Revalidation – where are we up to?

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Chair Expert Advisory Group Revalidation
RACP Congress 2017
EAG role:
- consider contemporary international research/practice
- provide *Interim Report* on options for revalidation in Australian context for consultation
- Provide *Final Report* Mid 2017
Expert Advisory Group

- Independent members
- No prior assumptions
- Serving the (unique) Australian environment
- Providing a clear definition of
  - the purpose
  - the conceptual basis of revalidation
  - the evidence, and
  - consequent opportunities for Australia
Interim report for consultation

- Add value - provide a thoughtful and intelligence-led basis for thinking about future models
- Articulate discussion points for inclusive stakeholder consultation
- Develop “return on investment” thinking
Consultation highlights

- Consultation **August to November 2016**
  - Colleges, CPMC, Medical Deans, AMA and others
  - State and territory Stakeholder forums >400 stakeholders
- >1000 individual doctors - online discussion forum and (+ consumers) online survey
- 116 written submissions
Consultative Committee

- CPMC
- AIDA
- Australian Medical Council
- Australian Medical Association
- Medical Deans Australia and New Zealand
- Health Workforce Principal Committee of the Australian Health Ministers’ Advisory Committee
- AHPRA
- Medical Council of New South Wales
- Health complaints entities
- Pre-vocational training organisations
- Professional indemnity insurers
- Community representatives
Dual aims of revalidation

- Maintain & enhance performance
- Prevent harm
- Reduce risk
A conversation

But how do we achieve a competent workforce?

“It can happen only if the individuals in the workforce keep learning. …the assurance of lifelong learning is the prime aim for which a regulator should strive. So the issue here is to develop …strategies that help learning.”

Southgate & van der Vleuten P. 14
The next purpose for the regulator is to guarantee patient safety by safeguarding the public from poorly performing individuals in the workforce.

“These two purposes should be separated, even firewalled, and treated differently in developing a ...strategy.”

Southgate & van der Vleuten p. 14
What supports our dual propositions?

- Significant high-level evidence about what works in CPD
- Insights are emerging about performance risk factors and supports
Underlying principles

Smarter not harder

Strengthened and reshaped CPD should increase effectiveness but not require more overall time
All recommended approaches should:

- integrate with – and draw on – existing systems where possible and avoid duplication of effort.
- focus on outcomes not inputs
Underlying principles

All recommended approaches should be

- relevant to the Australian healthcare environment
- feasible and practical to implement for doctors and Colleges
- proportionate to public risk
Strengthened CPD

Evidence-based approaches to CPD best drive practice improvement and better patient healthcare outcomes

Strengthened CPD in consultation with the profession and the community, is our core approach to maintaining and enhancing performance
Types of CPD

- Undertaking educational activities:
  - lectures
  - conferences
  - reading
  - research
  - supervision
  - workshops
  - grand rounds
  - online learning

- Reviewing performance:
  - peer review of performance
  - peer review of medical records
  - peer discussions of cases, critical incidents, safety and quality events
  - multi-source feedback from peers, medical colleagues, co-workers, patients, other health practitioners

- Measuring outcomes:
  - clinical audit
  - review of medical records
  - mortality and morbidity reviews
  - clinical indicators
  - comparison of individual data with local, institutional, regional data sets
  - review of individual and comparative data from de-identified large datasets, e.g., Medicare, PBS
Prevention of harm

A small percentage of doctors are not performing to expected standards

- Mandate to the profession:
  - Deepen understanding of factors associated with risk to performance
  - Improve understanding of supports
  - Continue to strive to improve patient safety
Understanding risk better: where can we look?

Known risk factors

- From regulatory data
- From complaints data
- From malpractice data
- From hospital outcomes data etc
Understanding risk better: what do we know?

Some known risk factors
- Older age
- Number of prior complaints
- Time since last complaint
- Isolated practice
- Specialty
- Male > Female
“Clearly, some doctors are complaint prone. The case for early and effective intervention to prevent an escalation of problems is starkly evident.”

-Ron Paterson, BMJ Q&S
Understanding supports better

Some known supports:

1. High quality CPD
2. Group/team practice
3. Volume
4. Organisational supports/scope
5. Early peer intervention (Vanderbilt)
...different avenues for thinking

- Individual risk factors
- System factors

→ Reduction of risk
Where to start?

POSSIBLE RISKS

- Older age (70 and beyond)
- Multiple complaints

UPSTREAM SUPPORTS

- Early identification and action
looking at risk

“Structural versatility”

- Investigate range of tools available
- Understand types of risk that pose special challenges to patient safety
- Improve action *where needed*

Malcolm K. Sparrow Harvard University
Early ID of performance issues requires equal focus on information sharing and educational strategies.
A better safety net: effective and proactive interventions

System design

- How can we support doctors to rapidly improve performance if required?
- Who is or could be responsible for action at various levels?
- What does action look like?
High self regulation

High external regulation
References

- All page numbers for references are as found in the Interim Report except for the following:
- Dickson N 2015 |JOURNAL of MEDICAL REGULATION VOL 101, NO 3 p. 10
- Thanks to Marie Bismark for 2 slides as presented at IAMRA 2016