THE MEDPRO GROUP DIFFERENCE

Guideline

Peer Review in Group Practices

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Contents

Introduction

Prior to 1986, physicians could easily relocate from state to state without disclosing any medical malpractice actions relating to their clinical practice. This nondisclosure allowed for an increase in patient harm due to unsafe and incompetent providers.

The Health Care Quality Improvement Act of 1986[1] (HCQIA) gave rise to the National Practitioner Data Bank (NPDB), which collects information about healthcare provider actions resulting in adverse outcomes and medical malpractice payments. Further, to increase the clinical competency of practitioners and improve patient safety, the HCQIA established immunity from civil monetary damages for providers who engage in peer review.

Peer review provides the framework for a systematic evaluation of patient care with the ultimate goal of reducing morbidity and mortality. The peer review process involves analysis of clinical decision-making and processes, and it offers opportunities to improve systems used for the provision of patient care. Peer review is a key component of quality improvement, risk management, and patient safety activities.

Objectives

The objectives of this guideline are to:

- Discuss the role of credentialing/privileging, professional practice evaluation, and quality improvement as a foundation for peer review
- Discuss important steps in developing a peer review program, including:
    - Evaluating peer review statutes
    - Establishing a peer review committee
    - Developing a thorough peer review process
    - Continuously monitoring provider competency and offering training and mentoring to improve competency
- Describe other considerations related to processes associated with, and documentation of, peer review

Preparing for Peer Review

A solid peer review program hinges on healthcare practices having thorough processes and criteria for credentialing/privileging, professional practice evaluation, and quality improvement. As part of these efforts, group practices should identify core clinical competencies for their healthcare providers and select clinical and process indicators.

Identify Core Competencies

Core competencies refer to defined levels of skill, knowledge, and behavior required for certain positions. The American Council for Graduate Medical Education, the American Board of Medical Specialties, and The Joint Commission have developed core clinical competencies, including:

- Patient care and procedural skills
- Medical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- System-based practices

Each of these competencies reflects healthcare providers' clinical skills and the manner in which they apply and execute those skills. Each group practice can determine the degree and specific parameters that should be encompassed within each core clinical competency.

Select Clinical and Process Indicators

Clinical indicators address high-risk, high-volume, or problem-prone processes or diagnoses. When selecting clinical indicators, it might be helpful to focus on (a) the top 20 percent of high-volume diagnoses (which potentially represent 80 percent of the group's total patient volume); or (b) the top 20 percent of problem-prone processes that are critical to safe patient care (these vital processes likely affect 80 percent of the practice's patient outcomes).

For example, diabetes might be in the top 20 percent of the practice's high-volume diagnoses and, as a result, identified as a clinical indicator. Thus, the practice might screen to ensure that certain critical processes related to diabetes management are in place, such as the completion of hemoglobin A1c testing for patients who have been diagnosed with Type 1 or Type 2 diabetes for at least 12 months. Exceptions to standard processes should be documented, such as if a patient is not a candidate for hemoglobin A1c testing.

Review Claims Trends

Analysis of malpractice claims trends can help group practices identify pertinent clinical indicators. MedPro claims data for physician offices/clinics show that diagnosis-related allegations account for the highest claim volume (37 percent), followed by medical treatment allegations (23 percent), surgical treatment allegations (19 percent), and medication-related allegations (12 percent).[2]

The practice also might screen to ensure that diabetic patients are receiving appropriate diabetes education and that the provision of education is documented.

Other examples of processes that the practice might routinely monitor include:

- Medication reconciliation for every patient at each visit.
- Communication of abnormal diagnostic results and subsequent care planning.
- Receipt, review, and follow-up of health records or written reports from consultants.
- Completion of preventive screenings.

In addition to clinical indicators, group practices should review process indicators, which are events that involve some sort of review and action (e.g., patient complaints, adverse outcomes, and incident reports). Often these indicators reflect on professional behavior as well as clinical skills. Persistent issues associated with clinical and process indicators (e.g., deviations from the above criteria, failure to meet the practice's standards, or numerous complaints) should be addressed as part of the peer review process.

Note: A standard review format should be in place so that all providers are consistently evaluated against the same criteria.

Initiating Peer Review in Group Practice

Evaluate Peer Review Statutes

With your attorney, evaluate your state's peer review statute, case law, and the HCQIA. Peer review statutes are designed to encourage physicians to analyze the quality of patient care. These statutes generally include language intended to protect good faith statements of opinion made during the peer review process. This protection is commonly referred to as "peer review privilege." Additionally, peer review statutes may be instructive in determining committee membership, authority, and process.

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Beyond statutes, case law also might influence your state's interpretation of peer review. Your attorney should be able to provide you with information about these rulings and their significance to your peer review process. Be advised that states may have conflicting laws or rulings.

In some states, peer review statutes may not be applicable to group practices. Instead, they might be intended for peer review completed in hospitals. If this is the case in your state, ask your attorney how to best review care and maintain a confidentiality privilege.

Patient Safety and Quality Improvement Act of 2005

Another statute to consider is the Patient Safety and Quality Improvement Act of 2005 (PSQIA), which promotes voluntary reporting of issues related to patient safety and quality. Under PSQIA, the Office for Civil Rights (a) oversees confidentiality protections for providers who report patient safety information (called patient safety work product [PSWP]) to designated patient safety organizations (PSOs), and (b) enforces penalties for confidentiality violations.

The PSQIA specifies the role of PSOs and defines PSWP and patient safety evaluation systems, which focus on how patient safety event information is collected, developed, analyzed, and maintained. Visit the Agency for Healthcare Research and Quality's website to learn more about PSQIA and PSOs.

Establish a Peer Review Committee

An initial step in developing a peer review program is establishing a peer review committee. Group healthcare practices should define, in writing, the peer review committee's:

- **Purpose.** Use language from your state statute (if applicable) and from the HCQIA and PSQIA.
- **Structure and authority.** Include information about committee membership and reporting relationships. (For example, to protect the confidentiality of the peer review process and associated documentation, the peer review committee must report to either the healthcare organization's governing board or the quality arm of the governing board.)
- **Scope.** The scope of the peer review process generally encompasses clinical indicators and process indicators (as described previously).

Develop a Process

Group practices should develop a written process for peer review with consideration given to state statutes (if applicable), case law, and the HCQIA and PSQIA. For example, state peer review statutes might define the initiation and termination of the peer review process. Additionally, the HCQIA describes standards for professional review actions. Discuss these processes with your attorney to ensure that the full benefit of peer review privilege is achieved.

Steps in the written process generally should address the following:

- A process for identifying clinical cases — e.g., clinical indicators, clinician referral, adverse outcomes, patient complaints, incident reports, risk management activities, concurrent case review, etc.
- A process for completing initial case screening — e.g., a designated clinician may initially screen for potential quality issues.
- A process for referring cases with potential quality issues to the peer review committee for further review.
- A process for identifying when external peer review is indicated (e.g., a situation in which a conflict of interest occurs, such as specialty physicians or practice partners being asked to peer review each other), and the procedure to initiate the request.

- A process for conducting external peer review, including specifying the referral process, identifying the external peer review providers, reporting the external peer review findings, and maintaining the confidentiality of all correspondence and documentation with the external peer reviewers.
- A description of interdisciplinary versus specialty-specific peer review (e.g., general tasks such as handoff reports and documentation are common among all providers; however, specialty-specific procedures may require a specialty expert peer review).
- A description of the peer review committee's severity ratings (if the committee is using a rating system) and the follow-up actions required for each category rating. For example, ratings may range from Category 0 (no substandard care or patient injury) to Category 5 (possible iatrogenic patient death).
- Written procedures relevant to HCQIA requirements, such as provider notification and appeal rights.
- A description of corrective actions, a timeframe for when actions are invoked, explanation of required follow-up actions, and guidance for oversight of the process to ensure appropriate use and compliance.
- A description of clinician-specific tracking of quality information — e.g., aggregate individual peer review information is reviewed at the time of recredentialing.
- A process for distributing peer review committee minutes — e.g., distribution is limited to the governing board, which is the peer review oversight committee.
- A description of a standardized system for routine destruction of peer review committee minutes. The system should be consistent with state laws governing peer review.

Develop a standardized checklist that outlines strict compliance with the practice's written peer review process. Preservation of a confidentiality privilege might depend on whether individuals follow the practice's written process.

Monitor Continuously

Safe patient care requires ongoing vigilance; thus, healthcare practices should continuously monitor providers to ensure competency. Monitoring is essential for maintaining high-quality services and identifying best practices leading to consistent patient care throughout the organization.

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Ongoing assessment of provider skills can help healthcare practices quickly detect and address improper performance. Providers can be retrained and peer monitored to prevent future occurrences. Two commonly used methods for performance monitoring and competency assessment include focused professional practice evaluation (FPPE) and ongoing professional practice evaluation (OPPE).

For more information about FPPE and OPPE, as well as other performance monitoring methods, see MedPro's *Credentialing and Privileging* guideline.

Other Considerations

Nonprivileged Documents

Although nonprivileged documents may vary by state, the following typically are not protected under a peer review privilege:

- Letters of staff education, unless specifically requested by a peer review committee
- Administrative memoranda, such as records created or maintained by the administrator/manager to describe a particular event (although these documents may be protected by a different privilege or law)
- Clinician-written personal notes regarding a patient's adverse outcome
- Investigations of adverse outcomes, unless directed as a peer review activity or completed by an insurance company, self-insured retention claim staff, or a specifically assigned claim defense attorney
- Peer review meeting minutes posted on an organizational intranet
- Quality data and patient events included in physicians' employment records

- Discussions of peer review committee activities outside of the committee meetings
- Departmental logs or communication books
- Incident reports (privilege is state specific)

Federal Protection Waivers

In some situations, federal protections for peer review might be waived.[3] Examples include:

- Antitrust issues
- Civil rights violations
- Whistleblower cases
- Emergency Medical Treatment and Active Labor Act violations

Documentation Guidelines

Although the aforementioned documentation is necessary in the day-to-day course of operations, the following guidelines should be observed:

- Document only the facts, not conclusions or speculations as to why something occurred.
- Do not use the phrase “meets the standard of care” in describing a provider’s clinical practice because it is considered a legal statement determined by expert testimony.
- When possible, document issues not specific patient identifiers.
- Do not disseminate patient-specific information beyond the peer review committee.
- Stamp all peer review materials “Confidential and Self-Critical” or “Confidential and Privileged.”
- Do not ask employees to prepare written statements following an adverse outcome. Rather, employees should understand that the process will be handled through peer review.
- Collect all handouts or minutes at the conclusion of peer review meetings. Refrain from discussing a specific adverse outcome outside of the peer review committee setting.

Conclusion

Peer review is an important tool for evaluating quality of care and clinical systems and processes. Group practices that wish to initiate peer review should (a) meet with their attorneys to review state-specific statutes and case law related to peer review; (b) establish peer review committees and define their role and scope; (c) develop a thorough, written peer review process; and (e) continuously monitor provider performance.

Implementing a well-designed peer review process can help healthcare practices ensure competency, quality, and consistency throughout the patient care continuum.

Resources

- Advances in Patient Safety: New Directions and Alternative Approaches (Vol. 2: Culture and Redesign): The Rural Physician Peer Review Model©: A Virtual Solution
- Agency for Healthcare Research and Quality: The Patient Safety and Quality Improvement Act of 2005
- American Board of Medical Specialties: Board Certification Standards
- Centers for Medicare & Medicaid Services: Physician Quality Reporting System (PQRS) Overview)
- Federation of State Medical Boards: Directory of State Medical and Osteopathic Boards
- Health Care Quality Improvement Act of 1986
- The Joint Commission: Ongoing Professional Practice Evaluation (OPPE) – Understanding the Requirements

Endnotes

[1] 42 USC §11101 et seq.

[2] MedPro Group. (2023). *Medical office & clinic-based cases: Data insight.* Retrieved from www.medpro.com/documents/10502/5086245/Medical+Office+%26+Clinic-Based+Cases_Data+Insight.pdf

[3] Federal Rules of Evidence, Rule 501. Privilege in General.

Appendix A. Sample Peer Review Policy Outline

I. Purpose/expected outcomes

   A. Process

   B. Activities

II. Policy

   A. Peer review committee

      1. Grant of authority and formation (include granting body)
      2. Member selection
      3. Roles
      4. Responsibilities
      5. Requirement for external review
      6. Process for external review

   B. Quality review committee

      1. Member selection
      2. Responsibilities

   C. Competencies/indicators

      1. American Council for Graduate Medical Education/American Board of Medical Specialties/The Joint Commission core competencies

         a. Patient care and procedural skills

         b. Medical knowledge

         c. Practice-based learning and improvement

         d. Interpersonal and communication skills

         e. Professionalism

         f. System-based practice

2. Indicators
    a. Patient outcomes
    b. Adverse patient outcomes/complications
    c. Incident reports
    d. Complaints/grievances
    e. Mandatory public health reportable events
    f. Case specific
    g. Quality data
        i. Diagnostic test results review and follow-up
        ii. Referral follow-up
        iii. Escalation or extension of follow-up care
        iv. Appropriate treatment
            a) Initiated
            b) Modified/enhanced
3. Timeframe
    a. Continuous
    b. Case specific

D. Professional practice evaluation
    1. Ongoing professional practice evaluation
    2. Focused professional practice evaluation

E. Peer review protection
    1. Document labeling
    2. Distribution limitations
    3. Retention and storage
    4. Limited access

III. Definitions

A. Peer

B. Peer reviewer

C. Peer review committee

D. Conflict of interest

E. External peer review

F. Quality review committee

G. Case

H. Practitioner

I. Core competencies

J. General professional indicators

K. Disruptive behavior

L. Specialty-specific indicators

M. Aggregate case review

N. Single case review

O. Ongoing professional practice evaluation

P. Focused professional practice evaluation

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