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New medical staff standards aim to ID problems before sentinel events occur

Credentialing, privileging should be 'educational, not punitive'

The Joint Commission's revised medical staff standards, which became effective Jan. 1, reflect the reality that credentialing and privileging is "really the single most important activity that an organization can do to ensure there are quality practitioners," according to **John Herringer**, associate director of standards interpretation for The Joint Commission, based in Oakbrook Terrace, IL.

For 2007, The Joint Commission has identified two types of reviews aimed at measuring physician competence based on evidence: focused professional practice evaluation (MS.4.30) and ongoing professional practice evaluation (MS.4.40).

The new standards have "given quality professionals new energy," says **Skip Freedman**, MD, executive medical director of AllMed Healthcare Management in Portland, OR. "This is an opportunity to raise the bar for how you do this," he says. "The new standards should greatly expand the hospital's peer review process beyond just the occasional bad thing that happens."

The previous standards required a periodic review only every two years, without giving a specific requirement for the evaluation process and allowing the use of peer recommendations. In 2005, this was specified as "relevant practitioners compared to the aggregate," but peer recommendations were still allowed when sufficient data were available.

"We realized that the standards weren't helping organizations to monitor the practitioner's performance and potentially identify performance issues earlier than every two years, and to implement any required action to resolve those on an earlier basis," says Herringer. "So we started to look at the whole concept of credentialing and privileging."

Organizations will need to determine which processes they will use for the focused review, who is going to be performing the review, and what approach

Next month: 2008 National Patient Safety Goals

Next month's issue of *Hospital Peer Review* will cover The Joint Commission's new 2008 National Patient Safety Goals. We'll predict what your toughest challenges will be and report on changes your organization may need to make in order to comply.

IN THIS ISSUE

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will be used — whether looking for a certain number of procedures or certain number of admissions.

The requirement for overview of new privileges, part of the focused review, will not go into effect until Jan. 1, 2008. "Our organizations range greatly in size — we have five-member medical staffs up to 1,000, so we really don't know how many requests for new applicants they get, or how many requests for new privileges," Herringer explains. "It may require some additional resources. That is why we are giving people a year to figure this out."

If your medical staff consist of two departments, medicine and surgery, each with 50 members, the department chair probably can't do the review. "But if you have many specialty departments with three or four members, you might be able to have the department chair do the focused reviews, because he is not looking at that many people," she says.

Not a punitive process

"Peer review is a great opportunity to partner with physicians to help each other keep abreast of the ever-changing standards of care," says **Angela Lenox**, peer review manager at Memorial Hermann Texas Medical Center in Houston. "If people keep viewing it as a punitive process, we will miss this great opportunity."

For both the focused and ongoing evaluations, your organization's written policy should emphasize that the peer review process is intended to be "educational, not punitive," says **Phil Zarone,** JD, an attorney with the health care law firm Horty, Springer & Mattern, based in Pittsburgh. Policies should avoid assigning "scores" and instead, focus on narrative evaluations that can be used as a basis for improving a practitioner's performance, he recommends.

Your process should emphasize communication between the peer reviewers and the practitioner under review, and the practitioner should be invited to provide input early and often, advises Zarone. "The policy should recognize the wide range of options that are available to develop a performance improvement plan to help the practitioner get better," he says.

This approach requires staff buy-in and awareness that the goal of the process is to make sure that good care is being provided, not to target individual practitioners. Many times, patients have comorbidities and no matter what is done, they aren't going to get better, acknowledges Herringer.

"If you are using everybody to monitor the quality of care, it is no longer a punitive process; it is a very constructive process," says Herringer. "You don't want to see the sentinel events and find out after two years this guy has really lousy practice and why didn't we know that earlier."

Compliance might mean spending more resources, and that will depend on your current process. "If you are meeting monthly and looking at all the data, you might have data for an extra 10 people but it might not mean much of a change," says Herringer. "But if nobody is looking at the data except every two years, it may mean developing a new computer program or hiring more people."

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The reality, though, is that many organizations currently look at data only every two years, and most have a peer review program that is outlier-based. "We want to be more proactive, but you can start small. Look at two charts a year for everybody — just randomly pull them," says Herringer.

The bottom line is that The Joint Commission doesn't want hospitals to wait until high infection rates or unexpected deaths occur to find out there is a problem with a provider. "Don't wait for something to happen. If nothing happens, then you have never looked at anybody," Herringer says. "Did nothing happen by luck or because nobody is doing a great job?"

Although The Joint Commission's performance improvement standards (MS.3.20) already had required the medical staff to incorporate performance improvement information into the ongoing evaluation of a practitioner's competence, the new standards impose somewhat more detailed requirements, and show that The Joint Commission is serious about this issue, says Zarone.

"The biggest challenge will be changing the mindset that a practitioner's performance need only be evaluated in a serious way once every two years, at reappointment," says Zarone.

It may be relatively easy for departments and the medical staff to adopt specialty-specific criteria for ongoing professional practice evaluation as required by The Joint Commission, and to generate reports every so often showing how a practitioner is doing. "The harder part will be asking medical staff leaders to find the time to review the data and sit down with practitioners on a periodic basis to discuss any potential issues," predicts Zarone.

There will be more data generated as a result of The Joint Commission's new requirements, says Zarone. "Quality professionals will hopefully have an expanded role in reviewing that data and communicating certain results to the practitioner, such as those that do not necessarily require physician review, such as failure to complete H&Ps, to the practitioner."

Look at all your data

Data collection requirements call for "a lot of work to be done by a lot of people," says **Christina W. Giles**, CPMSM, MS, president of Nashua, NH-based Medical Staff Solutions. "This needs to be a team effort." Include physicians, medical staff presidents, quality professionals, risk professionals, advanced practice registered nurses, physician's assistants, and any other practitioners who are granted privileges at a particular organization.

Most medical staffs have developed specialty- or department-specific indicators, which they have been using to assess some level of competence of their members, but the traditional approach has been, "'If there is a lack of negative information then that means everything is OK,'" says Giles.

Now, documented evidence of competence must be provided, says Giles. "In other words, we must have information that portrays that the practitioner is qualified to perform the privileges requested — which is totally different than what has been done."

By requiring hospitals to consider the Accreditation Council for Graduate Medical Education competencies in credentialing and privileging activities, The Joint Commission is recognizing a broader understanding of the term "competence," says Zarone.

"In the past, there may have been a tendency to focus on technical proficiency. Now, The Joint Commission is explicitly recognizing that a practitioner's ability to work as a member of a team is critical to providing safe and effective care," says Zarone.

Although the medical staff bylaws of many hospitals have addressed behavioral issues for years, The Joint Commission had not really required them to do so. "Now, every hospital will have to think about 'competence' in a much broader way," says Zarone.

The ongoing practice evaluation was added because The Joint Commission wants organizations to look at data as they become available instead of waiting two years, in order to take action on performance issues earlier. "Why would we want you to wait every two years when three months of data could have identified a problem and some sort of action taken?" asks Herringer. **(See related stories on complying with the ongoing practice evaluation on p. 108 and on data collection on p. 109.)**

To comply with the ongoing review requirement, The Joint Commission wants you to "look at everything — the good data, too, not just the bad data," says Herringer. Your "bad" data will serve as triggers to identify potential problems and comply with the focused review requirements, but good data are also important information.

"It's excellent news that somebody is an exemplary practitioner. And you might be able to extract some of his practice patterns to the rest of the medical staff," says Herringer. "For example, all of Dr. Brown's [congestive heart failure] patients have excellent outcomes, he has a shorter length of stay

and the cost of care is less. His outcomes are better than somebody else's, so can we learn from him?"

Other practitioners might be encouraged to adopt some of a high-performing physician's practices, such as medication regimens or therapy orders.

This is altogether different from the approach most organizations currently use —- to look for negative patterns or trends, which then get sent for peer review. "Everybody seems to associate data collection with trying to identify problems, but I want to see both," says Herringer. "You can learn things from good data, too. We want to know who the good practitioners are."

If your peer review process is triggered only by negative events, staff won't want to participate because punishment is the expected outcome, says Herringer. "That's not what we want it to be. We want you to learn and move forward based on good examples," he says.

For too long, peer review has been delegated to sentinel events with a reactive focus instead of proactive, says Freedman. "An awful thing happened, so let's circle the wagons and figure out what to do," he says. "The Joint Commission is trying to be more predictive, instead of putting the fire out once it starts to burn."

You can do the right thing and have a bad outcome, and you can also do the wrong thing and not have a bad outcome, says Freedman. "If you're not doing an ongoing review, how would you know the difference?" he asks. "Sooner or later something's going to happen, but that's not the first time it's been done. It's just the first time it went sour."

If doctors are put on the defensive, they are less open to receiving education that could change their future skills and behavior, says Freedman, and will be less defensive if a rotating approach is used. "If you realize that your cases are being looked at just because it's your turn, you are less defensive than if cases are only being pulled because something bad has happened," he says.

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Ongoing review: Change of mindset is now needed

No more 'bad apple' approach

The traditional "bad apple" approach to peer review is changing to a new emphasis on performance improvement, says **Nancy J. Auer**, MD, FACEP, chief medical officer of Seattle-based Swedish Health Services. "To reflect this change in our organization, we have changed the name to 'medical staff peer review/performance improvement,'" she reports.

The ability to perform effective physician performance improvement depends on a hospital's ability to gather accurate, credible, physician-specific data. "In fact, that is our major problem," Auer says. "For years, we collected only aggregate data on physicians, believing that they would not participate in PI activities if they thought we were collecting data on individuals. Now physicians are saying, 'If you want me to change, show me my data.'"

The organization is currently building physician-specific databases. "Some are very robust and some are sparse," says Auer. "A good database will provide information that is more independent of physician bias." If physicians can agree on indicators and what data will be collected in advance, the data will speak for themselves, adds Auer.

To ensure that quality care is provided, and guarantee competencies, use a variety of methods. Observations, interviews with coworkers, and validation of the entries in documents are a few methods, recommends **Paula Swain**, MSN, CPHQ, FNAHQ, director of clinical and regulatory review at Charlotte, NC-based Presbyterian Healthcare.

"Recently, I heard a Joint Commission surveyor describe the performance evaluation requirements of the medical staff as an extension of what nursing has been doing for years," Swain says. "Why is this scrutiny reserved for the hospital staff? The medical staff has as much at stake as anyone."

To make the new process seem less difficult, take the approach of using what is already done in other parts of the health care arena and extend it to the medical staff, says Swain. "These next two years will do much to bring the medical staff into the process of patient care delivery review, with a spotlight on how systems operate and how the medical staff operate within those systems," she predicts.

Here are effective strategies to comply with the ongoing review requirements:

• Enlist the help of a champion.

"After shock and awe amongst the ranks of the medical leaders, a medical champion must declare the absolute necessity of this for organizational operations," says Swain. The champion could be the chief of staff, the credentials committee chairman, or the vice president of medical affairs, says Swain.

• Design a plan that will provide medical staff leaders with valuable information.

"Medical staffs that have from 50 to 2,000 members will need to examine what's doable," she says.

• Consider adding in subjective data to your results.

Administrations in every type of facility will need to closely examine the sources of data as they fold them into performance evaluations, says Swain.

"There will need to be at least an Excel database managing this," says Swain. Volume statistics on admissions, discharges, surgeries, births, and procedures are useful, but adding more subjective data that may have been provided through peer review statements reported as meeting best practice brings another level of complexity, she says.

"Physicians have been afraid of 'numbers reporting,' 'economic credentialing,' and other accountabilities for years," says Swain. "This may be well founded in light of the poor data mining under way in many databases. However, with pay for performance at the door, there is little relief from the use of numbers identified by providers."

• Involve others when interpreting data.

The data for each provider will be put before peer review committees, who will need to deal with the nuances of multiple types of data, says Swain. "There should be questions from the committee requiring more drill-down questions, and involvement of nurses, ancillary staff, and cross-service physicians when looking for answers to twists found in data," she says.

The old peer review response of "acceptable exception" by a peer review committee will not be useful in the performance evaluation of the future, says Swain. "Conscientious review, referral to outside agencies, and longer credentialing committee meetings will be trends of the future."

Physicians and allied health professionals will need to be involved with what is going into their files, says Swain. Share stories of success through education sessions, such as grand round sessions and general medical staff meetings, she recommends. "Throughout the transition process, they should be taught that this is the expected standard for all."

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How to obtain the data for medical staff standards

You'll need data for every practitioner

Data for every practitioner, analyzed frequently, with the right people in the loop — you'll need to develop systems to ensure that all of these things happen on an ongoing basis, in order to comply with new medical staff standards from The Joint Commission.

"I had one organization say to me, 'Our departments all meet monthly and they look at all the data that is available monthly. Is that OK?' My question was, 'I like the frequency and that you are looking at all the data, but do you have data for everyone?'" says **John Herringer**, associate director of standards interpretation for The Joint Commission. "That is an important factor. If it is a low-volume person, you will have a small amount of data. But you do need to be collecting it."

First, determine which practitioners have data and which don't, and then determine why data are missing for certain practitioners and how you can get them.

"If the correct data are available and they are not getting funneled to you, that is another issue," says Herringer. "I am a firm believer that organizations have a lot more data than ever gets to the medical staff."

Herringer recommends meeting with your information technology (IT) and billing departments to find out what data are currently being collected, what format they are collected in, how often they are aggregated, if they are being shared with the correct departments, and if not, what it would take to correct this. If data are being looked at but not often enough, or if the right people aren't looking at them, you'll need to redesign your process.

Basically, you need to figure out what is currently happening at your organization and then tweak your process, Herringer says. "If you don't have data for everybody, figure out how you can get it," he says. "It sounds daunting, but I think that people are further along than they think they are. You may not have a good handle on how much data are already being collected. Once you sit down and research this, then you can fill in the gaps."

Individual departments should identify what they think is useful data, since the signs of good care will be different for each area. For example, the department of internal medicine might decide to look at whether the dose of medication or liter flow for the oxygen can be reduced for congestive heart failure patients, which is more detailed information than simply determining that a patient had no infection after surgery and was discharged in five days.

After the medical staff approve whatever the department says is a comprehensive, appropriate set of data to collect, your organization would then go about analyzing the data as they become available, and taking any actions necessary.

"At this point we're not prescribing this to be done monthly or quarterly. But if it is done every 12 months, I would classify that as periodic and not ongoing," says Herringer.

But at the same time, small amounts of data could be meaningless. "You could have two problem cases, but if it's two out of 500 cases a year, it may not be any kind of a pattern or trend," says Herringer.

Each organization needs to decide how much data are looked at and how often, but data do need to be collected for everyone, Herringer says. He acknowledges that there are some practitioners who will be difficult to collect data for, such as psychiatrists, because they don't do a lot of procedures other than admissions for certain diagnostic labels. If the patient gets discharged, that is clearly a good outcome because then the patient didn't need to be institutionalized; otherwise, it is very hard to collect practice data for confidential sessions, notes Herringer.

"You are not sitting in the room making judgments as to whether he is using the correct clinical approach, and the documentation won't necessarily reflect why a certain approach or medication was used," he says. "So they are a hard group to get a handle on."

Since direct observation won't work for this group, other options are chart review, monitoring of diagnostic and treatment approaches, and medications that are being prescribed.

Another group that is difficult is physician's assistants and dependent advanced practice nurses, because their work is often coded under their supervising practitioners. "So they will have some data, but it won't necessarily be linked to them. If one physician's assistant is working for three or four physicians in a practice group, it could be hard to pull that out," says Herringer.

However, there are ways in which data could be pulled from an automated record since every employee would presumably have an access code. Herringer advises working with IT to create a report on the number of times the practitioner wrote a progress note, or ordered a diagnostic test, or identified the patient. If you don't have an automated record, you might need to go in manually and review the records to extract the data.

Another challenge when locating data to put into the performance assessment is the issue of "active" staff, says Swain. If physicians don't admit, which is popular with hospitalists taking a larger role in hospitals, it will be difficult to get some of the hospital-related information, she explains.

However, all the occurrence data, such as generic screens, incident reports, and complaints from staff and patients, need to be classified by provider and submitted to the medical staff office. Other information such as blood and drug use, appropriate screening for procedures, infection information, and core measures data by provider are rich in performance review material, adds Swain.

"The change will be to systematically record it in the medical staff office," she says.

Gather a planning team with IT staff, nurses, ancillary staff, and administrators, to ferret out all the data streams of information at your organization, recommends Swain. Since the medical staff office has been on the sidelines of much of the clinical activities, they do not have insight to all the opportunities for provider data, she says.

"Pharmacists know about who orders off formulary too frequently, and nurses know who never calls back or who saves the day when no one else will respond," says Swain. "Good and bad, positive and negative, are all important now."

National Patient Safety Goal information needs to be funneled into the mix, adds Swain. "Who is always having problems pausing prior to a procedure? Who seldom responds to a critical result?" she asks.

Incorporate data on patient safety measurements, such as do-not-use abbreviations, suggests **Christina W. Giles**, CPMSM, MS, president of Nashua, NH-based Medical Staff Solutions. "Note that a practitioner never uses the disapproved abbreviations, that there have been no problems with legibility of handwriting, and kudos letters received from patients and their families," she says.

Data may already be reported to entities such as The Joint Commission, the Centers for Medicare & Medicaid Services, or large insurers. "If these data are already being collected, then we should be documenting them for the privileges requested as well," Giles says.

Some institutions are developing the use of a process similar to the "360-degree" assessment used in human resources, with individuals who work with the particular practitioner asked about his or her communication skills, professionalism, medical knowledge, overall patient care, and use of evidence-based practices, says Giles.

The Joint Commission gives suggestions for methodologies to collect data to comply with standard 4.40, including direct observation, chart review, and interviews with other team members about their treatment approach.

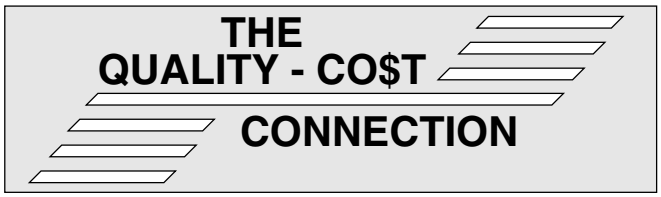
"I think you can use the same approach for focused review," says Herringer. "If you are seeing infections related to certain surgeons, you could have another surgeon watch the technique and see if they can identify any breaks in infection control."

Have that individual do a chart review to see if the physician is doing the right cultures, ordering the right medications, noting signs and symptoms of infection, and possibly identify some areas requiring additional education or training, recommends Herringer.

If the medical staff decide to use proctoring as an evaluation technique, they must establish a policy and procedure that defines how the proctoring will take place, what information will be collected, the roles and responsibilities of the proctoring physician and of the proctored physician, and where the information will be sent for review, says Giles.

To collect and aggregate all the data is going to be difficult, and will require merging the various databases being used throughout the hospital so that this information aggregation is not done by hand, says Giles. Work with clinical practitioners to identify the correct measures, then determine the best way to portray the information, she advises.

"This will impact a lot of individuals who have been working hard to try and achieve this for many years," says Giles. "I see The Joint Commission's standards as providing the impetus to accomplishing this sooner rather than later." ■



Meeting more explicit peer review imperatives

Includes ongoing monitoring and individual review

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Forest Grove, OR

(Editor's note: This is part one of a three-part series.)

Physician peer review has been an essential part of hospital quality since the American College of Surgeons first established minimum hospital standards in 1918. To this day an effective peer review process continues to be important. The 2007 Joint Commission (TJC) Medical Staff Standards reinforce the need for an ongoing, objective, and fact-based process. This concept is the foundation for the professional practice evaluation requirements in standard MS.4.40. This standard does not necessarily create new requirements; however, it does delineate in more specific language exactly what's expected of hospitals and the organized medical staff. The more explicit requirements are intended to reduce variation in the ongoing monitoring activities among accredited facilities and ultimately strengthen the link between peer review and performance improvement. To meet this standard, the medical staff must engage in two activities: ongoing monitoring of performance patterns and individual case review. The goal of these reviews is to ensure that physicians have the necessary skills, knowledge, and attitudes to care for patients. Although a physician's training is validated at the time of cre-

dentialing, it cannot be assumed that the training makes the physician competent. Competence can only be assured through demonstration of consistently appropriate patient care.

Ongoing monitoring involves the collection and analysis of departmental- and physician-specific performance measurement data. This includes measures of process and outcomes. Process measures evaluate whether the right things are being done and outcome measures evaluate the results of patient management practices. The Joint Commission standards allow hospitals some discretion when selecting measures to be used for physician performance evaluations; however, there are some "must do" requirements. For example, the standards call for the organized medical staff to regularly evaluate practitioner performance by reviewing the use of blood and blood components, appropriateness of operative and other procedures, medication use, significant departures from established patient care practices, use of autopsies, significant adverse and sentinel events, and patient or family complaints. Physician compliance with the safe practices recommended by The Joint Commission National Patient Safety Goals also should be evaluated. For instance, physicians' use of non-approved abbreviations should be monitored. Other relevant performance data may be derived from infection control, risk management, and utilization review activities.

Measure selection

Often data already being gathered for The Joint Commission- and CMS-required measures also are used to identify physician departures from established patient care practices. However, it is not sufficient to rely solely on data from these measures to evaluate the performance of every practitioner. The measures required by external groups cover only a few conditions and some physicians never care for patients with these conditions. Required measures must be supplemented with other discipline-specific performance data.

Each medical staff department should identify the set of performance measures that will be used to assess the performance of physicians in that department. Some of the measures may be the same in every department. For example:

- mortality rate;
- complication rate;
- rate of medication prescription and transfu-

Figure 1: OB-GYN Department and Physician-Specific Performance Profile

	All	Physician #103
	2006	**2006**
Total Discharges	923	173
GYN average length of stay	3.4 days	4.1 days
OB average length of stay	2.1 days	1.8 days
Ongoing Monitors		
Surgical wound infection rate	0.30%	0.00%
Nosocomial infection rate (excluding surgical wound)	0.60%	0.50%
Inpatient mortality rate	0.00%	0.00%
Neonatal mortality rate	0.20%	0.00%
Fetal loss after 14 weeks gestation	0.20%	0.00%
High-risk C-section rate	72.00%	65.00%
Low-risk C-section rate	18.00%	10.00%
Repeat C-section rate in low risk delivery	55.00%	32.00%
Rate of vaginal birth after C-section	11.00%	15.00%
Rate of maternal eclampsia	12.00%	9.00%
Rate of newborn birth injury or trauma – vaginal delivery	0.20%	0.50%
Rate of newborn birth injury or trauma – C-Section	0.00%	0.00%
Maternal ED visit or readmit within 7 days	2.50%	5.20%
Newborn ED visit or readmit within 7 days	0.87%	1.73%
# patient/family complaints	2	0
Percent of hysterectomy patients given preop antibiotic on time	86.00%	71.00%
Percent of hysterectomy patients given recommended antibiotic	95.00%	100.00%
Percent of hysterectomy patients with antibiotics discontinued on time	89.00%	80.00%

sion errors (not meeting established institutional criteria);

- compliance with patient record completion timeliness requirements;
- average length of stay of admitted patients;
- patient/family complaints;
- nosocomial infection rates;
- readmission rates;
- documentation issues such as number of illegible handwritten orders and timeliness of record completion.

Some of the measures will be department- or discipline-specific. For example, the department of surgery might also measure the rate of physician compliance with surgical care improvement project (SCIP) criteria, surgical injuries to a body part, unplanned procedures not noted in the patient's consent, wrong patient/wrong site surgeries, and incidence of postoperative deep vein thrombosis. In addition, the department of surgery may have some discipline-specific measures. The measures below might be used to evaluate the performance of cardiac surgeons who operate on adult patients:

- appropriate use of medications (beta blockers, anti-platelets, anti-lipids);
- use of internal mammary artery;
- incidence of prolonged intubation;
- surgical re-exploration rate;
- surgical volume for various types of procedures (isolated coronary artery bypass graft surgery, valve surgery, and CABG + valve surgery);
- rate of specific types of complications (e.g., deep sternal wound infection, cerebrovascular accident, postoperative renal insufficiency);
- risk-adjusted inpatient mortality for various types of procedures.

Review structure

In some hospitals, each medical staff department has a quality or peer review committee that is responsible for reviewing performance results and initiating further investigations as needed. Some hospitals have one medical staff quality oversight committee chaired by the medical director or another high-ranking medical staff leader. This oversight committee is usually comprised of the chiefs of each major department (e.g., medicine, surgery, pediatrics, obstetrics and gynecology, behavioral health, emergency services). These physicians may also serve on the credentials committee. This group can also include non-physician members such as the director of nursing services and vice president of operations. The oversight committee conducts an initial review of the performance results from all departments. Trends requiring further review are referred to the relevant department for in-depth investigation and appropriate action.

To meet Joint Commission standards, the medical staff must periodically evaluate performance results to identify variations for further examination. Each department's performance on selected measures should be evaluated at least quarterly. Departments in low-volume hospitals may need to wait for six months of data before the results are meaningful. Physician-specific results should be evaluated at least annually. If the medical staff only reviews physician performance data every two years — at the time of reappointment — opportunities for prompt intervention may be lost. Timely evaluation of measurement results is important so an in-depth evaluation can be rapidly initiated if department or physician performance is found to vary from expectations. In Figure 1 **(see p. 112)** is a physician performance profile for measures regularly evaluated by the OB-GYN department. Aggregate department-wide data are reviewed quarterly and physician-specific results are only reviewed annually.

It is not sufficient to merely report performance data for each physician. The medical staff must also define "trigger points" for determining when further investigation is warranted. For instance, the performance profile in Figure 1 shows that the maternal patients of physician #103 are more than twice as likely to visit the emergency department or be readmitted within seven days as compared to the patients of other physicians in the department. Without any predefined trigger point for this measure, the committee reviewing the results has no clear direction on what action to take. For some physicians, the committee may conduct a more in-depth review; whereas for other physicians, no action may be taken. To eliminate inconsistencies in the peer review process, it is important for the medical staff to delineate measure "trigger points" that signal the need for further action.

Data gathering

Gathering data for performance reports is time-consuming for the quality department. Some information may be readily available in the facility's electronic information system. Other data, such as appropriate use of medications or compliance with established patient care practices, often must be gathered by reviewing patient charts. Even if this information is collected from active records (while

patient is hospitalized), the data must be aggregated retrospectively to create department- and physician-specific performance scorecards. In some instances, the data may not be available for several weeks after patients are discharged. Ideally, the lag time between patient discharge and reporting of performance results is no more than three months so any new or recurrent problems can be quickly identified and investigated.

The second element in physician peer review is evaluation of individual cases. Techniques for selecting cases for review and conducting fact-based evaluations will be covered next month in part two of this three-part series on medical staff peer review. ■

Patient handoffs across units need improvement

Process needs to happen every time and everywhere

Almost half of hospital staff report there is room for improvement in the area of handoffs and transitions across units, according to the *2007 Hospital Survey on Patient Safety Culture Comparative Database Report* released by the Agency for Healthcare Research and Quality (AHRQ).

More than three-fourths (78%) of hospital staff believe there is a positive environment of teamwork within their units, but nearly half (45%) indicate there is room for improvement in the area of handoffs and transitions across units.

"Having worked in this area a lot, it was what we expected, but other people may find this surprising," says **James B. Battles**, PhD, senior service fellow for patient safety at AHRQ. "Teamwork may be viewed positively, but across work areas it may not be as strong as we would like. This data shows that you're not alone."

Handoffs may go smoothly in one clinical unit, but when the patient moves to another area, such as going to the intensive care unit from the emergency department, problems often occur.

The report is the first compilation of aggregated national data from AHRQ's *Hospital Survey on Patient Safety Culture.* It is based on data from 382 U.S. hospitals and survey responses from 108,621 hospital staff. The report found a number of strengths among hospitals, as well as areas for patient safety culture improvement, such as handoff communication.

CE *questions*

5. Which is required by The Joint Commission's revised medical staff standards?
A. An evaluation of a practitioner's performance is required only every two years.
B. Your peer review program should be outlier-based.
C. Focused reviews must be done by department chairs.
D. Data should be reviewed as they become available.

6. Which is true regarding The Joint Commission's requirements for practitioner data?
A. Data must be collected for every practitioner.
B. Data do not have to be collected for psychiatrists.
C. Data do not have to be collected for physician's assistants if they are working in a large practice group.
D. Direct observation must be used.

7. Which of the following is suggested by The Joint Commission as a method of data collection on practitioner performance?
A. direct observation
B. chart review
C. Interviews with other team members
D. any of the above

8. Which is recommended to improve handoff communication?
A. Do not use the Situation-Background-Assessment-Recommendation technique.
B. Use a standardized model.
C. Avoid using a standardized model.
D. Use handoff checklists only for units that have identified problems.

Answer Key: 5. D; 6. A; 7. D; 8. B.

CE instructions

Nurses participate in this continuing education program by reading the issue, using the provided references for further research, and studying the questions at the end of the issue. Participants should select what they believe to be the correct answers, then refer to the list of correct answers to test their knowledge. To clarify confusion surrounding any questions answered incorrectly, please consult the source material. After completing this semester's activity with the **December** issue, you must complete the evaluation form provided in that issue and return it in the reply envelope provided to receive a credit letter. ■

"I would say we are still reasonably early in this work," says **Michael Leonard,** MD, physician leader for patient safety at Kaiser Permanente in Evergreen, CO. "The awareness that it needs to happen is pretty high. We certainly know from Joint Commission data that the majority of things that go astray are related to handoffs."

The organization must decide what tool or technique to use for handing off, whether Situation-Background-Assessment-Recommendation (SBAR) or another model. "The really critical piece is the cultural agreement that it needs to happen every time and it needs to happen everywhere," says Leonard.

"Typically, people hand off in different ways. What you need is a standardized model that allows for the nuances of a particular environment. You have to build a system that supports that behavior and says it's not negotiable — that this is something that happens, always."

Handoffs should be done so consistently that the process becomes "the way we do business," says Leonard. "In medicine, there are many great tools and protocols that are used only a very small percentage of the time," he notes. He contrasts this with two pilots on the flight deck of an airplane who go through a checklist 100% of the time, and start over if they are interrupted. "What we need to do is to give people both practical tools and the leadership component."

For high-risk handoff areas, communication errors could lead to adverse events or even the loss of a patient's life. Researchers at Children's Hospital in Boston evaluated the handoff process for children who undergo surgical intervention and then return to the pediatric intensive care unit (PICU). A lot of variability in the process was identified, says **Kshitij P. Mistry**, MD, MSc, lead author and assistant professor of pediatric critical care medicine at Duke Children's Hospital in Durham, NC.[1]

Two other key findings were that the PICU environment is not conducive to good communication because of constant distractions from pagers and alarms, and also, that all the relevant providers pertinent to a patient's care were not present during the handoff.

When Mistry and his colleagues set out to improve the PICU handoff process, they first compared the information content of the current handoff process to what was ideal. "What we have done at Duke is try to address those deficiencies," he says. Six Sigma methodology was used, with the goal of decreasing the variability of the handoff process.

The hospital's PICU has 1,200 admissions a year, 30% of which are children with congenital heart disease. "That seemed like a logical patient population to start with. Given the high degree of complexity of these patients, they are at high risk for adverse events due to communication errors," says Mistry. These steps now occur every time a child who has undergone surgery for congenital heart disease surgery comes back from the operating room to the PICU:

All health care providers are present at the bedside, including not only the critical care nurse and physician, but also a representative from cardiothoracic surgery and cardiac anesthesia.

The concept of "sterile cockpit" from aviation is used, meaning that nonessential conversation

CNE objectives

To earn continuing education (CNE) credit for subscribing to *Hospital Peer Review*, CNE participants should be able to:

- Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes.
- Describe how the issue affects nurses, health care workers, hospitals, or the health care industry in general.
- Cite solutions to the problems associated with those issues based on guidelines from The Joint Commission or other authorities and/or based on independent recommendations from clinicians at individual institutions. ■

COMING IN FUTURE MONTHS

- Pros and cons of using standardized order sets
- Proven methods to track adverse drug events
- Update on the CDC's new infection control guidelines
- Strategies for concurrent chart review of core measures

does not occur during takeoff and landing, which are the times of greatest risk for crashes. "We applied that to handoffs," says Mistry. "When it is time for us to communicate information verbally, no nonessential conversation occurs."

Individuals talk in a specific order. First, the cardiothoracic surgeon explains what they did in the OR and what they are concerned about. Next, anesthesia gives their input, and lastly, critical care physicians and other team members ask questions. "So we all create a shared mental model of what this patient's trajectory should be," says Mistry.

Long-term outcomes, length of stay, and adverse outcomes are still being evaluated to find out the impact of the new handoff process. "Thankfully, our mortality rate is small, so that might not be the most sensitive indicator for us," says Mistry. However, the hospital's data show that delays in time-sensitive therapies, such as a chest X-rays and critical lab results, have decreased.

"So we can employ interventions faster, and place these patients on appropriate cardiorespiratory monitoring," says Mistry. "We are hoping that the timeliness of therapy will improve care, and, therefore, decrease morbidity and mortality."'

The organization is implementing the new handoff process for neurosurgical patients coming back to the intensive care unit (ICU) from surgery, and patients going to a non-critical care setting from the PICU. Often, the health care providers receiving the patient have not been involved in the patient's ICU care, so that is another communication gap potentially leading to adverse events, says Mistry.

Process improvement is often considered "soft science" because it's hard to have objective outcomes to measure, says Mistry. "I think that has been the biggest obstacle so far. But now people will see the improvement in patient outcomes related to improving the process," he says. "So I think that people will start to employ these interventions. For us, that has been the tipping point."

(Editor's note: A downloadable copy of the 2007 report is available on the AHRQ web site at http://www.ahrq.gov/qual/hospsurveydb/.)

Reference

1. Mistry, KP, Landrigan, CP, Goldman DA, et al. Communication error during post-operative patient hand off in the pediatric intensive care unit. *Critical Care Medicine* 2005: 33(12);A12.

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