Implementation of Peer Learning in a Small Academic Practice
Strategy, Outcomes and Next Steps

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Our experience with scored peer review....

- Not blinded to the reviewed radiologist
- Reviewed radiologist can figure out who did the review
- Reviewer has a stake in the current interpretation
- Reviewer has already formed an opinion of the case by the time they look at the prior
- Findings can be more conspicuous in retrospect
- Tension
- Distrust
- Bias
- Career concerns

- Limited participation
- Underreporting
- Judgement orientation
- Minimally useful (99% concordant)
Our peer review meetings....

- One meeting per month
- All radiologists and residents
- Adopted hospital peer review model: Standard of care met?
- Radiologist often presented his/her own cases
- Generated anxiety
“Examining Peer Review”

Facilitated session, asking:

• What do you value about your work in radiology?
• How does peer review fit in with those values?
• What do you appreciate about peer review?
• What deters you from participating in peer review?
Peer Feedback, Learning, and Improvement: Answering the Call of the Institute of Medicine Report on Diagnostic Error

organizations seek to identify incompetent professionals and when peers are used as the vehicle to identify the outliers, relationships between professionals are compromised, since peers are placed in an adversarial position relative to each other as they render judgments that are used to determine professional competency. To preserve these relationships, professionals often do not fully cooperate with the instructions to rate their peers' performance. System-level feedback

Another element that is rarely discussed is the emotional toll that the scoring-based peer review model exacts on radiologists. Those who claim that a scoring-based model is “nonpunitive” generally do not include in their definition of “punitive” less tangible aspects that are inherently associated with medical error, such as feelings of anxiety, shame, and humiliation. Even the threat of such negative experiences can have an extremely powerful negative effect on professionals whose personal identities are often tightly linked to their professional performance (43). Since no professional is perfectly all-perfect.
How do we get there from here?
Peer learning program development....

1. Elicited group’s values & preferences
2. Assessed our stakeholders
3. Defined program components
4. Developed program operations
5. Ensured peer review protection
6. Clarified path to compliance
7. Invited support
8. Staffed the logistics
9. Manage change
2. Assessed our stakeholders

• Radiologists, hospital leadership, accreditation bodies
• Why is peer review important to them? What need does it meet? Who do they need to answer to?
• What will be negotiable? What will be non-negotiable?
• Who will support this change? Who might be reluctant? Who are the naysayers?
2. Assessed our stakeholders

• Radiologists: Comfort and learning
• Hospital leadership: Error identification and improvement. Compliance with error reporting requirements (DPH). Competency.
• ACR/TJC: Error identification. Individual and systems improvements
3. Defined program components

Fundamentals:
1. Sequestered all peer learning cases from performance evaluation
2. Encouraged submission of all cases with learning opportunities, whether discrepancies, great calls, or systems issues (instead of random reviews)
3. Replaced numeric scores with qualitative descriptors
4. Set expectations for educational non-judgmental feedback and sharing of cases
3. Defined program components

Variables:
• Participation: All diagnostic radiologists required to participate in submission and conference attendance
• Method of submission: Electronic
• Subspecialization of reviews/conference: Yes
• Submitting radiologist anonymity: Yes
• Disclosure of cases to individual radiologists: Yes
• Method of sharing cases: In person conferences with teleconferencing
• Interpreting radiologist anonymity in conferences: Yes
• Records: Minutes, anonymized cases, just teaching points
• CME offered: No
• Scored peer review continues? No
• Incentive: Part of OPPE metrics, not financial

4. Developed program operations

• Needed to bring program to scale
• Paper-based or multiple application processes lacked necessary efficiency
• Worked with vendor to develop software that would allow management of the peer learning process within PACS
  • Case Submission
  • Case Review
  • Communication with radiologist
  • Conference preparation
  • Conference presentation
• Requisite component of our program’s success

https://www.youtube.com/watch?v=aNPkYlOBc3Y
5. Ensured peer review protection

- Consulted with local medical-legal expert
- Wrote policy using recommended language
- (Note: Specifics will be state-dependent)

6. Clarified path to compliance

- ACR Accreditation
  - Peer learning as an alternative peer review model
- Joint Commission
  - OPPE - development of alternative measures, currently using participation
  - FPPE - establishment of a **prospective** scored peer review process
- Hospital-level:
  - Reporting: commitment to hospital to report all SRE and events requiring disclosure
  - Peer review: establishment of an internal peer review committee
  - Credentialing: scored FPPE and alternative OPPE measures
7. Invited support from leadership

- Identified who needs to be involved:
  - CMO for Quality and Safety
  - Chief Patient Safety Officer
  - Hospital Peer Review Committee
  - Credentialing Committee leadership
  - Medical Staff Office leadership
- Met individually
- Articulated how peer learning help meets IOM goals
- Addressed their concerns:
  - Identification of error
  - Remediation of patient care
  - Assessment and remediation of radiologist competency
  - Compliance with JC, DPH, ACR and other standards

http://www.actfurniture.com/boardroom_tables.html
8. Staffed the logistics

- Administrative support essential
  - Schedule conferences
  - Reminders
  - Attendance
  - Manage minutes
  - In our case, also the person who manages FPPE/OPPE administrative tasks

- Administrative time for physician reviewers
9. Culture eats strategy for breakfast.

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Peter Drucker
So.... how’s it going?
Results:
Transition to peer learning significantly increased learning opportunities submitted

Case Submissions Before and After Peer Learning Implementation
(April 2014-March 2016 vs April 2017-March 2019)

5658 Cases reviewed in scored peer review (99% concordant); 2055 peer learning cases
Results:
Transition to peer learning significantly increased learning opportunities submitted

- Quarterly subspecialized conferences, teleconferencing available
  - Increased from 10 to over 30 conferences a year
- Quarterly whole department meetings: focused on systems issues
  - First annual “Celebration of Success” meeting December 2019
  - Profound effect of sharing positive cases on attendees
Our next steps

- Amplify learning through great calls
- Determine roll for rad-path correlation
- Start analyzing our data for trends
- Share lessons learned outside of live conference attendance
- Improve documentation of value-added, particularly regarding systems improvements

https://carey.jhu.edu/carey-the-torch/2017/05/3-lessons-learned-from-running-a-small-business/
Thoughts for the future of peer learning

- Require fundamental program features, allow others to vary.
- Include imaging 3.0 activities in fundamental features: systems improvements should be documented and shared
- Develop a guide to development and implementation with supporting resources
- Define alternative objective quality metrics for individual MDs to replace scored reviews
- Pool results (both diagnostic and systems improvement) across institutions to identify trends—importance of common data elements
- Apply trends to educational and AI initiatives
