Policy /Procedure Document	
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Origination Date:	11/17/2005
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Policy Owner:	Medical Staff
Required Approvals:	
Committee*:*	Medical Executive Committee
Leadership/Board:	Board of Trustees

TITLE:	**Medical Staff Peer Review**
SCOPE:	This policy is intended for all Practitioners granted Privileges at Memorial Hospital.
DOCUMENT TYPE:	N/A
PURPOSE:	To ensure that the Hospital, through the activities of its Medical Staff, assesses the Ongoing Professional Practice Evaluation (OPPE) of individuals granted Clinical Privileges and uses the results of such assessments to improve patient care and, when necessary, performs Focused Professional Practice Evaluation (FPPE).
PHILOSOPHY:	N/A
DEFINITIONS:	N/A
PROCEDURE:	

Goals:

1. Monitor and evaluate the ongoing professional practice of individual Practitioners with Clinical Privileges.
2. Create a culture with a positive approach to peer review by recognizing Practitioner excellence as well as identifying improvement opportunities.
3. Perform FPPE when potential Practitioner improvement opportunities are identified.
4. Promote efficient use of Practitioner and Quality staff resources.
5. Provide accurate and timely performance data for Practitioner feedback, OPPE, FPPE, and reappointment.
6. Support Medical Staff educational goals to improve patient care.
7. Provide a link with the hospital performance improvement structure to assure responsiveness to system improvement opportunities identified by the Medical Staff.
8. Ensure that the process for Peer Review is clearly defined, fair, defensible, timely and useful.

Definitions:

Peer Review
The evaluation of an individual Practitioner's professional performance for all relevant competency categories using multiple sources of data and the identification of opportunities to improve care.

The data sources may include case reviews and aggregate data based on review, rule, and rate indicators in comparison with generally recognized standards, benchmarks, or norms. The data may be objective or perception-based as appropriate for the competency under evaluation.

Through this process, Practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice as defined by the Joint Commission general competencies' described below:

- **Patient Care**
- **Medical Knowledge**
- **Interpersonal and communication skills**
- **Professionalism**
- **Systems-based practice**
- **Practice-based learning and improvement**

Peer
A "peer" is an individual practicing in the same profession and who has the expertise to evaluate the subject matter under review.

Peer Review Body
The Committee designated by the Medical Executive Committee (MEC) to conduct the review of individual Practitioner performance The Peer Review Body will be the Peer Review Committee (PRC) unless otherwise designated for specific circumstances by the MEC. The Peer Review Body may render judgments of Practitioner performance based on information provided by individual reviewers who possess appropriate subject matter expertise.

Ongoing Professional Practice Evaluation (OPPE)
The routine monitoring and evaluation of current competency for Practitioners with granted Privileges.

Focused Professional Practice Evaluation (FPPE)
The confirmation of current competency based on:

- Concerns from OPPE (i.e., focused review) or
- New Medical Staff Privilege Holders or new Privileges (e.g., proctoring)

Conflict of Interest:

A Member of the Medical Staff requested to perform Peer Review may have a conflict of interest and may not be able to render an unbiased opinion due to either involvement in the care of specific patients or because of a relationship with the Practitioner involved as a direct competitor or partner.

Peer Review Procedures:

A. Information Management

1. All Peer Review information is privileged and confidential in accordance with Medical Staff and Hospital Bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.

2. The involved Practitioner will receive provider specific feedback on a routine basis.

3. The Medical Staff will use the provider-specific peer review results in making its recommendations to the Hospital regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.

4. The Hospital will keep provider-specific peer review and other quality information concerning a Practitioner in a secure, locked file or secure electronic database. Provider-specific peer

review information consists of information related to:

a. Performance data for all dimensions of performance measured for that individual Practitioner.
b. The individual Practitioner's role in sentinel events, significant incidents or near misses.
c. Correspondence to the Practitioner regarding commendations, comments regarding practice performance, or Corrective Action.

5. Only the final determinations of the PRC, any subsequent actions or recommendations, and correspondences between the Committee and the Practitioner are considered part of an individual Practitioner's Quality File. Any written or electronic documents related to the review process other than the final Committee decisions shall be considered working notes of the Committee and shall be destroyed by policy after the Committee decision has been made. Working notes include potential issues identified by Hospital staff, preliminary case rating, questions and notes from the Practitioner reviewers, and requests for information from the involved Practitioners and any written responses to the Committee.

6. Peer Review information is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities. The Vice President of Medical Affairs (VPMA) will ensure that only authorized individuals have access to individual provider Quality Files and that the files are reviewed under the supervision of the Director of Quality Management or a designee. Access is limited to the following who are part of the Peer Review Process and, therefore, are afforded protection for Peer Review activities as outlined in this document.

a. Medical Staff President
b. Medical Staff Department Vice-Chiefs and Chiefs
c. Members of the Credentials Committee, PRC, MEC and Medical Staff Office Professionals;
d. VPMA, Director Quality Management, and Quality Staff supporting the Peer Review process
e. Hospital Risk Manager
f. Individuals surveying for accrediting bodies with appropriate jurisdiction, e.g. TJC, or state/federal regulatory bodies; and
g. Individuals with a legitimate purpose for access as determined by the Hospital Board.
h. The Hospital CEO for purposes of any potential professional review action as defined by the Medical Staff Bylaws.

7. No copies of Peer Review documents will be created and distributed unless authorized by Medical Staff Governance Documents, the MEC, the Board, or by mutual agreement between the President of the Medical Staff and the VPMA.

B. Circumstances requiring Internal Peer Review (IPR)

Internal Peer Review is conducted by the Medical Staff using its own Members as the source of evaluation of Practitioner performance. It is performed as an OPPE and reported to the appropriate committee for review and action. The procedure for conducting internal Peer Review for an individual case and for aggregate performance measures is described in Attachment A.

Focused Peer Review may be required for a Practitioner when the results of individual case reviews identify:

1. A sentinel event or "near miss" identified during concurrent or retrospective review; or

2. An unusual individual case or clinical pattern of care identified during a quality review; or
3. Alleged significant and unacceptable professional conduct; or
4. Significant substantiated patient complaints.

C. Conflict of Interest Procedure

An absolute conflict of interest would result if the Reviewer is the Practitioner under review or a first degree relative or spouse. Potential conflicts of interest are either due to the Reviewer being: 1)directly involved in the patient's care but not related to the issues under review or 2) a direct competitor, partner, or key referral source, or 3) involved in a perceived personal conflict with the Practitioner under review.

- It is the obligation of the reviewer to disclose to the Peer Review Body any potential conflict
- It is the responsibility of the Peer Review Body to determine on a case by case basis if a relative conflict is substantial enough to prevent the individual from participating
- When a potential conflict is identified, the PRC chair will be informed in advance and will determine if a substantial conflict exists
- When either an absolute or substantial potential conflict is determined to exist, the individual may not participate or be present during the Peer Review Body discussions or decisions other than to provide specific information requested as described in the Peer Review Process (Attachment A)

In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, the PRC or the MEC will replace, appoint, or determine who will participate in the process so that bias does not interfere in the decision-making process.

D. Circumstances requiring External Peer Review (EPR)

The PRC, MEC, or Board of Directors will make determinations of the need for External Peer Review.

No Practitioner can require the Hospital to obtain External Peer Review if it is not deemed appropriate by the determining bodies indicated above.

Circumstances that may require EPR include:

- Potential litigation or Fair Hearing: when the Medical Staff would benefit from confirmation of internal findings or an expert witness.

- Ambiguity – when dealing with vague or conflicting recommendations from internal reviewers or Medical Staff Committees.

- Lack of internal expertise – when no one on the Medical Staff has adequate expertise in the specialty under review; including new procedures or technology, or when the only Practitioners on the Medical Staff with that expertise are determined to have a conflict of interest.

- Audit of Internal Peer Review results; to verify the overall IPR process is credible.

- In addition, the MEC or Hospital Board may require External Peer Review in any circumstances deemed appropriate by either of these bodies.

Prior to submitting the EPR request, the authorizing body will define whether the results will be considered definitive regarding the quality and appropriateness of care rendered for the individual cases reviewed. This will be based on the nature of the review, the expertise of the reviewer, and the issues under review.

Once the results of the EPR are obtained, the report will be reviewed by the body that authorized the EPR and any designees as it sees fit within 30 days of receipt to determine if any improvement opportunities are present. If improvement opportunities exist, they will be handled through the same mechanism as IPR unless the issue is already being addressed in the Corrective Action process.

The authorizing body will also prospectively determine the nature of involvement of the Practitioner under review. Unless otherwise determined, the Practitioner will be made aware that EPR is being obtained and will receive a copy of the report. The Practitioner will be given an opportunity to provide input regarding EPR findings in the same time frames as for IPR and prior to the Committee's final decision regarding whether improvement opportunities exist or whether Corrective Action is needed.

E. Participants in the review process

Participants in the review process will be selected according to the Medical Staff policies and procedures. All participants will sign a statement of confidentiality prior to participating in Peer Review activities. PRC members will sign the statement on appointment and at least annually. Reviewers who are not committee members will sign a statement for each requested review.

F. Performance Measurement and OPPE

Individual Case Review

Peer Review will be conducted by the Medical Staff in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed by the QM Director/staff and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability.

Rate and Rule Indicator Data Evaluation

The evaluation of aggregate Practitioner performance measures via either rate or rule indicators will be conducted on an ongoing basis by the PRC or its designee as described in Appendix D.

Selection of Practitioner Performance Measures

Measures of Practitioner performance will be selected to reflect the general competencies and will utilize multiple sources of data described in the Medical Staff Indicator List in Appendix C.

Practitioner Performance Feedback and OPPE

- The best approach to improve Practitioner performance is to provide Practitioners their own data on a regular basis through a Practitioner feedback report (PFR) which can also be used for OPPE by Medical Staff leaders. The use of PFR and OPPE procedures are as follows:
    - The PFR will be distributed every eight months to Practitioners with significant clinical activity. The PFR data will be confidential and available only to the individual Practitioner and appropriate Medical Staff leaders.
    - The PFR is a starting point for identifying improvement opportunities and is not considered definitive until further evaluation, including FPPE if appropriate, is used to understand differences in performance relative to expectations.

- Vice-Chiefs will review the semi-annual PFRs and discuss any areas with opportunities for improvement with the Practitioner. After follow-up, the Vice-Chief will document conclusions or the need for further analysis. The Vice-Chief can request a Practitioner be evaluated by the PRC if there are significant areas of concern noted on the PFR.
- At the time of reappointment, the Department Chiefs will review the past two years of PFR data and document their interpretation of any indicator that shows opportunity. The Department Chiefs will also be provided a report of rule and case review results.

Thresholds for Focused Professional Practice Evaluation

If the results of OPPE indicate a potential issue with Practitioner performance, the MSQA may initiate FPPE. The thresholds for FPPE are described in the acceptable targets for the Medical Staff indicators in Appendix C. However, a single egregious case may initiate a focused review by the PRC.

G. Oversight and reporting

Oversight of the Peer Review Process is delegated by the MEC to the PRC as designated in the Medical Staff Organizational Manual.

H. Statutory Authority

This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, et seq. and the Indiana Peer Review Statute IC 34-30-15 et seq. All minutes, reports, recommendations, communications, and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities. Documents, including minutes and case review materials, prepared in connection with this policy should be labeled consistent with the following language: “Statement of confidentiality;” data, records, documents, and knowledge, including but not limited to minutes and case review materials, collected for or by individuals or committees assigned Peer Review functions are confidential, not public records, shall be used by the committee and committee members only in the exercise of proper functions of the committee, and are not available for court subpoena in accordance with the Indiana Peer Review Statute IC 34-30-15 et seq.

Appendix List

Appendix A: Case Review Process
Appendix B: Case Review Rating Forms
Appendix C: Medical Staff Indicators and Targets
Appendix D: Medical Staff Expectations for General Competencies

Document Revision History:		
Revision Date:	Reviewed/Revised By:	Summary of Changes:
08/01/2005		Original Document
08/2015	Cheryl Wibbens, MD	Major revisions made to entire document
12/20/2016	MSQA Committee	Annual Review
12/15/2017	Cheryl Wibbens, MD	Review and updates to document

APPENDIX A

Case Review Process:

Screening of charts

The Quality Management Department using Medical Staff approved quality screening indicators will screen charts.

Cases referred for Practitioner Peer Review include:

1. Cases, which have been identified in the screening process noted above using Medical Staff, approved quality-screening indicators.
2. Referrals from the patient representative regarding patient care concerns.
3. Referrals from the nursing department regarding quality of care concerns.
4. Referrals from Medical Staff Members or Privilege Holders regarding quality of care concerns.
5. Referrals from the patient representative, nursing, Medical Staff Members or Privilege Holders, or Hospital management regarding behavioral issues. These will be forwarded to be addressed by the Physician Assistance Committee.

Procedure for Peer Review

When a case is referred for Peer Review the Director of Quality Management will forward the case to the Vice-Chief of the appropriate department. The Vice-Chief after review will designate the outcome of the case as:

Assessment

1. No issue or concern – the care provided was appropriate.
2. Some issue or concern – the care provided was acceptable but an educational opportunity or opportunity for improvement was present.
3. Not Applicable – the particular area of assessment does not pertain to this case.

If the Vice-Chief is unable to review a chart due to conflict of interest, a lack of expertise, or other justifiable reason(s), the chart will be forwarded to the Chief for review. If the Chief is also unable to review the case due to conflict of interest, lack of expertise, or other justifiable reason(s), the case will be forwarded to the Chair of PRC and he/she will forward the case to the PRC for review. The PRC will then determine if there is necessity for an External Peer Review.

Peer Review Outcome

Only the final determinations of the PRC, any subsequent actions or recommendations, and correspondences between the Committee and the Practitioner are considered part of an individual Practitioner's Quality File. The Practitioner's file will be referred to the Vice-Chief of the applicable department if any patterns or trends are identified. The Practitioner will receive documentation of all of his/her cases where opportunities to improve or unacceptable findings are identified. The Practitioner will also be afforded the opportunity to document an analysis or discussion of the case in question and this documentation will be included in the file.

Review

Any Practitioner issues that are not resolved at the department level or at the PRC level will be forwarded to the MEC for discussion and action.

Appendix B

Memorial Hospital of South Bend

Confidential Peer Review Document

Case Review Form

Patient Name: _____ Practitioner: _____ #: _____

MRN#: _____

Discharge Date: _____

Admitting Diagnosis: _____ Procedures: _____

Reason for Review:

Special Indicator: _____

Reported Concern: _____

Patient Complaint: _____

FPPE/OPPE Outlier: _____

Sentinel Event: _____

Other: _____

PHYSICIAN REVIEWER: **Assessment**

Based on your review, did care by Physician demonstrate:	**No Issue**	**Some Issue/ Concern**	**N/A**
Current medical knowledge			
Appropriate clinical judgment			
Appropriate management of multiple/complex problems			
Accurate/timely medical record documentation			
Effective communication with other team members			
Professionalism with Family, Patient, and other health workers			
Efficient utilization of resources			
Compliance with clinical protocols/guidelines			

Practitioner Input **(Did you discuss with physician?)**

If yes, summarize discussion: _____

Was there any other questions raised from discussion? _____

Communication: Was there any indication communication problems contributed to any adverse outcome?

_____

Based on your review: Are there any system/policy/processes that could improve patient quality/safety?

_____

Additional Comments or Suggestions:

_____

FINAL OUTCOME: **Acceptable** _____ **Opportunity to improve** _____ **Unacceptable** _____

Physician Reviewer: _____ **Date:** _____

Appendix C

MEDICAL STAFF QUALITY SCREENING INDICATORS

I. General

1. Unplanned Transfer From General to Special Care Unit
2. Unexpected Death
3. Risk Management / Nursing Concern Referrals / Patient Complaints / Sentinel Events
4 Blood Usage Appropriateness
5. Surgical Case Appropriateness

II. Surgical

1. Surgical Wound Infection
2. Injury to Another Organ or Structure
3. Unplanned Return to Surgery
4. Surgical Mortality (Unexpected)
5. Normal Tissue Unexpected (Pathology Code 3)
6. Intra Operative Mortality
7 Major Discrepancy Between Pre and Post Operative Tissue Diagnosis (Pathology Code 4)

III. Anesthesia

1. Cardiac or Respiratory Arrest Within 4 Hours of Anesthesia
2. Mortality Within 24 Hours of Anesthesia
3. Post Dural Puncture Headache Within 72 Hours of Spinal or Epidural Anesthesia
4. Hypothermia Less Than 35 Degrees C in Recovery Room
5. Respiratory Distress or Re-Intubation in Recovery Room
6. Neurological Deficit in Recovery Room
7. Prolonged Recovery Room Stay Due to Respiratory or Cardiac Problems
8. Admission Score of <4 to Recovery Room
9. Dental Injury During Intubation

IV. Orthopedic

1. Post-Operative Compartment Syndrome
2. Neurovascular Compromise Post Operatively
3. Long Bone Fracture (Unplanned)

V. Obstetrical

1. Maternal
   a. Patient with diagnosis of Eclampsia
   b. Delivery of infant <2500 gms after elective induction or repeat C-section
   c. Maternal mortality
   d. Post-partum return to delivery or operating room for management
   e. Elective deliveries < 39 weeks
   f. Maternal transfer to a tertiary care center

2. Neonatal
   a. Neonates with Apgar of 5 or less at 5 minutes and birth weight > 1500 gms
   b. Neonates with a discharge diagnosis of significant birth trauma
   c. Term infant with diagnosis of hypoxic encephalopathy or clinical apparent seizure prior to discharge from hospital of birth (no alcohol syndrome)
   d. Death of infant weighing >500 gms; intra hospital deaths or stillborn

VI. Emergency Department

1. Admission to the Hospital within 48 hours of Being Seen in ER
2. Death within 24 Hours of Admission through ER
4. Unplanned Transfer to SCU within 24 Hours of Admission through ER
5. Transfer from ETC to another Facility (Excluding Madison Center)

Appendix C

MEDICAL STAFF QUALITY SCREENING INDICATORS

VII. Pediatrics

1. All Pediatric Deaths
2. Readmissions within 48 hours

VIII. Radiology

1. Angiography
   a. Puncture site complications
      - Hematoma requiring treatment
      - Thrombus
      - Pseudo aneurysm
   b. Non puncture site complication
      - Distal emboli
      - Dissection / occlusion
      - Vessel perforation
2. Contrast related
   a. Contrast extravasation
   b. Major allergic reaction, i.e., anaphylactic
   c. Contrast induced renal failure
3. Interventional radiology
   a. Bleeding requiring treatment
   b. Injury to target organ requiring admission or another procedure
   c. Unplanned admission following a procedure
4. Emergency Surgery
5. Missed Diagnosis

IX. Cardiac Cath Committee (Events in the Cath Lab)

1. Cardiac arrest
2. Entry site thrombus requiring Surgery
3. MI
4. Coronary Dissection Limited Flow
5. Unsuccessful PCI
6. Hematoma or Pseudo Aneurysm Requiring Surgery/transfusion
7. Emergency CAB from cath lab
8. Death s/p cardiac cath/PCI
9. V-fib / V-Tach Responding to Cardioversion
10. Return to Cath Lab in 24 hours

X. Vascular

1. Post op hematomas
2. Dissections
3. Post op Strokes
4. Wound infections
5. Unplanned return to surgery or IR within 72 hours
6. Surgical mortality
7. Blood transfusion
8. Type 1 endoleaks

XI. Psychiatric

1. Documented justification for the use of 2 or more antipsychotic medications.

Appendix D

MEDICAL STAFF EXPECTATIONS FOR GENERAL COMPETANCIES

PROFESSIONAL KNOWLEDGE, SKILLS, AND ATTITUDE

Patient Care: Provides patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease and care at the end of life.

Medical/Clinical Knowledge: Demonstrates knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.

Practice-based Learning and Improvement: Utilizes scientific evidence and methods to investigate, evaluate, and improve patient care practices. (Practice is reflective of use of evidence based medicine. Supports quality improvement initiatives as applicable.)

Interpersonal and Communication Skills: Demonstrates interpersonal and communication skills that enables him/her to establish and maintain professional relationships with patients, families, and other members of the healthcare teams.

Professionalism: Demonstrates behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their professional society, and society.

Systems-based Practice: Demonstrates an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare.

Respect: Demonstrates personal commitment to honoring the choices and rights of other persons, especially their medical care. Recognizes and responds to the psychosocial aspects of illness.

Management of complex problems; problem solving abilities: Demonstrates ability to manage or appropriately consult on patients with complex medical problems. Critically assesses information, risks and benefits and makes timely decisions and/or recommendations.

Integrity/Responsibility: Practice reflects commitment to honesty and trustworthiness in evaluating and demonstrating their skills and abilities.