

Colorado Medical Society  
2009 Spring Leadership Conference

Report of Breakout Group Four:

**Peer Review/ Quality Improvement/ Patient Safety Organizations**

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Notes: Ben Vernon, MD

The following general points were discussed:

We need a Systems Approach to peer review and quality improvement, rather than punishment. In order to have a systems approach we MUST have Just Culture. We need to balance Individual Accountability and Just Culture Systems.

We are missing opportunities to avoid error across (among) hospitals. We should look in the short term to:

- a. Better define role of peer review and its processes
- b. Standardize levels of infractions
- c. Standardize external review
- d. Standardize other entities that should be peer reviewed (EMT's, PT, etc)
- e. Standardize peer review processes and membership so one hospital looks like every other.

How do we protect physicians who participate?

We don't have the equivalent of a NASA (a safety reporting body independent of licensing body).

Peer review has had different forms over the years. Less effective now. Requires internal resources.

Peer review should be a learning experience, should be rewarded and rewarding.

Peer review requires effective communication; need to communicate and deal with difficult messages.

Can we utilize CPEP (a resource we already have) to help? Could defray cost of expanded or expensive teams of peer reviewers.

PSO hotline for evolving issues. Newly recognized problem processes.

Decouple liability from Accountability from litigation & compensation.

Can we get reporting broadened and reporting to other membership in PSO?

Old fashioned Morbidity & Mortality conferences were very valuable, but current peer review value diminished through QI processes. Need to expand M&M to whole hospital environment.

COPIC claims committee disseminates information key to safety improvement through risk managers.

Can we partner up hospitals with each other to cross cover peer review as external reviewers of each other?

Medical Kinetics has also applied as PSO; Do Medical Kinetics and Rocky Mountain PSO overlap?

Aligning peer review to allow every hospital to share findings (safety findings) to the extent we can.

How do we peer review the hundreds of physicians who practice outside hospital settings?

- a. When there is contact with a hospital?
- b. Through PDP like programs?
- c. Application of other measures?
- d. What is / will be our ongoing assessment of competence?

We need careful, detailed analysis of peer review opportunities for non-hospital physicians.

We need CRE program like that in aviation. Regulated by BME?

There are schools (programs) that train physicians who first start or continue in credentialing. Are there similar programs for peer review? Do we need to start one to provide uniformity discussed above?

Even in peer review there is a fundamental Mistrust that prevents real accountability from surfacing in root cause analyses.

What are the legal and social ramifications of all this?

NEXT WE ADDRESSED THE SPECIFIC POLICY QUESTIONS:

1. CMS should SUPPORT legislation to combine peer review and health care quality management (both in and out of facilities--hospitals) statutes. The envisioned statutes will:
  - a. Incorporate "just culture"
  - b. Permit (require) cross-facility reviews to enhance objectivity
  - c. Permit (require) reporting key safety findings to sister facilities and physicians
  - d. Consider centralized process to reduce duplication of services
  - e. Contribute to on-going safety improvement, continuous quality improvement, and reduce blame and shame.
2. Regarding the effectiveness of existing peer review and quality processes:
  - a. ACCEPT Policy option 1: Amend the peer review statute to
    1. Clarify its purpose and include (coalesce) all appropriate peer review entities
    2. Clarify confidentiality provisions (see caveat below)
    3. Allow sharing peer review & quality improvement information between entities and accrediting organizations.

USE STATEWIDE OUTCOME MEASURES.

DO NOT FORGET NATIONAL PROFESSIONAL ORGANIZATIONS' MEASURES

4. Immunity from suit for good faith peer review and quality review is ABSOLUTELY necessary. Appropriate external review should mitigate this issue.
  5. Clarify the due process rights of reviewed physicians.
- b. ACCEPT Policy option 2: Clarify the authority of the Committee on Anticompetitive Conduct.
- NOTE: PROPERLY DESIGNED PEER REVIEW BY ENTITIES COMPLETELY EXTERNAL TO THE SITUATION SHOULD ELIMINATE THE NEED FOR THIS COMMITTEE.
- c. ACCEPT Policy option 3: Peer review should be centralized, OR RE-ORGANIZED, and include review for non-affiliated providers.
  - d. ACCEPT Policy Option 4: Merge peer review and quality improvement statutes. ADDRESS ISSUE OF ABSENT FEDERAL PROTECTIONS.
  - e. ACCEPT Policy Option 5: Incorporate federal Patient Safety Organization information.

3. Regarding endorsement of Rocky Mountain PSO,

The members of the breakout session felt that, in general, this was appropriate. However, note is made of the current nebulous aspects of membership in the PSO, and its structure and function at the specific logistics level. The CMS should endorse the evolving RMPSO so long as its evolution is proceeding along the key discussion elements above, including simplification, standardization, clinical relevance, public acceptance for peer review and quality improvement processes.

The group was polled and it was the majority opinion that:

1. Peer review is working somewhat or poorly in their facilities.
2. Increased transparency to the peer review process should only occur if there is no increased risk of litigation of adverse outcomes.

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