Washington Association of Medical Staff Services
Lake Chelan, Washington

How to Move Peer Review from Quality Assurance to Performance Improvement

Jon Burroughs, MD, MBA, FACHE, FACPE
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On a Scale of 0 to 10, how do you feel about your medical staff’s peer review process?

0 = punitive, unfair and non-helpful

5 = sometimes constructive, fair, and helpful

10 = almost always constructive, fair, and helpful
Traditional peer review challenges:

- Punitive (search for negative outliers)
- Arbitrary and non-objective with wide variation depending upon who is doing it
- Riddled with conflicts of interest
- Focus on corrective action and not improvement
- Little (if anything) changes as a result of a lot of work!
What are the goals of an effective peer review program?

• Constructive and supportive
• Objective and transparent (criteria based and not ‘on demand’)
• Emphasis on positive performance and supportive improvement strategies
• Reliable feedback and data to facilitate continuous improvement
• Cost effective committee structure and process
Traditional Peer Review Structures

- Department Chair
- Department Chair leading the department
- Medical Director leading the service line
- All Department Chairs
- Medical and Surgical Departments

What are the challenges with these?
What is a more contemporary approach?

1. Centralized multidisciplinary peer review committee for each organization with non-department chairs trained to do peer review consistently and well

2. Super multidisciplinary peer review committee for the system to develop policies/procedures/performance indicators and deal with controversial issues that arise
How is a Centralized Multidisciplinary PR Committee organized?

- Respected clinicians who are trained to perform peer review in a transparent and consistent manner
- Staggered and longer terms to maintain continuity and skills
- Compensated with performance expectations and accountability
- Balance individual and system performance
Membership on a Centralized Multidisciplinary PR Committee organized

• Five to seven members from representative specialties
• VPMA/CMO, MSSP, and CNO to address nursing issues and systemic concerns
• Any member/non-member of the medical staff may serve as an ad hoc member to provide subject matter expertise
• Chair of the PR Committee serves as an ex-officio member of MEC
How is a Super Multidisciplinary PR Committee organized?

• Peer Review Committee Chairs and VPMAs/CMOs from each represented organization

• Focus on systemic issues and does not re-hash regional peer review

• Serves as an external peer review source for controversial or politically/economically conflicted cases

• Reports to Super MEC in a large system
How does a Centralized Multidisciplinary PR Committee work?

• Develops criteria for both external and internal peer review based upon the creation of review, rule, and rate performance indicators/targets

• Criteria are approved by MEC and the Board to assure transparency and integrity

• No case or quality issue comes to this committee that does not meet criteria (e.g. no ad-hoc referrals!)
What is the challenge with ad hoc PR referrals?

• All deaths
• Any leader or patient complaint goes to PR ‘on demand’
• Non-compliance with core/SCIP measures, blood utilization goes to PR
• All returns to _____ go to PR
• Professional conduct and/or administrative issues go to PR
A better approach—Criteria based referrals for PR:

• Criteria for External PR
• Criteria for Internal PR
  ➢ Significant unexpected events (review indicator)
  ➢ Significant number of events (rule indicator)
  ➢ Significant rate of events (rate indicator)
Typical criteria for External PR:

- Nobody in the system has the clinical expertise
- Irreconcilable conflict of interest
- Need for an outside non-conflicted ‘expert’ to testify at a fair/judicial hearing or civil litigation
- Peer Review Committee is conflicted, the matter is important, and the committee cannot decide
- The MEC/BOT wishes to audit an aggregate body of cases for privileging concerns
- What is not here?
What makes a good review indicator for Internal PR?

- **Inclusionary criteria:** Unexpected death or significant injury in a low risk inpatient (based on DRG classification)

- **Exclusionary criteria:** Does not include---
  - Deaths that are expected (high risk co-morbidities and DRG, DOA etc.)
  - Hospice/palliative care
  - Severe trauma with multiple organ injury
What makes a good rule indicator for Internal PR?

- Administrative and clinical issues that you would like to drive improvement over time
- Will manifest a high volume bias

Example: # of 30 day medical record suspensions/one year period-floating

Green = 0   Yellow = 1-2   Red = 3 or more

Create progressive interventions based upon the threshold triggered
Progressive interventions for rule indicator

0 suspensions = positive feedback and commendation

1 or 2 suspensions = department chair/medical director feedback and inquiry into systems issues and understanding

3 suspensions = mandatory meeting with peer review committee (improvement plan)

4 suspensions = mandatory meeting with MEC and final warning

5 suspensions = mandatory corrective action by BOT
What makes a good rate indicator?

Key clinical issue that you’d like to rapidly improve for a specialty or entire staff

Examples:

1. % of elective inductions performed prior to 39 weeks gestation
2. Risk adjusted mortality index for defined DRGs

Again, move the targets (increase or decrease) over time to improve performance and reduce variation
Manage conflicts of interest!

**Absolute conflicts** = oneself or first degree relative, spouse (including PR Committee members!)

**Management**: Automatic recusal

**Relative conflicts** = employer/employee, competitor

**Management**: adjudicated on a case by case basis
Refer relevant issues to hospital/system committees

• All **educational** opportunities sent to the MS for M and M Conference

• All **nursing** issues are referred to the Director of Nursing or CNO with expectation for written report within X weeks

• All **systems** issues are referred to the PI Committee (or equivalent) with expectation for written report within Y weeks

• If no report received, request made to VPMA/CMO and CEO to expedite
Create a standardized process to follow

1. Case identification based upon criteria
2. Pre-review screening to confirm that case(s) meet pre-existing criteria
3. Assignment to a physician or practitioner for review with standardized scoring system
Traditional scoring methodology and approach:

**Level 1:** No issues identified

**Level 2:** Unexpected occurrence - treated in a timely way

- **2A:** Appropriate
- **2B:** Uncertain, difference of opinion, or controversial

**Level 3:** Unexpected occurrence with opportunities for improvement.

**Level 2B or level 3** may be sent to the credentials committee for ‘further peer review’

What are the potential issues here?
Contemporary scoring methodology:

Physician reviewer is anonymous, non-conflicted, and technically qualified

1. Exemplary care (ratified by committee)
2. Appropriate care (ratified by committee)

3. Questionable or controversial care (evaluated by committee)
4. Inappropriate care (evaluated by committee)
Contemporary scoring methodology:

Issues to be considered when care is questionable, controversial, or inappropriate:

• Judgment
• Knowledge
• Technical skills
• Communication
• Hand-off/follow up
• Compliance with pathway/policy
• Responsiveness
• Professionalism
This results in a significant cultural shift

• Most reviews will either result in appropriate or exemplary scores
• Most reviews will result in positive feedback to the practitioners and his/her clinical department/service line
• A pre-defined number/% of exemplary reviews may result in re-appointment with commendation by the MEC and the BOT
• How will this impact your medical staff and your organization?
Create a standardized process to follow:

4. PR Committee discussion (agrees or disagrees with physician review)

5. Request for input for all necessary sources to make a final decision
   - Physician(s) in question will always be asked for focused input
   - May require subject matter expert input
Create a standardized process to follow:

6. PR Committee decision and referral for further action if necessary (e.g. referral for improvement plan, nursing or systems evaluation)

• Physician(s) in question may document disagreement with committee decision

• PR Committee will assure compliance and follow through with referrals or go up the chain of command
Common ‘systems’ issues identified in peer review:

• What is the most common nursing issue identified in peer review?
• If there are multiple cases from the ICU, what may be the problem?
• If there are multiple cases late at night, what may be the problem?
• If there are multiple cases due to lack of responsiveness while on call, what may be the problem?
• If there are multiple cases due to patient acuity, what may be the problem?
Remember David Marx’s ‘Just Culture’

Balance individual and systemic accountability:

1. Rare event for a good physician-console and address systems issues
2. Chronic event for a non-complier-re-train and utilize progressive discipline as a last resort
3. Egregious or reckless action with disregard for consequences-immediate progressive discipline and/or corrective action
At the end of the day....

Can you move from a culture of judgment to a culture of improvement?
Thank You for Joining Us!

Jon Burroughs, MD, MBA, FACHE, FACPE
jburroughs@burroughshealthcare.com;
603-733-8156