

Breakout Group Four

Peer Review / Quality Improvement / Patient Safety Organizations

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Peer Review And Quality Management: The Institute of Medicine's *Crossing the Quality Chasm, 2001* report called for fundamental change in the health care system and outlined recommendations to reinvent health care for the 21st century, stating that: "Private and public purchasers, health care organizations, clinicians and patient should work together to redesign health care processes."

Ten rules are identified for helping to achieve this goal. Rule #6 speaks to safety as a "system" property and recognizes that the biggest challenge to a safer system is changing the **culture** from one of blaming individuals for errors to a culture where errors are not treated as personal failure, but as opportunities to improve the system and prevent harm. In order to assess and remedy system failures, communication between all members of the health care team is vital.

Traditionally, health care culture holds individuals accountable for all errors that harm patients. By contrast, a "just culture" recognizes that individual practitioners should not be held accountable for failings of systems over which they have little or no control. The phrase "just culture" was popularized in the patient safety lexicon by David Marx, JD. He outlines principles for achieving a culture in which individuals feel comfortable disclosing errors—including their own—while maintaining professional accountability. Examples used by Marx involve transfusion safety, but his principles clearly generalize across domains within health care organizations. A "just culture":

- a. Recognizes many individual or "active" errors represents predictable interactions between human operators and the systems in which they work;
- b. Does not tolerate conscious disregard of clear risks to patients or gross misconduct; and
- c. Does not set a different level of a personal accountability for individuals at different levels within the organizational structure.

In summary, a "just culture" recognizes that competent professionals make mistakes and acknowledges that even competent professionals will develop unhealthy norms (shortcuts, "routine rule violations"), but has zero tolerance for reckless behavior across the organization. Thus, patient safety improvement requires a balance between a focus on the system and a focus on individual performance and accountability.

BREAKOUT INSTRUCTIONS:

1. **Discuss the questions posed in each topic area identified below and, if appropriate, make observations or recommendations to the ad hoc work group on patient safety and professional accountability;**

2. **Subject each option to a robust discussion and make one of the following recommendations**
 - a. **Reject the option and the concept;**
 - b. **Accept the option and the concept;**
 - c. **Accept the option and the concept with clarification**
 - _____
 - d. **Add the following policy options not currently contemplated in the report of the ad hoc work group on patient safety and professional accountability**
 - _____

COLORADO PEER REVIEW AND QUALITY ASSURANCE STATUTES:

There are two state statutes that provide legal protections for facility and physician quality review. First, the Colorado Peer Review Act C.R.S. § 12-36.5-101 *et. seq.* (CPRA) provides that professional review committees function as “...an extension of the authority of the board of medical examiners” and such committees, their members, and governing boards are granted “certain immunities” so that they “...can exercise their professional knowledge and judgment” in reviewing physician performance and competence. Additionally, the Quality Management statute at C.R.S. § 25-3-109 is designed to encourage hospitals and other health care entities to engage in quality management activities, including collection and analysis of patient safety information. Records of these professional review and quality management committees are considered “confidential.” Together, these two statutes are designed to encourage investigation and review of adverse events without the participant’s fear of discovery or undue litigation.

Thus, the Quality Management statute provides legal protection to facilities in the evaluation and assessment of all aspects of the health care system, including the impact of individual performance on the outcomes of care. In contrast, the CPRA provides legal protection to participants reviewing individual physician qualification, competence, and performance. In short, it focuses on the review process of individual performance. As a secondary function, a peer review may also identify various system issues for improvement.

While both statutes serve a useful purpose in the review of quality and safety issues, the two statutes establish separate and parallel review processes, different levels of legal protections and thus, create challenges for safety efforts.

Policy Options for Consideration:

1. Should CMS support, oppose, or be neutral on legislation to combine the peer review and quality management statutes into one that will support a “just culture” in a hospital to improve patient safety? In answering this question, participants should consider the extent to which lack of communication between parallel but separate review processes:
 - a. Impedes assessment of the entire course of care via a root cause analysis, including performance all individuals as well as all system issues?
 - b. Creates an obstacle to establishing a “just culture” and equity in how individual performance is evaluated?

- c. Impedes communication between the peer review committee and other review processes underway about the same event?
- d. Uses resources to “over” evaluate individual performance versus focusing resources on the most prevalent issue in patient safety, namely improving the system of care?
- e. Adds to the culture of blame?

EFFECTIVENESS OF EXISTING PEER REVIEW AND QUALITY PROCESSES

Although peer review statutes are technically not under the sunset umbrella, CMS considers reforms to Colorado’s peer review laws vital to patient safety. Patients have a right to expect that there are effective mechanisms in place to guard against system failures and individual practitioners who present a risk. In 2005, the University of Denver convened health and legal experts to develop consensus recommendations regarding integrated changes to Colorado’s peer and quality review laws. Legislation adapted from the recommendations was unsuccessful in the 2006 Legislature. Although these recommendations need updating, they merit reconsideration to close loopholes in the law that thwart effective peer review, and strengthen due process protections. The following assumptions drive the policy recommendations outlined:

- Retaliatory lawsuits by a disciplined physician and concerns over confidentiality protections deter effective peer review in many settings (including physician evaluation by outside organizations).
- In smaller practice settings or specialties, the relative intimacy among providers can compromise effective review (e.g. few highly trained subspecialists lack sufficient peers to review their work).
- Decentralization of medical practice to more outpatient settings leave many facilities unqualified under current law to conduct peer review.

Policy Options for Consideration:

1. Amending the peer review statute to:
 - Clarify its purpose and include all appropriate peer review entities
 - Clarify confidentiality provisions
 - Allow sharing of peer and quality information between entities and accrediting organizations
 - Provide immunity from suit and liability for good faith peer and quality review
 - Clarify due process right of peer reviewed physicians (access to information)
 - a. Reject**
 - b. Accept**
 - c. Accept with clarification**

2. Clarify the authority of the Committee on Anticompetitive Conduct, require mandatory review, and create claim for bad faith in pursuing action inappropriately against a peer reviewer.
 - a. Reject**
 - b. Accept**

c. Accept with clarification

3. Centralize peer review, including review by non-affiliated providers
 - a. **Reject**
 - b. **Accept**
 - c. **Accept with clarification**

4. Merge peer review and quality review statutes.
 - a. **Reject**
 - b. **Accept**
 - c. **Accept with clarification**

5. Incorporate federal Patient Safety Organization information.
 - a. **Reject**
 - b. **Accept**
 - c. **Accept with clarification**
 - d.

PATIENT SAFETY ORGANIZATIONS:

In 2005, Congress enacted The Patient Safety and Quality Improvement Act of 2005 authorizing creation of Patient Safety Organizations (PSOs) to improve safety and quality through collection and analysis of data on adverse patient events (“patient safety work product”) in a secure and legally protected environment. Passage of the Act was driven by a desire to accelerate collaboration among providers to improve patient safety by eliminating legal obstacles that inhibit sharing patient safety work product outside a provider’s own organization.

The Colorado Hospital Association (CHA) recently created the Rocky Mountain Patient Safety Organization (RMPSO) to provide PSO services for all types of Colorado health care providers. As of January 21, 2009, RMPSO is listed on the Agency for Healthcare Research and Quality (AHRQ) website as a federally certified PSO. RMPSO is the first and only PSO listed in the Rocky Mountain region.

What does a PSO do?

- Improves patient safety and quality of care delivery.
- Collects and analyzes patient safety work product/adverse event data.
- Protects patient safety work product in conformity with statute and regulations.
- Develops and disseminates information to providers.
- Encourages a culture of safety, providing feedback, and providing assistance to effectively minimize patient risk.
- Preserves confidentiality of data and patient safety work product.
- Assures use of qualified staff.
- Performs collection, management, and analytic activities related to PSO operation.

Rocky Mountain PSO: The goal of the RMPSO is to improve patient safety through sharing and analyzing data and lessons learned to reduce adverse events and improve quality of care delivery across the care continuum in Colorado and the region. The RMPSO continuum of care approach is unique to other PSOs. Of the PSOs listed, none have embraced the mission to encompass providers from all levels of care across the continuum. With this mission, RMPSO intends to achieve a focus that is patient-centered to improve safety in all settings. This approach is also in contrast to the traditional provider-centered approach currently in place among most of the provider improvement and patient safety efforts.

In addition, a continuum of care focus allows providers to receive information from a variety of organizations. Prior to the Act, exchange of patient safety work product was restricted due to concerns with confidentiality. PSO regulations eliminate this legal concern. Thus, in the protected legal environment of the PSO, providers across the continuum can learn from each other about reducing adverse events at all levels of care.

Initial priorities for the RMPSO are based on the following:

- Industry trends and initiatives.
- High-risk events.
- High cost events.
- Events that impact patient safety across the care continuum.
- Issues that align with other improvement efforts in the state.
- High volume, high-risk chronic conditions.

Based on these priorities, the RMPSO initial work will most likely include:

- NQF never events.
- Adverse events resulting in unplanned readmissions to hospitals.
- Adverse events at the point of hand off from one level of care to another.
- Adverse events resulting in unplanned admission to acute care from another level of care.
- Adverse events in patients with a chronic condition such as diabetes.
- Near misses related to all of the above.

The benefits for providers to participating in RMPSO include:

- Receive independent, external expertise to collect analyze and aggregate patient safety information.
- Share aggregation and analysis of large number of patient safety events to understand the underlying causes of patient harm and how best to improve.
- Receive federal legal protections from discovery of patient safety work product.
- Access to state wide, regional and national comparative data
- Collaborate with providers across the continuum of care.

Policy Options for Consideration:

1. What steps should CMS take to determine whether to endorse the RMPSO? In answering this question, participants should consider the benefits, governance, operational, and membership (physician participation) aspects of the RMPSO.

References:

For more information go to <http://www.ahrq.gov/>

Marx D. Patient Safety and the “Just Culture”: A Primer for Health Care Executives. New York, NY: Columbia University; 2001. Available at: http://www.mers-tm.org/support/Marx_Primer.pdf