

MEDICAL STAFF BYLAWS

APPENDIX “D”

DUPONT HOSPITAL

PEER REVIEW POLICY

I. PURPOSE

To ensure that patients receive quality services that meet professionally recognized standards of health care via ongoing objective, non-judgmental, consistent and fair evaluation by the Medical Staff.

The peer review in this facility will be conducted with focus on an individual practitioner arising from quality concerns (FPPE), as well as the on-going surveillance of the professional performance (OPPE) of all physicians and allied health professionals (AHP) who have delineated clinical privileges, which are based on the individual evaluation through the Standard of Care (SOC) process.

In addition, the peer review participants at Dupont Hospital shall establish triggers, subject to approval by the Board, for referring cases identified as variations of the quality indicators. It is the intent of this policy to improve the efficiency of peer review by focusing on issues or individuals identified through objective data analysis using objective criteria equally applied to all similarly privileged practitioners.

II. GOALS

- A. Improve the quality of care provided by the Medical Staff and AHPs
- B. Monitor the performance of the Medical Staff and AHPs
- C. Identify areas for performance improvement
- D. Identify educational opportunities for Medical Staff and AHPs
- E. Monitor significant trends by analyzing aggregate data
- F. Ensure the confidentiality of peer review information

III. DEFINITIONS

“Peer review” is defined as the evaluation of data or events relating to the performance or behavior of a specific practitioner, to determine if the practitioner’s performance or behavior meets the minimum standard of clinical care or behavior as established by the Medical Staff.

Peer review evaluates the strengths and weaknesses of an individual practitioner’s performance. The individual is evaluated compared to standards of care and the review offers constructive

criticism of the performance observed. Through this framework, practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

A “peer” is defined as a practitioner of the same licensure as the practitioner being reviewed. Because all physicians are considered to be “peers” of all other physicians, quality issues related to general medical care may be reviewed by another physician (MD or DO). For specialty specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a “peer” would be considered an individual well trained in that surgical specialty.

IV. PARTICIPANTS IN THE REVIEW PROCESS

Participants in the review process will be selected according to the Medical Staff Bylaws, policies and procedures. The work of all practitioners granted privileges will be reviewed through the peer review process. Clinical support staff will participate in the review process if deemed appropriate. Additional support staff will participate if such participation is included in their job responsibilities.

In the event of a conflict of interest or circumstances that would suggest a biased review, the Medical Executive Committee will replace, appoint or determine who will participate in the process so that bias does not interfere in the decision making process. Minority opinions and views of the practitioner under review will be considered and recorded.

External peer reviewers may be identified by the participating clinical service and/or Clinical Quality Committee. Upon approval of the Medical Executive Committee, the Medical Staff Office Coordinator will notify and facilitate transition of information necessary for the review process. Confidentiality of guest and practitioner will be maintained in accordance with hospital policy and laws regarding confidentiality of medical records.

V. POLICY

- A. All peer review information is considered privileged and confidential in accordance with state and federal laws and regulations covering peer review protection.
- B. Practitioner-specific feedback will be communicated to the involved practitioner on an ongoing basis.
- C. Practitioner-specific peer review results will be utilized in the Medical Staff’s credentialing and privileging recommendations and, as appropriate, the organization’s performance improvement activities.
- D. Specific practitioner names will not be disclosed during the review process. The practitioner being reviewed will be assigned a number for identification purposes.
- E. The peer review provider-specific peer review information on a practitioner will be archived separately from the practitioner’s credentialing file in a secure, locked cabinet. Provider specific peer review information is considered:
 - 1. Quality and utilization review data
 - 2. Incidents or variances
 - 3. Near misses or sentinel events
 - 4. Correspondence to the practitioner regarding corrective action.
- F. Peer review information will be available to authorized staff who have a legitimate need to know, such as:

1. Quality management
 2. Utilization management
 3. Medical Staff (clinical) services
 4. Credentialing, Quality, and Medical Executive Committee Members
 5. Individuals surveying for accrediting bodies with appropriate jurisdiction, e.g. TJC, NCQA or state/federal regulatory bodies
 6. Individuals with a legitimate purpose for access as determined by the organizations legal counsel and/or Board of Directors
 7. Practitioners may review their own peer review information in the presence of Medical Staff Office staff.
- G. No copies of peer review documents will be created and distributed unless authorized by legal counsel or specified in policy/ Rules and Regulations.
- H. Meeting minutes containing peer review information will be labeled as protected under Indiana Statute 34-30-15.

VI. INTERNAL PEER REVIEW

Ongoing peer review is conducted and reported to the appropriate clinical services committee for review and action with information reported to the Quality Committee, Medical Executive Committee, and the Board of Directors at least quarterly.

Root Cause Analysis or Intense Analysis will be conducted when there is:

- A. A sentinel event or “near miss” identified during concurrent or retrospective review; or
- B. An unusual clinical pattern of care identified during a quality review.

VII. EXTERNAL PEER REVIEW

External peer review may be utilized under the following circumstances if deemed appropriate by the, Medical Executive Committee.

- A. Litigation- when dealing with the potential for litigation.
- B. Ambiguity- when dealing with ambiguous or conflicting recommendations from internal reviewers or Medical Staff committees or when there does not appear to be a strong consensus for a particular recommendation.
- C. Lack of internal expertise-
 1. When no one on the Medical Staff has adequate expertise in the specialty under review; or
 2. When the only practitioners on the Medical Staff with that expertise are partners, associates or direct competitors of the practitioner under review and this potential for conflict of interest cannot be appropriately resolved by the Medical Staff.
- D. New technology- when a Medical Staff member requests permission to utilize new technology or perform a procedure new to this organization and the Medical Staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.
- E. Miscellaneous issues- when the Medical Staff needs an expert witness for a fair hearing, for evaluation of credential file, or for assistance in developing a benchmark for quality monitoring.

VIII. STANDARD OF CARE PEER REVIEW PROCEDURE

- A. The Medical Executive Committee approves the minimum clinical indicators identified for Peer Review annually. Criteria focus on high risk, high or low volume, and/or complications during or following a procedure. Circumstances requiring peer review include, but are not limited to the following indicators:
1. Mortality / Autopsy review
 2. Tissue discrepancy review
 3. Blood usage review
 4. Complications during/following procedures
 5. Unplanned return to surgery/Unplanned surgery
 6. Deaths
 7. Unexpected complication of pregnancy / delivery
 8. Neurological deficit within 24 hours of anesthesia
 9. Sentinel Events/Near Misses
 10. Behavioral Issues
- B. Information requiring Standard of Care Peer Review may be reported to Chief Quality Officer through:
1. Incident/variance reports
 2. Staff concerns
 3. Patient complaints
 4. Referrals from other Medical Staff and/or clinical services
 5. Referrals from external agencies.
- C. Standard of Care Peer Review Process and Timeline

Process	Time Period
Cases are identified with adverse outcome and/or potential for adverse outcome and are given to CQO. <ul style="list-style-type: none"> • Chart screened for clinical indicators. • Peer Review form initiated. 	Upon receipt.
Chart assigned to the appropriate Department Chairman, Section Chairman, or Medical Director.	Medical Staff Office Coordinator notifies reviewing practitioner(s) of assignment.
The chart is reviewed and a preliminary Standard of Care (SOC) score is assigned.	Within 90 days of receipt or at the next regularly scheduled committee meeting.
SOC levels 1 & 2	These results are reported at the next Department meeting. Documentation is secured by the Medical Staff Office for quality review and is incorporated into OPPE scorecards. All behavioral issues will be reported at the next Quality Committee meeting.
SOC levels 3 & 4 The involved practitioner will be notified of the preliminary SOC assignment by a certified letter. Further information,	The case will be reviewed at the next regularly scheduled Department meeting.

<p>clarifying the issues of care, will be requested and the practitioner will be encouraged to personally attend the next review of the case.</p> <p>If the second review finds the preliminary SOC 3 or 4 to be appropriate, the case will be referred to the Quality Committee. The Quality Committee may confirm or amend the SOC assignment.</p> <p>If the Quality Committee confirms the SOC 3 or 4 assignment, the case will be referred to the Medical Executive Committee. The Medical Executive Committee (MEC) may confirm or amend the SOC assignment. The MEC has final authority regarding the assignment of SOC levels.</p> <p>SOC 3 assignments will result in educational efforts being undertaken to reduce the likelihood of subsequent similar events.</p> <p>SOC 4 assignments will result in mandatory focused education and sanctions may be imposed.</p>	<p>At the next regularly scheduled Quality Committee meeting.</p> <p>At the next regularly scheduled Medical Executive Committee meeting. An ad hoc committee meeting may be called per the Chief of Staff, as needed.</p> <p>Documentation is secured by the Medical Staff Office for quality review and is incorporated into OPPE scorecards. The practitioner will be notified of the final designation in writing.</p>
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D. High Risk Case Time Lines

For high-risk cases, timely processing of practitioner-specific information is necessary to ensure proper adjustment to privileges if needed.

Case	Responsible	Time Frame
Sentinel Event	<ul style="list-style-type: none"> -Department Chair -Quality Chair -Chairman, Medical Executive Committee (Chief of Staff) -Chairman, Board of Directors <p>Ad hoc committee may be convened.</p> <p>Review and action taken will be determined upon completion of root cause analysis.</p>	Review within 72 hours of identification and final action/decision within 30 days of event.
Identification of case needing intense analysis but not considered a sentinel event (Near Miss)	Refer to appropriate Department Quality Committee Chair for review and action.	Review within 5 days of identification and final action/decision within 30 days of event.

	Review and action taken will be determined upon completion of root cause analysis. Ad hoc committee may be convened for review.	
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Additional information may be necessary before making a decision on action such as a literature search, second opinion, or external peer review. Under these circumstances, the timelines may be extended after approval from the Medical Executive Committee.

IX. PEER REVIEW PROCESS AND ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

The Medical Staff will conduct continuous, on-going review of the professional practice of departments, services, and members via aggregate collection of data and routing of Medical Staff Committee conclusions based upon Committee analysis of the data.

A. Method

1. Each Clinical Department will be responsible for developing indicators and the performance thresholds. The Medical Executive Committee will annually review and approve all indicators and performance expectations for all Clinical Departments.
2. Analysis of performance will occur by the individual Clinical Department Chairman. Analysis will be reported to the Quality Committee, MEC, and the Board at least twice per year. The data will also be reported to the Credentialing Committee for reappointment purposes.

B. Frequency

Frequency of reporting will be at least twice per year.

X. FOCUSED REVIEW OF A PRACTITIONER’S PERFORMANCE (FOCUSED PROFESSIONAL PRACTICE EVALUATION [FPPE])

A. Focused Professional Practice Evaluation allows the Medical Staff to focus evaluation on a specific aspect of a practitioner’s performance. This process is used when (1) a practitioner has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm competence in the organization’s setting, and (2) when questions arise regarding a practitioner’s professional practice during the course of the Ongoing Professional Practice Evaluation.

B. Focused review of an individual practitioner is triggered by the practitioner’s service, Quality Committee, Medical Executive Committee, a member of the Hospital Administration, or the Board, at anytime or during the course of the Peer Review Process as described above and/or upon the following occurrences:

1. Standard of Care Peer Review level 4.
2. “Sentinel Event” as defined by the Joint Commission that is directly associated with the care provided by the physician.
3. During the course of Ongoing Professional Practice Evaluation a pattern or trend is suspected regarding deviations from the Hospital’s standards of practice in the analyzed areas.

4. A pattern or trend in issues regarding patient safety and/or negative patient outcomes is identified during the course of OPPE.
5. The practitioner is cited for confirmed quality issues from an outside peer review or quality improvement organization requiring a plan for improvement.

C. Method for Focused Review

1. The Quality Committee Chair shall determine the individual physician(s) to perform the focused review and report back to the Committee. External peer review guidelines will be adhered to, as outlined above.
2. The Quality Committee Chair shall designate a set number of cases to be reviewed/proctored/monitored.
3. The Quality Committee Chair and/or individual physician reviewers shall exercise discretion in selecting the methods and means of evaluating the practitioner's care similar to the triggering event which may include, but shall not be limited to: chart reviews; monitoring clinical practice patterns; simulation; proctoring; external peer review; and discussion with other individuals involved in patient care including consulting physicians, surgery assistants, nursing staff, members of Hospital Administration, and others. During the course of any focused review, the practitioner whose case is subject of review shall be offered the opportunity to address the individual physician reviewer(s) and respond to their questions, if any.
4. The individual physician reviewer(s) shall report written findings and recommendations to the Quality Committee at its next regularly scheduled meeting following the completion of the focused review period. The practitioner under review will be provided with a copy of these written findings and recommendations in advance of the Committee meeting, and shall be offered the opportunity to address the Committee and respond to the findings and conclusions.
5. The Quality Committee shall make a written report and recommendations to the MEC concerning focused review. Quality Committee recommendations may include, but are not limited to: (1) Focused evaluation completed satisfactorily, (2) Focused evaluation completed unsatisfactorily, and (3) Focused evaluation not completed.
6. The Medical Executive Committee may adopt the recommendations of the Quality Committee and/or make further recommendations, including recommendation for further investigation and/or Corrective Action in accord with the Medical Staff Bylaws.
7. All recommendations of the MEC other than for further investigation or Corrective Action shall be delivered to the Board. The Board shall make a final determination concerning any actions warranted based on the findings and recommendations of the MEC.
8. Relevant information resulting from the focused evaluation process is integrated into performance improvement activities that are intended to preserve confidentiality and privilege of information. All reports, recommendations, and otherwise concerning the FPPE shall be documented and maintained in the physician's quality file. Reviews are aggregated and reviewed during the credentialing process at the time of reappointment.

9. FPPE is also utilized to establish a systematic process to ensure that there is sufficient information available to confirm the current competence of Practitioners who initially request privileges at Dupont Hospital.
- D. Method for Initially Privileged Practitioners or Additional Privileges
1. Practitioners who initially request privileges at Dupont Hospital are placed in a provisional period in which FPPE is reviewed.
 2. This period of FPPE will begin immediately upon the granting of privileges, initial and additional, and will continue until a predetermined number of cases have been reviewed.
 - a. For Internal Medicine and Family Practice 3 admissions involving 3 different body systems shall be reviewed
 - b. For Medicine Specialties 3 medical admissions shall be reviewed involving 3 different diagnosis within that specialty along with 3 cases for each procedural grouping in which they have requested privileges.
 - c. For Surgical Specialties 3 cases for each procedural grouping in which they have requested privileges shall be reviewed.
 - d. For Pathology, a minimum of 5 cases will be reviewed.
 3. Reviews are completed by the designated Clinical Department Chair. In the case that a physician holds privileges in more than one specialty, any specific questions regarding the care involved will be forwarded to the appropriate Clinical Department Chair for review.
 4. The written report of Focused Professional Practice Evaluation (FPPE), shall be presented to the Credentialing Committee. Recommendations from the Credentialing Committee will be forwarded to the MEC and Board.