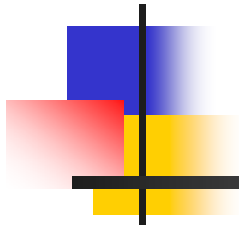


# Higgins General Hospital

## A Division of Tanner Health System

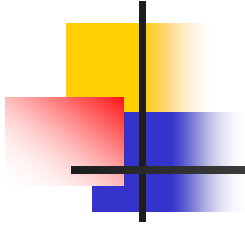


Peer Review in a Critical Access Hospital

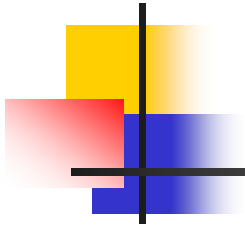
Jack Birge, MD

Medical Director of Quality Management

Tanner Health System



The quality of care delivered by physicians is no longer taken for granted. It must be proven by a system in place that will measure the performance of all physicians and provide corrective actions as indicated when quality of care falls below accepted standards.



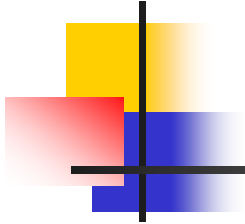
Most physicians do a good job which is the basis for the often prevailing physician sentiment that they should not be bothered by peer review.



## There are things physician must know as to why precise peer review is absolutely necessary:

---

1. The Institute of Medicine got the attention of the entire nation in 1999 when they reported that 40,000 to 80,000 persons died each year from medical mistakes.
2. Physicians are the captain of the healthcare team, therefore, they are being subjected to the most intensive scrutiny regarding the quality of care they deliver.
3. All accrediting and regulatory agencies are on board demanding physician peer review:
  - JCAHO – If you wish to be accredited, you must do it.



- Federal Agencies – If you want to avoid sanctions and penalties you will do it.

Case in point which occurred in California:  
Physician performed unnecessary heart surgery;  
this was detected by Federal Agency Review; the  
hospital was fined, hefty pay back of monies and  
sanctions.

Hospital's defense: "We didn't know"

Federal ruling: "No excuses. You must have  
sufficient peer review system so you will know."

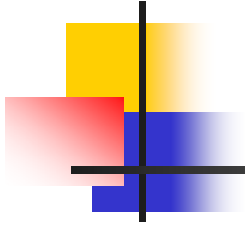


## Common Barriers:

---

- Time involved to do peer review
- Unpleasant feeling about sitting in judgment of a colleague
- Physicians fear loss of friendship of another physician if they judge him.
- Loss of physician referrals if their type practice requires this.
- Fear of retaliation legally
- There are many others

The **smaller** the medical staff the bigger the barrier.



Physicians must know that Peer Review must be done, there is no choice in the matter.

Physicians must know that they must accept the responsibility of peer review or it will be done by others.



## The foundation of an acceptable physician peer review plan is based on:

---

- a. The authority to deal with matters of physician peer review with the possibility of corrective action lies solely in the hands of the physicians of the medical staff, even though outside consultation may be utilized at the discretion of physicians participating in the peer review process.
  
- b. Peer review decisions will be made by consensus of at least three physicians, never by only one.



## consensus opinion

---

- The requirement of consensus opinion largely eliminates the potential of individual prejudices or influence.



## Process of peer review based on adequate, reliable information

---

After the foundation of peer review is established in the Medical Staff by-laws, a process of peer review must follow that is based on adequate, reliable information. It must pertain to all physician activities in the process of patient care that is automatic and continuous and applied uniformly to the entire medical staff.



## Types of information gathered:

---

- Proactive:
  - a. Variance reports from observations during the patient's hospital stay reported by physicians, nurses, administrative personnel, patients, family, or anyone.
  - b. Quality of care issues observed by other providers that may require immediate action by the medical staff.



## Retroactive

---

- Retroactive
  - a. Statistical analysis of outcome measures (mortality index, etc.), and efficiency measures (LOS, cost, etc.).
  - b. Mortality review
  - c. Focused chart review
  - d. Quality Indicators (core measures, etc.)
  - e. Citizenship indicators

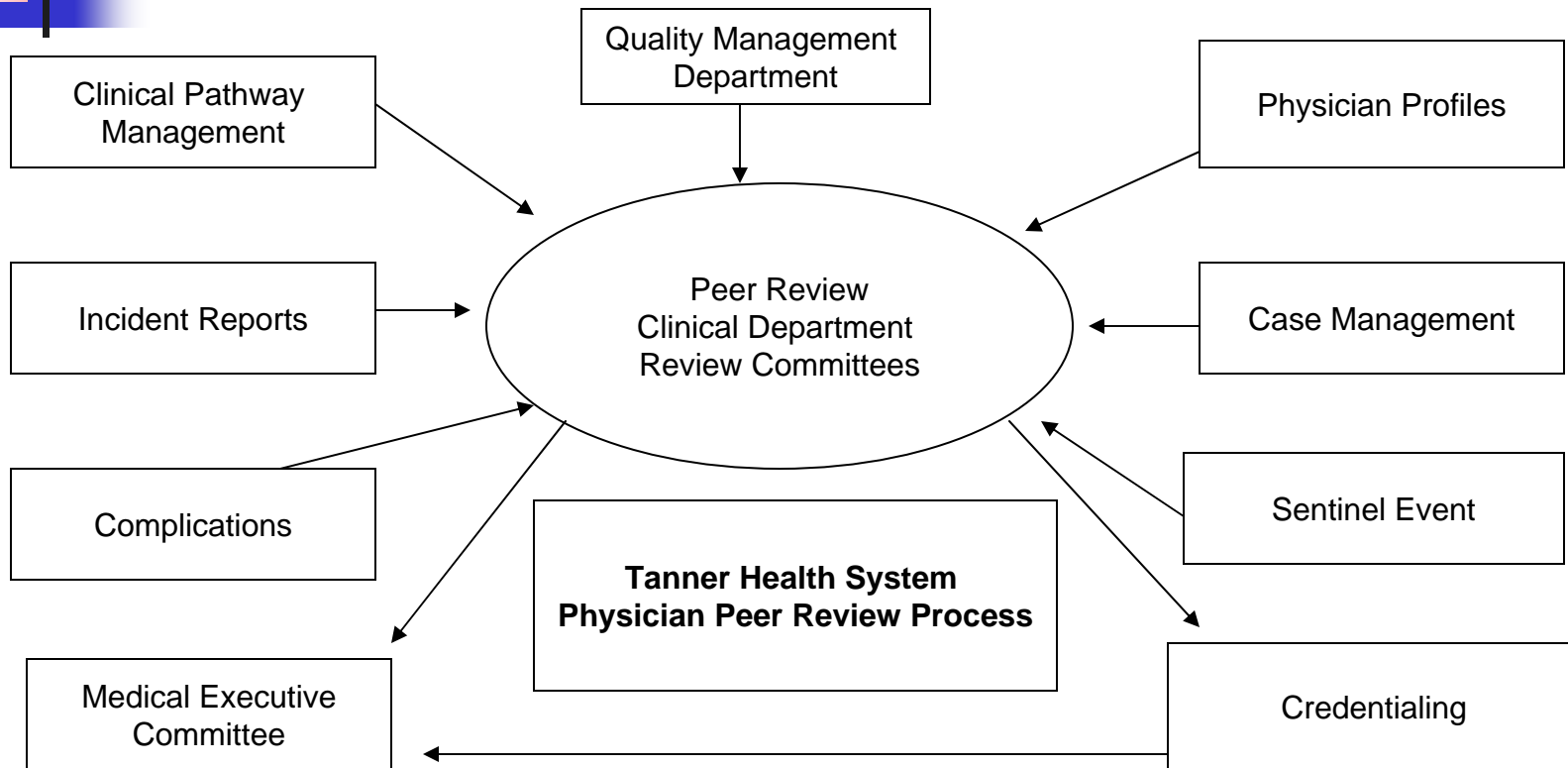


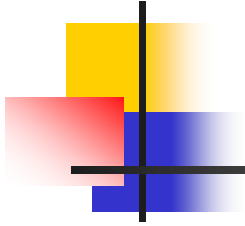
## Retroactive cont...

---

- f. Medicine errors and documentation
- g. Behavioral issues
- h. Process errors

# Peer Review Process





Peer Review will not happen without administrative assistance to provide the collection, formulation, organization, and presentation of the data to the committee by adequate support personnel.

Put the fully processed data before a committee of three to five physicians and they will draw conclusions and recommendations.



## What we faced at Higgins:

---

For small hospitals, this is not simple....

What we faced at Higgins:

A medical staff of four family practitioners who admitted almost all of the patients.

Physician specialists offering consultative services and procedures (surgery, lithotripsy, gastroenterology and cardiology from other hospitals



## Problems Faced

---

The problems faced were obvious:

- Only four dedicated physicians on staff
- A small number of specialists of varying discipline

How can you peer review that?



## Departmentalized medical staff

---

Higgins General Hospital is part of Tanner Health System – a system of three hospitals, two smaller hospitals and one larger in three different towns.

The early solution that was considered workable with the ability to perform all necessary medical staff functions was to combine all three hospital medical staff into one single medical staff which was departmentalized.

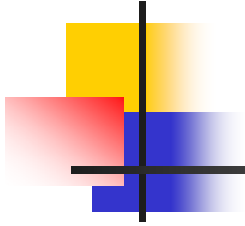


## The storm

---

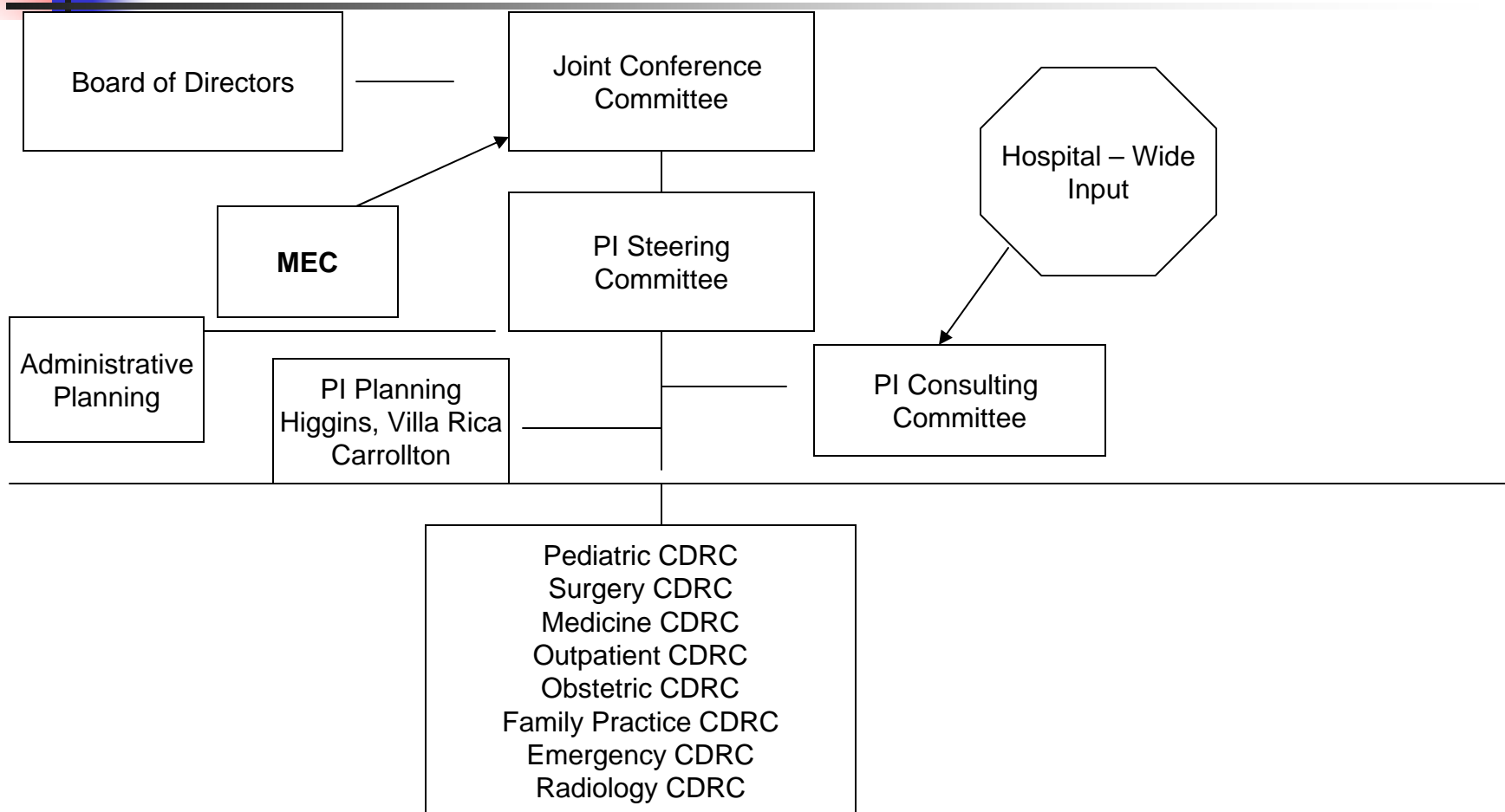
This was not a decision without a storm.

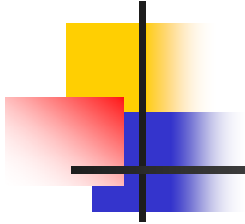
- The small hospital roared the loudest  
You can't judge us to the same standard as the big hospital – There is only one standard of care
- We are out numbered leading to unfair treatment – It didn't happen.



- A look at the medical staff organization plan at Tanner Health system

# Tanner Health System Performance Improvement Organizational Chart

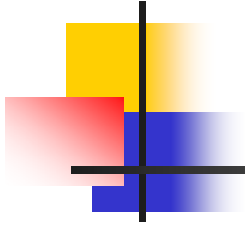




- A link in the system of departmentalized medical staff at three hospitals to assure consistent and uniform peer review and clinical department performance review:

1. PI Chairman of the Medical Staff
2. Director of Medical Quality for Tanner Health System

These two positions assumed by a medical staff member



- The PI chairman/Medical Director of Quality has no authority to make decisions pertaining to any medical staff member. That lies solely with the Peer Review committee.
- No data is considered significant to represent a quality problem unless it is so designated by the Peer Review Committee



## For example:

---

- An indicator is established by the department's Clinical Department Review Committee such as a mortality index of 1.25 or greater for two consecutive quarters for DRG 089 (simple pneumonia) may represent a quality of care problem.
- However, by case review, clinical management of the patients met the standard of care, therefore the peer review committee considered this not to represent a quality problem.



# The Peer Review Plan

---



I. Conduct quarterly review of physician data including:

---

a. Clinical quality: General

Risk adjusted mortality index, all DRG's

Risk Adjusted Complications index

Peer review results

Blood usage

Pharmacy recommendations accepted



## Conduct quarterly review of physician data including cont...:

---

- b. Clinical Quality: Department
  - Risk adjusted mortality index – DRG selected
  - Risk adjusted complication index – DRG selected
  - Core measure compliance



## Conduct quarterly review of physician data including cont...:

---

c. Service quality:

Number of variances for failure to respond

Number of delayed consultations

Number of patient complaints considered significant by Clinical Department Review Committee

d. Patient Safety:

Compliance with medication abbreviations

Incidents of illegible medication orders



## Conduct quarterly review of physician data including cont...:

---

- e. Resource Utilization: General
  - Severity adjusted LOS index – all DRG's
  - Severity adjusted cost index – all DRG's
  - Delayed starts in OR/procedure area
  
- f. Resource Utilization: Department
  - Severity adjusted LOS index for selected DRG's
  - Severity adjusted cost index for selected DRG's



## Conduct quarterly review of physician data including cont...:

---

- g. Peer and co-worker relationship
  - Physician behavior incidents
  
- h. Citizenship:
  - H&P/OP report not dictated within 24 hours
  - Number of documentation issues
  - Number of failure to record progress note
  - Medical records delinquency and suspensions
  - Meeting attendance



## II. Indications for focused review:

---

- a. Performance indices, 25% above an index of 1 for 2 consecutive quarters which are statistically significant or considered significant by the Clinical Department Review Committee.
  
- b. Quality of care issues of significance as judged by the Clinical Department Review Committee



## Indications for focused review cont...:

---

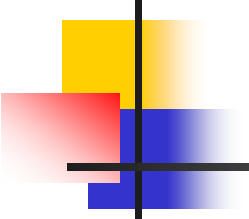
- d. c. Continued non compliance in variances after notification by the Clinical Department Review Committee
- d. Significant physician behavioral issues
- e. At the request of the Credentials Committee and/or MEC



### III. Focused review:

---

- a. Will begin immediately after determining its need. It will be conducted for 2 consecutive quarters and all parameters of provider performance.
- b. At completion of the 6 months focused review conclusions will be made based on adequacy of the data and findings of the physicians' compliance in suggested improvements
- c. Conclusions will be documented and made part of the physician profile.



IV. Actions that may be taken by the Clinical Department Review Committee based on conclusions from the review will consist of:

---

- a. No action warranted
- b. Notification of the physician reviewed of a significant variance with specific instructions for corrections of the variance and the time interval of continued monitoring to assure compliance with the required correction.
- c. Required attendance at a continuing education course as part of the corrective measure of quality of care issue, behavioral issue, or documentation issue.



## Actions that may be taken by the Clinical Department Review Committee cont....:

---

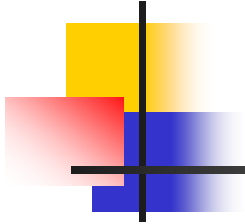
- d. Request the appearance of the reviewed physician before Clinical Department Review Committee for discussion of the variance or request explanation in writing for review by the Clinical Department Review Committee.
- e. Forward the matter to the MEC for action when the Clinical Department Review Committee recommends alteration in the physician's privileges or medical staff suspension.
- f. All actions taken will be documented and forwarded to the credentials committee.



## V. Documentation:

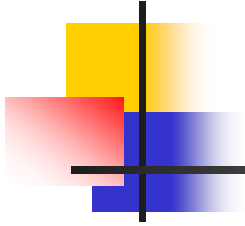
---

- a. Each variance report will be brought to conclusion and action recommended with documentation of basis for the conclusion
- b. Focused review will require documentation that clearly explains why their review was instituted as well as findings and conclusions with the basis for these conclusions.
- c. Actions taken will be clearly documented.
- d. Monitoring for compliance will be clearly documented.



e. Each plan of action will have the final outcome documented.

f. All information is included in the physician profile and will be reviewed by the department chairman at time of recredentialing prior to his recommendation of the physician and will be forwarded to the credentials committee for their review.



The peer review plan provides the data recorded in the physician profile.

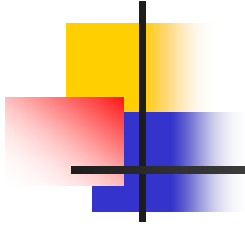


## Sample physician profile data

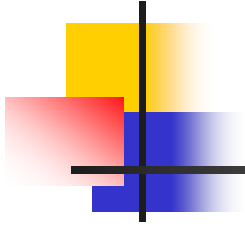
---

Data includes:

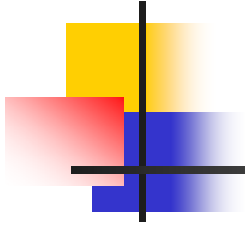
- Total inpatient discharges
- Acute care case mix index
- Total inpatient procedures
- Total consults
- Medicare ALOS
- Acute care ALOS
- Avoidable/denied days
- Acute care admission composite mortality rate



- Inpatient mortality rate
- Percent readmits <31 days
- Average reimbursement
- Average charge
- Charge variance
- Total prescribing medication errors
- Blood usage
- Conduct unbecoming/behavioral incidents

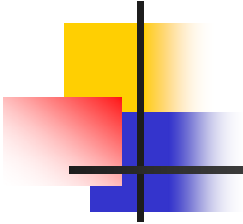


- Quality of care – best practice issue
- Other/miscellaneous



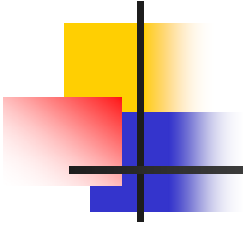
The physician profile is submitted to each member of the medical staff every 6 months.

The peer review committee is responsible for corrective action of the determined quality issues.

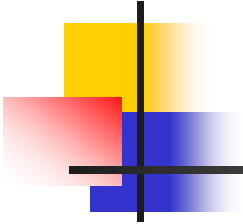


The corrective action options are as follows:

- At the time of recredentialing which occurs every 2 years, the peer review committee will provide the physician profile and supporting documentation to the department chairman for review prior to his/her recommendation of the medical staff member for recredentialing.



- The physician profile and supporting data (pertaining to a medical staff member) is provided from the peer review committee.
- The information is presented to the chairman of the Credentials Committee by the Director of Quality for review two weeks prior to the committee meeting.
- The Credentials Committee reviews the data as part of the recredentialing process, and recommendations are forwarded to the MEC for decision.



Each staff member is recredentialed every two years in the month of their date of birth, therefore staggering the process to make it manageable.

The fears and criticism from the smaller hospitals have faded due to their involvement in the process.