YOUR BEST SOURCE FOR JOINT COMMISSION COMPLIANCE

HPR HOSPITAL PEER REVIEW®

Accreditation • Credentialing • Discharge Planning • Medicare Compliance • Patient Safety • QI/UR • Reimbursement

AHC Media LLC

IN THIS ISSUE

Financial Disclosure:
Editor Staci Kusterbeck, Managing Editor Jill Robbins, Associate Publisher Coles McKagen, and nurse planner Paula Swain report no consultant, stockholder, speaker's bureau, research, or other financial relationships with companies having ties to this field of study. Consulting Editor Patrice Spath discloses she is principal of Brown-Spath & Associates.

OCTOBER 2007
VOL. 32, NO. 10 • (pages 133-148)

Prepare now for new Medicare ruling: No more payment for preventable errors

Will change result in better quality or punitive culture?

If a surgeon left an instrument inside you during an operation, would you expect the hospital to be paid for this procedure? Almost any patient would say no. Now the Centers for Medicare & Medicaid Services (CMS) has announced it will stop paying the costs of eight conditions resulting from preventable mistakes: objects left in a patient during surgery, blood incompatibility, air embolism, falls, mediastinitis (an infection after heart surgery), urinary tract infections from using catheters, pressure ulcers, and vascular infections from using catheters.

"This particular issue has been under discussion for quite some time," says **Patti Muller-Smith,** RN, EdD, CPHQ, a Shawnee, OK-based consultant who works with hospitals on performance improvement and regulatory compliance.

"Some individuals seem to approach the quality-of-care issue as a necessary but expensive cost to the health care facility," says Muller-Smith. "Now it will become a major contributor to a healthy bottom line, and will be brought to the forefront at all levels within hospitals."

Impact on quality

Many in the quality field argue that it took too long for this change to occur. "My first reaction is: Why did it take significant loss of life and well-being to bring this critical issue to the forefront? And why did it take a government organization to put 'teeth' into this?" says **Pamela Rowse**, RN, clinical nurse manager at Kindred Hospital in Las Vegas and former quality management coordinator at St. Rose Dominican Hospitals in Henderson, NV.

The Medicare rule will be a powerful catalyst for change in the quality field, predicts Rowse. "I see it as a monumental turning point in our profession," she says. "When you tie a dollar figure to the decision to do it right or you don't get paid for the care you do provide, I think we will see a significant change in the reduction of iatrogenic injuries and deaths."

Quality professionals "absolutely can use this to our advantage," says Rowse. "This will provide hospitals the opportunity to invest time and money into prevention, rather than intervention," she predicts.

However, other quality professionals worry that the ruling will put a strain

on already limited resources. **Tom Knoebber**, director of performance improvement for Asheville, NC-based Mission Hospitals, says he "sees potential issues down the road" as hospitals try to prioritize the many initiatives coming from CMS with proper documentation upon admission, Hospital Quality Alliance data elements, and other requirements.

Some predict the ruling will actually have a negative impact on quality. "Nonpayment is an easy but illogical solution to a complex problem," says **Claire Davis**, vice president of quality at Norwalk (CT) Hospital. "Those of us who have studied and operationalized the science of health care quality know that quantifiable improvements in process and outcome do not result from elimination of funding or cost reductions. The ruling assumes that the threat of nonpayment will force doctors and nurses to give better care. That is simply ridiculous."

Three of the conditions included in the ruling are identified as "never events" by the National Quality Forum. These are always the result of error and are "absolutely avoidable," says Davis, and hospitals should not be reimbursed for these. However, the other five conditions fall under a different category, she says.

"Falls, pressure ulcers, and various types of infection are not necessarily the result of poor care. They, in fact, do occur at times, even when all reasonable efforts have been made to prevent them," says Davis. Because of this, the ruling is a setback to progress already made in improving safety cultures and reporting of errors and near misses, and cause organizations to revert back to a punitive culture, Davis says.

"The rule will create massive administrative costs, and force hospitals to direct resources from other quality initiatives that actually do improve care," she continues. "Also, hospitals will be spending much time, energy, and money in proving that preexisting conditions existed prior to admission or transfer. Handoffs and interagency relationships may be negatively impacted by defensive posturing."

More power for QPs?

Internal strategies will be needed to prevent these eight conditions from occurring while the patient is hospitalized, and failures will need to be carefully analyzed to develop improvement strategies, says **Deborah K. Hale**, CCS, president of Shawnee, OK-based Administrative Consultant Service LLC, a consulting firm specializing in improving clinical and financial outcomes in health care. "In my opinion, the role of the quality professional will certainly be enhanced."

There is no question that preventable injuries cost CMS a significant amount of money each year, due to extended length of stay and increased cost. However, though it will sometimes be clear the injury was preventable, in other cases it will be difficult to determine if the hospital is at fault, notes Muller-Smith.

"If anything, the ruling will put the quality professional in a position of being very important to

Hospital Peer Review® (ISSN# 0149-2632) is published monthly, and **Discharge Planning Advisor**™ and **Patient Satisfaction Planner**™ are published quarterly, by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Peer Review**®, P.O. Box 740059, Atlanta, GA 30374.

AHC Media LLC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

This activity has been approved for 15 nursing contact hours using a 60-minute contact hour.

Provider approved by the California Board of Registered Nursing, Provider #14749, for 15 Contact Hours.

This activity is valid 24 months from the date of publication.

The target audience for **Hospital Peer Review**® is hospital-based quality professionals.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30-6 M-Th, 8:30-4:30 F EST. World Wide Web: www.ahcmedia.com. E-mail: customerservice@ahcmedia.com.

Subscription rates: U.S.A., one year (12 issues), $469. Add $12.95 for shipping & handling. Outside U.S., add $30 per year, total prepaid in U.S. funds. Discounts are available for group subscriptions. For pricing information, call Tria Kreutzer at (404) 262-5482. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. **Back issues**, when available, are $78 each. (GST registration number R128870672.)

Editor: **Staci Kusterbeck**, (631) 425-9760.
Senior Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcmedia.com).
Associate Publisher: **Coles McKagen**, (404) 262-5420, (coles.mckagen@ahcmedia.com).
Managing Editor: **Jill Robbins**, (404) 262-5557, (jill.robbins@ahcmedia.com).

Editorial Questions

For questions or comments, call **Staci Kusterbeck** at (631) 425-9760.

the overall bottom line for a hospital," she says.

Patient falls probably will be be the most difficult of the eight conditions to prevent, predicts Muller-Smith. Hospitals may identify patients at risk for falls and take the appropriate precautions, but disoriented patients may not follow instructions, she says.

"Short of having a health care provider in each patient's room on a consistent basis, there are times when even though all reasonable actions have been taken, the patient may still fall," Muller-Smith says.

To prepare, quality professionals "must immediately gear up and push the education process" at medical staff meetings, governing board meetings, and midlevel and upper management meetings, urges Rowse.

"Tight collaboration with the health information management department is essential," says Rowse. "The nursing division must also be included in the education process, as their documentation and practice is important."

All members of the medical staff must be fully educated on the new CMS mandate and its impact on the care and reimbursement of their patients, says Rowse. She recommends sending individual mailings to physicians with a required signed letter stating that they received the information, posting an announcement in all areas where physicians dictate, and providing education for emergency department physicians about the necessary documentation triggers.

"It will require a full commitment and buy-in by the chief medical officers and/or chiefs of staff to ensure that change occurs," says Rowse. "Involvement by the quality arm of the governing board of the hospital will further ensure that there are resources to assist in this project."

'Present on admission'

As of Oct. 1, 2007, coders must determine whether each of the diagnoses reported were present on admission. Your biggest challenge will be complete and accurate physician documentation, coupled with ICD-9-CM coding accuracy, says Hale.

Conditions identified as present on admission will be reported as a "Y," conditions not present on admission will be reported as an "N," and clinical undetermined conditions will be reported with a "W." As of Oct. 1, 2008, the MS-DRG payment will be reduced for any of the eight conditions developed during the hospital stay.

Urinary tract infections, pressure ulcers, and other hospital-acquired infections should be preventable with good patient care, says Muller-Smith. "If these issues are identified as present on admission, which requires good documentation during the admission assessment, the hospital will not be penalized."

However, some of the conditions might be overlooked as "present on admission," such as a decubitus ulcer. Hospital coders must use the physician's documentation to determine whether a condition was present on admission, says Hale. "For the most part, hospitals do a good job of wound care, but physicians often omit documentation of the presence of a decubitus ulcer or early skin breakdown at the time of admission, but they do order wound care."

In this case, the lack of physician documentation would result in the coder reporting the condition as not present on admission, or returning the record to the physician for additional documentation prior to billing, she explains. "This would slow down the billing process, not to mention the aggravation to physicians," says Hale.

A quality professional or clinical staff person will need to perform pre-billing review to assist the coder in determining whether certain conditions were present on admission or developed during the course of the hospital stay so the hospital's reporting will be accurate, says Hale.

In addition to the pre-billing review, when any one of the eight conditions are going to be reported as not present on admission, concurrent review by clinical documentation specialists can be helpful in obtaining additional documentation to support the circumstance of the admission and whether these conditions were, in fact, present on admission, says Hale.

If your hospital is already doing concurrent documentation to achieve accurate DRG reimbursement and compliance with core measures, adding review for these eight conditions will be "relatively easy to accomplish," says Hale.

"Coder productivity will be reduced if time is taken to thoroughly review records and make good decisions about present on admission," she adds.

To ensure accurate reporting of present on admission, a thorough assessment using a standardized form would be ideal, but multiple patient entry points and variable staff are challenges, says Knoebber.

"We are currently working with our health information management department and nursing staff to develop a standardized assessment

form for centralized evaluation and documentation," reports Knoebber.

Each of the present on admission elements are evaluated and any staff member is able to document if prior evidence is found, says Knoebber. "At this point, we are moving toward more concurrent coding," he says. "It does take more time as coders try to educate physicians and staff regarding quality documentation and terminology."

Adding additional case managers with specific education on mandates could be effective, says Rowse. "Armed with screening checklists for reviewing all admissions, they could identify gaps in documentation that would require an addendum to the physician's documentation," she says.

Tougher than it sounds

Denying reimbursement for hospital-incurred complications "sounds much easier to implement than it is," says **Patrice Spath**, RHIT, a health care quality specialist with Forest Grove, OR-based Brown-Spath & Associates. "It's a big issue that seems simple on the surface, but actually has lots of twists and turns that don't appear to be well addressed right now by Medicare."

At first glance, it may seem easy to identify a retained surgical instrument as not being present on admission, but Spath gives the following example: A patient has surgery at hospital X, then nine months later has surgery at hospital Y to remove the retained surgical instrument. The retained instrument in this example is "present on admission" for hospital Y.

"So does hospital Y get paid for the surgery to remove the retained instrument, or does hospital X pay the bill at hospital Y?" asks Spath. "And, just as important, is all of this tied to the surgeon's payment? And the surgeon that left the instrument in the patient on the first admission — will they get paid for doing the second surgery?"

Or if another surgeon removes the instrument at hospital Y, there is the question of whether that second surgeon gets paid by Medicare for removing the instrument. "Without tying the nonpayment to the physician side of reimbursement, it may be somewhat challenging to get physicians to adopt prevention strategies — especially for conditions such as urinary tract infections and pressure ulcers," says Spath.

It is not easy to determine if such conditions are present on admission, says Spath. "For example, should every Medicare patient have a urinalysis on admission to see if they have a urinary tract infection, or be carefully examined for skin breakdowns by the physician and/or nursing staff?" she asks. "All this will take more resources."

It also could be difficult to collect data on the incidence of hospital-acquired urinary tract infections or pressure ulcers when people aren't currently doing thorough admission evaluations to see if the conditions are present on admission, says Spath.

In addition, many infection control departments don't routinely gather data on the incidence of all urinary tract infections, notes Spath. "Just gathering data to evaluate the hospital's payment denial exposure will be challenging."

While most hospitals already are collecting data on these preventable conditions, there is a long way to go for obtaining buy-in from everyone, says **Kathleen Catalano**, RN, JD, director of health care transformation for Plano, TX-based Perot Systems.

"On top of that, once the data are collected, is there any evidence that action was indeed taken to remedy the condition? Therein will be the real issue," she says.

Catalano recommends answering these questions:

- Are you collecting data on these preventable conditions?
- If you are collecting data, what are you doing with them?
- Where are the data reported?
- Have data then been reviewed?
- Depending on the condition, has a failure mode and effects analysis been performed to learn the best way to prevent similar occurrences in the future?

"This move on the part of CMS should send a message to providers that they are serious about preventing these conditions," says Catalano. "Hopefully, it will get the ball rolling."

[For more information, contact:

***Kathleen Catalano**, RN, JD, Perot Systems, Healthcare Transformation, 2300 W. Plano Parkway, Plano, TX 75075. Phone: (214) 709-7940. E-mail: kathleen.catalano@ps.net.*

***Claire Davis**, Vice President, Quality, Norwalk Hospital, 34 Maple Street, Norwalk, CT 06856. Phone: (203) 852-2212. Fax: (203) 852-3436. E-mail: Claire.davis@norwalkhealth.org.*

***Tom Knoebber**, Director, Performance Improvement, Mission Hospitals, 509 Biltmore Avenue, Asheville, NC 28801. Phone: (828) 213-9194. E-mail: CIATXK@msj.org.*

***Deborah K. Hale**, CCS, President, Administrative Consultant Service LLC, 678 Kickapoo Spur, P.O. Box*

3368, Shawnee, OK 74802. Phone: (405) 878-0118. E-mail: DeborahHale@acsteam.net. Web: www.acsteam.net.

***Pamela Rowse**, RN, BS, Clinical Nurse Manager, Kindred Hospital, 2250 East Flamingo Road, Las Vegas, NV 89119. Phone: (702) 784-4300. Fax: (702) 784-4331. E-mail: Pamela.Rowse@kindred-healthcare.com.*

***Patti Muller-Smith**, RN, EdD, CPHQ, Administrative Consulting Services, Box 3368, Shawnee, OK 74802. Phone: (405) 878-0118. E-mail: mullsmi@aol.com.*

***Patrice L. Spath**, BA, RHIT, Health Care Quality Specialist, Brown-Spath & Associates, P.O. Box 721, Forest Grove, OR 97116. Phone: (503) 357-9185. E-mail: patrice@brownspath.com. Web: www.brownspath.com.]* ■

Medical staff: What should trigger a focused review?

Be sure your data are trustworthy

An operation done on the wrong body part is an obvious red flag calling for the need to closely examine a practitioner's competence. But what about a verbal complaint from a nurse who works closely with that physician? Or what if length of stay is increasing for that physician, but only slightly?

The Oakbrook Terrace, IL-based Joint Commission's new 2007 medical staff standards require you to define the "triggers" that indicate the need for a "focused evaluation" — an intense assessment of a practitioner's competence.

"We don't have a definition of triggers — organizations are free to define them however they want," says **John Herringer**, The Joint Commission's associate director of standards interpretation and lead interpreter of medical staff standards.

He notes that Element of Performance (EP) 2 requires you have criteria for conducting the evaluation once performance issues are identified, while EP 5 requires you to identify the triggers that are evidence of a performance problem.

"At EP 2, you may be concerned but you are not sure — it's a little more nebulous. The trigger is a little bit more definitive or exact, in terms of this is a performance problem," says Herringer. "I think triggers are a little bit more finite."

The two most common triggers are sentinel events and infection rates exceeding a certain predefined level. "If there is an unacceptable rate, that's an automatic trigger and you are going to look to try to see why this is happening," says Herringer. "You may end up finding there is no problem at all — the physician may have had just a lot of trauma or seriously compromised patients and nothing is wrong with his technique."

Standard MS 4.40 requires you collect ongoing data about performance for all practitioners. "You are collecting everything, not just the negative or outlier data. People tell me that we only look at them if certain things happen, but I say no, we want you to collect data on good performers, too," says Herringer. "The other thing is, zero data are data. The fact that somebody is not performing in your organization is an important thing to know."

This fact in itself might be included as a trigger for a focused evaluation. "You might want to say, 'If a physician hasn't done a certain procedure in x number of months, we are going to do a focused review of the first one, two or three procedures or admissions that he does do, because we are concerned that he's not coming here,'" Herringer says.

The data you collect for MS 4.40 may identify triggers that say a provider needs a focused review, but they might also tell you the opposite. "It's just as important with 4.40 to know that somebody is an exemplary practitioner as it is to know that he is a problematic practitioner," says Herringer. "You might be able to extrapolate some of his practice patterns into your clinical practice guidelines for other people to use."

Your organization also will need to define how much of a trend triggers a focused review, such as length of stay increasing. "The key is really understanding that you are collecting all kinds of data, and then funneling those data from 4.40 into 4.30. Based on what you get on 4.40, you might need to do a focused review," Herringer says.

Don't wait for bad things to happen

"When you say, 'It's time to do a focused review,' my question is: How did you get there in the first place? Because of a bad outcome in the OR, which may or may not have been bad?" asks **Doug Elden**, chairman of National Peer Review Corp. in Northbrook, IL, which conducts external peer review for hospitals. "The new standards are welcome, because most hospitals are unaware of the data they need to conduct peer review."

The real problem is that many hospitals are

reviewing only bad outcomes, and are not reviewing practice patterns, says Elden. "A hospital needs to work with its IT [information technology] system to find clinical screens that may indicate quality-of-care issues, and not just review bad outcomes," he says.

Hospital departments need to establish appropriate clinical screens or triggers for each specialty and subspecialty to identify cases for peer review, advises Elden. Cases identified by the clinical screens should be reviewed by the hospital's peer review coordinator, under the direction of the chair of the peer review committee, to determine if the clinical screens have appropriately identified the cases for peer review, he explains.

If the cases have been appropriately identified, and they are not false-positives, the peer review coordinator should refer the cases to the peer review committees, says Elden.

"By catching problems early through clinical screens and other methodology, you can educate physicians instead of disciplining them," says Elden. "It's easier to change a practice pattern if it's two or three cases vs. two or three hundred."

If hospitals are not reviewing practice patterns, benchmarks, and utilization data on a daily basis, and these data are not being funneled into the peer review committee, they will just be doing focused reviews when bad outcomes occur, says Elden.

Ideally, your hospital peer review system should have a data committee that works closely with your IT department. Elden gives the example of a hospital where doctors talked directly with the IT department for the first time. "They had never talked to their IT department before. The IT department was producing reams of reports and documents that the physicians didn't understand," he says.

If physicians and IT staff communicate directly through the structure of a peer review data committee, there is less chance of physicians questioning the data later on. "Physicians conducting peer review in a hospital setting must have complete confidence in the information provided to them before taking peer review actions," says Elden. "Without such confidence, most physicians are unlikely to jeopardize a colleague's career and livelihood, no matter how much they may suspect problems."

Physicians need to say to IT, "Here is what I need to make my decision," and IT people need to respond, "Here is what I can get you," and they need to arrive at a data set that is acceptable to the physicians, says Elden.

If peer review committees look only at bad outcomes, the committees will never identify cases when a practitioner is deviating from the standard of care without a bad outcome occurring. "If you cross the highway blindfolded and manage to get to the other side, it doesn't mean it was a good decision," says Elden.

Data may be contradictory depending on the source, which can cause distrust among physicians. "One hospital had internal data indicating that certain physicians were outliers; however, the physicians responded saying, 'My mortality rate is fine. [The Society for Thoracic Surgeons database] says I'm right in the middle. We don't believe the hospital data,'" says Elden. "In many instances it depends on how procedures are coded."

Hospitals should gather data in a uniform fashion. "In one hospital, one physician group was filling out their own STS forms, and for the other physician group the forms were being filled out by nurses," says Elden. "Data have to be collected uniformly, they have to be beyond reproach, and everybody has to buy into them."

In addition to the triggers, Elden says not to ignore the "whispers," meaning complaints verbalized in hallways or offices that aren't put into writing. "These often are not acted on, but if somebody makes a verbal complaint to an officer of the medical staff or to administration, I think you are on notice and you have a legal obligation to investigate," says Elden, who also is an attorney.

If written complaints go into your peer review system, so should verbal complaints, says Elden. Have the peer review coordinator pull the cases, see if there is a problem, and put this in writing, he recommends. "Then send your clinical people in to take a look at the particular cases," he says. "There may be a lot of dead-end streets, but if you do find a problem, it may be straightened out by educational peer review rather than disciplinary peer review."

How to define triggers

So how should organizations define triggers? "That is the $64,000 question," says **Christina W. Giles**, CPMSM, MS, president of Medical Staff Solutions, a Nashua, NH-based consulting firm specializing in assessment and development of medical staff organizational structures in the hospital environment.

"There are some obvious ones, like involvement in a sentinel event, or the same or similar issue happening more than once," says Giles.

Discharge Planning Advisor®

– the update for improving continuity of care

- Accelerated discharge
- Staff cooperation
- Placement strategies
- Reimbursement
- Legal issues
- Case management

Project targets diabetes in Latino community

'Secondary gains' affect willingness to accept help

The "yes-means-no" phenomenon was one of several challenges encountered by the team conducting a community case management pilot project for diabetes patients in Nogales, AZ, says **Donna Zazworsky**, RN, MS, CCM, FAAN, diabetes care center manager for the Tucson-based Carondelet Health Network.

The project — which targeted emergency department (ED) "frequent fliers" with diabetes — focused on establishing the care team and developing a case management toolkit for home diabetes education visits, she adds.

"Nogales is primarily a Latino community, with a very high incidence of diabetes," Zazworsky notes. "Carondelet Holy Cross Hospital had started an inpatient case management program where anyone hospitalized with diabetes would be seen by a nurse case manager/diabetes educator and referred to diabetes self-management classes held in the community."

This helped people who were hospitalized, but the process missed those ED frequent fliers with diabetes, Zazworsky says. "These individuals were not making their way to the classes.

"Many of these patients said that it was just too hard to get to the classes," she explains, "or there was a secondary gain they had. In one case, a gentleman wanted to get on disability and needed to get documentation, so he didn't want to get any better.

"Others wanted to [use their disease to] get attention from family," Zazworsky says. "They had the wherewithal to get to classes, but just didn't go."

Another barrier identified by the team was "the concept of 'yes means no,'" she points out. The phrase, used as the title of a book written in regard to Native Americans, also applies to Latinos, Zazworsky says. "It's not polite to tell you, 'No, I don't want to do that,' so they say, 'Yes.'"

Carondelet Holy Cross Hospital in Nogales received a grant from the Arizona Department of Health Services to conduct the pilot project in March 2007, she says, and had to complete it by June 30. We had to use [the funds] by the end of the fiscal year.

"We already knew the community nurse case management program would be funded beginning July 1, but we got the grant to fund the nurse to identify the tools, test them, and put them in place," Zazworsky adds.

"We had a tracking system in place for inpatients and were building a database for why we needed a program to extend beyond the walls of the hospital," she explains. "When the grant came along, it gave us the opportunity to put the structure in place for that program."

Starting line-up

The program was promoted to the hospital's ED nursing supervisor, case manager, and social worker, each of whom was involved in shaping the pilot, Zazworsky says. "The program targeted only patients who came through the ED for a dia-

betes-related episode."

One of the objectives of the project was to reconvene the Nogales Diabetes Partnership Team, which already had been instrumental in establishing a number of programs and services related to diabetes for the Nogales community. The team met every other Thursday from noon to 1 p.m. over a period of seven weeks.

In addition to Zazworsky, that team includes a diabetes nurse practitioner with the Carondelet Diabetes Care Centers; the diabetes nurse case manager and several other clinicians and administrative staff with Holy Cross Hospital; and three representatives from the Mariposa Community Health Center in Nogales.

The behavioral health specialist from the Mariposa center was an active member of the partnership team, Zazworsky notes, attending the biweekly meetings and available to coordinate visits to his counseling program.

As part of the pilot project, the team used assessment tools from the Case Management Adherence Guidelines (www.CMSA.org), as well as a risk assessment tool that was already in place for Carondelet diabetes inpatients, she adds. "We were targeting everybody and trying to get a baseline on readiness, knowledge, and motivation."

The tools were translated into Spanish by a licensed translator from the area who works with the Carondelet system, Zazworsky says. "This is important to guarantee that we are using the appropriate terminology specific to our Latino region.

"The bottom line was that we were able to get patients into the program and agree to have a nurse case manager make a home visit," she says. "The key was the ED nurse, who provided patient referrals to the community nurse case manager and explained the program to patients. There had to be some kind of handoff so that the patient was aware of the program."

To facilitate that process, Zazworsky notes, the ED nurse made 3x5 note cards explaining that the nurse case manager would call to set up a time for a home visit in order to see how she could help the patient.

The nurse case manager would call within 24 hours to set up the visit, and would then make the visit within 48 hours, Zazworsky says. During the visit, she adds, the nurse case manager would use the tools to gauge the patient's knowledge, readiness, motivation, and literacy level in regard to the diabetes.

Of 36 patients contacted about participating in the pilot, 20 — ranging in age from the 40s to older than 70 — became part of the project, she explains. Fifteen patients actually completed the project.

Short-term outcomes, she adds, showed that "the tools worked, and helped guide the case manager on how to do her work, and there was immediate improvement in patients' levels of confidence."

The project evaluation process showed that even with short-term nurse case management interventions in the home, the target goal of 4.5 out of 5 in confidence levels was met in these areas:

- make healthy food choices (4.5);
- identify foods with carbohydrates (4.5);
- find diabetes information and support (4.5);
- detect and take action for low blood sugar (4.8);
- examine feet for problems and know how to care for them (4.6);
- work with a health care provider (5).

However, project results showed that patient confidence levels went down in one area — how diabetes medications work and their possible side effects. That drop may be related, team members suggested, to an increase in medication awareness that happened as a result of patients' ED visits and their work with the case manager.

"Patients were either put on new meds or they realized they didn't understand the action of their medications," Zazworsky notes.

As a result of the pilot, she adds, the partnership team will continue to monitor numbers to determine appropriate cutoffs for risk level, adherence level, and intervention strategies.

"We still have those outliers that refused services from the nurse case manager and continued to use the ED," she says. "We know as case managers that we are not able to convince everybody that they could benefit from our help."

One of the team's observations in regard to the outliers, Zazworsky says, was that high knowledge/high motivation does not equal better self-care, and that in fact, modifiers — such as the desire for more attention from the family — have a greater effect on patient behavior.

"When we realized that, we really wanted those patients to have some behavorial health [intervention], but they weren't willing to get the appointment, and it wasn't the kind of scenario in

which we could have [therapists] come into the home."

One possibility for addressing that issue, she adds, is to look at "telebehavioral health" — a video phone setup that allows the therapist to work with the patient remotely.

"That can open the door to other modalities," Zazworsky says. "What it's about is building the trusting relationship."

(Editor's note: ***Donna Zazworsky*** *can be reached at donnazaz@aol.com.)* ■

Consultant: CM must move to DM model

Gap between research, practices cited

With studies showing that 10% of patients are using 90% of the nation's health care resources, traditional case management must move to a disease management model, says **Bob Whipple**, RNC, CCM, CCS, MHA, a Boston-based senior management consultant with ACS Healthcare Solutions.

"Moving to a disease management model gives greater flexibility for meeting new challenges," Whipple adds. "It is the future of case management."

Disease management — preventive, diagnostic, and therapeutic services for types of patients considered at risk — is widely considered to be a more cost-effective approach to care, he points out. The Disease Management Association of America, Whipple notes, defines disease management as "a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant."

Those conditions, he continues, include these chronic diseases:

- congestive heart failure;
- asthma;
- cancer;
- coronary artery disease;
- chronic obstructive pulmonary disease;
- cystic fibrosis;
- depression;
- diabetes;
- HIV/AIDS
- hypertension;
- lupus;
- multiple sclerosis.

Medical research has created a growing body of evidence on the most effective protocols for treating chronic diseases, Whipple notes. "However, reports by the Institute of Medicine and others have observed that a large gap often exists between such evidence-based treatment guidelines and current patterns of practice."

The case management model in place at most hospitals, he contends, is not adequately addressing the needs of the chronically ill.

Whipple points out a number of broad differences between case management and disease management, and elaborates on them as follows:

- **Characteristics of patient population.**

Case management: People at high risk for costly, adverse medical events and poor health outcomes. **Disease management:** People diagnosed with a specific disease.

- **Methods for identifying patient.**

Case management: Mailed questionnaires; data on use of hospitals and emergency departments; referrals by physicians using criteria to identify "high-risk" patients. **Disease management:** Data on presence of a particular diagnosis; prescription for certain drugs used to treat a disease; referrals by physicians who treat many patients with that disease.

- **Patient education.**

Case management: No standardization of curriculum or educational materials; highly individualized. **Disease management:** Standardized curriculum and educational materials for a specific disease.

- **Reliance on evidence-based treatment guidelines.**

Case management: Low. **Disease management:** High.

- **Reliance on protocols and standardization.**

Case management: Low. **Disease management:** High.

- **Importance of using social support services.**

Case management: High. **Disease management:** Low.

- **Importance of engaging family and caregivers.**

Case management: High. **Disease management:** Low.

- **Reliance on care coordinator.**

Case Management: High. **Disease management:** Medium.

A disease management program designed to improve health care quality and reduce medical

expenses for those with complex or clinically advanced illnesses resulted in a 38% decrease in hospital admissions, reduced costs by more than $18,000 per patient, and garnered high satisfaction rates among 92% of the patients, according to a recent report in a prominent medical journal.

The report — on a study of Blue Shield of California HMO members — was published in the February 2007 edition of *The American Journal of Managed Care,* Whipple notes, and examined the program's impact on those with illnesses such as late-stage cancers or degenerative neurological conditions.

Why traditional treatment models fall short

There are several reasons traditional treatment models fall short in the care of the chronically ill, he suggests, including the difficulty physicians have in keeping up with the latest developments in view of the tremendous growth in the number of medical studies.

In addition, Whipple says, patients with multiple medical conditions may receive care from many different physicians or providers at the same time, take a number of different drugs to treat their various conditions, and are often called upon to manage their own care at home.

As for what he calls the inadequacy of the case management model, Whipple says his experience as a consultant with a wide range of hospitals indicates that "there are lots of case managers and most are not certified."

"It's 'teach as you go,'" he adds. "There may be 15 or 20 case managers at a big hospital and not all have the same expertise." In many cases, Whipple says, "there is no way to ensure consistency, for example, on what they approve as inpatient or observation status.

"The big thing is case managers in the emergency department," he notes, "but some [facilities] have them, and they don't really know how to interact. They are floating between patients, and the physicians don't know who they are and sometimes resent them."

The best way to provide disease management in the hospital is to have advanced practice nurses make rounds with physicians, Whipple contends. "They are able to provide more interventions than a case manager.

"These nurse practitioners who round are actually involved with medical care, and determine whether a patient is compliant or not," he says. "They work with case managers to develop a discharge plan that really looks at the patient's needs. The big reason [chronically ill] patients get readmitted is lack of compliance."

Early identification important

Crucial to the development of an effective disease management program is early identification of patients with chronic conditions, Whipple says. "At a minimum, we need to learn to identify these patients on readmission. It's as important as getting the correct address and phone number."

That could mean instituting a different admission protocol, he notes, such as having a code to designate patients as "frequent fliers." That information should be communicated as soon as possible to case management staff, Whipple adds, so an appropriate treatment and education plan can be put in place.

What occurs more often than not in today's health care environment, Whipple says, is that patients — including the chronically ill — go through the care process under whatever designation they came in, whether it is correct or not.

"Often what happens is the patient comes in, especially if he or she is a frequent flier, sits in front of the registration person, and [the registrar] says, 'Any changes since the last time?' The patient says no, and [the employee] just automatically fills that in."

Whipple's experience doing assessments at all kinds of facilities — from 700-bed inner-city hospitals to 12-bed rural hospitals — has shown him that "admitters sometimes put patients on the floor that don't meet local medical review policies," Whipple says.

Physicians in the emergency department don't necessarily know anything about medical necessity, he points out, and residents in training at large teaching hospitals often want to admit a patient simply because many tests have been ordered on the person.

Adding clinical expertise to every part of the revenue cycle is one way to ensure that only patients who belong in the hospital are admitted, and that those who do need to be admitted receive the proper care, Whipple says. Someone in patient access, he adds, such as a preadmission coordinator, "needs to able to step in and say, 'This person doesn't meet medical necessity.'"

(Editor's note: ***Bob Whipple*** *can be reached at Bob.Whipple@acs-hcs.com.)* ■

"But the onus is really on each organization to define what their concept of quality of care is."

For example, if clinical practice guidelines have been put in place for treatment of pneumonia patients and they are not being followed, the practitioner must document why he or she chose not to follow the guideline, says Giles.

"A trigger could be a trend of not following adopted clinical practice guidelines and not providing supporting documentation for the decision not to follow the guideline," she says.

Medical staff also will have to establish acceptable thresholds, such as performance of a particular number of procedures with less than a certain percentage complication rate, which might be 1%, 2%, or 3%, says Giles. "They must define what the acceptable rate will be."

At Denver-based Catholic Health Initiatives, each of the 73 hospitals in the system has some latitude in determining its own triggers for an intensive review of a member of the medical staff, says **John Anderson**, senior vice president and chief medical officer.

"This latitude is important so hospitals can select triggers and methodology based on the availability of technology, resources, services offered, and the ability of the organization," he says.

Several hospitals have determined that, based on a review of a practitioner's individual cases over a period of time, those triggers can include any number of factors, says Anderson. Any single egregious case can act as a trigger, but in a time frame determined by the medical staff and based on the volume of admissions by a practitioner, other criteria also can act as a trigger, says Anderson.

He gives the examples of two cases where care is rated as inappropriate, four cases where physician care is determined to be controversial or inappropriate, or four cases rated as having documentation issues, regardless of the care rating.

The shift toward ongoing evaluation of clinical practice rather than episodic reviews will "truly advance patient safety," says Anderson. "What's more, continuous evaluation to ensure evidence-based practice without taxing current resources necessitates a greater dependency on electronic documentation and reporting, coupled with better physician alignment for participation in quality initiatives."

[For more information, contact:

***Douglas L. Elden**, Chairman, National Peer Review Corp., 1033 Skokie Boulevard, Suite 640, Northbrook, IL 60062. Phone: (847) 480-8800. Fax: (707) 988-8800. E-mail: douglas.elden@nationalpeerreview.com. Web: www.nationalpeerreview.com.*

***Christina W. Giles**, CPMSM, MS, President, Medical Staff Solutions, 32 Wood Street, Nashua, NH 03064. Phone: (603) 886-0444. Fax: (810) 277-0578. E-mail: chriswg@medicalstaffsolutions.net.]* ■

Most adverse drug events unreported: Take these steps

Use data to identify safety issues

Adverse drug events (ADEs) occur in about 3.1% of all hospital stays, according to a report from the Agency for Healthcare Research and Quality (AHRQ). Here are key findings:

- Most ADEs (90%) were due to side effects from a medication that was properly administered.
- Only 8.6% of ADEs were due to drug poisoning: accidental overdose, wrong drugs given or taken, or drugs taken inadvertently.
- Older patients were more likely to experience adverse effects from properly administered drugs.
- Drugs most commonly associated with ADEs were corticosteroids, anticoagulants, anti-cancer and immunosuppressant agents, opiates, and analgesics and fever reducers.
- Average total hospital costs for patients who experienced drug side effects or other ADEs were $10,100 compared with an average cost of $7,600 for patients who didn't experience ADEs.

However, these results are underreported for medication errors leading to ADEs, because the report used coding data, according to **Allen J. Vaida**, PharmD, FASHP, executive vice president of the Huntingdon Valley, PA-based Institute for Safe Medication Practices (ISMP).

"Very few errors are going to be picked up with coding data," he says. In fact, many of the "adverse effects" coded may have actually been due to errors, which practitioners and coders wrongly attributed to "adverse effects of drugs properly administered," notes Vaida.

"We frequently see that adverse effects — better called adverse reactions — are attributed to the side effects of the drugs, rather than errors in prescribing, dispensing, or administration, which oftentimes caused the effect," he adds.

To ensure that ADEs caused by errors are tracked accurately, perform focused reviews on certain medications, recommends Vaida. For

example, track blood glucose levels and episodes of hypoglycemia or hyperglycemia in patients receiving insulin or certain oral medications to treat diabetes. "Direct observation of medication administration is another proven method that has been used to quantify errors," he says.

The drug categories most commonly associated with ADEs are no surprise, says Vaida, and have been identified for years. He points to the ISMP's list of "high alert drugs" that includes opiates, anticoagulants, and other medications identified in this report. "Quality professionals must follow the safety literature, and implement known safety recommendations for this class of drugs," says Vaida.

Use data to support change

Make sure that recommendations for error prevention are implemented at your organization and track ADEs, Vaida advises. He recommends looking at elevated international normalized ratios and partial thromboplastin times, which could signal an ADE from some anticoagulants, and monitoring the use of reversal agents, such as naloxone or flumazenil, which are signals of excessive sedation from dosing or administration errors from opiates and benzodiazepines.

Use internal and external error reporting data to justify technology investments, such as electronic prescribing with decision support or bedside bar coding, says Vaida. You also can use these data to gain support for implementing low-cost measures such as independent double checks, standardized order sets, checklists, and other safety measures.

Use the external data, such as errors in the literature, to conduct a short, focused look at how your organization is performing in these areas. "If you have internal data, you can compare; if you don't have good internal data, you can gain support from committees to conduct the internal review by using the external data to justify it," says Vaida.

If the same safety issues are identified after the internal review is done, you then can use both the external and internal data to support change, says Vaida.

Your internal data should include information from your current medication error reporting system or incident reporting system, information from risk management on serious events that are in litigation or are being reviewed, and use of focused reviews.

This information doesn't necessarily give an accurate rate of errors or incidents, but it can help you see if the same occurrences from the external information are occurring in your hospital. "If you have a poor reporting system, perform the focused internal review for each of the areas identified in the safety publications," says Vaida.

Implement these practices

ADEs cannot be reliably predicted and not every ADE is preventable, says **Marybeth Farquhar**, director of AHRQ's quality indicators activities. "ADEs occur throughout the many steps of the medication administration process in hospitals," she says.

However, there are several practices that may minimize ADEs and their adverse effects on patients. For example, a thorough medical history should be taken from the patient and/or caregiver. This should include the names of all medications the patient is currently taking, including vitamins and herbal supplements, doses, and frequency.

"Some hospitals go so far as to ask the patient to bring all their medication bottles with them to the hospital, so that they can be recorded during admission procedures," says Farquhar.

Allergies to medications or foods and prior reactions to medications should be clearly noted in the patient record and visible to clinicians via patient identification bands, says Farquhar. Prescribing clinicians should consider the patient's age, weight, underlying condition, and renal function when ordering medications.

Good communication among the health care team is essential throughout the medication administration process, says Farquhar. "Patient monitoring is important to detecting ADEs. However, computerized systems can help hospital staff identify ADEs and minimize their effects," she says.

For example, a computer system can alert hospital staff if any signals of possible ADEs occur, such as certain lab test results, high or low levels of certain medications, and pharmacy orders for medications generally used to treat allergic reactions.

Also, by integrating the computer system to link pharmacy, lab, and other hospital information about the patient, pharmacists can identify and notify physicians about drug allergies, drug-drug interactions, drug-food and drug-condition contraindications, says Farquhar. She also recommends the following to prevent ADEs:

- using the Food and Drug Administration's MedWatch program to report serious drug reactions;

• improving hospital incident reporting systems;
• creating a culture of safety that encourages reporting ADEs;
• relying more on pharmacists to advise prescribing clinicians;
• promoting clinician education on medications and possible side effects;
• improving nurse medication administration and monitoring systems.

There should be more reporting of ADEs, says **Jeffery Laux**, clinical pharmacist at Covenant HealthCare in Saginaw, MI. "Most probably go unreported and therefore cannot be tracked."

Most events are picked up in retrospective reports, often by coders as they examine medical records, says Laux. "It makes it very hard to find complete information when the patient has already left the hospital," he says. "It is also helpful to interview personnel who witnessed the event."

If the events are reported, these must be followed up with some detail — this is the only way to determine why the event happened. "If you cannot figure out why the events happen, it is impossible to try to correct them," Laux says.

At Winston-Salem, NC-based Novant Health, a successful program to track ADEs was implemented, which included all eight hospitals in the system, says **Mike Gum**, director of pharmacy for Presbyterian Healthcare in Charlotte, NC.

For one week of every month, a clinical pharmacist reviewed all administrations of the following: vitamin K, naloxone, Kayexalate, Romazicon, and laboratory values of an international normalized ratio (INR) greater than 3.5 or elevated digoxin levels.

"After phase one, it was decided that elevated INRs was the biggest issue" says Gum. "We then concentrated on that. We were able to decrease the incidence of overall elevated INRs by 47%." The following steps were taken:
• A warfarin dosing program was developed.
• Routine laboratory monitoring of patients receiving warfarin was standardized to be done on admission and at least every three days.
• Clinical pharmacists were given the ability to order an INR if deemed appropriate.
• Physicians were routinely educated. "This was accomplished by letters to office-based physicians, because many of the elevated INRs were on admission, as well as routine updates of hospitalists," says Gum.

(The full report, "Adverse Drug Events in U.S. Hospitals, 2004," can be accessed at www.hcup-us.ahrq.gov/reports/statbriefs/sb29.jsp.)

[For more information, contact:
***Mike Gum**, Director of Pharmacy, Presbyterian Healthcare, 200 Hawthorne Lane, Charlotte, NC 28204. Phone: (704) 384-4000. E-mail: mogum@novanthealth.org.*
***Jeffery Laux**, Clinical Pharmacist, Covenant HealthCare, 1447 N. Harrison Street, Saginaw, MI 48602. Phone: (989) 583-4478. E-mail: jlaux@chs-mi.com.]* ■

THE QUALITY - CO$T CONNECTION

The real deal on holding successful case reviews

Keep in mind the purpose and critical questions

By Patrice Spath, RHIT
Brown-Spath & Associates
Forest Grove, OR

Unfortunately, the term "peer review" has negative connotations — it is generally associated with disciplining practitioners. The Joint Commission's medical staff standards stress the importance of viewing peer review as educational but this can be difficult to do when review outcomes are used only for credentialing and privileging purposes. To be truly accepted as an educational process, the primary purpose of peer review must be quality and patient safety improvement with individual competence assessments merely a byproduct.

It is common to find peer review policies that begin by stating the primary purpose is quality improvement. Except for that one statement, however, the policy focuses on the fact finding and disciplinary elements. How case reviews are conducted affects how practitioners view the peer review process. If, for example, reviewers are only asked to judge the appropriateness of other physicians' decisions, it is no wonder the review process is felt to be punitive. The disciplinary nature of review is further reinforced if physicians are only made aware of case review results when their decisions are being questioned.

The goal of peer review of individual cases is quality improvement, and corrective actions are important to this goal. In only rare instances will a practitioner need to be disciplined or sanctioned. In most situations, the case evaluation results provide a learning opportunity for those involved as well as those who care for similar types of patients. To further maximize the improvement value, the review process should extend beyond one practitioner's performance to include an assessment of the operational environment in which all practitioners function.

In this last installment of the three-part series on physician peer review, the case review process is described. The elements required by Joint Commission standards are covered, as well as techniques for transforming peer review into a more positive learning experience.

Educate reviewers

Practitioners serving on peer review committees should receive training in how to evaluate cases and how to complete whatever documentation is required by the medical staff. The aim of the training is to provide reviewers with an understanding of the techniques required for peer review assessment and the underpinning philosophy. Without such training there is no way to ensure consistency of case reviews throughout all medical staff departments.

Peer review evaluations should be based on appropriateness, medical necessity, and efficiency of services to assure quality medical care. But what standard of care should reviewers apply? Is the assessment to be based on the reviewer's own medical judgment and expertise? Are reviewers expected to consider community standards or are the generally recognized national levels of quality to be considered? These questions need to be addressed during reviewer training. To provide objective and consistent medical opinions, reviewers in all medical staff departments should have a similar basis for making case review decisions.

Often reviewers are expected to answer several questions about each case, such as:

- Does the care represent a deviation from accepted standards?
- Was practitioner judgment/decision making adequate?
- Could this incident have been prevented?

These questions may be easier to answer in retrospect. During reviewer training discuss the influence of hindsight bias on evaluation decisions —

CNE *questions*

13. Which is recommended to comply with new "present on admission" requirements?
A. Avoid use of a standardized form.
B. Have clinical documentation specialists do a concurrent review.
C. Do not require physicians to sign letters stating they received information about the new requirements.
D. Collect data retrospectively, not concurrently.

14. Which should be addressed regarding preventable conditions?
A. Determining if appropriate action was taken.
B. Reviewing data that have been collected.
C. Performing a failure mode and effects analysis to learn how to prevent similar occurrences.
D. All of the above.

15. Which is required regarding triggers for a focused review of a medical staff member?
A. Only outlier data should be considered.
B. Triggers must adhere to The Joint Commission's definition.
C. The organization must have criteria for conducting an evaluation once performance issues are identified.
D. Organizations must review bad outcomes as opposed to practice patterns.

16. Which is recommended to ensure that adverse drug events are tracked accurately?
A. Perform focused reviews on certain medications.
B. Do not use direct observation of medication administration.
C. Never use external error reporting data to justify technology investments.
D. Discourage clinical pharmacists from ordering an international normalized ratio.

Answer Key: 13. B; 14. D; 15. C; 16. A.

CNE 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. ■

knowing the patient's outcome can influence how past events are assessed. Practitioners involved in the case did not know the patient's outcome at the time treatment decisions were being made. Thus, what may seem obvious to reviewers may not have been apparent to the practitioners involved. Reviewers should be cautioned to guard against hindsight bias as much as possible.

Reviewers also should be introduced to the logics of the medical staff's peer review process. For example:

- what cases are selected for review;
- the first-level screening process by the quality department (if done);
- questions on the review forms;
- how quickly reviews are to be completed;
- what happens to a case if the reviewer discovers a possible quality-of-care problem;
- how additional information, if needed for the review, is obtained from the involved practitioners;
- what happens if a quality-of-care problem is confirmed;
- the types of cases selected for morbidity and mortality conferences;
- how practitioners are informed of peer review results;
- peer review confidentiality policies.

New reviewers should receive this training before they are assigned cases to evaluate. By staggering the membership on peer review committees, the medical staff will always have a core group of trained reviewers that can complete case evaluations while new recruits are being trained.

Dual purpose reviews

To reinforce the quality improvement goals of peer review, evaluations should go beyond determining if the care meets acceptable standards and is appropriate for the patient's condition. Although this judgment is needed for eventual use in the credentialing/privileging process, it should not be the only conclusion solicited from reviewers; it is just as important to identify the structures and processes responsible for adverse events or suboptimal outcomes. When peer review is focused solely on individual performance, the organization misses opportunities to make changes in problematic systems over which individual practitioners have little control.

Examples of systems problems are:

- information systems that delay or lose key elements of patient care, such as physician orders, patient records, lab results, etc.
- defective procedures that impede communi-

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

- ■ Avoid quality pitfalls with electronic health records
- ■ Novel ways to obtain data for all practitioners
- ■ The best strategies to manage disruptive behavior
- ■ Obtain skills to increase clout at your organization
- ■ Solutions for congestive heart failure core measures

cation among caregivers or delay delivery of services to patients.

• scheduling systems that inhibit timely access to services and personnel.

Along with evaluating individual practitioners' performance, reviewers should be encouraged to also identify problems in the support systems that may have contributed to suboptimal patient outcomes. For example, consider the case described below:

An orthopedic surgeon discharges his patient without noticing the patient's abnormally low platelet count. The patient is readmitted in just one day for treatment of thrombocytopenia secondary to an adverse medication reaction. Clearly the surgeon was responsible for reviewing lab results prior to discharging the patient, and the physician reviewing the case classified it as not meeting the standard of care. However, the reviewer also identified some system problems related to timely communication of abnormal lab results to physicians. The peer review committee referred these issues to the hospital's quality council for resolution.

Practitioners still have the responsibility to comply with acceptable standards. However, by also evaluating practitioner errors in the context in which they occur, it's possible to determine whether changes in the system of care can reduce the risk of future errors. Encourage reviewers to ask, "What must be done to make it more difficult for practitioners to make a similar mistake in the future?" This questioning process will lead to system improvements that can benefit all caregivers.

At the conclusion of a case review, the involved practitioners should receive feedback. In most situations, this simply will be a confirmation of the effectiveness of the practitioner's professional, technical, and interpersonal skills. If opportunities for improvement are identified, the involved practitioner should receive a written report detailing the issues and peer recommendations. The Massachusetts Medical Society's "Model Principles for Incident-Based Peer Review for Health Care Facilities" recommend the following information be provided to the involved practitioner[1]:

• The identified deviation (act or omission) in the process of care from the "standard of care."

• The "standard of care" from which the deviation occurred.

• The source for the above "standard of care."

• What specific steps of care should have been taken or not taken to meet the "standard of care."

• What specific remediation, if any, is recommended for the physician.

The feedback process closes the quality improvement loop and further reinforces the primary focus of peer review. The goal of case review should be to affirm the quality of professional practices and discover ways of improving both practitioner and system performance.

Reference

1. Massachusetts Medical Society. Model Principles for Incident-Based Peer Review for Health Care Facilities. June 2005. Web site: www.massmed.org. ■