NAVIGATING AN APPROVAL FOR REMOVAL

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Objectives

- Describe the ubiquitous nature of errors
- Overview of a Performance Improvement Program and what it fixes and what it doesn’t
- Describe importance of a decision matrix to address shades of grey
- Describe the need for objective reasons for loss of credential
- Define peer engagement and it’s importance
“To make no mistakes is not in the power of man; but from their errors and mistakes the wise and the good learn wisdom for the future.”

-Plutarch
3-4% of hospital patients are harmed by the healthcare system
7% of hospital patients are exposed to a serious medication error
50,000 – 100,000 deaths/yr from medical mistakes
The measure of your system is not in the mistakes you make...

It is in the action taken to address those mistakes.
Outcomes based and provider focused

Bad outcomes are caused by bad providers

Mistakes are the fault of a bad provider

Doesn’t seek out errors to fix
Catches errors to BLAME
- **Cognitive**
  - Errors of omission/commission
  - Knowledge deficits
  - Skill retention/Training
- **Process/procedure**
  - Unclear or no procedure/protocol
  - Structured communication
- **System**
  - Equipment
  - System design/fatigue
The healthcare professions have gotten better about this...

...to the exclusion of the contribution of the behavior of the individual?
Creating an program that seeks out errors in a non-punitive blame free environment does NOT mean that all behaviors can be tolerated.
Performance Improvement

- Education & Training
- Process or Engineering Control

Check Results / Analyze Data

Act on the findings

Plan an improvement / change

Clinical Performance Indicators
Clinical Event Reviews
Clinical Audits

Implement the Plan

Performance Improvement
Have a process to help identify the difference!
As professional caregivers you should WANT accountability for unacceptable behaviors to preserve:

- Trust
- Respect
- Value
- PRIDE

in what you do.
World of grey...much at stake

PROVIDERS

- Are in short supply
- Good ones want to work with like minded others
- Want validation of their contribution
- Define the quality of the care you provide and the System

STAKEHOLDERS

- Patients
  - IF they have a choice it is based on trust
- Hospitals/Physicians
  - Facilitate or hinder your clinical initiatives
- Community
  - Safety of your providers
  - Advocates for the service
- Politicians
  - Control your funding
Process and Structure

- Process to create reproducible decisions
  - Provides consistency
  - Defensible
- Structure of PI and review must be functional
  - Limited impact on System
  - Expedient for most event types
  - Increasing complexity and deliberation for more difficult cases
Process to Address Behaviors INDEPENDENT of Outcome

- Creates accountability for behaviors within the control of the clinician
- Ill intent doesn’t always result in bad outcomes
- Bad outcomes do not indicate ill intent
- Clearly defines unacceptable behaviors
Unacceptable “Deadly Sins”

- Impaired
- Intentionally harming a patient
- Intentionally withholding care
- Integrity violation
- Failure to remediate
Whack a Mole

The Price We Pay For Expecting Perfection

David Marx
Tenets of a Just Culture

- Errors will occur
- System failures contribute to many errors
- Self reporting and error acknowledgement is essential to improvement in the system
- PUNISHMENT does not deter normal errors
- WILLFUL reckless behaviors cannot be tolerated in Safety/Just culture
Just Culture

- Human error, lapse, slip or mistake
  - Manage through process, procedure, training
  - Console
- At risk behavior (choice) where risk not recognized or believed justified
  - Incentivize healthy choices and increased situational awareness
  - Coach
- Reckless behavior is conscious disregard of unreasonable risk
  - Remedial action or removal
  - Punish
Often used as the sole means of determining providers fate
Uses “reasonable” peer as standard for behavior
Often without education for participants
If unstructured can do more harm than good
More harm than good?

- Peers are far more critical
- Can result in harsher action than intended
- Challenge to maintain error friendly environment
- Belief that the outcome is predetermined
Patient Safety Committee

- 3 peers and 2 physicians from medical society
- Blinded review of fact pattern that led to decredentialing recommendation
- If not unanimous a majority and dissenting opinion are submitted

Physicians work with peers and see accountability
Assures no personality issues or influence on process or return to practice
Assures final decision is as informed as possible
Take Away

- Be proud of what you do, where you do it, and who you do it with
- PI focus should be on contributing factors but not to the exclusion of bad behaviors
- Create a non-punitive environment for errors but define and maintain accountability for unacceptable willful acts
- Use peer review assure process transparency and engagement for inside and outside stakeholders
“Personal responsibility is not only recognizing the errors of our ways. Personal responsibility lies in our willingness and ability to correct those errors individually and collectively.”

–Yehuda Berg