Addressing the Underperforming Clinician: A Leadership Challenge

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Medical groups striving for high performance often encounter the challenge of underperforming clinicians. This article examines common areas of low performance — productivity, clinical quality, and patient experience — and provides strategies for leadership to address and improve these issues. Productivity concerns are often linked to inefficiencies in interview skills, support personnel utilization, or electronic medical record (EMR) competency. Clinical quality issues may arise from inadequate patient monitoring, reluctance to adjust medication, or hesitation to escalate treatment plans. Low patient experience scores frequently stem from ineffective communication or a lack of empathy during patient interactions. Interventions such as shadowing, coaching, additional training, or peer mentoring can help struggling providers enhance their performance. Leaders must assume positive intent and provide support, while remaining prepared to address a lack of improvement through crucial conversations. By implementing targeted strategies, organizations can foster growth and minimize the need for more drastic measures.

KEY WORDS: Underperforming clinician; leadership challenge; medical group performance; provider productivity; clinical quality improvement; patient experience scores; EMR competency; peer coaching.

With the goal of providing timely access to high-quality, efficient care, successful medical groups set expectations for the performance of their providers. These standards usually include the categories of productivity, clinical quality, and patient experience, among others. The specific standards are most often created based on nationally accepted benchmarks, reported on a specialty-specific basis. In many groups, high performance in these categories is incentivized within the medical group's compensation plan.

For organizations that seek to be considered as a "high-performing" medical group, the standards are usually pegged at median or higher (e.g., target productivity is typically set at the 50th to 65th percentile wRVU productivity per specialty). This is a noble goal, yet the very definition of median implies that in any sizable group, there will be providers who fall below the median.

While organizations understand this phenomenon and allow for some degree of drift below median, high-performing organizations are adept at identifying those providers who continually fall seriously below median. These providers deserve attention from leadership to ascertain the reasons for low performance and to be given the opportunity and support to improve.

This article addresses the three most common categories of low performance and how they may be approached. For simplicity, primary care will be used as an example, although similar approaches may be applied for other specialties as well.

LOW PRODUCTIVITY

There may be no more frustrating situation for medical group administrators than the dreaded combination of high demand, poor access, and low provider productivity. Yet, this combination of factors is all too common.

Here, we are not speaking of the provider who has appropriate visit volumes and low wRVUs, as that is usually solved by addressing coding and documentation habits and should be easily resolved with education. Nor are we including the provider with a reputation in the community for delivering poor care with low quality and patient experience scores. These are addressed later in this article.

For this category of underperformance, we are singling out the clinician who simply sees too few patients compared to their peers. While the problem can easily be identified by looking at their schedule, one needs to dig deeper than just a visit count to be able to find a solution. Unless the

schedule template is rigorously managed centrally, it is often discovered that the provider has managed to adjust their template to allow fewer visits than expected — fewer than what is needed to achieve the target of median productivity. The administrative task then is to figure out why this is happening.

The answer usually lies in uncovering a struggling provider rather than a lazy one. The lament that "I need more time with my patients" can represent a cry for help. In this regard, there is no substitute for having the provider shadowed to determine what inefficiencies are present within the clinician's practice. The shadowing can either be done by a high-performing peer provider or a trained staff member. The uncovered obstacles to efficiency will usually be in one of three categories:

1. Interview Skills: The teaching of interview skills varies among medical schools and residency programs, and otherwise clinically competent physicians can enter the work force without an adequate understanding of how to conduct an efficient interview.

Moving quickly from open-ended to closed-ended questions, bringing the patient back from a tangential conversation to the subject at hand, and setting a visit agenda ("I know you are here today to follow up on your diabetes. Is there anything else you want to discuss today?") are all teachable techniques that can enhance the provider's and patient's visit experience. Many providers who struggle with productivity benefit simply from learning how to bring satisfying closure to the visit.

2. Utilization of Support Personnel: The modern office visit demands the collection of a vast amount of data, most of which can be done by ancillary office employees. Likewise, inbox messages including Rx refills and basic questions can and should most frequently be handled by non-provider staff, often assisted by established protocols approved by the clinician.

Offices that don't provide adequate support in this way should adjust their staffing to allow everyone to work up to the top of their license. Where the support is adequate, an effort needs to be made to facilitate the clinician's willingness to delegate these activities.

3. Electronic Medical Record Competency: Although most common among mid-career and older providers, a clinician of any age may find effective use of their electronic medical record to be a serious barrier to efficiency.

Providers opt for fewer or longer visits to compensate for inefficient EMR skills, either because they want to complete their note within the time allotted for the visit or because they want to finish their day earlier in order to write all their notes by the end of the day or in the evening.

Basic EMR training usually acquaints them with the ability to create a note, initiate orders, and complete the encounter. However, too few providers take the additional time to learn shortcuts and other efficiencies that would make their experience more satisfying. In this regard, further training by the EMR company trainers or by an EMR-savvy peer clinician can make a huge difference and provide much-needed guidance to the struggling provider.

POOR QUALITY PERFORMANCE

In the primary care setting, clinical outcomes for common diseases such as diabetes or hypertension are often included in measures that are part of an organization's (or specialty's) quality metrics. Once again, there are benchmark values that can be used for comparison, such as the percentage of patients with an A1C of <7 or BP <130/80.

Once external reasons for low performance have been eliminated (e.g., a new clinician who is getting lots of new challenging patients or a clinician who works in a severely indigent population location, where patients have poor access to a healthy diet or nutrition education) it is the responsibility of the administration to understand the reasons for the low performance that are truly linked to the clinician.

A close look at the details of the provider's practice habits will likely reveal the underlying problem. Frequent findings include:

1. Lack of initiation of home monitoring by the patient.
2. Unwillingness by the clinician to push to higher medication doses when the goal is not being achieved.
3. In the case of diabetes, unwillingness or inability of providers to move their patients from oral agents to insulin even when the former are not working.

Addressing the problem by offering (or insisting on) coaching by a successful peer clinician, requesting that the primary care clinician spend time with the appropriate specialist (diabetologist or hypertension specialist), or requesting the clinician attend a CME course may be sufficient to improve the level of care in most cases.

LOW PATIENT EXPERIENCE SCORES

Low patient experience scores often are bewildering and an embarrassment for providers, as they believe they are doing their best to promote a satisfying experience for their patients. However, they must be addressed as with any other performance metric.

Once again, it is crucial to eliminate any possible external causes for low scores that may be out of the control of the clinician (e.g., a pain management practice where the clinician may have a large number of manipulative patients to whom they must often say "no" to demands for more narcotics). Specialty-specific patient experience scoring can help eliminate some of these variables that exist from specialty to specialty. The available market data will be made up of peers with the same challenges.

When it comes to low patient experience scores, there is no substitute for direct observation of the clinician's patient visits. This can be done either by having a trained coach shadow the provider for a few clinic sessions or by videotaping the sessions for review at a later time. Video can be an especially effective tool, as it gives the provider the opportunity to actually observe their own behavior and how it can be perceived by the patient.

Observation of visits of providers with low scores often demonstrates an absence of several basic tenets of building an effective doctor–patient relationship:

1. Not allowing the patient the opportunity to share the story of their illness without interruption.
2. Using poor eye contact, not offering encouraging comments, and other techniques that let the patient know you are offering support (e.g., "yes," "go on," "uh-huh").
3. Absence of empathic statements (e.g., "that must have been difficult for you").
4. Absence of joint problem-solving, which includes the patient perspective.
5. Excess concentration on the computer to the exclusion of focus on the patient.

Simply giving feedback about these deficiencies can be enough to produce dramatic improvements in patient experience scores, provided there is follow-up monitoring and feedback to ensure the newly acquired skills are being consistently put into practice.

SUMMARY

Assuming positive intent (that the vast majority of providers want to perform well in their professional role), it is incumbent upon medical group leaders to make every available effort to give their clinicians the opportunity to improve their performance. If efforts to support improvement fail, or if there is an apparent lack of motivation to progress, a crucial conversation with the provider regarding the potential inability to "fit" within the practice may be in order.

Ultimately, the hope is that by applying some of the interventions described herein, this unfortunate and expensive conclusion can be avoided.

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