"The importance of ethics in vascular surgery: how to resolve interspecialty conflicts and remove bad doctors with poor outcomes: turf issues cannot be allowed to trump quality care"
Dr. Frank Veith

"How do we ensure the best, well-trained doctors do the right procedure for the right reasons and best outcomes with hospital guidance"

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Current Environment for Hospitals’ Assurance of Ongoing Competency

- Increased emphasis on continuous improvement in medicine:
  - CMS initiatives: value base payment models/penalties
  - Hospital financial performance: quality of clinical care
  - Evidence based medicine
  - Pressure to respond to rapidly evolving technology
  - Safe care

The ‘Typical’ Vascular TURF

- Community Hospitals
  - Independent physicians
  - Large Multispecialty Group/Employed MDs
- Vascular Procedures: Interventional Cardiology, Radiology, Vascular Surgery
- Early Years 2000s: Turf Wars and care concerns
  - AAA EVAR complications
  - Carotid Disease: CAS vs CEA
  - Endovascular Revolution
- Privileging/credentialing at hospital level
  - volumes, skills, training and quality

Vascular Care

- Opportunity to improve vascular quality and conflicts
- Need an objective catalyst to kick start the process: VQI and HVI
- Making good progress resolving ongoing quality, cost and service issues
- Learning process
- New hospital policies and protocols

The Turf is Bigger

- Many specialists now have vascular skills
- All well trained at some level
- IC, IR, VS all have the skills and understanding of vascular disease
- Quality results important
- Making vascular care a key piece of practice is key
- Vascular Specialists need to commit to a full spectrum vascular focus

Disclosures

- No financial conflicts with talk
SVS Guidelines in Review

- SVS Working Group: Guidelines for Hospital Privileges
- Public comment period
- Inclusive guidelines (VB, IC, IR)
- Reference for hospital credentialing committee: hospitals have own responsibility for safety and numbers
- Minimum annual case volume is beyond scope of SVS and other specialties: no real data
- Agree with 1 year of training devoted for PVI for cardiologists in addition to coronary intervention training
- Support Joint Commission: OPPE and FPPE
- Registry participation

What are the hospital options for better care?

- Organized, Focused Peer Review
- OPPE
- FPPE
- Using physician leadership and objective data to drive center excellence and “best” providers and practice programs

Characteristics of Contemporary Peer Review

- Less reliance on chart review than in past
- Greater reliance on data review
- Performance indicators are reviewed regularly
- Peer review committees are interdisciplinary - less department based
- Physician feedback is routine
- External peer review judiciously utilized

Peer Review Case Rating Form

Overall Patient Outcome:
- No adverse outcome
- Temporary Adverse Outcome
- Permanent Adverse Outcome
- Death

Overall Practitioner Care:
- Practitioner Care Appropriate
- Practitioner Care Inappropriate
  - The vast majority of Practitioners on the committee would not have provided care in that manner under those circumstances and the level of significance of issue was relatively high
  - Further Review Required
    - The majority of Practitioners on the committee would not have provided care in that manner under those circumstances
    - The care was not clearly inappropriate but an alternative approach was viewed as consistently better practice
    - While the care was not inappropriate, the level of significance of issue was relatively low
  - Practitioner Care Exemplary

Performance Improvement Tools

- Periodic performance feedback reports
- Mentoring from clinical colleagues
- Verbal feedback from peers, including medical staff leaders;
- Proctoring (concurrent, retrospective, and prospective);
- Traditional peer review - i.e. chart review
- External peer review
- FPPE and OPPE
- Root cause analyses and FMEAs (Failure Modes & Effects Analysis);
- Written communications from physician/hospital leaders, including: letters articulating and reinforcing performance expectations and deviations from such expectations; letters of reprimand; letters of warning regarding possible formal consequences for clinical or professional conduct
Ongoing Professional Practice Evaluation (OPPE) allows the organization to identify professional practice trends that impact on quality of care and patient safety. Such identification may require intervention by the organized medical staff. This is information is used for privileging.

Criteria may include the following:
- Review of operative and other clinical procedures performed and their outcomes
- Pattern of blood and pharmaceutical usage
- Requests for tests and procedures
- Length of stay patterns
- Mortality and morbidity data
- Practitioner’s use of consultants
- Other relevant criteria as determined by the organized medical staff

* The Joint Commission (TJC) Standard MS.08.01.03-Ongoing Professional Practice Evaluation

Focused Professional Practice Evaluation (FPPE) is done for a defined period during which the organization evaluates and determines the practitioner’s professional performance.

The organized medical staff:
- Evaluates practitioners without current performance documentation at the organization
- Evaluates practitioners in response to concerns about the provision of safe, high quality patient care
- Develops criteria for extending the evaluation period
- Communicates to the appropriate parties the evaluation results and related recommendations
- Implements changes to improve performance

* The Joint Commission (TJC) Standard MS.08.01.01-Focused Professional Practice Evaluation

Large Bore Policy: Community Hospital

- Purpose – ensure patient safety and informed consent
- Non-surgical provider complications noticed by VQI data
- Coverage – arterial vascular procedures with introducer sheath 14F or larger
- Policy – multi-disciplinary team evaluation. Surgery coverage and assigned.
- Chart documentation

Large Bore Pre-op Attestation Checklist

- Pre-procedure Evaluation
  - Physical Exam
  - Fluoroscopy
  - Ultrasound
- Pre-procedure Protocol
  - Peripheral Nerve Block
  - IV Access
- Pre-procedure Results
  - Arterial Pressure
  - Oxygen Saturation
- Pre-procedure Consent
  - Written
  - Signed
- Pre-procedure Documentation
  - Complete
  - Verified
- Pre-procedure Medications
  - Intravenous
  - Oral
- Pre-procedure Laboratory
  - Complete
  - Verified

Large Bore Arterial Pre-operative Procedure Checklist

- History and Physical Examination Complete
- Informed Consent
- Arterial Lines
- Hemodynamic Monitoring
- Transluminal Angioplasty
- Percutaneous Transluminal Angioplasty
- Angiography
- Angioplasty
- Embolization
- Balloon
- Stent
- Catheterization
- Implantation
- Surgery

Large Bore Arterial Post-operative Procedure Checklist

- Postoperative Evaluation
  - Vital Signs
  - Pain Management
  - Neurological Function
  - Hemodynamic Monitoring
- Postoperative Results
  - Complete
  - Verified
- Postoperative Complications
  - Bleeding
  - Infection
  - Nausea/Vomiting
  - Other
- Postoperative Medications
  - Intravenous
  - Oral
- Postoperative Laboratory
  - Complete
  - Verified
- Postoperative Radiography
  - Complete
  - Verified
- Postoperative Discharge
  - Complete
  - Signed
- Postoperative Follow-up
  - Complete
  - Signed

Physician’s Name: ____________________________  Signature: ____________________________  Date: ____________________________
Large Bore Compliance

Success Factors

- Administration support from C Suite
  - Focus on quality and costs
- Heart and Vascular Institute staff
- Physician Leadership crucial
- Physician transparency makes change possible
- The Mirror test

Conclusions

- Forget “turf” in 2018
- Focus on the patient care and outcomes
- Have the best training, skills, outcomes and have data to back it up
- Commit and dedicate to vascular care
- Be active in Peer Review
- Consider FPPE and OPPE
- Document the difficult journey

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Challenges to Hospital Assurances of Ongoing Vascular Competency

- Less hospital-based practice
- Lack of a single “gold standard” for maintenance of competency: Board certification, differences among national professional organizations and specialties
- “Turf wars”: specialty ownership and conflicts

Care Opportunity

- Transparency on provider volumes and quality
- Center opportunity for Improvement reports
  - CEA and CAS debate
  - Lower extremity bypass infection data
  - AAA EVAR volumes, LOS, complications and costs
- Privileging and re-appointment volumes important to insure quality: Hospital
- Foster change
  - Change is not easy for low volume providers
  - Mirror Test and challenges
**OPPE Mechanism**

Adopts rule and rate based indicators as a tool to identify cases for review
- Requires a comprehensive list of performance metrics
- Periodically reviews physician performance to metrics
- Metrics will be revised as needed to optimize value
- Employs an electronic tracking tool for consistency and oversight

The information used in OPPE may be acquired through:
- Periodic chart review
- Direct observation
- Monitoring of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, and nursing and administrative personnel

**Current Practices in Assuring Ongoing Competency**

- Using OPPE and FPPE to assess competency in the “gap” periods
- Changing focus of “peer review” from being associated only with disciplinary process.
- Changing focus to “clinical quality” reviews: routine reviews and collaborative reviews of all practitioners, just not those whose cases “fall out” on indicators.