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The Complete Guide to Performance-Improvement Focused Peer Review

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In medical peer review, physicians and advanced practice professionals (APPs) evaluate the quality of their colleagues' work for both punitive and non-punitive review to meet or exceed prevailing standards of care and to self-improve. Under value-based payment models, reimbursement is tied to value, amplifying peer review's importance. But how did we arrive at today's model of medical peer review, and how does it work?

What is medical peer review?

In medical peer review, also called clinical peer review, physicians and APPs professionally assess the work performance of "like" practitioners—those with the same or similar education, training, experience, and skill sets—using a formal evaluation system. In essence, it's a quality control mechanism in hospitals and some large private practice groups.

Payers also conduct clinical peer review, but their intent differs slightly. They focus on ensuring that the providers on their panels meet requirements for quality, coding, and medical necessity as well as the criteria for inclusion or de-selection based on performance and member satisfaction criteria. Peer review also enables healthcare organizations to:

- Ensure compliance with federal and state statutes
- Maintain facility accreditation with The Joint Commission, NCQA, and others
- Receive reimbursement from CMS and private payers
- Demonstrate improvements or actions taken with outcomes
- Retain clinicians by providing them with trusted data and assistance with any required education, resources, or additional training
- Track and adjust attribution and systems issues affecting the fairness of reviews

For individual clinicians, peer review provides a path to continuously improve the quality of care and services they provide and collaborate for best practices, which ideally fosters higher-quality care for patients.

Peer review data collection and analysis

In hospitals and health systems, the medical staff services department and the quality department collect and provide most data required for **peer review processes**, ideally using a digital quality, patient safety, and compliance solution. A departmental or multidisciplinary peer review committee—or multiple peer review committees—manages the function, reporting to the medical executive committee and the board. One individual or multiple individuals may serve as a peer reviewer for each case, and there are various types of reviews.

Historically, clinical peer review was retrospective. Patient charts were evaluated to determine the quality of care a provider already delivered—or malpractice suits, sentinel events, or adverse events triggered a review. Today peer review is completed retrospectively and concurrently with the provision of care. It's about looking at key performance indicators (KPIs) for each provider/provider type and using predetermined methods to evaluate practitioners to help them improve their performance for the good of all healthcare participants.

While most physician peer reviews occur among co-workers in the same health system, external peer review may be used when there's a lack of internal expertise or resources, or there are legal concerns. Payer organizations may use internal mechanisms for peer review, and/or contract with external peer review service providers for data collection and analysis.

The provider evaluation and performance cycle

Three main processes contribute to provider performance and evaluation in health systems:

1. **Peer review** technically includes focused professional practice evaluation (FPPE) and ongoing professional practice evaluation (OPPE), and describes the process of collecting periodic and ongoing reviews for providers that take into account measurements of performance against The Joint Commission's (TJC) Six General Competencies, departmental and specialty-specific performance targets and indicators, chart reviews, patient satisfaction surveys, incident reports, and more.
2. Hospitals conduct **FPPE** when a provider initially presents to the organization, whether they will be employed or affiliated. FPPE also occurs for a provider at reappointment, when their existing clinical privileges and/or medical staff membership is revoked or suspended, and when they request a new privilege(s). A "for cause" FPPE can be done at any interval in the cycle as well if the department needs to review an incident or issue with a provider.
3. **OPPE** evaluates and validates providers' performance at regular intervals (i.e., every 4-6 months), and under certain circumstances, according to their healthcare accreditation and/or regulatory body's standards. In other words, OPPE can be "for cause" (e.g., there has been an incident or event or something has happened with the provider), and it describes the typical role-based reporting/analytics that occur for performance assessment.

Attitudes toward peer review

Both the public and physicians strongly opposed medical peer review in the early 19th century. Despite the opposition, government and medical societies saw a need to standardize medical care to protect the public, medical organizations, and physicians. As a result, state medical licensure boards were created with an emphasis on monitoring physician behavior.

However, both the American Medical Association and the Department of Health and Human Services saw that existing peer review efforts didn't meet standardized criteria for improving care and enforcing disciplinary action. This deficiency was attributed mainly to physician unwillingness to conduct peer review.

Former peer review features	Peer review today
Derived from morbidity and mortality programs	**Evolved to engage the medical staff and provider in all aspects of review**
Viewed as negative/punitive focus	**Focused on performance improvement, competency, accountability**
Based primarily on case reviews	**Uses KPIs, case reviews, and ongoing/ focused professional practice evaluation**
Done in retrospect of care provided for job continuance or as a result of an incident	**Designed to be preventative, using retrospective and concurrent methods**
Same process used for minor and major issues	**Uses improvement plan design and monitoring based on goal, outcomes, and actions taken**

In the early 20th century, the American College of Surgeons began using peer review to define minimum standard-of-care requirements for hospitals and the physicians who practiced in them.

In 1952, TJC, the primary accreditor of U.S. hospitals, began requiring physician peer review at all U.S. hospitals. However, resistance to medical peer review continued, and organizations either failed to conduct physician peer review—and suffered few or no ramifications—or it was done as a primarily unstructured, informal, or verbal process.

Physicians' resistance to peer review during that time manifested in the form of negative attitudes toward it and/or the desire to keep it quiet, if done at all. Mistakes were often covered up, and the offending physician was protected. Little changed in the years that followed, until the case of Patrick vs. Burget was decided in 1986.

Patrick vs. Burget (1986)

Dr. Timothy Patrick, general and vascular surgeon, joined the Astoria Clinic as an employee, and one year later was invited to become a partner. However, he declined, choosing private practice, which made him a competitor to the clinic. Four years later, an Astoria Clinic physician reported Dr. Patrick to the Oregon Board of Medical Examiners for a case. The board review committee, chaired by another Astoria Clinic physician, issued a reprimand, which was rescinded under threat of legal action by Dr. Patrick.

Two years later, the Astoria Clinic's medical executive committee revoked Dr. Patrick's privileges. In the midst of the hearing, Dr. Patrick resigned and successfully sued William M. Burget, MD, et al (dba Astoria Clinic) for anti-competitive behavior—and was awarded $110,000 each against three physicians.

The effect of the verdict was widespread and caused many physicians to decline participation in peer review activities for fear of possible involvement in litigation. But physician resistance to peer review wasn't the only impact of Patrick vs. Burget. In fact, its ultimate legacy was threefold:

- A state's peer review law does not provide immunity for physician anticompetitive behavior
- The U.S. Supreme Court determined immunity should be decided by Congress
- Congress passed the Health Care Quality Improvement Act (HCQIA) of 1986

Other peer review barriers and setbacks

Along with the negative effects (e.g., fear of possible litigation) that the verdict in Patrick vs. Burget had on peer review participation, other factors contributed to **decreased physician cooperation**:

- Physician reviewers were fearful they'd be retaliated against socially by peers for reviewing other providers
- Attribution difficulty persisted when medical errors were made, and quality scoring systems remained ineffective (e.g., only standard deviations were used at times)
- There was little consistent data to identify triggers for peer review, no analytics, and little reliable reporting or tracking of quality indicators or targets
- Hospitals had difficulty demonstrating the continuum of reviews and workflows with actions and outcomes
- Healthcare organizations struggled to change the perception of peer review as a punitive measure

Peer review today

Today, the medical community is beginning to understand that medical peer review is designed to be an unbiased evaluation tool to help providers self-improve and to increase the quality of care patients receive. Done well, it's a valuable tool for both the medical staff and the hospital. Standardization is recommended for fairness.

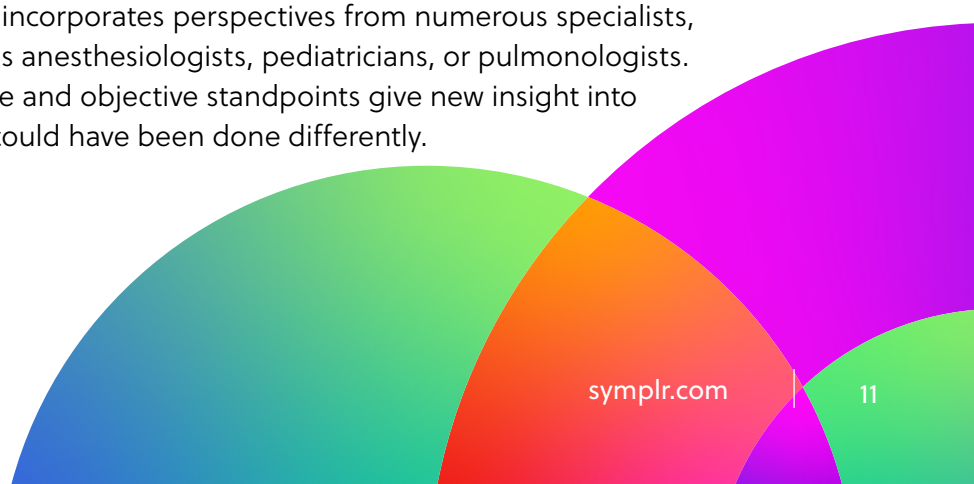
Reasons for independent medical peer review

It directly relates to quality of care: Above all else, peer review provides a way to directly improve patient care. When a medical event with an unexpected outcome occurs, it's in administration and the medical staff's best interest to understand and analyze the data. Medical errors and incidents are not entirely preventable due to system and human errors, but they can be mitigated and help effect change. What's important is that there is a well-defined process to promote quality care and prevent negative results from happening to another patient or provider. Peer review has saved countless lives and creates better trained and experienced physicians when used as a collaborative tool and executed promptly.

It identifies strengths and areas of improvement: Looking at a practitioner's performance evaluation over the long term—by gathering and reporting data for quality improvement—requires a complex set of activities. OPPE is a part of the peer review process and generally provides most of the data needed to make reappointment decisions. Reappointment might mean a provider is green-lighted to keep their privileges at a facility, remain on the medical staff, or both. Carefully going through any medical peer-review evaluation can assist with identifying not just a provider's strengths and weaknesses but also those of support staff and the hospital administration. Finally, receiving feedback from one's peers is one of the most effective ways to encourage growth and refinement.

It provides an exchange of ideas: Any instance wherein great minds can come together to overcome problems and learn from mistakes is good for healthcare. Providers understand the pressures and risks of the job, so it makes sense they have the opportunity to review each other's work and ultimately determine if the peer review subject could have prevented the negative outcome, or whether it was a system error. Additionally, when providers undergo peer review, it provides an opportunity to learn from mistakes, bolstering a hospital's **risk management** activities. It's important to note that peer review must be proactive and collective for this to happen, with the ultimate goal being performance improvement, not disciplinary action. Last but not least, peer review is used to spotlight positive contributions by a provider, who deserves commendation.

It can promote collaboration: Because physician peer review involves a wide range of specialists, it can promote increased collaboration within a hospital or across departments and s pecialties. This is often the case with multidisciplinary peer review, which incorporates perspectives from numerous specialists, such as anesthesiologists, pediatricians, or pulmonologists. Diverse and objective standpoints give new insight into what could have been done differently.



For quality collaboration to exist in medical peer review, there must be a balance between conducting the review and remembering every doctor operates differently. The point of a review is not to redesign how the physician works or place a strict set of rules and regulations upon them; it is to determine if errors occurred and how to prevent them in the future. The provider's methodology should not be the sole focus of the review.

It helps determine which providers are delivering appropriate and medically necessary care: Payers, under value-based care, require solid evidence of quality assurance and appropriate use of services and resources by providers. They may look at a provider's data even before agreeing to add a provider to their panel.

At the same time, reviews must follow all regulations and federal laws in place, which can often make them feel overly time-consuming. Any time an institution can streamline and simplify its peer-review process will help ensure that outcomes will benefit doctors, patients, and hospitals moving forward.

Steps in clinical peer review

As with any medical process, provider peer review should follow a strict set of guidelines outlined in the medical staff bylaws and/or policies and procedures documents. These, in turn, must adhere to regulations, accreditation standards, and the organization's own mission and values. A very simplified set of steps for peer review follows.

Step 1: The regular appraisal timeline occurs (non-punitive) or there is a trigger incident (punitive), and the provider under review is notified that the review will occur. Alternatively, a new provider presents to a healthcare organization for employment or affiliation, or to a payer for application to a panel.

Step 2: The medical staff services office, the quality department, and staff in the provider's department collaborate to gather the documents and data required for the review and assign the reviewer(s) following a workflow.

Step 3: The peer reviewers conduct their initial review of the documents and data, and request any additional material needed from the provider or any other party involved.

Step 4: The findings and recommendations are presented to the peer review committee, which reviews them and in turn present their findings to the provider under review. Software automates workflows for every peer review participant and gives insight for education and improvement.

Step 5: To maintain balance and equitability, the provider under review has an opportunity to respond to any reappointment, privileging, or other decisions made and document evidence or further explanations related to the decision(s).

Step 6: The peer review process concludes and the results are documented in the provider's credentialing and privileging file with the medical staff.

The best way to achieve performance-improvement focused peer review, drive optimal patient outcomes, and promote provider success is by using a comprehensive, configurable quality reporting and monitoring solution.

Learn more

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Our provider data management, workforce management, and healthcare governance, risk management, and compliance (GRC) solutions improve the efficiency and efficacy of healthcare operations, enabling caregivers to quickly handle administrative tasks so they have more time to do what they do best: provide high-quality patient care.

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