Linking Peer Review and Benchmarking to Improve Quality in Your Organization

ACHA 2017

Achieving Accreditation: A focus on Quality Improvement, Peer Review and Benchmarking
Ray Grundman, MSN, FNP-BC
University of Wisconsin – Milwaukee (retired)
AAAHC Surveyor
Welcome!

- Joy Himmel
- Psy D., PMHCNS-BC, LPC
- Surveyor since 2009
- AAAHC faculty
- Member of the AAAHC Board of Directors representing ACHA
- Member of the Accreditation Committee
- Liaison for ACHA

IMPROVING HEALTH CARE QUALITY THROUGH ACCREDITATION
Today’s Topic

- Describe the process of establishing criteria for peer review
- How to analyze the results of peer review using internal/external benchmarking
- Understand the ten steps of a QI study
- How to develop QI studies based on peer review data
- Understand the components of a good QI study
Benefits of Peer Review

- Compares professional performance
- Identifies variation in performance among providers in your organization, including identifying outliers
- Helps identify performance goals to determine whether a problem is provider-specific or organization-wide
- Drives appropriate interventions
- Establishes criteria for granting or denying privileges
Process Cycle

- Organization policies
- Regulatory requirements
- IPC/Risk/Safety
- Clinical Outcomes
- Pt Satisfaction

Establish Criteria for Peer Review
Std 2.III.F

Collect and Analyze Data
Std 2.III.G, 5.I.B.1

Solve the QI Equation
Std 5.I.B.6

Compare Performance
Std 2.III.G, 5.I.B.1, 5.I.B.4

- Tools for audit
- Observation

- Quality Activity (QA)
- Provider-Specific Intervention
- Quality Improvement Study (QI)

- Current Performance
- Internal benchmarking
- Performance goal
Establish criteria for peer review

Transparency and Buy-In
Standard 2.III.F

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

- Who is included: Physicians, Nurse Practitioners, Physician Assistants, Counselors, RN’s, Health Promotion Professionals, Psychiatrists or other health care professionals?

- Who is able to conduct peer review for whom?

- 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?
Developing Criteria

- Align with peer review policy - do what your policy says - get input from staff
- Evaluate existing data (what you’re already collecting)
- Include data important to the organization
- Think about outcomes, benchmarks, etc.
- Identify key performance indicators
Key Performance Indicators

Identify the key indicator(s) that will be compared:

- Complications
- Compliance
- Cost
- Timeliness
- Efficiency
- Documentation
- Outcomes
Standard 2.III.G

Data related to established criteria are collected in an ongoing manner and periodically evaluated to identify acceptable or unacceptable trends or occurrences that affect patient outcomes.
Three Data Collection Methods

1. Retrospective Review
   - Using a chart audit tool

2. Prospective Data
   A prospective cohort study is a longitudinal cohort study that follows over time a group of similar individuals (cohorts) who differ with respect to certain factors under study, to determine how these factors affect rates of a certain outcome.
   - Special tools (survey, form)
   - Patient satisfaction

3. Observation
   - Direct observation for clinical competency by a similarly licensed peer
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
### Example: Health Services Dashboard

#### 1st Quarter
January – March 2017

<table>
<thead>
<tr>
<th>Metric</th>
<th>Dr. A</th>
<th>Dr. B</th>
<th>Dr. C</th>
<th>Dr. D</th>
<th>Dr. E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction</td>
<td>95%</td>
<td>98%</td>
<td>78%</td>
<td>92%</td>
<td>98%</td>
</tr>
<tr>
<td>Following Guidelines for Asthma Care</td>
<td>92%</td>
<td>65%</td>
<td>49%</td>
<td>72%</td>
<td>80%</td>
</tr>
<tr>
<td>+ Dep. Screening addressed</td>
<td>71%</td>
<td>68%</td>
<td>67%</td>
<td>72%</td>
<td>78%</td>
</tr>
<tr>
<td>Wait Time</td>
<td>20</td>
<td>15</td>
<td>12</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Following guidelines for prescribing Azithromycin</td>
<td>21%</td>
<td>42%</td>
<td>25%</td>
<td>23%</td>
<td>14%</td>
</tr>
</tbody>
</table>
### Example: MH Peer Review

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Last 3 digits ID number</th>
</tr>
</thead>
<tbody>
<tr>
<td>High CCAPS scores were checked as reviewed with client if indicated and increased or high risk symptoms addressed</td>
<td></td>
</tr>
<tr>
<td>Therapist documented plan for sessions at intervals which match severity of symptoms.</td>
<td></td>
</tr>
<tr>
<td>Client-centered goals address the major presenting symptoms/concerns.</td>
<td></td>
</tr>
<tr>
<td>Progress notes address progress on the stated client goals at regular intervals.</td>
<td></td>
</tr>
<tr>
<td>Clinical notes clearly document interventions used at each session and are appropriate based on the client.</td>
<td></td>
</tr>
<tr>
<td>Clinical notes clearly identify current symptoms.</td>
<td></td>
</tr>
</tbody>
</table>
Analysis of Data Collected

Standard 5.I.B.1

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:

1. Analysis of the results of peer review activities
Identify Current Performance

- Peer review data is analyzed for overall performance as well as for each provider’s performance

- Easily display current performance using a dashboard or scorecard to provide a visual
A format with which to compare individual performance within the organization and with each other. This is useful for visualizing opportunities for improvements.

✓ **Dashboards** are used for performance monitoring, are updated in real-time, and in an “automobile” it shows “how your car is operating” (eg. On-time starts)

✓ **Scorecards** are used for performance management, are aggregated and updated periodically (monthly), and in an “automobile” it shows “where you have been” (eg. SSI’s)
## Example: Primary Care Dashboard

<table>
<thead>
<tr>
<th>Metric</th>
<th>Overall Current Perf.</th>
<th>Dr. A</th>
<th>Dr. B</th>
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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
Standards

Compare Performance

Standard 5.I.B.4

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:

4. **Comparison of the organization’s performance to internal and external benchmarks**
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
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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Setting a Performance Goal

- Internal and/or external benchmark is optimal for setting a performance goal
  - Provides a rationale for the performance goal; the goal is not randomly selected

- A benchmark is not always applicable
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<td>+ Dep. Screening Addressed</td>
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## Peer Review for Behavioral Health: Example

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<th>Overall Performance</th>
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<th>Dr. B</th>
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<th>Dr. D</th>
<th>Dr. E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction</td>
<td>90%</td>
<td>91%</td>
<td>92%</td>
<td>98%</td>
<td>75%</td>
<td>92%</td>
<td>96%</td>
</tr>
<tr>
<td>Clients who complete treatment</td>
<td>78%</td>
<td>66%</td>
<td>52%</td>
<td>65%</td>
<td>68%</td>
<td>70%</td>
<td>77%</td>
</tr>
<tr>
<td>PHQ9 less than or equal to 9 at 12 weeks</td>
<td>65%</td>
<td>61%</td>
<td>45%</td>
<td>70%</td>
<td>60%</td>
<td>63%</td>
<td>65%</td>
</tr>
<tr>
<td>Wait Time</td>
<td>&lt; 10 minutes</td>
<td>18 minutes</td>
<td>20</td>
<td>30</td>
<td>8</td>
<td>14</td>
<td>16</td>
</tr>
<tr>
<td>Documented progress on treatment plan objectives</td>
<td>95%</td>
<td>85%</td>
<td>75%</td>
<td>88%</td>
<td>85%</td>
<td>86%</td>
<td>90%</td>
</tr>
</tbody>
</table>
Standard 5.I.B.6

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:

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

- The organization’s overall current performance meets or exceeds the performance goal
- No corrective action is needed for the organization or for individual providers

Current Performance \( \geq \) Performance Goal

THEN

Continue monitoring;
it’s a QUALITY ACTIVITY
Using Peer Review Data for Improvement

Discuss options for improvement:

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

If you identify an outlier, consider creating a provider-specific intervention

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

- If the problem is system-wide, where most providers do not meet the performance goal, a QI study is useful.
- A corrective action should be implemented that addresses the source(s) of the problem.
- Re-measurement should occur to determine whether the performance goal is now met.

Current Performance < Performance Goal

Consider developing a QUALITY IMPROVEMENT Study using the 10 elements.
## Quality Improvement

<table>
<thead>
<tr>
<th>Data Collected</th>
<th>Current Performance</th>
<th>Benchmark</th>
<th>Performance Goal</th>
<th>QI vs QA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptom reduction; 5 pt. reduction in PHQ by wk. 8</td>
<td>40%</td>
<td>50%</td>
<td>60%</td>
<td>QI</td>
</tr>
<tr>
<td>Improved client function by wk. 8</td>
<td>45%</td>
<td>50%</td>
<td>60%</td>
<td>QI</td>
</tr>
<tr>
<td>Successful completion of objectives at D/C</td>
<td>45%</td>
<td>70%</td>
<td>70%</td>
<td>QI</td>
</tr>
</tbody>
</table>
## Quality Improvement

<table>
<thead>
<tr>
<th>Data Collected</th>
<th>Current Performance</th>
<th>Benchmark</th>
<th>Performance Goal</th>
<th>QI vs QA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of scheduled sessions matches severity</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>QA</td>
</tr>
<tr>
<td>Suicide risk assessment documented on all patients with PHQ &gt;11</td>
<td>75%</td>
<td>100%</td>
<td>100%</td>
<td>QI</td>
</tr>
<tr>
<td>Successful completion of objectives at D/C</td>
<td>45%</td>
<td>70%</td>
<td>70%</td>
<td>QI</td>
</tr>
</tbody>
</table>
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)
  - Data Description (5.I.C.3)
  - Evidence of Data (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)
What makes a GOOD study

- Address issues that are important
- Measurable performance goal
- Involvement of staff and resources
- Sharing of progress and results
  - Goals are realistic and come from reliable sources/ or through consensus of key personnel
  - Well-written description
  - Show how and why it is important
  - Clearly describe corrective actions/interventions
Toolkits

Patient Safety Toolkit: Credentialing and Privileging

Patient Safety Toolkit: Peer Review and Benchmarking
Questions