

July 2005

Quality Outcomes through Meaningful Physician Peer Review

Our January 2005 Health Care Quality Brief defined quality health care as "Patients getting the right medicine, treatment or test at the right time, given the patient's condition." We also noted that, while the definition is simple, the measurements systems are not.

This Health Issues Brief will outline the longstanding process of Physician Peer Review, one of the many systems hospitals use to measure and ensure quality patient care. It will also highlight Florida Hospital's leadership in physician peer review processes.

Physician Peer Review

Physician Peer Review helps maintain and improve the quality of medical care in the hospital setting. The American College of Surgeons initially implemented peer review in 1918 to set minimum standards for hospitals and the medical profession. Today, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), which licenses all hospitals, requires peer review for all US hospitals.

Confidentiality in Peer Review

By its very nature, peer review is confidential and non-confrontational. In a sense, it resembles grand jury testimony. Its goal is to gather and evaluate facts to determine action relating to a physician's care of a patient. Peer review allows all parties to hold frank and truthful discussions about the appropriate "standard of care" -- or failure to achieve it -- without concern for later consequences. This, in turn, allows for the successful evaluation of physician performance, the identification of potential and real system failures, and improvements to the processes impacting the failure.

Various state courts and the Florida Supreme Court have held confidentiality to be essential for meaningful peer review and quality improvement processes. The federal government passed the Health Care Quality Improvement Act of 1986; it gives "immunity from civil lawsuits to peer review panels so they may frankly discuss quality improvement without fear of legal reprisal." As a result, the discussions and conclusions of most peer review sessions cannot be released to any outsiders or used in medical malpractice actions.

In healthcare we have struggled to create a culture that encourages error reporting—just as the major industries do. They recognized that confidential error-reporting systems are the only way to ensure quality and improve processes.

*Joseph D. Portoghese, MD
Medical Staff President*

Making Peer Review More Accountable

The Florida Hospital Medical Staff revised its entire peer review process in January 2004.

"We want to maintain confidentiality but also create greater accountability," said Joseph Portoghese, MD, Medical Staff president. "The result is a streamlined multi-level process with different layers of accountability." Physician peer review at Florida Hospital is "blind." All patient, physician and clinical staff "identifiers" are removed from the patient's chart before it is sent to review. This way, staff and physician reviewers do not know which physicians or staff members they are reviewing.

"Now, we look at both physician performance and the circumstances that may have impacted the occurrence," Portoghesi explained. "The benefit is the identification and correction of system/process problems as well as appropriate physician discipline."

Clinical Performance Improvement at Florida Hospital

Peer review begins with the Clinical Performance Improvement (CPI) Department. This team of specially trained registered nurses conducts random chart reviews, and responds to complaints and "quality of care" concerns.

- Level 1 Review involves quarterly tracking of both "process" and "rate-based" trends (mortality, infections, etc.). If a physician or department's trends seem higher than average, further analysis is conducted. For example, if Dr. X's surgical infection rate is determined to be statistically significantly higher, the CPI team initiates a deeper review.
- Level 2 Review addresses specific Medical Staff Bylaw violations, such as using non-approved abbreviations on a patient's chart. These violations trigger an education letter to the physician. If a physician has three or more occurrences within a quarter, further action is taken.
- Level 3 Review investigates "specific patient occurrences." These automatically warrant a full review of a patient's case in one of two ways. Many departments have criteria that result in an automatic review, such as all pediatric or newborn deaths. Level 3 reviews can also be prompted by potential medical liability claims, and concerns reported by physicians, staff, patients or family members. While Level 3 reviews are the most in-depth, they are not automatically indicative that a problem exists.

Physician Peer Review

If the Clinical Performance Improvement team identifies a quality of care concern, the case moves to a multi-level process including the CPI team and certified physician reviewers. As previously noted, all cases are blinded to remove all identifying information related to the patient, physicians and supportive clinical staff.

The first step is Department Review -- e.g., Orthopedics -- in which the physician's department makes recommendations. If further investigation is warranted, the case moves to multi-specialty Review. Here, three separate multi-specialty teams outside the physician's department review the case and make recommendations.

Next, the four case summaries and recommendations are presented to the appropriate Medical Staff oversight committee: Medical Peer Review, Surgical Peer Review, or Women's and Children's Peer Review. The oversight committee members determine whether the standard of care was met.

If the standard was not met, the Committee notifies the physician's department chairperson, who takes appropriate action. Depending on the severity of the infraction, actions can include an educational letter, a requirement of continuing education related to the root cause of the occurrence, or temporary/permanent suspension of privileges.

"We have multiple quality indicators throughout the hospital, but only one peer review process," said Gayle Leonard, RN, Florida Hospital CPI Director, "so the physician component of the peer review process ensures that our physicians are providing quality and safe care, and help us determine any related hospital system issues. Our goal is quality, safe care for every patient."