Building a Peer Review System

On Just Culture Foundations

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Confluence Health

Formed in 2013 as an affiliation between Wenatchee Valley Medical Center and Central Washington Hospital

Mission is to improve our patients' health by providing safe, high-quality care in a compassionate and cost-effect manner.

Clinics in 12 communities over 12,000 square mile service area in North Central Washington State

270 physicians and over 100 advanced practice clinicians

About 200 inpatient beds in two hospitals in Wenatchee

“The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes.”

Lucian Leape, MD
Harvard School of Public Health

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Traditional View of Failure

- People are the problem
- Human error is the cause
- If people try hard enough, they will not make any errors
- If we blame and punish people when they make errors, they will make fewer of them
- Getting rid of the person gets rid of the problem

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CLOSE TO HOME JOHN McPHERSON

McPherson

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4-26

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“Good news, Mr. Duffman! You’re not crazy after all. You *have* been hearing voices coming from your abdomen. We discovered that Dr. Gremley’s pager accidentally got sutured inside you during surgery!”

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CH Peer Review: Before

- Oversight by Physician Practice Excellence Committee (PPEC)
- Incidents triaged by quality department management and medical staff leadership
- Referral to PPEC depending on severity and degree of provider involvement
- Other incidents triaged to dept. chairs or other parties to review
- Occasional Root Cause Analysis

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PHYSICIAN CASE REVIEW

CONFIDENTIAL – NOT PART OF THE MEDICAL RECORD

COMPLETED CASE REVIEWS ARE FILED IN THE MEDICAL STAFF OFFICE

Event # ______
Closed: ______

Submitted for Review Date:
Patient Name: Account Number: MR#
Event Date: Involved Physician:
Physician Reviewer: Initial Memo Date:
Referral Source: *Check the corresponding box*

☐	Indicators Screening	☐	Risk Management	☐	Medical Records	☐	Nursing	☐	Pharmacy	☐	Patient Relations	☐	Medical Staff	☐	Other

Review Criteria/Referral Issue:

Case Summary:

Outcome:

Key Issues:

Please complete items 1 through 5 in order. Issues identified pertain to the above-mentioned physician only. Comments regarding processes, staff, or other physicians can be added on page 2.

PPEC Reviewer/Date: ______ **Physician Reviewer/Date:** ______

1.	Physician Care:	2.	Physician Documentation
☐	Excellent Physician Care	☐	No Issue(s)
☐	Acceptable Physician Care	☐	Minor issue(s)
☐	Issue(s) – Check below:	☐	Documentation does not substantiate clinical course and treatment
☐	Citizenship/Professionalism	☐	Documentation not timely to communicate with other caregivers
☐	Conduct/Behavior	☐	Documentation unreadable
☐	Clinical Judgment/Decision Making	4.	Non-Physician Care/Systems Issues
☐	Diagnosis		
☐	Technique/Skills		
☐	Knowledge		
☐	Communication/Responsiveness		
☐	Policy Compliance		

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PHYSICIAN CASE REVIEW

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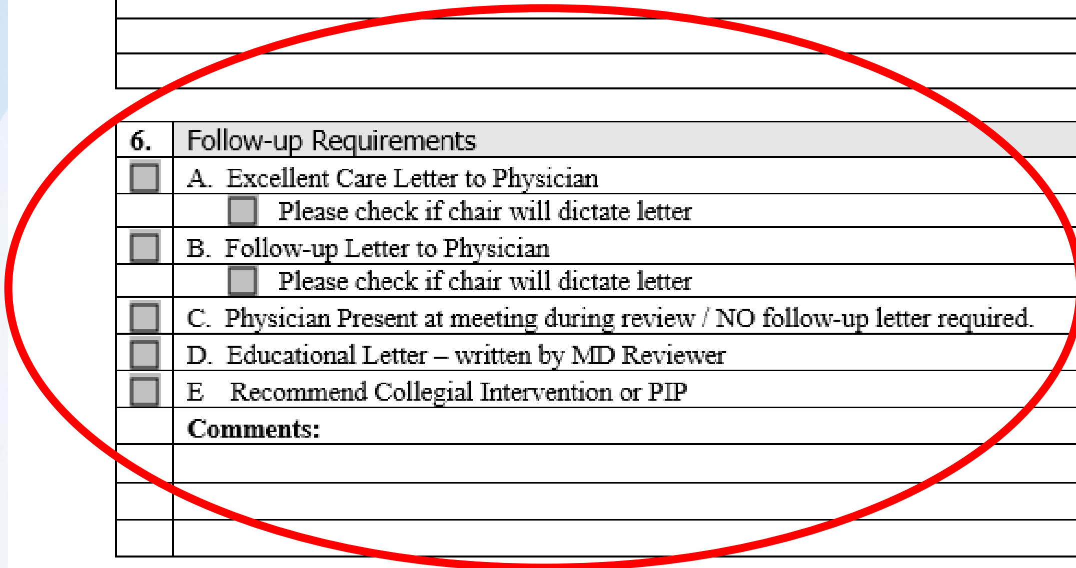
5.	Overall Comments (document rationale):

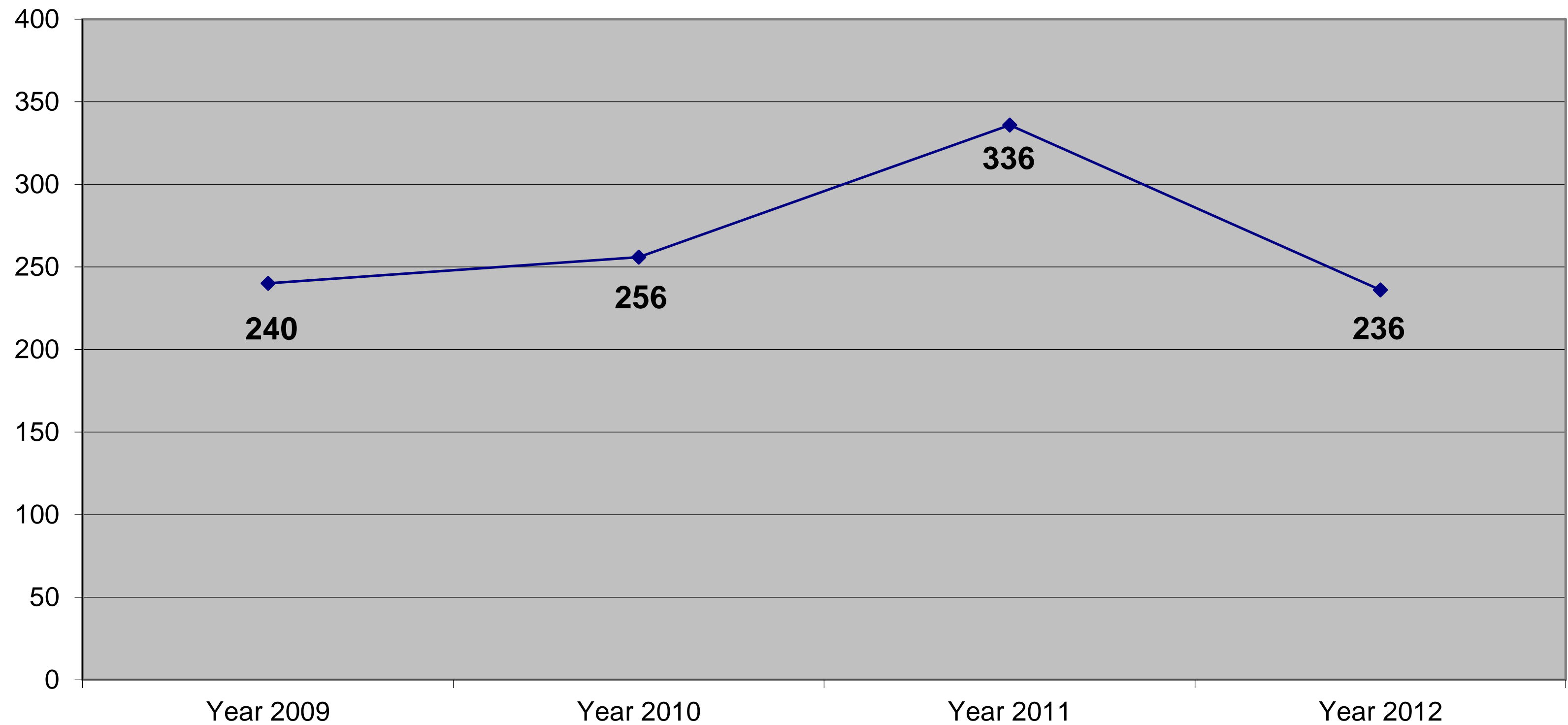


6.	Follow-up Requirements	Complete Date
☐	A. Excellent Care Letter to Physician	
	☐ Please check if chair will dictate letter	
☐	B. Follow-up Letter to Physician	
	☐ Please check if chair will dictate letter	
☐	C. Physician Present at meeting during review / NO follow-up letter required.	
☐	D. Educational Letter – written by MD Reviewer	
☐	E Recommend Collegial Intervention or PIP	
	Comments:	

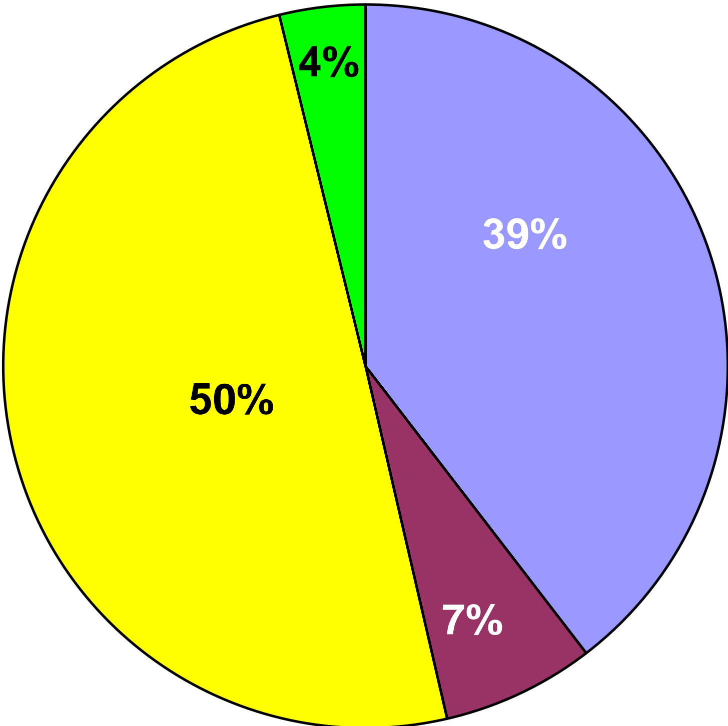
Completed by Medical Staff Officer/PPEC

☐	**Collegial Intervention**	
	☐ Letter of Counsel	
	☐ Discussion and Follow-up Letter	
☐	**Performance Improvement Plan**	
	☐ Focused Retrospective Review	
	☐ Additional Education/CME	
	☐ Second Opinions or Consultations Required	
	☐ Concurrent Monitoring Required	
	☐ Participation in Formal Evaluation/Assessment Program	
	☐ Agreement to Refrain from Exercising Privileges While Obtaining Additional Training	
	☐ Educational Leave of Absence	
☐	Referral to Credentials Committee	
☐	External Review	

Total Number Peer Reviews



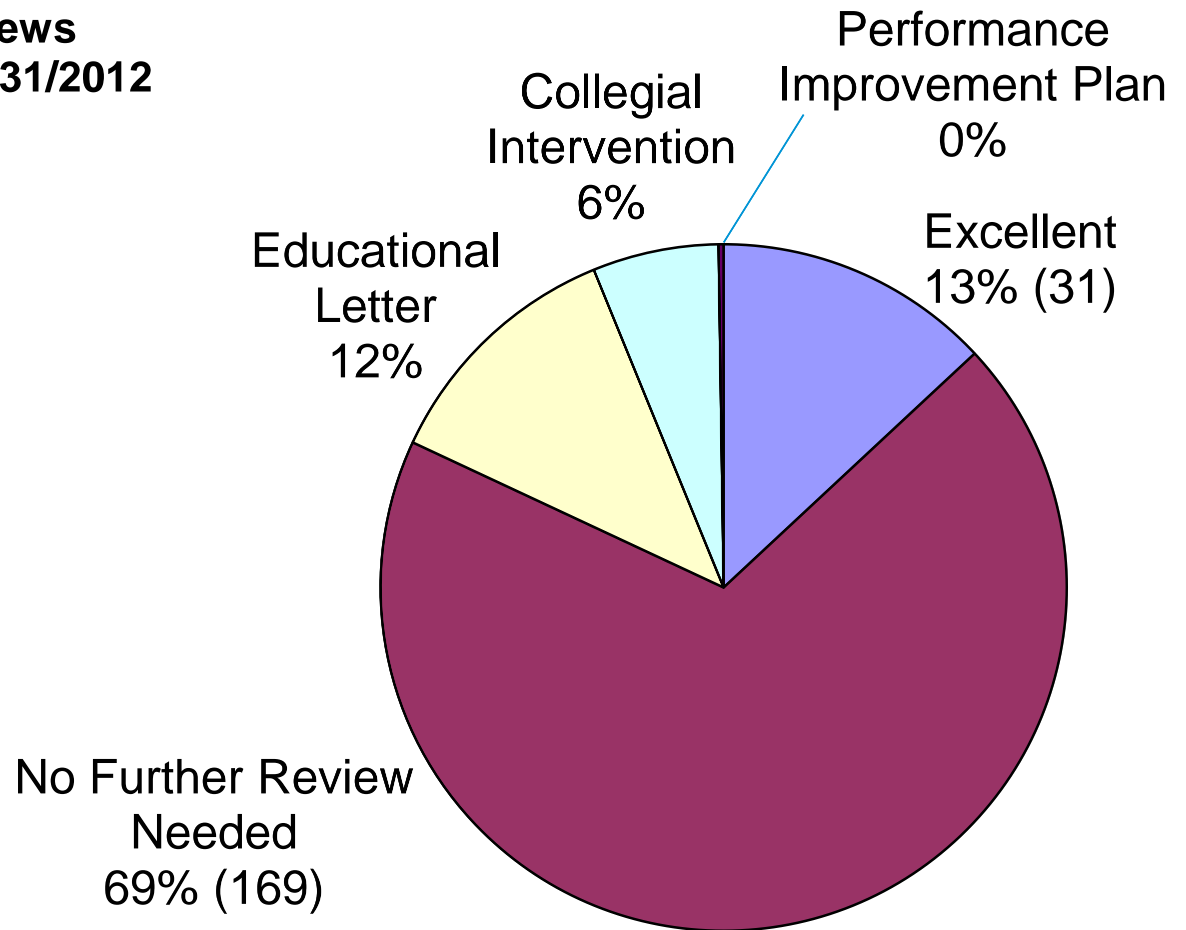
How Review was Performed



1 external peer review

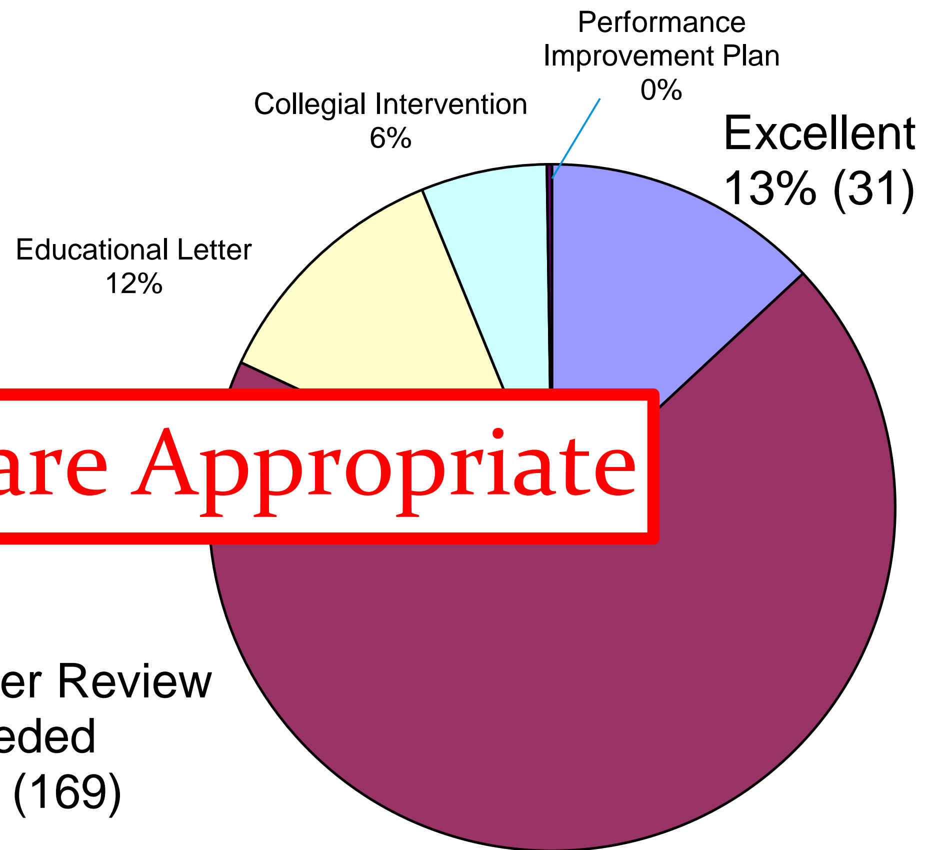
Outcome of Peer Review

236 Reviews
1/1/2012- 12/31/2012



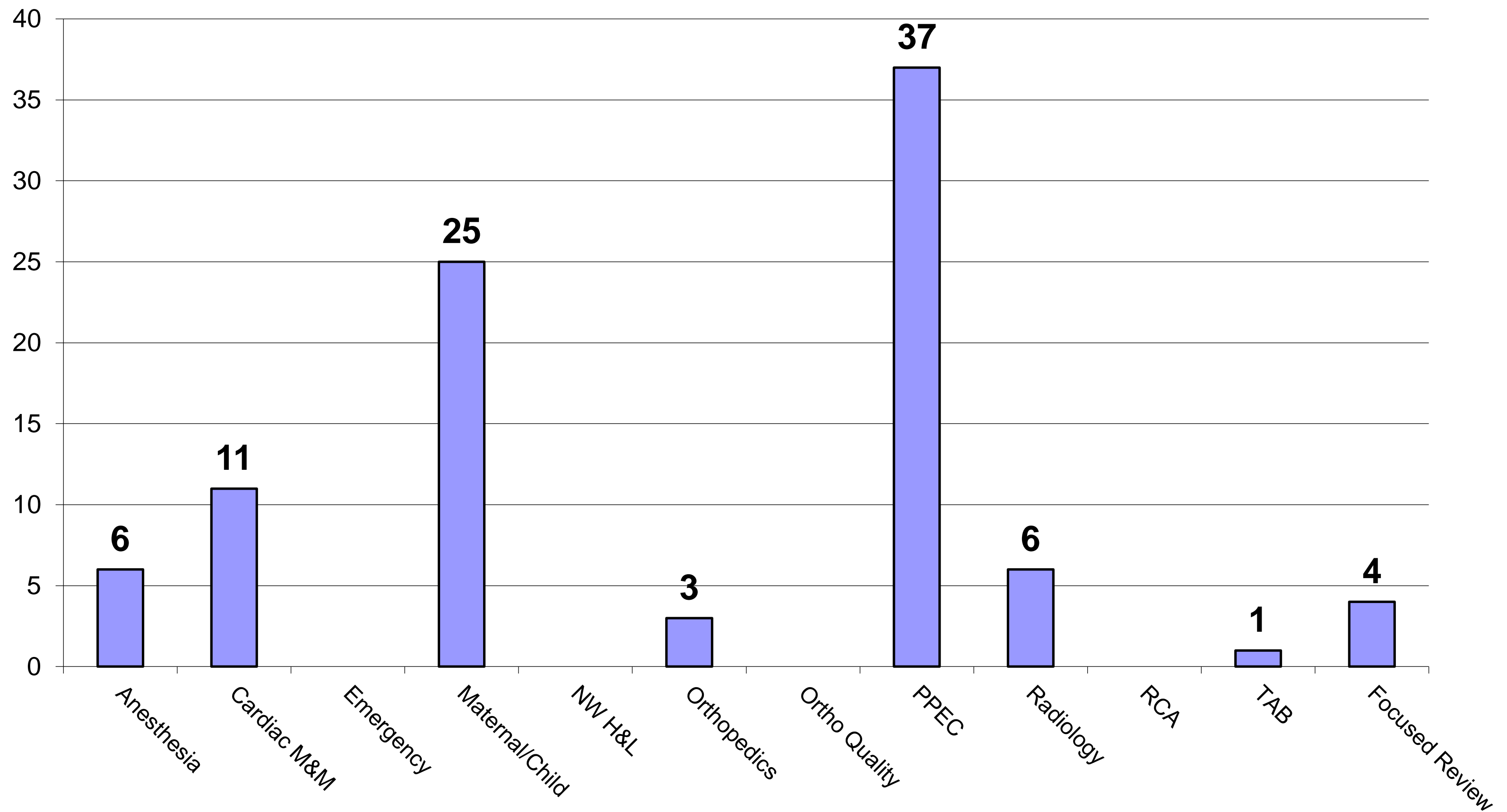
Outcome of Peer Review

236 Reviews
1/1/2012- 12/31/2012



200 (82%) =Care Appropriate

Group Case Review



Just Culture View of Failure

- Error is an organizational problem
- "Human error is not an explanation for failure but rather demands an explanation"
  - Sidney Dekker

- Human fallibility is recognized
- Accountabilities are different

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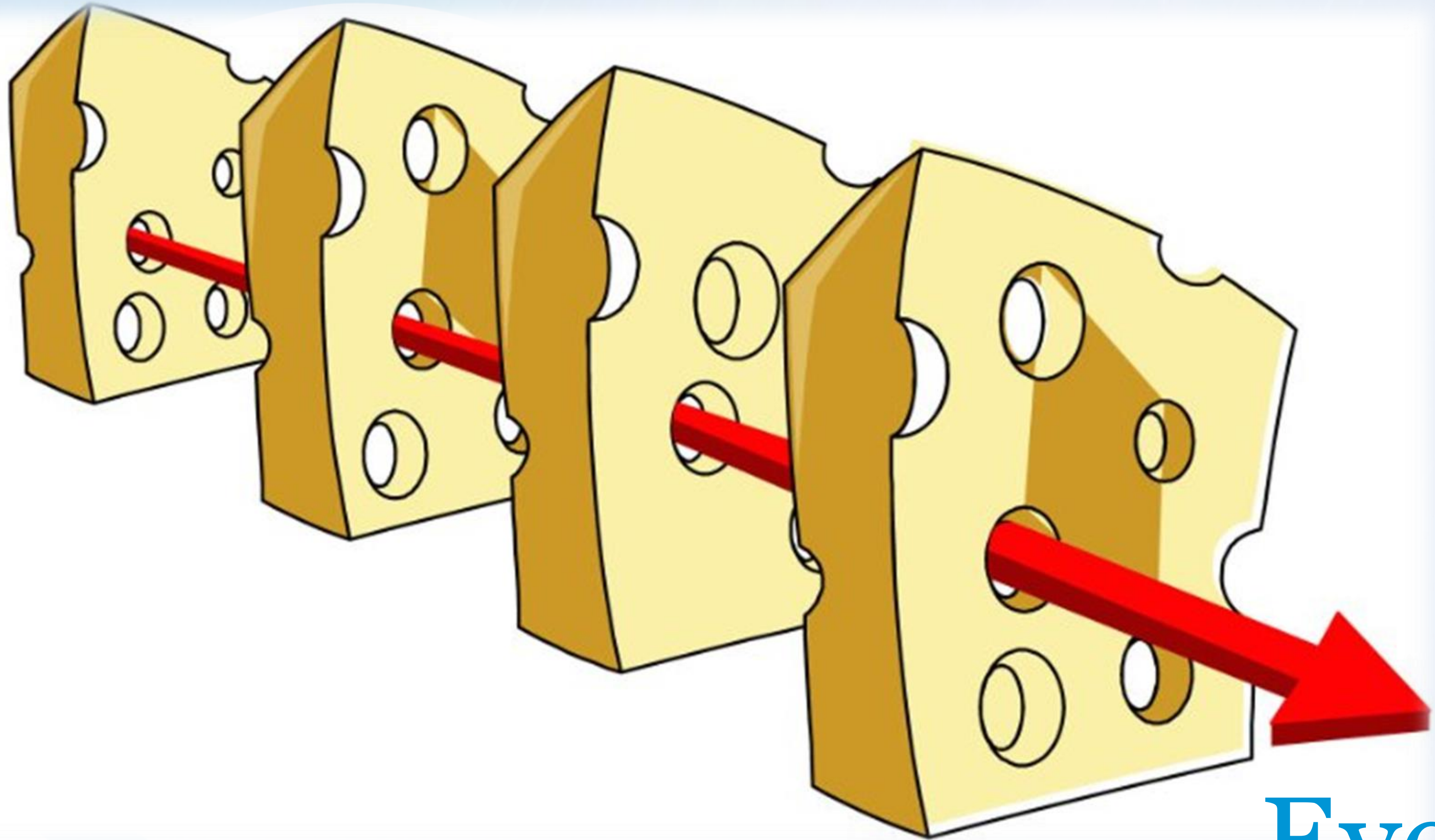
The problem lies not with individuals. . .

. . .but with the systems surrounding them

Mistake



Event

Emphasis is on learning from mistakes

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“JUST CULTURE” INCIDENT DECISION TREE

DELIBERATE HARM TEST

Were actions intended?

YES → Criminal act?

NO →

INCAPACITY TEST

Health
Substance abuse

YES → Appropriate intervention

NO →

COMPLIANCE TEST

Was there deviation from protocols or procedures

YES →

Were protocols:
- Safe
- Available
- Intelligible
- workable

YES → Address behavior

NO → Investigate system failure

NO (Compliance test) →

SUBSTITUTION TEST

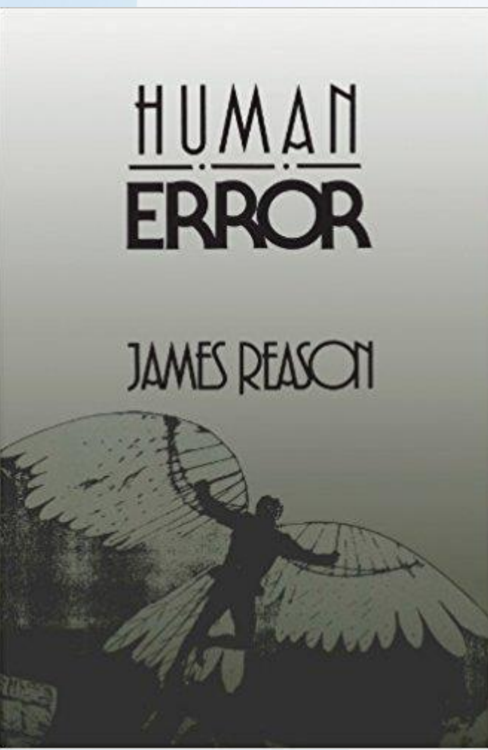
Would a similarly qualified individual behave in the same way in the same circumstance

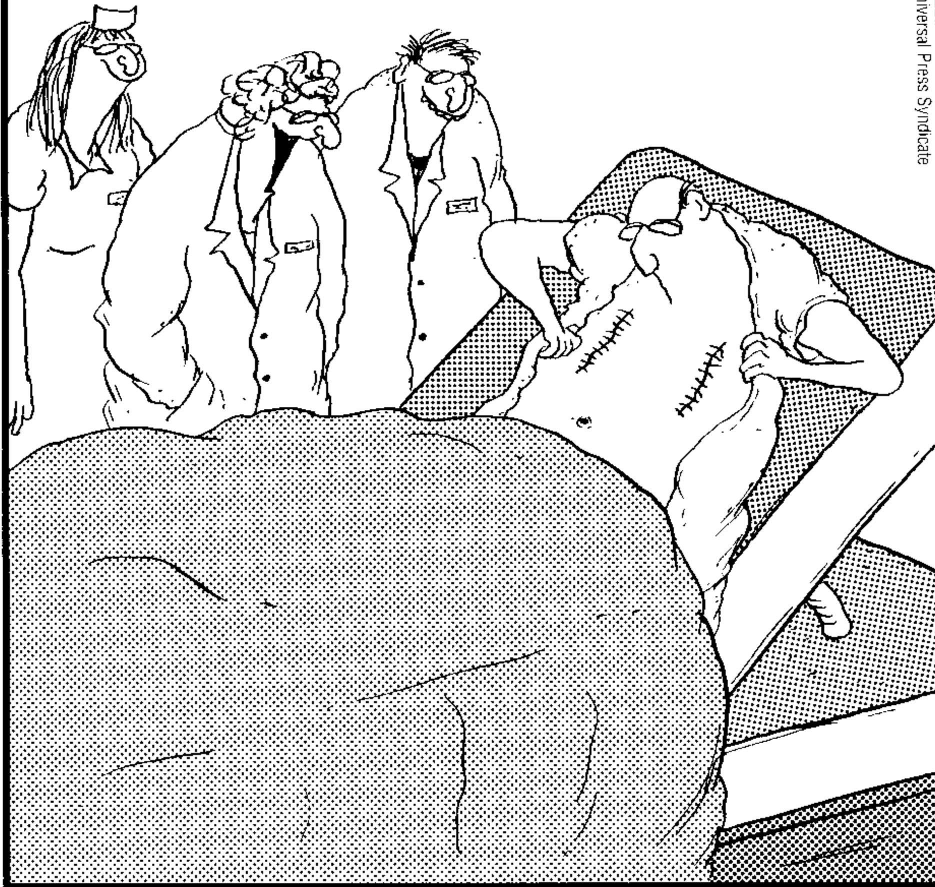
YES → **Investigate system failure**

NO →

Explore deficiencies in:
- Training
- Experience
- Supervision

Consider Circumstances





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CH Peer Review: After

- Integrated with incident management system
- Formal event triage system
  - Incident Management Dept.
  - Care Incident Review Committee (CIRC)
    - Physicians, nursing, pharmacy, admin, quality
- Practice Performance Committee (PPC)
  - System oversight, accountability
  - Performance improvement plans
  - Rarely directly reviews events

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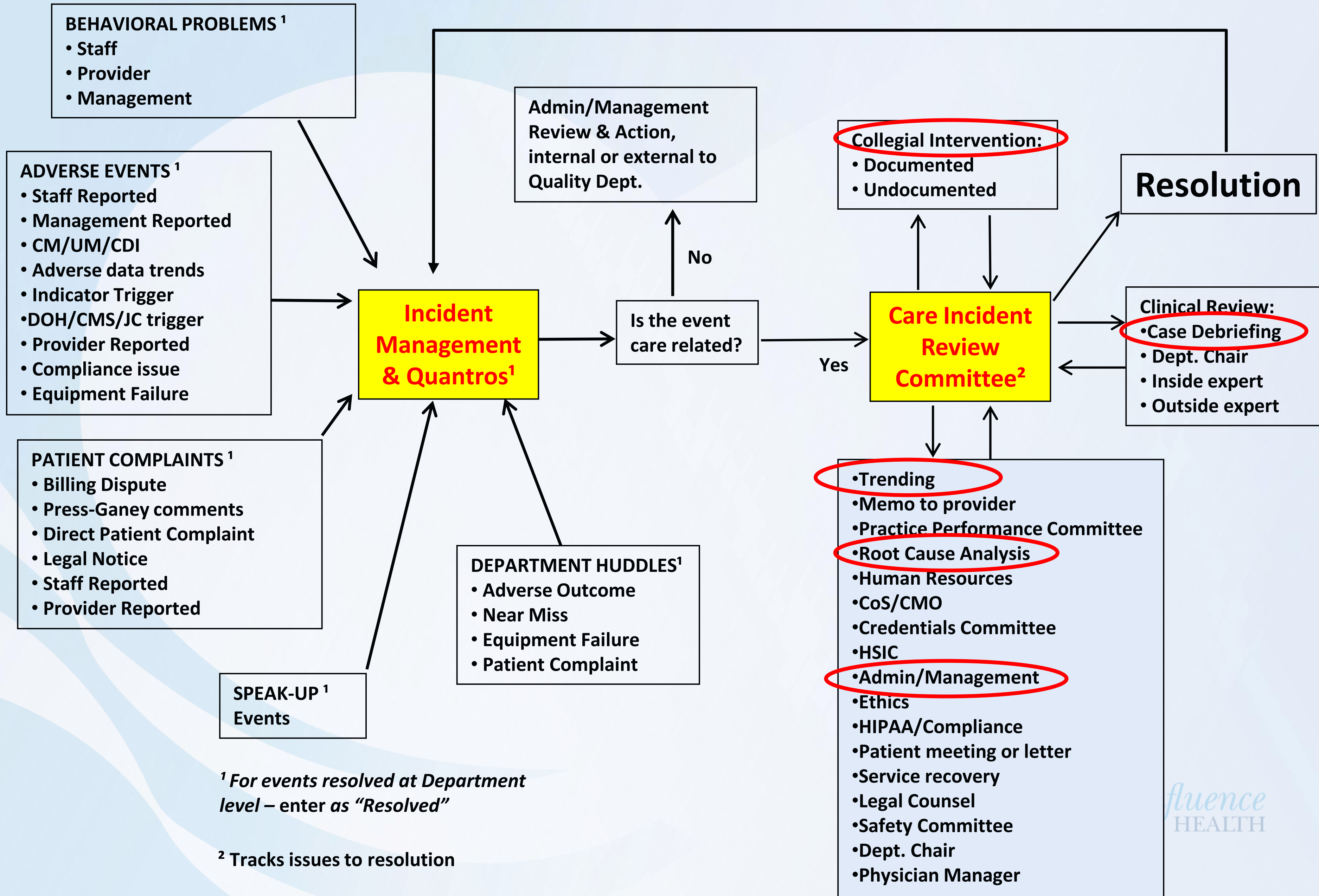
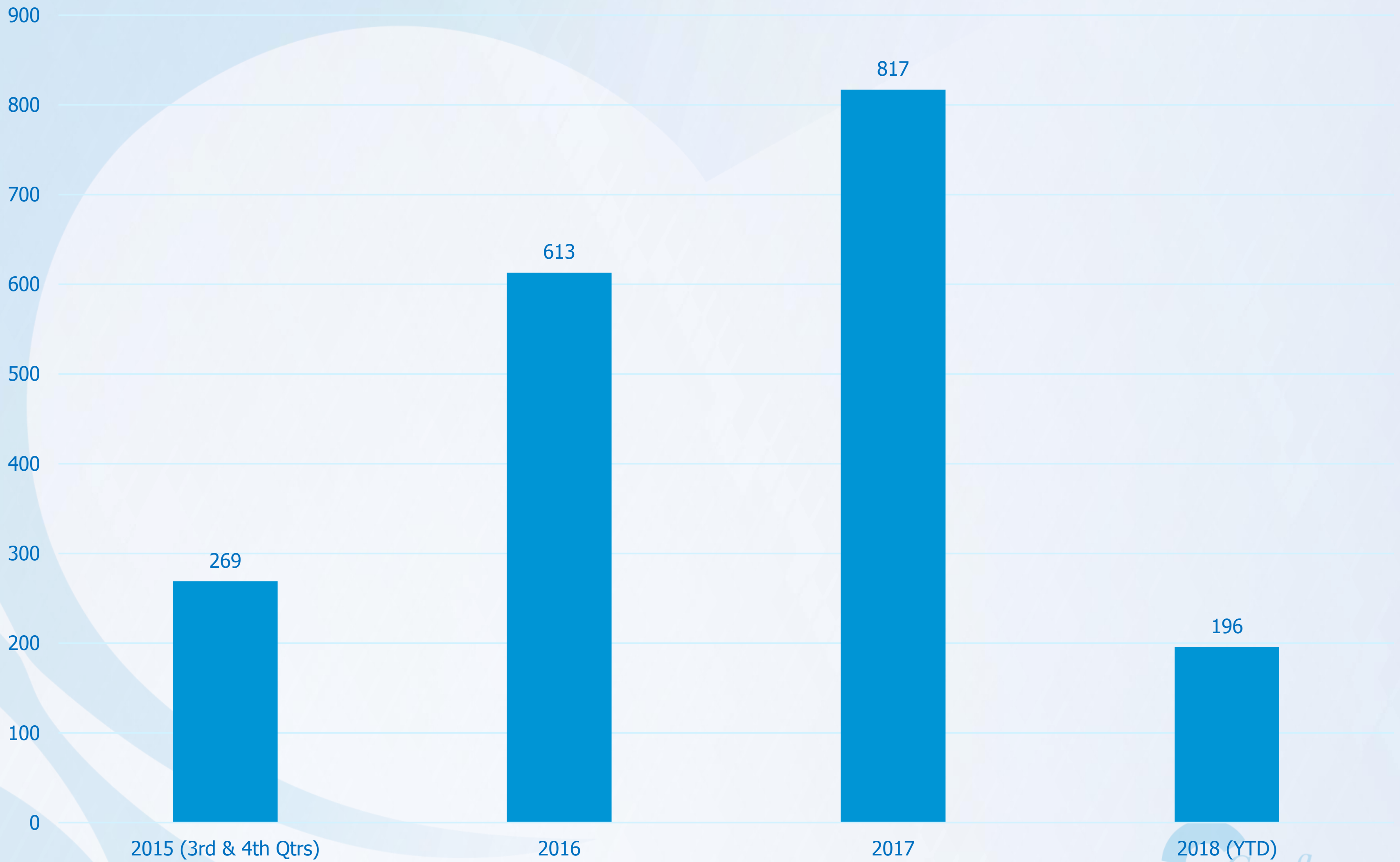
CONFLUENCE HEALTH INCIDENT MANAGEMENT SYSTEM



[1] *For events resolved at Department level – enter as "Resolved"*

[2] Tracks issues to resolution


Annual Total of CIRC Cases
900
800
700
600
500
400
300
200
100
0
269
613
817
196
2015 (3rd & 4th Qtrs)
2016
2017
2018 (YTD)
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Types of Issues

- NOW events
- Wrong or missed/delayed diagnosis
- Procedural complications/poor outcomes
- Patient complaints
- Medication/treatment errors
- Communication failures
  - With patients
  - Within care teams
- Epic
- HAPI, Falls

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CIRC Disposition Breakdown

Changes to CIRC Process

- 2016
  - Adopted RCA2 process
- 2017
  - “Coffee Chat” changed to collegial intervention
    - Documented
    - Not documented
  - Stopped sending routine memos about patient complaints
  - Starting CIRC with a positive story
  - Started appreciation memos

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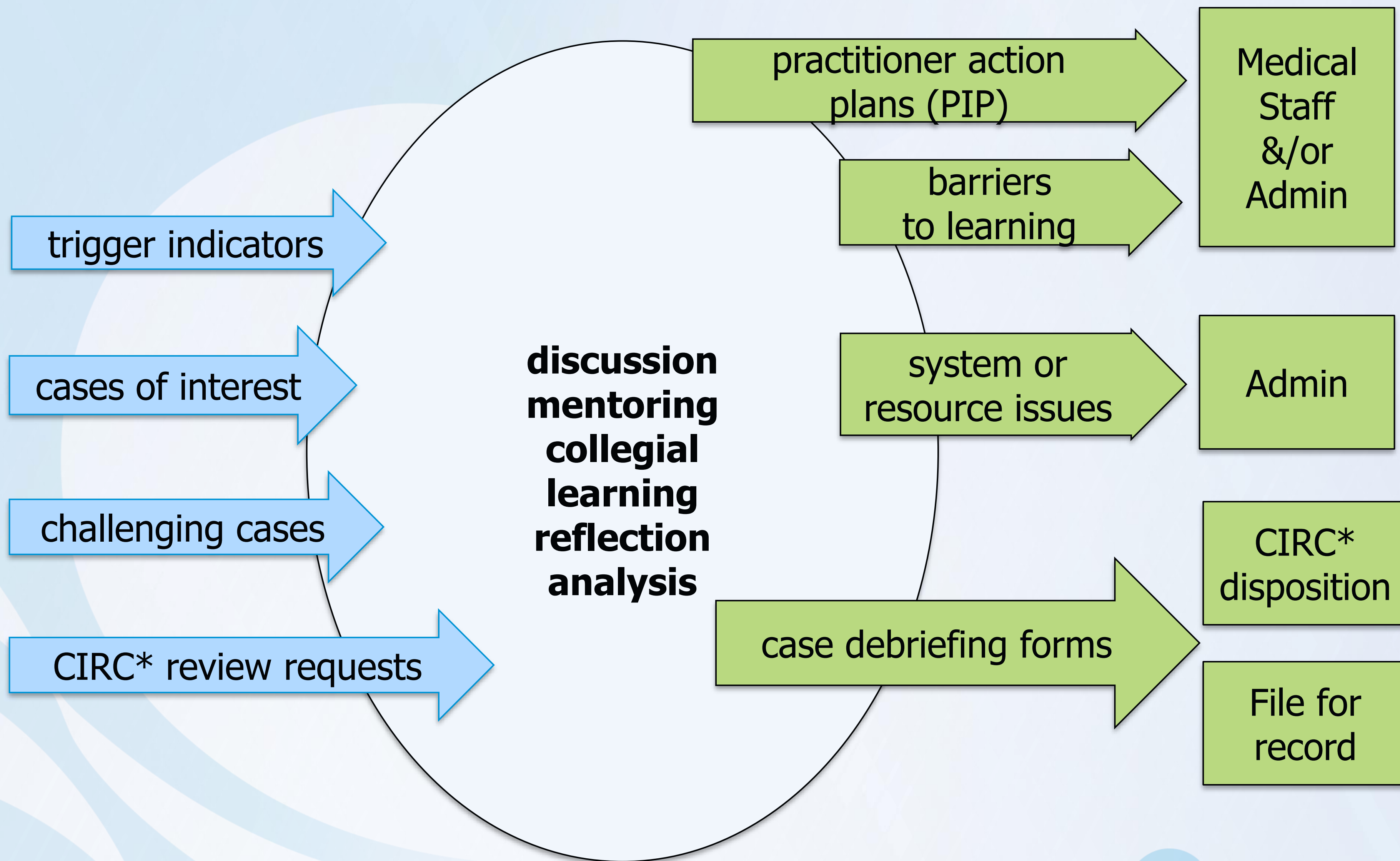
Case Debriefings

CASE DEBRIEFING		
Patient Name and ID#:		
Reason for review:		
Possible learning opportunities identified by CIRC preliminary review:		
Date of care:		
Providers of care:		
Date of debriefing:		
Type/Name	Department	
Quality Dept Facilitator:	Randal Moseley, MD	
Attendees:		
1. What was done well:		
2. What could have been done better:		
3. What was learned:		
4. What additional action is needed and who is responsible for follow up:		

This information is protected and confidential. Data, records, documents, and knowledge, including but not limited to minutes and case review materials, collected for or by individuals or committees assigned peer review functions are confidential, not public records, shall be used by the appropriate medical staff and administration only in the exercise of proper functions of the peer review process, and are not available for court subpoena in accordance with RCW Chapter 4.24, specifically including RCW 4.24.240 and RCW 4.24.250 and RCW Chapter 70.41, specifically including RCW 70.41.200.

Departmental Case Debriefing "Cocoon"



*Care Incident Review Committee

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Total Case Debriefings from CIRC
By Quarter 2015-Present
60
50
40
30
20
10
0
24
38
46
27
27
30
18
17
39
34
54
2015 3rd Qtr
2015 4th Qtr
2016 1st Qtr
2016 2nd Qtr
2016 3rd Qtr
2016 4th Qtr
2017 1st Qtr
2017 2nd Qtr
2017 3rd Qtr
2017 4th Qtr
2018 1st Qtr
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Case Debriefing Examples

- Reviewing the medicine:
  - Context and the value of rapid flu testing
  - Embolic prophylaxis in atrial fibrillation
  - Statins and drug interactions
  - Evaluation of vaginal discharge
  - Evaluation for infection in prosthetic joints
  - Risks/benefits of spinal traction for back pain
  - "GI cocktail" in abdominal pain evaluation
  - Importance of ETOH history in elective surgery
  - Surgical technique and complication risks

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Case Debriefing Examples (cont.)

- Cases emblematic of systems problems:
  - POLST storage, retrieval, validation
  - Endoscopic provocation of PTSD relapse
  - Ownership of abnormal test results
  - Delayed recognition of sepsis
  - Poor planning for post-op care
  - Post-operative opiate addiction

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Old vs. New

Traditional System

- Mostly hospital issues
- 236 cases screened
  - 82% care appropriate
- 52 cases with full dept. review
- Occasional RCA
- Individual learning

Just Culture System

- Mix of hospital and office issues
- 817 cases screened
  - Almost zero with no action
- 195 cases with full dept. review
  - CIRC 108
  - Dept. generated 87
- 45 RCAs
- Group learning

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Process Accountability

- Quarterly CIRC report at Medical Executive Committee and Credentials Committee
- Quality Oversight Committee
- CH Board Internal Affairs Committee
- Monthly department Case Debriefing presentations at PPC
- Department Chair/Physician Manager
- Data tracking, shaming

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Process Challenges

- Reporting
  - What to report
  - Timeliness of reporting
- Case Debriefings adoption
  - Still viewed as punitive by some
  - Radiology, pathology required adaptations
  - Variability in department buy-in
    - Outpatient departments poorly engaged
  - Long turnaround times
  - Self-generated Case Debriefings lagging
  - Spreading lessons learned beyond departments

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