Fast-Start Implementation Guide
2015 Peer Review Manual

READ THIS FIRST!

Getting Started

A system of peer review should be considered as an integral component of any Quality Assurance program. Peer Review is designed to maintain established Standards of Care consistency within an organization and the community. Ultimately, peer review should lead to an actual improvement in the quality of care that is provided. Lastly, it should be used to provide trends for clinician performance and as a tool for feedback.

Selection of Charts

A minimum # of charts per year should be reviewed per clinician per annum. While this number has not been widely established, 25 charts per clinician annually have been considered to be an acceptable minimal number. Charts should be selected at random as overseen by the quality assurance department and/or designee. Special attention should be paid to ensure that the same charts are not pulled for the same clinician in successive peer review sessions.

At times, a serious quality of care concern may arise regarding patient care provided by a particular clinician. It may become necessary to pull 20-25 charts at one sitting to fully assess the care being provided by said clinician.

Charts should be selected for review with visits no longer than 3 months prior to the peer review audit. This will ensure that when interventions/recommendations are made, future charts will be selected in a time frame that reflects any attempted efforts at improvement (if applicable).

If at all possible, charts pulled for a certain clinician should have had 3 or more visits with that clinician during the previous 3-month period. This will allow for the clinician to be held accountable for the recommendation/accomplishment of health maintenance issues regardless of whether they are the designated primary care provider.

In the event that certain clinicians (part-time, locums or per diem) do not have patients that have been send three or more times in the preceding 3 months, then charts should be pulled for 2 or more visits. If this is also not possible, charts can be pulled for 1 visit in the preceding 3 months. In either case, the clinician being reviewed cannot be held responsible for the lack of recommendation/accomplishment of health maintenance and should be given credit regardless of whether the health maintenance has been addressed.

Traditionally, since the poorest area of compliance revolves around addressing health maintenance issues, charts are generally selected with the 3 or more times in 3 month rule. Of note, this may result in a selection bias of sicker patients (or frequent flyers) as opposed to picking the occasional acute care patient.

While it may be fruitful to examine an entire chart of care provided, it is prudent to select an index visit within the 3-month time period prior to the audit and scrutinize this visit more closely.

In some cases, a possible clinical care deficiency may be identified by one clinician regarding another clinician's care. If it is determined that the concern is not immediately threatening to the patient (by the Chief Dental Officer/Dental Director), the chart may be placed into the regular peer review audit process for review by the committee. This provides a mechanism for clinicians to anonymously have questionable care reviewed without reprisal to the clinician bringing forth the concern.

Generally, only health center charts are selected for the peer review audit process. Peer review of care that takes place in the hospital setting is usually conducted by hospital quality assurance committees.

Selecting an Audit Tool

It is important to identify areas that clinicians have the sole or majority of influence over with regards to the provision of care. Any areas such as medical assistants filling out chief complaints or signing in red ink should be factored out of the clinician peer review process.

Audit tools should have clearly defined questions that minimize subjectivity and interpretation for both the reviewer and person being reviewed. This will minimize bias across different reviewers.

An audit tool should have a section relating to general care with questions including, but not limited to the following:

- Adequate History & Physical Documentation
- Appropriate Diagnosis & Assessment
- Appropriate Plan pertaining to medications, diagnostic studies, referrals and follow up intervals

It is also suggested that a section exists with regards to dental records etiquette relating to such areas such as legibility, problem list use and chronic medication lists. Lastly, it is important to have a preventive care/oral health maintenance section pertinent to the patient population being reviewed. Examples include sedations and use of active child restraint. Other sections such as continuity of care and utilization can also be considered.

The tool should also have an area or question that identifies whether there are any significant findings that need further review. This section should be confined to those occasional things that might be discovered and have the potential for having a profound impact on the care of a patient.

Audit tools should contain the name of the person being audited, the date of the index visit being examined, chart identification # and date of birth of the patient and the date of the audit. The tool should also have an area to write in the name of the auditor (s) reviewing the chart.

Audit tools can be developed for general review of any chart. You may also choose to develop disease specific peer review audit tools for entities such as diabetes, asthma, chronic pain, childhood obesity, etc.

Selecting a Committee & Audit Frequency

The audit committee should consist of the CDO/Dental Director and selected rotating dentists. It is critical that all regular clinicians participate in the audit process during the year although peer review may need to be rotated to various clinical sites so that all clinicians are included. One of the benefits of group participation is immediate feedback derived from the group's discussion of a case.

Clinician reviewers need no special auditing experience, but should be aware of the process and the audit tool questions.

One concern of the audit process is that some clinicians who need the most improvement in their own documentation and care might be weak links in the auditing process. For this reason, it is important for the CDO/Dental Director to have oversight over the auditing of all charts. It is important to not remove weaker clinicians from the audit process due to the educational aspect of having to review other clinicians regarding their quality of care provided.

Audits should be conducted on at least a quarterly basis for review by the audit committee. This allows for a frequency that will exhibit improvement in care provided.

During the Audit

An audit tool should be completed for each chart/index visit being reviewed. Any possible deficiencies identified should be reviewed by a second reviewer. In the event that two reviewers do not agree with an area of deficiency, this should be examined by the CDO/Dental Director and an appropriate final determination can be made. CDO/Dental Director should be engaged in the entire process to ensure that reviews are being conducted satisfactorily and to ensure that the review process is equal for all involved.

After the Audit & Discoverability

After completion of the audit, a copy of each audit tool should be kept in a separate file for each clinician for future reference and documentation. Proceedings and records within the scope of a peer review committee of a health care entity shall be held in confidence and are not be subject to legal discovery. No individual who attends a meeting of a peer review committee or provides information to a peer review committee shall be permitted or required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings.

Completed audit tools should be used to calculate a summary no less frequently than on a quarterly basis, which will then be reviewed such that trends can be monitored, recommendations for corrective action can be made if needed and positive reinforcement provided if earned. Summaries of peer review scores should be blinded to protect confidentiality in the event that there is potential quality of care concerns. Due to variations amongst clinicians taking care of different population sets, summaries should be matched comparing clinicians of similar specialties.

In the event that a significant finding is identified that needs further review, the following process should be conducted. A copy of the pertinent chart pages, audit tool and a documentation form should be forwarded to the clinician being audited for his/her review and subsequent response. The documentation form should state the possible findings that need further review and should

request written response and signature within a specified time frame. The involved clinician's response should then be reviewed at the next peer review meeting and a conclusion should be reached regarding the care provided. If the involved clinician fails to return a written response within the specified time frame, the case will be reviewed and a conclusion will need to be reached without benefit of the clinician's response.

After a conclusion has been reached, rationale for all conclusions should be noted on the clinician peer review documentation form and actions taken and/or recommended should be noted as well. In the event that an untoward event occurred with regards to care given to a patient, a category level (as defined below) will be assigned to the case. A summary of all category levels assigned to cases audited should be forwarded to the Quality Assurance committee for further review on a regular basis. Involved clinicians should be notified of the results of the review with a copy forwarded to them. A copy should be kept in a separate file for each clinician for future reference, competency assessment and performance evaluations.

Category Levels

Level 0	No quality of care issues.
Level 1	Pertains primarily to art of caring and communication issues.
Level 1a	Surgical complications-untoward or post surgical events, which are not determined to be due to negligence or poor technical ability.
Level 1b	Pertains to minor system problems including documentation issues.
Level 2a	Pertains to system problems with the potential for adverse outcomes to the Patient.
Level 2b	Pertains primarily to clinical issues and/or clinical judgment directly impacting patient care with potential for mild to moderate adverse effects on the patient.
Level 2c	Clinical issues, which reflect the potential for significant to serious adverse effects on the patient.
Level 3	Medical mismanagement with a significant adverse effect on the patient.

Be sure to keep your audit records for at least six (6) years. Remember to audit two charts per month. Review your audits and look not only for micro issues, but study them for macro issues (repeated mistakes, which can include missing out on legitimate reimbursement).

These records should be secured and are to be considered confidential. If you are subjected to an audit, contact your attorney. Make him or her aware THAT you audit and provide them this proof. If Dental Compliance Specialists can assist you further we surely welcome the opportunity. It is our pleasure to serve you and your dental team.

We are committed to your success. If you have any questions call or e-mail us at (817) 755-0035 or info@dentalcompliance.com.

Protecting and serving Dental Professionals,