CIVILIAN EXTERNAL PEER REVIEW PROGRAM

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The Civilian External Peer Review Program (CEPRP) was initiated in 1986 to generate a report card on health care provided by the Department of Defense (DoD). CEPRP has also supplemented internal quality management programs by monitoring the quality of care in military treatment facilities (MTFs) and by supporting the education of providers.

Since its implementation, CEPRP has bolstered confidence in military medicine by consistently showing that DoD provides health care complying well with professional review criteria. These criteria have been developed by practicing clinicians of medical specialty societies and reflect nationally accepted professional standards. CEPRP remains the sole external mechanism available to DoD to document the overall performance of its medical care.

In June, 1993, a member of the Department of Legal Medicine at the Armed Forces Institute of Pathology was appointed the Contracting Officer's Representative (COR) for CEPRP. The COR is responsible for verifying compliance with the technical requirements of the contract, including the timely submission of reports. To perform this duty, the COR conducts or supervises inspections of the contractor and informs the Contracting Officer of any deficiency.

CEPRP PROCESS AND SOME RESULTS

The current CEPRP process involves a series of discrete steps.

1) Clinical diagnoses, procedures, and events with an increased potential for complications or adverse outcomes are chosen for review by representatives from the Offices of the Surgeons General, faculty of the Uniformed Services University of the Health Sciences, and other designated military physicians; 2) A medical advisory panel composed of practicing civilian and military clinicians of various specialties develops standards of care screening criteria; 3) Using a computer-assisted sampling program, the MTFs identify patient records to be reviewed; 4) Data is abstracted from the records and compared with the standards of care screening criteria. Care is presumed acceptable in those cases whose records meet the criteria; 5) The records that do not meet the criteria are referred to a panel of physicians for further review and adequacy of care determination. Care is presumed acceptable in those cases whose records meet the panel's criteria; 6) Reports on all records not meeting the panel's criteria are sent to the MTFs for comment; 7) A final review of these records and adequacy of care determination is made by the physician panel in light of those comments; and 8) A report of all records having one or more deficiencies is sent back to the MTFs.

In 1987, CEPRP reviewed the medical records of between seven and eight percent of all discharges from military hospitals.[1] Approximately 85 percent of the total records reviewed met computerized screening criteria, and care was presumed acceptable. The remaining records were referred to the physician peer review panel for initial assessment.

Slightly more than three-quarters of the referred records were judged compliant with screening criteria by the peer review panel. The remaining (between three and four percent of the total reviewed) were judged noncompliant by the panel and required feedback from the MTFs. Three-quarters of the cases receiving feedback were subsequently cleared by the physician peer review panel.

Ultimately, less than one percent of all reviewed cases failed to comply with standards of care criteria. In a more recent study reported in 1992, approximately two percent of the records reviewed were deemed noncompliant with standards of care criteria.[2] DoD has been unable yet to compare these results with those of other health care systems, because studies employing the same methodology have not been reported for other systems.

CEPRP FUTURE

A specific profile defines the Civilian External Peer Review Program of 1993 and beyond. It is and will continue to be:

1) physician designed and clinically driven; 2) based on objective information; 3) decentralized in its gathering of clinical information; 4) centralized in its data analysis and reporting; 5) synergistic with internal quality assessment activities; 6) reliant upon dialogue, feedback, learning and local leadership; 7) nondisruptive of command structure and authority; 8) organizationally distinct, while communicating better with those interested in its output; 9) adaptable in review capability to include cases at MTFs in which acute care is not provided and cases upon which longitudinal studies of beneficiaries' care can be based; and 10) known to military physicians.

In CEPRP's next phase, these characteristics will be strengthened. Additionally, the review process will be refined to minimize less productive program elements, and the program will be made more customer driven.

Discussions are underway to associate the Uniformed Services University of the Health Sciences more closely with CEPRP. These discussions encompass suggestions to use CEPRP as a research resource, linking it with graduate medical education, and publishing special *ad hoc* studies. For instance, the largely untapped databases already resulting from CEPRP can provide valuable material for studies that would benefit many clinical specialties.

CEPRP may also be used by MTFs as they work to meet accreditation standards of the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO). CEPRP can compliment the monitoring of indicators focused upon by JCAHO and serve as an early warning system for potentially problematic areas.

In all likelihood, however, the most critical task of CEPRP will continue to be its role in assessing the overall quality of DoD health care. By performing this task well, CEPRP can continue to assist providers in delivering an improving quality of care to beneficiaries of military medicine.

REFERENCES

1. Mayer W, Clinton JJ, Newhall D. A first report of the Department of Defense external civilian peer review of medical care. JAMA. 1988; 260:2690-2693.

2. Merry M, et al. The Department of Defense civilian external peer review program: An interim report. MILITARY MEDICINE. 1992; 157:40-46.