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for AMBULATORY HEALTH CARE, INC.

Linking Peer Review and Internal Benchmarking to Improve Quality in your Organization

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Association for Ambulatory Health Care

IMPROVING HEALTH CARE QUALITY THROUGH ACCREDITATION

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Speaker

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Learning Objectives

- Describe the process for establishing criteria for peer review
- Analyze the results of peer review using internal and external benchmarking
- Develop QI studies based on peer review data
- Incorporate peer review into the process for granting continuation of clinical privileges

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Benefits of Peer Review

- Compares performance
- Identifies variation in performance and identifies outliers
- Highlights organization-wide problems
- Helps identify performance goals to determine whether a problem is provider-specific or organization-wide
- Drives appropriate interventions
- Establishes a criterion for granting or denying privileges

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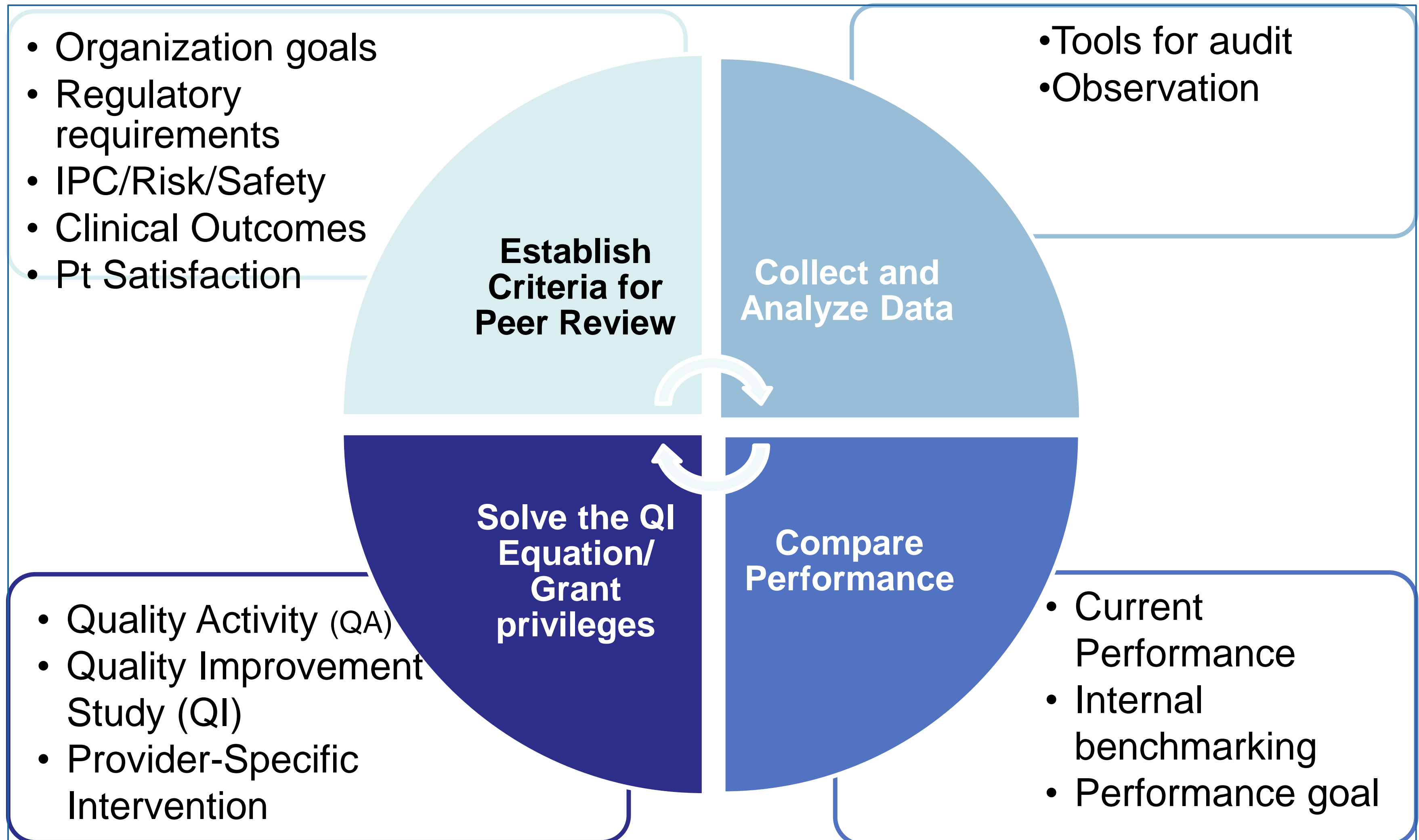
Process Cycle



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Establish Criteria for Peer Review

Health care professionals participate in the development and application of the criteria used to evaluate the care they provide.

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Considerations

- How is peer review currently conducted?
- Who is included: physician/dentists and/or other health care professionals?
- Is the peer review performed by at least one similarly-licensed peer?
- Is the data used to monitor important aspects of care provided by the organization?
- Is the data regularly evaluated to identify trends, outliers, and organizational problems?

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Developing Criteria

- Require input from participants—those whose performance will be reviewed
- Align with peer review policy
- Evaluate existing data (what you're already collecting)
- Identify and add key physician performance indicators
- Ensure data is valid, comparable and consistent

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Information Important to the Organization

- Organizational goals
- Services provided
- State and other regulatory requirements
- Programs
- Clinical outcomes

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Key Performance Indicators

Identify the key physician indicator(s) that will be compared to identify benchmarks:

- Complications
- Compliance
- Cost
- Timeliness
- Efficiency
- Documentation
- Utilization

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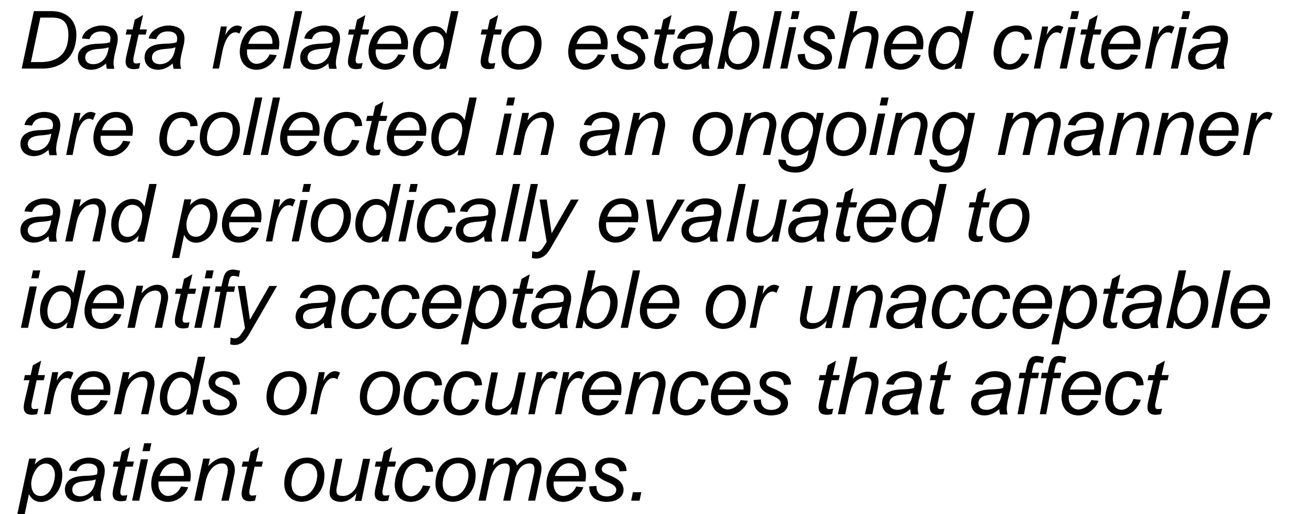
Collect and Analyze Data



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Applying Data Collection Methods

- Retrospective review
  - Using a chart audit tool
  - Reporting Indicators
- Prospective use
- Real time collection
- Observation
  - Direct observation for clinical competency by a similarly licensed peer
  - Observe communication skills between patient and health care team

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Displaying Peer Review Data

- A format designed to compare individual performance within the organization and with each other (i.e., dashboard or scorecard)
- Useful for visualizing peer review and demonstrating opportunities for improvements

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Example: Surgical Scorecard

3rd Quarter July-September 2015					
Metric	Dr. A	Dr. B	Dr. C	Dr. D	Dr. E
SSI	0.5%	0%	0%	1%	0%
Patients Receiving Antibiotics < 1 Hour	75%	98%	92%	93%	98%
On-time Start	75%	64%	72%	45%	78%
Time Out	75%	100%	100%	100%	100%
Comprehensive H& P	100%	27%	100%	35%	55%

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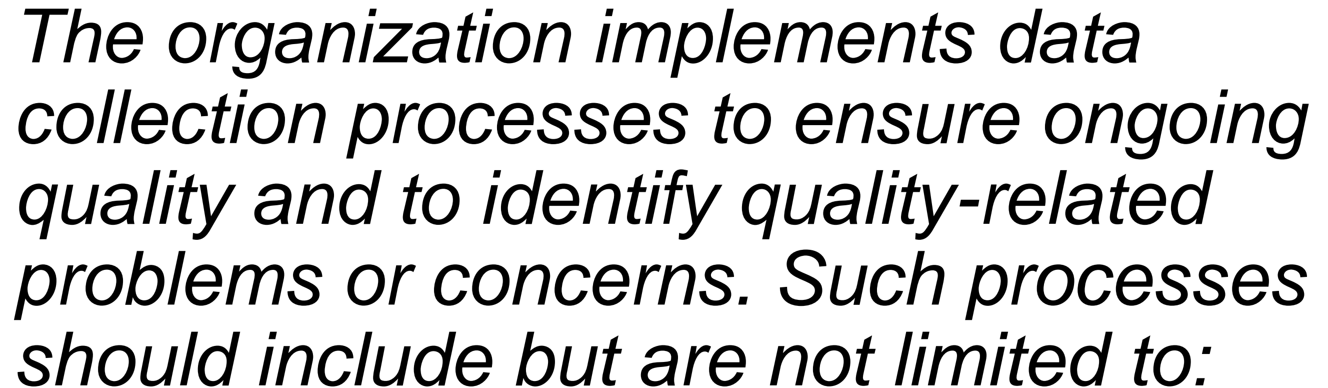
Analysis of Data Collected



The organization implements data collection processes to ensure ongoing quality and to identify quality-related problems or concerns. Such processes should include but are not limited to:

- *Analysis of the results of peer review activities*

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Identify Current Performance

- Peer review data is analyzed for overall performance as well as each physician's performance
- Easily display current performance using a dashboard or scorecard to provide a visual

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Example: Surgical Scorecard

Metric	Current Performance	Dr. A	Dr. B	Dr. C	Dr. D	Dr. E
SSI	0.3%	0.5%	0%	0%	1%	0%
Patients Receiving Antibiotics < 1 Hour	91%	75%	98%	92%	93%	98%
On-time Start	67%	75%	64%	72%	45%	78%
Time Out	91%	75%	100%	100%	100%	100 %
Comprehensive H& P	63%	100%	27%	100%	35%	55%

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Compare Performance

The organization implements data collection processes to ensure ongoing quality and to identify quality-related problems or concerns. Such processes should include but are not limited to:

- *Comparison of the organization's performance to internal and external benchmarks.*

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Benchmarking

- Definition:
  - A comparative best as a baseline for improvement
  - Identifies best practices which become the ‘benchmarks’ against which others are measured
- Types:
  - Internal
  - External
- Used for setting performance goals
  - Overall performance
  - Provider-specific performance

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Internal Benchmarking

The comparison of performance within an organization, such as by a physician or department, or over time

- Look for internal best practice
- Organizational history
- Between providers

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Comparing Current Performance and Internal Benchmarking

- Compare the organization's overall performance to that of individual performers
- Compare your best performer to your lowest performer
- Identify trends in the data
- Use a performance goal to identify outliers vs. system-wide problems

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Example: Surgical Scorecard

Metric	Current Performance	Dr. A	Dr. B	Dr. C	Dr. D	Dr. E
SSI	0.3%	0.5%	0%	0%	1%	0%
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Setting a Performance Goal

- Using an internal and/or external benchmark is optimal for setting a performance goal
  - Provides a rationale for the performance goal rather than a random selection
- A benchmark is not always applicable

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Displaying Peer Review Example: Surgical Scorecard

Metric	Performance goal	Overall Performance	Dr. A	Dr. B	Dr. C	Dr. D	Dr. E
SSI	1.8%	0.3%	0.5%	0%	0%	1%	0%
Patients receiving antibiotics < 1 hour	90%	91%	75%	98%	92%	93%	98%
On-time start	88%	67%	75%	64%	72%	45%	78%
Time Out	100%	91%	75%	100%	100%	100%	100 %
Comprehen-sive H& P	95%	63%					

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Displaying Peer Review Example: Surgical Scorecard

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Comprehensive H& P	95%	63%	100 %	27%	100 %	35%	55%

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Solving the QI Equation

The organization implements data collection processes to ensure ongoing quality and to identify quality-related problems or concerns. Such processes should include but are not limited to:

- *Evaluation of the information and data obtained through the above data collection activities to identify the existence of unacceptable variation that requires improvement.*

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Quality Activity vs. Quality Improvement

- The organization's overall current performance met or exceeded the performance goal
- No corrective action is needed for the organization or for individual providers

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Using Peer Review Data for Improvement

Discuss options for improvement:

1. No change needed and continue monitoring as a Quality Activity (QA)
2. System-wide improvement needed using a Quality Improvement (QI) study
3. Provider-specific intervention needed

What do you mean?

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Example: Surgical Scorecard

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Quality Improvement

- If the problem is system-wide, where most of the providers do not meet the performance goal, a QI study is expected.
- A corrective action must be implemented that addresses the source(s) of the problem.
- A re-measurement is required to see if the performance goal is met.

QI

Current Performance < Performance Goal

Consider developing a **QUALITY IMPROVEMENT Study** using the 10 Elements.

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Displaying Peer Review
Example: Surgical Scorecard

Metric	Performance goal	Overall Perform-ance	Dr. A	Dr. B	Dr. C	Dr. D	Dr. E
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Using the 10 Elements (Standards 5.I.C.1-10)

- AAAHC QI study template is optional
- Addressing the 10 elements is required
  - Purpose (5.I.C.1)
  - Performance Goal (5.I.C.2)
  - Description of Data to be Collected (5.I.C.3)
  - Evidence of Data Collection (5.I.C.4)
  - Analysis-Current Performance (5.I.C.5)
  - Compare Current Performance with Performance Goal (5.I.C.6)
  - Corrective Action (5.I.C.7)
  - Re-measurement (5.I.C.8)
  - Additional Corrective Action and Re-measurement, if necessary (5.I.C.9)
  - Reporting (5.I.C.10)

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Provider-specific Intervention

If you identify an outlier, a provider-specific intervention needs to be created

- Sometimes being aware of this will “fix” the problem
- Ensure data collected on physician is comparable data to the others
- Assess the source of the problem
- Involve physician in solution/intervention
- Re-measure performance after intervention

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Displaying Peer Review Example: Surgical Scorecard

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Granting of Privileges

- Results of the peer review should be used as part of the process when granting privileges
- If you have a consistently low performer, an action plan may need to be implemented

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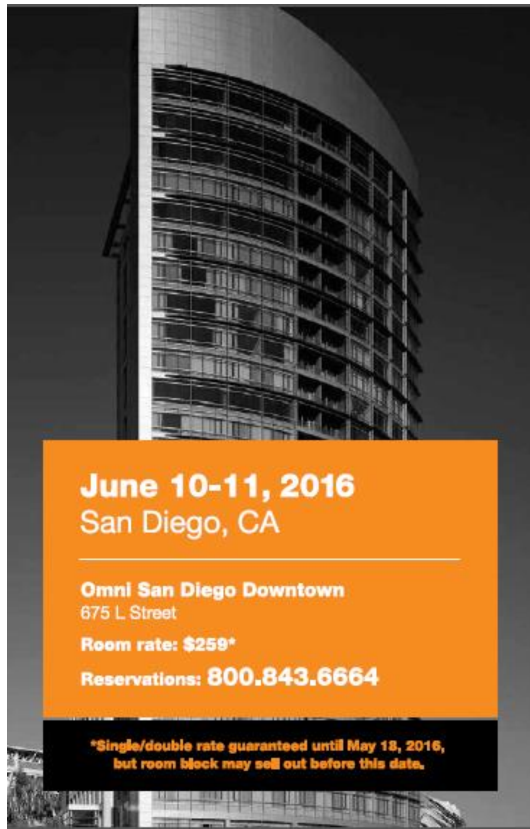
Achieving Accreditation Conference



Sample Conference Agenda

Friday

- **7:15 – 8:00 am** .... Registration and breakfast
- **8:00 – 9:30 am** .... Welcome, Introduction, and Core Standards
- **9:30 am** .... Refreshment Break
- **9:45 – noon** .... Core Standards continued
- **Noon** .... Box lunch
- **1:00 – 5:00 pm** .... Break-out sessions: *Illuminating QI*
- **5:15 pm** .... Networking reception

Saturday

- **7:30 – 8:00 am** .... Breakfast
- **8:00 – noon** .... Adjunct Standards for Surgical/ Procedural or Primary Care settings (includes refreshment break)
- **Noon** .... Box lunch
- **1:00 – 4:30** .... Elective sessions

Additional details and online registration at www.aaahc.org/education/achieving-accreditation.

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Questions

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