S1Ep005-E01-Good Clinical Risk Management FINAL

Welcome to Under the Microscope, brought to you by the Right Credentials Network and your host, Dilsa Bailey, a certified medical services professional for over 20 years. Under the microscope is where we will examine the many layers of the medical services profession using the acronym SCOPE. That's scope E, which stands for S services for Onboarding and Maintaining providers in a health care organization, C, credentialing and privileging providers to ensure that they are competent and qualified enough to treat patients safely in a health care organization. O, operations and data management utilizing the health care organizations resources efficiently and overseeing the security of its data. Promoting patient and provider safety and P, provider enrollment affiliating providers with health plans and government payers so that the providers can get paid appropriately, and E, evaluating and monitoring provider performance to ensure patient safety. As a medical services professional in the health care industry, our primary focus is to promote patient safety. Though we do a lot, we can't accomplish this on our own. It takes a village to collaborate. That's why this podcast will also include the contributions of our healthcare partners with the same objectives. So, stay tuned to hear from those other stakeholders in the health care industry, too. Joining us, in addition to medical services, professionals will be experts in risk, legal, revenue cycle, quality, and more. So, stay tuned. Keep us under the microscope so we can help expose all the little details of the medical services profession. We want you to remember how valuable you are to the health care industry.

If you're watching this on YouTube, please subscribe. Drop us a like and hit the bell so you will know whenever we add the latest episodes. And in the meantime, follow us on LinkedIn or reach out to us at info@therightcredentials.com. In each episode, we will discuss a separate topic related to the letter in the acronym of the moment, but we won't be discussing it alone as I mentioned. Each episode will feature a guest who will share their expertise providing advice, training, and support wherever possible. So let's get started with the latest episode, and if you like this one, don't forget to subscribe on YouTube and continue to listen to us on your favorite podcast platform.

DILSA: Welcome back to Under the Microscope. In this episode, we're going to focus on the letter E and the acronym SCOPE and what does E stand for? Well, it stands for evaluating and monitoring provider performance to ensure patient safety. You know, those are the key words ensuring patient safety. And as always, I've invited a guest to walk us through a specific topic or to just help us out, help us understand this specific, a specific area related to the letter E, and today's topic is one that sometimes is very challenging for the medical services professional because in order for us to provide that information to the clinical leadership to assess the provider's performance, we have to reach out to our stakeholders, our healthcare partners in the healthcare organization. So one of those individuals or one of those departments that we reach out to is Risk. So today we're going to talk about what makes good clinical risk management. What are the practices to make that key to helping us? Because we're usually using Risk. And I'll mention a couple other departments that we'll actually use. But today we're

focusing on risk. We use Quality, Compliance, Human Resources, Revenue Cycle, and all of the individual clinical departments. Depending on the type of the organization you're in, and they may have different names because I've come across so many different names for some of the same procedures or the same processes, but every organization is unique, so you'll have to figure out which one of your departments meet this requirement. But today in today's episode, we're going to take a good take a good look at good clinical risk management practices. And we're going to talk to our subject matter expert who I'm so happy to see. I hadn't seen her in so many years Kathleen Pendleton yay yay yay. Now Kathleen is our guest, who will be talking about the contributing factors that are available to determine whether a provider should continuously or is continuously fit to be affiliated with your organization. And I know that's a mouthful, but you want to remember these two words continuously fit to be a part because, um, you want to make sure we have the right people in the right place treating our patients safely. So that's right. Kathleen, welcome to Under the Microscope. I'm so glad to see you again. So glad we're still in the health care game. But after I jump into all the questions, because I know everybody is waiting with bated breath to find out how this all works together, can you tell us about your experience, period. And especially with clinical risk management?

KATHLEEN: Oh, sure. Okay. Thank you for inviting me today. It's awesome to be here. So I have worked in clinical risk for, I hate to say it, many years. I'm not going to say how many. Um, I'm certified in clinical risk, patient safety and health care quality. So I currently work in patient safety. But I do maintain my risk certification. And I still, as you know, because I post on LinkedIn a lot, I still keep my hand in clinical risk management, did it for a long time and had some really great leaders like you that I learned a lot of information from. So I love being here and I'm happy to be part of your process.

DILSA: Thank you. I'm so happy to have you. I'm trying to promote collaboration between all our health care partners. We all have to work together to make sure our patients remain safe.
KATHLEEN: That's right.

DILSA: Yeah. So I'm going to jump in the question into the question. So. Sure. Yeah. So why is the provider credentialing process good clinical risk management.

KATHLEEN: Well, that's where risk management really starts. You want to make sure the providers. And this isn't just for physicians. This is also for advanced practice providers. You want to make sure that these folks are who they say they are, what their medical malpractice background looks like. And just generally, are they going to fit into your culture and your safety culture. So when you're evaluating that practitioner and I'm going to say practitioner and or physician, you want to make sure that they have the background that you're looking for. I'll give you an example. There's been a lot of stuff in the media recently about physicians that or people that represented themselves as physicians that really weren't, right, or they appear in hospitals and say, I'm Doctor so-and-so, and everybody just takes them

at their word and they're touching people and trying to take care of people, and they're not physicians or advanced practice practitioners. So I think looking at that process, you want to make sure, yes, this person is legitimate. They've had the background. They say they have. They have the education, they say they have, etc. And that's really where your risk management starts because, you know, if you have an adverse event. It usually does involve a practitioner. So when all that comes out in a litigation, and everything comes out in litigation except for the peer review part, which is protected. So they're going to look at, you know, did this person really go to XYZ medical school? Did they do this residency. And that's really incumbent on the medical staff team and professionals to validate. Yes, this person is legitimate. What's their background look like? What is their medical malpractice background look like. Are there any red flags here? And I really appreciate that. And I was taught like, that's really where your clinical risk starts is with the credentialing process.

DILSA: Yeah, I agree. I mean it fits the if the credentialing department did not exist or the credentialing process did not exist, our patients would be in dire trouble.

KATHLEEN: I mean, oh my God, yes.

DILSA: And I'm like you, I see all of that good stuff on the news and and wonder, you know, how did they get in there and how, you know, how did they walk around like they were, um, physicians and. Right. You know, it's like. What we do is very valuable. And yes, you know, it is the gate. We are the gatekeepers. I know that's the the motto. Yes. Motto for the NAMMS organization. But yes, we're definitely the gatekeepers. So the next question I have for you is what can we do if we already start processing a provider and we realize he's or she is not a fit?

KATHLEEN: That's a time when you escalated up the chain of command and say, hey, you know, chief medical officer, vice president of medical affairs, and that's usually who's involved in that process, or take it to the medical exec committee and say, you know, I have some concerns about this, or our team has some concerns about this, and these are what the concerns are. And, you know, physicians, the Med Exec Team is made up of physicians. They want to know just the facts and they want to know it very clearly and concisely. So you can't go in there and be like, well, I have a dissertation about why this person isn't a good fit. You need to say this is why. Bullet point, bullet point, bullet point. You know, this is why this person's not a good fit. And I think it's scary to do that because it can be intimidating, an intimidating atmosphere. But hopefully if there's a collaboration, a good collaboration, you feel okay going in there and saying, I have concerns and they trust that team enough to say, okay, what are the concerns? Because that's really where you want to catch it right before the person starts, because once the person signs their contract and you know this and they start, it's much harder to get that person out of the organization because of the way the laws and rules and regs are set up. And you have to have the due process. So it's much easier to do it in the front and say, hey, this person may not be a good fit and this is why. And then if they, you know, send it through or

say, we need to talk to the attorneys or whatever and they get vetted to come in, then, you know, you've done your due diligence and you've done what you can.

DILSA: Awesome. Yeah, that's that's a great way to explain what to do because I know, um, especially working in the hospitals, you can get very intimidated because most of the time, a lot of the time, you get face to face with these people who don't want you to block them or block the person that they're trying to come in, come in the door and they will, um, confront you. Um, but you have to, you know, follow the guidelines and, and, and, and follow your gut too.

KATHLEEN: And that's also, I'm sorry, interrupted. You go ahead. I'm sorry.

DILSA: No, you go ahead.

KATHLEEN: I was going to say that's also the time you can bring risk in and say, you know, I've taken this up to the physician, you know, chain of command or medical executive team. And I want to let you know as well. And I will tell you that there is an avenue to work with the attorneys. And say, hey, you know, there's some concerns about this physician, you know, and they may be able to opine not from the corporate standpoint, but from the medical practice standpoint and say, hey, you know, we've seen a case like this before or we've seen a similar situation, and you can take that as well as part of your case as to why that may not be a good fit.

DILSA: Okay. Great advice, great advice. Kathleen. Now here's a good question for you. I know some MSPs, some people in my profession may be new and they may be listening to this just to get some information, but then there are some who may be in an organization that does not require this because of the organization type. But tell us about the National Practitioner Data Bank. Mhm.

KATHLEEN: Yeah. Um it's a good tool. It's a great tool.

DILSA: It's a great tool. Yeah. So how is that credentialing. How is that used in the credentialing process for risk management.

KATHLEEN: So I will say I have kind of limited experience with this. You probably have much more experience, but I do know that that is part of the credentialing process, and it does have information about the physicians that has to be reported, usually codified, you know, like in a law. And it will say, if you have a medical malpractice lawsuit over X number of dollars, it has to be reported to the National Practitioner Data Bank. And that I wouldn't say it's by law. It's like by regulation with the medical boards. So as part of credentialing process, the credentialing professionals will pull that information and say, okay, this practitioner may have, will be specifically physician may have X number of lawsuits. And then they can ask that physician, can you give us some more information about this?

Right now? You know, sometimes with litigation people get angry and they sue. But I mean, if you see a pattern and you start seeing a pattern over different states too. Like, you see some in Florida and you see some in Alabama and you see some in New York, and they're similar, you may have a pattern there of practice behaviors you may not want in your organization. Right. Yeah. Especially in today's litigation environment.

DILSA: Yeah. So it is a great red flag for especially the medical malpractice cases. Um, and that was the other thing I was going to ask is what if a provider has med malpractice. But you just described what would be a concern. It's like what are those patterns. Because are they continuously operating on the wrong site, you know. Right. Do they have maybe they have a whole bunch of little, um, claims that were settled, but why do they have so many?

KATHLEEN: You know, that's right. That's exactly right.

DILSA: So those are the kinds of things that affect credentialing. And that's when also risk needs to take a look at that. Because I know in some organizations risk um, is involved with the malpractice because the organization provides like, um, an umbrella. That's right. Umbrella insurance policy. And they bring risk in to look at some of that data. And in order to make sure that there's no pattern that's, you know, exceptional that says we don't want to cover this person because we're going to end up putting out all this cash for that.

KATHLEEN: That's right. That's exactly right. Yeah.

DILSA: So here's a question for you, too. Um, and I think this is this covers credentialing and risk. How about the practitioners provide their private lives like divorces, traffic tickets, DUIs. Um, should we be Googling these practitioners? How does that you know? Yes. Are we getting too invasive?

KATHLEEN: No. You're not. And I'm gonna give you an example. And this is a public example, and I'm not going to name names, but this is a recent example. And then I'm gonna give you another one. So the first example, there was a case out of Texas where a physician was tampering with I.V. bags in an ambulatory surgery center. So that turned into a criminal case and a medical malpractice case because there were lots of patients harmed, a patient died. So there was a lot of med mal medical practice around that. But there were also some criminal issues. So it came out with this physician that he had several criminal issues, although they were small, but like a divorce and a neighbor situation and things like that came out. That should have been red flags to the credentialing folks, but for whatever reason that they didn't know, or maybe they knew and thought, well, not really that big of a deal. But then all of that turned into this tampering case with the IV bags, because he tampered the IV bags because he was angry at the facility.

DILSA: Oh, wow. That part I didn't know, right?

KATHLEEN: Why he was angry? Because he was being investigated for some standard of care issues, and he got upset at being investigated, and this was like a retaliation. So and this is all public information that's out there in the media, not mentioning names. That is a real case. Another case that I personally was involved in is we had, actually when you and I worked together, we had a physician who had a very active social media presence, and some of it was not very savory. And that started coming out of medical malpractice cases, because at that time there were limited privacy settings on social media. Yeah. So all of this information was public and anybody could see it. So I always teach when I teach like new resident orientation or new nursing orientation. All your social media is discoverable. Every bit of it doesn't matter if you have private you you know, you say that you only have five followers. It doesn't matter. It is all public information, LinkedIn, Instagram, Snapchat, Tik Tok, Facebook all of that is discoverable. So if there are pictures of practitioners drinking, smoking marijuana, um, you know, doing other things, wearing inappropriate clothing. People judge that and they're going to say, and I saw this happen with my eyes and my ears, you know, okay, there's we have a picture of you drinking an alcoholic that what seems to be an alcoholic beverage. Are you drunk right now? Were you drunk the day this event occurred? Do you have a drinking problem? Do you drink and drive? Do you have a DUI? Should we do a background check on you? This all was in a deposition. So people have to understand that physicians and nurses are held to a higher standard. So when people see this, they're going to judge it. And the plaintiffs' attorneys have a field day with it. So in my opinion, yes, I do think you need to Google people, look at social media. And, you know, we had to have our attorneys tell the physicians you need to pull back your social media if you have inappropriate things on there or what other people may deem to be inappropriate. So you and all of that is discoverable. Text messages are discoverable. All of that is discoverable information in a lawsuit, whether it's a divorce, a lawsuit with a neighbor or a friend or a family member, or a medical malpractice lawsuit.

DILSA: Now. And it never goes away. Never goes away. It goes away.

KATHLEEN: Snapchat does not go away. People think, oh, I'll do a Snapchat and it disappears in a minute or whatever. No it doesn't. They have records of all of that. Yeah.

DILSA: Wow. Maybe the practitioner should be listening to this too, right?

KATHLEEN: For sure. But it's good to know because a lot of people don't realize, you know, like they get in a car wreck and they sue, right? And they think, oh, well, my social media is mine. It's private. No, it's not private. No, neither yours or the person that hits you. So it's not just medical malpractice. It's really for anybody.

DILSA: That's true. Wow. You know, we're all, you know, open to the public. Every last one of us, you know.

KATHLEEN: Uh, yesterday I was asked if I wanted to have another session. Yeah.

DILSA: Yesterday, I was asked if I wanted to apply for a credit card in a store I was in, and I said, no, I don't want to give anybody else any more information about me, right. It's like, that's enough. I don't need to give out anymore. That's right. You know, and, you know, and I mentioned before I was like, are we getting invasive? But there are concerns these days. And I know some, some concerns out there about how much we should know about a practitioner's mental health and their current status with substance abuse. Um, I know there's some application changes going on where we can't ask, can only ask so much now. You can only ask about their current and not their past. I think, you know, I need to go back and review that piece, but I know that change is coming down the pike in a lot of different areas. Um, does that fall under what you would consider a clinical risk management concern? Because, yeah, burns me a bit.

KATHLEEN: Yeah, yeah it does. And so I know there's a lot of physicians out there, especially younger physicians. They're really championing not discriminating against people that have mental illness. And there's one physciain, in particular he's a resident right now, and he's got a very active social media where he claims, he says, you know, I had mental illness and I'm becoming a physician and I'm, you know, working through that. And it's perfectly fine. And I definitely see that. I totally see that. The problem is, unfortunately, when you get into a medical malpractice lawsuit, all of not, that doesn't become discoverable because that's HIPAA protected information. But, you know, the plaintiffs' attorneys will fight to get that information and they can pull like DUI and things like that. Um, and I will say, you know, in this and you know, this everywhere you go in Atlanta smells like marijuana. I mean, literally everywhere you go when you go to a restaurant or you're driving down the street or whatever, people are smoking weed, like everywhere you go, and it's become much more normalized. But then you have to ask the question, do you want your physician to be impaired in some way when they're practicing medicine? And is that okay? And I think that will probably modify in the next few years as we work through all those issues with the more relaxed requirements of what we consider to be drug use. But I and it's become more normalized. But I think also perception is often people's reality. So I do think that that comes into play. Um, you know, if you have a, let's say, a team member of the facility that's questioning the physician or APP's state of mind, and they refer them for drug testing, let's say that they it's a they decide, okay, we're going to test this person for drugs. And they turn out to be positive. You know, a lot of times they will send the physician for treatment. You know, that they'll send nurses for treatment to try to get them to a place where they can come back into the organization. And that's a total sea change. It used to be like they were gone. But now it's like, we're going to send you for treatment and then see how you do and then invite you to come back and we'll work with you. So I think that's changing. But also that perception too is out there. Like, do you

really want your physician? Because sometimes people think, well, they smoke marijuana, they're fine. But if they have four margaritas, they're not fine. But then really, what's the difference? So you know, you're still taking something into your body that's modifying your, your mindset. So but I think all that's going to change the next few years, I really do.

DILSA: Yeah. Um. It's, you know, I can see it from both sides, I really can. Um, it's just that when I also read all the cases that when you come in, when you're credentialing and you see all the cases and you're going like, how did this one get through? You know. Right. So there's, there's, um, you know, there's the good side and the bad side, you know, it's but it all still all boils down to patient safety. So you got to figure out how to make sure that balances out somehow.

KATHLEEN: Yeah. And you know, the way I always look at it, and you and I dealt with this when we worked together. We had some folks that were doing TV shows. Mhm. You may recall that. And you know, there was a lot of chatter about like how is that going to affect this person's job and is it going to affect their job. And how is that going to look. And it is I understand and I remember it didn't end up great. And there was a lot of like, what do we do? So I think we're starting to get more into uncharted territory with media, social media, you know, there's a lot of physicians that have very prominent social media accounts. And me. The first thing I do when I see especially one particular physician comes into mind. I always think this is going to be gold to a plaintiff's attorney. That's what I'm always thinking in my mind, because they're going to look at this and be like, well, were you busy making a Tik Tok or were you taking care of your patients? And when you were taking care of your patients, were you thinking about making a TikTok? And when you're driving your $100,000 car. Are you stealing money from your patients? You know, this is all the stuff I'm thinking in my mind, right?

DILSA: Are you exposing the patients information, you know. Right.

KATHLEEN: Exactly, exactly. Are you exposing their information? Are you giving medical advice that you, as a physician shouldn't be giving because it's about another subject? Yeah. So I really think that that's going to be a new thing to deal with in medical malpractice. Plaintiff attorneys will love it, though. And I tell you,

DILSA: yeah, they're gonna have a field day.

KATHLEEN: Yeah. And I think that something credentialing should ask now actually, is do you have a social media presence and what is your Instagram? What is your Facebook? Do you write books? Do you have a blog? I think we probably need to know all that information and not be surprised.

DILSA: Yeah, I think you're absolutely right about that. Yeah. Very good advice. Yeah, I agree with that. Now let's see. Next question is. Can you explain how quality metrics specific to the practitioner, how that's used in the credentialing process from the clinical risk perspective?

KATHLEEN: Sure. That's really, um, like our clinical peer review folks. But what they do is they look at what's called OPPE and FPPE. So they're looking at like a snapshot of their quality and then their continuing quality metrics. And if they start seeing anything going wrong, so to speak. And I don't want to say wrong in a bad way, but let's say, you know, like you said earlier, let's say you have a surgeon who had no wrong sight procedures for three years, and all of a sudden they have four. You know, they would bring that up to the med exec committee probably, and say, hey, we have something going on here you may want to take a look at. Right. So they have certain metrics they look at. We have our incident reporting system that's for risk that has any adverse events in there. Anything that's out of the ordinary that happens for patients that we can look at from Risk. And I used to bring it up to my supervisors and say, hey, I'm seeing a pattern here. Let's dig into this a little bit more. Is it the same physician every time? Is it the same team? You know, is it the same type of patient population? You know, what's going on? Like let's say you see a medication error and you're seeing the same one over and over, you know, is that a pattern. So that type of thing. So there's different ways you can find that information. But primarily it's through that OPPE and FPPE process, practice evaluation is what it's called okay. Yes ma'am. Yeah. And that's usually mostly in a hospital setting. Yes, ma'am. It is okay.

DILSA: Yeah. All right. Um, so you mentioned some of the concerns that would be raised under the OPPE and FPPE. Um. What do you think is. Well, I think you probably answered that question too. Well, it's because you mentioned that this could be based on the frequency of the concern. And also I was wondering the severity level, or would that be what would trigger the first, the frequency or the severity. And I guess probably both would be triggers. Oh yeah.

KATHLEEN: Both. You know, we're very outcome driven in healthcare and very severity driven. So we have a tendency this is where my just culture stuff comes in. But we have a tendency to overlook the events where there's no harm. So that's your frequency. So if you're seeing these events and even if there's no harm, and when there is harm, it's the same behaviors. It's just you had a different outcome. So I think we as healthcare could get better at evaluating those no harm events, instead of just looking at the events where harm occurred.

DILSA: Wow. Yeah. And you mentioned that the continued behavior. That's. Yeah. Yes, definitely. The behavior. The same behavior.

KATHLEEN: Yeah. That's right. Yeah.

DILSA: That's right. Because we've both seen that.

KATHLEEN: Yes we have. Yes we have. Oh yes.

DILSA: Yes. Okay. So um, do you guys get the patient complaints in risk management as well. Have you, do you come across those or how their how are they considered, you know as part of the do the practice evaluation. Yeah.

KATHLEEN: Yes. So I used to have to give those to our credentialing team. So every quarter they would send me a list of physicians. And I would have to look in our grievance log and say, okay, we've I'm making this up. We've had five complaints against doctor A and four complaints with doctor B, and then I would send that. And if they wanted more information they would come back and say, okay, can you tell me what types of complaints these were? Were they, you know, from patients, from family members, you know, was was it substantiated, like that kind of stuff. So and if it went to peer review, I would just tell them, you know, I referred this to peer review and I'm not privy to that. So I would just tell them, you know, this was referred to peer review, but they were really looking, in my opinion, for volume. So are we getting the same complaints for the same practitioners? And then that information, like every quarter I would give to the credentialing folks.

DILSA: Okay. Wow. Well, this has been very interesting, Kathleen. Thank you so much. Very informative. You know, very supportive. I you know, I know this is going to help a lot of people. And before I end this though, I want to ask your question of what's your contact information. How can you reach out to you and get get more information or to ask you questions or to get your help?

KATHLEEN: My email people can email me. I'm happy to help would be the talk. Dilsa, you can help too, so I'm happy to help as needed.

DILSA: And you're also on LinkedIn. You know, we're very I am on LinkedIn.

KATHLEEN: On LinkedIn, yes, I am on LinkedIn. And you can contact me there anytime. You can email me through LinkedIn.

DILSA: Awesome. Thank you so much, Kathleen, and I want to thank the listeners for listening in and listening to this valuable information. You know, we'd love to get your feedback here. If there's anything else you'd like to know, because I'd love to have you back again, Kathleen, I'm sure. Oh, Pick your brain. Aw. And as usual, folks, if you're listening or if you're watching us on YouTube, please hit the subscribe button. Hit the like button, hit the bell so you can hear about us again. And please share these podcasts with other medical services professionals and the other stakeholders in your health care organization. People like Kathleen, who can be very helpful and, um, you guys need to

collaborate, collaborate with each other and collaborate with your health care partners, because I want absolutely everybody to remember how valuable the medical services profession is and how valuable we are, we all are when it comes to patient safety. Remember the bottom line is patient safety. So that's right. Kathleen, thank you again for joining us and covering so many layers of the medical services profession. And I want the listeners please have a great day or a great evening, whatever time frame you're listening to this. Have fun listening to it. Come back and visit us again and share it with everybody in your hospital or your your health care organization. Share it with the medical services professionals so we can all help each other, um, learn and grow. Thank you.

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