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Hospital Peer Review Guide IV:

Taking Control of Peer Review

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Components of a Peer Review System Infrastructure

A strong infrastructure is the key to taking control of a hospital's peer review system and conducting effective, proactive, educational peer review.

The peer review systems of many hospitals only review cases with "bad outcomes" i.e. unexpected outcomes, complications, egregious cases, reported cases and other obvious cases. This type of reactive peer review process often does not identify and track inappropriate clinical performance and medical errors at their onset. As a result many aberrant practice patterns are not discovered until a bad outcome occurs, if they are discovered at all.

A uniform, detailed infrastructure consists of many components that not only facilitate the conduct of peer review itself, but make peer review a more objective, definable process. Each of these components, working together, is essential to the successful operation of the hospital peer review system.

Specifically, an effectual infrastructure is:

- Established in writing in sufficient detail to provide a comfort level to the medical staff leaders and administrative personnel required to act
- Supported by an effective centralized control mechanism that monitors cases in the system
- Enhanced by a multidisciplinary structure
- Based upon compliance with standards of clinical practice and standards of professional conduct adopted by the medical staff and the hospital administration
- Operated by participants (medical staff and administration) trained in peer review with an understanding of the legal consequences of peer review activities
- Conducted uniformly with respect to each member of the medical staff in a timely fashion
- Conducted with protocols for referral of cases and practitioners into the peer review system
- Structured with a strong External Peer Review Policy and a fair Policy for Peer Review by Business Associates
- Conducted with separate protocols for clinical peer review and professional conduct peer review
- Structured to create a sentinel effect on clinical performance and professional conduct
- Structured to integrate peer review data into the recredentialing process
- Installed as a system and not vulnerable to medical staff rotation or turnover of hospital personnel
- Operated with an updated information system that provides accurate, meaningful and timely internal and external data
- Endorsed by a hospital and medical staff leadership who are willing to take decisive action
- Audited internally and/or externally for system breakdowns

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With the right peer review infrastructure in place, the hospital can significantly enhance its ability to monitor the quality of care provided at the hospital, thereby increasing patient safety and avoiding legal liability. The first step in taking control of the peer review system, is addressing the effectiveness of each of these components. If peer review is either conducted sporadically or not being conducted at all, or if peer review is conducted without uniformity, the hospital should examine each of these components to determine the components that require attention.

In addition, a peer review system with appropriate protocols for referral into the peer review system, which uses updated data systems to identify inappropriate clinical performance and medical errors at their onset and facilitates acting on peer review matters with a sense of urgency promotes an educational approach to peer review. With these components in place, most physicians will be receptive to education and appropriate adjustments to clinical practice patterns. Delay may exacerbate the situation to such an extent that adversarial remedial action becomes necessary. The issues, which often could have been resolved earlier by education, can subsequently only be resolved by confrontation.

The key is finding the methods for establishing and appropriately implementing each component of the peer review infrastructure. The following is a hands-on method for successfully taking control of the hospital's peer review system to make peer review an integral component for increasing the hospital's quality of care.

Effective Peer Review

Peer Review System Manual

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. These documents, taken together, typically comprise less than fifteen (15) pages, may be contradictory and usually fail to clearly describe the peer review process. As a result, the medical staff leaders and administrative personnel required to act to ensure patient safety and take action in conformance with the Health Care Quality Improvement Act cannot confidently conduct peer review (See, also, Hospital Peer Review Guide I "Avoiding Money Damages" on the National Peer Review Corporation website at www.nationalpeerreview.com).

A comprehensive peer review system manual provides the information needed to make sure that the medical staff leaders and administrative personnel conducting peer review have the appropriate "comfort level." As the single source of authority to perform peer review and take necessary action, the peer review system manual should contain detailed, unambiguous instructions for performing day-to-day peer review activities (See "Peer Review System Manual" on the National Peer Review Corporation website at www.nationalpeerreview.com).

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The peer review system manual should provide detailed instructions for performing appropriate and effective peer reviews including:

A description and the peer review responsibilities of:

- All peer review committees
- All officers of the peer review system, the medical staff and administrative personnel

- A description of the peer review infrastructure
- A description of the protocols for referral into the peer review system

Protocols of the peer review system (day-to-day operation of the peer review system), including:

- How to conduct a clinical peer review and a professional conduct peer review.
- How to conduct a peer review action for a clinical peer review and a professional conduct peer review.
- When to obtain an external peer review for individual cases and practitioners.

- The development of standards of clinical practice
- Standards of professional conduct
- A description of the multidisciplinary peer review data committee

Policies for:

- External peer review
- Peer review by business associates
- Right to an attorney in the peer review system
- Impaired practitioners
- Confidentiality and handling of peer review documents
- Discussions with practitioners under review
- Communications to practitioners under review
- Access to legal counsel by peer review committee members

- Training and education for peer review participants
- Auditing of the peer review system

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Centralized Peer Review System

Effective peer review requires the establishment of a centralized multidisciplinary peer review system that mandates a uniform method by which peer review is performed. The peer review system should be designed with a strong multidisciplinary peer review committee (MPRC) established as a subcommittee of the Medical Executive Committee (MEC). Subject to the authority of the MEC, the MPRC should have overall jurisdiction for the operation of the peer review system.

In contrast, most hospitals have a decentralized peer review structure in which cases are initially referred to department peer review committees. The department committees typically act with little oversight from the MEC or a peer review committee designated by the MEC with overall jurisdiction for peer review.

As a result:

There is a lack of uniformity in the conduct of peer review and protocols and procedures may be applied inconsistently. One of the biggest misconceptions in peer review is that physicians innately know how to conduct an effective peer review. Usually physicians receive only "on the job training" which, due to decentralization, is often limited to the protocols used and developed by their own peer review committee. Despite the committee's good faith efforts, these protocols and procedures are often based upon the experience of individual peer review participants and include misinterpretations of law and unworkable operational procedures. The lack of uniformity means that:

- Physicians may be judged by different standards or not judged at all.
- The peer review system does not create a sentinel effect on clinical performance and professional conduct for many (or most) practitioners.
- The hospital does not have an effective peer review system. Without uniformity, the effectiveness of the system is dependent on the abilities of the various department peer review chairs or peer review committees.
- There is unlikely to be a physician who has overall responsibility for peer review.
- There is a lack of a multidisciplinary component to peer review. A centralized operating multidisciplinary peer review committee allows the peer review system to handle cases which, based upon the care provided to the patients, require reviews by physicians in more than one specialty.

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There is a lack of oversight and operation of the peer review system by administration. Whether due to distrust of administration by the medical staff and/or disinterest on the part of administration, peer review is often conducted solely by the medical staff. Without appropriate involvement of hospital administration, the management of the peer review system is hampered by:

- The lack of a member of administration who is responsible for peer review.
- The lack of a peer review coordinator with a staff who is responsible for the administrative aspects of peer review.
- The inability of administration employees to fulfill their peer review function due to other primary responsibilities.

Establishing a centralized multidisciplinary peer review system and a uniform method for performing peer review are key components in avoiding these problems. Essential to this process is the establishment of a strong multidisciplinary peer review committee (MPRC).

Subject to the authority of the MEC, the MPRC should have overall jurisdiction for the operation of the peer review system. At a minimum, the specific duties and authority of the MPRC should be to:

- Conduct the operation of the entire peer review system as provided in the peer review system manual and as directed by the MEC.
- Communicate the standards of practice and the standards of professional conduct established by the medical staff and the hospital to the medical staff and inform the medical staff that each member will be held responsible for compliance with these standards.
- Appoint a subcommittee of the MPRC to work with the peer review coordinator and the departments and sections to review existing standards of practice, clinical screens and benchmarks and develop or update the standards of practice, screens and benchmarks for each specialty.
- Provide recommendations to the MEC concerning matters relating to peer review at the time of medical staff appointments and reappointments, department and medical staff category assignments, privileges, and corrective actions.
- Investigate charges of violations of the medical staff bylaws, the standards of practice, the standards of conduct or a breach of ethics by any member of the medical staff or any other act or conduct which reflects unfavorably on the medical staff, the hospital or the professional practice of medicine.

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The chair of the MPRC should be the physician who has overall responsibility for peer review. Subject to the authority of the MEC and the MPRC, the chair of the MPRC should:

- Provide direction and oversee the peer review system and supervise all activities related to the peer review system.
- Enforce the peer review system.
- Be accountable for the clinical policy-making activities of the peer review system and work with the department chairs to coordinate peer review activities among the MEC, MPRC, subcommittees of the MPRC, the departments, administration, nursing and patient care support services.
- Ensure that the MPRC fulfills its obligation to appoint a subcommittee of the MPRC to work with the peer review coordinator and the departments to review the existing standards of practice, clinical screens and benchmarks and develop standards of practice, screens and benchmarks for each specialty.
- Recommend to the MEC and the MPRC the requirements for training and continuing education activities for the peer review system participants.
- Conduct preliminary investigations and interviews with practitioners, nurses and other staff regarding peer review matters, whether or not such matters have been officially referred to the peer review system.
- Serve as a resource to the peer review coordinator in determining which cases should be subject to peer review.
- Act as a liaison between the medical staff and the administration regarding peer review matters.
- Implement the decisions of the MEC and the MPRC relating to the peer review system.
- Identify cases or practitioners that have been selected for peer review but may not have been reviewed, that have received a cursory review or have been reviewed by business associates or related parties.
- Identify cases or practitioners that have been selected for peer review in bad faith and recommend that the MPRC remove these cases from the peer review system.
- Recommend cases for external peer review to the MPRC and the MEC in accordance with the hospital's policy for external peer review.

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Due to the limited time that physicians have for peer review, the administrative burden of peer review should be delegated to the member of administration who is responsible for peer review (the vice chair of the MPRC) and a peer review coordinator whose sole job is to oversee the operations of the peer review system. Effective peer review requires that administration, through the peer review coordinator and his/her staff, administratively "set the table" for the physicians to allow the physicians to make the actual peer review decisions and "clear the table" of administrative obligations once these decisions are made.

Prudent use of the peer reviewers' time will make the peer review system more productive and will encourage more physicians to be involved in peer review.

Establishment and Enforcement of Standards of Practice

The establishment of accepted clinical standards of practice by hospital and medical staff leaders is vital to maintaining high quality care within the department and preserving the resources of the hospital. More specifically, clinical standards provide the necessary foundation for an effective peer review system. Without clinical standards there is no sentinel effect on the practice of medicine within the department and:

- The conduct of routine peer review activities becomes extremely problematic except in extreme cases.
- The quality of care at the hospital suffers.
- Each individual physician determines his/her level and quality of practice.
- Physicians are not required to explain deviations from expected outcomes or standards of care.
- Peer review committees remain focused solely on the outcome of an individual case, rather than performing a comprehensive review and investigation of any deviations from the standards of practice. As a result, opportunities for educating physicians are overlooked and peer review becomes more of a punitive process.
- A "no harm, no foul" rule may exist meaning that harm to a patient must occur before action is considered.
- The insurance companies deny claims and perform de facto utilization management at significant expense to the hospital.
- The individual physicians, through their practice patterns, control much of the allocation of the hospital's resources instead of the Board (which has this legal obligation).
- The medical staff and the Board do not control or regulate the quality of care at the hospital.

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While the ultimate decision regarding the care of a patient lies with the attending physician, establishing standards of practice allows the hospital to screen cases for deviations from these standards, review these cases and request information from the attending physicians to explain why such deviations occurred.

With standards of practice in place, each physician is on notice that:

- The leadership of the hospital has determined the level and quality of practice required at the hospital.
- Compliance with these standards is required, although variations from the standards may be expected in certain individual cases.
- Variations from the standards, while expected in certain individual cases, will require an explanation in the medical record and, if necessary, to a peer review committee.
- Patterns of variations from the standards will require an explanation to a peer review committee and may subject a physician to education or discipline under the peer review system.
- If a physician disagrees with the standards, appropriate channels may be used to revise the standards, but the standards cannot be disregarded if the physician intends to continue to practice at the hospital.
- Each physician will be judged, through the peer review system, based upon these standards.

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The use of clinical standards facilitates an open discussion between the peer review participants. The members of the medical staff should be educated regarding the accepted standards of practice and the need to fully document deviations from the protocols or unexpected results in the medical record. Such documentation will facilitate a comprehensive discussion regarding the rationale for such deviations between the physician and the peer review committee.

Incorporating the standards of practice into the peer review system also reduces the subjectivity of the process, adding to the "comfort level" of the participants. Cases can be automatically screened for deviations from the standards rather than requiring individual physicians to pull a questionable case performed by a colleague and peer review committee members are provided with an impartial basis for evaluating cases.

Reducing the perceived level of subjectivity in the peer review process is particularly important for hospitals where peer review by business associates or referring physicians is typical.

Protocols for the Conduct of Clinical Peer Review and Peer Review Action

The peer review system manual should include detailed guidance for the conduct of clinical peer review. This guidance should include:

- Incorporating the standards of practice into the peer review system.
- Protocols for the conduct of clinical peer review that describe the manner in which clinical peer review activities will be conducted by a designated peer review committee, noting the focus on the totality of the care provided rather than only the outcome of the case.

Protocols for peer review action for a clinical peer review to be followed by the peer review committee upon the completion of the protocols for the conduct of a clinical peer review.

Detailed protocols for the conduct of clinical peer review and protocols for peer review action for a clinical peer review provide uniformity in peer review across specialties by preventing each peer review committee from inventing its own methodologies (sometimes on a case by case basis).

Detailed protocols also preclude the use of a "scoring system" adopted by many hospitals, usually without a detailed definition of each scoring grade. Without detailed definitions of each grade, the scoring system becomes a matter of "gut reaction" (i.e. "I know a 5 when I see one") instead of an in depth analysis of each case under peer review. As a result, there is a lack of uniformity in the application of the peer review system to medical staff members.

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In addition, the use of a scoring system to designate a peer review grade is fraught with danger if the peer review is challenged in a professional review action. Initially, the attorney for the physician under review will dispute the validity of the scoring system itself. In the case of the scoring system used at many hospitals, it is likely that a fact finder would conclude that the scoring system:

- Is currently used as a shorthand system to assign blame without valid comparisons in specialties.
- Precludes an in depth analysis of many of the cases brought for peer review.
- Is vague, applied inconsistently, and is easily subject to personal, competitive, and political motivations that are not easily discernable due to the lack of documented discussion regarding the rationale for the category assigned.

Once the system has been weakened by this argument, the attorney for the physician under review will dispute the score awarded.

In summary, the validity of the scoring system diverts attention away from the real issue, quality of care.

Establishment and Enforcement of Standards for Professional Conduct

Hospitals have the legal obligation to investigate and take action to protect the safety of patients and the hospital staff from the disruptive conduct of a physician.

In the Sentinel Event Alert issued on July 9, 2008 titled "Behaviors that undermine a culture of safety," the Joint Commission recognized the serious problem disruptive providers pose to patient safety, stating:

Intimidating and disruptive behaviors can foster medical errors, (cites omitted) contribute to poor patient satisfaction and to preventable adverse outcomes, (cites omitted) increase the cost of care, (cites omitted) and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. (cites omitted) Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team… (cite omitted) Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients. (cites omitted) All intimidating and disruptive behaviors are unprofessional and should not be tolerated.

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The Joint Commission has developed a Leadership standard (effective January 1, 2009) that addresses disruptive and inappropriate behaviors in two of its elements of performance:

> EP 4: The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.
>
> EP 5: Leaders create and implement a process for managing disruptive and inappropriate behaviors.

However, in many instances, medical staff and administration decision-makers hesitate to initiate a review of certain physicians alleged to be disruptive physicians. One reason for this hesitancy is that many hospitals do not have clear, established standards for professional conduct and, as a result:

- Politics at the hospital usually overrides action.
- The medical staff leadership and administration sidestep the problem unless the conduct is particularly egregious or potentially embarrassing.
- The peer review participants often find the evidentiary basis for the review to be too subjective to support a peer review action.
- Differing interpretations of the conduct by the alleged disruptive provider prevents action.
- An "us versus them" mentality may result in a defensive stance by the medical staff.
- Physicians and the staff tend to "work around the problems" because they are aware that disciplinary action will be avoided.

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Hospitals cannot ignore the legal obligation to investigate and take action to protect the safety of patients and the hospital staff from the disruptive conduct of a physician. Eventually, if this conduct persists, it is likely that the EEOC or the judicial system will act and impose liability on the hospital for this failure. Rather than sidestep the problem, the hospital should be proactive in instituting standards of conduct and enforcing those standards through the peer review system.

With standards of conduct in place, each physician is on notice that:

- The leadership has determined that certain conduct will not be tolerated at the hospital.
- Compliance is required.
- The standards cannot be disregarded if the physician intends to continue to practice at the hospital.
- Each physician will be uniformly judged, through the peer review system, based upon these standards.

Protocols for the Conduct of Professional Conduct Peer Review and Peer Review Action

The peer review system manual should include detailed guidance for the conduct of a professional conduct peer review. This guidance should include:

- Incorporating the standards of professional conduct into the peer review system.
- Protocols for the conduct of professional conduct peer review that describe the manner in which professional conduct peer review activities will be performed.
- Protocols for peer review action for a clinical peer review provide a menu for corrective action following completion of the protocols for the conduct of a clinical peer review.

The use of the Protocols will assure that all medical staff members are treated uniformly with respect to professional conduct issues. This is particularly true if the MPRC (see Section 2), subject to the MEC, is the only peer review committee conducting professional conduct peer reviews.

(See, also, "Hospital Peer Review Guide I: Avoiding Money Damages" and "Hospital Peer Review Guide III: Handling the Disruptive Provider" and the NPRC Disruptive Provider Review on the National Peer Review Corporation website at www.nationalpeerreview.com.

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Protocols for Referral into the Peer Review System

In many hospitals it is unclear how individual cases and practitioners are identified for peer review. Typically, the hospital's data system monitors various "clinical screens" and, using these screens, cases with unexpected outcomes, complications, egregious cases, reported cases and other obvious cases are referred into the peer review system. However, most peer review systems do not have a comprehensive protocol for identifying cases and submitting them to the peer review system.

As a result:

- The peer review system is reactive and reviews cases with unexpected outcomes, complications, egregious cases, reported cases and other obvious cases rather than conducting proactive, educational peer review by identifying, tracking and resolving inappropriate clinical performance and medical errors at their onset.
- The peer review system is limited to reviewing reported incidents of disruptive conduct rather than conducting an appropriate investigation of the total conduct and the effect of such conduct on hospital operations.
- The review of cases requiring peer review may be significantly delayed or may not be reviewed at all because the peer review system fails to detect or properly process the cases.
- Based upon the belief that it would be improper or illegal for the Board, the CEO, the MEC, an officer of the medical staff, peer review committee or peer review committee chair to request the review of a case that was not been obtained "through the system," the review of cases is delayed or never undertaken.
- Unwritten complaints are usually not investigated because the complainant refuses to put the complaint in writing. The participants believe that it would be improper or illegal to base a referral into the peer review system on a verbal complaint. The officer of the hospital or an officer of the medical staff may be unaware that the oral report has put the officer on notice of a problem which may require action.
- Peer review of disruptive conduct is avoided due to the lack of standards of conduct and protocols for referring disruptive practitioners into the peer review system.

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- Data which is indicative of the need for peer review is ignored unless the case or the practitioner's conduct is egregious.
- Peer review occurs through a loose system of informal reporting that is not based on accepted standards of practice and relies on casual observance of cases which may, or may not, require review.
- Without protocols for multidisciplinary review, peer review committees do not have a written basis for referring multidisciplinary cases to other applicable peer review committees. As a result, the review of cases requiring multidisciplinary review is significantly delayed or does not occur.

In order to effectively remedy this situation, a comprehensive protocol for the referral of cases and practitioners into the peer review system should be included in the peer review system manual (See Section 1 of this Guide).

In general, this protocol should provide that a practitioner will be subject to a referral into the peer review system whenever the practitioner engages in, makes or exhibits acts, statements, demeanor or professional conduct, either within or outside of the hospital, which is reasonably likely to be any of the following:

- Below the defined standards of practice or indicative of poor clinical judgment.
- A violation of the standards of professional conduct (as incorporated in the peer review system manual).
- Contrary to the medical staff bylaws or the peer review system manual.
- Detrimental to patient safety or to the delivery of patient care within the hospital.
- Detrimental to the safety of others in the hospital.
- A violation of state or federal criminal statutes.

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More specifically, the protocol for referral of a practitioner into the peer review system should provide that referral will occur based upon the following:

Sentinel Event. Upon the occurrence of a sentinel event or near miss, as defined by the Joint Commission.

Clinical Screens. Cases identified by the clinical screens will be reviewed by the peer review coordinator to determine if the clinical screens have appropriately identified the cases (i.e., the case is not a false positive) for peer review. If the cases have been appropriately identified, the peer review coordinator will refer the cases to the MPRC to determine if peer review is required.

Benchmarks. Practitioners identified as outliers with respect to the benchmarks established by the medical staff will be reported to the chair of the MPRC and referred to the MPRC to determine if peer review is required.

Practice Patterns. Practitioners identified through defined performance data as outliers with respect to practice patterns or practitioners whose practice patterns fail to comply with the standards of practice will be referred to the MPRC to determine if peer review is required.

Malpractice Cases. Cases that have resulted in malpractice claims which were not previously subject to peer review will be referred to the MPRC for peer review.

Utilization Data. Cases which may contravene the standards of practice as identified in resource utilization data that were not previously subject to peer review will be examined by the peer review coordinator, under the direction of the chair of the MPRC, to determine if the cases represent a pattern of failure to comply with the standards of practice. If so, the cases will be referred to the MPRC for peer review.

Compliance Hotline. Clinical matters received through the compliance hotline which, in the opinion of the chair of the MPRC, require the immediate attention of the MEC will be referred to the President of the Medical Staff for corrective action. Matters which merit peer review but do not require immediate attention will be referred to the MPRC for assignment by the MPRC. Matters which, in the opinion of the chair of the MPRC, do not merit peer review will be recorded in the general log with a detailed explanation of the disposition of the matter.

Authorized Requests for Peer Review. The Board and the MEC, in their sole discretion, may require that cases or practitioners be subject to clinical peer review or professional conduct peer review. The CEO, the chair of the MEC, the chair of the MPRC and other appropriate officers of the medical staff may, in their sole discretion, bring cases or practitioners before the MPRC to determine if peer review is required. These bodies and officers need not have first hand knowledge of the facts.

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Written Complaints. All written complaints will be brought before the MPRC to determine if a practitioner should be subject to peer review. Matters which do not merit peer review will be recorded in the minutes of the MPRC meeting with a detailed explanation of the disposition of the complaint.

Verbal Complaints. Verbal complaints will be assigned to the peer review coordinator to investigate and verify the subject of the complaint. Verified verbal complaints will be brought before the MPRC to determine if a practitioner should be subject to peer review.

An Effective Peer Review Report

The essential element in the peer review decision-making process is the peer review report.

Whether obtained by internal or external peer review analysis, the peer review report should provide an unambiguous basis for determining if additional peer review action is necessary. Based upon the information provided in the report, hospital boards, administrators and medical staff officers should be confident that their actions fulfill their legal obligation to provide quality care to patients and that the appropriate course of action has been taken regarding the physician under review.

Specifically, a peer review report should contain:

- An executive summary that concisely encapsulates the findings of the peer review report.
- A complete abstract of the medical records and imaging studies.
- Answers to pertinent clinical questions within the expertise of the peer reviewer.
- Clear explanations of any clinical practice variations.
- Clear and concise findings and conclusions.
- References to current medical literature and comparative data, benchmarks and accepted national standards used in the peer review report.
- The curriculum vitae of the peer reviewer performing the peer review.

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If properly constructed, the peer review report also provides legal, financial and political protections for the hospital and medical staff. Legally, an effective peer review report will preserve hospital and medical staff immunity from money damages, as provided under the Health Care Quality Improvement Act (See, also, Hospital Peer Review Guide I: "Avoiding Money Damages" at www.nationalpeerreview.com). A properly prepared report can also preserve the hospital's financial resources by abbreviating the peer review process, which often involves many hours of administrative and medical staff time. In addition, by providing a sound basis for decision-making, a properly constructed peer review report preserves the hospital's political resources. It provides the credibility and support necessary to take appropriate peer review actions without the delays and indecisiveness that contribute to divisions among and between the medical staff and the hospital administration.

Given the significant impact of the peer review report, hospital decision-makers should carefully consider the issues outlined in NPRC's Hospital Peer Review Guide II: "An Effective Peer Review Report" (at www.nationalpeerreview.com) in determining if the peer review report is providing the hospital with all the benefits available.

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An Effective Policy for External Peer Review

In order to ensure that appropriate cases receive external peer review, a comprehensive policy for external peer review should be included in the hospital's peer review system manual (See Section 1 of this Guide). NPRC has developed the NPRC Policy for External Peer Review to provide hospitals with detailed instruction for obtaining and requesting external peer review. (The NPRC Policy for External Peer Review is available for free download at www.nationalpeerreview.com).

For example, the NPRC Policy for External Peer Review provides an extensive list of officers of the peer review system who may request an external peer review to avoid a "bottleneck" in the process. This list includes the following:

- The MEC
- The President of the Medical Staff
- The MPRC
- The Chair of the MPRC
- The Board of Directors of the Hospital
- The President of the Hospital
- A Department Chair on behalf of a member of the Department
- A Section Chair on behalf of a member of the Section
- The Chief Medical Officer
- The Vice President of Medical Affairs
- General Counsel

The NPRC Policy for External Peer Review also requires that the request for external peer be in writing and directed to the Chair of the MPRC or the President of the Medical Staff. In the request for external peer review, the requesting party is required to cite the perceived need for external peer review based upon a set of established guidelines (e.g., conflict of interest, lack of internal clinical expertise, new technology, or anticipation of hearing or litigation). Final approval of the request by the MPRC or the MEC and the President of the hospital is then required.

Adopting the NPRC Policy for External Peer Review means that the use of external peer review will be clear, the officers of the peer review system will have broad authority to institute external peer review and the approval process will be centered in a hospital committee providing the necessary institutional support.

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Useful and Sufficient Data

Physicians conducting peer review in a hospital setting must have complete confidence in the information provided to them before taking peer review actions. Without such confidence, most physicians are unlikely to jeopardize a colleague's career and livelihood, no matter how much they may suspect problems.

While hospital information systems produce a multitude of data that could be useful in the peer review system, many hospitals have difficulty providing the peer review system with appropriate data in a timely, functional and reliable manner. In many instances there is a disconnect between the data provided and the data that the physicians need to perform effective peer review. As a result, cases ripe for peer review are missed, the data supporting the peer review is late, deficient or unreliable and the physicians performing peer review lack confidence in the data they receive and hesitate or abstain from taking action.

To remedy this situation, the peer review system should incorporate a multidisciplinary peer review data committee ("PRDC"), as a subcommittee of the MPRC or the MEC, to address the data requirements of the peer review system. The PRDC should be composed of key physicians (e.g., the chairs of the MEC and the MPRC) and administrators (e.g., the vice chair of the MPRC and the peer review coordinator) in the peer review system and the executive level personnel responsible for producing peer review reports and other information. The members of the PRDC should meet at least monthly.

The minimal duties of the PRDC should be to:

- Determine the availability of data to identify peer review issues.
- Determine the use of data sources to detect quality issues requiring peer review.
- Identify the specific data needs required by each component of the peer review system.
- Evaluate the accuracy and timeliness of internal data sources used to provide peer review information and make recommendations for enhancements.
- Evaluate the external databases for comparative/normative data and make recommendations on the selection and use of such databases.
- Evaluate the validity and usefulness of the quality of care indicators including making recommendations for modifications, additions or deletions.
- Evaluate and make recommendations regarding necessary enhancements to the information management capabilities of the hospital to fulfill the goals and objectives of peer review data collection and reporting.

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- Make recommendations to the MPRC regarding content, format, frequency and distribution of reports, including trending reports, necessary to fulfill the data needs of each component of the peer review system.
- Identify the training needs and methodologies related to data to enable all participants in the peer review system to understand and appropriately use the peer review reports.
- Make recommendations to the MPRC regarding audit procedures related to the accuracy and overall effectiveness of the data provided to the peer review system.

Analyzing "Trended" Data

The conclusion of many internally reviewed peer review cases is to "trend" the cases of the reviewed practitioner to monitor outcomes. However, the trended cases are often forgotten and the patterns reflected by the trended cases are not analyzed at the appropriate levels of the peer review system. This effectively negates the time and resources used for the initial peer review and fails to adequately supervise potential problems.

Appropriate trending of cases requires the hospital to:

- Consistently monitor one or more categories of quality events of practitioners whose cases are being trended to determine if the cases reviewed represent aberrant practice patterns.
- Produce reports, designed by the PRDC in a format approved by the MPRC, summarizing the practice patterns of the practitioners' cases that have been trended.
- Review these reports at the MPRC or the MEC level.

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Integrating Peer Review Information into Recredentialing

A critical feature of recredentialing is the inclusion of peer review information into the recredentialing process. However, many hospitals reappoint practitioners without including the peer review information in the credentialing file. Without this vital information, the MEC and the Board are unable to properly evaluate the practitioner.

In order to remedy this situation, the peer review system manual should provide specific direction to those operating the peer review system and the credentials committee of the medical staff regarding the placement of peer review information into the practitioner's credentialing file. The credentials committee should be instructed to receive and analyze all information from the peer review system, including, without limitation:

- Details of all final peer review matters handled by the Board, the MEC, the MPRC, and all of the peer review committees.
- Details of all peer review matters in progress, at any phase, which have been referred into the peer review system.
- Information from the quality improvement activities, utilization management activities and risk management activities and other activities at the hospital pertaining to the qualifications of practitioners.

This information should remain in the credentialing file throughout the recredentialing process and be reviewed by all of the decision-makers at each level.

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Peer Review as Education

Peer review is an effective, established procedure for upgrading a physician's clinical knowledge, enhancing his/her medical practice, reducing medical errors and improving patient safety. However, too often, peer review is seen as a confrontational process designed solely to discipline practitioners.

The key to effective educational peer review is early detection and prompt action to re-educate the physician. Approaching peer review as an opportunity to educate physicians promotes a professional atmosphere of collegiality to resolve issues. By avoiding adversarial activities, the hospital preserves its resources, both financial and political.

Most importantly, educational peer review, on an individual and institutional level, is instrumental in identifying, tracking and resolving inappropriate clinical performance and medical errors at their onset, thereby increasing patient safety and the quality of patient care.

In a centralized peer review system with uniform application and appropriate training of the peer review participants, peer review as education can be the basis for peer review in theory and in practice.

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Approaching Peer Review with a Sense of Urgency

When the internal mechanisms of the hospital identify patterns outside recognized standards, professional conduct problems or other circumstances that endanger the safety of patients, hospital decision-makers must act with a sense of urgency. Effective, timely action includes steps to protect patients, assure due process to the physician under investigation and preserve the immunity of the hospital and medical staff.

In many instances, however, this sense of urgency may be lacking. Whatever its cause – fear of the political consequences, inadequate peer review procedures, delays by the decision-makers or by the physicians under investigation, inattention or just plain negligence - the failure to act quickly often results in adverse consequences.

If the hospital acts with a sense of urgency and avoids delay, most physicians are receptive to education and appropriate adjustments to clinical practice patterns and behavior. Delay may exacerbate the situation to such an extent that adversarial remedial action becomes necessary. The issues, which may have been resolved earlier by education, can subsequently only be resolved by confrontation.

In addition, commencing and proceeding diligently with the peer review process when the event is fresh in the minds of the peer review participants typically results in a more effective peer review and improved acceptance by the medical staff and the physician of any corrective action.

A centralized peer review system obtaining accurate data, operating in accordance with appropriate detailed procedures with trained peer review participants, can operate at the proper speed to facilitate timely and fair peer review.

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Auditing the Peer Review System

The operation of the peer review system is dependent on many factors. Components working properly during one year may not be working during the next year due to medical staff rotation or turnover of hospital personnel. In many hospitals the peer review system may be repaired or a new system installed and peer review may be effective for a while only to lapse into disrepair after a year or two.

The recommendations set forth in this Guide are meant to assist hospitals in ensuring that the peer review system is installed as a system that is less vulnerable to turnover and individual performance. However, in order to remain effective the peer review system must be monitored. Therefore, the hospital should establish an internal audit procedure and, at some point, obtain an external audit.

Auditing the peer review system should be as automatic as an audit of the hospital's finances. Confirming that the peer review system is operating and monitoring the quality of the practitioners should be as vital as confirming that the funds of the hospital are being handled appropriately.

The external audit of the peer review system should be an objective analysis of the operations of the hospital's peer review system. The audit should identify peer review system breakdowns and provide the hospital with a written report containing the information and recommendations necessary to operate an effective peer review system. (See the "NPRC Peer Review System Evaluation" on the National Peer Review Corporation website at www.nationalpeerreview.com).

Establishing a Peer Review System with Positive Medical Staff Leadership

It is not unusual for medical staff leadership to view the peer review system as cumbersome, inefficient, ineffective, in need of substantial overhaul and, in many instances, punitive. Therefore, medical staff leaders are often unwilling to take decisive action except when required by "bad outcomes" i.e. unexpected outcomes, complications, egregious cases, reported cases and other obvious cases. Without physicians taking the lead, peer review is ineffective or non-existent.

The key to engaging the medical staff leaders in the peer review process is structuring the peer review system as a joint venture between the medical staff and administration. Working together, the medical staff and administration can create an appropriate peer review infrastructure that addresses their respective concerns and issues and accommodates the hospital's structures, services, data capabilities and political environment. Through this mutual effort, the leaders of the medical staff can take ownership of the new peer review system. Ownership by the physicians is vital to the successful operation of the peer review system.