COMMENTARY

Peer Review: Innovating Change

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There are in fact two things, science and opinion; the former begets knowledge, the latter ignorance. —Hippocrates[1]

Abstract

Medicine has traditionally focused on specialty and subspecialty expertise, which subsequently leads to fragmentation, inefficiencies, and lack of accountability. From this focus came a new idea: The Institute. The Institute has transformed our culture, fundamentally affecting the way we approach patient care and how we foster accountability rather than blame. It focuses on system failures rather than on individual ones, which ultimately drives us to act. The result is a peer-review process built on strong interdisciplinary relationships.

Introduction

Columbia St Mary's (CSM), like so many health systems, historically structured its organized medical staff around specialties and subspecialties, which led to fragmentation and inefficiency. As a result, peer review followed the same form, which fostered feelings of frustration and disappointment. What for years passed as peer review was nothing more than the opinions of the powerful, used against the less well prepared or less confident. Out of this frustration came a new idea: The Institute. This innovative approach renewed enthusiasm and engagement.

The Institute is a concept that moves from a traditional, specialty-focused, and physician-centric model to one that is interdisciplinary, service-oriented, and patient centered. The Institute promotes transparency, efficiency, and accountability. This innovative approach brought CSM out of our myopic paradigm and propelled us forward to a culture of high reliability. Our ultimate vision is to incorporate clinical practice, quality improvement, education, and research as illustrated in Figure 1. In this article, we describe the essential elements and process steps of The Institute concept, an exciting outgrowth of bringing functional data analysis to effect real change in real time.

Essential Elements

Four essential sets of elements have influenced the formation and success of The Institute at CSM: 1) the right people with the right attitude, 2) timing and tempo, 3) a common language, and 4) a common process.

The Right People with the Right Attitude (Stacking the Deck): The key to any initiative is not the project idea itself but the people who embody the concept. Finding champions is simple in theory but difficult in practice. The "right" people should have certain character traits that allow the concept to take root and grow:

- They should be well-respected clinicians who are open and honest and yet exhibit a healthy level of caution and prudence, rather than cynicism or pessimism.
- They should promote teamwork and be capable of facilitating difficult but needed discourse while remaining focused, respectful, and professional.
- They should be not only champions of the concept but also formal or informal leaders.

Finding one or two individuals with the right attitude is quite possible; finding an entire group can be challenging. This leads us to the second set of elements: timing and tempo.

Timing and Tempo (Pull, Don't Push): The key to the success of The Institute at CSM was medical staff involvement in design and implementation. We started small and focused on areas of need or interest. As those areas experienced success, other areas began to show interest and the concept spread. Our strategy was to recognize those individuals who were ready for change and to provide them with timely knowledge and support. Having the right people at the right time was not enough. We needed the third element: a common language.

A Common Language: A common language is the cornerstone of the exchange of ideas. To advance The Institute concept, we had to adopt a common language. To achieve this, we formed a relationship with Healthcare Performance Improvement, LLC, a consulting company specializing in improving human performance in complex systems. They developed the Safety Event Classification as a reliable methodology to define, classify, and measure harm in health care. This taxonomy allowed us to exchange ideas more effectively and efficiently. We were then ready to implement the fourth element: a common process.

A Common Process: The common process begins with qualified individuals, extends to multidisciplinary group consensus, and concludes with an action plan that incorporates both individual and system issues across the continuum of care. Respecting the integrity of the process forces us to focus on the facts rather than the individual. This process prevents the hijacking of a healthy exchange of ideas. The following five steps outline the common process.

The Process Steps

There are five steps in our peer review process: 1) identifying a reason for review, 2) conducting the review, 3) reaching a consensus, 4) creating an action plan, and 5) improving performance. By completing these steps, we have transformed from a physician-centric, specialty-focused model to one that is multidisciplinary, patient-focused, and accountable.

Step 1. Identifying a Reason for Review: As a first step, the reason for review is identified by a quality-improvement professional assigned to The Institute. Review reasons serve as primary

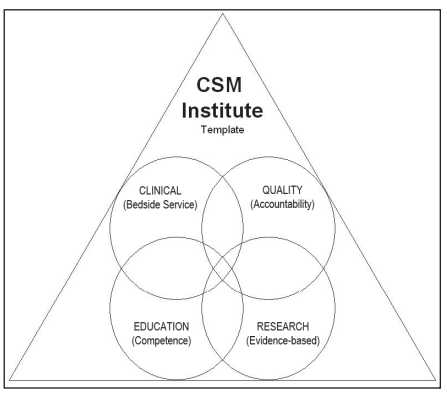

Figure 1. Template for The Institute model.
CSM = Columbia St Mary's

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filters for case selection and vary according to the patient population served by The Institute. The categories can include the Joint Commission's core measures,[2] unscheduled readmissions, unplanned returns to the operating room, and referrals. The Safety Event Classification is then applied, and the level of harm and event type are determined. Finally, a case summary is presented.

Step 2. Conducting the Review: A qualified reviewer leads step 2. Typically a physician, the reviewer clarifies the area of concern, using the chosen common language. The reviewer identifies and categorizes each area of concern by articulating the reason for occurrence (ie, who, what, when, where, and why).

Step 3. Reaching a Consensus: In step 3, consensus is reached regarding the area of concern and reason for event occurrence. These two components of review focus on system needs and institutional change rather than solely on individual corrective actions. In this process, learning is inherent.

Step 4. Creating an Action Plan: The discourse of issues in step 3 leads to step 4, creating an action plan. The action plan explicitly defines accountability for the individual practitioner, the peer group, and the institution as a whole. This promotes system reliability and cultural transformation.

Step 5. Improving Performance: The final step is improving performance. What hospitals need in this dynamic health care climate is an informatics platform that supports performance improvement, one that stores data, analyzes trends, and provides reports in a consistent and timely manner.

Discussion

Every new concept requires time to flourish, and this certainly was the case for The Institute. Initially we encountered limited physician engagement and skepticism. We learned early on that we had to educate both formal and informal leaders so that they could develop an understanding of and trust in The Institute concept. We started with informal, one-on-one discussions, using case-by-case examples. These conversations resulted in a level of understanding that evolved into enthusiasm and support, allowing us to take the next step—implementing a pilot that incorporated a multidisciplinary approach. By moving in this direction, we discovered that the existing medical staff infrastructure did not efficiently or effectively address complicated care issues.

By reorganizing the medical staff structure, we promoted more rapid change throughout the organization. Our Institute of Hospital Medicine incorporated physicians from the emergency medicine, hospital medicine, internal medicine, family medicine, and critical care areas, along with pharmacy, nursing, administration, and clinical excellence. Use of a standard taxonomy has broadened our approach to discussing and solving problems.

Similar institutes are formed in the areas of surgery, behavioral medicine, cardiovascular, women, infants and children, and orthopaedics. We envision additional institutes being formed in clinic-based medicine, cancer, and neuroscience. The concept is translatable to the evaluation of nursing care processes (that discipline has begun using The Institute concept at CSM), pharmacy, and perhaps more divergent hospital services such as environmental services, human resources, and finance. Time will tell.

Conclusion

This is the start of our story, as depicted in Figure 2. What has been most gratifying is how this work has been embraced intuitively by the medical and hospital staffs. Our ultimate vision is to move toward a patient-centered model that removes the fragmentation—the silo effect—by integrating clinical, operational, and administrative responsibilities. This culture exhibits a sense of interdisciplinary accountability that leads not to embarrassment or punishment but instead to innovation and reliability. ❖

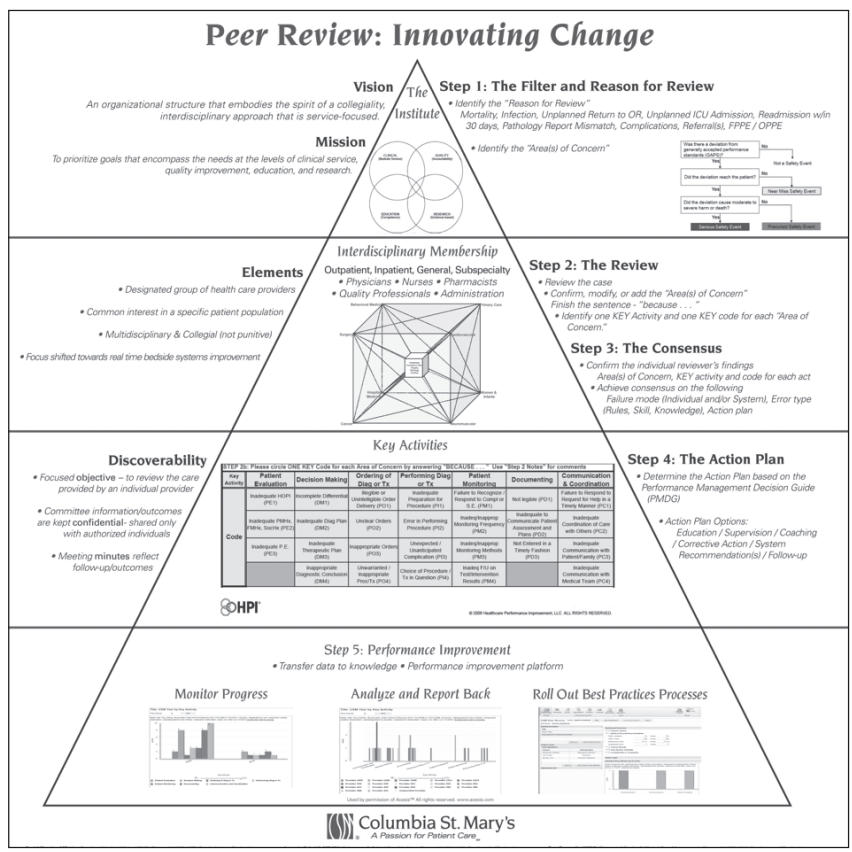

Figure 2. Details of functions of The Institute.

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

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References

1. Hippocrates. Law (Section 4). In: Hippocrates Vol 2, translated by Jones WHS. New York: Putnam; 1923-95. p 265.
2. Core Measure Sets [monograph on the Internet]. Oakbrook Terrace, IL: The Joint Commission; 2010 Oct 20 [cited 2012 Jan 23]. Available from: www.jointcommission.org/core_measure_set/.