

Effectively Using the “Cup of Coffee” Conversation

Physician Leadership and Minimizing
Licensure Risk

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Disclosure

- Member of the Mississippi State Medical License Board (MSMLB).
- The perspectives presented are personal leadership experiences.
- They do not represent official MSMLB policy.

Overview

The “Cup of Coffee” leadership concept

When informal intervention works

When it fails

Situations requiring formal escalation

Goal is prevention



The “Cup of Coffee” Approach

An informal leadership conversation used to:

- Build trust and influence culture
- Improve patient safety
- Address concerning behavior/performance early
- Prevent small issues from becoming formal disciplinary/contractual events

Note:

This approach is **not defined in bylaws** or policy. It relies on **leadership, judgment, credibility, trust, and finesse!**

Why Coffee?

Intervention without punishment....yet

Physicians often respond best to trusted peer leadership
CMO/ Medical Director personally invites doctor to discuss concerns
and listens with purpose as a mentor

Keeps tone friendly, casual, and conversational in nature vs. emails,
texts, formal meetings, legal counsel, HR involvement, etc.
“Let’s meet and see if we can make some progress”

Early and supportive intervention promotes culture of accountability
without escalation to MEC, BOT, State Board, etc. yet

Common Reasons to use the “Cup of Coffee” Approach



Common Pitfalls of the “Cup of Coffee” Approach



Waiting too long to intervene



Approaching the conversation without data



Making the discussion accusatory or dismissive



Failing to document concerns



Ignoring warning signs requiring escalation

**Do NOT pass go for a
“Cup of Coffee”**

When Informal Intervention
is Inappropriate

Formal documentation and Medical Executive Committee engagement are necessary when issues involve:

Sexual Misconduct/Boundary Violations

Criminal Activity

Gross Negligence

Lack of Improvement after Coffee Conversations

Diversion

Does the “Cup of Coffee” Work?

Personal Experience = 50/50

Most effective when:

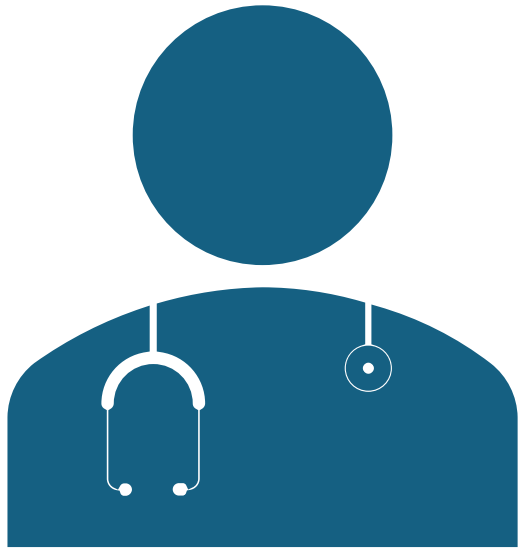
- The physician has not previously received feedback
- The concern is behavioral or communication based
- There is objective data supporting the discussion
- Trust exists between leadership and physician

Failure is common when:

- The physician is defensive or dismissive
- Data is inaccurate or attributed to wrong doctor
- Concerns involve integrity or competence

Case Study: When Coffee Goes Bad

- **Concern** – Pattern of over-diagnosing a specific illness
- **Approach** – Informal discussion supported by Epic data and compliance reports
- **Response** - “I am just smarter than other doctors. I don’t need to do all those tests to get to the diagnosis.”
- **Outcome** – Rapid escalation to suspension and eventual loss of license
- **Leadership Lesson** – Outcome was predictable within the first 5 minutes



Case Study: When the Coffee is Good

- **Issue Identified** – ER physician had poor patient satisfaction scores and high left without being seen rates with multiple complaints (supported by two years of data)
- **Discovery** – The physician revealed the ER group had never been shown their performance data
- **Intervention** – Leadership began sharing performance metrics transparently at ER meetings
- **Outcome** – The physician became chair of the group and an advocate for transparency
- **Leadership Lesson** – Seek first to understand, then take action!

Hospitalist Specific “Coffee Talk”



Behavior - doctor/nurse communication, timely response, verbal/phone orders, medical staff conflicts



Performance - data driven CMI, LOS, Patient/nursing satisfaction, peer to peer, mcc/cc capture rate, documentation/coding issues



Knowledge Deficits - work hour restrictions in residency, AI, smaller training programs
tough one



Contractual - don't understand RVU or by laws, want top compensation for average production or performance

Coffee Remedies

- * PIP to include direct observed rounding by group leaders
 - * CME on coding /documentation
 - * Physician life coach
- * Monthly touch base with director for updates
 - *Charm school
- * Doctor led lunch and learns with staff



Thorough onboarding process to lay out expectations for all new providers is helpful!

Be Aware!

Mature doctors with a new, sudden problem typically indicates a personal issue - health, family, substance, mental health, etc.



Most Common Issues for Physician License Review

The below often result in licensure restriction, suspension, and/or loss:

Inappropriate Prescribing

Impairment/Substance Abuse

Sexual Misconduct/Boundary Violations

Repeated Peer Review Concerns

Documentation/Billing Fraud

“Too Good to be True” Scenarios

Inappropriate Prescribing Indicators



Pharmacy board sees high percentage of controlled substances



PDMP alerts



Prescribing to self, family, friends, with no medical record entries



Lack of pain contracts, UDS, compliance with controlled substance policy

Inappropriate Prescribing Indicators



BENZO/ OPIATES
TOGETHER



“ FRIENDS”



WEIGHT LOSS MEDS WITH
NO DOCUMENTATION



PAY FOR PILLS

Signs of Impairment/Substance Abuse

Alcohol use/disuse – people are looking ALL the time...

Unusual behavior at work...

Criminal activity, repeat DUI...

Staff or self reporting...

To save the physician, we need to act early, encourage self reporting, and get rapid treatment with IPN. There is a high success rate of return to practice if done right!

Remember – Your professional reputation is on the line at all times!



Misconduct and Boundaries

Examples include:

- Inappropriate relationships with patients or staff
- Improper dissolution of physician-patient relationships
- Unencrypted or unsecure communication such as social media or direct texting

Note: Digital communication is discoverable and it is amazing what well trained investigators can discover!





Peer Review Activity

- Medical staffs should **self-govern whenever possible**.
- Peer review systems must be **credible and consistent**. All programs are NOT created equal!

Red Flags:

- Frequent loss of privileges
- Denials of privileges
- Repeated suspensions

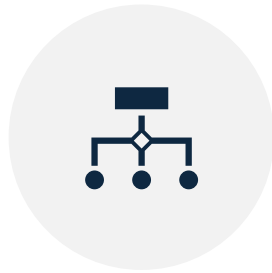
Remember:

- **Suspensions > 30 days** must be reported to the National Practitioner Data Bank (NPDB)

Documentation/Billing Fraud



PROCEDURES NOT INDICATED
(SPINE /ROTATOR CUFF WITH
NORMAL IMAGING)



WITH VIRTUAL ACCESS (MY
CHART), PATIENT CAN SEE ALL
THE RECORDS



BETTER DO WHAT YOU
DOCUMENT



CUTTING /PASTING

If It Seems “Too Good to be True”.....Look Closer

Hospitalist and Conflict of interest issues

Always ask: *What exactly am I responsible for and how is my license being used?*

Practice Arrangements Frequently Creating Licensing Risk Include:

- **IV hydration/wellness clinics**
Know exactly what services are being provided and what you are supervising.
- **Hospice/ Home Health medical directorships**
Understand your responsibilities beyond simply lending your name.
- **Tele medicine/virtual care models**
Be certain billing and patient evaluation requirements are met.
- **APP supervision arrangements**
Know the limits on number supervised, chart review requirements, and geographic oversight expectations.
- **Aesthetic practices**
Many operate outside traditional clinical oversight; understand supervision responsibilities and carefully consider blurred lines.

Reminders

- If it's too good to be true ... it's probably too good to be legal or ethical
- Always better to self report if issue exists such as substance, criminal, peer review
- Know your by-laws, rules and regs, state statutes, and CMS guidelines
- Most of these issues - whether with CMO, Program Directors, State board - can be worked out with open, humble, & honest communication



Goal of the “Cup of Coffee” is not discipline, but prevention.

- Have a “Cup of Coffee” early with common goal to improve performance/behavior
- Lead with data and honest conversation
- Know when to escalate
- Protect your license and your colleagues’

Discussion & Questions

