M-LiNk, Session #3 - June 3, 2011

M-LiNk's third session, ***Engaging Physicians in Health Care Facility Patient Safety and Quality Programs***, was a mini-conference sponsored by the Board of Registration in Medicine (BORM) on June 3, 2011 at the University of Massachusetts Medical School in Worcester, MA.

If you have any questions, please contact Jennifer.Sadowski@state.ma.us for more information

Please note:

All 3 presentations from this conference are included in this PDF file.

Strategies to Engage Academic Physicians in Quality and Safety Activities

Quality and Patient Safety Division Conference
University of Massachusetts Medical School

Kathy Jenkins, MD, MPH
Senior Vice President/Chief Patient Safety and Quality Officer
Professor of Pediatrics
Kobren Family Trust Chair
Friday, June 3, 2011

Four Ways to Engage Academic Physicians

- Accountability/Ownership
- High Quality Data
- Credible Experts
- Academic Productivity

Four Ways to Engage Academic Physicians

- **Accountability/Ownership**
- **High Quality Data**
- Credible Experts
- Academic Productivity

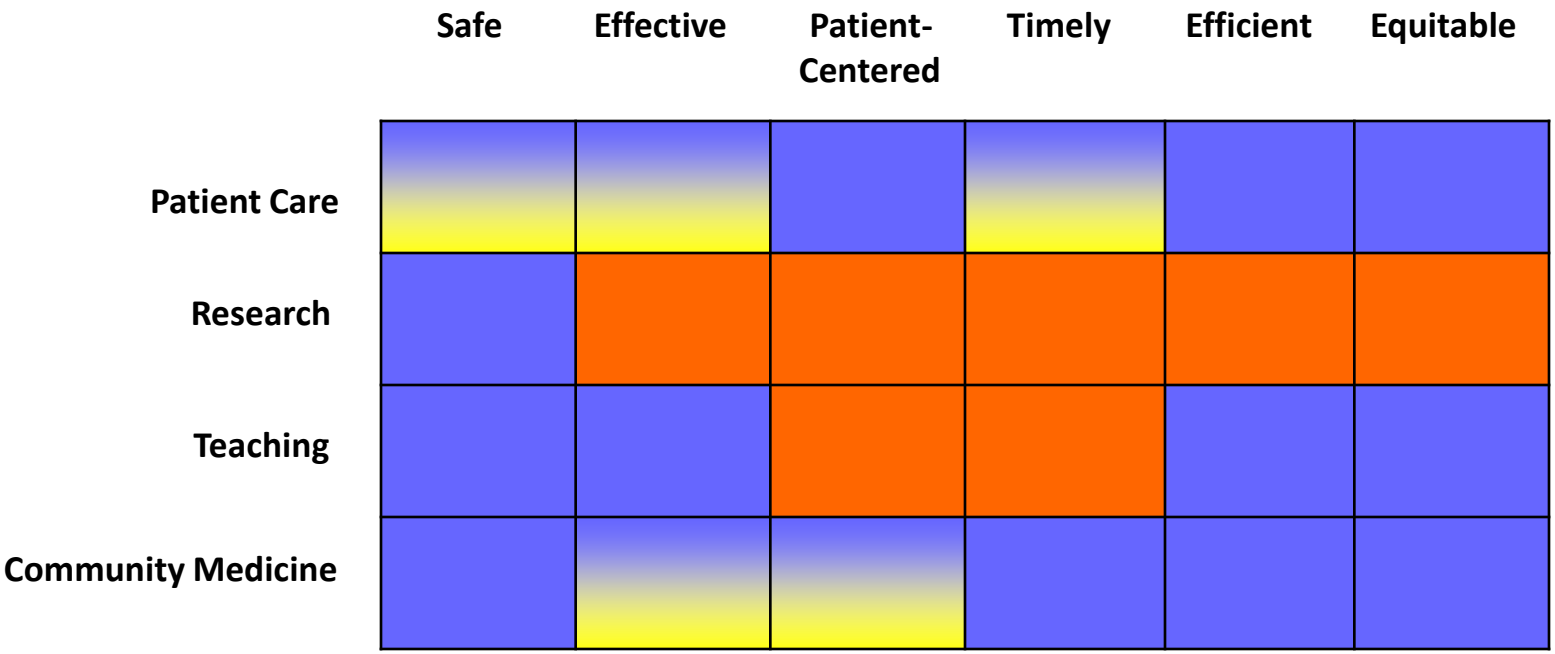
Accountability/Ownership High Quality Data

Examples:

- **Comprehensive Quality Report**
- Physician Performance Metrics Project
- Strategic Plan for Clinical Safety and Quality

Comprehensive Quality Report

Comprehensive Quality Report Framework for Measures



Using the Data to Improve Performance

- Physician lead as “measure owner”
- Writes response based on the data
- Presented to the Senior Clinical Quality Committee and recommendations made to elevate to an expanded response
- Presented to the Patient Care Assessment Committee of the Board of Trustees
- PCAC provides feedback in the form of individual letters to each “measure owner”
  - Acknowledgement of work
  - Strive to do better and identify targets
  - Presentation to PCAC

Physician Measure Owner Response-Excerpt

The actual incidence of laryngospasm in pediatric anesthetic practice is difficult to determine, however it occurs more commonly in pediatric anesthetic practice than in adults. Many pediatric anesthetists will encounter it in their everyday practice with varying severity. Reported numbers are 17/1000 anesthetics in children up to 9 years. In addition, other studies show that young age increases the incidence of laryngospasm even higher.

After reviewing all anesthetics at Children's Hospital Boston from 2000-2009 (N=236, 478), we found 2 factors associated with an increased risk of anesthesia-related cardiac arrest. Age less than 1 year and ASA physical status classification of 3 or higher. The patient in this event is less than 1 year old and despite an ASA physical status classification of 2 is still at increased risk of cardiac arrest.

The event was reviewed and discussed at the Department of Anesthesia, Perioperative and Pain Medicine Morbidity and Mortality conference and the Perioperative Systems Improvement Committee. Upon review there was no finding of any deficiency in the care given and the child was discharged with no untoward effects.

Response from the PCAC to the Measure Owner-Excerpt

Thank you very much for submitting your efforts to improve care related to "Cardiac Arrest in Anesthesia Cases" in the safety domain of the Children's Hospital Boston Comprehensive Quality Report.

The Children's Hospital Boston Patient Care Assessment Committee (PCAC) commends you on your thorough event review, inclusion of your analysis of 9 years of data and the identification of 2 risk factors for cardiac arrest. We are also pleased that you have normalized the episodes of cardiac arrests to volume of procedures in this report as requested. We look forward to your participation in the Wake Up Safe national registry, and we are pleased that you participate in the Cardiac Surgery and Anesthesia Database System (CSANDS) national registry, as this is consistent with the Children's Hospital Boston Clinical Strategic Plan.

Physician Measure Owner Response-Excerpt

The Heart Transplant Program SMR for 1 and 3 years is not statistically significantly different than that of any of the other listed programs. The heart failure consult program at CHB continues to expand, with regional referrals increasing each month. The large heart transplant program is the only one in the region and continues to receive referrals from all over the country. Of all heart transplants performed in patients < 18 years of age in 2008 and 2009 (through October) in New England, the heart transplant program at CHB had a market share of 100%. The case mix is higher than most programs as evidenced by the heart transplant program's 25 % sensitized patient group, >50% congenital etiology and almost 20 % pre-transplant mechanical support. Lastly, CHB is a participant in the Berlin Heart national clinical trial, using the device as a bridge to transplant for extremely ill patients. A number of Berlin Heart patients end up being heart transplant recipients further increasing the case mix of patients served by the heart transplant program.

Response from the PCAC to the Measure Owner-Excerpt

We wish to thank the members of your team for submitting current efforts to improve care related to "Solid Organ Transplant Outcomes" in the effectiveness domain of the Children's Hospital Boston Comprehensive Quality Report (CHB CQR).

The PCAC recognizes the multifaceted approaches being taken at both the individual program level and overall transplant program to improve outcomes. The Committee is very pleased with the progress of the Pediatric Transplant Center's Quality Assurance/Performance Improvement program in developing and implementing a robust transplant-specific QA/PI and in including transplant metrics in departmental quality triads.

The Committee applauds that the 3-year standardized mortality ratio for transplants performed from CY04 Q3 through CY06 Q4 further decreased to 0.63, remaining below 1.

The PCAC appreciates that you are providing a comprehensive up-to-date overview of transplant outcomes on May 3, 2011 as requested. The Committee understands that you collect more data than are included in the CQR, and we are interested in seeing current shorter-term data than the 3-year standardized mortality ratios that are reported here.

Accountability/Ownership High Quality Data

- Comprehensive Quality Report
- **Physician Performance Metrics Project**
- Strategic Plan for Clinical Safety and Quality

Physician Performance Metrics Project

Goals:

- Develop sound evidence-based outcome measures to fill the void found in pediatrics
- Provide comparative data for use to assess competency
- Part of the on-going professional practice evaluation
- Provides support for development of provider-level pediatric outcome measures

Physician Performance Metrics

- Chief of each department/division appointed physician leader
- Clinical research experts, quality and safety personnel and biostatisticians assigned to assist
- Data collected/analyzed by Program for Patient Safety and Quality personnel
- Medical and surgical groups met to discuss progress and metric development

Physician Performance Metrics Project
Example of Metrics

Ophthalmology

Evaluate the outcome of Esotropia corrective surgery in children with a history of failure to resolve symptoms after conservative treatment

Dentistry

Individual pediatric dental attending radiographic diagnosis of imterproximal dental caries in primary teeth for children having treatment in the operating room

MSICU-Anesthesiology

Trial of extubation within six hours if ERT passed; if no trial of extubation, rationale is documented in the attending physician note

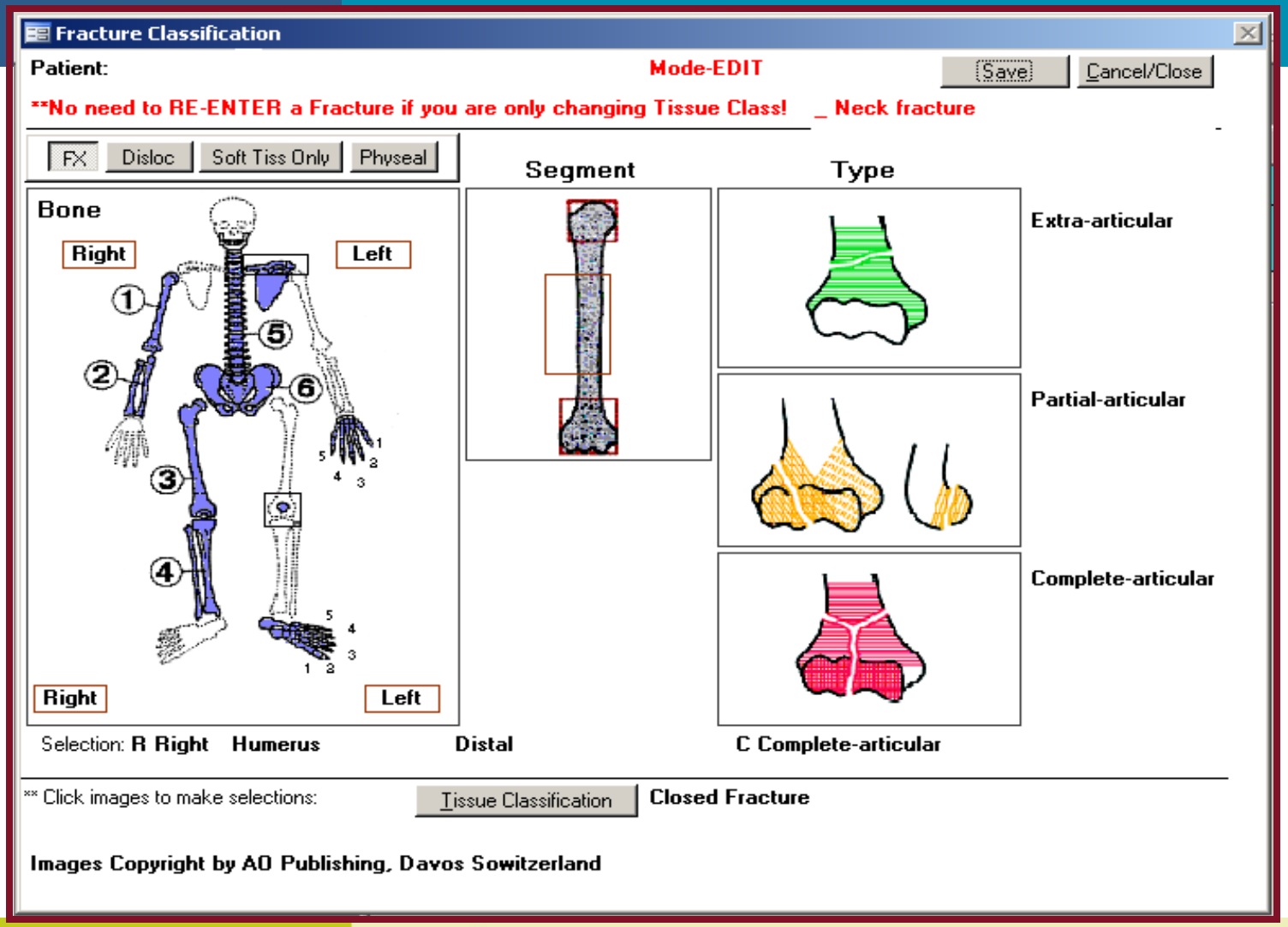
Urology

Fistula rate after hypospadias repair within 12 months of surgery

Emergency Medicine

Total number of unplanned return visits that result in hospital admission

Orthopaedic Data Utility for Documentation and Education (Ortho DUDE)™



Children's Hospital Boston

PSQ Program for Patient Safety & Quality

Accountability/Ownership High Quality Data

Examples:

- Comprehensive Quality Report
- Physician Performance Metrics Project
- **Strategic Plan for Clinical Safety and Quality**

Clinical Outcomes and Benchmarking

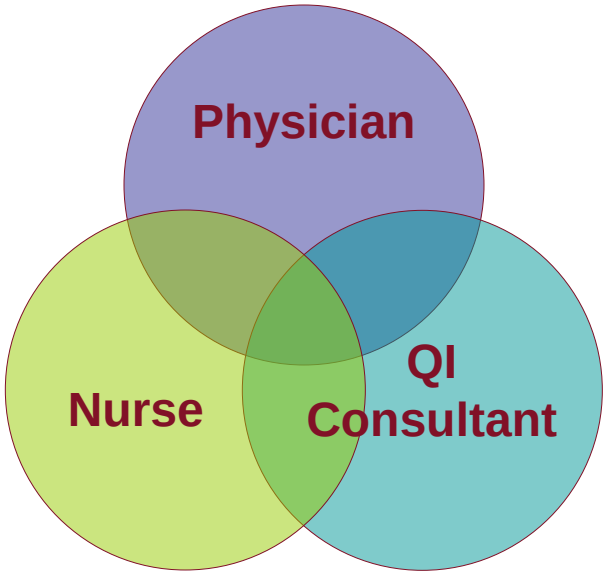
Programs will:

- Have clinical outcome measures for ***all*** conditions for which care is offered and for which it is possible to create valid measures.
- Participate in, and benchmark themselves against, existing national, specialty-specific performance measures when available
- Contribute to the development of external benchmarks in areas where none currently exist

Clinical Outcomes Committee

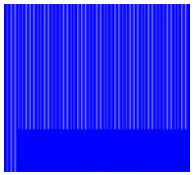
To provide oversight and guidance to each department/division's quality and safety leadership team (physician, nurse, and quality consultant) to further implement the Strategic Plan for Clinical Safety and Quality

Infrastructure to Support Safety and Quality
Physician, Nurse, QI Consultant Triad

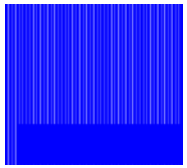


Outcome Measures – Percent of Services Represented (by Department)
(Measures must be externally benchmarked and have readily available data. Each bar represents 20% completion)

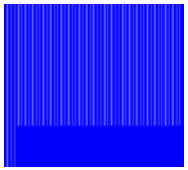
Anesthesiology



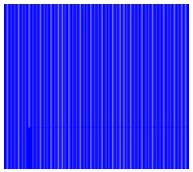
General Surgery



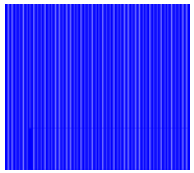
Neurosurgery



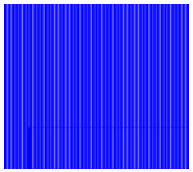
Otolaryngology



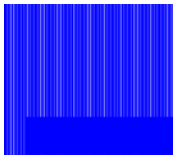
Plastic Surgery



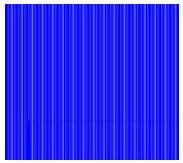
Urology



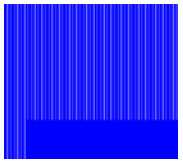
Cardiac Surgery



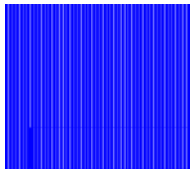
Lab medicine



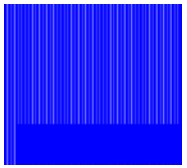
Nursing



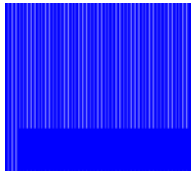
Pathology



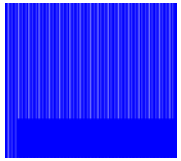
Psychiatry



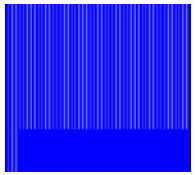
Cardiology



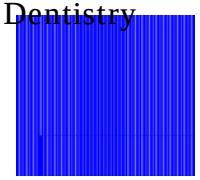
Medicine



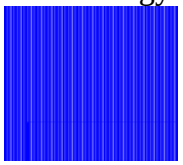
Orthopaedic Surgery



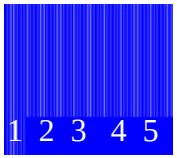
Dentistry



Neurology



Key



1= 1-20%
2= 21-40%
3= 41-60%
4= 61-80%
5= 81-100%

NICU Outcome Measures Dashboard

Medical Patients 80%		Surgical Patients 20%	
Preterm 17%	Term 83%	Preterm 28%	Term 78%

SNAPPE II Adjusted Mortality Rate

in infants admitted at ≤ 48° of age (relevant to 34% of all admissions)

Central Line Infection

(relevant to 45% of all admissions

Patients with RDS, MAS or PPHN

who develop a PTA (relevant to 25% of all admissions)

NSQIP Measures

(relevant to 20% of all admissions)

Preterm infant outcome

(CLD, NEC, IVH, PHH, PVL, ROP)

Preterm infant outcome

(CLD, NEC, IVH, PHH, PVL, ROP)

only applies to percentage of patients (estimate of % provided)

applies to all patients

Risk adjusted mortality stratified

by prematurity and benchmarked to PHIS

(relevant to 20% of all admissions)

Children's Hospital Boston

PSQ Program for Patient Safety & Quality

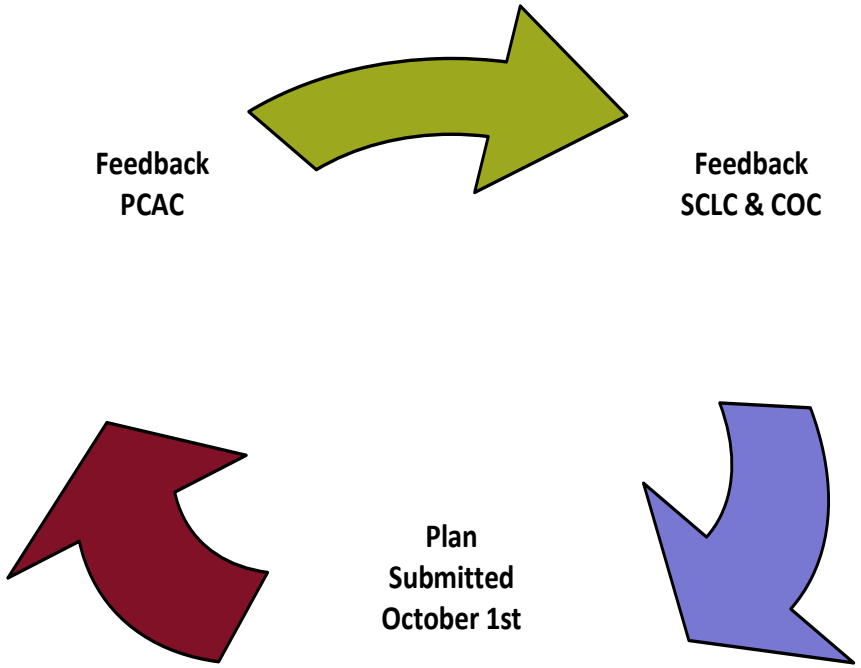
Components of an Effective Safety and Quality Program

Quality Management Plan Development

- To create an effective Quality and Safety Management plan for each Department or major Clinical Division
- To work collaboratively with the Program for Patient Safety & Quality, to implement the Clinical Strategic Plan for Safety and Quality

Quality Management Approval

- The CHB Patient Care Assessment Committee of the Board of Trustees will review the final Plan and provide comments to the Chief and team



Quality Management Plan Evaluation

Department/Division Quality Management Plan Evaluation Tool

Department Name:_____

Reviewer:

Date:

Evaluation Criteria:

Comprehensive: Does the Plan reflect ***all aspects*** of the care provided?

Aligned: Is it evident that the Plan is ***aligned*** with the CHB Strategic Plan for Clinical Safety and Quality?

Aspirational: Is the Plan designed to truly improve care, regardless of how well they are doing now-or does it just support the status quo?

SCORING 1-5 with 5 as highest possible score

Domain	1	2	3	4	5
Comprehensiveness					
Alignment					
Aspirational					

Four Ways to Engage Academic Physicians

- Accountability/Ownership
- High Quality Data
- **Credible Experts**
- Academic Productivity

Credible Experts

Examples:

- **Risky Business Conferences**
- Collaboration with the Harvard Business School
- Leadership Training

Risky Business Conferences
Leadership Training

Risky Business: Safe Solutions Learning from High Risk Industries for the Delivery of Safe and Quality Care

Dates of Past Conferences:

- October 6, 2007
- June 10, 2009

Next Program

- November 2, 2011

Partial List of Faculty

Richard Bohmer, MBChB, MPH
Senior Lecturer of Business Administration
Harvard Business School
Clayton Christensen, BA, M.Phil, DBA
Robert & Jane Cizik Professor of
Business Administration
Harvard Business School
Atul Gawande, MD
Surgeon & Research Director
Brigham and Women's Hospital
Center for Surgery and Public Health
Allan Goldman, MBChB
Director, Cardiac Intensive Care Unit
Great Ormond Street, London, England
Wyc Grousbeck, AB, JD, MBA
Managing Partner and CEO
Boston Celtics

Space Shuttle Disaster
Terence 'Tom' Henricks
President, McGraw-Hill Aviation Week

Celtic Teamwork and Leadership
Wyc Grousbeck, AB, JD, MBA


Great Ormond Street
Allan Goldman, MRCP

Credible Experts

Examples:

- Risky Business Conferences
- **Collaboration with the Harvard Business School**
- Leadership Training

Children's Hospital Boston

CRICO RMF Protecting providers. Promoting safety.

PSQ Program for Patient Safety & Quality

Children's Hospital Quality and Safety Leadership Development Program

January 7 - 9, 2008

HARVARD BUSINESS SCHOOL
EXECUTIVE EDUCATION

100 YEARS 1908-2008

Click On Above Photo For Campus Map

Schedule

Full Schedule

Schedule for: 1/31/2008 Calendar go

Thursday, January 31, 2008

No events scheduled.

Welcome to Harvard Business School

Welcome to the **Children's Hospital Quality and Safety Leadership Development** program website.

On behalf of our faculty and administrative team, we are delighted to welcome you to the Harvard Business School. To prepare for this program, we recommend that you complete all of the assigned pre-work under Pre-program Preparation. Early preparation is essential to ensure you are best equipped to take advantage of the unique learning opportunity inside the classroom and in the discussion groups.

To assist you in making your travel plans, please note, registration will take place Monday, January 7th, from 11:00 am - 1:00 pm in Hawes Hall 3rd floor. Please take a moment to look at the HBS Campus Map and Driving Directions. Parking will provided for you in the visitor parking lot located off of Western Ave on Batten Way.

Professor Steve Bradley will begin the **Opening Session and Overview of the Program** promptly at 1:00 pm in the Hawes 3rd Floor Classroom. Please plan to give yourself ample time for registration.

We look forward to meeting all of you.

Pre-program Preparation

To assist you in preparing for your sessions at Harvard Business School, please view Getting the Most from your HBS Experience. This tool outlines ***Learning By The Case Method*** the primary learning method you will encounter at Harvard Business School. An understanding of this method will make your classroom and discussion group experience more valuable. This tool also explains the dynamic nature of ***Discussion Groups*** and how to make the most of the time allotted for them.

Cases and Assignments

Please prepare the following cases and assignments before arrival to campus.

Program Schedule and Assignments *(printable version)*

Leadership Development Course

Children's Hospital Quality and Safety Leadership Development Program
April 28 - 30, 2008
Harvard Business School

Credible Experts

Examples:

- Risky Business Conferences
- Collaboration with the Harvard Business School
- **Leadership Training**

Physician Leaders Symposium

Course Description:

- This program is designed to prepare Patient Safety and Quality Leaders in their new role.
- The program will cover three key areas:
  - Healthcare Business Knowledge
  - Leadership and Strategy Knowledge
  - Skills for Managing in their new role

Curriculum Outline-Physicians

Members of the Harvard Business School Faculty:

Session 1	Strategy	Bharat N. Anand Henry R. Byers Professor of Business Administration
Session 2	Objectives–Advantage–Scope	Felix Oberholzer-Gee Andreas Andresen Professor of Business Administration
Session 3	Children's Health Care Model	Members of Children's Senior Leadership Team
Session 4	Activity Based Costing	Robert S. Kaplan Baker Foundation Professor
Session 5	Leadership and Motivating Teams	Scott A. Snook Senior Lecturer
Session 6	Influence and Negotiation	Deepak Malhotra Associate Professor
Session 7	Strategy Map Presentations	Das Narayandas
Session 8	Customer Service	James J. Hill Professor of Business Administration Chair, Program for Leadership Development

Curriculum Outline-Nurses

In collaboration with Pat Reid Ponte, DNSc, RN, FAAN, Chief Nurse, Dana-Farber Cancer Institute and Children's Hospital Boston's nursing leadership the following sessions were provided:

Session 1: Introduction/Negotiating, Leading, and Managing Team Conflict

Session 2: Health Care Quality Overview, Theory of Profound Knowledge, Systems Thinking; Change Concepts.

Session 3: Magnet Program – A Blueprint for Quality in Health Care Organizations

Session 4: Children's Health Care Model

Session 5: Leading Interdisciplinary Teams, Process Improvement Methods to Improve Clinical Quality, Nurse Sensitive Outcomes

Session 6: Measurement, Evidence Based Practice, Clinical Guidelines, Research and Quality Improvement

Session 7: Strategy Map Presentations

Session 8: Healthcare Quality and Safety Policy at Local/National Levels, Participant Presentations

Curriculum Outline-Quality Consultants

Under the leadership of Andrea Colon, Prerna Kahlon, Lara Khouri, Isabella Gasior, Lori Petersson, Marcie Brostoff and Nina Rauscher the following programs were provided.

Session 1: Health Care Environment and Children's Hospital Boston Strategic Goals

Session 2: Change Management

Session 3: Team Development

Session 4: Project Management

Session 5: Quality Management Tools

Session 6: Analysis and Measurement

Session 7: Improvement Methodologies

Session 8: Continuous Survey Readiness

Session 9: Implementing Normative Behavior

Session 10: Efficiency Measures, Financial & Budgetary Basics

A two day review course will be held at Children's' Hospital on June 9 and 10th to prepare nurses, QI consultants and interested physicians to prepare for CPHQ certification.

Four Ways to Engage Academic Physicians

- Accountability/Ownership
- High Quality Data
- Credible Experts
- **Academic Productivity**

Academic Productivity

Examples:

1. Faculty Development
2. Program for Patient Safety and Quality Grants
3. Teaching/Mentorship

Percent Effort Funded by the Program for Patient Safety and Quality for Faculty

Faculty	Job Title	Department	Percent Effort
	Associate Professor	Otolaryngology	40%
	Associate Professor	Anesthesiology	15%
	Associate Professor	Anesthesiology	10%
	Associate Professor	Anesthesiology	10%
	Assistant Professor	Pediatrics	10%
	Assistant Professor	Cardiology	10%
	Assistant Professor	Urology	10%
	Assistant Professor	Cardiology	10%
	Assistant Professor	General Pediatrics	10%
	Instructor	Medicine	10%
	Instructor	Orthopaedics	10%
	Instructor	Pediatrics/Pulmonary	10%
	Faculty Associate	Harvard Medical School	16%
	Professor	Harvard Medical School	14%

Center for Clinical Outcomes Research

Create an academic environment, enfranchising others and enhance careers through publications, grants, abstracts, fellowships, and presentations in the area of quality outcomes research.

- Leverage IT to be academically productive
- Leverage what we have done already
- Creation of new opportunities
- Education

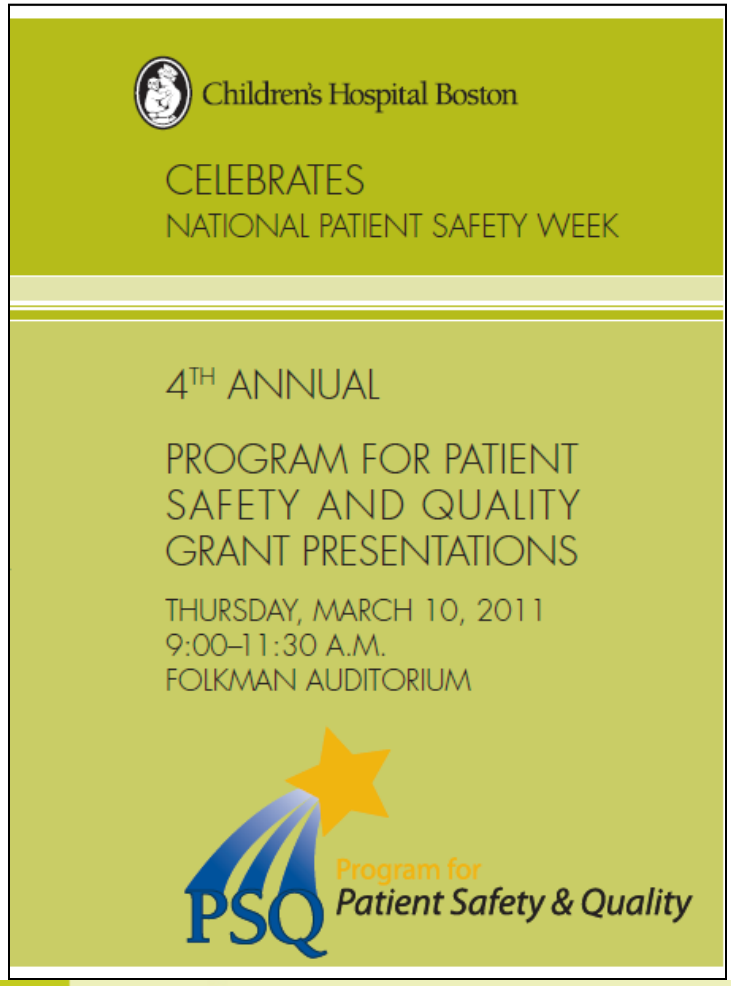
PPSQ Grants Program

- PPSQ grants program supports new academic activities led by Children's Hospital employees that address patient safety or quality issues
- Trainees, staff, and faculty members may propose any research consistent with the mission of PPSQ
- Maximum award is $20,000, average award: $10,000
- Since inception of grants program in 2006:
    - 173 applications received
    - 82 grants awarded
- April 2011 PPSQ grant funding cycle:
    - 24 applications received
    - 10 grants awarded

April 2011 PPSQ Grant Awardees

Principal Investigators	Department/ Division	Proposal Title	Award
	Cardiac Surgery	Use of Technical Performance Scoring as a Tool to Measure Early and Intermediate Outcomes in Open Repair of Complex Congenital Cardiac Defects in Neonates, Infants, Children, and Adults	$20,000
	Emergency Medicine	Implementation of a Pediatric Early Warning System in the Emergency Department	$6,750
	Developmental Medicine	Measuring Outcomes of Multidisciplinary Neurodevelopmental Evaluations: Feasibility and Validity	$9,075
	Urology	A Quality Improvement Intervention to Reduce Radiation Exposure During Pediatric Ureteroscopy	$9,944
	Cardiology	Consortium for Congenital Cardiac Care Measurement of Nursing Practice (C4-MNP)	$19,997
	Emergency Medicine	A Quality Improvement Intervention to Increase Adherence to Pediatric Advanced Life Support Guidelines for Severe Sepsis and Septic Shock within a Pediatric Emergency Department	$19,436
	Children's Hospital Primary Care Center	Implementation and Evaluation of a Pilot Quality Improvement Secondhand Smoke Prevention Program within the CHPCC Asthma Medical Home	$20,000
	Psychiatry	Implementation of a Web-Based Tool to Communicate and Monitor Medication Safety of Patients Receiving Psychiatric Care	$19,314
	Newborn Medicine	Quality of Life among Caregivers and Families of Preterm Infants after Discharge from the Neonatal Intensive Care Unit	$19,815
	Neurology	Outcome in Pediatric Status Epilepticus	$18,845

4th Annual PPSQ Grant Presentations



Teaching/Mentorship

- IHI Curriculum
- Partnership between the Graduate Medical Education Committee and the Program for Patient Safety and Quality
- Grant funds for small projects
- Harvard Quality and Safety Fellowship

IHI OPEN SCHOOL
for health professions

Welcome
John Doe
Logout

Search

My Learning | Course Catalogue

View by: All Courses and Lessons | All Courses | All Lessons

Quality Improvement

QI 101: Fundamentals of Improvement (60 min)

- Not started — Lesson 1: Errors Can Happen Anywhere□and to Anyone (15 min) — ★★★★☆ (2955 ratings)
- Not started — Lesson 2: Health Care Today (15 min) — ★★★★☆ (2482 ratings)
- Completed — Lesson 3: The Institute of Medicine's Aims for Improvement (15 min) — ★★★★☆ (2210 ratings)
- Not started — Lesson 4: How to Get from Here to There: Changing Systems (15 min) — ★★★★☆ (2028 ratings)

QI 102: The Model for Improvement: Your Engine for Change (75 min)

- Not started — Lesson 1: An Overview of the Model for Improvement (15 min) — ★★★★☆ (1714 ratings)
- Not started — Lesson 2: Setting an Aim (15 min) — ★★★★☆ (1543 ratings)
- Not started — Lesson 3: Measuring (15 min) — ★★★★☆ (1480 ratings)
- Not started — Lesson 4: Developing Changes (15 min) — ★★★★☆ (1424 ratings)
- Not started — Lesson 5: Testing Changes (15 min) — ★★★★☆ (1378 ratings)

QI 103: Measuring for Improvement (45 min)

- Not started — Lesson 1: Measurement Fundamentals (15 min) — ★★★★☆ (1338 ratings)

Primary goals:

- Train physician-scholars who are prepared to lead operational improvement efforts within the Harvard system and across the nation.
- Create scholars who can perform rigorous research about measurement of quality in clinics and health systems, the impact of demonstration studies, rigorously designed intervention trials, and effective implementation and dissemination.

Four Ways to Engage Academic Physicians

1. Accountability/Ownership
2. High Quality Data
3. Credible Experts
4. Academic Productivity

Cultural Change – The Journey to Medical Staff Engagement in Performance Improvement

MA BoRM Quality and Patient Safety Division Workshop
June 3, 2011

Marc S. Rubin M.D.

NORTH SHORE MEDICAL CENTER

PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

Cultural Change – Engaging Medical Staff in PI
Disclosures

I do not have all the answers

Our medical staff is not fully engaged

I spend most of my time trying to find solutions to this problem

My PCA coordinator deserves most of the credit for the success story you are about to hear

Cultural Change – Engaging Medical Staff in PI
The Problem

- Adverse events happen that should be preventable
- Health care and hospital systems are complicated
- Determining why something bad happened can be difficult and may require resources and skills that are limited at your institution
- Once the cause(s) are identified you need clinician attention, buy-in and assistance to make the changes that will prevent these events from recurring
- But MDs and other staff are focused on other important things and have less time than ever to participate in what often are time consuming improvement efforts
- And they are being bombarded from all sides with regulatory mandates, health system requirements and pay for performance goals that must be met

Cultural Change – Engaging Medical Staff in PI
The NSMC story

- Where we started *circa* 2003
  - » Administrative leadership team more focused on operations than outcomes
  - » Physicians loosely affiliated with Medical Center and rarely asked to join strategic or operational planning efforts
  - » Medical staff and Departmental physician leadership determined by vote or seniority
  - » Small Performance Improvement Department with limited skills
  - » Belief that occasional adverse events were “the cost of doing business”

Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

- And then in 2004…
- Communication from the Board's PCA Division to NSMC's new CEO:
  - » "NSMC could do better…regarding the timeliness, quality and depth of content of…reports"
  - » "There is much more internal analysis, action planning and learning possible from events than [NSMC] has demonstrated"
  - » "You seem to have adopted a risk avoidance approach to reporting"
- …and a site visit:
  - » Unclear whether NSMC's quality assurance process was identifying weaknesses in prevention of harm and ensuring that all necessary steps were taken to prevent recurrence of adverse events
- This was a real wake up call

Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

- NSMC Senior leadership analysis:
  - » Performance improvement not prominent enough on strategic agenda
  - » PI Department under-resourced and lacking necessary skills
  - » MDs not engaged in clinical improvement
- The solution:
  - » NSMC needs to establish a new PI structure and process*

* Donabedian, A: The Quality of Care, *JAMA* 1988;260:1743-1748

Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

- Structural changes:
  - » Director of Performance Improvement elevated to Vice President and charged with developing annual PI plan
  - » PI Department enlarged and PI staff trained in process improvement (FMEA/RCA, rapid cycle improvement, high reliability, Healthcare Delivery Improvement*)
  - » Decision made to employ Department Chairs and to hold them accountable for engaging the members of their Departments in clinical improvement
  - » Strategic goals adjusted to place clinical performance improvement at the same level as operational improvement

* Intermountain Healthcare

Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

- Process Change: Driving performance improvement through multidisciplinary peer review
  - » Peer review already developed in all clinical Departments
  - » Peer review widely accepted by MDs as an important element in patient care and part of their responsibility as a professional
  - » With good event reporting it should be possible to have almost all adverse events analyzed at peer review in some clinical department

Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

- But…
  - » Peer review was barely connected to the medical center and not connected at all to any formal improvement work at NSMC
  - » Peer review process would need to be redefined and redesigned:
    - To enhance event identification
    - To improve event analysis
    - To enable peer review across disciplines
    - To add accountability for improvement action
    - To follow cases until corrective changes enacted

Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

- Motivating physician participation
  - » Critical to success of new PI process…but little written on how to do it
  - » What doesn't work:
    - Telling MDs they have to do something
    - Not being transparent about your motives
    - Making a case that is not supported by data
  - » What works sometimes:
    - Paying MDs for their time (works variably depending on implementation and has regulatory risks)
    - Creating hard stops that force participation (works, but best as a last resort)
  - » What does work
    - Addressing issues they care about (aka aligning incentives)
      - Patient outcomes and experience usually at the top of the list
      - Note: everyone does not care about the same things!
    - Leveraging fears
    - Leading by example/peer pressure
    - Sharing decision-making
    - Appealing to professionalism
    - Rewarding successes
    - Fairness

Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

- Redesigning the peer review process at NSMC
  - » NSMC leadership:
    - Promoted adverse event reporting as “blame free” and the best way to identify improvement opportunities and prevent recurrences
    - Protected reporting by policy
    - Hired additional FTEs to PI Dept. and paid for improvement skills training
    - Added analytic support to each Dept. to provide data
    - Resourced improvements identified by Peer review/PCA process
  - » Chairs:
    - Made the case that many of the adverse events in their Dept. were preventable.
    - Showed data that most events were due to systems issues not practitioner issues.
    - Challenged MDs to be accountable for leading improvement “for their patients sake”
    - Mandated peer review attendance
    - Agreed to standardized peer review methodology, scoring and reporting and to transparency

Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

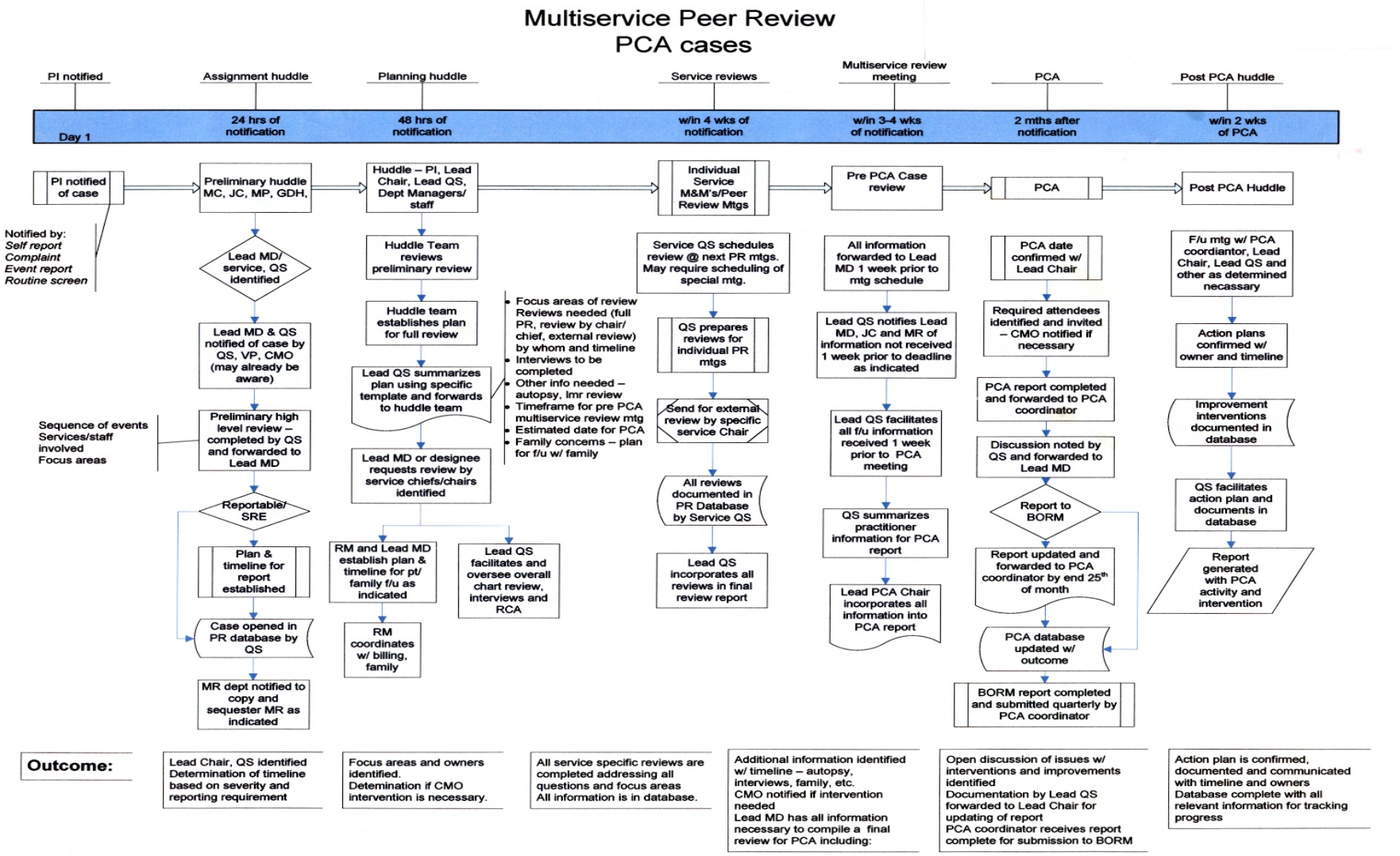
- Redesigning the peer review process at NSMC *cont*.
  - » PI Department:
    - Added ways to identify/report adverse events – making it easy to do the right thing
    - Quality Specialists with clinical improvement skills assigned to each Dept.
    - Created tools and databases and provided improved access to them
    - SWAT team approach to serious adverse events with immediate huddle
    - Added risk management and peer support for MDs
  - » PCA Committee redefined
    - Highest level of peer review
    - Vehicle for positive change (including it's reporting function)
    - Members committed to multidisciplinary transparency, critical examination of each others cases
    - Inclusive (all Departments represented, all involved MDs invited)
    - Supportive PCA Coordinator with good working relationships with Chairs
    - Empowered to effect change
      - Shared accountability
      - Reporting to NSMC Board

Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

- Redesigning the peer review process at NSMC *cont*.
  - » Other keys in changing the culture
    - Value of new process showcased whenever possible
      - Improvement stories shared at Department and medical staff meetings
      - MD beneficiaries of new support efforts sharing their experiences
      - Feedback at staff meetings about reported events and what was done about them
    - Leadership walking the walk
      - Clinical leaders show the way when their cases are presented (cooperation, participation, transparency, willingness to report)
      - Administration values recommendations coming from PCA Committee and the peer review process and provides resources for safety and quality improvements
      - Blame free culture
    - Recognizing the BoRM QPSD as a partner
      - » MD blind reporting
      - » Peer protection
      - » Newsletter highlighting best practices
      - » Annual recognition awards

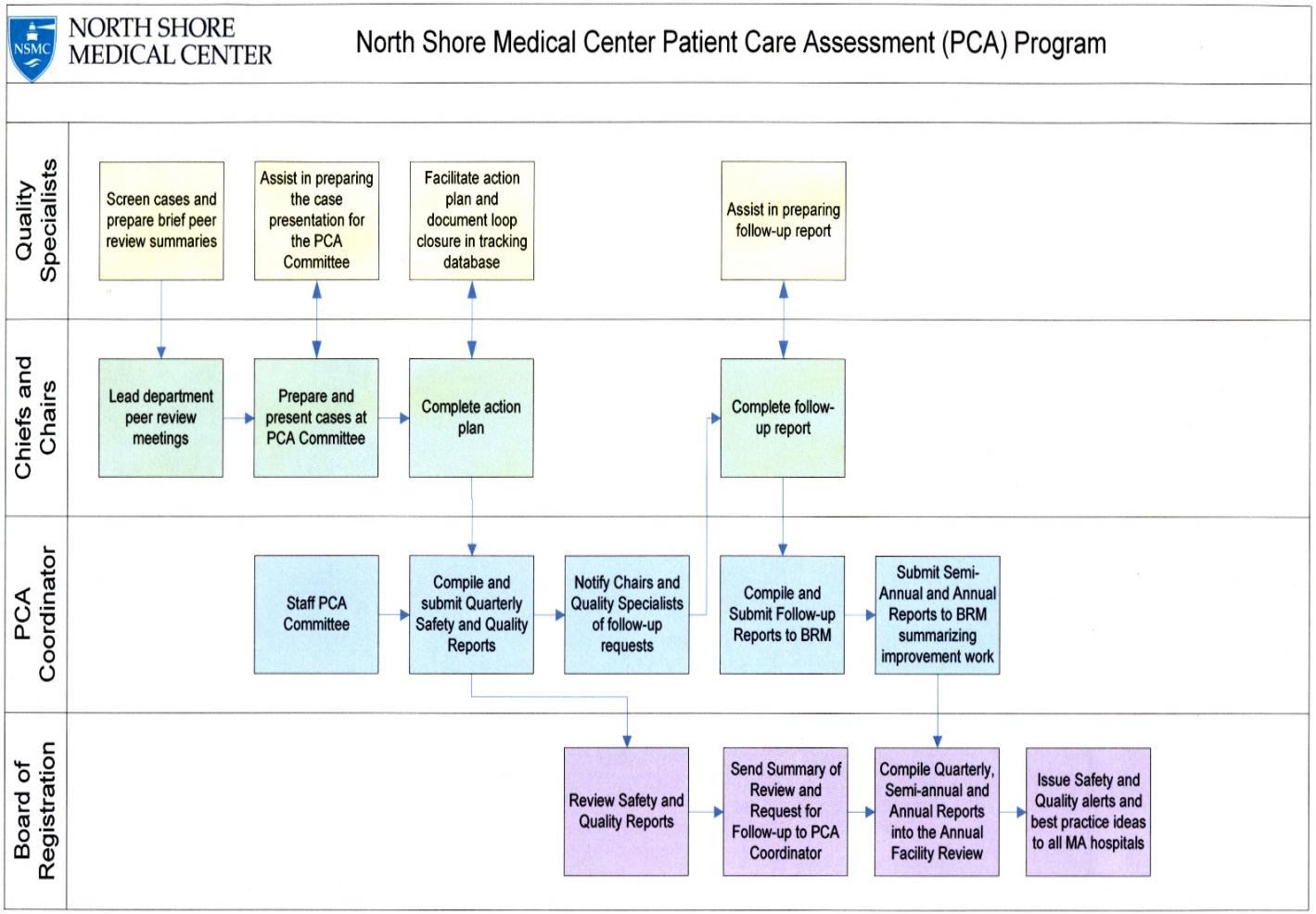
Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*



Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*



Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

NSMC Dept. of Surgery Guidelines for Reporting an Adverse Event to SEC or PCA

- Physician Score >2
- System Score >2
- Major or permanent impairment or death (outcome score D or E) which fulfills either one of the following
  - Event was ***not probable*** in light of the patient's admitting diagnosis and condition
  - Event may have been ***preventable***
- Significant adverse outcome (score C,D or E) despite low risk (score 2 or 3)
- Death or impairment from unexpected or rare cause
- Serious Reportable Events (see list below)
- Serious patient/family complaint to NSMC or outside organization
- Affirmative answer to a generic peer review question (see list below)

NSMC Department of Surgery Generic Peer Review Questions

- Was the outcome/event preventable or potentially preventable?
- Could or should something have been done differently?
- Were there systems or interdisciplinary issues that compromised care?
- Should a guideline/protocol/policy be instituted by the Section, Department or Medical Center to prevent the adverse event from happening again?
- Was there a component of care that was not delivered in the fashion in which you would teach it?

Cultural Change – Engaging Medical Staff in PI

The NSMC story *continued*

MR#:

PEER REVIEW SCORES

Outcome Score (circle one):

A	No adverse outcome
B	Minor adverse outcome (eg. minor transient impairment)
C	Moderate adverse outcome (eg. prolonged transient or mild permanent impairment)
D	Major adverse outcome (eg. permanent significant impairment)
E	Catastrophic adverse outcome (eg. loss of life)

Physician Score (circle one):

P0	Commendable care
P1	Evidence based or accepted practice followed (includes supported approaches that are controversial)
P2	Minor variation from evidence based or accepted practice
P3	Significant variation from evidence based or accepted practice
P4	Unacceptable variation from evidence based or accepted practice

Physician deficit(s) (check one or more):

- ☐ Fund of knowledge
- ☐ Judgement
- ☐ Diagnosis
- ☐ Technical skill
- ☐ Behavior
- ☐ Documentation
- ☐ Supervision
- ☐ Hospital policy compliance
- ☐ Other_____

System Score (circle one):

S1	No systems issues
S2	Minor systems issues
S3	Moderate systems issues
S4	Major systems issues

Systems Issue(s) (check one or more):

- ☐ Process failure: _____
- ☐ Communication/ Handoff
- ☐ Responsiveness
- ☐ Coverage
- ☐ Service assignment
- ☐ Chain of command
- ☐ Conflict resolution
- ☐ Documentation
- ☐ Resource availability
- ☐ Equipment failure
- ☐ Other:

Risk Score (2 - 6 total, circle one complexity level and one risk level):

1pt	case required clinical judgment/skills of low complexity
2pts	case required clinical judgment/skills of moderate complexity
3pts	case required clinical judgment/skills of high complexity
	PLUS
1pts	low risk (ASA 1)
2pts	moderate risk (ASA 2 - 3)
3pts	high risk (ASA 4 - 5)

Disposition (check one or more):

- ☐ no action required
- ☐ Refer to SEC
- ☐ Refer to PCA
- ☐ Report to BRM
- ☐ Recommend focused review
- ☐ Discuss with practitioner
- ☐ Outside case review
- ☐ Refer to _____ (department/committee/administrator)
- ☐ Recommend educational program for _____ (department)

Comments: _____

_____

_____

_____

_____

Section Chief Signature/Date

(Draft revision 1.12.09)

NORTH SHORE MEDICAL CENTER

Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

Template for Reports to SEC and PCA

CONFIDENTIAL – PEER REVIEW

PATIENT CARE ASSESSMENT PROGRAM
SAFETY AND QUALITY REPORT

North Shore Medical Center (NSMC) – XXXX Hospital Campus
Date of Incident:
Medical Record #:

NARRATIVE DESCRIPTION:
What happened in 1 sentence

HISTORY, ASSESSMENT, AND HOSPITAL COURSE:
The detailed course of events

DEPARTMENTAL PEER REVIEW:
The discussion at your Section's Peer Review meeting

PRACTITIONER PERFORMANCE REVIEW:
Any relevant issues involving the practitioner's performance historically e.g. pattern of adverse events, deviations from standards of practice etc

PATIENT AND FAMILY:
How were they involved after the event

SYSTEMS ISSUES:
Your assessment of any problems that may have contributed to the event

PRACTITIONER ISSUES:
Your assessment of any problems that may have contributed to the event

SAFETY AND QUALITY IMPROVEMENT MEASURES:
Your action plan to prevent the occurrence of similar events. Presented in the following format:

1. The Chief and Associate Chief will develop a program to review….
   Responsible parties:
   Timeline for completion:
   Status at the time of this report:

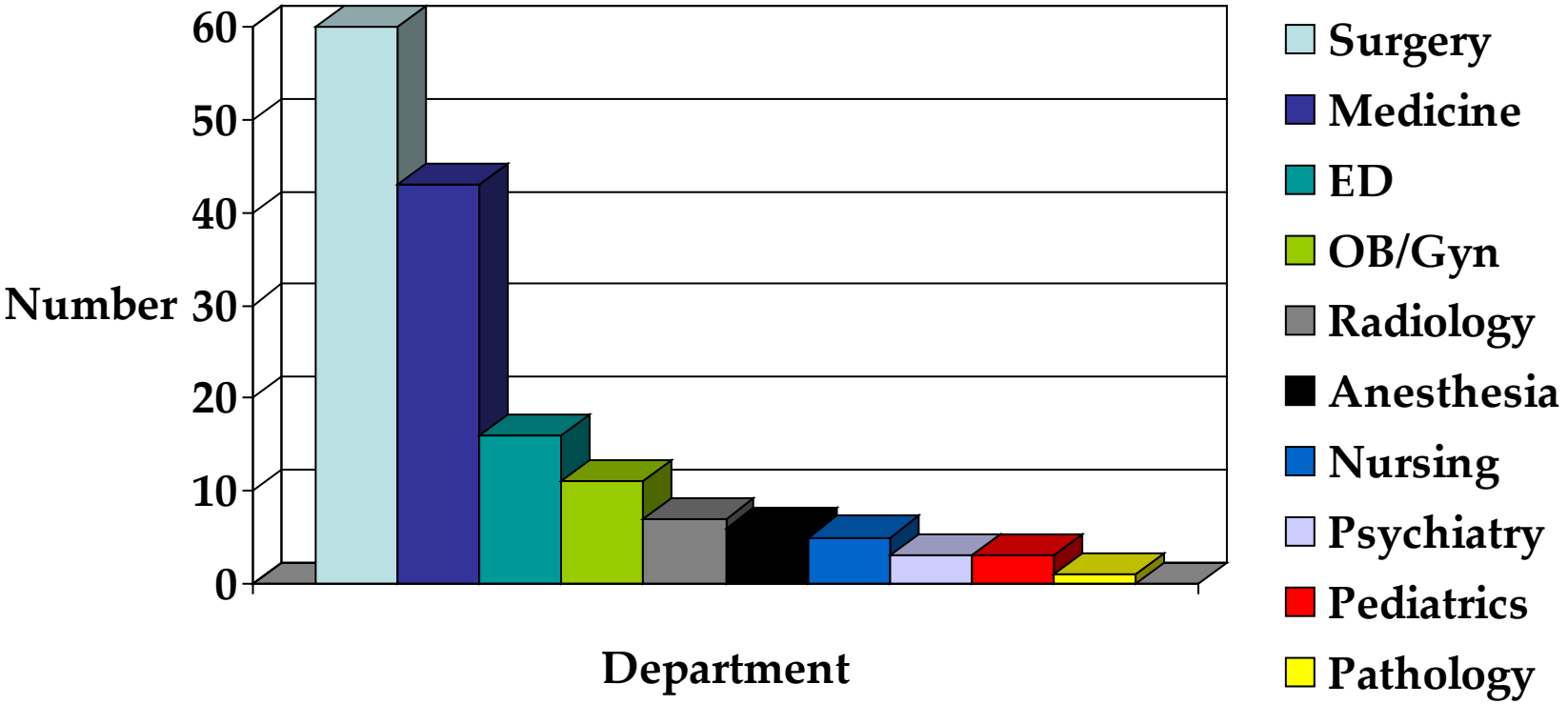
2. The surgeon involved in this case will….
   Responsible parties:
   Timeline for completion:
   Status at the time of this report:

NORTH SHORE MEDICAL CENTER

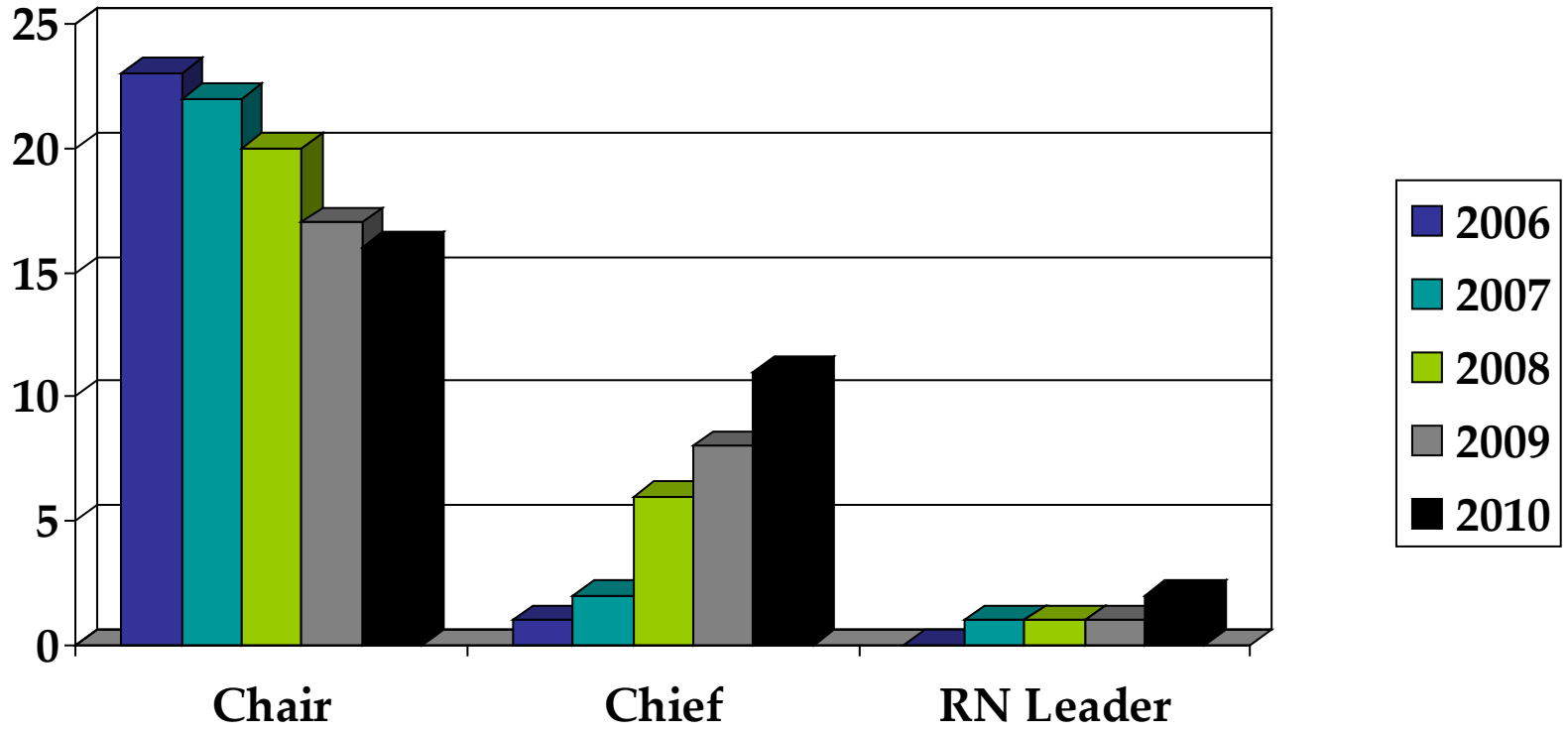
Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

- Outcomes
  - » 2005-2010 NSMC PCA Committee
    - 155 cases reviewed
    - 364 Action items
    - Over 70% completed/closed
  - » 2010 NSMC Departmental peer review:
    - 511 Cases underwent peer review at departmental level
    - 26 Cases brought to PCA Committee
    - Department of Surgery
      - 11 sections reviewed 231 cases
      - 15 cases presented at PCA Committee

PCA CASES BY DEPARTMENT 2005-2010



PCA COMMITTEE CASE OWNERSHIP 2006-2010



Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

- Outcomes *cont.*
  - » Case Example #1
    - Date: 2/23/06
    - Adverse event: Retained foreign body at laparotomy
    - Action Item: Revise count policy to ensure accurate counts and reduce retained foreign bodies to zero
      - Responsible Party: Chair of Surgery
      - Process: Immediate implementation of X-ray policy…Review of NSMC experience (6 retained FBs over past 4 years – 4 lap pads, 2 pieces from disposable staplers)…Quality specialist performs failure modes and effects analysis…literature review…workgroup of frontline staff and surgeons convened…major policy revision (pause prior to closure, mandatory X-ray for high risk cases, limits on reliefs, communication and documentation of FBs in body cavities, counting of disposables)…recommendation for addition of technology…pilot and universal implementation of bar coded sponge counter.
      - Outcome: No retained foreign bodies for 4 years

Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

- Outcomes *cont.*
  - » Case Example #2
    - Date: 8/29/08
    - Adverse Event:: Wrong level kyphoplasty
    - Action Item: Develop guidelines for accurate assessment of spine anatomy prior kyphoplasty whether performed by Neurosurgery, Orthopedics or Radiology
      - Responsible party: Chief of Neurosurgery
      - Process: Convened task force of stakeholders, quality specialist performed root cause analysis, failures or near misses identified in both surgery and radiology, surgery chiefs and radiology chair agree on guideline and implement as standard of practice
      - Outcome: No wrong level kyphoplasties since implementation of guideline

Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

- Outcomes *cont.*
  - » Case Example #3
    - Date: 9/1/09
    - Adverse event: Delay in notifying MD of a post-CEA change in mental status
    - Action Item #1: Improve communication between RNs and MDs in the event of a deterioration in patient's condition
      - Responsible Parties: Chair of Surgery, Associate Chief Nurse
      - Process: Quality specialist performs and identifies communication barriers… RCA…Workgroup of RNs, MDs creates list of events/signs/symptoms for which RNs should contact MD…List vetted and approved by medical staff…Guideline created for use on all units.
      - Outcome: Pending
    - Action Item #2: Ensure that all staff that care for patients with increased risk of neurologic deterioration have the competencies and support to perform adequate assessment
      - Responsible party: Associate Chief Nurse
      - Process: Group of RNs identified to update skills…Protocol for neuro assessment developed and made policy…Assignments tailored to provide neuro RNs adequate volume of experience and reduced load when performing frequent assessments
      - Outcome: Pending

Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

- Outcomes *cont.*
  - » Case Example #4
    - Date: 2/24/10
    - Adverse event:: Respiratory arrest and death following elective hip replacement
    - Action Item: Improve monitoring of post-operative patients to prevent or allow early identification of respiratory depression
      - Responsible party: Chair of Anesthesia
      - Process: Quality specialist reviews all reported post-op respiratory depression/ near misses and performs FMEA…Multidisciplinary team formed to devise intervention (Surgery, Anesthesia, PACU and med/surg RNs, Pharmacist, Pulmonary and Critical Care Medicine)…Screening tool for OSA piloted then implemented in pre-surgical testing, level of monitoring based on OSA score and anesthesia assessment…Capnography monitors piloted and purchased for use in high risk patients…OSA testing facilitated
      - Outcome: Pending

Cultural Change – Engaging Medical Staff in PI
The NSMC story *continued*

- Next steps:
  - » Continue to drive peer review improvement process deeper into organization so that improvement can be driven at the Department, Section and Unit level
  - » Add to provider support
  - » Continue to enhance the PCA Committee and its role in NSMC's overall strategy
  - » Involve patients, families, patient advocates

Cultural Change – Engaging Medical Staff in PI
Conclusions

- Cultural change happens slowly and it's iterative. Start with what you have that's good and build on it.
- Invest in getting the structure right. Then you can put a good process in place that will help you get to your outcome.
- Engaging clinicians requires aligning incentives which means understanding what they care about. It's always best to have an honest, transparent dialogue. The fastest way to credibility is "walking the walk" - including demonstrating your commitment with resources.
- Fortunately, better patient outcomes and experience is at the top of the list for both doctors and hospitals. Consider making clinical improvement a core business strategy.

THE "TEACHING PRINCIPLE"

Process for Medical Staff Review of Unexpected Events: Peer Review

"Engaging Physicians" Conference

June 3, 2011

Leslie G. Selbovitz, MD
Senior Vice President & Chief Medical Officer
Newton Wellesley Hospital

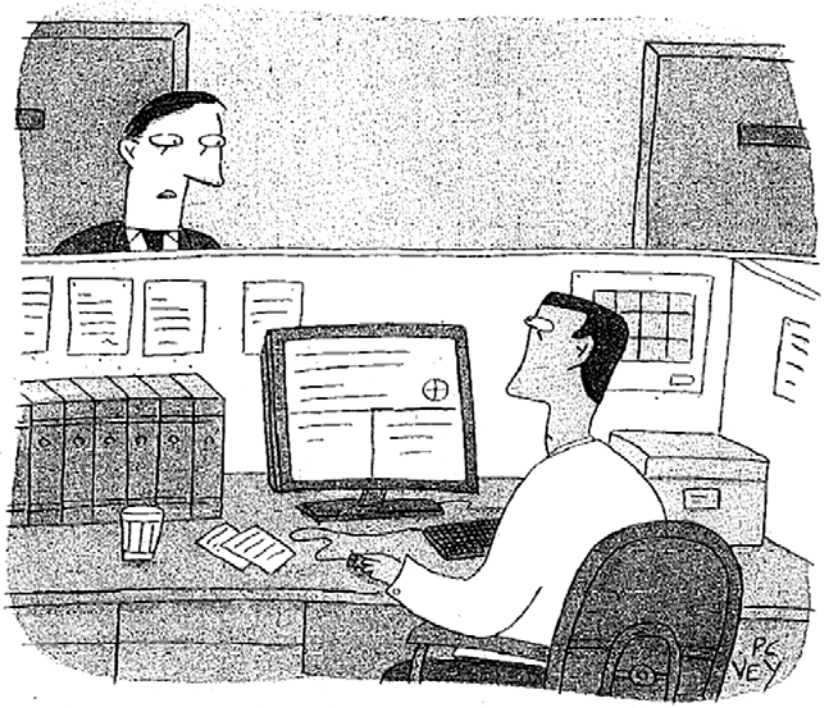
Clinical Professor of Medicine
Tufts University School of Medicine

NEWTON-WELLESLEY HOSPITAL

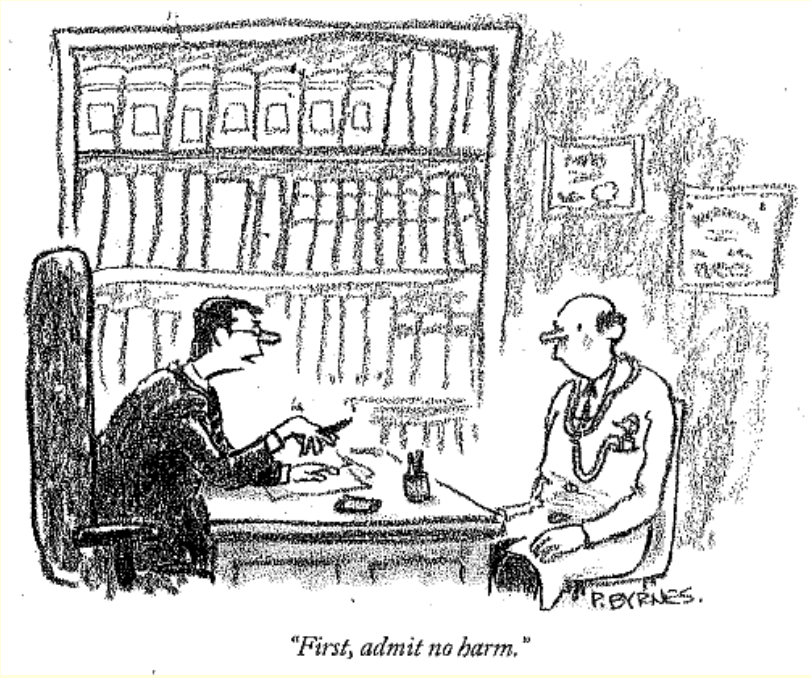
MEDICAL PEER REVIEW

"There is nothing difficult about the system except for the human nature part."

A supporter of Dr. Ernest Amory Codman, a surgeon at MGH, who resigned in protest over the lack of institutionalization of his proposed "end results system" (now called Outcomes Studies). Reverby, S. *Stealing the golden eggs: Ernest Amory Codman and the science and management of medicine.* Bulletin of The History of Medicine. 1981; 55: 156-71.



"We're ready to begin the next phase of keeping things exactly the way they are."



"First, admit no harm."

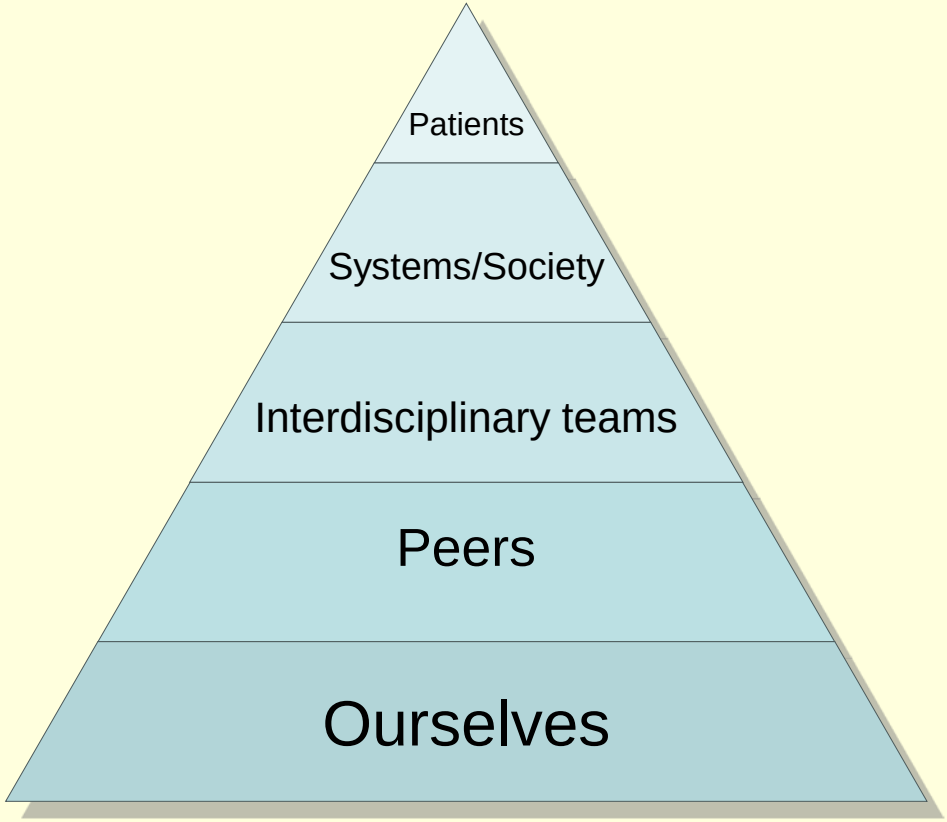
Accountability

- Diffusion of accountability across a care team should never be the dilution of individual accountability but instead redefinition of accountability.
- The team leader still bears the burden of the patient's trust and therefore the burden of

COLLECTIVE ACCOUNTABILITY

Moorman DW. Communication, Teams, and Medical Mistakes. *Ann Surg.* 2007; 245:173-175.

Accountability



Do we have to ask for what?

And – at what moment in time?

PEER REVIEW

- **Foundational Principle**:
  Impartial assessment and feedback by knowledgeable experts can improve the quality of a work product and reduce medical errors

- **Multiple Nuances To The Meaning Of Peer Review:**
  Professional role in quality and safety of medical care
  Focused practitioner or departmental performance assessment
  Professional conduct
  Corrective actions and discipline
  Massachusetts statutes and case law, Chapter III, Section 1, Section 204, Section 205
  Serious reportable events and complaints challenge (105 CMR 130.33 (AND 130.330)
  Joint Commission and ACGME core competencies
  Research and publications
  Patient Safety Organizations (AHRQ)

NWH DEFINITION OF MEDICAL PEER REVIEW

A PROCESS TO IMPROVE THE QUALITY AND SAFETY OF MEDICAL CARE BY WHICH PHYSICIANS ARE COLLEGIALLY, BUT, FORMALLY ORGANIZED TO REVIEW OR INVESTIGATE PROFESSIONAL PERFORMANCE WITH ATTENTION TO THE APPLICABLE STANDARDS EXPECTED TO BE INCORPORATED IN THE DOCTOR-PATIENT RELATIONSHIP AND AS AN ACCOUNTABLE MEMBER OF THE HEALTH CARE TEAM.

FRAMING MEDICAL PEER REVIEW

- Extends to all providers on the professional and medical staffs.
- Caveats: division between individual performance and the systems enveloping that performance can be indistinct.
- Peer review is a center piece of a larger quality and safety agenda.
- All group judgment methodologies have their limitations, including structured implicit and explicit analytics.
- Smaller institutions have special issues for (Board of Trustees approved) medical peer review committee work.
  - ? Role of Patient Safety Organizations (AHRQ)
- Tying to Core Competencies

THE ESSENTIAL CONCEPTS OF MEDICAL PEER REVIEW

- Non-punitive system by definition in annually updated Patient Care Assessment Plan (vs. Corrective Action under Medical Staff Bylaws).
- Adoption under Medical Staff Bylaws of Patient Care Assessment Plan and Explicit QI/Peer Review Policy of Medical Staff to help assure statutory protection from discovery and preservation of qualified immunity (Federal and State) – All Board of Trustees approved.
- Ergo, confidentiality of all aspects of related proceedings is vital: Patient Care Assessment Coordinator demonstrates that the materials are necessary to comply with required Risk Management and Quality Assurance programs and are necessary to the work product of Medical Peer Review Committees.

THE ESSENTIAL CONCEPTS OF MEDICAL PEER REVIEW

(continued)

TO THE EXTENT POSSIBLE, the Department of the Attending Physician, or the Department principally responsible for the outcome of care, controls the expertise for the primary case analysis of professional performance and may identify systems' issues. Plan for interdepartmental and interdisciplinary reviews.

- Impartiality – Avoidance of Bias
- Good Faith
- Attentive to conflicts of interest

THE ESSENTIAL CONCEPTS OF MEDICAL PEER REVIEW

(continued)

- Due Process (aside from Hearings/Appeals under Corrective Action Section of Medical Staff Bylaws)
- Input into credentialing and granting of privileges.
- Achievement of validity and reliability through consistency of core committee membership while rotating other members, repetition, monitoring of peer review database for patterns of judgments made by department peer review committees and variation within and across departmental committees and providing feedback. Smooth out inter- and intra-observer variability over time.
- ADHERENCE TO THE TEACHING PRINCIPLE OF QUALITY AND EMPHASIS ON PROFESSIONALISM

THE TEACHING PRINCIPLE of QUALITY

"UNLESS EACH AND EVERY COMPONENT OF CARE WAS/IS DELIVERED IN THE EXACT FASHION IN WHICH YOU WOULD TEACH IT, THERE IS OPPORTUNITY FOR IMPROVEMENT."

Leslie G. Selbovitz, MD

The Teaching Principle

- Appropriate Care vs. Teaching Principle

- THE TEACHING PRINCIPLE
  - Do it as you would teach it
  - Avoid passive justification

THE TEACHING PRINCIPLE OF QUALITY

Characteristics:

- Reliance on professionalism and highest sense of self.
- Every physician reviewer is a Professor.
- By participating in the review process, hopefully one inculcates the principles used to judge others – do not be disingenuous.
- A return to a culture of medicine as a calling, not just a business.
- Incorporates professionalism in a relentless cycle of quality improvement.
- Attentive to performance within The Team

THE TEACHING PRINCIPLE of QUALITY

- No need to be a “Teaching Institution” to apply the teaching principle.

- It is in the spirit of Abraham Flexner’s 1910 notion that formal analytical reasoning should hold pride of place in the intellectual training of physicians. (Cooke et al, *NEJM* 2006; 355:1339-44)

- Doctors and other health care professionals are life-long learners and need a congruous supporting matrix to improve quality of care.

- Assessment drives learning.

- Structured Implicit Group Judgment allows for the potential integration for scientific discoveries and context-specific continuous improvement of medical practice – supporting innovation while defining role of IRBs in adoption of new technologies and approaches.

MEDICAL PEER REVIEW

THE TOOL KIT:

1. Medical Staff Bylaws, Rules and Regulations, Supporting Policies - especially one dealing with Medical Staff Peer Review and its procedures. (Peer Review Committees for quality analysis have no disciplinary authority).
2. Patient Care Assessment Plan, annually updated and including an explicit Medical Peer Review Policy and Procedure (Step-by-Step Approach).
3. Physician-led Committee Structure.
4. Accountability to Board of Trustees.
5. Peer Review within the context of a larger quality and safety agenda. e.g., Simulation

MEDICAL PEER REVIEW
THE TOOL KIT (continued)

6. Dynamic relationship between professional performance peer review and systems of care.
7. Worksheets -- NWH uses modified Structured Implicit (and Explicit) Approaches principally (originally created at Rand Corporation).
8. Databases to correlate processes of care with outcomes of care through the eyes of physicians – ANALYZE PATTERN OF PERFORMANCE AND ASSESS VARIABILITY OF JUDGMENTS.
9. Role of Medical Staff and Hospital leadership: View of one Chief Medical Officer.
10. The individual physician and the community of the medical staff: a supporting, scholarly environment to learn and to improve practice.

MEDICAL PEER REVIEW

THE HOPE:

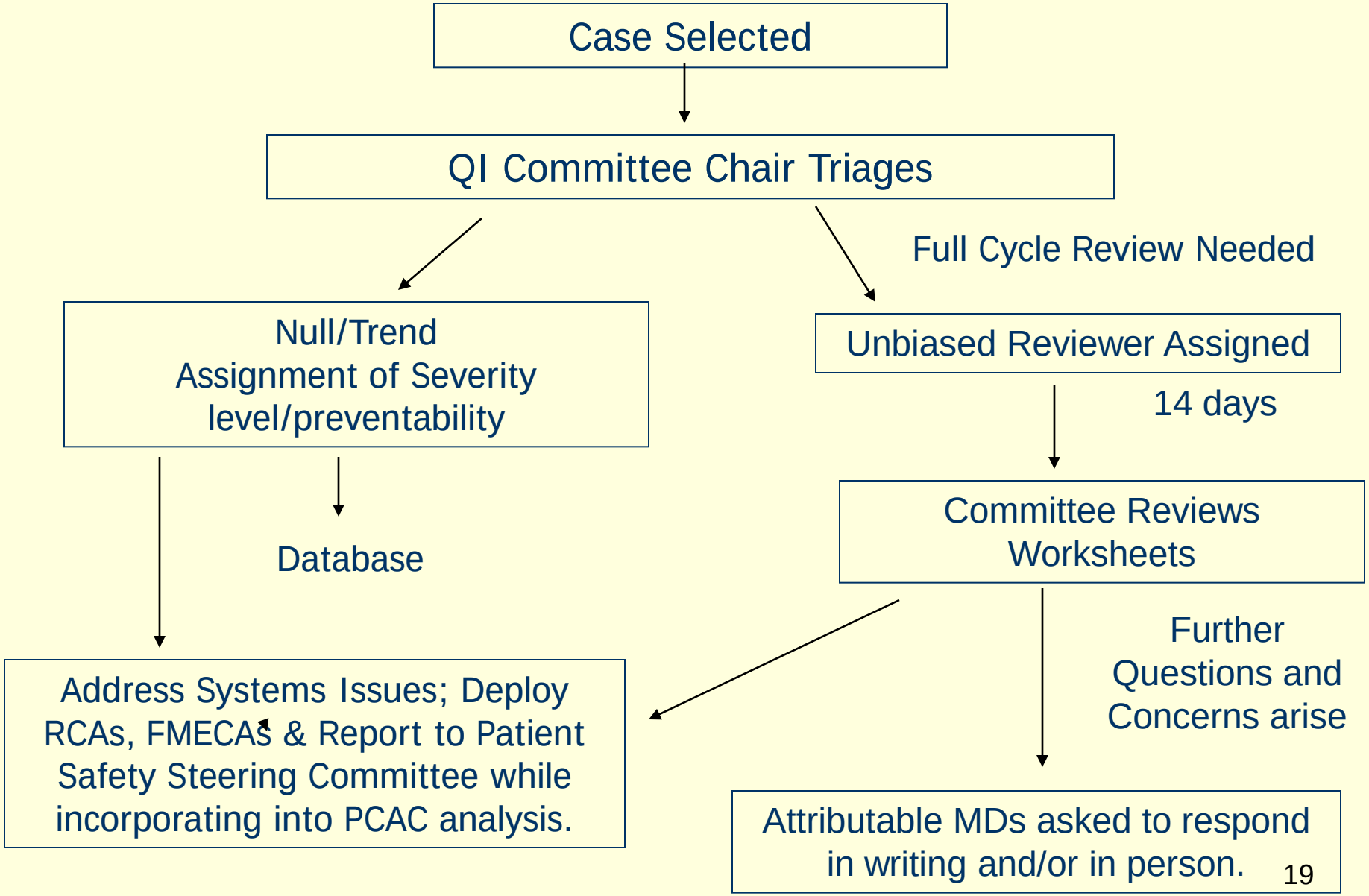
One intuitively considers in real time doing “it” as one would teach it.

THE EMPHASIS:

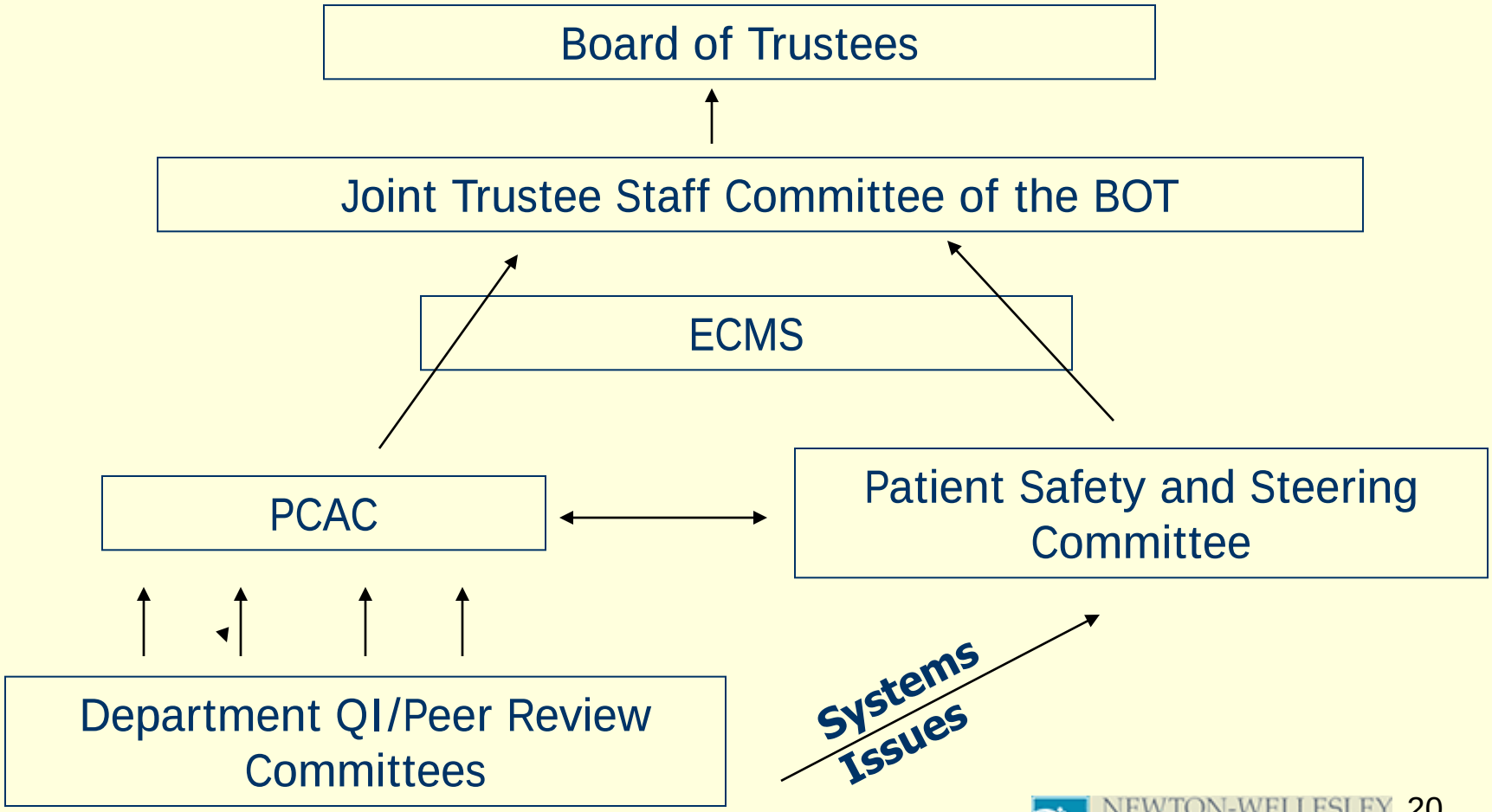
- Professionalism.
- Non—punitive system of accountability until you hit the wall.
- Codification of non-punitive approach to assure statutory protections while not eliminating the strength of Corrective Action sections of Medical Staff Bylaws

A LOOK AT THE NWH COMMITTEE STRUCTURE, METHODS AND INSTRUMENTS

PEER REVIEW FLOW DIAGRAM



STRUCTURE, PROCESS AND OUTCOME
(DONABEDIAN)
Schematic of peer review committee flow of information



PEER REVIEW DIAGRAM USING STRUCTURED IMPLICIT WORKSHEETS

CASE WRITE-UPS

- For PCAC minutes.
- For BORM QPSD, DPH, other regulators.

  The QI Committee Chair, Department Chair, Service Chief, or knowledgeable physician designee.
- HCQ assists in physician profiling data for QPSD report.
- CMO/Chair reviews write-ups, edits as appropriate and submits mandated reports.
- Note: HCQ QI RNs assist in PCAC minutes and assembling fundamental data.

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MEDICINE, FAMILY MEDICINE, SURGERY, OBSTETRICS & GYNECOLOGY, PEDIATRICS, EMERGENCY MEDICINE, PSYCHIATRY

"Dear Doctor:

Thank you for participating in the medical staff and hospital quality improvement program. Your input is highly valued. Please remember that your initial screen of the case will be presented to a group of peers who will use the analysis to dissect the care..."

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"In answering the questions, please consider the following guide: if each individual component of care was not delivered in the exact fashion in which you would teach it, there is opportunity for improvement."

"This process is strictly confidential. You may not dialogue about this case outside of the medical staff approved peer review process."

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QI-RN Review

Narrative_____

_____

_____

Reason(s) for referral: _____

_____

Focus Questions:

_____

_____

_____

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PHYSICIAN REVIEWER - START HERE:

Review of Components of Care

LEGEND	
5 =	Superb, Would Emulate. No room for improvement. Excellent teaching example.
0 =	Entirely unacceptable

Note: If question is non-applicable, rank as 5.

For any grade of 3 or less, please explain in Overall Case Analysis.

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Check one box for the response to each question:

1. The history was comprehensive in initial data gathering including pertinent positives, pertinent negatives and medication reconciliation?
   □ 5 □ 4 □ 3 □ 2 □ 1 □ 0

2. The physical examination was comprehensive and/or appropriate to the differential diagnosis?
   □ 5 □ 4 □ 3 □ 2 □ 1 □ 0

3. The formulation of the initial differential diagnosis and diagnostic impression met the teaching standard?
   □ 5 □ 4 □ 3 □ 2 □ 1 □ 0

4. The (initial / subsequent) use of diagnostic tests met the teaching standard?
   □ 5 □ 4 □ 3 □ 2 □ 1 □ 0

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5. The interpretation of diagnostic test(s) met the teaching standard?
   □ 5 □ 4 □ 3 □ 2 □ 1 □ 0

6. The (initial / subsequent) therapeutic (including pharmacologic or invasive or surgical) interventions met the teaching standard?
   □ 5 □ 4 □ 3 □ 2 □ 1 □ 0

7. There is evidence of appropriate resident, fellow, medical student, physician assistant, and/or nurse practitioner and/or midlevel student supervision (cosigning notes, timely responding) in the medical record?
   □ 5 □ 4 □ 3 □ 2 □ 1 □ 0

8. There is other evidence of good communication including evidence of timely notification of attending upon adverse change in patient condition and during handoff's?
   □ 5 □ 4 □ 3 □ 2 □ 1 □ 0

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9. There is evidence that the patient was monitored according to the teaching standard?

□ 5 □ 4 □ 3 □ 2 □ 1 □ 0

10. There is evidence of a timely response to potentially life-threatening clues including critical values?

□ 5 □ 4 □ 3 □ 2 □ 1 □ 0

11. Progress Notes, including those describing procedures, are well documented with relevant information to monitor patient's progress and justify need for ongoing hospitalization?

□ 5 □ 4 □ 3 □ 2 □ 1 □ 0

12. There were effective drug orders, administration, monitoring and overall excellent pharmacologic management including medication reconciliation documentation?

□ 5 □ 4 □ 3 □ 2 □ 1 □ 0

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13. Pain management is thoughtful and effective?

□ 5 □ 4 □ 3 □ 2 □ 1 □ 0

14. Psychosocial and spiritual dimensions of care are thoughtfully and effectively addressed?

□ 5 □ 4 □ 3 □ 2 □ 1 □ 0

15. Palliative care consultation was sought in accordance with the teaching standard?

□ 5 □ 4 □ 3 □ 2 □ 1 □ 0

16. There is a picture of the overall functional status of the patient on admission and discharge?

□ 5 □ 4 □ 3 □ 2 □ 1 □ 0

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17. At discharge, a contact is made with primary care physician in a timely fashion, the medical record documentation demonstrates discharge diagnoses, studies pending at discharge, medication reconciliation, allergies and other adverse drug reactions, safe warfarin continuation, code status and use of life sustaining interventions (as appropriate), condition on discharge, and 24/7 physician contact at hospital to allow for a smooth transition to the next level of care?

□ 5 □ 4 □ 3 □ 2 □ 1 □ 0

18. Professionalism met the teaching standard?

□ 5 □ 4 □ 3 □ 2 □ 1 □ 0

OVERALL CARE:

Considering everything you know about this patient, please rate the overall quality of care:

□ Consistently Met Teaching Standard
□ Inconsistently Met Teaching Standard
□ Did not Meet Teaching Standard

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FOR AN UNSATISFACTORY OUTCOME:

Given the state of medical science, do you feel that the patient's *a priori* risk for this adverse outcome was:

□ High □ Intermediate □ Low

OVERALL CASE ANALYSIS – FOR ALL QUESTIONS YOU MARKED WITH A SCORE OF 3 OR LESS IN QUESTIONS 1-18 ABOVE, PLEASE EXPLAIN. HOWEVER, PLEASE COMMENT ON ALL IMPORTANT ASPECTS OF CARE INCLUDING ADDRESSING FOCUS QUESTIONS ORIGINALLY RAISED.

(IF MANUAL, PLEASE PRINT LEGIBLY OR TYPE AND USE ADDITIONAL PAPER IF NECESSARY):

_____

_____

_____

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CONCLUSIONS:

TREND: An adverse patient outcome, or potential for an adverse patient outcome, **that was not necessarily preventable** and/or not due to errors in management **(i.e. for no confirmed quality of care defect)** but is **trendable** for pattern analysis. If system issues see below. If system issues, include filling out **XI.** and **XII.** below.

___ YES

___ NO (If NO, and **the case troubles** you beyond just "Trending", **check one box below and indicate your level of certainty by checking a second box of preventability**.)

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I. **FLAW** in the **PROCESS** of care, not associated with a measurable adverse outcome

- ❑ a. Possibly Preventable
- ❑ b. Probably Preventable
- ❑ c. Definitely Preventable

II. **ADVERSE PATIENT OUTCOME** (including prolonged hospital stay), **but does NOT involve IRREVERSIBLE END-ORGAN DAMAGE NOR LIFE-THREATENING NOR PERMANENTLY DISABLING EVENT**

- ❑ a. Possibly Preventable
- ❑ b. Probably Preventable
- ❑ c. Definitely Preventable

III. **ADVERSE PATIENT OUTCOME** which **involves IRREVERSIBLE END-ORGAN DAMAGE AND/OR LIFE-THREATENING AND/OR PERMANENTLY DISABLING EVENT**

- ❑ a. Possibly Preventable
- ❑ b. Probably Preventable
- ❑ c. Definitely Preventable

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XI. Were the teaching standard violations due solely to **SYSTEMS ISSUES**?

□ YES □ NO □ N/A

XII. Identify SYSTEMS ISSUES by checking all that apply:

- ❑ A - Clinical Transitions and Hand-Offs including Premature Discharge
- ❑ B - Communication - Data Presentation and Formatting
- ❑ C - Communication - Dissemination and/or Implementation of Policy
- ❑ D - Communication - Inadequate Policy
- ❑ E - Communication - Verbal (not identified elsewhere)
- ❑ F - Communication - Written (not identified elsewhere)
- ❑ G - Congruency/Consistency/Checks and Balances
- ❑ H - Consultant Expertise and/or Timely Availability
- ❑ I - CPOE or Other Electronic Care Management System
- ❑ J - Decision Support
- ❑ K - Ethics and/or Patient Rights
- ❑ L - Infection Control
- ❑ M - Knowledge Inadequate
- ❑ N - Leadership and Responsibility

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Identify SYSTEMS ISSUES by checking all that apply:

- ❑ O - Medical (Cognitive) Knowledge Deficit
- ❑ P - Medical Records Documentation and/or Organization
- ❑ Q - Medication Related
- ❑ R - Monitoring
- ❑ S - Orientation and/or Training
- ❑ T - Policy Related
- ❑ U - Rapid response
- ❑ V - Research Protection
- ❑ W - Safety and/or Security and/or Emergency Management
- ❑ X - Staffing Patterns for Patient Severity and Hospital Occupancy
- ❑ Y - Supervision/Chain of Command (Conduct of Care/Conflict Resolution)
- ❑ Z - Timely Availability of Services and/or Information
- ❑ AA – Serious Reportable Events OR "Never Event" YES NO UNCERTAIN
- ❑ BB - NPSG Violation YES NO UNCERTAIN
- ❑ Other: _____

Comment: _____

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MORTALITY REVIEW

FOR PEER REVIEW COMMITTEE USE ONLY

RECOMMENDATIONS: _____

_____

ACTIONS: _____

_____

FOLLOW-UP: _____

_____

I . _____ _____ _____
QI Team Chairperson's signature (Peer Review Chair) Date

II . _____ _____ _____
Service Chief's signature Date

III. _____ _____ _____
Department Chair's signature Date

IV. _____ _____ _____
Senior Vice President for Medical Affairs Date

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PEER REVIEW SUMMARY

1. Optimize use of expert knowledge: Create comprehensible peer review programs in language that flows naturally from the best practice of medicine.
2. Distinguish this non-punitive approach to improving quality of care from disciplinary proceedings under Medical Staff Bylaws Corrective Actions.
3. Adopt the *Teaching Principle* of Quality As The Standard To Be Measured Against: Practice As You Would Teach It and Build Systems to reinforce this concept *a priori,* e.g., order set guidelines, transition standards, RRTs, simulation.
4. Emulate the adored principles of education and scholarship in quality improvement programs.

PEER REVIEW SUMMARY

5. The energy should feed off itself to create a relentless system of performance improvement within a supportive framework.
6. Create databases to correlate the processes of care with outcomes of care through the eyes of physicians.
7. Consistency of QIC membership significantly dampens concerns with reliability.
8. Individuals ⇔ Teams ⇔ Systems
9. Electronic Health Records (EHR) and Meaningful Use (MU) will impact work flow.
10. There will be a challenge for Transparency and Disclosure.

Case Study

Chief complaint: 63 year old obese female presents to ED via EMS with left groin pain for one day, followed by “bruise” in that same location.

HPI: Morbidly obese with BMI of 45.1, wheelchair bound, with 6/10 thigh pain associated with development of large ecchymotic plaque left medial superior thigh. No trauma.

Past History:

- Chronic atrial fibrillation
- Hypertension
- CAD
- Anemia of chronic disease
- COPD with 120 cigarette packs/year (without for three years)
- Girdlestone procedure of the left hip due to osteonecrosis in 2004, complicated by Staphylococcal sepsis, ischemic bowel with perforation requiring right colectomy, acute renal failure requiring hemodialysis, respiratory failure requiring intubation and lengthy ventilator dependence with tracheostomy, and neutropenia
- Nephrolithiasis and left ureteral stone treated with lithrotripsy
- Depression
- Agoraphobia
- Alcohol abuse in the past
- No thromboembolic events
- CHADS2 score of 1.

Case Study (Continued)

Medication Reconciliation: Six constant medications plus warfarin (Coumadin) with dose recently increased to 3.5 mg daily from 2.5 mg. The patient stated that her baseline warfarin dose was 2.5 mg (she took half of a 3 mg tablet plus a 1 mg tablet), and her dose had been increased by her PCP to 3.5 mg one month previously. The patient was confused and thought she had been instructed to take one of each pill, so she was taking 4 mg. Follow-up measurement of the INR in one month had been scheduled by the PCP.

ROS: No heart failure, diabetes, liver disease, diarrhea, poor dietary intake, fever or ecchymoses, petechiae or bleeding elsewhere. No other cardiac or neurological symptoms. No decompensation of chronic illnesses.

Labs: INR >9.2. No exacerbation of anemia or new thrombocytopenia. PT>80, PTT>150, WBC 11.5, Hgb 8.9, Hct 29.7 (baseline 32), platelets 325K, BUN 50, creatinine 1.9 (baseline, 1.5), BNP 245.5, anion gap 8, d-Dimer 0.41. Urinalysis revealed large amount of blood by dipstix and >150 WBC/HPF, and a urine culture was added in the ED.

Case Study (Continued)

Physical Exam: Normal VSs and not orthostatic. Rest of PE of the patient revealed a 5-6 cm ecchymotic plaque on the left superior, medial thigh with no warmth or induration. No trauma was noted. No enlarged nodes. No focal neurological deficits. Lung sounds were clear; abdomen was non-tender with no organomegaly or peritoneal signs; stool was trace heme-positive. Bilateral LE 2+ non-pitting edema (shins). Cardiovascular exam was otherwise unremarkable. No additional new findings on musculoskeletal or neurological examination. No other ecchymoses or petechiae or areas of palpable purpura were noted.

Imaging studies: Ultrasound of left leg performed was negative for deep venous thrombosis. Pelvic Xray performed was negative for fracture but showed chronic left hip destructive changes with dislocation, chronic severe right hip osteoarthritis and chronic left iliac bone sclerosis.

ED interventions: Low-dose, IV morphine sulfate for pain control in ED. Ceftriaxone administered.

Admitted by Hospitalist To Observation

Therapy: Vitamin K_1 5 mg po times one. No FFP. (In concert with ED physician.)

Rationale: *Chest* guidelines (Ansell et al. *Chest* 2008; 133:160S) determined this seemingly localized soft tissue bleeding was “not serious” or “life threatening”. Decided against IV vitamin K_1 and/or FFP or PCC and/or rFVIIa.
Exquisite medical record documentation – to a point.

Hospital course: Two hours later, acute neurological catastrophe with large intracerebral hemorrhage with subfalcine and uncal herniation. Patient declared braindead.
In discussions with family, decision made to limit treatment, and patient expired evening of admission.

Inpatient Peer Review: Teaching Standard

Q.E.D.: Care appropriate but did not fully meet teaching standard

- Rationale for oral vitamin K_1 and close monitoring well documented and not in violation of recent *Chest* guidelines, but:
- *Chest* guidelines do not define “serious” or “life-threatening” bleeding
- *Chest* guidelines do not specifically address this exact situation of uncertainty of severity of bleeding in patient with INR ≥ 9.0 (9.2 is upper limit of NWH laboratory reporting)
- INR ≥ 9.0 should be considered as equivalent to well under 5% of normal plasma concentration of prothrombin complex (FFP requirements would have been 18 units!)
- Was this evidence of bleeding clinically significant?
- Ecchymosis was spontaneous and preceded by pain for 24° – suggesting possibly larger and more deep-seated, serious (retroperitoneal) bleed; no additional investigative imaging to raise diagnostic certainty about extent of bleeding.

Inpatient Peer Review: Teaching Standard (Continued)

- CNS bleed is an independent event in this anti-coagulated patient although biologically plausible that a spontaneous ecchymosis in one area might indicate a higher risk for bleeding in another area with excess anti-coagulation – but not evidence based! Difficulty in risk assessing patient.
- *Chest* guidelines do not offer explicit guidance on managing bleeding of a not immediately life-threatening nature in face of INR ≥ 9.0. Guidelines suggest options.
- Without active bleeding and INR≥ 9.0, hold warfarin and administer vitamin K_1 2.5 mg to 5.0 mg orally with close INR monitoring and repeat administration of vitamin K_1 as needed; Graded IB *UpToDate*
- Alternatively, with serious bleeding and regardless of level of anti-coagulation, suggest treat aggressively with IV vitamin K_1 10 mg and FFP or PCC and/or rFVIIa, : Grade IC *UpToDate*.
- Documentation is expected to reflect understanding of the limits of guidelines – not all situations fit neatly.

Outpatient Peer Review

Ambulatory care fell well below Teaching Standard:

- Two different doses of Coumadin prescribed set the stage for confusion with dosage adjustments
- Lack of timely and consistent follow-up of INRs (40 percent increase in warfarin dose)
  - Four weeks is too long