

Best Practices for Enhancing Quality

Most states protect doctors involved in hospital peer review. Still the professional working relationships among doctors make peer review difficult. Doctors do not want to review colleagues for fear of criticizing their friends and possibly being censured in return. It's also more work, often uncompensated, that takes time away from treating patients. Despite existing peer relationships, probable conflicts of interest, and busy practices, doctors reluctantly participate. Some feel that by participating in a peer review panel they are being forced by a hospital and credentialing organizations to give subjective decisions that can ruin careers. As a result, peer reviews often aren't completed—or worse, substandard care becomes acceptable in the interest of “getting along.”

Burdened with internal politics, including personal and economic conflicts of interest, peer review is at best complex and at worst combative. Conflict of interest is a persistent issue to overcome whenever colleagues work at the same hospital and conduct peer reviews. Most hospitals, and even hospital groups, commonly lack a deep pool of specialist medical knowledge within the range of specialty areas they provide because they just have too few specialists. The doctors on a peer review panel in the best position to evaluate a colleague generally face conflicts of interest because partner relationships or economic competition make it difficult for them to render objective case decisions based solely on the medical facts while disregarding personal biases or feelings.

Culture is another aspect of patient safety, care quality, and peer review that is hard to address when seeking improvement. The common beliefs, values, behaviors, and traditions shared within a hospital form its patient safety and quality care culture. Effective peer review requires doctors to change tradi-

tional thinking and behavior, as well as their role and self-image. But achieving continuous improvements in patient care often means changing the cultural. For improvement to occur in an environment, a culture of vigilance must be matched with the flexibility to adjust the peer review processes for the patient's benefit. That's why setting up best management practices is increasingly important.

What are best practices for peer review?

Peer review has a long history, but quality-improvement techniques for enhancing quality of care initiatives have only been in use for about a decade. Today the two work hand in hand, and peer review best management practices are emerging that hospitals need to consider. Obviously, the base-line of best practices is for the hospital and peer review to meet all mandated state and Federal laws and to follow stated hospital policy, as well as the guidelines documented in its peer review manual. Beyond that are many other best practice considerations for improving the process.

Look at a peer review process like a business process. This approach provides a system for adjusting and “fixing” things to improve both the efficiency and effectiveness of the process and, by doing so, the quality of care. Make sure that it provides:

- *Consistency* with hospital policy and a fair standard for referring all peer review cases.
- *Timeliness* as defined by the peer review panel manual and hospital policy. Often peer review is driven by case volume and conducted monthly or quarterly.
- *Objective, defensible conclusions* citing current

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literature, hospital policy, and external perspective when needed.

- *Balance* so that minority opinions and views of the physician reviewed are considered and recorded.
- *True peer review* so that an orthopedic surgeon is not evaluated by a gynecologic surgeon, but a peer orthopedic surgeon.
- *Useful action* suggestions so the physician under review has the opportunity to improve techniques, skills, and abilities to achieve the needed level of competency.
- *Regular auditing* increases the quality of patient care, reduces liability, and can also address any negative publicity from the media or vociferous family concerns on the Internet. It also identifies any peer review system breakdowns and provides the committee and the hospital with new information and suggestions to improve the effectiveness of the peer review system.

Connect peer review to credentialing. Making sure that all physicians meet the threshold criteria and that any questions about their credentials, behavior, references, training, and education are received from primary sources helps

filter out potentially troublesome physicians before they get into a hospital. Once accepted, however, notes about any disciplinary actions resulting from peer review must go into an offending doctor's credential file to become part of the physician's next credentialing cycle.

Clearly define terms and expectations. Definitions of terms like quality of care, quality of service, citizenship, resource utilization, patient safety, professional conduct, standards of practice, and professional and peer relationships can vary from hospital to hospital, and by professional experience and background. Characterizing these, establishing expectations, and defining the policy and process for referring peer review cases creates an environment of mutual accountability among the medical staff and helps reduce the perception of capricious and subjective peer review.

Clearly establish the roles and responsibilities of the peer review committee. Members of the peer review committee must understand their roles and responsibilities to the committee, the hospital, and their profession. These ought to be outlined in the required peer review manual and can also serve to set overall expectations and tone for clinical and professional conduct within the hospital.

Create a sense of urgency for peer review. Making peer review an educational process means proactively detecting problems early and then acting quickly to re-educate a physician. When a hospital acts with a sense of urgency, most doctors will be receptive and make appropriate adjustments to their clinical practice patterns and behavior. Fear of acting, delays, and inattention worsen the problem and make the process confrontational and harsh action more likely. Issues that could have been resolved earlier by education can later be resolved only using more severe corrective action. Maintaining a sense of urgency and clearing time to meet in advance will help the hospital avoid confrontation and conserve its economic and political resources.

Assure that the peer review committee is trained. This provides the peer

review committee members with the specialized knowledge to confidently perform timely peer review. Training helps reduce the committee's uneasiness about performing peer review and can reduce delays or indecision about making peer review decisions. The training should offer the committee clear guidelines for identifying the applicable standard of practice; how to determine whether medical care in a case fits the standard of care or not; how to determine whether the medical documentation provides a basis for peer review; how to attribute causality (if any); whether poor clinical judgment increased patient risk; and what subsequent actions to take and when.

Address disruptive physicians quickly. Hospital leaders often vacillate about reviewing a disruptive physician. Besides considering the internal politics, they are reluctant because the "behavior" for the review can appear too subjective for a peer review action. Despite this, a hospital cannot ignore its legal obligation to take action to protect the safety of patients and the hospital staff from the disruptive behavior of a physician. Clearly defining in advance what constitutes "disruptive behavior" and the evidence needed to show an "adverse affect" on patient care in a hospital is necessary to accomplish this.

Use peer review as an educational process. Many doctors see peer review as confrontational, subjective, and punitive. Using it as a way to educate individual physicians as well as the staff in general means that it's integrated into the hospital's overall quality care processes. Educational peer review, for both the doctor and the hospital, is a tool for identifying, tracking, and resolving inappropriate clinical performance and medical errors in their early stages. This only increases patient safety and overall quality of care.

Consider compensating doctors for peer review participation. Peer review places additional demands on a physician's time. Hospitals that find a way to compensate doctors for their extra effort partially remove the dread of the extra work.

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Commit physicians to the peer review committee for a minimum of two years. Consider the first year as one of learning the process. By the second year, doctors know what they are looking for and better understand how the process works.

Watch the data trends. Looking at the trends for every doctor in the hospital and seeing whether they fall within the standards that the hospital has set establishes quality patient care consciousness and adjusts the process when needed. Reasons for doctors falling outside the norm must be understood also. Those who do fall outside the norm may need to upgrade their skills. In addition, not only are the trends in the individual hospital important to know, but physician performance outside the hospital in other institutions is well worth knowing, too. This knowledge can help a hospital maintain its quality of care.

Use like specialists. Finding a suitable "peer" or "like specialist" within a hospital group or small community is sometimes impossible. If one does exist, more than likely there are issues surrounding personal or professional relationships, perceived competition for

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patients, or other conflict of interests. Yet to conduct a legitimate peer review, it's important for the physician under review to be judged by a "true peer," that is a physician in a similarly sized hospital with similar capabilities and in exactly the same medical specialty. Sometimes it is necessary to go outside the hospital to find the needed expertise.

Review randomly selected case charts on an ongoing basis. Randomly pulling charts and reviewing them tightens the link between peer review and overall hospital quality. It helps take subjectivity out of the review equation making doctors feel better about it because everyone's work is continually reviewed. It also provides insights into any statistical data trends—and reinforces peer review as an educational process.

Consider "templating" the process as a model for others. The "template" outlines the processes needed and sets expectations, while allowing each hospital to adjust as needed. One advantage of "templating" is that it helps assure a higher degree of conformity among groups of hospitals. It gives others a model of the processes to follow so that all hospitals within the group know what is expected. Although the "templating" process can take time to implement, it assures consistency across groups of hospitals.

Establish policies for referring cases for external review. Given the responsibility to maintain high quality standards and impartiality, it's important that hospitals and other healthcare providers have an objective and expert resource for evaluating quality of care concerns or controversies. Many hospitals are

moving toward including an independent review organization (IRO) as an unbiased external review authority and as a best practice whenever there is:

- Doubt about the case analysis.
- A perceived economic or other conflict of interest.
- A need for a second opinion or outside perspective.
- A pool of specialists that is small or when no appropriate "peer" is available.
- A physician under review making an appeal.
- No one on the staff qualified to review a particular specialty.
- A need for objectivity about disciplinary action
- New technology being used that the staff is inexperienced with it.
- A high likelihood of litigation
- Either a general or specific concern about clinical outcome.

Today many risk and quality managers in hospitals understand these issues; an increasing number of them are turning to external reviews to ensure their peer reviews remain unbiased.

Conclusion

Peer review best practices processes won't tip the balance of the healthcare cost and quality scales immediately, but it is one of those "fix it at the source" solutions that can have a significant impact long term. Without an exacting peer review process, it's impossible for a hospital to continually improve its patient safety and quality of care. Appropriate and ongoing peer review evaluations require hospital decision-makers to assess not only an individual doctor's performance but a number of clinical and procedural processes that influence a hospital's effectiveness on a continuing basis.

Peer review best practices are a basic mechanism for quality care and

COMMON BARRIERS IMPEDE PEER REVIEW

Organizations that help hospitals set up better peer review processes identify common barriers that obstruct the process. Below are some things to avoid:

- Establishing a peer review system with negative, rather than positive, medical staff leadership.
- Making peer review a disciplinary process, rather than educational one.
- Not approaching peer review with a sense of urgency.
- Decentralized peer review structure.
- Not having a peer review manual.
- Picking an inappropriate peer reviewer for the review.
- Not establishing or enforcing standards of practice and professional conduct.
- Poorly defined or unclear rules for referring a case into the peer review process.
- Reviewing reported incidents of disruptive physician conduct versus scrutinizing them.
- No real policy for external peer review.
- No useful and sufficient data for the review.
- Breakdowns in analyzing data trends.
- Not connecting peer review information with re-credentialing and regular evaluations.
- Not auditing the peer review process.

should make it easier for hospital boards, administrators, and medical staff officers to fulfill their legal obligation to provide quality care to patients, while at the same time protecting the hospital and medical staff from legal damages. **IPSQH**

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