Development and Implementation of an External Peer-Review Process

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Organizational Information
The network of hospitals described in this case report is part of an integrated healthcare system that owns, manages, and leases 15 hospitals. In addition, it includes numerous senior care facilities, behavioral health, rehabilitation services, and physician practices. In aggregate the network has more than $3 billion in annual net revenue and employs 27,000 people. The system’s flagship hospital was founded in 1940 and now serves as the largest tertiary hospital in the state, with 816 beds and a comprehensive teaching hospital for multiple residency programs and allied health professions. Most of the other hospitals within this network have their own independent origins but joined together to form one system in the mid-1990s and now serve more than 2 million patients per year in two states. Thirteen of the 15 hospitals are community hospitals with fewer than 300 beds, and each hospital has its own independent medical staff.

Brief Summary of the Problem
Shortly after assuming the position of medical director for this developing network of hospitals, I was asked to find areas in which the resources of the integrated system could add value to the operations of the member hospitals and associated medical staffs. One of the first areas on which I focused my attention was improvement of the medical review process.

Description of the Problem
One of the unique challenges for healthcare providers in small, rural communities is an unbiased peer review process. In most instances the expertise for informed, capable peer review exists. However, because of the limited number of physicians practicing in a particular specialty, finding an expert reviewer who is not a partner of the physician under review or a member of a group in direct competition is difficult. Therefore, unbiased expert opinion that cannot be criticized for prejudice or bias is difficult to obtain in any given rural community. Also, expert medical review available from external sources may use different practice standards and is often prohibitively expensive.

Most medical staffs place a high priority on quality patient care and are therefore willing to participate in reasonable peer-review processes. If adequate resources...
for unbiased peer review by experts who understand the community’s standards of care are available, these reviews will be helpful and valuable.

A benefit of any integrated system is the availability of resources across the system, which any individual unit cannot provide. In the instance of peer review the necessary resource existed across the system: unbiased, expert medical opinion that shares the same community standard. However, none of the required resources existed in any individual unit. The model I proposed provided for the sharing of local resources that did exist across the system. The task in developing and organizing a practical, workable service required the following:

• Approval by senior management of the organization
• Local acceptance by each member hospital’s administration and medical staff of an external peer-review panel
• A workable organizational structure for the governance and work of the external peer-review panel
• Legal consultation for protection and confidentiality of patients being reviewed, physicians being reviewed, physician reviewers, and member institutions and organizations
• Procedures that ensure smooth communication for referral of cases, communication of findings, and confidential archiving of reviewed cases and deliberations
• Governance of the peer-review panel
• Financial compensation for physician reviewers

ADMINISTRATIVE DECISIONS
After an appropriate amount of research and discussion with key stakeholders, I recommended the following:

• Initial appointment of a governing committee for the external peer-review body
• The governing committee will be assisted by management’s designee for ongoing administrative support and by the system’s legal counsel on an as-needed basis
• Development of the necessary bylaws and contracts as determined by the governing committee and its legal counsel
• Considerations for protection to include the following, at least: the protection of the confidentiality and privacy of all participants, and maximum limitation of liability for all participants and their associated institutions
• Development of a panel of physicians who practice in multiple localities, in multiple specialties, and using the same community standards to serve as unbiased expert reviewers of patient care
• All hospitals that are participants in the network will be permitted and encouraged to join the peer-review process
Physicians from each community will be encouraged to volunteer to serve on the peer-review panel if they meet the criteria for membership.

A presentation will be made to the administration of each hospital; if this presentation is acceptable, another presentation will be made to its medical staff’s leadership. This presentation will orient the medical staff and management regarding the purpose, process, and protocols of this peer-review process.

When the medical staff determines that external peer review is appropriate, the chairperson of the medical staff’s medical review body (which in many instances may be the chief of staff of the medical executive committee) will contact the external peer-review office for facilitation of the review.

Once the review is complete, the findings will be communicated by letter to the chairperson of the requesting hospital’s medical review body.

Each physician reviewer will be financially compensated through the external peer-review office, which will be responsible for all appropriate documentation and accounting procedures.

All case-review content will be held strictly confidential between the hospital, external peer-review office, physician reviewers, and governing committee for external peer review.

It was believed that the external peer-review body should consist of a governing committee and a review panel of physicians that would be available for the actual peer review of individual cases. It became evident early in the planning of this service that its smooth ongoing function would depend on a governing committee that consists of a reliable, small group of knowledgeable individuals who could meet regularly and provide direction for the practical implementation of the stated mission: external expert peer review when requested by the member hospitals. It would be the responsibility of this governing committee to assign cases to appropriate members of the panel, review their findings for “reasonableness,” communicate findings back to the requesting hospital, and coordinate the entire effort.

From the outset the first choice and intention was to include physicians throughout the entire network who could provide the leadership for development of a multidisciplinary panel of reviewers and the subsequent assignment of cases to the appropriate members of the panels. However, it quickly became evident that the constraints of time and travel would not allow for a geographically dispersed membership with comprehensive clinical responsibilities to be present on a regular basis, which was required for successful development and implementation of this program. In the end it was accepted that the governing committee would have a centrally located membership. However, we remained diligent in recruiting regional community physicians from each local hospital for the review panel and in the actual assignment of cases. Attention was given to ensuring that the governing committee had representation with at least reasonable familiarity with the disciplines.
in which it anticipated requests for review. Four initial appointments were made to this committee by the board of the hospital network.

For the administration of the operational and practical details, management assigned an associate vice president to assist and facilitate the operations and deliberation of the external peer-review body. These duties include the following:

- Assist with governing committee meetings by preparing agendas, recording meeting minutes, and organizing cases requested for review and their findings
- Manage correspondence
- Collect and disburse fees for expert peer review
- Maintain records

In the development stage of this project the governing committee worked closely with legal counsel on the development of the following documents:

- “External Peer Review Operating Plan,” which serves as the bylaws of the external peer-review body
- “External Peer Review Services Agreement,” which defines the governing committee’s relationship with the hospital’s medical review body that requests external peer-review services
- “Agreement to Provide Peer Review Services,” which defines the contracted relationship between the physician reviewers

Since the initial legal research and document preparation were completed, there has been limited need for ongoing legal counsel, but lawyers remain available to the governing committee for counsel and assistance as needed.

Once approved by senior management, this program was presented to the facility executives at one of their regular round-table meetings. They unanimously endorsed the concept and supported its implementation. Over the next several weeks each hospital’s medical executive committee was presented with a complete description of the proposed process for external peer review. The benefits of external peer review were presented, and it was emphasized that participation of the hospital and medical staff was voluntary. Furthermore, physicians from each hospital were invited and encouraged to become a part of the physician review panel. Criteria for membership and expectations were explained at that time. The presentations were well received and often precipitated productive discussion. A formal written contract and applications for review-panel membership were left at each hospital with instructions for them to be completed and returned if the hospital and its medical staff chose to participate. Following these presentations each hospital elected to participate and, with some encouragement by hospital and physician leadership, respected members of each hospital agreed to participate on the panel. Within a few weeks, more than 70 physicians from varied specialties and hospitals were on the medical review panel.
Within a few months of its development, the panel began to receive requests for external peer review. With each request, two copies of the chart were required—these were chronologically ordered, tabbed by chart division (e.g., progress notes, labs), had all patient and physician identities blacked out, and were accompanied by the question to be answered by the peer reviewers. The governing committee met monthly and assigned each case to two appropriate reviewers from the panel. Each reviewer was given a questionnaire to complete about the case; it included a synopsis of the case, the assignment of a severity index, specific routine questions, and comments. Each reviewer was also asked to document the number of hours spent. (If they anticipated spending more than four hours, I asked that they contact me for further instruction, but in no instance has anyone contacted me or spent more than four hours.) If any further direction was needed, a phone number was provided and I returned the call. Occasionally, but not frequently, a request was made, usually about how to handle inadequate documentation within the chart. My usual direction was to assess the care on the basis of what was there and to let the chart stand for itself. If the reviewer found the documentation deficient, he or she was encouraged to acknowledge that deficiency as a finding and comment accordingly. Without any exception to date, I have found our reviewers to be cooperative and thorough. It has been gratifying to find so many physicians willing to take seriously their responsibility to contribute to meaningful peer review.

Once the two reviews were received back from the reviewers, the governing committee reviewed them at its monthly meeting. The objective was to determine if the reviews were reasonable and consistent, but never to unilaterally alter their content. If the reviews were inconsistent, the committee could have taken one of several alternative paths:

- Contacted one or both reviewers for further clarification (they may have misread or misinterpreted the severity index)
- Assigned a third reviewer for comment
- Sent the conflicting reviews as they were (acknowledging that sometimes honest controversy exists)

Fortunately, most often the reviews were consistent. When the governing committee was satisfied, the reviews were forwarded to the medical review committee (often the medical executive committee) of the requesting hospital. The hospital was billed $100 for each hour spent by the reviewers, who were paid accordingly. In all instances the names of each patient, care provider, and reviewer were kept private and confidential. In particular, the personal identity of the reviewers was never shared with the requesting hospital or its medical staff.

**RESULTS**

Since beginning this program in 1998 the external peer-review body has reviewed 83 charts from 14 different hospitals. Seventy-eight physicians from 19 specialties
have been recruited for the panel. The majority of the panel members have participated in the review of at least one case, and many of the members have reviewed multiple cases. The most common specialty reviewed has been obstetrics. Satisfaction surveys and verbal feedback have been consistently favorable, indicating that the peer reviewers’ assessments and comments have been helpful. The effect of this program seems to have extended beyond the assistance with the individual cases reviewed. When medical staffs are provided with the potential for external peer review, they seem more willing to assume responsibility for their own internal peer review and deal seriously with their own issues.

**SOURCE MATERIALS**

References used include the healthcare system’s annual report (2001) and the state’s hospital guide (2003).

After ten years of private practice in urology and active participation in the leadership of his hospital medical staff, **Johnson Kelly, M.D., M.B.A., FACHE, FACPE**, joined the administrative team of Cleveland Regional Medical Center, a 261-bed hospital with Carolinas HealthCare System, as vice president of medical affairs. Over the last ten years, he has been active in facilitating improvements in quality and peer review for his medical staff and other hospitals within Carolinas HealthCare System. Dr. Kelly believes that while peer review is still an important element of a quality program, it is only one component of a successful hospital strategy. To better approach the theoretical ideal, a method that focuses on systems theory is required. This case study represents a part of Dr. Kelly’s ACHE Fellow Project. It was voted one of the best case studies in 2003. To view this Fellow Project online visit [http://ache.org/mbership/AdvtoFellow/fellowproj.cfm](http://ache.org/mbership/AdvtoFellow/fellowproj.cfm).