Seven Secrets to Getting Real Value Out of Peer Review

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Practitioner peer review is an essential component of high-quality healthcare. But all too often, the peer review process is a compulsory exercise to meet regulatory requirements rather than gain real value.

Healthcare organizations have begun to recognize they can't afford to spend valuable practitioner time on processes that don't contribute to the value chain. When an organization invests in peer review, or any kind of performance improvement, it's critical to get a return on that investment. Otherwise, the process effectively siphons off revenue earned by taking care of patients in order to revisit how to take care of patients.

So why is there no return on investment? Mostly, because the typical peer review process is not designed to improve performance, which requires training, effective physician leadership, and a culture conducive to change.

Secret 1

Standardize the Case Review Process to Drive Out Bias.

Is Peer Review the Same Thing as Case Review?

Peer review began as case review. If a patient had a bad outcome, like an unexpected death, hospitals wanted to learn how to prevent it from happening to other patients. But medicine never really embraced collegial performance improvement. Instead, peer review became punitive. Practitioners preferred to ask, "How did you make this mistake?" rather than, "How can we improve?" To make matters worse, case reviews were conducted inconsistently, giving rise to accusations of bias. It's important to standardize the case review process to get buy-in from stakeholders.

Secret 2

Minimize the Use of Case Review and Maximize the Use of Data, Such as Rule and Rate Indicators.

Individual case reviews are the single most subjective, time-consuming, resource-intensive, conflict-engendering way to measure and improve practitioner performance. You can mitigate personal bias by moving case review performed by individuals into case review performed by committees; you can mitigate specialty bias by moving case review performed by specialty committees into case review performed by multispecialty groups.

Practitioners think peer review equals case review. But case review is only a subset of peer review, only one of the ways to measure and improve practitioner performance. The best way to mitigate bias in case review is to determine whether the case can be more effectively reviewed, and with less bias, by using objective measurements such as rates or rules. Peer review programs should also include the use of data, such as rule and rate indicators.

Secret 3

Use Two Targets for all Rate and Rule Indicators.

Rule examples include compliance with medical staff-endorsed clinical protocols, such as transfusion guidelines or other evidence-based guidelines, compliance with hospital policies (think medical records), or compliance with Code of Conduct rules. If a practitioner violates a rule, it can be measured. When it happens, the response should be straightforward feedback to the practitioner that the rule has been violated, accompanied by reminding the practitioner that compliance with the rule is expected going forward. It's not punitive. It's just measurement and feedback.

The same applies to rate-based indicators, where both a numerator and a denominator can be measured. Examples of rate-based indicators include mortality, complications, and surgical-site infections. These events are known to happen but should not be happening too often.

If you use one target, it creates two categories of performance, good and bad. When this is the case, practitioners tend to set the target low, not wanting to tell fellow practitioners they are "bad." A better performance improvement approach is to pick two targets: a "good enough" target, below which would be "bad," and an "excellence" target, which would be aspirational for those who are performing "good enough." This creates three categories of performance: excellent, acceptable, and needs improvement. As overachievers, practitioners naturally push themselves toward excellence. Using two targets in this manner supports a performance improvement culture that is largely self-motivated.

Secret 4

Constantly Seek the Optimal Balance Between Manage Loose and Manage Tight in Your Practitioner Culture.

What Role Does Culture Play in Enhancing or Undermining the Value of Peer Review?

An essential aspect of practitioner culture (indeed the culture of any organization), is the balance between "manage loose" and "manage tight." Many practitioners, when they look at a fellow practitioner's performance, particularly poor performance, end up thinking, "That could be me." So, practitioners tend to be "manage loose" with fellow practitioners, especially in peer review.

The challenge is that healthcare as an industry is in the midst of a journey from having been too "manage loose" to becoming more "manage tight." That's what evidence-based medicine is, as well as pay for performance, transparency, accountable care, and the patient safety movement. But there's such a thing as too "manage tight," which leads to accusations of cookbook medicine, restraint of trade, or what some would call sham peer review. It's important to continually balance between the two.

Secret 5

Invest in Training Physicians to Lead and Perform Peer Review.

Culture change is hard, especially the shift to managing tighter without becoming overly tight. This calls for effective physician leadership, which doesn't happen on its own.

Secret 6

Balance Continuous Performance Improvement With a Hefty Dose of Appreciation.

Part of a more manage tight culture is the expectation of continuous performance improvement from everyone in the organization. In other words, as good as you are today, a year from now you should be better, including you personally, your group, your medical staff, and your hospital. Year after year you're expected to continuously improve.

What's missing is an adequate dose of appreciation. Do we appreciate the practitioners who are getting up in the middle of the night, taking care of angry patients who threaten to sue them, and then get up the next morning and do it again? Are we appreciating all the sacrifices they make with their family and personal lives, and often their sleep and health, to do this work? Your peer review program needs to appreciate what practitioners already do well, because most practitioners are good docs giving good care, making significant sacrifices. Who's saying thank you?

Secret 7

Be Careful to Protect Peer Review Information but Don't Let Fear of Discoverability Stop You From Doing the Right Thing.

Which Is More Important: Performing Effective Peer Review or Protecting Peer Review Information From Discovery?

It's both. The legislature for almost every state in the country has passed a state statute that protects peer review information from discoverability because conducting effective peer review is in the public's interest. To get the most value out of peer review, everyone involved needs to do all they can to protect peer review information from discoverability. But peer review statutes vary from state to state, as does case law, which in many states has eroded peer review protections.

Does this mean practitioners should stop doing peer review if it can't be fully protected from discoverability? No. If you've got a poorly performing practitioner hurting patients and creating liability for the institution and fellow providers, physician leaders still need to take effective action.

The Best Steps to Get Better Value Out of Peer Review

The best first step is to educate physician leaders about today's proven ways to make peer review more fair, efficient, and effective. The next best step is to involve the practitioners in a redesign of the peer review process, incorporating everything that they have learned. Once practitioners learn the seven secrets to getting real value out of peer review, most will embrace them. If the culture isn't ready for this change, it's often helpful to start with an assessment that identifies what's being done well in peer review and the major opportunities for improvement.

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