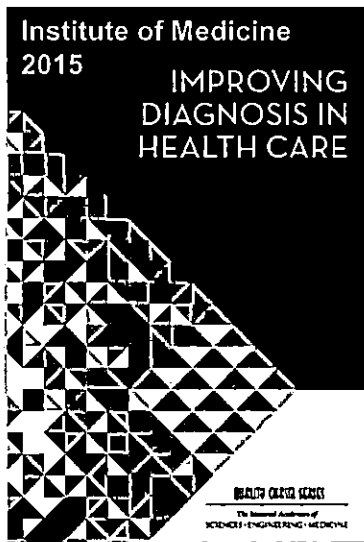


Testimony from: Richard Sharpe Jr, MD, MBA
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Advocating for continued peer review protections in the medical practice act

- The 2015 Institute of Medicine report on improving diagnostic accuracy in medicine focused on “developing a reporting and medical liability system that facilitates improved diagnosis by learning from diagnostic errors and near misses,” and further specified that a key component of this goal is “the creation of legal protections for peer review disclosures.”
- At Kaiser Permanente, we raised awareness of peer review protections and created a peer learning program. As a result, submissions increased by a factor of 12, learning point distributions to the team increased by a factor of 19.5, and these submissions were converted to patient care improvement projects. Examples below:
 - Creation of targeted resources to standardize interpretations of various findings, ensuring effective communication and follow up.
 - Creating an electronic safety net to ensure appropriate care if follow up care goes unremembered by the care team and patient.
 - Interdisciplinary care improvement projects
- Removal of peer review protection would be:
 - An unfortunate and significant setback for patient safety
 - Contrary to the best practices advocated by the Institute of Medicine.
 - A deviation from domestic norms (only one other state has eliminated protections)
 - And would compromise the ability of care teams to learn and improve.



Goal No.	Goal
Goal 1	Facilitate more effective teamwork in the diagnostic process among health care professionals, patients, and their families
Goal 2	Enhance health care professional education and training in the diagnostic process
Goal 3	Ensure that health information technologies support patients and health care professionals in the diagnostic process
Goal 4	Develop and deploy approaches to identify, learn from, and reduce diagnostic errors and near misses in clinical practice
Goal 5	Establish a work system and culture that supports the diagnostic process and improvements in diagnostic performance
Goal 6	Develop a reporting environment and medical liability system that facilitates improved diagnosis by learning from diagnostic errors and near misses
Goal 7	Design a payment and care delivery environment that supports the diagnostic process
Goal 8	Provide dedicated funding for research on the diagnostic process and diagnostic errors

Goal 6: Develop a reporting environment and medical liability system that facilitates improved diagnosis by learning from diagnostic errors and near misses

RECOMMENDATION 6A	RECOMMENDATION 6B	RECOMMENDATION 6C	RECOMMENDATION 6D
The Agency for Healthcare Research and Quality (AHRQ) or other appropriate agencies or independent entities should encourage and facilitate the voluntary reporting of diagnostic errors and near misses.	AHRQ should evaluate the effectiveness of patient safety organizations (PSOs) as a major mechanism for voluntary reporting and learning from these events and modify the PSO common formats for reporting of patient safety events to include diagnostic errors and near misses.	States, in collaboration with other stakeholders (health care organizations, professional liability insurance carriers, state and federal policy makers, patient advocacy groups, and medical malpractice plaintiff and defense attorneys), should promote a legal environment that facilitates the timely identification, disclosure, and learning from diagnostic errors. Specifically, they should: <ul style="list-style-type: none"> • Encourage the adoption of communication and resolution programs (CRPs) with legal protections for disclosures and apologies under state laws. 	Professional liability insurance carriers and captive insurers should collaborate with health care professionals on opportunities to improve diagnostic performance through education, training, and practice improvement approaches and increase participation in such programs.

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Implementation of a Peer Learning Program Replacing Score-Based Peer Review in a Multispecialty Integrated Practice

OBJECTIVE. The aim of this study was to compare the efficacy of a peer learning program to score-based peer review in a radiology department.

MATERIALS AND METHODS. Our score-based peer review program was transitioned to an open, inclusive, education- and improvement-oriented peer learning program. Program performance was evaluated by learning opportunity submissions, program participation, number of learning opportunity distributions to radiologists, number of practice improvement projects resulting from program, and radiologist survey results before and after implementation.

RESULTS. Outcomes for the score-based peer review program compared with those of the peer learning program were as follows. The mean number of radiologists participating monthly increased from 3.0 to 35.2 ($p < 0.01$); submissions increased from 3.0 discrepancies per month to 36.0 learning opportunities per month ($p < 0.01$); the mean monthly learning opportunity distributions to radiologists increased from 18 to 352 ($p < 0.01$); improvement projects performed during the study periods increased from 5 to 61 ($p < 0.01$); and mean monthly continuing medical education credits earned by radiologists increased from 7.7 to 50.6 ($p < 0.01$). Radiologists felt peer learning accomplished goals better than did score-based peer review.

CONCLUSION. In transitioning our score-based peer review program to a peer learning program, our radiologists identified, discussed, and converted more learning opportunities into practice improvement and perceived peer learning to be of higher value than score-based peer review.

- The Kaiser Permanente Colorado Radiology Department converted their previous review program that was seen as punitive to a just culture based peer learning program that promotes discussion of learning opportunities and errors.
- Monthly learning opportunity distributions to radiologists increased from 18 to 352 ($p < 0.01$).
- Because of this change, the department experienced a significant increase in the number of submissions of possible improvement opportunities, an increase in discussion and learning from these opportunities, and increased conversion of these submissions into meaningful patient care improvements.

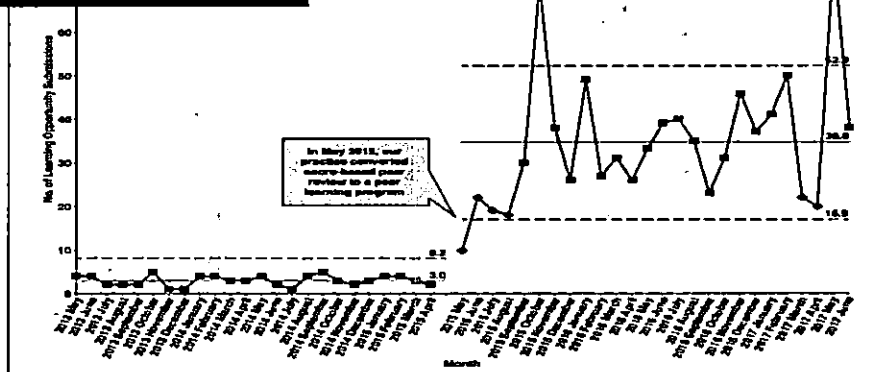


Fig. 2—Statistical process control chart (control chart) showing monthly learning opportunity submissions to peer learning program after significant increase in learning opportunities submitted with peer learning compared with score-based peer review. Blue horizontal lines denote mean, red horizontal lines denote upper and lower confidence limits.

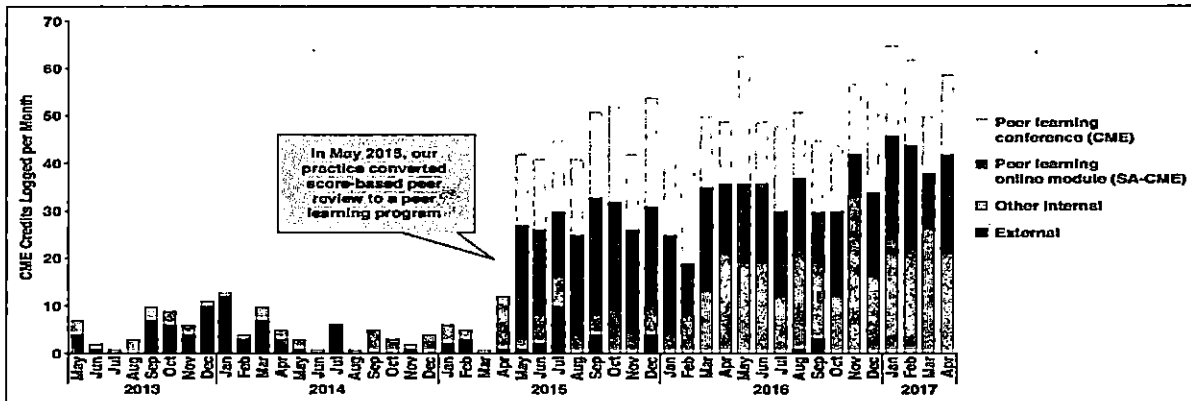


Fig. 4—Continuing medical education (CME) credit logged into internal education system by month and event type. SA-CME = self-assessment CME.