Vanderbilt Center for Patient and Professional Advocacy

The Pursuit of Safety Requires Accountable Professionals

Gerald B. Hickson, MD
Joseph C. Ross Chair in Medical Education & Administration
Professor of Pediatrics
Founding Director, Vanderbilt Center for Patient & Professional Advocacy

@VUMC_CPPA

From shame and blame…

…to systems…to…

Reliability

"Failure free operation… effective, efficient, timely, patient-centered, equitable"

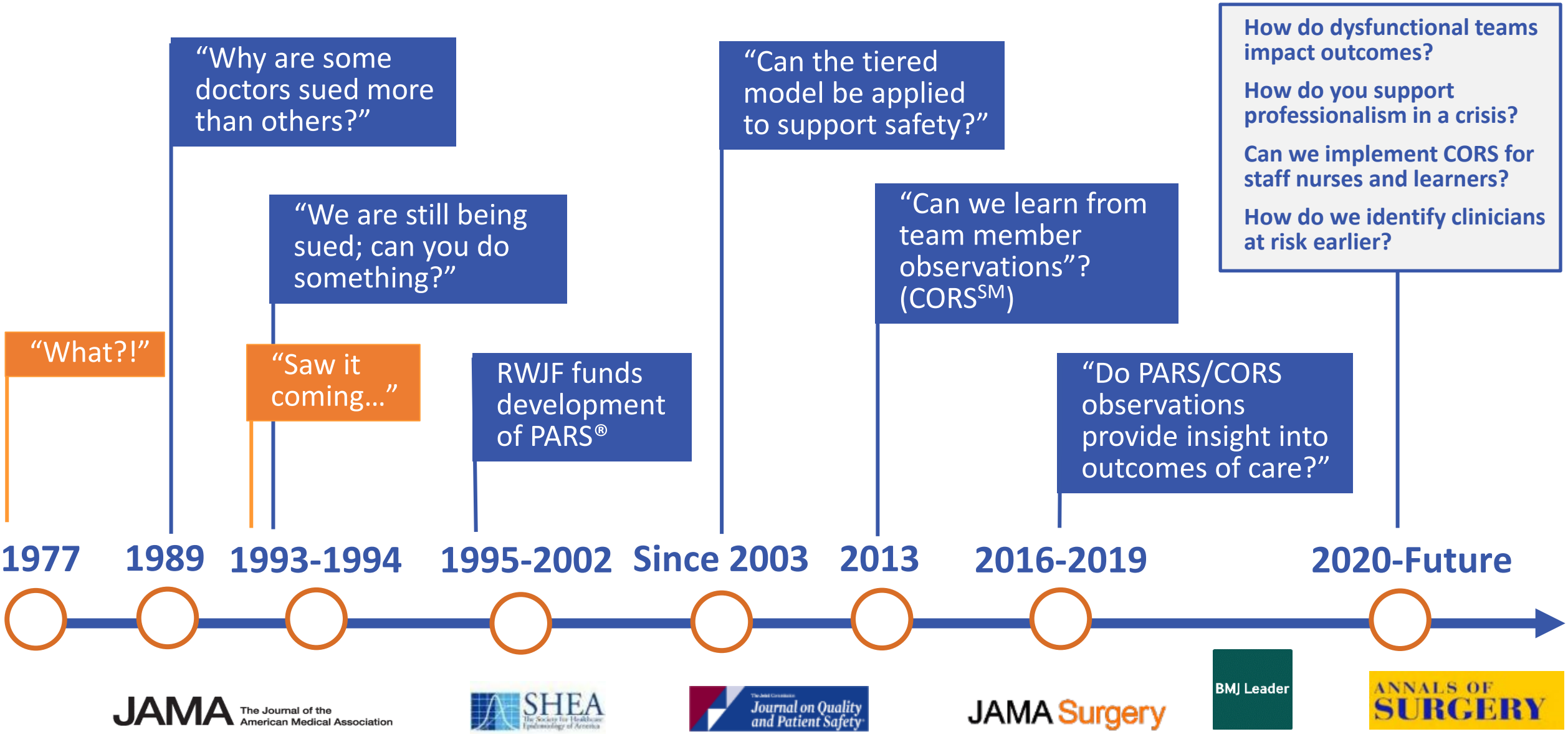
- **Vision/goals/core values**
- **Leadership/authority**
- **A *safety* culture includes:**
  - Psychological safety
  - Trust

Institute for Healthcare Improvement

Nolan et al., Institute of Medicine, 2001; Nolan et al., Boston: Institute for Healthcare Improvement, 2004; Hickson et al., Joint Commission Resources, 2012.

Joint Commission Resources

CPPA Timeline



JAMA The Journal of the American Medical Association

SHEA The Society for Healthcare Epidemiology of America

Journal on Quality and Patient Safety

JAMA Surgery

BMJ Leader

ANNALS OF SURGERY

Hickson et al., *JAMA*, 1992. Entman et al., *JAMA*, 1994. Hickson et al., *JAMA*, 1994. Hickson et al., *JAMA*, 2002. Talbot TR et al., Infect Control Hosp Epidemiol., 2013. Webb et al., The Joint Commission Journal on Quality and Patient Safety, 2016. Cooper, et al., JAMA Surgery, 2017. Cooper, et al., JAMA Surgery, 2019. Cooper, et al., *BMJ Leader*, 2021. Cooper WO, et al., Annals of Surgery 2022 (in press).

Professional?

Safe?

A sign?

Dr. Lee

- Medical Specialist

Patient reports: "…I just had one last question…Dr. Lee got angry, 'Look, I'm the doctor here not you' and left."

Nurse reports: "I needed clarification about Dr. Lee's orders, he replied, 'You can read, can't you?' and walked off."

Why might these stories represent threats to safety?

Pursuing the Right Balance

Joint Commission Resources

JAMA Surgery

Hickson et al., *Joint Commission Resources*, 2012.
Talbot TR et al., *Infect Control Hosp Epidemiol*., 2013.
Cooper, et al., *JAMA Surgery*. 2017. Cooper, et al., *JAMA Surgery*, 2019.

Patients see and experience….

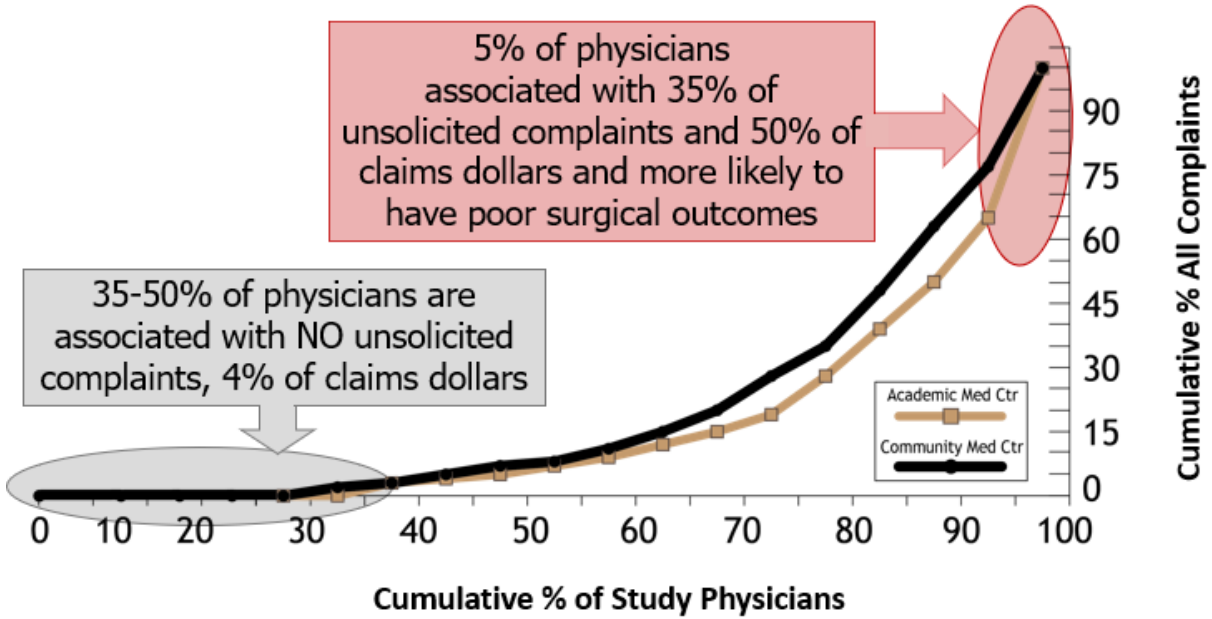
PARS®
Patient Complaints

"While asking Dr. XX about my diagnosis, responded that my questions were annoying..."

"Asked to sign a consent… for another patient (same last name)."

"Dr. YY examined me without any protective attire… didn't wash hands either…"

Cumulative Distributions of Physicians by Patient Complaints



JAMA The Journal of the American Medical Association

Hickson et al., *JAMA*, 2002; Moore et al, *Vanderbilt Law Review*, 2006; Hickson et al., *So Med J*, 2007.

And sometimes team members see things…

CORS℠

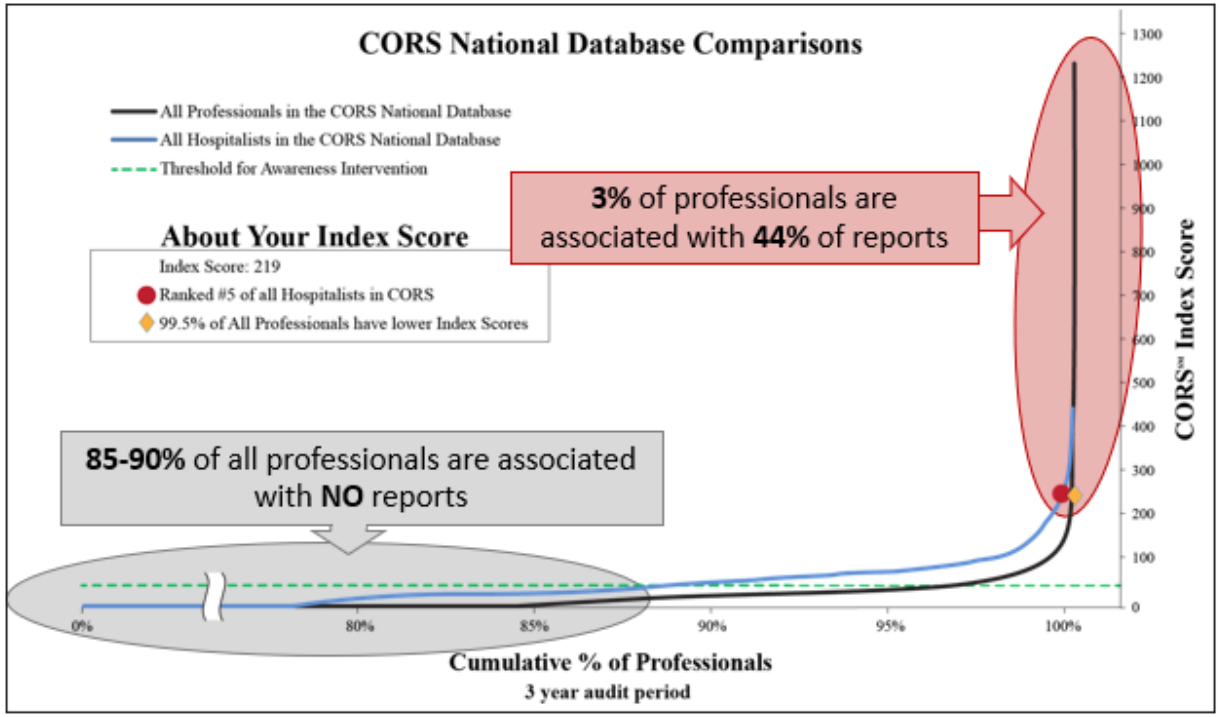
Co-worker Concerns

"Dr. XX was about to enter a patient room...did not pause to foam in…I asked Dr. XX...Dr. XX replied, "Don't start with that…the HH police are everywhere..."

"Dr. YY asked me if I hated my job because I did it so badly."

"I stated we needed to do the timeout before procedure. Dr. ZZ declared, 'Wow, aren't you a bossy cow.'"

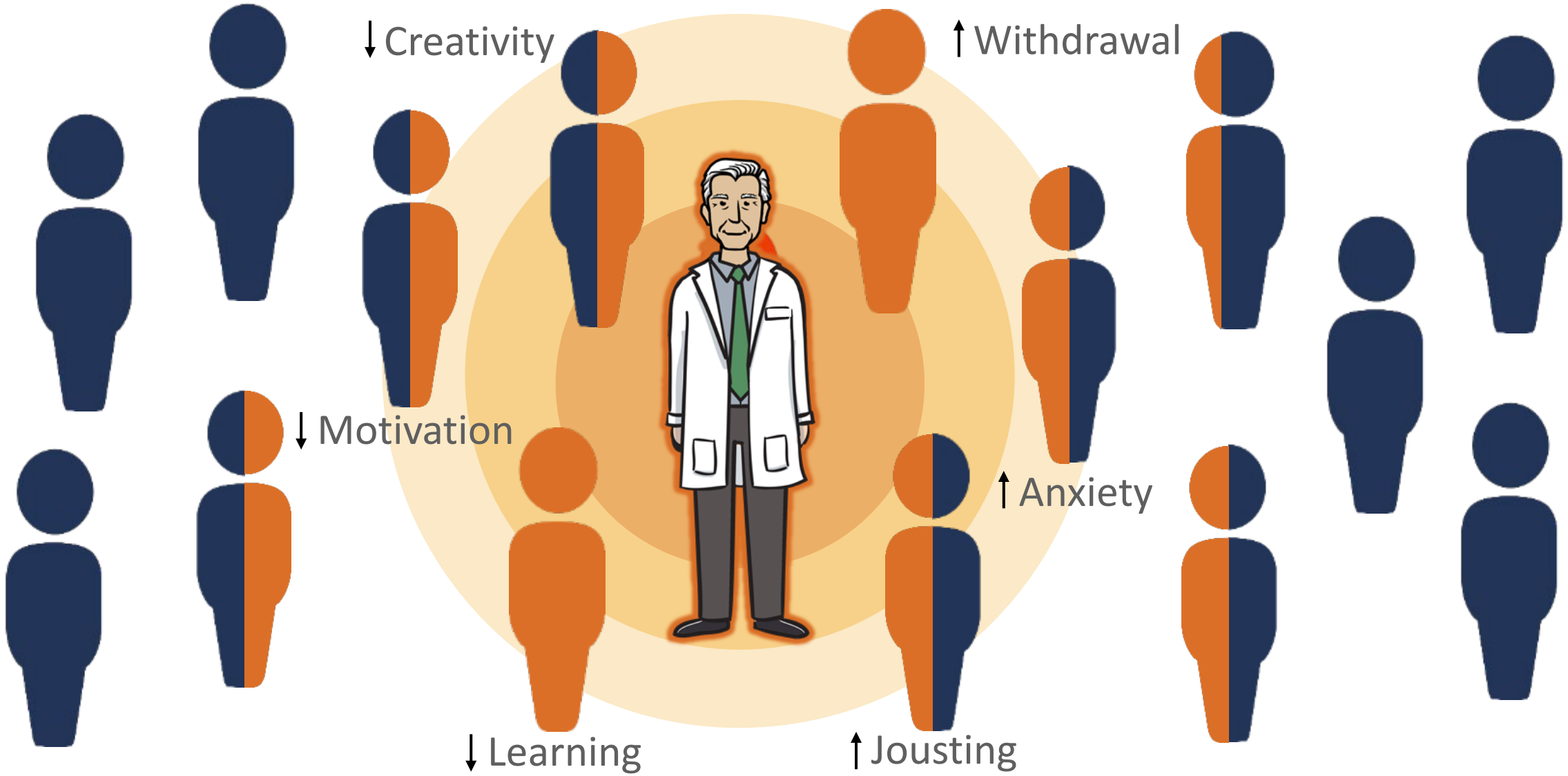
Co-Worker Report Distribution



JAMA Surgery

Webb et al., *The Joint Commission Journal on Quality and Patient Safety,* 2016; Martinez et al. *Journal of Patient Safety*, 2018; Cooper et al. JAMA Surgery, 2019.

Disrespectful Colleague: Impact on Others



Felps W et al. How, when, and why bad apples spoil the barrel: negative group members and dysfunctional groups. Research and Organizational Behavior. 2006;27:175-222.

Physicians who model disrespect account for:

50-70% of your organization's malpractice claims experience and cost

And if you personally need care:

You are 20-30% more likely to have a surgical site infection

You are 20-40% more likely to develop Sepsis

You are 24-30% more likely to die if you require trauma care

*Includes surgical site infections, wound disruptions, and medical complications (e.g. pneumonia, embolism, stroke, MI, UTI)

JAMA Surgery

Cooper, et al., *JAMA Surgery*. 2017 & 2019

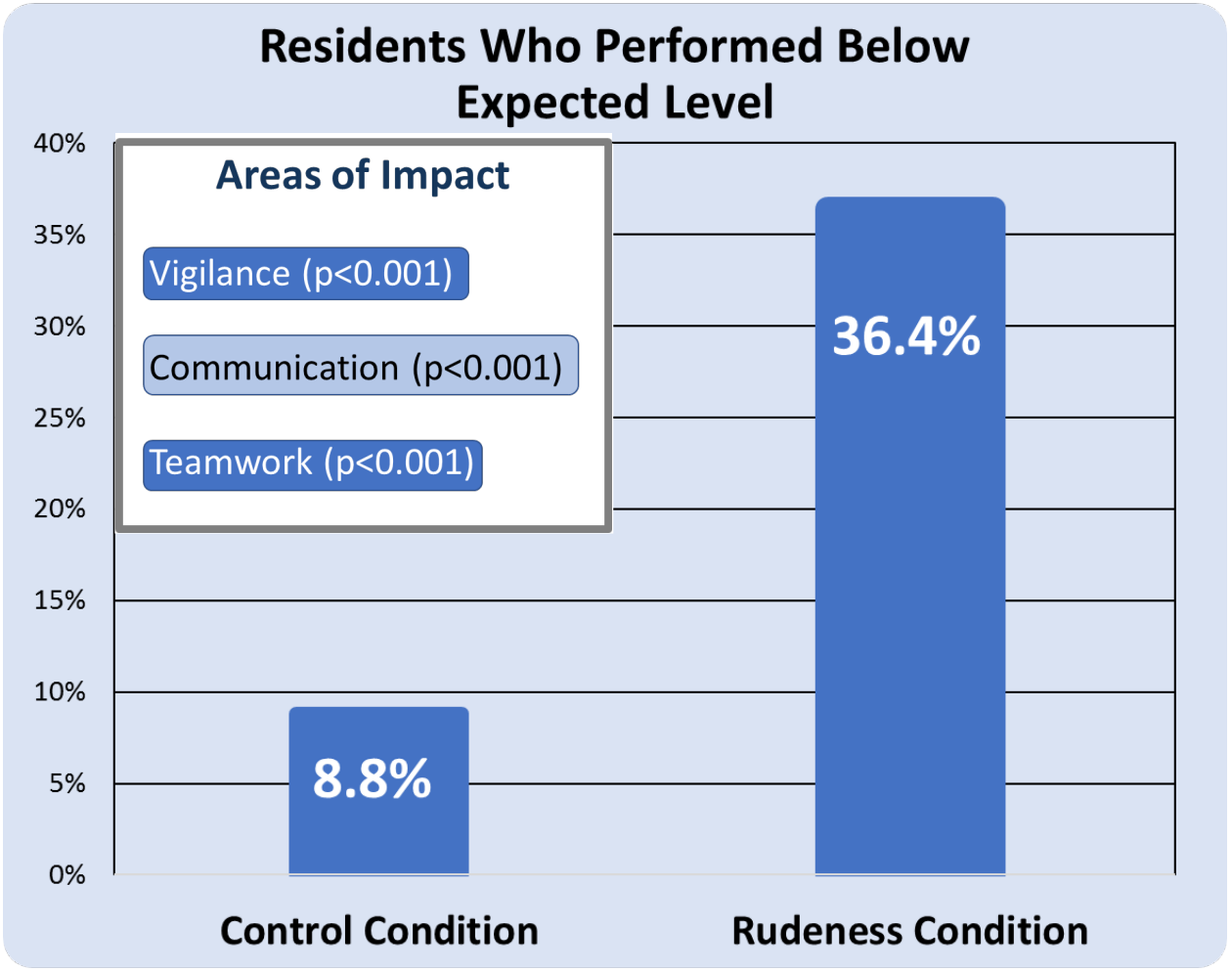
JAMA The Journal of the American Medical Association

Hickson et al., *So Med J,* 2007.
Moore et al, *Vanderbilt Law Review,* 2006.
Hickson et al., *JAMA*, 2002.

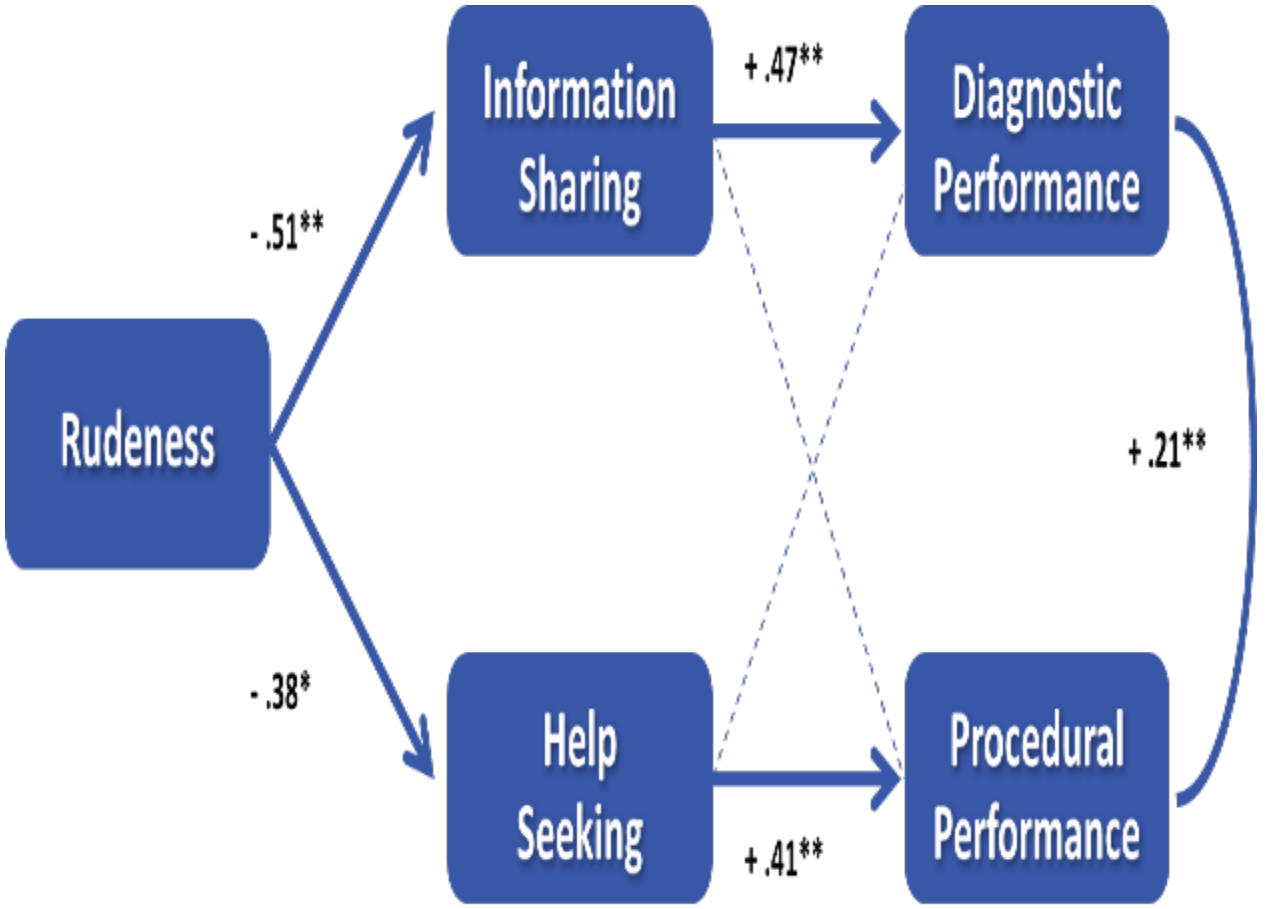
ANNALS OF SURGERY

Cooper, et al., Annals of Surgery 2022

The Impact of Rudeness on Individual & Team Performance



BMJ Katz et al., BMJ, 2019.



PEDIATRICS Riskin et al., Pediatrics, 2015.

Failure to Address Disrespect

Pursuit of Professional Accountability Requires an Infrastructure

PEOPLE

- Committed Leadership
- Project Champions
- Implementation Teams

ORGANIZATION

- Clear Goals and Values
- Policies and Procedures
- Sufficient Resources
- Tiered Intervention Models

SYSTEMS

- Tools, Data and Metrics
- Reliable Review Process
- Training

Joint Commission Resources

Hickson et al., Joint Commission Resources, 2012.

Tulane University School of Medicine

TULANE UNIVERSITY SCHOOL of MEDICINE

Mission:

- We improve…through ***DISCOVERY*** and ***TRANSLATION*** of the best science into clinical practice and education; to ***DELIVER*** the ***HIGHEST QUALITY*** patient care and ***PREPARE*** the next generation…

Core Values:

- Accountability
- Compassion
- Quality
- Collaboration
- Integrity
- Diversity
- Creativity

“….you can read can’t you.”

Why might a team member hesitate to speak up or report?

Promoting Professionalism Pyramid

- Project Champions
- Implementation Teams
- Tiered Intervention Models
- Training

Messenger

Lee

"…you can read can't you?"

Adapted from: Hickson GB, Pichert JW, Webb LE, Gabbe SG. A complementary approach to promoting professionalism: Identifying, measuring, and addressing unprofessional behaviors. Acad. Med. 2007 Nov;82(11):1040-1048.

What if complaints continue?

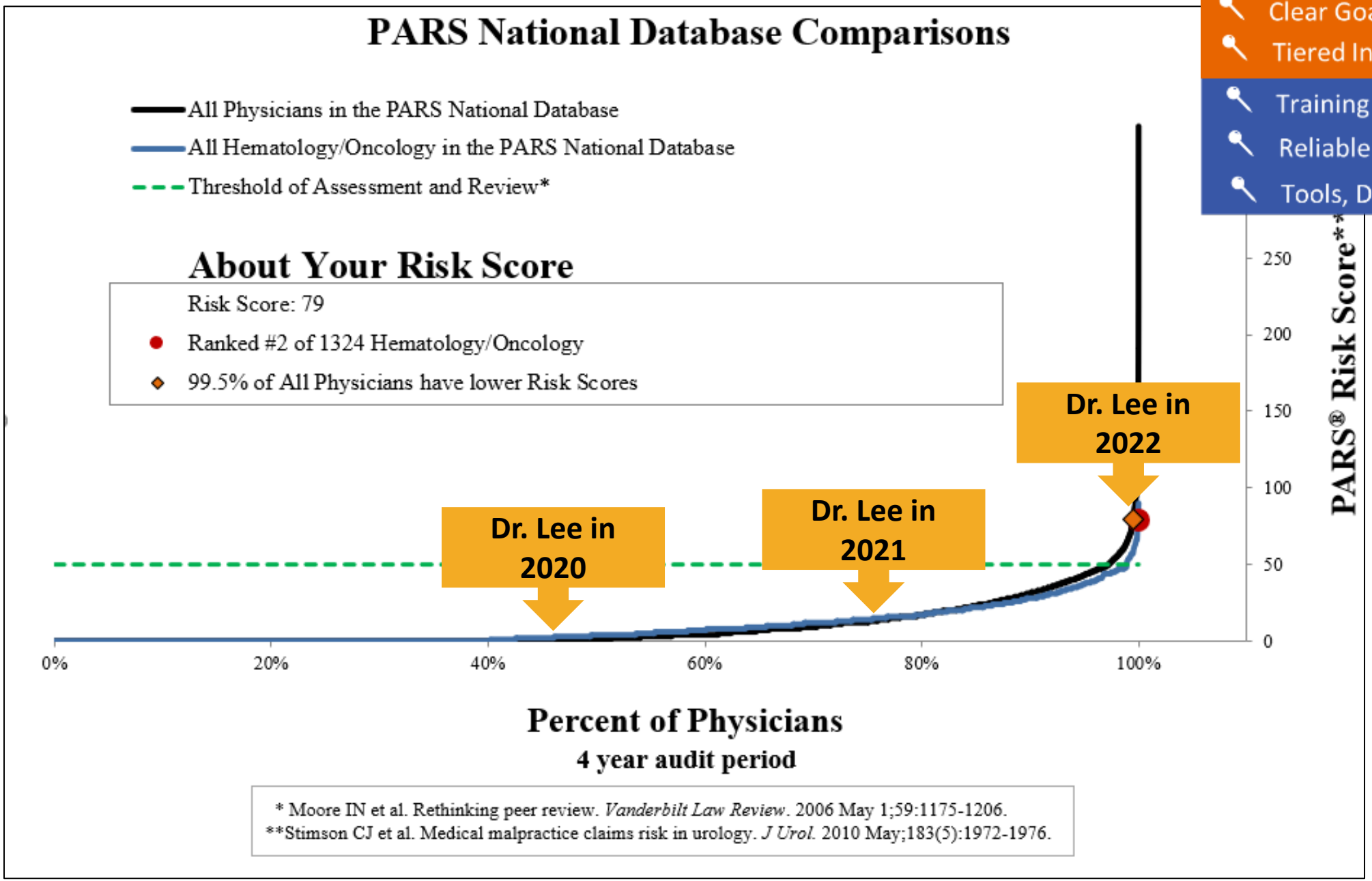
Patient reports: “I asked Dr. Lee a question and he responded saying, ‘Why do you keep asking me irrelevant questions?...’”

Patient reports: “Dr. Lee wrote that I am a 60 y.o. male and that I have hepatitis C, that is wrong.”

Patient reports: “Dr. Lee clearly didn’t want to see me, he sighed and said, ‘Who keeps referring you to me?’”

- Committed Leadership
- Clear Goals and Values
- Tiered Intervention Models
- Training
- Reliable Review Process
- Tools, Data and Metrics

PARS National Database Comparisons



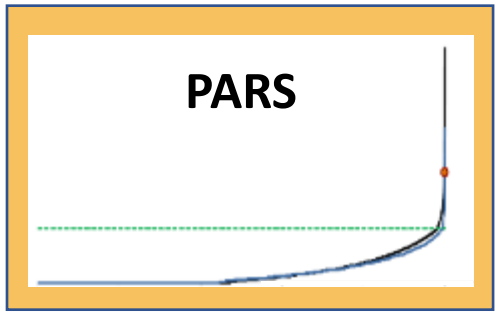
* Moore IN et al. Rethinking peer review. *Vanderbilt Law Review*. 2006 May 1;59:1175-1206.
**Stimson CJ et al. Medical malpractice claims risk in urology. *J Urol.* 2010 May;183(5):1972-1976.

Promoting Professionalism Pyramid

Project Champions
Implementation Teams
Tiered Intervention Models
Training

Messenger

Lee



No change

Pattern persists

Apparent pattern

Single concern (merit?)

Egregious

Mandated

Level 3
"Disciplinary" Intervention

Level 2
"Guided" Intervention
By Authority

Level 1
"Awareness" Intervention

Informal
"Cup of Coffee"

Mandated reviews

Delivered By:

PARS: Authority
CORS: Authority

PARS: Peer Messenger
CORS: Peer or Authority
Messenger

PARS: Patient Relations
CORS: Peer Messenger

Majority of professionals
(provide routine feedback)

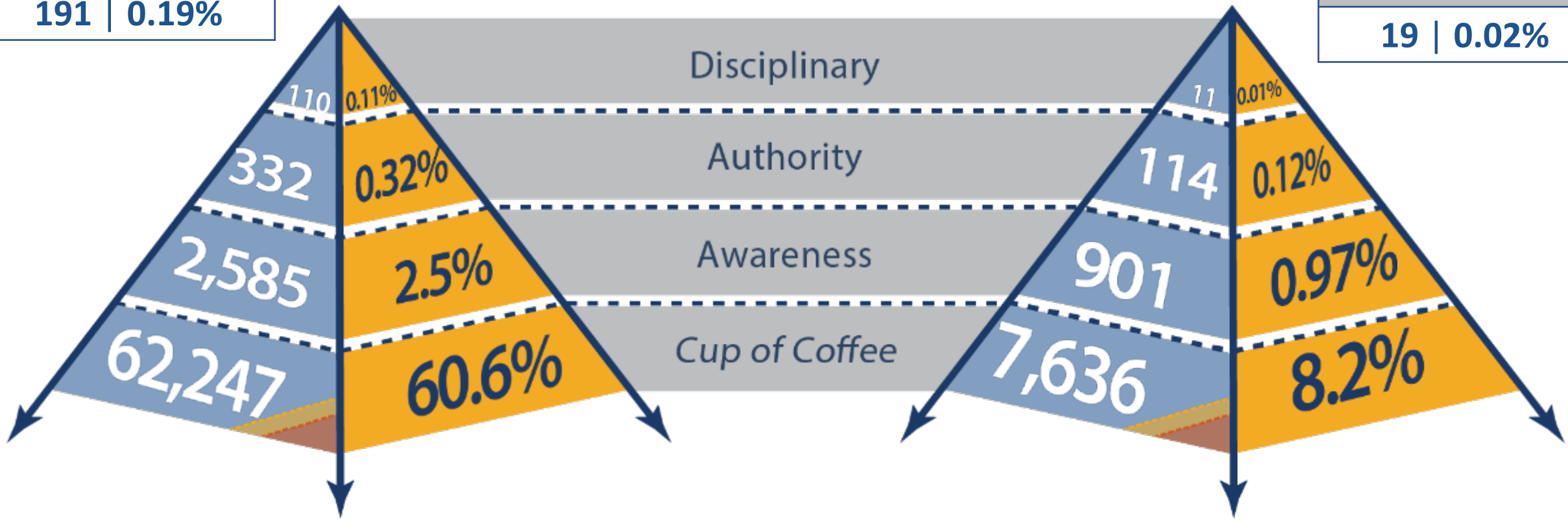
Adapted from: Hickson GB, Pichert JW, Webb LE, Gabbe SG. A complementary approach to promoting professionalism: Identifying, measuring, and addressing unprofessional behaviors. Acad. Med. 2007 Nov;82(11):1040-1048.

CPPA Outcomes

- Committed Leadership
- Tiered Intervention Models
- Tools, Data and Metrics
- Training

Depart Unimproved
191 | 0.19%

Depart Unimproved
19 | 0.02%

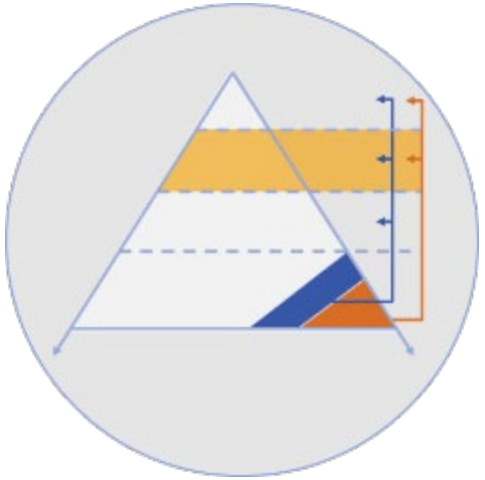


102,744 Physicians in the **PARS** National database

93,050 Professionals in the **CORS** National database

A threat to patient safety?

A threat to Dr. Lee's safety?



Patient reports to nurse manager:

"Dr. Lee walked in and looked disheveled… I wasn't sure he knew who I was… didn't seem to understand why I was there… is he ok?"

Reports that might need investigation…

Culture/Bias

- "Dr. came in and said, 'If you report me again'…"
- "Did not use my name… but said that 'black woman'…"

Aggressive/ Violent

- "… grabbed my ID badge…"
- "…Dr. headbutted fellow…'That's a knucklehead move'…"

Boundary Issues

- "What does it for me, in addition to your hair, is that tattoo…"
- "Dr. grabbed the nurse's arm pulled her close…"

Integrity

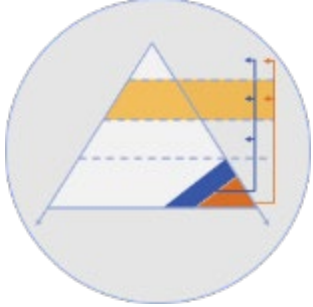
- "Dr. looked at celebrity's medical record…"
- "Dr. cosigns 100% of our notes, but rarely assess…"

Impairment

- "Dr. kept forgetting the patient's treatment plan…"
- "APN smelled like alcohol…"

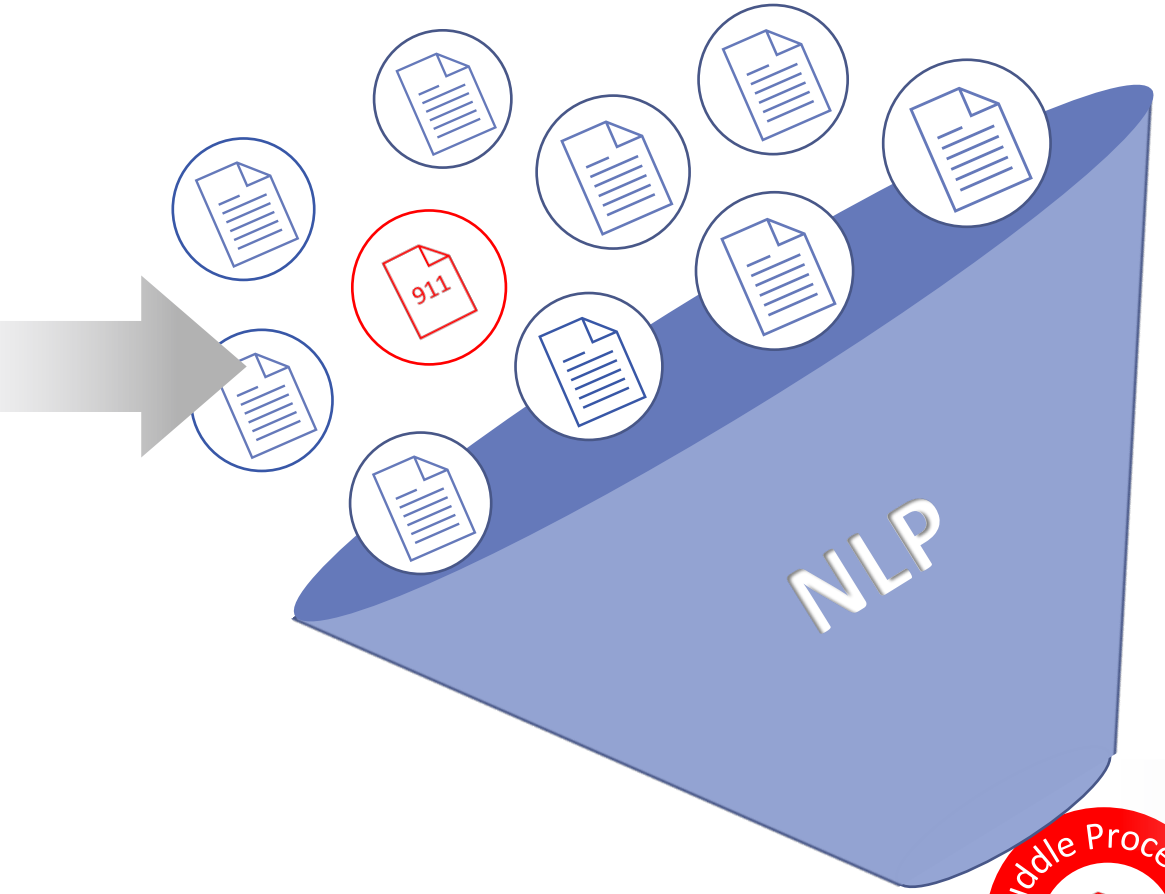
CY 2017 – CY 2022

Identification of Reports Requiring Investigation



Dr. Lee looked dishevled...”

- Culture 48.3%
- Aggressive/Violent 23.9%
- Boundary Issues 14.5%
- Integrity 11.4%
- Impairment 1.9%



Huddle Process

911

Thoughtful Review

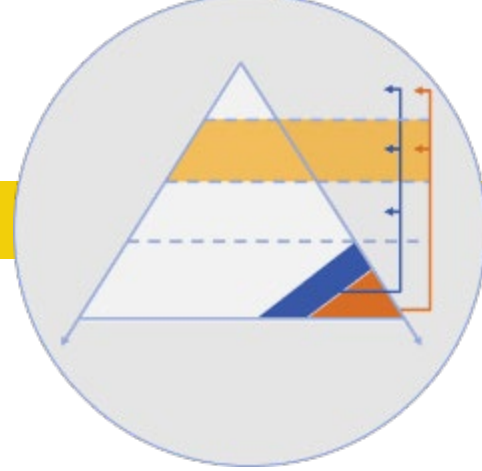
Investigation & Resolution

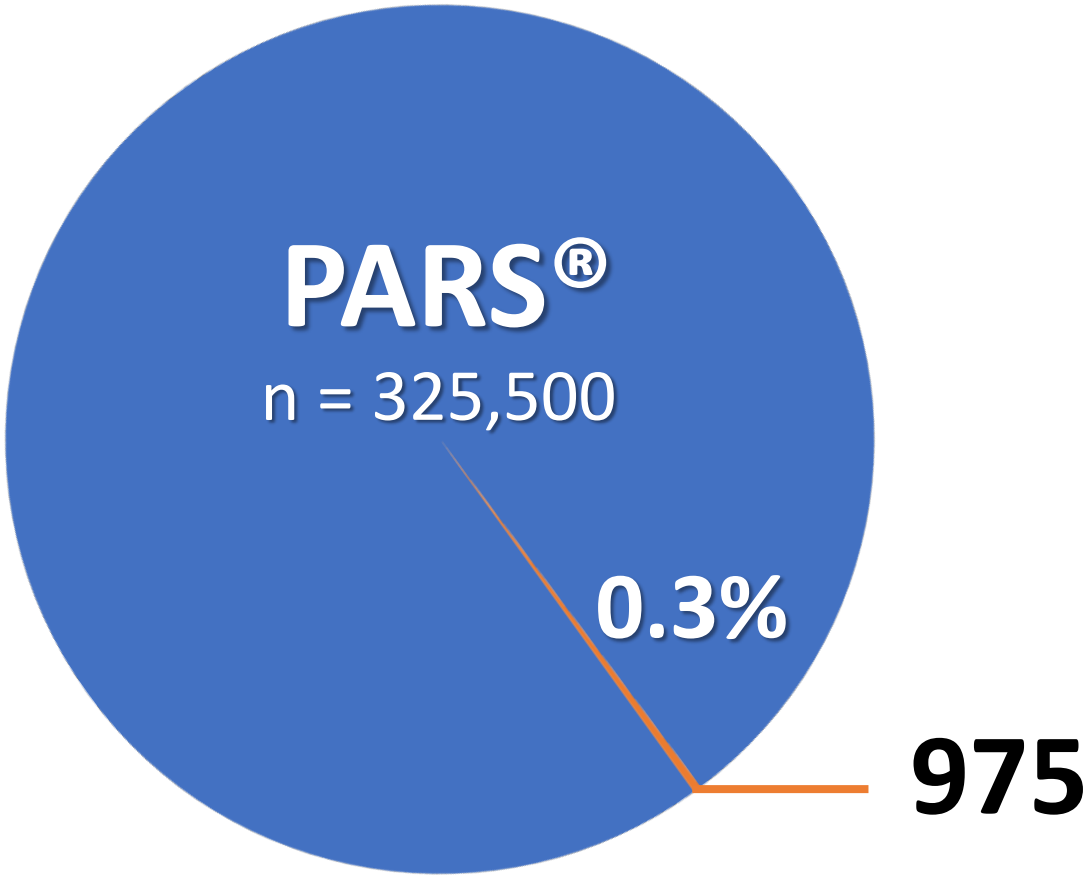
Address Routinely

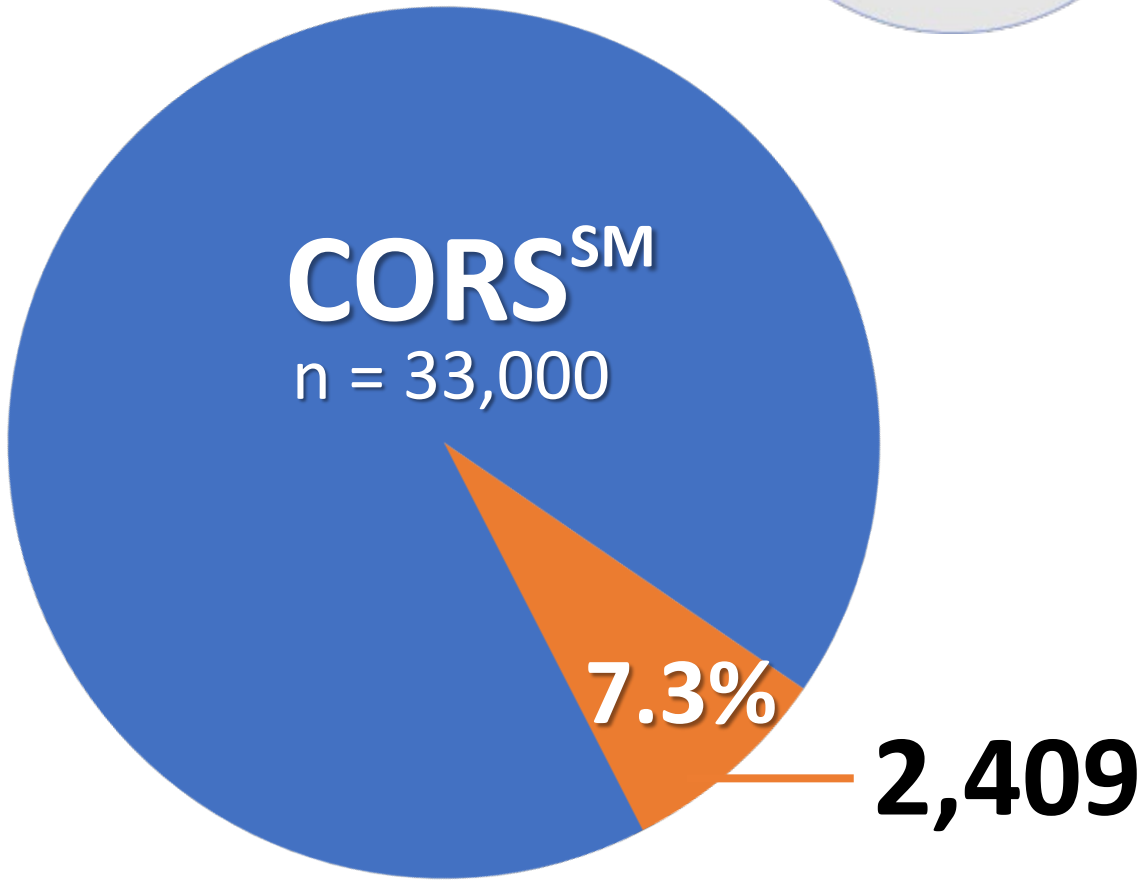
- Reliable Review Process
- Committed Leadership
- Sufficient Resources

Reports identified for investigation?

2017 - 2022







Huddle Process

- Committed Leadership
- Policies and Procedures
- Reliable Review Process
- Tools, Data, and Metrics

CPPA PARS/CORS Huddle Procedure & Script

For Internal Use Only

Purpose

To facilitate a huddle with VUMC leadership for review of potentially egregious reports (Including behavior mandated to be investigated by law, regulation, or policy), and to coordinate appropriate next steps.

Pre-Huddle:

1. Determines if a huddle should be scheduled
2. Schedules conference call or in person meeting as soon as possible with a minimum of 3 appropriate leaders *(CMO, VPMA, Human Resources, GME, Faculty Affairs, Legal Affairs, Risk Management, etc.)*.
3. Distributes report as a protected document:
   - Transmits un-redacted report and/or pertinent information to huddle participants securely *(e.g., using encryption or password)*.
   - Document cites relevant law - e.g., peer review or quality improvement statute(s) - related to privilege and confidentiality.

Huddle Script:

Huddle facilitator follows the huddle script to ensure fidelity of the huddle process:

1. "Please confirm who is on the call."
2. "Did anyone not receive the report to be discussed?"
3. "The purpose of today's huddle is to assess whether report #_____ appears to warrant further investigation."
4. "Is anyone aware of any action that has already been taken on this report?"
5. "Would each person on the call provide his/her perspective on whether the report might warrant further investigation and, if so, by whom?"
6. Provides information on whether there have been previous reports for the professional involved.
7. Seeks consensus from participants on whether the report may warrant further investigation.
8. "Who else needs to be made aware of the report and/or action that needs to be taken?"
9. "Is there any concern about this clinician's ability to safely practice at this time?"
10. "Is there any concern about the clinician's well-being at this time?"
11. "Is there any concern about the reporter's well-being at this time?"
12. Summarizes the recommended actions of the group and confirms the individuals accountable for any follow up action.

Post-Huddle:

Huddle facilitator

1. Records all huddle actions and accountabilities in '911 huddle log'.
2. Forwards un-redacted report to officials evaluating the report for investigation and redacted report* to department/service line official as determined *(Note: Privacy of reporter's name should be protected, except for those who are asked to review the report for further investigation)*.
3. Follows up with those accountable for further review of the report to document the disposition of the report and inform huddle call members of the status of the investigation.

- **Medical Staff**
- **Service Chief**
- **Nurse Admin**
- **Risk**
- **HR**
- **Prof Committee**

1. Purpose: Does the report **warrant investigation** and by **what office**?
2. **Who** is accountable for follow up and **when**?
3. **Who** notifies the **local leader**?
4. Are there **concerns** about:
   a. *The reported individual and their ability to **continue to work today**;*
   b. *The **reporter** and **team's wellbeing**;*
   c. ***The patient***

Promoting Professionalism Pyramid

Leader

Dr. Lee

Committed Leadership

Sufficient Resources

Policies and Procedures

Training

No change

Pattern persists

Apparent pattern

Single concern (merit?)

Egregious

Mandated

Majority of professionals
(provide routine feedback)

Delivered By:

PARS: Authority
CORS: Authority

PARS: Peer Messenger
CORS: Peer or Authority Messenger

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Level 3
"Disciplinary" Intervention

Level 2
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"Awareness" Intervention

Informal
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Mandated reviews

Adapted from: Hickson GB, Pichert JW, Webb LE, Gabbe SG. A complementary approach to promoting professionalism: Identifying, measuring, and addressing unprofessional behaviors. Acad. Med. 2007 Nov;82(11):1040-1048.

Best Practices to Support the Non-Responder

- Committed Leadership
- Sufficient Resources
- Policies and Procedures
- Training
- Tools, Data and Metrics

Design Game Plan

Determine Policies and Procedures

Understand Professionalism Standards

Engage Leaders (including end around strategy)

Identify Wellness Resources

Access to System and Individual Data

Plan for Refusal to Cooperate

Adapted from CPPA Roundtable, October 2017 https://ww2.mc.vanderbilt.edu/cppa/45373

Professionalism Dashboard

Tools, Data and Metrics

Committed Leadership

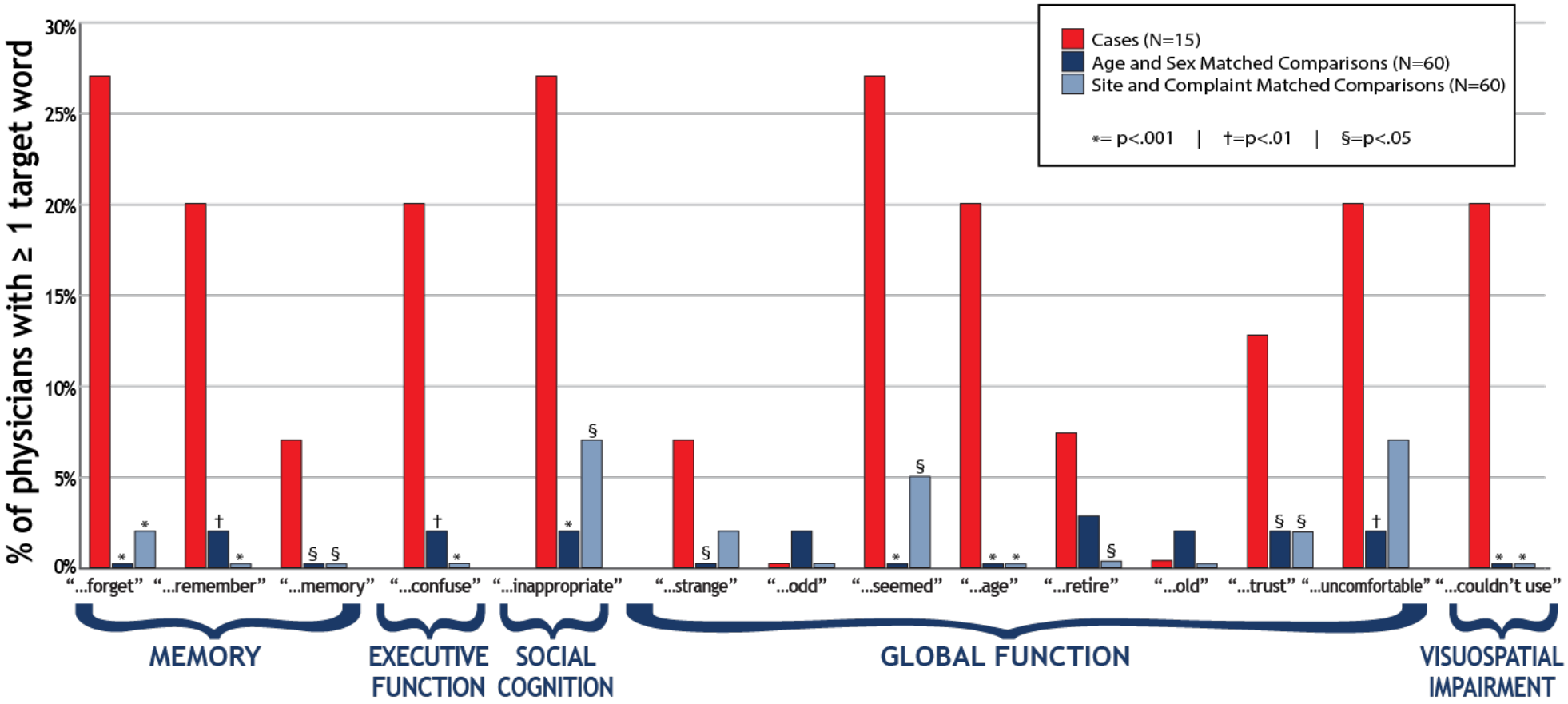
					Professionalism & Interpersonal Communication Skills	Patient Care			Medical Knowledge	Systems-based Practice	Practice-base Learning	
	Name	Department	PARS	CORS	Patient Satisfaction % Likely to Recommend	Patient Satisfaction Quality of Care Received	Quality Metric 1	Quality Metric 2	Mortality Morbidity & Improvement	Service Recovery Completed	Coder Query Response Rate	FPPE - date if applicable. Reassess 6 mos.
→	Lee	AAAA	L2	L1	84.3	81.7	78%	77%	Yes	Yes	47	?
	*******	AAAA	L0	L0	91.5	88.8	85%	90%	Yes	Yes	79	N/A
	*******	AAAA	L0	L0	93.2	91.1	87%	90%	Yes	Yes	96	N/A
	*******	AAAA	L0	L0	78.1	79.2	83%	88%	No	Yes	74	N/A
	*******	AAAA	L0	L0	94.5	95.6	85%	89%	Yes	Yes	90	N/A
	*******	AAAA	L0	L0	77.4	73.9	86%	82%	Yes	Yes	87	N/A
	*******	AAAA	L0	L0	97.1	93.2	87%	87%	Yes	Yes	94	N/A
	*******	AAAA	L0	L0	95.1	90.7	88%	84%	Yes	Yes	95	N/A
	*******	AAAA	L0	L0	78.9	79	82%	82%	Yes	Yes	90	N/A
	*******	AAAA	L1	L0	82.1	83.4	84%	85%	Yes	Yes	79	N/A

Good

Monitor

Address

Can Natural Language Processing Help Identify Clinicians at Special Risk? Words Linked to Cognitive Impairment



AAGP American Association for Geriatric Psychiatry

Cooper, et al., *American Journal of Geriatric Psychiatry, 2018.*

Dr. Lee…

Patient reported:

"Dr. Lee walked in and looked disheveled… I wasn't sure he knew who I was… didn't seem to understand why I was there… is he ok?"

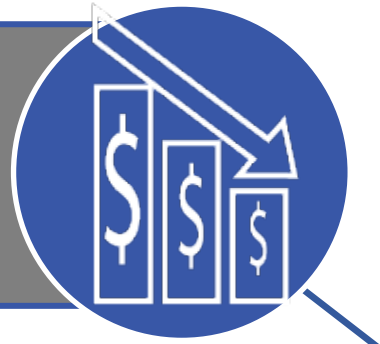
Assessment:

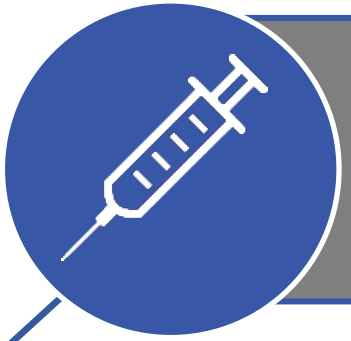
Later… Dr. Lee identified with evidence of early Cognitive Impairment.

Does the VUMC Professional Accountability Model Work?

Improves and sustains hand hygiene practices:
From 50% to > 95% compliance[1]

Reduces malpractice claims & expenses:
By > 70%[3,4]

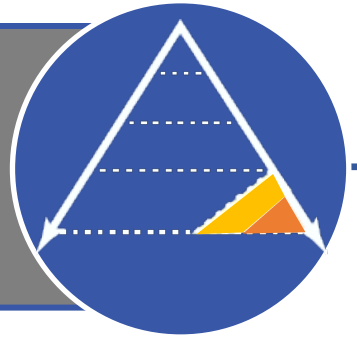




Improves and sustains vaccination compliance:
From 80% to 97%[5]

VANDERBILT®
Vanderbilt Center For Patient and Professional Advocacy

PARS/CORS: Address Unprofessional Behaviors Towards Patients & Coworkers[2-4]

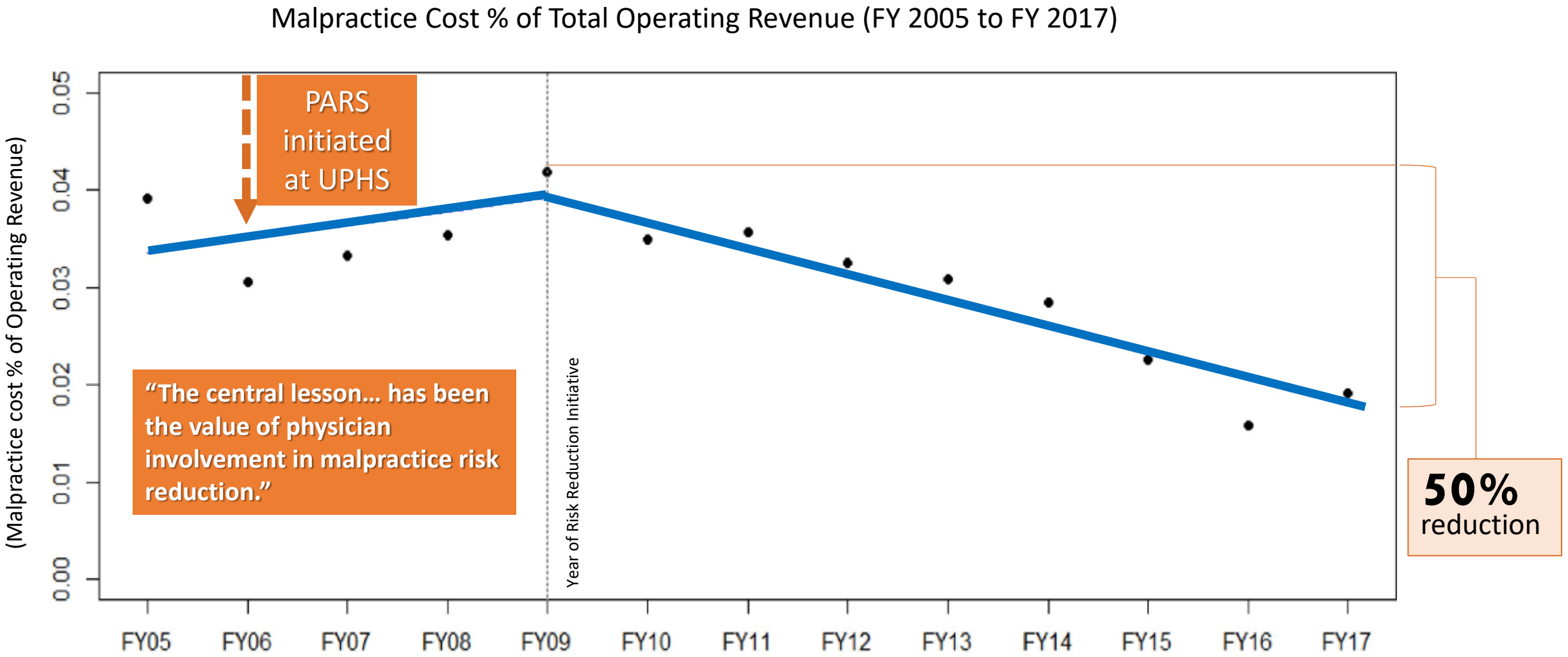


Improves adherence to surgical bundles to reduce infections

JAMA SHEA Journal on Quality and Patient Safety

1 Talbot et al., *Infect Control Hosp Epidemiol*, 2013.
2 Schaffner et al., *JAMA*, 1983; Ray et al., *JAMA*, 1985; Ray et al., *JAMA*, 1986.
3 Catron et al., *Am J Med Qual*, 2015; Webb et al., Joint Commission, 2016.
4 Hickson et al., *JAMA*, 2002; Hickson., *South Med J*, 2007; Pichert, AHRQ, 2008; Hickson, Jones & Bartlett Publishers, 2012; Pichert., *Jt Comm Jnl*, 2013, Webb *Jt. Comm Jnl* 2016
5 Talbot TR et al., *Infect Control Hosp Epidemiol*, 2021

Malpractice Risk Reduction: A UPHS Case Study



Adapted from: Journal on Quality and Patient Safety Diraviam, SP et al. 2018; 44:605–613

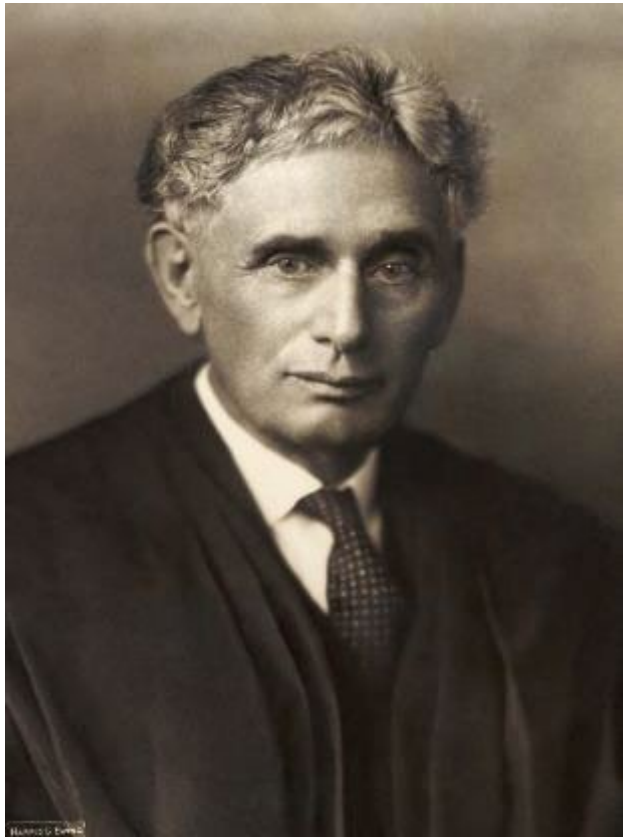
What does it mean to be a professional?

Three Characteristics Define a Profession: Justice Louis Brandeis

Body of knowledge that is owned by the profession; distinguished from mere skill.

Occupation pursued largely for others; financial return not the accepted measure of success.

Obligation for self regulation. *(group regulation too)*



Center for Patient and Professional Advocacy

VANDERBILT UNIVERSITY MEDICAL CENTER

Thank you

Vanderbilt Center for Patient and Professional Advocacy

Or visit: vumc.org/patient-professional-advocacy

Let Us Hear Your Comments and Questions