgery, OB-GYN, and—occasionally—pediatrics.

With the explosion of subspecialty medicine after World War II, physicians began to focus on their narrow areas of practice. During the same period, The Joint Commission became an increasingly important regulatory organization, issuing standards that focused department activities much more intensely on peer review and credentialing functions. Specialists found that medical staff department meetings involving multiple specialties were less focused on their
Medical staff structure (continued)

particular concerns. As a result, they insisted that medical staffs grant them the autonomy to regulate their own affairs, and large departments of medicine and surgery began to develop clinical sections that were subspecialty in nature.

The development of specialties also spurred turf disputes, and physicians formed various opinions about the best way to prioritize and organize hospital services, equipment, and staffing. Soon, clinical sections were demanding representation on the MEC to advance their own interests. Because the typical MEC was composed of officers and department chairs, clinical sections began to clamor for departmental status. Today, it is common to see medical staffs with 10 to 15 departments, and some institutions have two to three times this many.

From relatively simple and straightforward organizations, medical staffs have morphed into large bureaucratic entities that require considerable support staff and make heavy demands on physicians’ valuable and limited time. The list of responsibilities that department chairs must fulfill is imposing, perhaps made even more so considering that Joint Commission surveyors can challenge department chairs to demonstrate how they meet each one of those responsibilities as listed in MS.01.01.01 EP 36.

It is noted that departments are not required by The Joint Commission or HFAP. However, if your medical staff is organized into departments, it must meet certain requirements to comply. DNV-GL has no regulatory standards for departments.

Clinical departments usually have their own policies and procedures—and even an array of officers to organize their activities and comply with these requirements. All of this requires time, effort, and expertise on the part of physicians to administer effectively. In addition, an increasing number of external parties (e.g., department of health, regulators, Office of Inspector General) are scrutinizing the work performed by the organized medical staff to ensure that important functions are not simply given lip service. If a clinical department is responsible for peer review, it must do more than simply go through the motions.

Many clinical departments are looking for less burden-some ways to fulfill their responsibilities more effectively. Physicians have less time than ever to devote to medical staff citizenship responsibilities, especially as many are spending less time at the hospital to grow their private practices or pursue other professional activities. Many medical staffs have found that their work is best accomplished by a small cadre of well-trained leaders who can represent the broad interests of physicians and carry out medical staff work efficiently. Downsizing the medical staff bureaucratic structure facilitates this kind of transformation and, as a result, many medical staffs are consolidating their departments, with no detriment to the staff’s ability to carry out critical functions.

The federal government and accrediting bodies do not require the medical staff to be organized around departments, as long as it accomplishes its delegated functions. However, if a medical staff has departments, then each one must meet all of the requirements per the standards of the individual accreditation agency.

Whether the medical staff is organized into departments or not, many medical staffs have centralized the core functions and may simply carry out their critical work through key committees (e.g., the MEC, credentials committee, and peer review/quality committee). These committees can call on subject-matter experts from other departments’ staff as necessary to facilitate initiatives.

As mentioned previously, reducing the number of departments or abolishing departments altogether often leads medical staffs to become concerned about maintaining adequate representation on the MEC. Changes in departmental configuration raise questions about which individuals will serve on the MEC, but there is no reason that the composition of the MEC must be tied to departmental structures.

The bottom line is that medical staffs are free to select from various organizational arrangements, and they should thoughtfully consider their options. Choose a medical staff structure that maximizes effectiveness and minimizes the burden on physicians’ time. Given the challenges posed by our evolving healthcare system, medical staffs should not assume that a bureaucratic structure that served well in the past will remain the best choice going forward.

Source: The Guide to Medical Staff Bylaws, Mary J. Hoppa, MD, MBA. (HCPro 2014.)
Understanding OPPE, part 7: Concluding thoughts

by William K. Cors, MD, MMM, FACPE, chief medical officer, Pocono Health System; East Stroudsburg, Pennsylvania

The intent of this series was to demystify the OPPE process and offer best practices that could be implemented in your organization. The fundamental underlying principle of OPPE is the ongoing determination of physician competency, a requirement by CMS in the Conditions of Participation (CoP). Peer review is also all about the ongoing determination of physician competency. In other words, effective peer review is effective OPPE with the caveat that peer review requires expansion beyond just case or chart review. Peer review (OPPE) is the ongoing evaluation of an individual physician’s performance for multiple performance dimensions, using all appropriate and relevant sources of practitioner performance data that are available.

While the data are important, your peer review/OPPE program is only as effective as your physicians think it is. Underlying this entire series is to help answer the question: does your peer review program have F-A-C-E? This means:

• **Fairness.** Bias has been minimized to every extent possible both on a personal and a group basis.
• **Accuracy.** You have the right data for the right physician.
• **Consistency.** You have standardized expectations, indicators, targets, feedback, and management of poor performance.
• **Efficiency.** You don’t waste a lot of physician and staff time.

Let’s talk about each of these attributes in more detail.

**Fairness**

A hallmark of an effective OPPE/peer review program is the degree to which it is perceived as being fair because bias has been eliminated or minimized whenever possible. If your medical staff feels the peer review process is biased, they will not buy into its findings. Bias can be structural (departmental peer review versus a single multi-specialty committee) and is beyond the scope of this series. Bias can also be process driven (unclear expectations applied unevenly). The five-step process employed in designing an OPPE system that was offered throughout this series is a way to maximize fairness of process. This includes:

1. **A succinct statement defining the expectation of the desired performance.** It is important for medical staff leaders to set expectations of what it means to be part of the medical staff. These should be well thought out, objective wherever possible, and applicable to all medical staff all the time. Examples chosen for this series were representative of how to implement a process, but the choice of expectations must match your organization, its challenges, and its ability to collect performance data.

2. **A clearly defined indicator of that performance.** A clear definition of the performance metric that will be measured needs to be established. Again, this clearly defines the “rules” and “rates” and “reviews” by which all physicians will be assessed. And it needs to be done in advance; not after the problem has occurred.

3. **Pre-established targets of performance against that indicator.** Delineation of targets for the indicator establish acceptable and less than acceptable performance. Again, defined in advance and not after the problem is history. It is repetitive but bears repeating that all measurements of performance against expectations and target ranges should be established prospectively.

4. **Timely feedback to the practitioner.** The presentation of physician performance data to each practitioner on a regular basis in confidence is a great tool for building trust and driving improvement. Transparency about providing findings to an individual physician about his or her performance begins to erase the “black box” or “secret quality file” mentality that many physicians harbor about the OPPE/peer review process.
5. **A process to manage poor performance.** Most medical staffs struggle with managing poor performance especially in real time and absent a prospective system for handling this challenge. This will take longer to design on the front end but the payback on the back end will be enormous. It behooves every medical staff leader to become conversant with tools that can be used to help manage poor performance short of invoking medical staff due process.

**Accuracy**

Physicians may claim that the data used to carry out OPPE/peer review is invalid. This is a claim that many medical staff leaders have heard. It is true that the discovery of even the slightest inaccuracy will invalidate the entire performance report in the minds of some physicians. They will assume, and no one would blame them, that if the report includes one inaccuracy it is likely that there are additional inaccuracies. The problem is that data are often imperfect and waiting for perfect data may be an impossibly long wait.

"Physicians have traditionally held that only a physician ‘peer’ can assess the competency of another physician. Yet many physicians struggle greatly when asked to assess and evaluate the work of another physician."

It is imperative, however, that data be as accurate as possible. When hospitals and their medical staffs establish expectations of physicians, it is critically important that the organization has the ability to provide accurate physician-specific measurements that can be offered with reasonable assurances of accuracy in an individual physician performance report. By way of example, the organization may wish to report compliance with an evidence-based protocol. If the electronic health record (EHR) is robust, utilized by the vast majority of admiters, and is capable of producing a report automatically, this would be a good measure. On the other hand, if the system is poorly utilized and manual abstraction is required to determine compliance, this measure may be a poor choice given the intensity and level of resources required to obtain specific physician performance metrics data that are accurate.

**Consistency**

Consistency is the hallmark of an effective OPPE/peer review process. It means that you have standardized expectations, indicators, targets, feedback, and management of poor performance. Additionally, this involves standardization of forms, processes, measurements, feedback, and reviews wherever and whenever possible. The rule of thumb for consistency is to seek out and eliminate unnecessary variation wherever and whenever you find it.

**Efficiency**

Physicians often find holding peers accountable to be uncomfortable if not downright impossible. An inefficient OPPE/peer system adds another layer of hesitation or excuse for medical staff leaders to avoid conversations about poor performance with their peers. Nevertheless, physician leaders have an accountability to patients, the board, and their organization to step up to the plate to help mentor poorly performing physicians. As has been emphasized throughout this series, all the steps in the ongoing physician performance evaluation process need to be developed and elucidated in advance. Without that, the task of holding underperforming physicians accountable goes from being very difficult to positively nightmarish.

**Conclusion**

Physicians have traditionally held that only a physician “peer” can assess the competency of another physician. This has been the fundamental building block of “peer review” as we have come to know it today. Yet many physicians struggle greatly when asked to assess and evaluate the work of another physician. This series was designed to help physicians with that struggle. By peeling back some layers of the onion, the hope is that some of the mystery about how to design and implement a truly effective OPPE/peer review program has been removed.

Next month, we sail the seas of perils and promises as a series on the challenges of employed physicians as medical staff members is launched. Until then, be the best you can be.
Physician impairment refers to situations in which practitioners are rendered unable to perform their professional responsibilities adequately because of a variety of health problems, including medical disease, psychiatric problems, or substance abuse (Physician Impairment by Substance Abuse, Medical Clinics Volume 81, Issue 4, Patrick G. O’Connor, MD, MPH, Anderson Spickard Jr, MD).

According to the Federation of State Medical Boards (FSMB), there is a need to educate the medical profession and the public about physician impairment and illness that can lead to impairment (Policy on Physician Impairment, FSMB, 2011). This starts with knowing that there is a difference between impairment and illness. The 2011 FSMB policy points out the distinction between the two:

“The diagnosis of an illness does not equate with impairment. Addiction, as an example, is a potentially impairing illness. Impairment is a functional classification. Individuals with an illness may or may not evidence impairment. Typically, addiction that is untreated progresses to impairment over time. Hence, in addressing physician impairment, it makes sense to identify addiction early and offer treatment and recovery prior to the illness becoming impairment.”

Physician impairment is most commonly associated with medical illness and addiction. However, another factor, age, must be considered when dealing with the potential for impairment. While many medical staffs are addressing the aging physician, there are some differences amongst legal experts about the “how” issue on this topic. The Age Discrimination in Employment Act of 1967 (ADEA) statute protects employees 40 years of age and older, and it is here that the potential for age discrimination presents challenges for the adoption of policies that protect against negligent credentialing while ensuring compliance with the federal statute.

Patient safety is clearly a paramount concern when impaired practitioners are in practice. The identification and treatment of impaired physicians is vital for improving both practitioner and patient health. Colleagues must also play a role in the impaired practitioner equation (Physicians Impaired by Substance Abuse Disorders, The Journal of Global Drug Policy and Practice, Kimberly B. Gold, MS4, Scott A. Teitelbaum, MD, FAAP, ASAM, 2010).

This is the first of a series of articles in which we will examine some of the major issues that organized medical staffs should consider when modifying practices to address practitioner age, health, and other potential impairment issues.

Aging practitioners

Aging physicians and allied health professionals present many challenges in regard to credentialing and privileging. For those practitioners who are hired by the organization, a “fitness for work” evaluation may be an optimal means for working with the practitioner to voluntarily modify his or her scope of practice (The Aging Physician: Balancing Safety, Respect, and Compliance, MedStaff News, Jonathan H. Burroughs, MD, MBA, FACHE, FACPE, James B. Hogan, Esq., Jennifer H. Richter, Esq., American Health Lawyers Association, 2013). This type of evaluation is not one completed by a primary care practitioner, but by a qualified individual who conducts a vocational evaluation that compares a practitioner’s cognitive and physical evaluation to the specific functions required to perform the clinical privileges requested (American Health Lawyers Association, 2013).

An article featured in The Washington Post in December 2012 pointed out that about 42% of the nation’s 1 million physicians are older than 55 and 21% are older than 65, according to the American Medical Association, up from 35% and 18%, respectively, in 2006. This trend is expected to increase as many work past the traditional retirement age of 65,
The Age Discrimination in Employment Act of 1967

The ADEA prohibits employers from failing or refusing to hire or discharging an individual or otherwise discriminating against any individual with respect to his compensation, terms, conditions, or privileges of employment, because of such individual’s age; and limiting, segregating, or classifying employees in any way that would deprive or tend to deprive an individual of employment opportunities or otherwise adversely affect his status as an employee, because of such individual’s age.

A policy cannot single out individuals based upon age for mandatory physical examinations. If the sole determining factor is age and there are no specific concerns in regard to the performance of his or her job, the policy may be viewed as discriminatory if the practitioner is an employee, unless the employer can establish the age-related requirement is a “bona fide occupational qualification” (BFOQ) under 29 U.S.C. § 623 (f)(1).

Even though a written agreement may be given consideration, the following factors must be assessed:

- The hiring party’s right to control the manner and means by which the product is accomplished
- The required skills
- Source(s) of the instrumentalities and tools
- The location of the work
- Duration of the relationship
- If the hiring party has the right to assign additional projects to the hired party
- The extent of the hired party’s discretion over when and how to work
- The method of payment
- The hired party’s role in hiring and paying assistants
- If the work is part of the regular business of the hiring party
- Whether the hiring party is in business
- Provision of employee benefits
- Tax treatment of the hired party

The BFOQ standard requirement calls for job qualifications (in this case age requirement) to be reasonably necessary to the essence of the business and they (the employer) are compelled to rely on age as a safety-related job qualification (Western Airlines v. Criswell, 472 U.S. 400, 413-414, 1985).
Ultimately, the determination of whether or not an employer-employee relationship exists may be decided by a court. It is important to note that when such a relationship does exist, the practitioner is protected by both the ADEA as well as the American Disabilities Act of 1990 (Pub. L. 101-336). Title I of the ADA, which became effective for employers with 25 or more employees on July 26, 1992, prohibits employment discrimination against qualified individuals with disabilities. Since July 26, 1994, Title I has applied to employers with 15 or more employees. Title V contains miscellaneous provisions which apply to the Equal Employment Opportunity Commission’s enforcement of Title I.

It is important to note that there is no immunity protection under HCQIA when the practitioner is protected under the ADEA and the ADA.

While it is important to be proactive in dealing with issues that may arise with aging physicians or allied health professionals, for some, there may be no other choice but to initiate corrective action as provided for under the medical staff bylaws or allied health policy.

PACE program

The following summary is from a 2012 interview with William A. Norcross, MD, Geriatrician and Professor of Family Medicine at the UCSD School of Medicine and founder of the PACE program, from the ReportingOnHealth.org website. He provides some keen insight that organizations should consider when reviewing their aging physicians/practitioners:

- The most common physician [that comes to the PACE program] is one who results from some sort of disciplinary action or perhaps even the anticipation of a disciplinary action from the Medical Board of California or some other state medical board. The majority of the referrals come from the Medical Board of California. Coming in at a strong second are referrals from hospitals and medical staff groups directly.
- The average physician age is around 62, which is four or five years above what the average age is for California doctors.
- The PACE program sees several cases a year with a doctor with an age-related health problem, most typically a cognitive problem.
- If you look at the national prevalence for dementia, like Alzheimer’s, and look at the statistics for physicians in practice by age, the conclusions would be that right at this moment in time, there must be about 8,000 practicing physicians in the U.S. with full-on dementia. Not just forgetfulness, or “I don’t remember where I put my car keys,” but actual dementia.
- Typically, the program lasts a total of seven days in two phases. They come to San Diego and can stay anywhere they want. Phase I is two days of multiphase testing and oral clinical exams. These are standardized tests created by the National Board of Medical Examiners, and we watch them perform a history and physical on a mock patient. A person just being himself or herself. Then we perform a complete history and physical on the doctor, looking for illnesses that could interfere with his or her ability to practice. We don’t do breast, pelvic, or rectal exams, but we do everything else. The oral clinical exam is performed by a doctor in the doctor’s specialty.
- PACE accepts doctors of all recognized specialties. If there are no major health or cognitive problems, they come back for Phase II. This is five days, usually consecutive, in a residency level site that is in their specialty. If it’s a hospitalist, it would be with other hospitalists in a hospital. If it’s a primary care physician, it would be with primary care physicians in an outpatient setting. They don’t have responsibility for patient care, but they observe and are incorporated into the educational activities and ask questions as they go along.
- When a physician fails, the results go back to the medical board. It’s up to the medical board to do what they want. They could ignore our work, but they don’t. They recognize and respect it. Pretty much invariably it results in a temporary suspension of license, and that’s immediate. Then the doctor has a decision as to whether he wants to fight it, wants to remediate it and do better on a second attempt, or wants to surrender his license. If he chooses to remediate it, we do provide
guidance, which is free of charge. We counsel physicians as to what their deficiencies are and how we would recommend that they go about a program of self-study.

• But, if they fail, they cannot go through PACE again to be reassessed until at least six months has passed. We feel that if a doctor fails, that is a very significant deficiency and it would take a minimum of six months for them to improve. It would take intensive study (like you were a medical student). Three or four hours a day pretty much steadily reading the literature, listening to audio, watching video, going to conferences (Reporting on Health, The California Endowment Health Journalism Fellowships, William Heisel, April 30, 2012).

If your hospital does not offer a program such as PACE, it is worthy of your consideration to investigate such a program in more detail.

Conclusion

Horty Springer put it best: “Dealing with older physicians typically feels like the proverbial ‘rock and hard place.’ ” The same can be said about older allied health professionals.

“Therefore, we recommend that the best approach, to address concerns about patient care and safety, is to improve your peer review process and address concerns as they arise. This improvement can start with education. Physicians, advanced practice providers, and staff alike need to understand their obligation to report concerns through the peer review process. Enabling an impaired physician, even if that physician is a beloved elder surgeon, is not good for patients and ultimately not good for the physician” (Horty Springer).

Ensuring patient safety must be the ultimate goal. Providing an effective program for aging practitioners that provides respect as well as offers remediation is what they deserve.

Who should be involved in peer review?

During the recent webcast, “Peer Review: Seven Challenges and Realistic Solutions,” speakers Robert J. Marder, MD, and Mark Smith, MD, MBA, FACS, answered a range of questions regarding data collection, peer review committee meetings, and process improvement. Some of their responses are provided here.

Q Can you comment on routine peer review data collection vs. case review peer view (triggered by specific identifiers or an event)?

Dr. Marder: The differentiation here is one of an audit, in which case you’re picking random charts. Usually we see this more in critical access hospitals or smaller hospitals where they are obligated to do that because they may not have the kinds of events that [trigger a case review].

I would rather see more OPPE and trying to get aggregate data than doing routine chart audits, but sometimes you’re obligated to get information when you don’t have much else going on. In general, try not to use audits unless you’re auditing for a specific indicator like indications, then you can aggregate that information up.

Dr. Smith: Traditionally, the routine random audit hasn’t been terribly productive because as you can imagine, the [largest] percentage of work is great and if you randomly audit work that’s great, you’re going to get great results. But it may not reflect the entire practice. Unless you have absolutely no other source of information, I wouldn’t routinely recommend falling back on a random audit process.

Dr. Marder: The other thing about random audits is, if your medical staff or physicians can give abstractors and screeners a clear understanding of what to look for and the criteria for an audit, then at least you don’t have to have physicians reviewing those as a peer review process. You can turn those audits into specific data elements that are then aggregated up over time, which is really what they should be—rather than calling it peer review, where you’re looking at all these things.
Sometimes, in an audit, physicians may have to decide whether there was an adequate plan of care. In those cases, have the physician do just that piece, and have the quality staff do the other parts of the audit that are more routine, such as whether an H&P is present, etc. Those are readily audited by non-physicians.

**Dr. Smith:** When you create those criteria, then essentially, it’s not a random audit anymore. You’re creating a basis for aggregate information collection.

**Q** Should any member of the administration—such as hospital compliance officer, CMO, or CEO—attend peer review committee meetings?

**Dr. Smith:** This is always a big point of contention because physicians always feel that non-physicians should not be at peer review meetings. [But you need to have] your quality support staff there to be able to do the meeting, and people look at quality support staff as being different than any other administrative person. Any time someone brings value to a meeting, then it’s worth having them there. Part of this goes to effective communication for systems quality issues vs. individual peer review—and having a person who can provide that linkage is good.

The other thing an administrative person may provide is a better understanding to convince the administration about supplying the resources necessary to do the quality work. So there are good arguments for having an administrative person there; however that person has to show value for being there. It shouldn’t just be open to everyone to be there just for prurient interest in the peer review process.

**Dr. Marder:** I hate peer review committees where you’ve got eight physicians sitting at a table and 12 people around them watching what they’re doing. I think that inhibits dialogue and discussion, candor. They should be there because they add value specifically. Apart from quality staff, I generally recommend the chief nursing officer be an ex officio member, without a vote, because they can bring perspective that will help in the decision-making process.

The CMO and CEO are tricky. The CMO generally is a physician but has a different hat, even though he or she may be a member of the medical staff. In general, it depends what the role is. If the role is to predominantly support the quality program, etc., and is not involved in physician contracting, then the CMO is generally a very good person to have involved in the committee.

What I’ve seen lately is the CMO is involved in physician contracting for employed physicians or the CEO is there and is involved in contracting. Physicians tell us now they’re concerned that these people are getting inside information on quality or issues of discussion. They’re worried it will inhibit candor at the meetings because they know [an issue] could turn into a contract wedge or lever when negotiation time comes around. That’s where the question of conflict of interest of administrative people comes into play, and whether they can adequately participate to the medical staff’s satisfaction.

**Q** What should the quality management department’s role be in peer review—should it be involved in the peer review process and the OPPE process?

**Dr. Marder:** That varies by institution. For the most part, quality management is responsible for data so these are the people getting the data. Mainly it’s important for organizations to understand that whoever does it, they’re supporting and serving the medical staff, and look for direction from the medical staff rather than just telling them. “This is what you’ve got and this is what we’re going to do.” It doesn’t matter which department does these functions as long as they have the expertise and the physician-service focus, engagement, and interaction with medical staff.

**Dr. Smith:** It’s the skill set that people bring to the table that’s useful, not the name of the department. So if the people with that skill set are somewhere else, it’s fine for them to fill those roles.

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