White Paper:
Improve Your Peer Review Effectiveness

For Hospital Groups, ASCs and Specialty Medical Facilities

Executive Summary

The peer review process serves to ensure that physicians are properly credentialed, competent, and trained to safely treat patients. Unfortunately, many hospitals only perform peer review on cases with poor outcomes, which does not identify and track inappropriate clinical performance and medical errors in their broader context. Effective peer review relies on a solid framework that clearly defines the peer review process and emphasizes effective leadership and a supportive culture, efficient operations, efficient evaluations, and compliance with accreditation standards. When properly executed, peer review can reduce medical errors through ongoing, objective evaluations performed in a nonpunitive, educational context that supports a healthy culture of continuous improvement. Increased transparency and accountability is a byproduct of physicians knowing that their work will be objectively evaluated at regular intervals, thereby leading to improved quality of care and patient safety. Self-assessment of its peer review program allows the hospital to identify the strengths and weaknesses in its existing framework and to implement changes as needed in order to ensure that their practitioners are providing the highest standard of care.

Introduction

Effective, proactive, educational peer review requires a strong framework. Many hospitals take a reactive approach to peer review, reviewing only cases with negative outcomes and missing opportunities to identify and track inappropriate clinical performance and medical errors in their broader context, in order to prevent their future occurrence. As a result, many poor practice patterns are not discovered until a bad outcome occurs, if they are discovered at all.

Leadership does not fully support the peer review process and/or views it negatively, this results in hesitation to follow it except in the most difficult cases. Organizations that only conduct peer review in isolated/reactive manner can compromise the effectiveness of the program.

A uniform, detailed framework not only facilitates the peer review process, but also makes peer review a more objective, definable process. Effective peer review relies on a number of factors that fall under four major categories, including:

- Effective leadership and a supportive culture
- Efficient operations
- Effective evaluations
- Compliance with accreditation standards

Working together, each of these components is essential to the success of hospital peer review. Self-assessment of your peer review process can help your hospital to identify the strengths and weaknesses in your system, pinpointing areas that need improvement.

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Leadership/Culture

Administrative and Medical Staff Leadership

Breakdown

Administrative and medical staff leadership often view the peer review process as slow, cumbersome, ineffective, and, in many cases, punitive. This results in hesitation to follow it except when required by negative outcomes. Organizations that only conduct reactive peer reviews can end up with a punitive culture in which there are no opportunities for critique and constructive feedback.

Best Practices

The peer review system should be structured as a joint venture between the medical staff and administration and strongly supported by the hospital's leadership team. This allows the medical staff and administration to create a strong peer review framework that addresses their respective concerns and issues and accommodates the hospital's structures, services, data capabilities, and political environment.

Effective peer review relies on a solid framework that clearly defines the peer review process and emphasizes effective leadership and a supportive culture, efficient operations, efficient evaluations, and compliance with accreditation standards.

The key to effective peer review is leadership's support for developing a strong process that is proactive in nature. A proactive approach to peer review facilitates identification and resolution of potential problems at their onset, thereby increasing patient safety and the quality of patient care. Commitment to continuous improvement through education, rather than punitive actions, promotes a culture that is open and honest about deficiencies.

Practitioners and Staff

Breakdown

Some hospital cultures may be so focused on physician authority and autonomy that the medical executive committee (MEC), peer review committee, medical staff, or administration may be reluctant to review a physician's performance through the peer review process. A survey of nearly 3,000 physicians, published in the *Journal of the American Medical Association* in 2010, found that about one third who knew of an incompetent colleague did not report the person to the relevant authorities, even though the American Medical Association (AMA) has a code of ethics that states that doctors have an ethical obligation to report such behavior. Reasons for not reporting included the belief that someone else would take action, the belief that nothing would happen as a result of a report, and the fear of retribution.

Best Practices

Peer review should provide objective evaluations in a nonpunitive, educational context that supports a healthy culture of continuous improvement. Educational peer review, for both the practitioner and the hospital, is a tool for identifying, tracking, and resolving inappropriate clinical performance and medical errors in their early stages. Ongoing evaluation of physicians can also uncover problematic practice patterns, as well as physician- and hospital-level issues that need to be addressed.

Increased transparency and accountability results from physicians knowing that their work will be objectively evaluated at regular intervals, thereby leading to improved quality of care and patient safety and, over time, reducing a hospital's professional liability claims and costs. A strong framework for peer review, with clearly defined performance expectations

and objective processes, provides practitioners and staff with the knowledge that any concerns they raise regarding a practitioner's performance will be taken seriously and fully investigated by medical staff.

Peer Review Operations

Peer Review Oversight

Breakdown

Most hospitals initially refer cases to department peer review committees, which frequently lack staff representation. Peer review committees often act with little oversight from the MEC and some physicians simply do not have the training or experience to conduct effective peer review, resulting in a lack of uniformity in the peer review process, as well as inconsistent application of protocols and procedures across all specialties. Many hospitals do not have policies regarding external peer review, and some hospitals simply have too many committees, which bog down rather than facilitate the peer review process.

Best Practices for Effective Oversight

In most hospitals, the peer review system is described in the medical staff bylaws, in a peer review policy and sometimes in medical staff policies and procedures. The bylaws should clearly define the structure, policies, and procedures for both internal and external peer review. Well-written bylaws clearly define the purpose of the medical staff and outline the rights and responsibilities of its members; enhance credentialing, privileging, peer review, and performance-improvement processes; and set unequivocal expectations for appropriate behavior.

Effective peer review requires a centralized multidisciplinary peer review system that utilizes a uniform method for peer review activities. The peer review system should be designed with a strong multidisciplinary peer review committee established as a subcommittee of the MEC, which is ultimately responsible to the board for ensuring that the peer review program is carried out by its medical staff in accordance with the intent and procedures documented in the organization's peer review policies. The peer review committee should have overall jurisdiction for the operation of the peer review system, assuring the MEC that all required peer review procedures and required program elements are effectively implemented. This is especially important for identifying and eliminating conflicts of interest (COI). Hospitals should provide peer review committee members with proper training, and they should also streamline the peer review process by limiting the number of committees.

All peer reviews should be completed within 30 days of initiation, and ideally within one week. Hospitals should make arrangements to have a review conducted externally if it lacks adequate physician resources to conduct timely performance analyses.

Turnaround Times

Breakdown

Hospitals often have a limited number of qualified staff to conduct reviews, and involvement in a peer review committee presents yet another time-consuming responsibility to add to an already overloaded schedule for many physicians. Heavy workloads often delay the peer review process, preventing the implementation of quality-of-care improvements that the process is intended to oversee. In some cases, reviews are not given the attention they require.

Best Practices for Timely Reviews

All peer reviews should be completed within 30 days of initiation, and ideally within one week. Hospitals should make arrangements to have a review conducted externally if it lacks adequate physician resources to conduct timely performance analyses.

Practitioner Evaluation

Performance Expectations

Breakdown

In many cases, hospitals do not clearly define or monitor what is expected of the members of the medical staff. Practitioners do not know how they are being measured unless a common set of expectations are defined. Without these expectations, peer review decisions may appear arbitrary or even capricious.

Best Practices for Performance Expectations

The hospital and medical staff should jointly define what is meant by quality of care, appropriate resource use, patient safety, professionalism, and accountability for active participation as a team member in the care system. Setting these expectations ensures that practitioners are treated uniformly and held up to the same standards, while ongoing monitoring helps to promote practitioner compliance with these expectations—practitioners may resist and/or protest the hospital's findings and actions even when they are legitimate.

The peer review process carries inherent COI arising from social or professional relationships or from too few physicians being available in a particular specialty.

Once the medical staff leadership has set and communicated practitioner performance expectations, they must ensure that all physicians know that their performance will be measured, how it will be monitored, and how it will be compared to that of their peers.

Evaluations of practitioner performance should be conducted regularly and not just at the time of re-appointment, and data should be maintained for all practitioners.

Some cases may require further investigation of a practitioner's performance. Hospitals must identify triggers for focused evaluations and apply them consistently. All deviations from performance expectations should be investigated, with action taken when warranted. Examples of cases or events that might trigger peer review include:

- Unexpected patient death
- Complication
- Delay in diagnosis or treatment
- Wrong site or wrong patient procedure
- Disruptive practitioner behavior
- Inadequate hand-off among practitioners
- Missed or wrong diagnosis
- Serious patient complaint

Evaluations of Practitioner Performance

Breakdown

The peer review process carries inherent COI arising from social or professional relationships or from too few physicians being available in a particular specialty.

Best Practices for Evaluating Practitioner Performance

Hospitals must have a comprehensive COI policy that clearly defines both real and perceived COI and how it is to be avoided. Physicians conducting reviews should be educated about all potential COI issues. Hospitals must understand the web of economic, competitive, and social or personal relationships that might raise concerns. Whenever a reviewer is in a professional partnership, competes for patients, or socializes with the physician undergoing review, the question of COI arises. An educated reviewer will alert the committee chair when a conflict exists and request an alternate reviewer. If a suitable one is not available, the committee should seek an external peer review. Specific provisions should be made for the use of external peer review when peer review committee members are compromised by COI, when a practitioner under evaluation is in a position of authority on the medical staff or MEC, or whenever the sensitivity of the case makes it difficult for the peer review committee to objectively evaluate cases.

Potential COI are not limited to any one particular specialty. Many hospitals must deal with a limited number of specialists on staff, which increases the potential for professional or personal relationships, just as smaller hospital groups and hospitals in smaller communities face the challenge of matching specialists because the pool of specialists is smaller and the potential for COI is higher.

To meet quality-of-care guidelines, ensure objectivity, and bring about positive outcomes to protect patients, practitioners must review only others who are "like specialists." That is, cardiologists should review cardiologists, not other internal medical specialists. Similarly, general practitioners may not have the training or experience in the multidimensional approaches to treatment or have the most up-to-date information for standards of care used in specialties such as interventional cardiology or neurosurgery. An evidence-based approach requires review of actual work performed by a specialist with the same credentials and practice experience.

Accreditation Standards

In 2007, the Joint Commission instituted new standards for monitoring performance and intervening when safety and quality-of-care concerns are identified. According to the standards, hospitals of all sizes are required to demonstrate that objective decision-making is in place in the credentialing and privileging of their physicians. The Joint Commission requires two types of reviews to ensure physician competence: ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE). Case-by-case peer review is not sufficient to meet the Joint Commission standards. Focused and ongoing evaluations often involve analyses of clinical practice patterns, using evidence-based and comparative data when available. The data to be evaluated in these analyses and the trigger points for peer review must defined by the hospital and the medical staff and documented in the hospital bylaws and rules/regulations, along with required processes and procedures. In addition, practitioner competence must be evaluated in all required areas.

Evaluating Your Peer Review Program: An Ongoing Process

The Peer Review Scorecard helps hospital medical staff, quality professionals, and peer reviewers perform a self-assessment of their peer review framework and identify areas for improvement. Using a simple rating scale, hospital staff can quickly identify the strengths and weaknesses of their organization's peer review program and pinpoint areas needing attention. The findings provide the basis for taking remedial action with individual physicians when appropriate, as well as for developing action plans to address essential follow-up issues and deficiencies. Ongoing, periodic re-assessment allows the hospital to measure progress and to fine-tune their peer review program as needed.

Hospitals should develop procedures to turn to external peer review as required by their own particular circumstances. Hospitals with high volume and few willing or qualified reviewers may decide to outsource all cases in a particular specialty, or a certain number of cases at regular intervals, quarterly, semi-annually, or annually. Cases in which internal reviewers cannot reach a conclusion or a consensus should be subject to external peer review, as should unresolved quality issues related to a particular department, procedure, or practitioner. In addition, cases in which physician behavior or demeanor may have impacted clinical outcomes would benefit from objective outside review by a peer with no prior personal knowledge of the physician.

Conclusions

Hospitals continually face the challenge of monitoring and evaluating the quality of care that their practitioners provide. Although peer review has long been regarded as an essential component of safe and effective patient care, the process often suffers due to lack of internal expertise, COI, heavy workloads, and unclear or inconsistent standards. In order to weather today's uncertain economy and the increased scrutiny they face, hospitals must consistently measure, monitor, and compare practitioner performance, while fully complying with accreditation standards.

Bibliography

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