FIRST
Do No Harm
Quality and Patient Safety Division, Board of Registration in Medicine
Special Supplement - December, 2011

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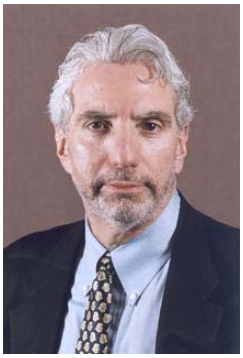
Highlights from the presentations at the Medical Staff Engagement Conference, June 3, 2011.

"Lessons Learned" from the Quality and Patient Safety Division Conference on Engaging Physicians

On June 3, 2011 the Quality and Patient Safety Division (QPSD) held a presentation on Medical Staff Engagement in Performance Improvement. Dr. Leslie Selbovitz of Newton Wellesley Hospital, Dr. Kathy Jenkins of Children's Hospital Boston and Dr. Marc Rubin of North Shore Medical Center, candidly discussed their experiences with bringing about the culture change necessary to support effective Performance Improvement (PI) processes at their hospitals. The presentations provided invaluable insight and guidance to a challenging but critical component to improving patient safety and quality care.

Summarized here are highlights of the presentations.



The "Teaching Principle"
Process For Medical Staff Review Of Unexpected Events: Peer Review

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

Dr. Selbovitz's presentation began with an overview of accountability, focusing on collective 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." (citing Moorman DW. Communication, Teams, and Medical Mistakes. Ann Surg. 2007; 245: 173-175.)

Dr. Selbovitz then turned to the issue of peer review and its foundational principle: an impartial assessment and feedback by knowledgeable experts can improve the quality of a work product and reduce medical errors. Newton Wellesley Hospital defines medical peer review as: 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 the issue of medical peer review requires an understanding that:

- peer review must be extended to all providers on the professional and medical staff;
- the division between individual performance and the systems enveloping that performance can be indistinct;
- peer review is the center piece of a larger quality and safety agenda;
- all group judgment methodologies have their limitation, including structured implicit and explicit analytics;
- smaller institutions have special issues for medical peer review committee work –a possible role for Patient Safety Organizations; and
- the importance of tying the process to core competencies.

The essential concepts of Newton Wellesley Hospital's medical peer review are:

- A non-punitive system (process) is defined within the annually updated Patient Care Assessment Plan (vs. corrective action under medical staff by-laws).
- Incorporation under the medical staff by-laws of the patient care assessment plan and an explicit quality improvement/peer

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"The Teaching Principle"

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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.

- 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.
- To the extent possible, the department principally responsible for the outcome of care, controls the expertise of the primary case analysis of professional performance and may identify systems issues.
- There is a plan for interdepartmental and interdisciplinary review that is: impartial, shows good faith and is attentive to conflicts of interest.
- Due Process is ensured.
- There is input into credentialing and granting of privileges.
- Achievement of validity and reliability through consistency of core committee membership while rotating other members.
- Monitoring of peer review database for patterns of judgments made by departmental peer review committees and variation within and across departmental committees.
- Adherence to the "teaching principle."

The "Teaching Principle" as defined by Dr. Selbovitz is: "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." Doctors and other health care professionals in any health care environment are life-long learners and need a congruous supporting matrix to improve quality of care. Their assessment drives ongoing learning.

Characteristics of the Teaching Principle include:

- 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.
- It is a return to a culture of medicine as a calling, not just as a business.
- Incorporates professionalism in a relentless cycle of quality improvement.
- Attention to performance within the Team.

The Teaching Principle Tool Kit:

- Medical Staff By-laws, rules and regulations and supporting policies that support peer review and its procedures.
- The Patient Care Assessment Plan is annually updated and inclusive of an explicit peer review policy and step by step procedure.
- A Physician led committee structure.
- Accountability to the Board of Trustees.
- Peer review occurs within the context of a larger quality and patient safety agenda.
- There is a dynamic relationship between professional performance peer review and systems of care.
- Worksheets for review are standardized.
- Databases are established to correlate processes of care with outcomes of care through the eyes of the physician – analyze pattern of performance and access variability of judgments.
- Established role of medical staff and hospital leadership.
- The environment is supportive of learning and improving practice.

Dr. Selbovitz, in summary, reinforced the following principles:

- Optimize use of expert knowledge: create comprehensible peer review programs in language that flows naturally from the best practice of medicine.

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"The Teaching Principle"

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- Distinguish this non-punitive approach to improving quality of care from disciplinary proceedings under the Medical Staff By-laws Corrective Actions.
- 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, for example, order set guidelines, transition standards, RRTs and simulation.
- Emulate the adored principles of education and scholarship in quality improvement programs.
- The energy should feed off itself to create a relentless system of performance improvement within a supportive framework.
- Create databases to correlate the processes of care with outcomes of care through the eyes of physicians.
- Consistency of QIC membership significantly dampens concerns with reliability.
- Individuals ‹–› Teams ‹–› Systems.
- Electronic Medical records and meaningful use will impact work flow.
- There will be a challenge for transparency and disclosure.

"Strategies To Engage Academic Physicians In Quality And Safety Activities."

Kathy Jenkins, MD, MPH
Senior Vice President/Chief Patient Safety and Quality Officer
Director of the Program for Patient Safety and Quality
Children's Hospital Boston

The Children's Hospital Boston Program for Patient Safety and Quality (PPSQ) seeks to pursue excellence in care delivery and improve the safety of Children's clinical services, research and training by combining existing efforts within the institution. It also recruits faculty to participate in new initiatives related to communication, education and measurement and also oversees all risk management and health care related regulatory activities. Dr Jenkins presentation described how Children's Hospital Boston has developed four ways to engage academic physicians: (1) accountability/ownership; (2) high quality data; (3) credible experts; and (4) academic productivity.

Dr. Jenkins explained how Children's Hospital Boston has created a comprehensive quality report designed to engage physicians through ownership and the generation of high quality data. This report measures quality in patient care, research, teaching and community medicine. It provides recognition of safe, effective, patient centered, timely, efficient and equitable care in specific categories.

For example, a physician takes the lead as a "measure owner" for cardiac arrest in anesthesia cases. The physician is responsible for the review of the relevant cases; looking for quality of care issues and presenting the findings to the Patient Care Assessment Committee, who provides written feedback.

A demonstration of accountability and ownership is the physician performance metrics project. The goals of the project include: developing sound evidence-based outcome measures; providing comparative data to assess competency; use of the project outcomes in ongoing professional practice evaluations; and the development of provider-level pediatric outcome measures. Examples of projects include: the total number of unplanned returns to the ER that resulted in admission; and the fistula rate after hypospadias repair within 12 months of surgery.

Children's Hospital Boston has also developed a strategic plan for clinical safety and quality. The plan is built within a structure that supports improvement initiatives, accountability/governance, normative behavior and evidence based event review. The goal is to establish clinical outcomes measures for all conditions for which care is offered and for which it is possible to create valid measures. All departments participate, will benchmark themselves against existing measures and contribute to the development of external benchmarks where none currently exist. A Clinical Outcomes Committee has been developed to provide over-

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Strategies to Engage Academic Physicians

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sight and guidance to each department/division's quality and safety leadership team (physician, nurse and quality consultant) to further implement the strategic plan.

The third component of engaging physicians is the impact of their contact/relationships with credible experts. Medical staff is encouraged to attend relevant quality and patient safety conferences, such as the Risky Business Conferences where experts outside the health care environment discuss their industries successes with managing risk and safety. The hospital has also partnered with the Harvard School of Business to design a quality and safety leadership development program. Children's Hospital Boston also supports a physician leaders symposium designed to prepare safety and quality leaders in their new roles. The symposium covers healthcare business knowledge, leadership and strategy knowledge and management skills, and offers a curriculum to all members of the safety team: physicians, nurses and the quality consultants.

The fourth component of engaging physicians is academic productivity, which includes faculty development, quality and patient safety grants, and teaching/mentorship. The hospital now supports a percentage of faculty's time devoted to quality and patient safety. This set aside time is intended to create an academic environment, enfranchise others and enhance careers through publications, grants, abstracts, fellowships and presentations on quality outcomes research.

Children's Hospital Boston has funded 92 grants since 2006 with the average award of $10,000. Teaching and mentoring is supported through programs such as the IHI Open School, partnerships between the Graduate Medical Education Committee and the Program for Patient Safety and Quality, and the Harvard Quality and Safety Fellowship. The Fellowship is designed to train physician-scholars who are prepared to lead operational improvement efforts within the Harvard system and across the nation.

"Cultural Change"
The Journey To Medical Staff Engagement In Performance Improvement."

Marc Rubin, MD,
Chair, Department of Surgery
North Shore Medical Center

Dr Rubin described cultural change as a journey that will extend over many years' time. Physician engagement is critical to implementing change. Physicians are often loosely affiliated with the health care facilities they practice at and are rarely asked to join strategic or operational planning efforts. Medical staff and departmental physician leadership may be determined by vote or by seniority. PI Departments are often small groups with limited skills and resources. There is often a belief that occasional adverse events are "the cost of doing business." It may take a catastrophic event to convince physicians that change is needed.

Dr Rubin stated that PI needs to be prominent on a healthcare facility's strategic agenda with the full support of hospital leadership. The PI Department needs to be adequately resourced and supported.

This change in direction may require a change in PI structure and process. North Shore Medical Center elevated the role of the Director of PI to Vice President and charged the role with developing an annual PI Plan. The PI Department was enlarged with full time employees and PI staff were trained in process improvement, including failure mode and effects analysis (FMEA), root cause analysis (RCA), rapid cycle improvement, high reliability and healthcare delivery improvement. Analytic support was added to each department to enable the data collection process, and resourced improvements were identified by the PR/PCA process. North Shore Medical Center made the decision to employ Department Chairs and make them accountable for engaging the members of their departments in the PI process.

The PI Department added ways to identify and report adverse events, to make it easy to do the right thing. Quality Specialists with clinical improvement skills were assigned to each department. Tools and databases were created, access to them was improved. A SWAT Team approach to serious adverse events was adopted, with immediate huddles. Risk Management and peer support for clinicians was added. They promoted adverse event reporting as "blame-free" and the best way to identify improvement opportu-

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Cultural Change

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nities and prevent recurrences. They protected reporting by policy.

North Shore Medical Center's Departmental Morbidity and Mortality meetings were supplemented with hospital-wide multidisciplinary peer review. This was identified as the process to drive Performance Improvement because peer review was already developed in all clinical departments and was widely accepted by physicians as an important element of patient care and a part of their professional responsibilities. With robust event reporting it is possible to have almost all adverse events analyzed through the peer review process in at least one clinical department, with those cases with the greatest improvement opportunity then being elevated to the Medical Center's multidisciplinary Peer Review.

A hospital peer review process may require redesign to: enhance event identification, to improve event analysis, to enable peer review across disciplines, to add accountability for improvement actions, and to follow cases until improvement measures are enacted and effective.

Department Chairs at the hospital began to make the case that many of the adverse events in their departments were preventable. They shared data showing that most events were due to systems issues, not practitioner issues. The Chairs challenged physicians to be accountable for leading improvement "for their patients' sake." Peer review attendance was mandated and a standardized peer review methodology, transparency, scoring and reporting were agreed on.

Dr Rubin described how motivating physicians to participate is critical to the success of a hospital's PI process, but little is written about how to accomplish it. Medical center leadership should be transparent about their motives and make their case with strong data. It is helpful to pay physicians for their time, and create hard stops that force participation. Successful physician participation is enhanced by addressing issues physicians care about, (i.e. aligning incentives), with patient outcomes and experience at the top of the list. Other strategies that work: leveraging fears, leading by example, using peer pressure, sharing decision making, appealing to the physician's professionalism ethic, rewarding successes and always treating physicians fairly and equitably.

The PCA Committee, which provides the forum for multidisciplinary peer review at North Shore Medical Center, is the vehicle for positive change. PCA Committee members are committed to transparency, with critical examination of each others cases and inclusion of all departments. All involved physicians are invited to attend. A supportive PCA Coordinator with a good working relationship with Department Chairs is most effective. The PCA Committee must be empowered to effect the changes recommended, with shared accountability and reporting to the hospital Board.

Other keys to redesigning the peer review process and culture are showcasing the value of the new process whenever possible. Improvement stories are shared at department and medical staff meetings. Physicians are beneficiaries of new support efforts sharing their experiences. Feedback at staff meetings about reported events and what was done about them can be very valuable positive reinforcement.

What comes next? Continued advancement of the peer review process is necessary, deeper into the organization so that improvement can be driven at the Department, Section and Unit level. Enhancement of physician support to allow them the time to do this should be ensured. Continue to enhance the PCA Committee and its role in hospital strategy. Involve patients and laypersons in the process; their participation will ensure that the patient perspective is considered.

Pearls:

- Cultural change happens slowly and it's iterative. Start with what you have that is good and build on it.
- Invest in getting the structure right; then you can put a good process in place that will help get you to the desired outcome.
- Engaging clinicians requires aligning incentives (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.
- Better patient outcomes and experience are at the top of the list for both doctors and hospitals.
- Consider making clinical improvement a core business strategy.

The QPSD Newsletter, FIRST Do No Harm, is a vehicle for sharing quality and patient safety initiatives of Massachusetts healthcare facilities and the work of the Board's Quality and Patient Safety Division and Committee. Publication of this Newsletter does not constitute an endorsement by the Board of any studies or practices described in the Newsletter and none should be inferred.