The Peer Review Issue

AAAHC surveyors find that most organizations conduct peer review but some struggle to use the process fully and appropriately (e.g. for privileging and quality improvement). In this issue of Connection, we’ll take a close look at how AAAHC defines peer review, what it looks like in practice, and how it contributes to quality care and organizational excellence.

Peer review. What is it? AAAHC defines peer review as a participatory process that monitors important aspects of care provided by an organization’s individual practitioners, and by those practitioners in the aggregate.

Who is a peer? Ideally, peer review is undertaken by those with like credentials and like specialties, however, this may not always be possible or practical. In some organizations it makes sense for a surgeon to provide peer review for an anesthesiologist; a family physician for a nurse practitioner. Your organization should identify what roles act as peers.

Anyone who is authorized to initiate, alter, or terminate care or treatment must be privileged. Anyone who is privileged is subject to peer review.

Anyone subject to privileging should also be...
peer reviewed.

of peer review policies and procedures. AAAHC surveyors will first review your peer review policies and then how you perform and document peer review, to confirm that you are doing what you say you will do. Most of this documentation will be found in credentialing and privileging files, and in the QI program (Std. 5.I.A & B*).

While a clinical record review (often referenced as a chart audit) is an element of peer review, alone, it is not sufficient. A robust peer review program should include:

1. Clinical record review

How is patient care documented? Surveyors look for records that are complete and consistent. (though electronic records have largely addressed this issue). They expect to see evidence of clinically appropriate follow-through for patients. Reports from diagnostic studies/consultations should be authenticated, and patient notification and appropriate other action taken when indicated.

2. Review against benchmarks

Individual performance should be reviewed in the context of internal benchmarks (Std. 2.III.D). Critically examine your organization’s policies to define the types of data that will be collected: If it is your organization’s policy that documentation of a patient interaction is recorded on the day that care is provided, a surveyor will want to be able to confirm that the policy is followed. If you expect that a surgeon will be in the facility within a specified period before case initiation, does that happen consistently and is it documented? When you conduct satisfaction surveys with referring physicians, are they satisfied with the care their patients receive from the provider being reviewed? Are his/her patients satisfied?

A scorecard or dashboard is a common method of aggregating individual results to identify internal benchmarks. Scorecards are also used to track specific health outcomes, e.g. incidence of surgical site infections. Using this kind of tool, a peer reviewer can easily identify when and where there is an opportunity for the provider to improve. S/he will also be able to see when a provider is an outlier as well as when someone is doing great work that can be replicated among peers.

3. Observation

Including an observational element in peer review, while not a requirement of AAAHC Standards, is a great way for a reviewer to see first-hand how an individual provider interacts with staff, with patients, conducts a team huddle or a time-out, manages his/her time, etc. This is intended less to review competency with a specific procedure than as an opportunity to determine how
closely a provider adheres to organization policies, such as expectations of patient satisfaction, on-time appointment hours, or efficient use of equipment and supplies.

**Who participates?** Everyone being reviewed participates. Of course, they do this by permitting review of their performance, but there should also be broad provider participation in developing and applying the criteria for review (Std. 2.III.A).

In a larger organization, a Medical Education Committee that includes providers may take on the role of identifying what will be covered in the review. In a smaller organization, the professional staff may meet in groups of like-licensed individuals to discuss and determine meaningful peer review criteria. For a solo practitioner, it is essential that a second, outside provider be enlisted to participate.

**What about allied health professionals?** Everyone involved in patient care should be regularly evaluated with regard to their competency. How that evaluation takes place may depend on defined roles in the organization. Where a position description defines duties (for APRNs, PAs, CRNAs, counselors, nutritionists, therapists, and others), a confirmation of competencies is generally managed through performance review by a supervisor. This does not preclude these professionals from participation in the professional staff peer review activity. The organization defines its own policy.

**How/when does it happen?** Reviewers should schedule time to review a selection of patient records, to analyze information from scorecards or other data collection tools. S/he should document this activity (including a signature and date) for inclusion in credentialing/privileging files, communication to the governing body, and integration into the quality improvement (QI) program (Std. 5.I.A.7).

For individuals who are new to your organization, peer review information will not be available for the purpose of granting initial privileges. However, at the time of re-credentialing and application for re-appointment, peer review results must be a part of the process for granting continuation of privileges (Std. 2.III.H). AAAHC Standards mandate that formal peer review is included for this purpose (re-privileging) at a frequency defined in your policies but at least every three years (Std. 2.II.B.5).

**Peer review and quality**

AAAHC expects that the results of peer review will be used not only in decisions about continuation of privileges, but also integrated into quality improvement efforts.

Monitoring aspects of care involves continuous collection of data. Like all data collection, the real key—the aspect that gives value to the activity—lies in what you do with the information you collect.

When regular analysis of quality monitoring data (especially of outcomes) indicates performance movement away from an
established benchmark, peer review provides an opportunity to encourage and sustain a return to prior higher performance.

Ultimately, the purpose of peer review is to ensure consistent quality of care for patients and on-going adherence to organizational policies and procedures. Transparency in the process promotes a culture of continuous improvement.

*Standards identified in this article refer to those in the 2014 edition of the Accreditation Handbooks.*