Physician peer review is critically important to safe care, but it can be difficult to get physicians involved. It’s also problematic for standards compliance. “It is very hard to get the physician staff to understand that this is something that needs to be done and is protective for them and the facility,” says Sheryl Walker, MD, a surveyor and member of the accreditation committee for the Accreditation Association for Ambulatory Health Care (AAAHC). She is also medical director and chief of anesthesia at The Surgicenter of Baltimore, Owings Mills, Md.

AAAHC standards require organizations to have “an active and organized process for peer review that is integrated into the quality management and improvement program.” The standards also say that peer evaluation is used in credentialing and privileging.

Dr. Walker and 2 nurse managers described how their facilities manage the peer review process. Jerry Henderson, RN, MBA, CNOR, CASC, is executive director of The Surgicenter of Baltimore, a freestanding, multispecialty center with 5 ORs serving 112 physicians and performing about 13,200 procedures a year. Marilyn Christian, RN, BSN, CNOR, CASC, is chief operations officer for Special Surgery of Houston, a 4-OR physician-owned multispecialty ASC. Procedures performed include orthopedics, podiatry, interventional pain management, and reconstructive plastic surgery. The center has about 20 physicians and performs about 2,200 procedures a year.

Who is on your peer review committee?

Christian: Our peer review process is guided by our medical review board, which consists of a physician from each specialty in our center, including anesthesia. At a minimum, the committee has an orthopedist, a podiatrist, a plastic surgeon, a pain management physician, and the medical director, who is an anesthesiologist.

Henderson: We have a peer review committee, which consists of 6 physicians representing various specialties, including anesthesia. The committee is chaired by one of the physician owners, a pathologist. Physicians rotate membership.

Please describe your peer review process.

Christian: We review 5% of each provider’s charts each quarter, or 3 charts, whichever is greater. This is a random selection. In addition, a focused review is conducted if there is an unusual occurrence. That is our standard of practice.

For the randomly selected charts, physicians on the committee conduct a medical review for the following components, which are part of the State of Texas and Medicare guidelines:

- treatment consistent with clinical impression
- history and physical present
- operative note present
- pathology report present
- adverse events.

The same charts are also reviewed for anesthesia services. These items include:

- Was the ASA [American Society of Anesthesiologists] score consistent with bylaws?
• Was a consultation obtained when indicated?
• Was the preoperative anesthesia assessment completed?
• If indicated, was medical clearance obtained?
• If complications occurred, were they managed appropriately?
• Did the record reflect the patient’s course or change in condition and results of treatment?
• Was the anesthesia outcome satisfactory based on the diagnosis and treatment plan?
• Was postoperative pain management adequate?

Also, for our own internal audit, we ask whether there are any suggestions for improvement.

In addition, the surgeons are asked to complete an infections and complications report every month, and we monitor the responses through the committee. If there were a complication, that would trigger a focused chart review.

**Henderson:** We have a quality indicator sheet that goes with every patient. The sheet, an alphabetical list of about 250 items, includes all kinds of issues that can occur, from operational issues like late starts to patient complications such as a hospital admission, bleeding, aspiration, and so forth.

The circulating nurse circles any items that apply to a particular case. The sheet has a place to explain the incident; who reported it; who witnessed it; whether the incident was referred to the surgeon, anesthesiologist, or a nurse; and what the findings were. The sheet then comes to me as well as to the medical director and nursing director.

Certain complications and all sentinel events are automatically referred to the peer review committee for immediate attention.

The information then is logged into our AdvantX computer system in a section for quality indicators. This enables us to track information and print out reports by physician, staff member, or types of occurrence.

We also do random chart audits on every physician who does cases in our center. Before the charts go to the peer review committee, nurses review them for documentation, completeness, accuracy, and appropriateness of care. Two nurses are assigned this responsibility. They do the chart reviews during down time from their other duties. We have regular meetings of the peer review committee where the charts are reviewed.

**Q** The AAAHC standards say you will collect data in an ongoing manner and identify trends that affect patient outcomes. Could you give an example of how you do this?

**Henderson:** Our indicator sheet and computerized information enable us to do this easily. We can run reports on any item in our indicator list. For example, if we have an ENT doctor who has a patient with unusual bleeding, we could do a search to see what percentage of his patients have had that problem. This enables us to see trends or problems with any particular physician. The reports go to the peer review committee and are used in the recredentialing and privileging process.

**Q** How do you tie peer review to recredentialing and privileging?

**Christian:** Our reappointments are done every 2 years, which is required in Texas. For some states, it is 3 years. AAAHC allows 3 years. At the time of reappointment, we examine each physician’s confidential peer review file along with the reappointment application and primary and secondary source verifications of credentials.

The file would include any practice issues that are out of the norm and have been reviewed by the Medical Review Committee. The reports and recommendations are forwarded to the governing board for final endorsement.

Also in each physician’s file are reports on the random reviews, which also are
sent to the governing board. These reports include which physicians were evaluated, how many files were reviewed, and that the services reviewed were within our guidelines. A file may be outsourced for review if the review board decides that is appropriate.

Our peer review files are consulted if there is a question about a physician’s practice, such as appropriate patient selection. This is also noted in the physician’s file. This provides documentation in case there is inappropriate activity. That would be referred to the Professional Services Committee and then to the governing board, which addresses the issue with the individual provider. This process takes place long before we reappoint someone.

**Henderson:** When it is time to recredential a surgeon, we run a report for that physician from our computer system and can see every incident, whether it is a complication or not. The reports are used by the peer review committee in considering the reappointment.

**Q** **Do you pay your physicians to review charts?**

**Henderson:** No. I don’t think you should pay anybody to do reviews. I believe it is part of their duty to keep up the quality of their profession.

**Dr Walker:** I think they probably should be paid if they are not owners or investors. I think this indicates that you really value this activity and want it done correctly.

**Q** **Do you have a problem getting physicians to complete their chart reviews?**

**Dr Walker:** I think it is a matter of education. Many physicians think an accident can never happen to them. I just gave a lecture for physicians and nurses in our center where I cited some actual malpractice cases that happened in 2003 and 2004. We dissected the cases and discussed what went wrong. In one case, a woman had a trocar placed in her abdomen for a laparoscopic cholecystectomy when she was actually having a shoulder repair. Case review is a good exercise and really gets people’s attention.

**Christian:** Most of the time when there are obstacles, I find it is because physicians are unaware of the requirements. I sell them on the importance of this. I explain it is a requirement and is part of doing business.

I also try to make it easy for them. All of our charts, when completed, are automatically scanned into our system. I have the ability to randomly select charts, de-identify them, and burn them onto a CD. I then hand-deliver the CD, a hard copy, and the forms to the physicians who will be reviewing them. When they have completed the review, the CD and documents are returned to the committee. We have chosen to keep our peer review records on paper in a confidential file rather than electronically because of discoverability issues.

**Henderson:** As in any group, you have some who work harder and more consistently than others. Everybody takes a turn on the committee because that is part of running a center. We have about 20 owners, so the duties can be rotated. Our physicians take this pretty seriously.

**Q** **Do you have physicians from different specialties review each other’s charts?**

**Christian:** The AAAHC standard advises that at least 2 physicians be involved in peer review but does not say they have to be from the same specialty. We prefer to have a specialty evaluate its own specialty.

**Henderson:** Yes. The physicians on the committee are not necessarily from the same specialty as the charts they are reviewing. I think that distances them a bit. Others who are in single-specialty or single-doctor centers have to have someone else do their peer review. They need to have an arrangement with another physician, whether in their specialty or in another specialty.

**Dr Walker:** I think it’s fine and maybe even a little better to have a physician from a different specialty review charts. A person from a different specialty may be more
likely to say, “What’s going on here? This doesn’t seem right to me.” The bar may be a little higher.

**Q** How do you manage peer review for nonphysician professionals such as certified registered nurse anesthetists (CRNAs)?

**Christian:** Anesthesia services provided by CRNAs are evaluated by the anesthesiologists.

**Henderson:** The CRNAs are reviewed through the peer review committee using the same process as for physicians. Any incidents are captured on the indicator sheet, and their documentation is audited in the chart review. If we see a trend, such as deficiencies in documentation, we are able to present this evidence to them during their evaluation. Nurses’ documentation is reviewed in the same way.

**Q** What are the advantages and disadvantages of outsourcing peer review?

**Christian:** An outside review is an advantage if your facility is small or your medical review board feels it is too personally involved in a situation. The state medical association usually has a committee that will review charts for a fee. Some specialty associations also provide this service. You may also be able to arrange for peer review with another center, such as one operated by the same management company. Charts need to be de-identified before they are sent out.

**Henderson:** We do not outsource peer review. I think the advantages are that you get an unbiased review. The disadvantage is that it may be hard to find someone who is willing to do it without added expense.

**Dr Walker:** For a small center or a solo practitioner, it may be necessary to send charts out for review. It provides objectivity and takes a burden off the person who is in the center. Also, if an outside reviewer runs across something that is inappropriate or unethical, it would be easier for them to take the proper action, such as reporting to the licensing board or the peer review body of the medical society.

The AAAHC standards are available at www.aaahc.or or by phoning 847/853-6060.

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**Should peer review data be kept electronically?**

Should peer review information be kept in your surgery center’s information system? Or is it safer to keep peer review documents only on paper? Would electronic peer review data be discoverable by plaintiff’s attorneys in case of a lawsuit?

“Information gathered solely for peer review proceedings should be labeled as such. If the files are electronic, they should be electronically secure and should not be co-mingled with other information,” says Michelle Marsh, an attorney with the firm of Waller Lansden Dortch & Davis, Nashville, Tenn.

Typically, information routinely gathered but later used in peer review is not discoverable from the peer review file, she says. But the information may be discoverable from the original source if it was gathered in the course of “customary operations.”

For example, suppose an unusual event occurred during a procedure, and a staff member noted the event in the patient’s medical record. The patient’s case was then reviewed by the peer review committee, and a summary of the analysis (including copies of pages from the record) became part of the committee’s files. The summary prepared only for peer review and kept in the peer review file would not be discoverable. But the medical record would be discoverable in accord with state and federal medical records privacy laws.

Also, some states require certain quality information to be reported. Depending
on state law, this information could be publicly available.

The federal Health Care Quality Improvement Act (42 USC § 11101) is the basis for many of the restrictions on availability of information in peer-review files. In addition, each state has its own privilege and peer review immunity protections.

Marsh provided these 3 tips:

1. Don’t treat electronic information with less concern than you treat paper documents. If the document should be in a locked cabinet and marked “privileged and confidential peer review information,” take steps to accomplish the same thing electronically by segregating and securing the information.

2. Follow your facility’s policies and procedures regarding maintaining privileged peer review information regardless of the medium. Failure to follow your own standards is one of the easiest ways to get into trouble.

3. Discuss with an attorney familiar with your state’s laws and federal law any concerns you have about your facility’s policies or security of documents used in peer review, whether stored electronically or on paper.

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**AAAASF to launch on-line peer review**

The American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF) plans to introduce web-based physician peer review this month.

The new system will allow each facility to create and register a web-based physician peer review group. The group will review reports that facilities submit to meet AAAASF’s quality improvement standards. The peer group could consist of physicians from accredited facilities or from outside.

Under AAAASF standards, accredited facilities must submit electronically at least 6 cases per surgeon, or 2% of cases in a group practice, every 6 months. If a surgeon has performed fewer than 6 cases during the reporting period, all of the cases must be submitted.

Facilities must also submit all unanticipated operative sequelae occurring within 30 days of surgery. This includes, for example, unplanned hospital admissions; unscheduled returns to the OR for complications; or untoward events such as infections, bleeding, wound dehiscence, or inadvertent injury to a body structure.

The data are aggregated and analyzed by the association as an overall quality check on its 1,200 accredited facilities. The system was developed in the 1990s when questions were raised about outcomes of surgery performed in office-based facilities.

The first report of the aggregated data, published by Geoffrey R. Keyes, MD, and associates in *Plastic and Reconstructive Surgery* in May 2004, covered more than 400,000 procedures. Incidence of unanticipated sequelae was 0.34%. The death rate was 1 in 51,450 procedures, or 0.002%.

AAAASF monitors to see that facilities are submitting their peer review data in a timely manner, explains communications director Jaime Trevino. This is also checked during a reaccreditation self-review and by AAAASF inspectors, who review charts.

If an inspector sees a red flag or there is a delay in reporting the random cases or sequelae, the facility receives a deficiency. Recurring problems or other standards violations are referred to an investigative committee.

*Information about AAAASF is available at www.aaasf.org or by phoning 888/543-5222.*