If you Google “medical peer review” you will find numerous articles on the formal process that occurs in response to an adverse event. What you won’t find is a wealth of information on the continuous retrospective chart review process that we are also responsible for conducting. This process is for quality assurance and quality improvement (QA/QI). I became interested in this process at my last post when I came into the OIC role early January 2011 and had a host of OPPEs (ongoing professional performance evaluations) due and realized that many of my providers were significantly behind on their chart reviews. I started wondering why that was and what was the true purpose we were trying to achieve with these chart reviews? Was it a check the box process, which is what it seemed to have become, or was there an educational purpose to it?

First, peer review has been defined as a “continuous, systematic and critical reflection by a number of care providers, on their own and colleague’s performance, using structured procedures, with the aim of achieving continuous improvement of the quality of care” (Grol, 1994). The AAFP states that the “end product of peer review should be improvement of patient care through physician education and health system improvement”. Although both definition and purpose apply to the formal process, they can be extended to the less formal QA/QI process.

After doing some research and a small survey of the providers on post, what I found out was both surprising and informative. First, despite thoughts to the contrary, most providers felt that the 2-5 minutes per chart that they were spending was the ideal amount of time to spend. Almost 50% of the providers felt uncomfortable making comments on chart reviews due to concerns about possible backlash or confidentiality issues. Conversely, there was overwhelming feeling of frustration about the lack of feedback from the peer review system. Finally, of my providers, 60% felt that we were not meeting the goal of peer review as laid out by the AAFP. Another survey by Richard Grol (1994), conducted on 234 providers, found that they felt the most useful aspects of peer review to be: 1) exchanging experiences, 2) becoming aware of system and personal knowledge gaps and 3) being informed of new guidelines.

KEY INGREDIENTS OF PEER REVIEWS

Dr. Marc Edwards (2009) argues that that there can be many benefits to a comprehensive peer review approach. He suggests that a peer review system should have the following key ingredients:

Performance not competence evaluation – Dr. Edwards states that “competence is an enduring quality that is unlikely to change quickly in the absence of a physician health problem” but that performance is more encompassing and context sensitive. This means that performance will vary more when processes are not well controlled. Competence only looks at standard of care of the provider, whereas performance looks at the whole encounter.

Quality improvement project – Peer review should be approached as a QI project, not a judgmental or punitive process. This should help take the stigma out of the process and relieve some of the providers’ fears about their participation in the process. Providers often are hesitant to report on one and another due to fear of retribution or getting a friend or colleague in trouble. The AAFP recommends “Physicians conducting peer review should be afforded confidentiality,
but the evidence and clinical decision making used in developing peer review decisions should be transparent and open to scrutiny.” (AAFP 2011)

**Self-Improvement** - Providers must approach peer review as a self-improvement, learning process. Professionals are often resistant to the idea that they might not be doing things perfectly. In order for peer review to be effective and achieve its goals, then the provider must be open to feedback. The AAFP recommends “Physicians conducting peer review should be afforded confidentiality, but the evidence and clinical decision making used in developing peer review decisions should be transparent and open to scrutiny”. (AAFP peer review policy 2011)

**Standardize the process.** Employees within the same MTF, within the same specialty should be subject to the same peer review process, no matter in which location they work. This reduces complaints and confusion. It ensures everyone is subject to the same standards within a department.

**Timely Feedback** – If the point of a peer review process is education and to improve performance, both of the system and the individual, then constructive feedback is essential. The AAFP recommends that there should be a process for rebuttals as well. It is highly recommended that if there is a serious concern, then the person should be talked to in person, either by the reviewer or the supervisor, if the reviewer is hesitant to do it. The supervisor should also be made aware of serious chart review concerns as soon as possible.

**Monitor Outcomes** - Even though this is a non-judgmental process, it is also a QA/QI process with measurements and must be tracked. The Army requires it to be mentioned in the semi-annual OPPEs. Peer review participation and performance should be part of providers’ performance objectives. Supervisors should not be caught by surprise by results and problems should be identified and addressed early. Results for providers that are not directly supervised by the MTF (i.e. unit providers) should have their results shared with them and their supervisor. This allows the supervisors to have a better understanding on how their providers are performing clinically, which is useful when filling out re-credentialing paperwork and evaluations.

**BUILDING A PEER REVIEW SYSTEM**

So we have reviewed the purpose and key objectives of a peer review system. How is that translated into practicality? Some thoughts to consider if you are interested in updating or changing your peer review process:

**Electronic versus Paper** – Paper reviews requires MANY more man-hours and resources to prepare. A benefit to paper, though, is that it can be made anonymous. Paper is also often perceived by providers to be easier to use due to not having to log onto a system and look up charts. Paper chart reviews can be easily done intermittently (i.e. 5 minutes here and there of down time between patients). Electronic reviews have the potential to be more accessible (could be done at home without bring “paper records” home). They use overall less material and manpower resources but can be more time consuming for the provider who has to log on and off of ALTHA. Electronic reviews are also hard to make anonymous.

**How to get feedback to providers?** – Email? Verbally? Copies of the handwritten or typed reviews? This has the potential to take a significant amount of time and resources if a process isn’t set up and streamlined. Supervisors also need to consider how to get feedback to those providers that you don’t see very often (volunteers, locums, unit providers, etc…).
How to manage disputes – Professionals often don’t like criticism, no matter how constructive. How do you protect anonymity (if you can get it in the first place), validate results and mediate any disputes?

Scoring system – You need to take a good look at what elements are important enough for you to review. The list needs to be succinct but cover what needs to be covered. 30 questions is probably too many; 3 or 4 is probably not enough. Do you evaluate chronic disease metrics and if so does that change your scoring system, since some charts will have this and some not? Do you use a Yes/No question system or a Lichert scale? What are your cut off points for concern or those requiring FPPE action? The items identified by the providers in my survey were: thorough history, appropriate physical, detailed assessment, appropriate medication usage (to include antibiotic usage and dosing), appropriate utilization of ancillary services and documentation of follow up.

Procedures – Should procedures be reviewed differently than other chart reviews? Which procedures should be reviewed, how frequently and using what scale (review steps above)? I caution you to be careful when determining this. For example, we had a policy that all procedures had to have 100% chart review, this included joint injections. We had a sports medicine provider working within our clinic. If this policy were to be applied, we would have been chart reviewing close to 100% of his charts or 15-20 charts per day, which would have been extremely overwhelming.

Motivation – How do you motivate your providers to make peer review a priority in addition to all their other time consuming requirements? How do you get your unit providers (which you are not in the supervisory chain for) to participate and give you charts, if they are not seeing patients within the clinic?

Organizational considerations - Many of our providers carry licenses from different states than the one they work in. These different states have different licensing requirements for different professions. Peer reviews should ideally be done by peers “people of the same level and profession” but this isn’t always possible. In addition many PA’s and NP’s need to meet certain chart review requirements for their state licensure. The Army regulation states that the state license maintenance requirements must be met by the individual and it is their responsibility to inform the supervisor of these requirements. The supervisor must be aware of, document and meet those requirements. You can find state requirements at http://www.nccpa.net/StateBoards and http://www.aanp.org/.

The peer review process doesn’t have to be a “check the box” ordeal. In fact, there seems to be interest and value in having a comprehensive peer review system that meets the goal of “improvement of patient care through physician education and health system improvement” (AAFP, 2011).
References

