

ARTICLE

Peer review structures

What's out there and why

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Centers for Medicare & Medicaid Services (CMS) and all hospital accreditation organizations require peer review, but do not require any particular way to organize peer review programs. This is a plus for those who want to conduct effective peer review to meet the needs of their particular medical staff culture and resources.

Whatever review structure you choose, make sure it is able to produce a process that is unbiased, reliable, and efficient. This piece explores the pros and cons of the common structures used currently and how these structures influence the functions of peer review.

Functions of the peer review process

The structure of the peer review process must accommodate two functions. The first, called the evaluation function, is the familiar process of evaluating a practitioner's performance.

The second, called the oversight function, is less familiar. It involves all the actions necessary to oversee the process to ensure that it is done correctly.

You can achieve each function using a different set of structural models.

The evaluation function

Many medical staff members are accustomed to the evaluation function, although, today, it involves more than simply reviewing individual charts. It now includes looking at rate measures and compliance with rules. You may fulfill the evaluation function using one of the following four models:

- The department chair model (a committee of one)
- The department-based peer review committee
- The single, central, multispecialty peer review committee

- Several multispecialty peer review committees

The oversight function

The oversight function is less familiar because, in many hospitals, the peer review process is not organized to perform it. Medical staff oversight of the peer review process may simply be an afterthought; the medical staff may do only what the quality staff members tell it to do with regard to measurement, evaluation of data, and so forth or it may resolve controversial cases only. To create an evaluation process that truly focuses on practitioner improvement, the medical staff must establish an active oversight structure with clearly assigned responsibilities that support the goals of peer review. Such an oversight structure will, for example, select relevant practitioner measures for all six general competencies and prioritize resource use. Listed below are critical responsibilities for effective oversight of the peer review process:

- Standardizing and coordinating the case review process to ensure reliability
- Ensuring the consistent interpretation of practitioner performance data
- Selecting relevant practitioner-driven measures for all performance dimensions or general competencies
- Ensuring that data are systematically collected and analyzed
- Addressing identified performance improvement opportunities
- Ensuring the availability of practitioner performance data for feedback and reappointment
- Prioritizing the use of resources for measuring practitioner performance

With The Joint Commission and Accreditation Commission for Health Care standards for ongoing professional practice evaluation (OPPE) and general competencies, the oversight function has become even more important. This function ensures that all three components of the OPPE formula (i.e., measurement, evaluation, and follow through) are accomplished. It also ensures that the non-specialty areas of the general competencies are appropriately measured using a common target for evaluation across all specialties.

Selecting the right model

How do you decide which model is best for your medical staff? Albert Einstein once said, “All things should be as simple as possible, but no simpler.” In other words, there should be a balance between simplicity and necessary complexity. And, as our stated goal is to have an unbiased, reliable, and efficient process, any structure must enhance—or at a minimum not detract from—that goal.

In addition to reducing bias, increasing reliability, and increasing efficiency, consider how much cultural change would be needed before your medical staff would accept the model.

Bias: Individual, group, specialty, and professional

No model can do away with bias, but some models can reduce it more effectively than others. Bias is not only about how things are done, but also about how they are perceived to have been done. That is why examining the composition of the peer review committee(s) is so important. Note that although bias can never be removed, it can be reduced by including a perspective outside of the individual or group.

Individual bias is when a given individual's relationships or values may affect the evaluation. If a reviewer is a close friend, it would be difficult for that friendship not to affect that reviewer's evaluation, no matter how earnestly they tried to be impartial. Peer review is, in theory, the responsibility of the entire medical staff. Thus, when it delegates its power to individual practitioner reviewers, the opinion of one reviewer gets preference, and it may not reflect that of a department or the medical staff as a whole. Individual bias can be reduced by blinding reviews, which is difficult, or by performing the final evaluation as a group.

Group bias is when an entire group's values or relationships may affect the evaluation. Specialty bias is a common type of group bias, and the concern, when it comes into play, is that the opinion of a department may not reflect that of the medical staff.

Remember, except in situations in which the question of technical quality of care hinges on specialty, or department-specific clinical issues, a practitioner in a given specialty or department does not have to be evaluated by other practitioners in that specialty or department. Specialty bias can be reduced through multispecialty peer review committees.

Another form of group bias is professional bias. Here, the concern is that the opinion of the practitioners may not reflect that of the community. Professional bias can be reduced by seeking multidisciplinary (i.e., nonphysician clinician) input into peer review.

Reliability

A reliable peer review process is one that produces consistent results. If one reviewer determines that care was appropriate, would the majority of other reviewers agree most of the time? Similarly, if the peer review committee determines that care has a significant opportunity for improvement, would the same committee, with different members, reach the same conclusions a year later? For a process that is reliable, the answer to both questions should be yes.

Reliability is adversely affected if a larger number of reviewers and committees perform reviews. It also is affected by how effective medical staff oversight is. For example, does the oversight function extend to matters such as ensuring the adequacy of reviewer and committee training? For these reasons, examining the oversight structure, as well as the number and complexity of the committees to be overseen, is important.

Remember, a consistent process is not only perceived to be fairer, it is fairer.

Efficiency

Efficiency means achieving a result using the minimum amount of resources. In peer review, the primary resource is practitioner and support staff time. The three main factors that affect time are the types of measures used to evaluate practitioner performance, the procedures used in the evaluation process, and the number of committees and individuals involved.

Having multiple departmental peer review committees means more practitioners spend time in peer review meetings, not to mention the time that the administrative support staff spends to organize the meetings and prepare the documents. The hours quickly add up, and that doesn't even account for the time the quality department personnel spend vetting cases and screening them for the practitioners.

Culture

Although the primary goal is for the peer review process to be unbiased, reliable, and efficient, a model is useful only if it is implemented. That depends on the current culture of the organization. If the strategy is in tune with the culture, implementation is easy; however, if it requires cultural change, implementation is more difficult. Therefore, consider any potential cultural resistance to change before deciding which model to use.

The evaluation function: Basic peer review models

There are four basic models for the evaluation function, although there are variations within each.

The department chair model

This model is most often found in academic hospitals where the appointed department chair reviews all quality-of-care issues, interacts directly with the practitioner involved, and comes to a conclusion without input from others. It is, in effect, a committee of one. This model is also used in community hospitals where the elected department chair is assigned this responsibility.

This model is simple and the most efficient form of governance in that a single individual often makes more efficient decisions than a committee. Another plus is that because it is a traditional model, it requires little or no culture change, although it has significant drawbacks in terms of individual and specialty bias.

The department-based peer review committee

The departmental (or specialty-based) peer review committee model is the most common today. It derives in part from the university setting, where peer review and mortality and morbidity conferences were, in the past, often combined.

In this model, a clinical department selects a subset of its members (usually between 5 and 10) to meet at prescribed times (usually monthly) to carry out peer evaluations.

Cases are identified for review based on various indicators and are usually assigned for review prior to the meeting. The committee meets to discuss the relevant charts and other materials and determines whether care was appropriate.

Departmental peer review committees may also determine the indicators to be used, typically by reviewing the previous year's list and making minor changes. This group may also be used for departmental performance improvement (e.g., specialty practice guidelines).

While this is also a traditional model that requires little or no culture change, organizations should consider the cost to the peer review process. This model has significant issues related to bias, reliability, and efficiency. Although this model is widely used, its failure is the most common reason medical staffs seek professional counsel on how to improve their peer review process.

For example, a departmental peer review committee certainly reduces the individual bias concern present in the department chair model, but it still suffers from specialty bias and, because of the group process it uses, it often magnifies that bias. In addition, reliability problems stem from the multiplicity of reviewers and the variability in how different departments perform the process (although reliability can be improved with strong, active central oversight). It is also the least efficient model because of the number of department and section committees often involved.

The single, central, multispecialty peer review committee

In this model, a single multispecialty peer review committee performs all case reviews and performs the oversight functions related to other measures of practitioner performance. This model is often viewed as the most radical change from the traditional model and, therefore, requires the greatest amount of culture change. In reality, many smaller hospitals already use this model out of necessity.

Ideally, the committee is composed of seven to nine practitioners from different specialties or departments. The goal is not to have representation from every specialty but, rather, to create a cadre of dedicated, clinically credible, and respected peer reviewers who are well trained in the peer review process.

Peer review committee members act as the initial practitioner reviewers, but if additional clinical expertise is needed, the committee can request assistance from any specialist on the medical staff. All determinations of appropriateness of care are made by the committee. An advantage of this model is that it can, in one review, look at all practitioners involved and their interactions.

This model has many advantages. It's multispecialty, so there is less individual and specialty bias. And because it is a single centralized committee, there are fewer reviewers to train and, as they work together over time, they will normalize the evaluation process and increase reliability. It also removes the issue of variability because there is only one committee. This model is most efficient because it has the fewest committees to support and it eliminates the need for establishing a separate oversight committee. It also reports directly to the medical executive committee (MEC) and consolidates the quality reporting processes.

One concern often raised about this model is that with fewer practitioners doing peer review, those practitioners would be doing more work and would quickly become overloaded. However, this committee is also responsible for oversight of performance measures, so once it is educated on the proper use of rate and rule indicators, it can limit practitioner chart review to only those cases of a serious or complex nature. In fact, in some instances, practitioner chart review may decrease.

Although this model was originally thought to be best suited for smaller and medium-sized hospitals, large hospitals are increasingly finding this model effective. Surprisingly, several large tertiary care academic medical centers have also recently and successfully implemented this model.

Several multispecialty peer review committees

Although not as efficient as the single, central, multispecialty committee, this model has several advantages over the department model. It reduces individual and specialty bias by having multiple perspectives at the table during the evaluation process, instead of adding them after the fact via a second department review or appeal to an oversight committee, as is often done with the department model. It can reduce the total number of committees and practitioners involved in peer review, which increases inter-rater reliability and makes oversight easier. Additionally, many practitioners enjoy the cross-disciplinary dialogue and learning, which increases participation.

What are the downsides? Because there may be six or more of these committees, this approach still requires substantial oversight to ensure reliability; thus, efficiency is not as high. Also, some hospital-based departments will need to participate in several committees. For example, emergency medicine practitioners would be on the cardiovascular, maternal/child, and respiratory diseases peer review committees.

The oversight function

The oversight function can be performed by the peer review committee, the MEC, or an oversight medical staff quality committee. For all of the peer review function models, except for the single multispecialty committee (which is its own oversight committee), full oversight by the medical staff quality committee or the MEC is the only way to significantly reduce the reliability issues of those approaches. It is designed based on the principle that responsibility must be coupled with authority.

Even then, the more committees the medical staff quality committee must oversee, the more difficult its job is. And because it hits the cultural nerve of department autonomy, this model often requires more cultural change than the previous models.

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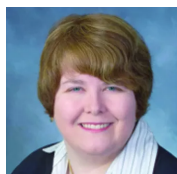
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