PEER REVIEW & QUALITY COMMITTEE

Essentials Handbook

Richard A. Sheff, MD

Robert J. Marder, MD

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HCPro

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Richard A. Sheff, MD, Author
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About the Authors

Richard A. Sheff, MD

Richard A. Sheff, MD, is principal and chief medical officer with The Greeley Company, a division of HCPro, Inc., in Danvers, Mass. He brings more than 25 years of healthcare management and leadership experience to his work with physicians, hospitals, and healthcare systems across the country. With his distinctive combination of medical, healthcare, and management acumen, Dr. Sheff develops tailored solutions for the unique needs of physicians and hospitals. He consults, authors, and presents on a wide range of healthcare management and leadership issues, including governance, physician–hospital alignment, medical staff leadership development, emergency department call, peer review, hospital performance improvement, disruptive physician management, conflict resolution, physician employment and contracting, healthcare systems, service line management, hospitalist program

optimization, patient safety and error reduction, credentialing, strategic planning, regulatory compliance, and helping physicians rediscover the joy of medicine.

Robert J. Marder, MD

Robert J. Marder, MD, is an advisory consultant and director of medical staff services with The Greeley Company, a division of HCPro, Inc., in Danvers, Mass. He brings more than 25 years of healthcare leadership and management experience to his work with physicians, hospitals, and healthcare organizations across the country. Dr. Marder's many roles in senior hospital medical administration and operations management in academic and community hospital settings make him uniquely qualified to assist physicians and hospitals in developing solutions for complex medical staff and hospital performance issues. He consults, authors, and presents on a wide range of healthcare leadership issues, including effective and efficient peer review, physician performance measurement and improvement, hospital quality measurement systems and performance improvement, patient safety/error reduction, and utilization management.

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CHAPTER 1

Roles and Responsibilities of the Peer Review/Quality Committee

Note: The committee responsible for assessing and tracking practitioner performance is often called the "medical staff quality committee" or the "medical staff peer review committee." Throughout this text, the committee will be referred to as the "medical staff peer review committee."

When most people think of peer review, they envision a group of practitioners sitting around a table looking at charts. In reality, peer review has evolved into a much more complex process. A more contemporary definition of peer review is the evaluation of a practitioner's performance for all defined competency areas, using multiple data sources.

This modern definition of peer review implies that clinical knowledge is not the only practitioner competency. Rather, practitioners are now evaluated based on six competency areas that The Joint Commission and the Accreditation Council for Graduate Medical Education have identified. This new definition also implies that case review is only part of peer review. Case review is an

important part of peer review, but there are other tools, such as rate and rule indicators, that provide a more fair and balanced view of practitioner performance.

Also consider the definition of a peer, which has also changed over time. In the past, a peer was a practitioner in the same specialty, because practitioners believe that only another practitioner in the same specialty can adequately evaluate their care. In reality, it takes a more flexible definition of a peer to make peer review effective. Just because a neurosurgeon performs a procedure does not mean that a neurosurgeon must review a case in its entirety. For example, if the issue is one of whether the neurosurgeon used the correct size shunt for the ventricle to reduce hydrocephalus, then one would presume (and would be correct) that another neurosurgeon should review the case. However, if the issue is how the neurosurgeon managed postoperative anticoagulation or preoperative cardiac clearance, certainly other physicians could act as peers, because they would have the content expertise to evaluate those issues.

The Joint Commission has also redefined peer review over the last few years by introducing the following terms:

- **Ongoing professional practice evaluation (OPPE):** The routine process of monitoring the current clinical competency of medical staff members. It is what medical staffs traditionally think of as "peer review."

- **Focused professional practice evaluation (FPPE):** The Joint Commission uses the same term to describe two different types of peer review. One type of FPPE addresses concerns raised about a practitioner's performance during OPPE. The second type of FPPE applies to new medical staff members or those requesting new privileges. For a focused period of time, medical staffs must evaluate practitioners' performance to ensure that they made an informed decision when granting or denying a practitioner privileges.

- **General competencies:** The general competencies provide the framework for measuring and evaluating practitioners. The competencies are:

  - *Patient care*
  - *Medical knowledge*
  - *Practice-based learning and improvement*
  - *Interpersonal and communication skills*
  - *Professionalism*
  - *Systems-based practice*

When it comes to conducting effective peer review through ongoing and focused professional evaluation for current medical staff members, there are three components. They are:

- **Systematic measurement:** The peer review committee needs a process to obtain performance data regularly and consistently.
- **Systematic evaluation:** The peer review committee must ensure that policies and procedures allow the committee to evaluate practitioner performance using good data. The data must allow the committee to routinely identify outlying performance—both good and bad.
- **Systematic follow-through:** The peer review committee must establish policies defining who will follow up with a practitioner whose performance raises a red flag and when this follow-up will occur. Policies should also detail at what point the committee will take further action when a performance concern is raised.

How Will Modern Definitions of Peer Review Affect Your Peer Review Program?

Many organizations are already conducting FPPE and OPPE, so the modern definition of peer review should not affect them. However, it will affect organizations that traditionally relied on chart review, because The Joint Commission requires that organizations go

beyond simply evaluating the same data more often. Organizations must go beyond case review to look at aggregate data (i.e., rate and rule indicators, which we will discuss later in this chapter) and evaluate physicians using all six competencies. Medical staffs must also establish policies that identify when it is necessary for medical staff leaders to conduct follow-up on FPPE results (i.e., how many deviations will trigger the peer review committee to dig deeper?).

What Are the Goals of a Great Peer Review Program?

The goals of any peer review committee should include the following:

- To create a nonpunitive culture that results in performance improvement. This does not mean that the committee doesn't take action when necessary, but it follows a process that allows practitioners an opportunity to improve before taking action.

- To create effective and efficient committee structures and processes. The committee shouldn't waste practitioners' time by having too many subcommittees or meetings that run long because it is reviewing cases that don't need to be reviewed.

- To establish valid and accurate practitioner performance measures. If the peer review committee is going to measure

practitioner performance, it must ensure that the selected measures accurately measure practitioner performance at the aggregate and individual levels.

- To provide practitioners with timely and useful feedback. If practitioners are going to improve, they need to understand their own performance data and receive it in time to do something about it.

- To create well-designed and collegial performance improvement strategies to ensure that when a practitioner's performance is lacking, he or she views it as an opportunity for improvement.

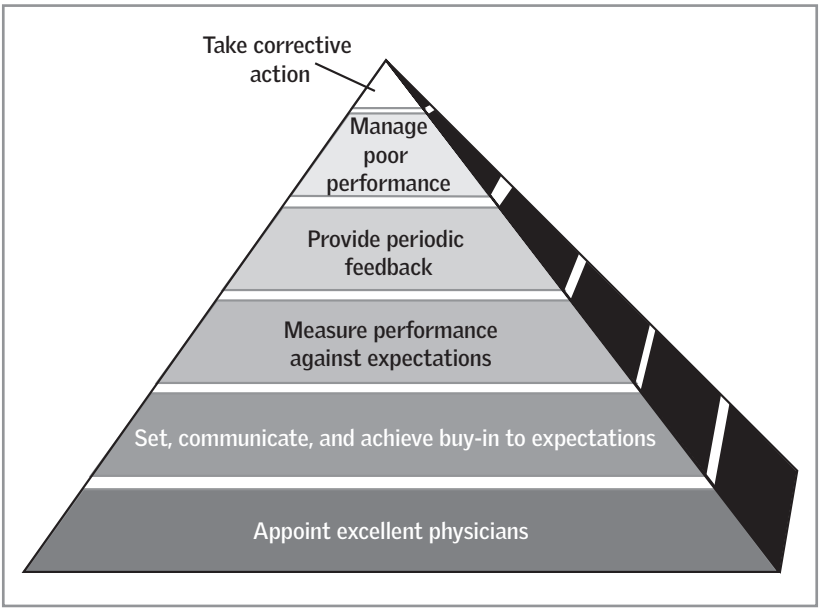
- To collect reliable data for ongoing evaluation and reappointment. Yes, peer review committees in hospitals that are Joint Commission–accredited must meet The Joint Commission's standards for reappointment, but if the peer review committee achieves the other five goals, compliant reappointment processes will occur naturally.

The Power of the Pyramid

The performance pyramid describes how medical staffs can achieve a nonpunitive culture. By spending more time on the lower, bigger layers of the pyramid, medical staffs will rarely have to spend time on the top layers. Let's review each layer of the pyramid that appears in Figure 1.1.

Figure 1.1

THE PHYSICIAN PERFORMANCE PYRAMID



1. **Appoint excellent practitioners.** This layer focuses on the medical staff's credentialing processes to ensure that applicants meet the medical staff's eligibility criteria.

2. **Set, communicate, and achieve buy-in to expectations.** Many organizations make the mistake of measuring practitioner performance without setting performance expectations or defining what areas of practice should be measured and why.

3. **Measure practitioner performance.** Measuring practitioner performance is best done using a clear set of performance expectations and a good rationale for measuring each indicator.

4. **Provide periodic feedback.** Periodic feedback drives a performance improvement culture. Not only is it important for practitioners to see their own performance data, but they should receive both positive and negative feedback. In any performance improvement process, people need to know when they are excelling and not just hear the bad news.

5. **Manage poor performance.** Although medical staff leaders hope that providing practitioners with performance feedback will spur them to self-improve, some practitioners do not understand what they need to do or are somewhat reluctant to do it. They may need additional assistance from key medical staff leaders. Medical staff leaders should partner with these practitioners to help them improve their performance.

6. **Take corrective action.** Unfortunately, some practitioners are unwilling or unable to improve their performance. Taking corrective action, such as suspending privileges, is an option only after the medical staff has provided the practitioner with ample opportunity to improve his or her performance.

How Can the Medical Staff Develop a Nonpunitive Culture?

Creating a nonpunitive culture does not mean looking the other way when practitioners make mistakes. Rather, it is establishing fair and efficient measurement systems to make sure the peer review committee is capturing data that paints an accurate picture of practitioner performance. For example, it's unfair to attribute a C-section to a hospitalist who merely consulted.

The second aspect of creating a nonpunitive culture is to use data evaluation systems that improve physician performance and accountability.

Primary Responsibilities of an Effective Medical Staff Quality Committee

There are three areas that help to drive a great physician performance program. They are:

- Measurement system management
- Evaluation of practitioner performance
- Improvement opportunity accountability

Measurement system management

Let's talk about each one of these in more depth, starting with measurement system management. The peer review committee is responsible for reviewing all indicators, the attribution of those indicators, and the targets that are used to measure practitioner performance at least annually. Typically, peer review committees simply look at a list of indicators and approve them, but the medical staff as a whole needs to be more engaged in the decisions regarding attribution and defining the targets that constitute excellent and acceptable performance.

The medical staff should also be involved in defining and designing the screening tools and referral systems that are used for case review. Department chairs and medical staff members should always be allowed to provide input into the measurement system management process. For example, if a department chair feels that the indicators chosen for a specialty create an inaccurate picture of practitioner performance, he or she should be allowed to present a case to the peer review committee for consideration.

As needed, the peer review committee approves requests for additions or deletions to medical staff indicators, criteria, or targets. Over the course of the year, new ideas come up that weren't discussed or identified previously. These ideas should be vetted through the peer review committee to ensure the best use of the hospital's quality resources.

The peer review committee also designs and/or approves focused studies (FPPE) when necessary to further analyze a practitioner's performance. With the credentials committee, the peer review committee defines the appropriate content for OPPE and practitioner performance feedback reports.

Evaluation of practitioner performance

Evaluating practitioner performance involves two components:

- **Individual case evaluation.** The peer review committee reviews practitioner performance based on individual case review and obtains input from the practitioners as to why certain outcomes occurred. Practitioner input is extremely important, and we will discuss where that comes into the process later in this chapter.

- During individual case evaluation, the peer review committee decides whether the care a practitioner provided was appropriate. The committee also triggers FPPE studies when needed to determine if improvement opportunities exist.

- Although it is not the peer review committee's job to identify potential hospital system or nursing practice improvement opportunities during the course of individual case review, practitioners may identify such issues. These concerns must be passed on to the appropriate leaders to address. The peer review committee needs to hold those

leaders accountable to help improve systems in which practitioners treat patients.

- **Evaluation of aggregate data.** The second component of practitioner performance evaluation is the evaluation of aggregate data. There are several steps to evaluating aggregate data. First, the peer review committee must regularly review the medical staff rule and rate indicator data, or it may delegate this task to a subgroup or individual to ensure that it is done properly.

- Second, the peer review committee identifies potential opportunities for individual practitioners to improve. It may determine that an FPPE study is needed because the data has shown that a practitioner has exceeded a rate beyond what is expected.

- Third, the peer review committee should identify the potential for medical staff–wide improvement opportunities. Perhaps the individual practitioner performance data look fine, but the overall medical staff is not performing as well as it could. As a result, the organization must determine how to improve the group's performance.

- Lastly, by evaluating aggregate data, the peer review committee identifies opportunities for the hospital system or the nursing practice to improve. For example, perhaps

the lab is not staffed adequately during the hospital's peak hours, therefore delaying test results and, thus, diagnoses.

Improvement opportunity accountability

Although it is not technically the peer review committee's job to direct improvement accountability, it is important that the committee follows through to ensure that the appropriate individuals address issues raised during the evaluation of practitioner performance. When the peer review committee identifies an opportunity for a practitioner to improve his or her performance, it must notify the appropriate medical staff leader (typically the department chair) and ensure that the leader is conducting further evaluation and developing an improvement plan. The committee should make sure that the plan was implemented and report results regarding the practitioner's progress to the medical executive committee.

External Peer Review

Even the best peer review program could use some help, because it can't always perform every aspect of peer review internally. The peer review committee should have a policy that clearly details when external peer review is necessary. There are six common situations that require external peer review. They are:

1. **Lack of internal expertise.** Only one individual on the medical staff can perform a particular procedure or spe-

cializes in a particular area, and the medical staff needs another practitioner to evaluate his or her performance.

2. **Ambiguity.** If differing opinions among committee members render the committee unable to come to a conclusion, an external third party can settle the dispute.

3. **Credibility.** When conflicts of interest arise between members of the peer review committee and the practitioner being reviewed, the peer review committee may need to call in a neutral external party to maintain the credibility of the peer review process and make an appropriate decision.

4. **Legal concerns.** If the peer review committee fears that the physician may be litigious or that corrective action is the next step, the committee may want to cover its bases by enlisting the help of a neutral third party.

5. **Benchmarking.** Having an independent source review practitioner review cases can help peer review committees benchmark their own performance.

6. **Lack of internal resources.** The peer review committee may need to do a large focused evaluation, but it simply doesn't have the time to do so.

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Peer Review & Quality Committee Essentials Handbook compares and contrasts the traditional and contemporary definitions of peer review and offers strategies to initiate focused professional practice evaluation based on peer review activities. This handbook can be used as a comprehensive guide for peer review & quality committee members, providing them with the necessary knowledge and skills to perform their roles effectively. Plus, to make staff training easy, this handbook includes a customizable PowerPoint® presentation highlighting key takeaways covered in the handbook.

Benefits of *Peer Review & Quality Committee Essentials Handbook:*

- Compare and contrast the traditional and contemporary definition of peer review
- Measure performance by selecting performance targets based on the core competencies
- Explain eight key steps in conducting effective case review
- Recognize all levels of performance data with normative data
- Initiate focused professional practice evaluation based on peer review activities
- Define discoverability and immunity
- Derive strategies to streamline peer review and quality meetings

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