

DEVELOPING AN EVIDENCED-BASED
PEER REVIEW POLICY

by

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October 2010

DEDICATION

I dedicate this clinical project and paper to my three sons, Brian, Jeff, and Ross Marty. Thank you for your support, encouragement, and humor.

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ABSTRACT

A peer review process was encouraged by a National Veterans Health Administration internal review team as a way to assess quality of care and documentation and also promote improvements in nursing care, collegiality, and job satisfaction. The first step in the development of a peer review process was a literature review and policy development. A Peer Review Committee was formed and used evidence to develop a policy that was used to develop a peer review process. The committee used an effective group change model to educate and acquire the acceptance of the Rocky Mountain Region Home Telehealth team regarding peer review. The policy received approval and the process was piloted by the Peer Review Committee.

CHAPTER 1

INTRODUCTION

The Committee on the Quality of Health Care in America detailed the “chasm” between the quality of health care Americans receive and the quality of care we could expect (Institute Of Medicine, 2001). Peer review is one internal process to assess and document quality of care. Using the information gathered through the peer review process, quality of health care can be improved. Peer review was identified as a possible tool to monitor and document the care provided by registered nurses during a Veterans Health Administration (VHA) review of the Care Coordination Home Telehealth (CCHT) program in October 2008. It was determined that a peer review policy developed by registered nurses would enhance the standardization of processes and procedures and provide for staff involvement, satisfaction, and professional development. The goal of the development of an evidence-based peer review policy for Home Telehealth nurses is to help ensure veterans receive the quality of care they deserve.

Peer Review

Peer review is defined by Marquis and Huston (2009) as “when peers rather than supervisors carry out monitoring and assessing work performance” (p. 580). Peer review is part of an overall evaluation process for staff. Peer review can be seen as a “developmental method of evaluation. That is, the employees are involved in the development and implementation process” (Yoder-Wise, 2007, p. 299). Staff

involvement in the entire process, from the original discussion to policy development and implementation, and, finally, to evaluation of the peer review process, is essential. The staff must take a very active role. Marquis and Huston (2009) discussed inherent difficulties that must be addressed prior to implementing a peer review process. These difficulties or issues can be addressed by ongoing, frequent staff discussions and problem solving through group interactions. It is important to note some of the key issues: tools must be standardized and easy to use, staff must receive a thorough orientation, and specific guidelines about data collection must be clearly articulated to the staff. These challenges must be addressed in the initial discussion and policy.

The value of developing a peer review policy and further establishing the process of peer review is based on the belief that “nursing has an obligation and accountability to monitor the quality of nursing care and to ensure that standards of practice are followed” (Fujita, Harris, Johnson, Irvine, & Latimer, 2009). Most organizations monitor the quality of nursing care by the review of agency or facility nurse-sensitive measures. This ignores the individual nurse’s practice, which is more difficult to measure and evaluate. Peer review can measure this practice and monitor accountability and quality of care.

Currently, no VHA standards for nursing peer review exist; however, other professions, such as VHA psychologists, do use a peer review process. The Joint Commission on the Accreditation of Healthcare Organizations (2010) requires a peer review process called “focused professional practice evaluation” for initially requested privileging and thereafter as needed for physicians; again, there is no such requirement for nursing. One form of peer review for professionals is used in the VHA when an

untoward or sentinel event, such as an unexpected death or serious injury, occurs. The peer review process in this situation reviews the actions of professionals in relation to the actions surrounding the event.

Statement of the Problem

The VHA Rocky Mountain Region (or Network), which includes Montana, Wyoming, Utah, and Colorado, is a health-care organization committed to a culture of safety. It is within this culture that development of a peer review process was first envisioned. The Care Coordination Home Telehealth (CCHT) program uses in-home technology to monitor veterans' chronic disease symptoms and vital signs as well as provide education, encouragement, and care coordination. The CCHT program focuses on the veterans most in need of this help—the chronically ill, many of whom live in very rural areas of the western United States. The twenty-seven care coordinators are registered nurses located across more than 525,000 square miles. Each care coordinator has a panel of 60 to 100 patients whom they monitor, call frequently, and provide with appropriate services. These care coordinators function independently; they are in isolated offices often with no other professionals from the CCHT program in the facility.

CCHT is a very large program within the VHA system. National, regional, and facility goals and expectations are difficult to monitor. The goals are initiated at the national level and are presented to the regional and local staff with expectations for quality, cost-effective care for veterans. There is an expectation that goals will be met while strictly following the standards of clinical practice.

An individual nurse's adherence to the standards is especially difficult to monitor. It is also challenging to provide the educational and technical support and collegiality needed for nurses to have high job satisfaction. Job satisfaction is imperative to retention of well-trained and qualified nurses (American Nurses Association, 2005). The Rocky Mountain Region has suffered from staff turnover during a time when it has seen a high rate of growth in veteran numbers. The growth of CCHT also increased as the VHA recognized the benefits of Home Telehealth in controlling costs associated with frequent admissions for the exacerbation of chronic conditions. Staff turnover and program growth have led to differences in individual and facility processes. For example, documentation and coding of encounters can vary, leading to differences in data collection. Staff turnover and isolation have also led to lower job satisfaction among the CCHT nurses. The goal of the peer review process is to address these issues. The nurses and managers in CCHT would like to use a peer review process to help ensure patient safety, standardize procedures and policies, learn and share best practices, and provide professional support. The first step toward addressing these goals is the development of a policy.

Purpose

The purpose of this project is to develop an evidence-based peer review policy for telehealth nurses in the VHA that addresses evaluations of individuals in the entire Rocky Mountain Network CCHT team. It is anticipated that the peer review process will assess and document critical thinking and patient safety, identify learning needs, and provide

increased staff satisfaction through the assessment of individual practices. This will ultimately enhance patient care, promote job satisfaction, and decrease turnover.

CHAPTER 2

LITERATURE REVIEW

Peer Review

A review of the literature, using as primary sources CINAHL, PubMed, and Medscape, produced some qualitative but no quantitative research that addressed peer review. The terms peer review, assessment, nurse satisfaction, policy development, and telehealth were searched. The specific topic of remote peer review with community-based registered nurses using telehealth technologies was not addressed in the literature.

Peer Review is the term often used to evaluate personnel after an untoward event occurs when using a root cause analysis approach (Diaz, 2008) or in referring to the assessment of articles prior to publication. This author eliminated articles dealing with root cause analysis or the critiquing of research and publications. The literature review concentrated on articles documenting a background of peer review information, the establishment of peer review policies and processes, qualitative research investigating the best peer review processes, telehealth, and job satisfaction.

The literature has a multitude of articles that provide suggestions for initiating a peer review process. Davis (2009) encouraged the development of a process that is most effective “if it has a grassroots design and staff buy-in” (p. 254). Input from other nurses, such as in a peer review, can increase individual and group accountability (Davis, 2009). Diaz (2008) encouraged peer review based on nursing standards with a focus on improvements in processes and systems (p. 475). Briggs, Heath, and Kelley (2005)

suggested an evaluation tool that closely reflects the “values and expectations of the individuals to be reviewed” (p. 4). Much of the literature is anecdotal writing about inpatient units that have established a peer review process. No models dealt with a community or home model in a very rural environment. It is important to note that the available literature reviewed also did not include research involving the VHA or telehealth care models using peer review. A search of VHA sites and documents on the topic of peer review noted peer review was used to evaluate sentinel events, in which case the peer review is part of the root-cause analysis of the issue.

A variety of methods are used to assess the competency of nurses. Wright (2008) detailed eleven specific methods, including exams, return demonstrations, case studies, exemplars, presentations, discussions, and peer review. Peer review is used to measure “interpersonal skills, as well as critical thinking skills” (Wright, 2008, p. 95). Critical thinking enhances nursing practice and patient outcomes (Forneris & Peden-McAlpine, 2007).

The American Nurses Association (1988) defined peer review as follows:

Peer review is an organized effort whereby practicing professionals review the quality and appropriateness of services ordered or performed by their professional peers. Peer Review in Nursing is the process by which practicing Registered Nurses systematically assess, monitor and make judgments about the quality of nursing care provided by peers, as measured against professional standards of practice.

Wright (2008) describes the functions of peer review as an evaluation and reinforcement tool. The evaluation of individual nurses and of programs or departments and oversight of the entire process, are the goals and consequences of peer review.

Peer review of individual nurses to improve quality of care has been used in a variety of health-care situations, and the conclusion is often that nurses should be reviewing their own care against nursing standards (Hogston, 1995; Harrington, 2008). Peer review could be what Melnyk and Fineout-Overholt (2005) described as a self-improving practice: “it is the goal to achieve this self-improving practice through science and experiential clinical learning and correction, rather than a closed or deteriorating tradition that repeats errors” (pp. 169-170). To decrease errors and increase patient safety, the nursing profession must take steps to ensure adherence to standards. It is concern for the standards of patient safety that turns nurses to peer review. Diaz (2008) encouraged a peer review process to establish a "culture of safety" (p. 475). Hogston (1995) encouraged nurses to be in the forefront of reviewing quality of nursing care, lest nurses “become agents of health economists, who will utilise quantitative data which may preclude indications of the real quality and value of nursing care” (p. 163).

Nurses work together as a team to accomplish positive patient outcomes. Yoder-Wise (2007) defined a “Team” as a “very special type of working together” that requires effective communication to confront issues and solve problems or tasks (p. 348). Using a team approach, peer review “establishes quality nursing care as being the domain of nurses and not managers” (Hogston, 1995, p. 168).

The literature focused on the value and need for nurses to be involved in a professional peer review process. Davis, Capozzoli, and Parks (2009) documented that the peer review processes enhance the quality of relationships between professionals and fosters a positive work environment. Nurses must trust and respect each other to

willingly and enthusiastically be involved in the peer-appraisal process (Yoder-Wise, 2003, p. 299). It is this collegiality and professionalism that will aid in staff satisfaction and nurse retention.

The literature offered several recommendations for the successful establishment of a peer review process. Ringerman, Flint, and Hughes (2006) advocated staff meetings at every step to keep nurses involved, enthusiastic, and comfortable with the peer review process. The staff meeting allows the nurses an opportunity to provide input and share information or concerns. Nursing staff must understand the purpose of the peer review; the stated purpose will guide the development and implementation of a peer review policy and tool (Briggs et al, 2005). Briggs et al. (2005) also discussed the benefits of explicit reviews. The explicit peer review has very strict criteria for auditing the patients' charts, which is in contrast to an implicit review, which is based on informal perceptions and "gut feelings." Nurses must quantify the quality of care that is delivered with tools and guidelines identified in the policy. The policy must also include details to deal with any negative findings or safety problems. A process of constructive feedback must be developed to encourage patient safety and satisfaction, staff growth, and program excellence.

The peer review process must be formalized and objective as well as quantitative, so managers see its value (Hogston, 1995), and, since peer review is a process, it should be continually improved to ensure the appropriateness of the tool and value to the patient, the nurse, and the organization. All of these suggestions must be addressed during policy development.

Veterans Health Administration and Telehealth

The Veterans Health Administration is a large and complex health-care organization, serving 5.6 million veterans per year (Darkins et al., 2008). Within the VHA structure, the registered nurse care coordinators are tasked with providing the guidance and oversight for care to veterans via telehealth technologies. Telehealth is integrated into primary care and mental health in the VHA system (see Appendix A for a brief organizational chart of the Rocky Mountain Region Home Telehealth structure showing the relationship between care coordinators, who are registered nurses, and providers with veterans). The veterans who are targeted for these services are individuals who are frequent users of services and rural veterans.

The VHA defines Care Coordination:

A process of assessment and on-going monitoring of selected patients using Telehealth proactively enables prevention, investigation, and treatment that enhances the health of patients and prevents unnecessary and inappropriate use of resources. This process allows for the appropriate information to be communicated to providers and the healthcare system to assure the right care, at the right place and at the right time. (Office of Care Coordination Services, 2010)

Veterans are initially assessed for the CCHT program using criteria based on hospital admissions, number of medications, and emergency room visits. These criteria identify veteran patients who have a high risk of hospital readmission. Once these basic admission criteria for CCHT are met, the veteran is further assessed, including a consult from the provider ensuring interdisciplinary collaboration.

Care coordination is an integrated approach where registered nurses use the nursing process to assess, plan care, provide interventions, and evaluate that care for

veterans with the help of technology. Specifically in Home Telehealth, the veteran has a small computer, called a Health Buddy, which interfaces with the home phone service. The Health Buddy is manufactured by Health Hero/Bosch. Daily, the computer pulls information and education for the veteran to read and provides questions for the veteran to answer (see Appendices B and C for information on the device and an example of the questions). The vendor, in this case Health Hero/Bosch, collects the information and transmits it to the nurse's desktop via a secure web site (see Appendix D for Decision Support Tools). The data is risked to easily identify problems that must be addressed (Health Hero/Bosch, 2010). Care coordination is provided by registered nurses from VHA facilities to the veteran's home. The care coordinator, a registered nurse with specialized training, reviews patient input daily from the Health Buddy and follows up with veterans who have a risk identified from the technology questions or data entered by the veteran.

The veteran is assigned a Disease Management Protocol (DMP). The DMP consists of a set of questions most appropriate for the diagnosis or problem that is to be monitored. The veteran logs on daily and may input vital signs, relevant information, such as if the veteran took all of his medication in the last twenty-four hours, or symptoms, for example increasing depression or suicidal thoughts. The nurse uses the office computer to log on to the secure vendor web site daily to receive updated information from the veteran. Following a review of the information or data, the registered nurse will determine if follow-up is needed. Generally follow-up is via a phone call to the veteran. The phone call includes a discussion about improving self-

management and determining whether there is a need for early intervention or support. The care coordinator will then follow up by making referrals to appropriate services and documentation of the care interventions. The care coordination model emphasizes early assessment and intervention while promoting self-management and cost control.

Waldo (2003) suggested that remote monitoring allows for cost-effective, quality care that also creates a bond between the patient and provider. The nurse knows his/her panel of patients. It is critical that the registered nurse recognizes changes or concerns that require follow-up. Dansky, Vasey, and Bowles (2008) noted that remote monitoring allows nurses to efficiently detect changes, intervene, and help patients with self-management skills. The patients must be educated that Home Telehealth is not emergency care; rather, it is a non-urgent mechanism to help them improve their self-management skills with the help of a registered nurse.

Care coordination, with the help of monitoring devices, has been shown to reduce bed days of care in the Rocky Mountain Region of the VHA by 89% in fiscal year 2010 (VHA Support Service Center, 2010). Bed days were calculated by comparing the veteran's bed days of care in the year prior to enrollment in CCHT to the year after enrollment.

The Veterans Health Administration has a sophisticated medical record system. The primary method of communication is via the Computerized Patient Record System (CPRS). This system includes health-care provider notes, labs, and test results from VHA facilities and the Department of Defense. The nurses within this CCHT program document all patient encounters in the patient record. After the registered nurse

completes and signs the CCHT intervention note in the CPRS, he or she can electronically notify providers or other VA personnel who will receive an alert indicating they have a note to read and sign. The interdisciplinary cooperation documented in the patient's record is essential to the coordination of services as well as the documentation of services provided.

Job Satisfaction

Job satisfaction is defined and measured in many ways. The nursing profession has a number of assessment tools that have been developed to measure job satisfaction, including the Home Healthcare Nurses' Job Satisfaction Scale (Ellenbecker & Byleckie, 2008) and the Nursing Workplace Satisfaction Questionnaire (Fairbrother, Jones, and Rivas, 2010). Ellenbecker, Byleckie, and Samia (2008) noted that "all of the available evidence suggests that nurses' job satisfaction is composed of multiple constructs" (p. 153). Some of these factors such as feeling valued by other professionals, providing quality care, being a member of a team, and being heard by leadership are often more important than schedules, pay, and personalities. Professional autonomy is crucial in achieving job satisfaction (Ellenbecker et al., 2008, p. 161). Furthermore, the hospital structure itself may be an impediment to job satisfaction: "The bureaucratic cultural norm of hospital, with its hierarchical structure, rules, and regulations, and heavy emphasis on measurement of outcomes and costs, may not be the culture most conducive to enhancing nurses' job satisfaction and commitment" (Gifford, Zammuto, & Goodman, 2002, p. 13).

The peer review process is designed to emphasize the individual professional's work and the value of excellent patient care and improved outcomes. When nurses work together, they can support and complement each other. They also “help reinforce behaviors we would like to see in our teams” (Wright, 2010, p. 95). These are the outcomes the CCHT nurses are looking for with the implementation of a peer review process.

In the current environment of increased patient panel requirements coupled with a shortage of nurses, retaining well-trained, experienced nurses is a priority. Enhancing the quality of work life may be more important in improving nurses' job satisfaction and retention than improved compensation and benefits strategies (Gifford et al., 2002, p. 13). Enhancing the quality of work life requires managers to gain insights into the current state of the staff and their work. Manager involvement and insight is “essential to developing a more engaging workplace that is characterized by high-performing, creative and fully activated staff” (Nelson, Batalden, & Godfrey, 2007, p. 122).

The involvement of managers in the development of the peer review process will help them understand the role, work, and frustrations of the CCHT nurse. The manager will be better equipped to provide the support that is needed and subsequently improve the job satisfaction of the nurses.

Policy Development

Organizational vision and mission statements guide policy development. Policy statements direct the development of guidelines, protocols, and processes. In the VHA,

policies are usually developed at the unit level and go through a prescribed chain of review before final approval. According to Marquis and Huston (2009), “policies are plans reduced to statements or instructions that direct organization in their decision making” (p. 158). These policy statements set guidelines and boundaries for action within an organization. Marquis and Huston (2009) divided policies into implied and expressed policies. Expressed policies are delineated, orally or in writing, and are available to staff to encourage “consistency of action” and outcomes (p. 159). The involvement of the affected staff is essential to policy development and ultimate success. Staff must have input throughout the development and implementation phases of a new policy: “Input from subordinates in forming, implementing, and reviewing policy allows the leader-manager to develop guidelines that all employees will support and follow” (Marquis & Huston, 2009, p. 159). It is through this policy development phase that the organization and most especially the staff involved begin to understand how work flow, documentation, and care will change.

CHAPTER 3

POLICY PROPOSAL

As discussed in the previous chapters, the development of a peer review policy is the first step toward initiating a peer review procedure. The Lewin (1947) model of change served as the model for developing the peer review policy and process. The Lewin model is a classic model that has stood the test of time and is used to understand the change process. The Lewin model identifies three phases for planning and implementing an organizational change: 1) unfreezing, 2) experiencing the change, or movement, and 3) refreezing (Lewin, 1947). The Peer Review Committee used each of the three phases when planning, developing, and implementing the peer review policy during this policy development project. Unfreezing refers to the awareness of a need or problem and the understanding of the appropriate actions needed for change. Lewin used examples of planned social change and group dynamics to illustrate how groups are motivated and make decisions. The change or solution is developed in the second stage, when the group experiences the change (Lewin, 1947). The refreezing in regard to the development of the peer review policy occurred during the pilot phase of the project implementation. Following successful implementation of the pilot testing phase, another cycle of the Lewin model will then commence.

In his classic article, Lewin (1947) discussed the relationship between the parts that make up the group characteristics. Group or social management takes into account all these parts or factors in planning change. Without considering the parts or

individuals, “it seems impossible to predict (or anticipate) group behavior” (Lewin, 1947,p.12).). The assessment of the group characteristics begins the “circular causal process of change” (Lewin, 1947, p. 22).

Needs Assessment

The need for a peer review policy and subsequent process was first addressed during an internal telehealth VHA review of the Rocky Mountain Region Care Coordination Home Telehealth programs in October 2008. The VHA surveyor visits, evaluates, and provides program development assistance to each program every two years. The VHA Telehealth programs are not reviewed by other accrediting agencies unless a Joint Commission tracer follows a veteran who is discharged with care coordination services or had these services prior to an admission. The VHA surveyor noted differences in the procedures of the nurses in carrying out their CCHT interventions and documentation. The reviewer suggested peer review as a mechanism to identify these differences, identify best practices, and begin a standardization of processes and procedures. Discussion with the team of CCHT nurses also uncovered other expected benefits of peer review. The Home Telehealth nurses wanted to increase the collegiality of the group and identify best practices. The nurses expect increased job satisfaction and a final outcome of enhanced patient safety.

Policy Development

Establishing a peer review process was identified as a strategic goal of the Rocky Mountain Region Home Telehealth program during a strategic planning session in June 2009. Very broad guidelines were described by the strategic planning group. The development of the peer review policy was undertaken in a committee of six CCHT nurses; the author served as the chair of the Peer Review Committee. The nurses represented each of the facilities in the Rocky Mountain Region and had broad and diverse nursing backgrounds. The committee met monthly for 10 months. Initially, the committee reviewed and discussed the literature regarding peer review. In addition, the Peer Review Committee reviewed the available research and developed a plan for the policy development, considering the unique features of the VHA and CCHT. The committee worked with the assumption that chart review would be the best practice, considering the geographical distances between the peers. The committee agreed that the policy and documentation guidelines would be completed by January 2010 and that they would be the cohort for the pilot test of the peer review process by March 2010. Reports were given to the entire CCHT team, consisting of approximately 30 registered nurses, on weekly conference calls. Discussion was encouraged in both the committee meetings and team calls, and lively dialogue occurred. The Peer Review Committee used the standard VHA format to develop a policy that was reviewed by the entire CCHT team twice over the course of policy development and again before policy adoption. The policy was approved by the Network Care Coordination Telehealth Council (see Appendix E for the policy).

The entire Home Telehealth team of registered nurses was informed of the progress of the Peer Review Committee work during weekly team conference calls. Concerns expressed by the group were concerns about logistics and also how the committee, facility, or VHA would use the results. The team was repeatedly reassured that the peer review process was non-punitive and would be used to document successes, as well as areas where education, training, or clarification were needed. Nurses were informed that if safety issues were identified, the peer review process would immediately cease, and the appropriate supervisor would be notified. It is hoped that the peer review process would provide validation of the excellent care and documentation that is ongoing in this program, while identifying best practices for areas needing improvement.

The care coordinators were trained and completed the required documentation so that they could view the Computerized Patient Records System (CPRS) throughout the VHA Rocky Mountain Region. The training was an interdisciplinary endeavor led by the author and the Information Security Officers (ISO) at each facility. The ISO is responsible for ensuring that the patient records are secure and available only to those who have a documented need to have access to these patient records.

Home Telehealth is dependent on data and input from the veteran through a vendor. The VHA has contracts with four vendors for CCHT equipment. Currently the most popular equipment in the Rocky Mountain Region is the Health Buddy model from Bosch. The Health Buddy is a small computer that is connected to the World Wide Web through telephone lines to the VHA secure intranet. The vendor sites stratify the veterans' inputs for the CCHT registered nurses to review and intervene by contacting the

veteran via telephone. The care coordinator provides necessary interventions and documents the encounter.

Using the vendor sites and the CPRS, the nurses are able to look at their colleague's interventions and documentations to accurately review the care provided to the veteran by the care coordinator for the purposes of peer review. Each registered nurse is able to review the assigned colleague's interventions and documentation from his or her own work area at a convenient time. This peer review process will occur throughout the Rocky Mountain Region by all care coordinators on a quarterly basis.

The names of the nurses and the registered nurse peer reviewer are selected randomly by the regional data analyst. The data analyst uses a patient SharePoint site to randomly select the three patients per nurse that the colleague would review. The data analyst and the program manager are the only people who have access to personally identifiable information. When the completed peer review assessment tool is loaded into the SharePoint site, the document and attached names are no longer visible to anyone with general access to the site. The peer review assessment tool was developed as part of the Peer Review Committee work (see Appendix F for the peer review tool). It is anticipated that the assessment tool will have revisions as the policy is initiated and the peer review process evolves (see Appendix G for the process outline).

Implications

This peer review policy in the Rocky Mountain Region will have local, regional, and national significance with regard to patient safety, nursing satisfaction, and process

standardization. It is important to note that the peer review policy, with subsequent pilot, was the first use of peer review used as an evaluation process for individuals and groups of nurses in the Rocky Mountain Region. The 27 registered nurses on this team provide care to approximately 1,600 veterans daily. The data collected will inform managers and administrators that the appropriate intervention and documentation required of CCHT nurses is taking place. This process will augment the current evaluation process by managers, providing the manager with appropriate and timely documentation from the staff who know the CCHT program very well. It is anticipated that this policy will be adopted for social workers within the CCHT program and for other staff in various telehealth programs in the Region and nationally (see Appendix H for VHA description use approval).

It is anticipated that this project will have a significant impact upon VHA Home Telehealth nurses' job satisfaction as well as retention of experienced nurses. Follow-up data will include percentage of required notes completed, appropriateness of interventions, a nursing satisfaction survey, and retention rates. This data will be compared to available national data, and areas of concern will be addressed with education and remediation. It is anticipated that nurses will value input from colleagues who understand the program requirements. The registered nurses will gain insight into their own practice as well as that of colleagues. Finally, it is anticipated that the quality of interventions will be optimized using shared best practices, which will be identified by positive outcomes such as decreased bed days of care and positive nurse satisfaction.

The weekly team conference call for all the care coordinators from the Rocky Mountain Region is an engaging place to discuss and adopt this policy.

This policy can be used by other VHA Regions or private entities to establish peer review processes. Also, this policy model can serve as a guide to other health-care organizations. It will also serve to encourage other nurses to establish a peer review process. As stated by Briggs et al. (2005), "The hallmark of a true profession is the ability to self- regulate" (p. 3).

CHAPTER 4

CONCLUSIONS

The policy formation process was undertaken to begin a peer review process for CCHT within the VHA's Rocky Mountain Region. The policy was developed after extensive review of the literature and discussion. The policy development process itself has led to nurses' engagement in the discussion and anticipation of peer review evaluation. Additional outcomes will be analyzed as the process is adopted by the other professionals involved in telehealth in the Rocky Mountain Region and across the VHA. The Rocky Mountain Region will be encouraged to collect satisfaction data as well as information on patient safety and initiation of best practices to document the outcomes of peer review.

As a participant in the development of this peer review policy, this author learned a significant amount about the process of leading a team through an endeavor that can be threatening and exciting at the same time. One of the greatest challenges was the lack of time for the committee and pilot team to engage in this project. It is very satisfying to complete the policy that will be used to better veteran health care and provide the registered nurses with an evaluation process they are proud of and look forward to using.

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APPENDICIES

APPENDIX A

ORGANIZATIONAL CHART, CCHT VHA
ROCKY MOUNTAIN REGION

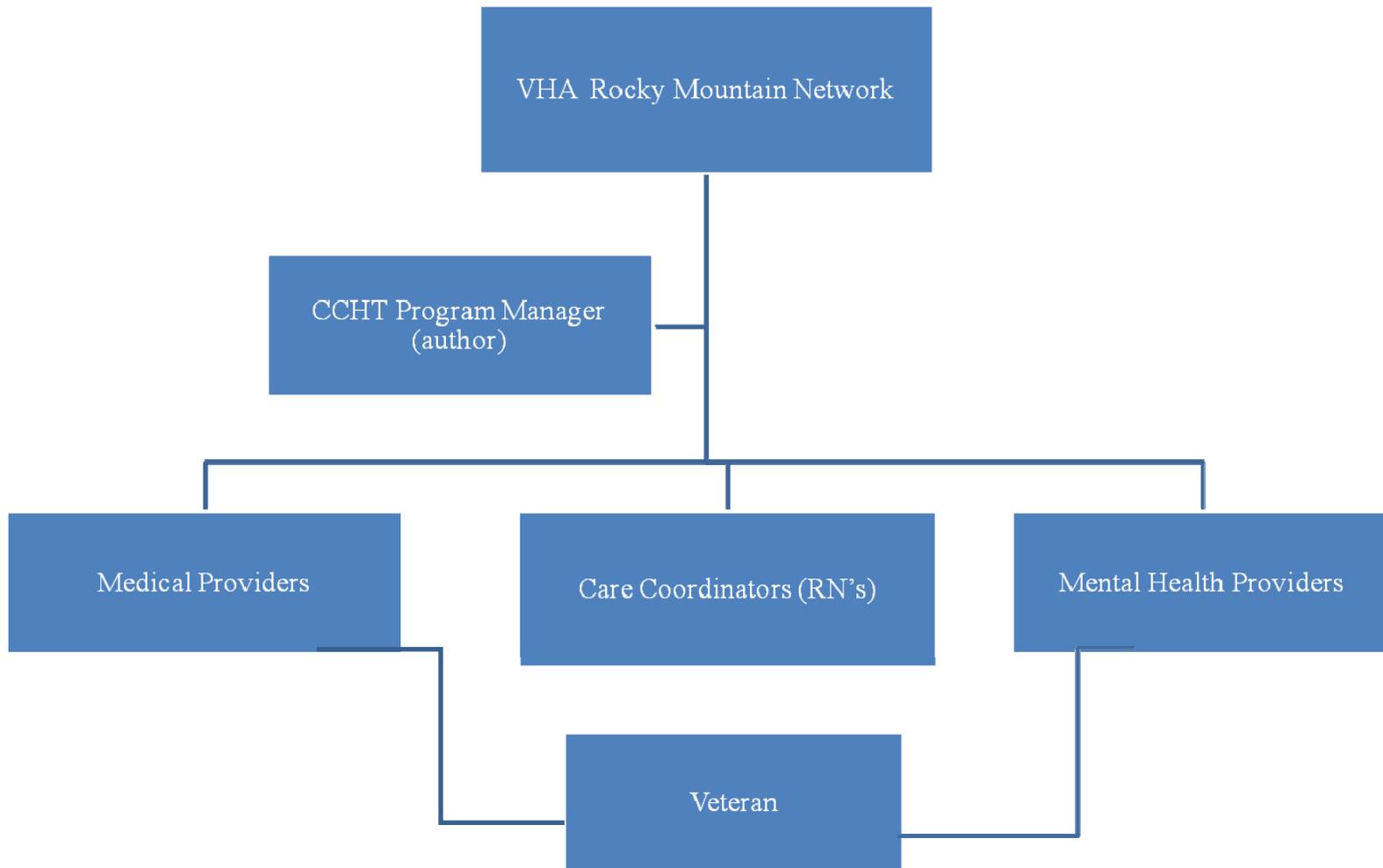


Figure 1. Organizational Chart, Care Coordination Home Telehealth (CCHT)
VHA Rocky Mountain Region

APPENDIX B

HEALTH BUDDY DEVICE

HEALTHBUDDY[®]Summary

Robert Bosch Healthcare's health management programs are uniquely designed to focus on monitoring, self-care, education and patient guidance. Each program is designed to collect standard outcome measures, including utilization, patient satisfaction, quality of life, compliance and individual patient population reporting. The health management programs, based on standard practice guidelines, are delivered via monitoring technologies such as the Health Buddy[®] appliance, to assess and educate patients, enhance medication compliance and improve patient behaviors. Robert Bosch Healthcare offers over 100 different programs, which have been used in tens of thousands of patient homes across the nation.

Signs & Symptoms • Behaviors • Knowledge

A health management program contains three categories of questions that measure a patient's signs and symptoms, behaviors and knowledge. Questions about signs and symptoms allow the care provider to assess the patient's physiologic status. Behavior and knowledge questions provide data on a patient's understanding and management of his or her health condition(s). The result is a unique model of care that captures the patient's overall health status. With daily feedback on patient status, care providers can identify patients at risk for exacerbation and intervene appropriately to avoid emergency room visits and hospital admissions. Educating patients and encouraging active

participation in self-management of their chronic conditions can modify high-risk behaviors. The continuity of care provided by the Health Buddy® appliance and health management programs helps establish a partnership between patients and providers for better healthcare with controlled costs.

Dynamic Branching

Health management programs are designed to deliver questions that include dynamic branching to varied responses. The dynamic branching can include further assessment questions, additional information, motivation, education, reinforcement, reminders and incentives for patients. A dynamic branching diagram is show below.

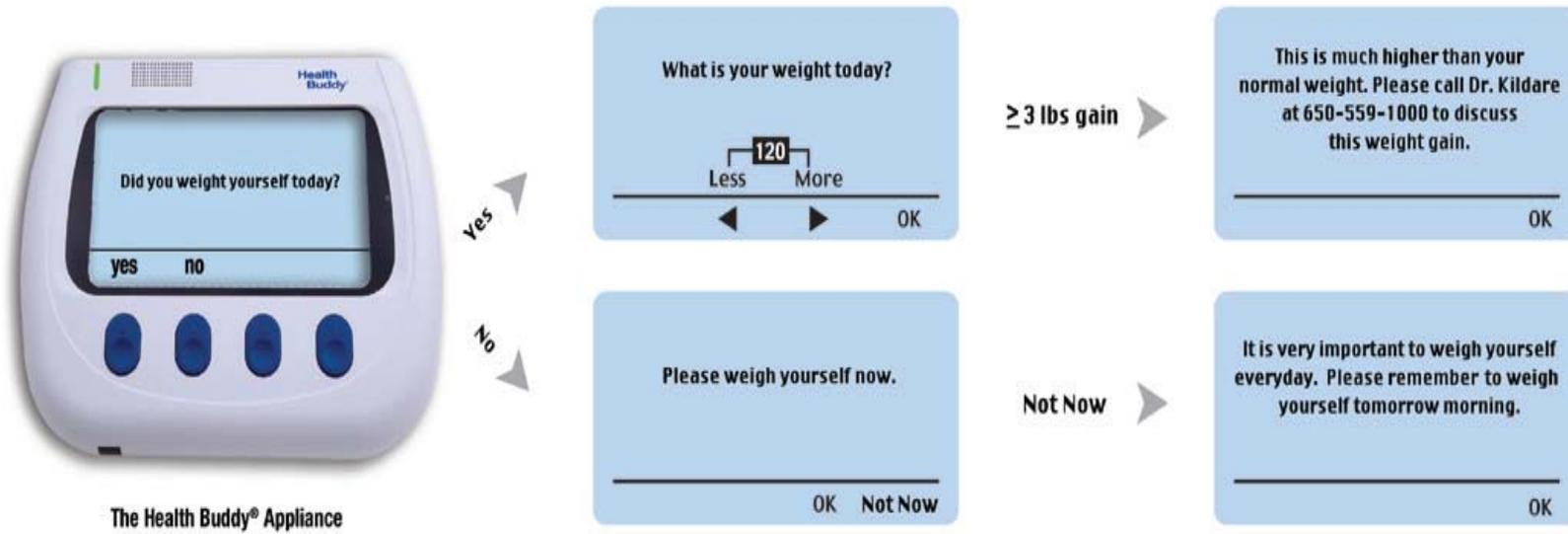


Figure 2. Dynamic Branching Diagram.

APPENDIX C

EXAMPLE OF HOME TELEHEALTH QUESTIONS

EXAMPLE OF QUESTIONS FOR A DIAGNOSIS
OF CONGESTIVE HEART FAILURE

1. Hello, how are you feeling today?
 - a. Great
 - b. OK
 - c. Poorly*

2. (Poorly) Please tell us why you are not feeling well.
 - a. I am short of breath*
 - b. I did not sleep well
 - c. I don't know

3. (Short of breath) Do you have ankle swelling?
 - a. Yes*
 - b. No

4. (Yes) Have you taken all of your medications in the last 24 hours?
 - a. Yes
 - b. No

5. (No) why have you not taken your medications in the last 24 hours?
 - a. I forgot
 - b. I am out of some or all of my meds

Please input your weight from this morning

The branching questions continue in a similar fashion for 8-10 total questions each day. The Veteran would be instructed to call the care coordinator, registered nurse, after some of the responses. The care coordinator will also see these responses and call the veteran as needed.

APPENDIX D

HEALTH BUDDY DESKTOP

DECISION SUPPORT TOOLS
HEALTH HERO REGION
WWW.HEALTHHERO.COM

SUMMARY

Health Hero Region's decision support tools, such as those found in our Health Buddy® Desktop, are

Internet-enabled patient management tools that care providers use to manage patients with chronic illnesses. Health Hero Region's decision support tools offer clinical trends, risk stratification, and the ability to efficiently monitor large groups of patients with multiple chronic diseases. These tools provide secure access to a series of features and reports that are designed to risk-stratify patient populations, enabling care providers to improve clinical outcomes and quality of life while managing the total cost of care.

HEALTH BUDDY® DESKTOP – HOW IT WORKS

Care providers simply log into the Internet-enabled Health Buddy® Desktop with a user name and password. No special software needs to be installed at the care provider location. Care providers assign health management programs to patients based on their chronic condition(s). These personalized programs are communicated via monitoring technologies (the Health Buddy® appliance) and include questions to help monitor and assess a patient's clinical condition. Patient data can be sent back to care providers immediately, at a pre-determined time, or based on a specific patient response. The data is sent through a secure data center where it is then available for review on the Health Buddy® Desktop.

QUICKLY IDENTIFY AT-RISK PATIENTS

Health Hero Region's decision support tools are designed to quickly risk-stratify and present patient results, enabling proactive providers to intervene before a patient's condition becomes acute. Patient responses are color-coded by risk level as High (red), Moderate (yellow) and Low (green) based on symptoms, patient behaviors and self-care knowledge.

Table 1. Decision Support Tools.

Responses on Wednesday, July 23, 2003						
Patient	Response Time	Symptoms	Behavior	Knowledge	General	
Carey, Doug	02:58 PM PDT	High	High	High	None	
Chamura, Mark	09:38 AM PDT	High	High	Medium	None	
Schmidt, Anna	03:07 PM PDT	High	Medium	High	None	
Fish, John F.	01:09 PM PDT	High	Low	Medium	None	
Flock, Kimberly	10:43 AM PDT	High	Low	Medium	None	
Rubenstein, David	05:14 AM PDT	High	Low	Low	None	
Kawahara, Aolani	02:17 AM PDT	Low	High	Medium	None	
Chen, Ying	11:46 PM PDT	Medium	Medium	High	None	
Linton, Lloyd L.	06:19 PM PDT	Medium	Medium	Medium	None	
Nguyen, Thanh	03:20 AM PDT	Medium	Medium	Medium	None	
Parish, Jason M.	12:55 AM PDT	Medium	Medium	Low	None	
Chen, Angela	07:22 PM PDT	Medium	Low	Medium	None	
LeSur, Vincent A.	05:29 PM PDT	Low	Medium	Medium	None	
Barone, Rodrigo	01:02 AM PDT	Low	Medium	Medium	None	
Smith, Elle	08:31 AM PDT	Low	Medium	Medium	None	
Spencer, Sharleen A.	06:36 PM PDT	Low	Medium	Medium	None	

Result of Day 46 of 360 day Comorbid CHF/DM Program from Comorbid CHF/DM Program Taken on Tuesday, Jan 06, 2004 08:39 PM America/Los Angeles				
Risk	Question	Response	Category	Aspect
	Hi Laurie! Thank you for coming back! Your Health Buddy is here for your health. Begin when you are ready.	continue	General	None
low	Did you weigh yourself today?	Yes	Behavior	Weight
	What is your weight today? (Use the arrows to indicate your weight)	118	Symptoms	Weight
high	This is higher than your usual weight. This could be a sign that your body is retaining fluid. One cause of fluid retention is eating foods that contain too much salt.	Okay	Symptoms	Weight
	Remember to limit your salt intake and take your medications exactly as prescribed by your doctor. Also, weigh yourself every day, at the same time, wearing the same amount of clothes.	continue	Symptoms	Weight
	Also, please call your case manager to discuss this mistake	continue	Symptoms	Weight

TREND AND REPORT PATIENT DATA

The Health Buddy® Desktop provides a number of trend graphs, numeric data tables and patient reports that allow care providers to understand, respond to and communicate patient data to other healthcare professionals. Care providers can create summary reports on individuals or groups of patients including compliance, patient trend, and result reports, as well as many others.

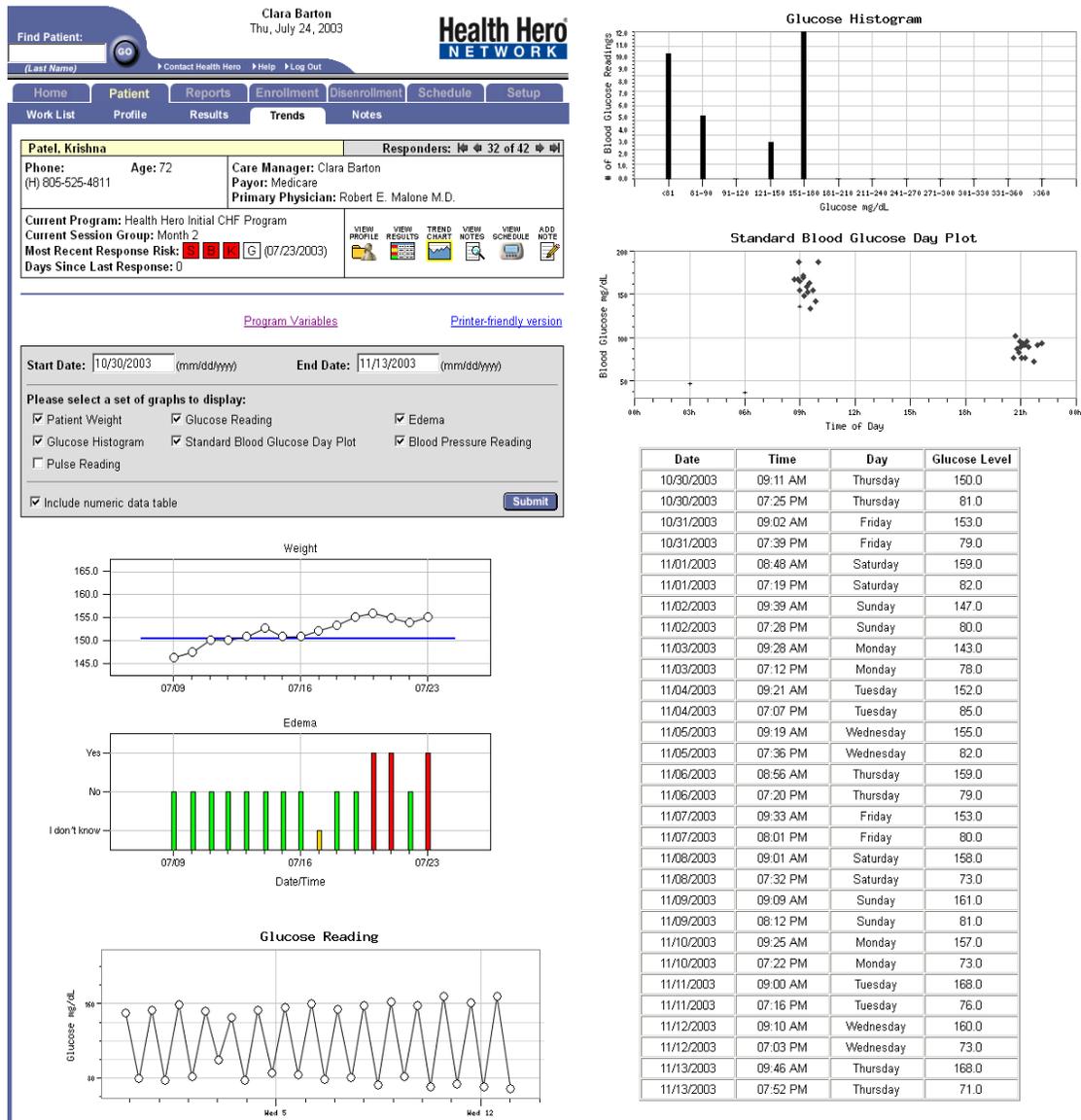


Figure 3. Health Buddy Desktop: Graphs, Tables, and Reports.

Task- Oriented PATIENT MONITORING

Our decision support tools enable true paperless data collection and disease management by improving the frequency and quality of data collected without increasing administrative burdens. Audit trails, designed to enhance healthcare organizations' compliance with HIPAA privacy regulations, allow care providers and administrators to track which patients have been reviewed, when and by whom. A task list offers care providers improved workflow and the ability to quickly and easily focus on high and medium risk patient responses, which are triggered by a specific patient response to selected questions.

DESIGNED FOR VERSATILITY

With their versatile design, Health Hero Region's decision support tools can be applied to a wide range of disease areas, disease management systems and patient populations. Care providers can efficiently manage a larger patient population while delivering customized care to each patient daily. Our tools are designed to allow care providers to use their current care plans, algorithms, policies and procedures.

APPENDIX E

PEER REVIEW POLICY

Department of Veterans Affairs

November 17, 2009

I. Subject: Peer Review Process for VISN 19 Care Coordination Home Telehealth Program

II. Purpose: This Care Coordination Home Telehealth (CCHT) policy establishes a Peer Review process for the Care Coordinators in this program. It is designed to ensure quality and safety in the VISN 19 CCHT Program by assessing the individual Care Coordinators (CC) practice. This process will also promote collegiality among the staff, document program quality, and identify best practices in CCHT.

III. Action: It is VISN 19 CCHT policy that all facilities' CCHT program will implement the standardized Peer Review process and engage in VISN training and evaluation of this process.

- A. Care Coordination Telehealth (CCT) Manager: Provide the leadership to ensure The Peer Review policy development and process adherence. Reports to VISN Leadership.
- B. CCHT Program Manager:
 - i. Ensures a confidential, random process for selection of CC and veterans' records to be reviewed
 - ii. Ensures data is reported to CC, facilities, and VISN Leadership
 - iii. Ensures safety and quality issues are addressed in a timely manner, while maintaining confidentiality as appropriate
 - iv. Coordinates the ongoing Peer Review policy, process, and tool evaluation and revision
 - v. Provides frequent updates and clarification as needed on the weekly CCHT Team calls
- C. Care Coordinator:
 - i. Receives quarterly assignments and thoroughly reviews vendor and patient records to complete Peer Review tool
 - ii. Maintains confidentiality of information regarding other CC, patient records, and results
 - iii. Notifies the Program Manager immediately of suspected patient safety issues

A confidentiality statement will be on each quarterly Peer Review document. Once each quarter (every 3 months) the Data Analyst or Program Manager will forward the names/code/ individual identifier to the reviewer Care Coordinators with the identification of three of the reviewed CC patients identified. The reviewing CC will have access to all the facility CPRS documentation and the vendor's web sites. The reviews will be completed and loaded into the CCHT Share Point within 2 weeks after the information is sent from the Data Analyst or Program Manager. The items to be assessed will be identified by the Peer Review committee for the items to be identified, and forwarded to the data analyst to include with the assignments.

The information will only be available to the VISN 19 CCHT Program Manager (PM), Program Analyst, and the CCT Manager. If there is any ethical or professional question about patient safety, the PM will contact the CC clinical supervisor.

If there is a question about individual or team remediation needs, training will be provided and follow-up monitored, using the same monitoring items again in the next quarter.

APPENDIX F

PEER REVIEW ASSESSMENT TOOL

Care Coordination/Home Telehealth Quarterly Peer Review

Care Coordinator being reviewed: _____
 #2 ___ #3 ___ #4 ___

FY Quarter: #1___

Reviewer: _____

DATE REVIEW COMPLETED: _____

*Instructions: VISN 19 CCHT staff will randomly select then send each reviewer a list of Home Telehealth patient charts to be reviewed via encrypted email. Only currently enrolled charts of active patients enrolled within the past year, are eligible for review. This Peer Review form is to be downloaded from the CCHT Sharepoint, completed, and refiled in the designated CCHT Sharepoint site at [link here]. Most information can be easily located by selecting CPRS – view – Signed Notes by Author. **If a patient safety issue is identified, VISN Program Manager is to be notified via phone call or encrypted email immediately.** Please evaluate your peer using 0= Not done, 1=poor, 2=meets criteria, and 3= excellent or NA in the box next to the appropriate patient number.*

1. Within the past 3 months, when a red flag appears on the vendor website, there is generally appropriate Care Coordinator follow-up
2. Within the past 3 months, when there were multiple identical alerts on the vendor site, they were addressed at least monthly
3. A detailed note has been written and submitted to the provider at least every 90 days (Non Video Intervention/Summary of Episode)
4. Initial assessment is complete with all identified concerns addressed, Ex: smoking cessation consult
5. NIC evaluation/re-evaluation is done at least every 6 months.
6. A 683 (Non-Video Monitor Review/summary of Episode) note is done monthly.

Patient Number 1,2,3 or NA COMMENTS and COMPLIANCE (percent)

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Length of time to complete 3 reviews:

APPENDIX G

PEER REVIEW PROCESS

EVIDENCE-BASED PEER REVIEW POLICY DEVELOPMENT

1. During an October 2008 an interval VHA Telehealth review, peer review was suggested as a way to may improvements in the Home Telehealth program.
2. A strategic planning session in June 2009 identified peer review for the CCHT registered nurses as a priority.
3. Shortly after a Peer Review Committee was formed of five RNs and the author.
4. The Peer Review Committee met monthly, for ten months, and reviewed progress with the entire team during weekly team conference calls
5. The peer review policy was approved in February 2010.
6. The Peer Review committee piloted the policy and process in March 2010 with some revisions recommended:
 - a. Clarify the privacy process in the policy
 - b. Reformat the peer review tool for easy of completion
 - c. Allow 2-3 weeks to complete the peer review to allow for vacation and schedule issues
 - d. Give immediate feedback to the team after a peer review is complete
7. The first team peer review was completed in May 2010 and we made some minor revisions for clarification in the tool. The policy was followed and the process was very positive for the registered nurses.
8. The second quarterly peer review will be in October 2010.

APPENDIX H

ROCKY MOUNTAIN NETWORK, VISN 19

**Department of
Veterans Affairs**
VISN 19, Rocky Mountain Network

Memorandum

Date: October 19, 2010
From: Care Coordination Telehealth Program Manager, VISN 19
Subj: Permission to use descriptions of VA programs for class paper
To: Dr. Kinion, Elizabeth, EdD, MSN, APN-BC, FAAN, Bozeman Campus Director and Professor

It is my understanding that Claire Marty has completed the process of developing a peer review policy for our organization as part of her master's project. I further understand that all of the student's projects are submitted to Montana State University online service.

Permission is granted to use descriptions of the VHA, Rocky Mountain Network, and Care Coordination Home Telehealth in this paper.



Jeffrey R. Lowe