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INSIDE

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Negligent Credentialing Poses Major Risks to Hospitals

Credentialing of physicians is a fundamental responsibility of hospitals, with failure leading to both personal tragedies and tremendous liability.

One example is the story of a fugitive spinal surgeon who is the subject of lawsuits from 500 plaintiffs in Ohio. They alleged malpractice — specifically, that he performed unnecessary procedures, used improper treatments and devices, and failed to obtain informed consent. They also claimed the hospitals and health systems were liable for negligent credentialing.

Many of the claims were in two class-action lawsuits. The patients sued a health system and two hospitals. Individual hospital executives also were named in the lawsuits.

In 2013, the surgeon was indicted on 46 federal charges, including False Claims Act allegations that he had another surgeon operate in his name, allowed employees to write oxycodone prescriptions on presigned orders, and submitted fraudulent bills. He pled not guilty and fled to Pakistan, where he is currently living and working, according to the U.S. Attorney in Ohio.

> THE HOSPITAL GOVERNING BODY IS ULTIMATELY RESPONSIBLE FOR ENSURING ONLY COMPETENT PHYSICIANS PRACTICE AT THAT HOSPITAL.

Lawsuits Continue

The lawsuits against him are proceeding, and one plaintiff's case recently went to a jury, which awarded $350,000 for actual damages and an undisclosed amount for punitive damages, according to local media reports. The same jury was set to hear testimony in a new

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medical malpractice trial accusing the health system and a hospital of negligent credentialing, but unconfirmed media reports said those cases were settled.

At any rate, the story illustrates several lessons for hospital peer review professionals, says **Stephanie Russo**, JD, partner with the law firm of Nelson Mullins Broad and Cassel in Miami.

The hospital governing body has the final say on who is granted privileges and who is allowed to continue practicing in the hospital, and with this authority comes the ultimate responsibility for ensuring only competent physicians practice there, she explains.

That means the hospital also is liable for any harm suffered by a patient if the governing body was negligent in fulfilling this responsibility.

Hospitals must be diligent in making the initial decision whether to appoint a physician, in deciding whether to reappoint a physician (which must be done at least every two years), and at all times in between, acting swiftly in the face of concerns, Russo says.

Liability Not Automatic

Hospitals take on enormous responsibility with credentialing physicians, says **Karen Owens**, JD, an attorney with Coppersmith Brockelman in Phoenix. When a physician is not employed by a hospital, a medical malpractice case against the physician does not automatically implicate the hospital or subject it to liability, she notes, but an aggrieved patient may seek to sweep the hospital into the case by claiming that the physician acted as the hospital's agent.

That type of allegation often does not work, Owens explains, because hospitals take numerous steps to differentiate themselves from their nonemployed medical staff members.

For example, a hospital's conditions of admission document typically states that the patient understands the physicians treating him or her in the hospital may not be employees or agents of the hospital, Owens notes.

"So, in order to bring the hospital into the lawsuit and access the hospital's deep insurance reserves, the patient may claim that the hospital negligently allowed the physician to even belong to the medical staff to begin with," Owens says. In the Ohio class action cases, "this type of allegation must have been a no-brainer," she says.

Competence at Issue

But Owens says it is not a foregone conclusion that the hospital improperly or negligently allowed the physician to belong to the hospital's medical staff just because a physician committed malpractice in a hospital.

While the legal elements of negligent credentialing vary from state to state, generally to prove such a claim Owens says the plaintiff must prove these points:

- malpractice occurred;
- the hospital owed the patient a duty to perform reasonable credentialing and ongoing peer review sufficient to keep the patient safe;
- the hospital breached its duty by granting privileges or failing to adequately oversee the physician's practice in the hospital;

• the breach caused harm to the patient.

"In other words, the malpractice plaintiff must prove that the hospital knew or should have known the physician was not competent to treat the patient — and that but for the hospital's negligent credentialing or peer review, the physician would not have negligently treated the patient," Owens says.

In the Ohio case, the plaintiff class needed to show that if the hospital had properly performed its job in credentialing the surgeon and peer reviewing his work, the surgeon would not have been a medical staff member or had privileges to treat members of the class, Owens explains.

Confidentiality Can Backfire

Courts have long held that a hospital must have its organized medical staff undertake credentialing and peer review activities through an organized process which provides that only professionally competent physicians receive and maintain privileges, Owens explains. (For one example of case law supporting this view, see *Purcell v. Zimbelman*, 18 Ariz. App. 75 500 P.2d 335 [App. 1972.]) But on the plus side, most states have statutory peer review confidentiality laws that shroud the credentialing and review process in hospitals. Those laws help protect hospitals and physicians from liability for actions, or inaction, in the peer review process, Owens says.

"However, confidentiality can be a hindrance to hospitals defending themselves against a negligent credentialing claim," she says. "It is difficult for a hospital to show that it took appropriate actions under its organized process without revealing the inner workings of medical staff review of physician colleagues. Even if a hospital chooses to take this course, not all states even allow a hospital to waive the confidentiality requirements."

That can leave hospitals with few options. They can share non-confidential information to the jury about the doctor's education, training, prior employment, awards, society membership, publications, and specialty board certification, Owens explains, hoping that information helps establish that the initial credentialing process was sound.

Of course, that will not help if the doctor had a poor history before ever joining the hospital's medical staff, she notes.

"They can explain to the jury how the ongoing peer review process works and provide meeting dates to show that the medical staff was paying attention, and the ultimate outcome of the review process," she says. "Credentialing experts are often engaged to examine these facts and processes and try to deduce, working around the edges of peer review confidentiality, whether the hospital's approach met the standard of care."

Malpractice History Matters

When plaintiffs allege negligent credentialing, juries may be swayed by certain facts more than others, Owens says. They may be especially interested in prior malpractice cases, a category of information sometimes discounted in credentialing. Hospitals and health systems may look at malpractice history from the perspective of insiders who know that good doctors still get sued, but jurors are more likely to think a malpractice case indicates fault with the physician's knowledge or performance.

Juries also may find timing issues very persuasive, Owens says. What looks to hospital leaders like a deliberate, thoughtful inquiry into concerns about a physician may seem different to a jury.

"A hospital may be able to show that meetings about a physician took place over many months, but to a jury, this information may prove that the hospital negligently failed to take prompt action," Owens says.

Sensational cases that garner media attention show how a hospital can be vulnerable to negligent credentialing claims, but the same claim can arise in less egregious circumstances, Owens says. Plaintiffs and their attorneys are on the lookout for opportunities to assert negligent credentialing claims, especially when a physician has a history of publicly accessible malpractice cases or professional board actions, she says.

(See the story on page 100 for best practices to avoid charges of negligent credentialing.)

Punitive Damages Possible

The potential liability in such a case includes damages for the harm suffered by patients, such as past and future medical expenses, loss of enjoyment of life, physical

and mental pain and suffering, lost earnings, and loss of future earnings, Russo explains.

"In some instances, punitive damages may be awarded as punishment for intentional or grossly reckless conduct — for instance, if the hospital knew the procedures performed by the physician were medically unnecessary, but continued to allow the physician to perform the procedures anyway to enhance its own profit," Russo says.

She notes that many states set a cap on the maximum amount of damages a patient can recover. The amount of the cap and the categories of damages capped vary by state. In addition to this potential liability is the hospital's consequent loss of reputation in the community, Russo says. That can be significant if the allegations against the physician are sensational and garner wide media attention.

Insiders May Blow Whistle

Hospitals and health systems can be subjected to claims of negligent credentialing in several ways, Russo explains. Allegations of performance of unnecessary surgical procedures often are made by insiders like competitors, including other physicians on staff in the same specialty but not part of the same physician group practice, she says.

The claims also may come from internal whistleblowers such as physician leaders, medical directors, and hospital-employed staff such as nurses.

Russo notes that a *qui tam* lawsuit in the name of the United States may be filed by the whistleblower for alleged fraud against a government program like Medicare or Medicaid. The complaint is unsealed and becomes public record after the Department of Justice decides whether it will intervene in the suit.

The hospital may enter into a corporate integrity agreement with the Office of Inspector General as part of a settlement of a federal healthcare program investigation involving alleged false claims.

Such agreements also are public record, so plaintiffs' attorneys can use that information to launch lawsuits alleging negligent credentialing.

There are two common mistakes that lead to negligent credentialing charges, Russo says. The first is when physicians take action, but the action is not timely. Physicians are often reluctant to take corrective action against their peers except in the most egregious circumstances, Russo says.

The second is when hospitals adopt criteria for privileges, but do not apply the criteria or do not document that the physician meets the criteria.

"For example, the written criteria for open heart surgery privileges require the physician perform a minimum of at least 100 open heart surgery procedures each year to be granted privileges," Russo says.

"However, there is no documentation in the credentials file showing the number of procedures he performed, or the documentation shows he did not perform 100 procedures." ■

SOURCES

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- Stephanie A. Russo, JD, Partner, Nelson Mullins Broad and Cassel, Miami. Phone: (305) 373-9400. Email: srusso@broadandcassel.com.

Best Practices to Avoid Negligent Credentialing Claims

These recommendations for avoiding negligent credentialing claims are offered by **Karen Owens**, JD, an attorney with Coppersmith Brockelman in Phoenix:

• Have an up-to-date, well-documented credentialing process and be sure the medical staff follows it.

• Assure that the medical staff leaders who perform the actual reviews have appropriate training and understand that events that could seem relatively unimportant to them (like a malpractice judgment) may well be quite significant to a jury.

• Don't ignore malpractice claims, especially when they involve big dollars.

• Make sure to drill down when there are unusual circumstances.

• Be sure to maintain up-to-date

standards for the use of medical devices and biologics, both for the permitted uses of the devices and a physician's ability to use them.

• Remember that timeliness matters. Concerns about physician quality problems should not be allowed to drift over months and years.

Stephanie Russo, JD, partner with the law firm of Nelson Mullins Broad and Cassel in Miami, adds this advice for avoiding allegations of negligent credentialing:

• Adopt and implement a robust credentialing process on the front end. It is better to avoid appointing a physician than to have to remove a physician once he or she is appointed.

• Conduct due diligence on all red flags raised by the information received from the physician or third parties. Request all information needed to answer any questions about competence.

Require the applicant to authorize third parties, like other hospitals, to provide information about the physician directly to the hospital — for example, about their termination or denial of privileges.

• Put the burden on the physician to establish competence. If the physician does not provide sufficient information to convince the hospital he or she is competent, consider the application incomplete for processing.

• Adopt and implement a policy to actively monitor and review performance on an ongoing basis. This includes timeliness of medical records, sufficiency of patient signed informed consent documentation, whether procedures performed were clinically indicated, and outcomes of procedures.

• Conduct a focused evaluation of any concerns or questions raised in a timely manner.

• Impose appropriate action to address problems identified, including termination, where appropriate.

A negligent credentialing claim may be asserted even with those safeguards, Owens says, but it will be much easier to defend. "And more importantly, the claim may never come up at all if a deficient practitioner is timely removed from the medical staff," Owens says. ■

After One-time Training Fails, Long-term Approach Developed

A Texas hospital has learned that a checklist and one-time training do not always yield lasting results, so it developed a systematic, long-term approach to a vexing problem.

Addressing the issue of incomplete information for patient handoffs, leaders at Midland (TX) Memorial Hospital first implemented TeamSTEPPS, a set of evidence-based strategies and tools from the Agency for Healthcare Research and Quality that includes checklists and mnemonic devices. TeamSTEPPS is intended to improve teamwork and communication in healthcare settings. *(More information on TeamSTEPPS is available at: http://bit.ly/2p0Ysd2.)*

Midland Memorial required all surgeons, anesthesia providers, nurses, technicians, and other clinicians in the perioperative unit to undergo TeamSTEPPS training, explains **Bob Dent**, DNP, RN, senior vice president, chief operating officer, and chief nursing officer at the hospital.

Long-term Solution Needed

TeamSTEPPS has a good track record of helping hospitals improve quality and patient safety, and the first few months at Midland Memorial were no different. But while staff and physicians adhered to the processes they learned in the TeamSTEPPS training at first, they soon slipped back into their old ways, says **Wes Barnt**, vice president of ancillary services at Midland Memorial.

The more time passed after their training in the program, the less they used the checklists and communication techniques they had learned, Dent says.

Midland Memorial still uses and endorses the TeamSTEPPS approach, but for the patient handoff problem they found that they needed a strategy that would have a more lasting effect than the previous training. So, they developed another approach that involved ongoing education.

"Whatever training you're doing, we learned that you have to follow up or you revert back to old behaviors and you don't make the changes you want," Dent says.

"It takes relentless leadership and oversight to do that, but in a strong culture people step up and do that. We feel that we have been working on a strong culture of ownership and using TeamSTEPPS as a foundation for a culture of safety. We just needed to follow up on a process that was broken."

A new program was implemented in six stages that included introducing a new handoff procedure, studying the initial implementation before formalizing it as a policy, and then following up with refresher training.

Involve All Parties

A first step was to show everyone involved in patient handoffs that the current performance was not satisfactory, Dent says.

"Once we got them to agree that the current process was not working, then the next step was to get everyone thinking about where we wanted to go," Dent says. "From there we used evidence-based guidelines and put together a checklist, trialed it, improved it, and we also developed a way to maintain our proficiency in the new process. We knew that simply training staff was not going be enough, that there had to be a way to keep that momentum going."

The new process was developed with input from nurses, anesthesia providers, and anyone else who had some part in the patient handoff, Barnt says.

"An important part of the effort, and one thing we think ultimately was key to it being successful, was including all members of the team that provide care to the patient when we developed this new process," Barnt says. "We were able to draw on the expertise of everyone involved in the handoff to determine how to design the best process, and to get their feedback on how any proposed changes would actually work on a day-to-day basis."

Dent attributes the success of the handoff program to a combination of strong leadership support and seeking the input of clinicians from all levels and different departments. Midland Memorial is now looking at opportunities to improve similar processes with the same approach.

One area of concern is the number of patients arriving in the OR without proper consent forms. A study from Johns Hopkins found that consent forms were missing for 66% of surgeries, and that missing consent forms delayed 10% of all surgical procedures and cost hospitals an average hospital $580,000 each year. *(The study is available online at: https://bit.ly/2zuaRNx.)*

"We still hear that there is inconsistency with completing that perioperative checklist, including getting consent, when preparing the patient for surgery," Dent says. "It doesn't happen often, but there's enough that we can probably take what we've learned here and reverse for improving the handoff to the perioperative area." ■

SOURCES

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- **Bob Dent**, Senior Vice President; Chief Operating Officer; Chief Nursing Officer, Midland (TX) Memorial Hospital. Email: bob.dent@midlandhealth.org.

Volunteer Advisors Round in ED to Reduce Falls, Improve Care

In 2012, leaders at Health Central Hospital in Ocoee, FL, were concerned that the patient voice was not heard and thought overall patient care and satisfaction could be improved by listening to them more. They created a patient and family advisory council (PFAC) to ensure that patients and family members were included in all hospital operations.

Patient and family advisors (PFAs) now are a key part of hospital operations, participating on 12 hospital committees and conducting more than 11,000 patient experience visits a year. They donate 7,000 hours each year, which the hospital values at $158,900. More than 90% of the donated hours involve PFA patient rounding, in which the volunteers observe key interactions between clinical staff and patients and family members and round on patients in the hospital and ED. *(For more information on creating a PFAC, see the story on page 104.)*

Their immediate goal is to identify unmet needs, but they also gather information that will help guide policy and practices for future improvements in patient

care, says **Christina McGuirk**, MSHA, BSN, RN, NEA-BC, CENP, chief nursing officer at Health Central Hospital.

The effort began in 2010, when hospital leaders heard anecdotal feedback from patients and family that was not encouraging. They invited patients, family members, and community members to come in and discuss their concerns about the hospital, says **Bibi Alley**, patient experience consultant at the hospital.

"Sometimes it's hard to see the trees for the forest, so when you sit behind a desk you don't really know what's going on in the trenches," Alley says. "After several focus groups and other meetings over a couple of years, we weren't seeing improvement in the comments, so we did some research into the ways we decided to form a patient and family council that reports to our board. We train them as a new team member, onboard them like anyone else joining the organization, and welcome them as part of this hospital."

Variety of People Selected

Participants are first invited by the hospital to join the council and then must undergo a background check. Health Central invites a range of people from different demographics and experiences with the hospital so they can bring a variety of opinions and ideas, Alley says. Potential PFAC members also may meet with McGuirk, the hospital president, and the chief operating officer.

"It's almost like an interview, where we're trying to get a sense of their background and we're trying to think where they might have the most impact in our operation," McGuirk says. "But they're interviewing us, too, because we want them to start finding out who we are as a hospital, our goals, and see if this is a good fit for them to do volunteer work."

Volunteers are trained in HIPAA and other compliance issues before they are allowed access to patient areas.

The PFAs can spend more time with patients and family than clinicians sometimes can, McGuirk explains, and they relate with fellow patients and family members in a different way. Patients and family members will sometimes be less intimidated when talking with a PFA and disclose important information or ask for help that they didn't want to request from the doctor or nurse.

Alley points out that people recruited for a PFAC all will come with their own agendas, borne of their prior experience with the hospital. Those desires can be useful for identifying problem areas, but be aware of personal agendas and make clear the overall goals of the PFAC, she advises.

Rounding Has Big Impact

PFAs can be assigned to specific projects within the hospital, but Alley always asks new volunteers to simply visit the hospital and give their first impressions.

"They told us things like how they came to the hospital and had no idea where to park. The parking lots had no differentiation or indicators where you should park depending on why you were at the hospital," she recalls. "That was not a good introduction to your hospital experience, so we decided to color coordinate the parking areas. That's how we began our journey, looking from the outside at first impressions — the parking, signage, everything."

But the biggest impact came from having the volunteers round on the floors, Alley says. Introduction of PFAs has been credited with a reduction in patient falls and improved patient experience scores regarding staff concern for privacy, McGuirk says.

"They bring a different eye and ask questions we wouldn't think of, or they see things in a different way," McGuirk says. "We involved them in a project to look at the whiteboards in patient rooms and how we use them, looking for ways to revise that. We got feedback from clinicians, but then we put them in front of our PFAC members and they helped us identify how information was not clear to them. That had a big influence on the way we currently use whiteboards."

PFAs also have observed hand hygiene practices, visiting floors and watching whether people wash their hands when entering and exiting patient rooms. They can be especially useful with projects like that, which require a time commitment but not the skills of a clinician or manager, McGuirk says.

No One Dies Alone

Input from PFAs also resulted in a new ED policy to allow family members to remain with loved ones while clinicians remove life-sustaining equipment.

Doctors and nurses thought

they were doing the right thing by having family members leave the room while completing the task, then ushering them back to the patient's bedside. But moving in and out of the room was disruptive and sometimes resulted in the patient dying without loved ones.

The clinical staff asked PFAC how the process could be improved.

"They told us that no one should die alone, so we created that policy," Alley says. "'No one dies alone' is now our policy. The team member and the chaplain and staff all work together so that we can streamline the procedure and have some loved one sitting at the bedside, versus everyone crowded around. We bring everyone back in afterward and everyone gets the same information together."

The PFAC involvement has helped improve the nursing component questions on Press Ganey surveys, Alley says. PFAs talk with patients about questions similar to those on the survey, such as how long it takes for a nurse to respond when the patient uses the call button. Information gathered in that way can help identify issues that may need to be addressed throughout the hospital, or it can show that there is a problem in a particular area.

"There was one unit where that information led us to really focus on some patient satisfaction issues, and the results pre- and post-intervention were dramatic," Alley says. "This is the kind of information that we can glean from the time our volunteers spend with patients, information we might never have found before."

PFAs also have assisted with patient experience training for staff, posing as patients and role-modeling interactions, McGuirk notes. The PFA may role-play a particular type of patient interaction that could prove difficult or result in an unhappy patient, giving an instructor the opportunity to teach the best way to handle the situation. The volunteer also provides feedback and suggestions to the staff member.

"It offers a safe space for the team to continue to learn, from people who have either been patients or family members at our hospital," she says.

Build Relationship With Staff

It is important to build a relationship between the PFAs and the hospital staff with whom they will interact, Alley says. The hospital introduces the volunteers to department leaders and frontline staff so they can understand their background and why they are donating their time.

Alley and other hospital leaders also meet with the staff separately to explain the goals of the volunteer program.

"If the PFAC members just show up on the unit, unfortunately the team kind of questions why they're there, what information they are collecting, and how it will be used," Alley says.

"We want them to view the volunteers as an extension of the team, rather than something separate or a secret shopper, which people don't take to very well. As long as they know the background and the purpose, they embrace them and now they get disappointed if they're not there to help." ■

SOURCES

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- **Christina McGuirk**, Chief Nursing Officer, Health Central Hospital, Ocoee, FL. Email: christina.mcguirk@healthcentral.org.

Patient and Family Councils Make a Difference

A strong quality improvement infrastructure can be the perfect setting for developing a patient and family advisory council (PFAC), says **Libby Hoy**, founder and CEO of Patient and Family Centered Care Partners in Long Beach, CA, which works with hospitals to encourage patient and family participation.

"Some organizations have a very strong QI [quality improvement] infrastructure and that can be the most appropriate way to engage patients and family, by welcoming them into that structure," Hoy says. "The goal is to create consistent messaging and to create some guardrails around the effort, so that everyone comes in with consistent messaging and common goals."

Recruitment is especially important for PFAC because the members should accurately reflect the population served by the organization, Hoy says. She has served on a hospital's PFAC herself.

"It's a top area for opportunity

in this work. Most councils are not hitting that diversity profile yet, and that is an important thing to strive for if you are developing a council," she says.

A common recruiting mistake is to ask leading physicians to recommend someone who would be a good patient or family volunteer, Hoy notes.

That is an easy way to recruit and can yield a good number of participants, she says, but it does not always yield the best results.

"After a honeymoon period of three to four months, we find that a lot of advisors who came to the council that way fall off. That is because if a physician is treating my family and comes to me asking me to be part of this council, what am I going to say?" Hoy asks.

"I'm going to say 'yes' because he's treating my family and I want to maintain a good relationship. But three months down the line when I'm not seeing that doctor so regularly anymore, I'm going to find a way out because I didn't have any intrinsic commitment to the idea."

Staff members may be reluctant to suggest potential advisors because they worry about being held responsible if the volunteer doesn't work out, Hoy says. The best approach is to allow patient and family members to self-select but to manage the council membership so it has the right diversity, she says.

Train Volunteers Properly

Training and educating PFAC members also is a key concern, Hoy says. Failing to provide proper orientation is a common pitfall and undermines the overall effectiveness of the council, she says. It can lead to volunteers becoming frustrated or losing interest, and staff members can be skeptical of the volunteers' motives or lose patience with them not knowing the hospital's basic functions, she explains.

"The orientation to the advisor role is a key piece that I see get dropped pretty often. People are brought in and that stay in that mindset of being a previous patient or family member, rather than joining the hospital and being part of that team," Hoy says.

"If we can move people from their roles as patient and family members into the advisor role, we can get them to see themselves differently in terms of what they can do. That's when we get what we call high-impact advisors."

Integrating the volunteers into the quality improvement structure can address many of those potential pitfalls and help draw out the most meaningful information, Hoy says.

Too often, she says, hospitals use a customer service approach and ask patients and families questions like "What do you think of this?" and "How could we do better?"

"That opens up a whole dialogue that may or may not be relevant to the organization. We find it's much better to put that into the context of the QI context and tell them you're working on improving admissions, specifically these parts of the process, so what do they see that maybe you're not seeing?" Hoy explains.

"Narrow the conversation so that you can get the most useful information and not have them feeling like they're being asked to think of a lot of different things that may be unrelated."

Educate About QI

Many patients and family members will not be familiar with the concept of quality improvement within a healthcare organization or that a specific department exists. Hospitals establishing a PFAC should include education about the how quality improvement works within the organization and introduce quality leaders.

Hoy became involved with a PFAC after her son was treated in a hospital and at that point she had never heard of a quality improvement department.

"I just knew my son's physician and care providers. The idea that there was an entire department dedicated to improving quality at the hospital, and that there were people who made this their profession, that was a new idea to me," she says.

Many Benefits Possible

The potential benefit from a PFAC is significant, Hoy says. PFAC members can provide a perspective that is unique to the organization, making their input useful in ways that more generalized advice cannot match, she says.

Hoy notes an example in which she was working with a hospital's PFAC, as a family member, to address the facility's ED outpatient clinic wait times. She didn't know what to expect from the experience, especially what the eventual outcome might be.

"That's also key for PFAC participants: getting comfortable with the idea of not knowing the outcome. Quality improvement people are probably more

comfortable with that, having used the PDSA and continually improving," Hoy says. "Being comfortable with not knowing the outcomes means you're getting the highest level of value out of your advisors because you have not predetermined the outcome. You have left room for that patient and family voice to inform and guide you."

She had another experience in which a physician was meeting with the PFAC and expressed frustration with parents who do not follow up with appointments and test results. Hoy told the physician that, as a parent, she also was frustrated with the difficulty of reaching someone to discuss those issues. She was frequently sent to voicemail and had other difficulties communicating with the physicians.

"We had a discussion with the administrative team and the front office staff, and together we were able to identify that the phone tree was set up so that when parents called in they were being routed to message boxes of staff members who weren't with the clinic anymore," Hoy says. "We looked in one message box and there were a hundred messages in there from patients and family. I think that highlights the partnership, because you can't get to that without every perspective in the room joining the conversation."

Councils More Common

The use of PFACs has increased exponentially in the past several years, Hoy says. Hospitals and other healthcare organizations are embracing the idea as a useful quality improvement tool, she says, with about 54% already using patient and family advisors in some capacity.

"The idea of having advisors is taking hold in the healthcare community, but it's spreading now beyond the idea of having one council for your hospital or health system," Hoy says. "We're seeing councils developed for research, measurement development teams, and quality improvement organizations themselves. That is continuing to spread."

Hoy recently met with a major health plan that is developing a PFAC to help design benefit packages.

Watch for Pitfalls

There are potential pitfalls when establishing a PFAC, Hoy notes. To get the most value from a council, the hospital should take it on as a serious endeavor and not merely a casual nod to listening more to patients and family. An organization can start slowly, but still, a council is more than just having a few volunteers in for lunch a few times a year and asking them for suggestions, she says.

"There is a risk of not being intentional enough up front, not understanding for the organization what the specific value is to them and how to best implement this plan, which often means working through your quality improvement framework," Hoy says. "It can start as a small test of change and develop organically from there, rather than jumping in all at once with a full council. But some organizations are ready to move forward in a deliberate way. The important thing is to know what you want from this effort and being intentional about that from the start."

When you don't establish the council with that mindset, it can become only a reactive resource. The council might provide feedback, but that information is provided to the organization without structure, Hoy says. The recipients do not know what to do with it or how it fits into the hospital's quality improvement efforts. "That's when things get really loose and the value just diminishes," Hoy says.

Another pitfall is not closing the communication loop. It is discouraging for council members to discuss an issue or policy and see no evidence that their input was valued or led to any changes, she says. Volunteers don't expect the hospital to accept and act on all their suggestions, Hoy says, but they do need to hear that the information was received and considered.

"It's very important for organizations to close that loop by telling them that their information went to the appropriate committee and for this reason and that reason the committee decided not to alter the policy, or the decision is on hold for another six months," she says. "Whatever the explanation it is, it's important to pass that on to the advisors so they don't lose momentum."

PFCCP has many resources available online at: https://bit.ly/2v69W1m. ■

SOURCE

- **Libby Hoy**, Founder and CEO, Patient and Family Centered Care Partners, Long Beach, CA. Phone: (562) 961-1100. Email: libby@pfccpartners.com.

Hip Replacement Guarantee Required Solid Metrics

Geisinger health system's decision to offer a lifetime guarantee on total hip replacements could only be made after reaching quality metrics that would make any hospital proud. Getting to that level of quality is the background story to the health system's promise to pay any future costs related to its hip replacement procedures.

Geisinger announced recently that it is expanding its ProvenCare Total Hip program by standing behind the costs associated with orthopedic surgeries for a lifetime. The health system will provide a Geisinger Health Plan member who was receiving hip replacement surgery an unlimited time frame for future surgical care and cost that may be needed, explains **Michael Suk**, MD, JD, MPH, chair of the Geisinger Musculoskeletal Institute and the Department of Orthopedic Surgery.

This is the first time ever that a patient will be afforded the full range of care — both hospital care and device replacement — for future revisions at no charge, he says.

The costs will be shared between Geisinger and Medacta, which provides the medical devices used in the procedures. The guarantee covers the device itself and all hospital costs for as long as the patient remains with Geisinger Health Plan and is treated by Geisinger providers.

The first patient enrolled in the newly expanded program was a 53-year-old woman who underwent successful total hip replacement surgery on Feb. 26, 2018.

"We're saying to our patients we will provide such a good level of service that we will take care of any problems down the road 20 or 30 years from now. We can say that because we don't think there will be problems for any significant number of patients because of what we're doing to ensure the highest level of care in the first place," Suk says.

The original ProvenCare program covered post-surgery expenses for 90 days, and the 90-day outcomes were favorable enough that Geisinger started looking at what it would take to expand that guarantee to a lifetime.

"When we posed that question, everyone's immediate reaction was that this was an impossibility. How could you possibly guarantee it for a lifetime?" Suk says.

"For me, I asked why not. What would it take for us to provide a level of care so high, and have the data to show it, so that we could guarantee the results for a lifetime and have that be a reasonable proposition financially?"

Suk determined that a good 90-day outcome could be extended to a lifetime outcome by enhancing factors like patient engagement, encouraging patients to commit to the Geisinger system for future care, and increasing patient access so that Geisinger could intervene sooner than might be typical for hip replacement patients experiencing problems.

The commitment by Medacta to share the expenses was dependent on the data showing that the lifetime promise made sense financially, Suk says.

Geisinger's good metrics were the result of years of devotion to using clinical evidence to drive best practices, he says. There are certain things that have to be done a specific way every single time, he says, and that can be a difficult message for surgeons who see themselves as more artist than tactician.

"That's always the main question: What is the clinical evidence behind what you are doing?" Suk says. "The harder part is actually driving your physicians and decision-makers to adhere to those algorithms and processes. It all has to do with driving unwanted variation out of the system."

Geisinger introduced its ProvenCare program in 2006. The program uses evidence-based bundles and a fixed per-case rate that covers preadmission, inpatient, and follow-up care, including any complications 90 days post-procedure. Then in 2014, Geisinger launched ProvenCare Hip Fracture, Total Hip, Total Knee, and Lumbar Spine.

Suk says that the model, created by Glenn D. Steele, Jr., MD, Geisinger's CEO from 2001 to 2015, has reduced complications, lengths of stay, and readmissions, and that the result has been increased efficiency and profit. Suk says the program also helps to reduce variation in healthcare by strengthening buy-in from clinicians around best practices.

More information on Geisinger's ProvenCare model is available online at: https://bit.ly/2vuDIvY. ■

SOURCE

- **Michael Suk**, MD, JD, MPH, Chair, Geisinger Musculoskeletal Institute and the Department of Orthopedic Surgery, Danville, PA. Phone: (570) 214-5605.

HOSPITAL PEER REVIEW
YOUR BEST SOURCE FOR ACCREDITATION COMPLIANCE

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CE QUESTIONS

1. **According to Karen Owens, JD, what is one risk a hospital faces in a negligent credentialing case when it shows that it conducted a lengthy investigation into concerns about a physician?**
   a. The jury may perceive that the hospital negligently failed to take prompt action.
   b. Launching the investigation may be seen as an admission of guilt.
   c. The jury may perceive the investigation as too hasty and incomplete.
   d. The hospital forfeits confidentiality protections by discussing the investigation.

2. **What does Stephanie A. Russo, JD, say is one common problem that leads to charges of negligent credentialing?**
   a. Hospitals refuse to respond to patient concerns about physician performance.
   b. Hospitals adopt criteria for privileges but do not apply the criteria or do not document that the physician meets the criteria.
   c. Physicians provide false information about their credentials.
   d. Physicians are too quick to criticize their colleagues.

3. **How many volunteer hours do the patient and family advisors at Health Central Hospital in Ocoee, FL, typically donate each year?**
   a. 2,500
   b. 5,000
   c. 7,000
   d. 12,00

4. **Why does Libby Hoy, founder and CEO of Patient and Family Centered Care Partners in Long Beach, CA, say it often is not a good idea to ask physicians to recommend volunteers for a patient and family advisory council?**
   a. They are not sufficiently familiar with the hospital or organization.
   b. They may volunteer to please the physician but then drop off the council in a few months.
   c. They often are parents who do not have enough time to serve on the council.
   d. Physicians usually are reluctant to recommend their own patients or their family members.

CE OBJECTIVES

Upon completion of this educational activity, participants should be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, healthcare workers, hospitals, or the healthcare industry in general.
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.