Contemporary Peer Review: Creating a Positive Approach through Reducing Bias

Presented by

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Contents

Agenda ................................................................. 4
Speaker Profiles ....................................................... 6

Exhibit A ................................................................. 7
  Exhibit A: Presentation by Robert J. Marder, MD, CMSL, vice president

Resources ............................................................... 25
Agenda

I. Redefine peer review

II. The types of bias and how to reduce it
   A. Personal
   B. Group
   C. Systematic
   D. Statistical

III. Peer review committee structure
   A. Trends
   B. Measure physician competency
   C. Targets
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Robert J. Marder, MD, CMSL, vice president

Dr. Marder serves as vice president at The Greeley Company. He brings over 25 years of healthcare leadership and management experience to his work with physicians, hospitals and healthcare organizations across the country.

Dr. Marder’s many roles in senior hospital medical administration and operations management in academic and community hospital settings make him uniquely qualified to assist physicians and hospitals develop solutions for complex medical staff and hospital performance issues. He has consulted, authored, and presented on a wide-range of healthcare leadership issues including effective and efficient peer review, physician performance measurement and improvement, hospital quality measurement systems and performance improvement, patient safety/error reduction, and utilization management.

Prior to joining The Greeley Company, Dr. Marder’s experiences included assistant vice president for quality management at Rush Presbyterian St. Luke’s Medical Center and vice president for medical affairs at Holy Cross Hospital. He also served as the national project director for indicator development and use at The Joint Commission from 1988 to 1991. He is a board certified pathologist and was assistant director of laboratories and director of clinical immunology at Northwestern Memorial Hospital, and associate clinical professor at Northwestern University Medical School.

Dr. Marder is a graduate of Rush Medical College and received his residency training at Rush-Presbyterian-St. Luke’s Medical Center in pathology with a fellowship in microbiology/immunology.

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Contemporary Peer Review: Creating a Positive Approach through Reducing Bias

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Peer Review Isn’t Easy

- Physicians feel they are caught between a rock and hard place
Why are Physicians Reluctant to Perform Peer Review?

- Effect on relationships with colleagues
- Effect on their time
- Use in court (discoverability)

What Happens if a Hospital Does Not Perform Evaluation of Physician Competency?

- Loss of accreditation
  - Medicare payment
  - Reputation
- Exposure to corporate negligence
  - Negligent credentialing
  - Negligent peer review
How Have Medical Staffs Addressed Physician Reluctance to do Peer Review?

- Effect on relationships with colleagues
  - Create a positive culture of mutual accountability

- Effect on their time
  - More efficient approaches

- Protection
  - Good policies and practices

Redefining Peer Review

- Traditional definition:
  - Evaluation of patient charts to determine the quality of care provided by individual physicians
Redefining Peer Review (cont’d)

- Contemporary definition:
  - Evaluation of a physician’s professional performance for all defined competency areas using multiple data sources

- Case review is only a part of peer review

The Joint Commission Terms Defining Peer Review

- General Competencies
  - The framework that defines the competency expectations to be measured and evaluated

- Ongoing professional practice evaluation (OPPE):
  - Routine monitoring of current competency for current medical staff members

- Focused professional practice evaluation (FPPE):
  - Establishing current competency based on:
    - Concerns from OPPE (focused review) or
    - New medical staff members or new privileges (proctoring)
Minimizing Bias in Peer Review

What is bias?
- A tendency or preference toward a particular perspective or result
- A systematic error introduced into sampling or testing encouraging one outcome over other

Can we remove it?
- Not completely, but it can be reduced

Types of Bias Affecting Peer Review
- Human nature: Psychological “shortcuts” to reduce complexity and ambiguity
  - Personal bias
  - Group bias
- Systematic bias: Evaluation system flaws
- Statistical bias: Study design flaws
Reducing Bias in Peer Review

- **Personal bias**
  - Minimize personal effect on the final decision
  - Conflict of interest standards
  - Require content-based opinions
  - Improve inter-rater reliability
    - Case review
    - Data interpretation
    - Preserve reviewer anonymity

- **Group bias**
  - Committee structure
  - Committee membership

Reducing Bias in Peer Review (cont’d)

- **Systematic bias**
  - Case rating systems
  - External peer review

- **Statistical bias**
  - Selecting valid, reliable, and accurate measures
  - Selection of the right type of measure
How do You Reduce Bias in Your Peer Review Program?

- Look for bias in your structures, procedures, and results
- Manage bias through your policies and systems

Why Examine Your Peer Review Committee Structure?

- Improve efficiency
  - Physician time
  - Staff time
- Reduce systematic bias
What is Your Definition of a Peer?

“Only someone in the same specialty can adequately review my care!”

- Alternative definitions:
  - A peer is an individual in the same specialty
  - A peer is an individual practicing in the same profession who has expertise in the appropriate subject matter under review

Peer Review Structures

- Department-/specialty-based peer review:
  - Department chair
  - Department committee

- Multispecialty-based peer review:
  - Single multispecialty committee
  - Multiple (e.g., service line) multispecialty committees
What is the Trend?

- Increase in community and academic medical staffs moving to central multispecialty peer review

Why?

- Reverses the flow to minimize specialty-specific *bias*

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**Single Multispecialty Physician Quality Committee**

- Performs all initial case review
- Obtains appropriate subject matter expert input when needed
- Monitors rule and rate indicators for all dimensions of performance
- Refers identified problems to department chair and/or MEC for improvement plan or action
- Tracks improvement plans for implementation
- Approves and deletes all medical staff indicators and studies with specialty input
-Communicates system problems
Reasons for Moving to Centralized Multispecialty Peer Review

- **Fairness**
  - Increased consistency across departments/reviewers
  - Decreased specialty bias
  - Cross-department dialog and learning
  - Increased physician understanding of quality methods
  - Improved oversight of quality resources

- **Efficiency**
  - Fewer medical staff committees
  - Decreased total physician time
  - Increased staff productivity

If You Want to Keep Department-Specific Review, How Can You Improve It?

- A multispecialty central oversight committee with real authority
- Representation on department committees from other specialties to minimize bias
- Standard case review procedures and rating system
### Measuring Physician Competency: Who are You Measuring?

- **Validity**: The degree to which the performance measure actually measures the aspect of performance that it is purported to measure.
- **Reliability**: The degree to which the performance measure provides consistent or reproducible results.
- **Accuracy**: The degree to which the performance measure result is close to the actual or true result.

### Physician Competency Validity, Reliability, and Accuracy Issues

- **Physician-relevant (validity)**
  - CHF discharge medications?
  - Aspirin on admission for AMI?
  - Antibiotic times for pneumonia patients?

- **Individual physician-specific (reliability, accuracy)**
  - CHF discharge order medications?
  - CHF risk-adjusted mortality?
How Should You Measure It?

- Three types of physician competency indicators:
  - Review indicators (unusual events)
  - Rule indicators (immediate feedback)
  - Rate indicators (frequency questions)

What if an Indicator Data is Zero?

- Was there an opportunity (activity) to have an event?
  - Activity related to particular privileges
  - General activity or involvement in patient care
- If YES, it is data:
  - Zero events for review or rule indicator
  - Zero numerator for rate indicator with denominator data
- If NO, look at:
  - Indicator does not apply to that physician or specialty
  - Nonuse of privilege should be evaluated
Normative Data

- **What is it?**
  - Data that provide comparison with some defined group
    - What is the group? How was it chosen?

- **Why use it?**
  - Improve interpretation bias
    - Recognize all levels of performance
    - Move with improvement in the field
      - Percentile rank vs. absolute value

Practitioner Attribution: The Problem

- Patients in hospitals are complex and usually cared for by a team of physicians

- Who gets the particular issue or event assigned to them?
Solutions to Practitioner Attribution Issues

- Use appropriate practitioner type for claims data
- Medical staff definitions for HIM to modify claims data
- Specific abstracting for practitioner-relevant indicators
- Group rates
- Accepting attribution variance as a sign of supervision issues
- Electronic medical record not based on defaults

How Can You Reduce Bias in Data Interpretation?

- Set prospective indicator targets

- Comparative data vs. data target:
  - What’s the difference?
    - Comparative data doesn’t define “good”
    - Targets are a cultural choice
How Many Targets: Effect on Your Medical Staff Culture

One target = Two performance levels

Acceptable Target

Acceptable performance
Unacceptable performance

Cultural effect: Bad apples approach
• Focus on poor performance
• Assumes everyone else is the same

Two targets = Three performance levels

Excellence Target

Excellence performance
Acceptable Target

Acceptable performance
Needs follow-up

Cultural effect: Drives physician improvement
• Recognizes top performers
• Stimulates self-improvement of the middle
• Addresses potentially poor performance
Who Determines the Targets?

- The medical staff, based on department recommendations for specialty-specific measures
## Physician Feedback Report

**Provider:** Anderson, Hugh  
**ID:** 38798  
**Specialty:** Internal Medicine

### Interpersonal & Communication Skills

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<th>Acceptable Value</th>
<th>Excellence Value</th>
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### Professionalism

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### System Based Practice

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<td>4</td>
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Key: **Green** = Excellent; **Yellow** = Acceptable; **Red** = Needs attention  
*Monday, March 18, 2008*
Greeley Medical

Resources
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a 60-minute audio conference

Rick Sheff
Chairman and Executive Director
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