

# ***MEDICAL STAFF BYLAWS***

## ***APPENDIX “D”***

### **HOSPITAL POLICY REGARDING PEER REVIEW**

This Peer Review Policy is adopted in connection with the Medical Staff Bylaws and made a part thereof. The definitions and terminologies of the Bylaws also apply to the Peer Review Policy and procedures described herein.

#### **I. PURPOSE:**

The primary purpose of this peer review policy is 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.

Peer review is properly conducted when based on evidence of objective trend measurement and/or quality concerns for clinical management, and evaluation of outcomes. A quality concern is a concern with a significant or potential for a significant, adverse effect on the patient’s wellbeing.

The peer review in this facility will be conducted both where focus is on an individual practitioner arising from quality concerns, as well as the on-going surveillance of the professional performance of all physicians who have delineated clinical privileges. Peer review will also be conducted in order to evaluate the competence of each licensed independent practitioner’s performance, in accordance with the renewing of credentials.

In addition, the peer review participants in this Hospital shall establish triggers, subject to approval by the Board, for referring cases identified as variations of the quality indicators or quality screens. 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 equivalent objective criteria.

#### **II. DEFINITION OF PEER:**

For purposes of this policy, the term “Peer” refers to any practitioner who possesses the same or similar knowledge and training in a medical specialty as the practitioner whose care is the subject of review.

#### Examples include:

- Internal Medicine / Family Practice
- Pediatrics / Family Practice
- General Surgery / ENT / Urology
- Podiatry – reviewed by the same specialty
- Orthopedics – reviewed by same specialty
- Radiology – reviewed by same specialty
- Pathology – reviewed by same specialty
- Anesthesiology – reviewed by the same specialty

If a determination is reached that no physician on the staff is qualified to conduct the review, (i.e., the hospital has only one physician in a particular specialty, or the pool of eligible reviewers is otherwise conflicted or unable to serve (see Part III, Paragraph B(2) below), the MEC or the Board of Trustees may request external peer review consistent with the hospital's External Peer Review Policy by a physician who is Board certified within the same specialty.

### **III. PEER REVIEW PROCESS AND ONGOING PROFESSIONAL PRACTICE REVIEW:**

These policies and procedures shall be applicable for all practitioners credentialed by Lutheran Musculoskeletal Center including, but not limited to, MDs, DOs, DPMs, physician assistants, and nurse practitioners. 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. Ongoing Professional Practice Review**

The Peer Review Process is coordinated by the Quality Department. Cases identified with quality of care issues are referred to the department for case review. Cases may be identified through member services, concurrent review, case management, risk management, audits, sentinel events, clinician referrals, allegations of substance abuse and other sources. In addition, the criteria for peer review listed in Attachment 2 of this Policy will trigger an initial review by the Quality Department. Any quality issue regarding patient care will be initially reviewed by a nurse in the Quality Department with oversight of the Chief of the Department and/or President of Medical Staff. If there are no quality of care issues identified following this quality management review, the case is closed, the findings are documented and trending is performed in the Quality Department. Results of peer review cases concerning medical care complaints are tracked for individual practitioners and incorporated into the physician's re-credentialing process.

Aggregate data regarding all practitioners will be reviewed and presented to the medical staff for pattern and trend analysis. Outliers identified by this analysis will be assigned for focused Peer Review by the committee chairperson if the analysis indicates an issue with an individual's performance.

Incidences/complaints received which may require intervention to ensure quality patient care is delivered, will be forwarded for peer review and/or MEC review. The data collection is the comprehensive review done by non-physician reviewers, using objective and non-judgment dependent criteria.

- Medical Staff approved indicators for screening purposes will be utilized by non-physician reviewers. (See attached list of screening criteria)
- Findings are analyzed and trended for presentation to the appropriate medical staff committee. Conclusions of the data analysis will be routed as indicated in the table below.

<b>Conclusion:</b>	<b>Action:</b>
Related to an individual's performance	Refer for peer review / focused review by appropriate Medical Staff Committee
Related to one medical or non-medical staff department's performance	Refer to the appropriate medical staff department or hospital administrative representative
Related to more than one department's performance	Refer to Quality Council for consideration of PI Team
Related to a process or system not working effectively	Refer to Quality Council for consideration of PI Team

### **B. Focused Review of a Practitioner's Performance**

Intensified (focused) review of an individual practitioner is triggered by the practitioner's department, Quality Improvement Committee, Medical Executive Committee, member of Hospital Administration, or the Board, at anytime or during the course of the Peer Review Process as described above and/or otherwise upon any of the following occurrences:

- Unexpected Patient Death;
- Emergency transfer following inpatient admission;
- "Sentinel Events" as defined by the Joint Commission;
- During the course of On-Going Professional Practice Evaluation a pattern or trend is suspected regarding deviations from the standards of practice;
- A pattern or trend in issues regarding patient safety and/or negative patient outcomes is identified during the course of On-Going Professional Practice Review;
- The practitioner is cited for quality issues from an outside peer review or quality improvement organization requiring a plan for improvement;
- Other occurrences which may affect the delivery of safe, quality patient care, including but not limited to the triggers for review delineated in Attachment 2 of this Policy.

The Department 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.

The Department Committee Chair shall designate a deadline within which the individual physician reviewers shall complete the focused review which shall not be greater than 60-days. Should the focused review involve periods of evaluation and monitoring of the practitioner delivering patient care services, the time to complete the focused review may be extended by the Department Chair for a single additional 30-day period.

The Department Committee Chair and/or individual physician reviewers shall exercise discretion in selecting the methods and means of evaluating the practitioner's care which may include, but shall not be limited to: periodic internal or external chart reviews; direct observation of delivery of patient care services; monitoring (retrospectively or concurrently) diagnostic and treatment techniques and clinical practice patterns; proctoring; and/or discussion with others 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.

The individual physician reviewer(s) shall report written findings and recommendations to the Department or 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 Department/Committee meeting, and shall be offered the opportunity to address the Department or Committee and respond to the findings and conclusions.

The Department Committee shall make a written report and recommendation to the MEC concerning the focused review.

## **1. Reviewer Selection & Duties**

Reviews are completed by the designated Medical Staff Committee. (i.e. a chart will be reviewed by the committee where the privileges are monitored. Medical care will be reviewed by the Medical Care Review Committee, Surgical care by the Surgical Care Review Committee, etc.). However, in the case where a physician holds privileges in more than one specialty, any specific questions regarding the care involved will be forwarded to the appropriate medical staff committee for review.

Physician members of the department or service shall be designated by the Committee Chairperson to review medical records prior to the Committee meeting. The physician reviewer will present the results to the Committee. Patient and practitioner identities shall be redacted from the presentation and discussion.

The designated physician reviewer may not review a case where he/she participated in the care (including radiology and pathology). Members of the same physician groups cannot review the other members of the group.

## **2. Reviewer Disqualification & Replacement**

If a reviewer does not feel he/she can adequately review a medical record due to a conflict of interest or believes he/she is not qualified to address a certain issue, the reviewer may discuss the issue with the Chairperson of the Committee. If the Chair concurs, the Chair shall reassign the record(s) to another reviewer. If a member has reviewed a record that needs to be presented but is unable to attend the meeting, the member shall report to the Chair so that the presentation may be reassigned to another Committee member or presented by the Chairperson. If the chairperson is the practitioner subject to review, the record review will be assigned to another Active Staff member by the President of Medical Staff. If the hospital has only one physician in a particular specialty, or the pool of eligible reviewers is otherwise conflicted or unable to serve, the MEC or the Board of Trustees may request external peer review consistent with the hospital's External Peer Review Policy by a physician who is Board certified within the same specialty.

### **3. Review Form Summary**

Reviewing physicians must fill out the Peer Review Form, Attachment One, clearly and concisely. The reviewing physician must sign his/her name on the review form which shall grade the care and outcome based on the following schedule:

1. Some aspect of case fell outside screening indicators, but Section finds no evidence of any error in judgment or technique.
2. Clinical result not necessarily desirable but not totally unexpected.
3. Clinical result or technique neither desirable nor expected.
4. Clinical result neither desirable nor expected.

### **IV. DOCUMENTATION OF PEER REVIEW ACTIVITIES:**

The written reports of On-Going Professional Practice Evaluation findings and recommendations, and any Focused Review of Practitioner Performance, shall be presented to the MEC at its next regularly scheduled meeting. The MEC may adopt the recommendations of the Department Committee and/or make further recommendations, including recommendation for further investigation and/or Corrective Action in accord with the Medical Staff Bylaws.

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.

All reports, recommendations, and otherwise concerning the Focused Review of Practitioner Performance shall be documented and maintained in the physician's quality file. Reviews are aggregated on the Reappointment Physician Performance Profile form and reviewed during the credentialing process at the time of reappointment.

A physician may review his quality file by making an appointment with the Chief Operating Officer and the President of Medical Staff. No copies of the quality file may be made, nor may the physician remove any portion of the quality file from the Hospital. In the discretion of the CEO, in consultation with the President of Medical Staff, personal information, such as the identity of external or internal peer reviewers, or the identity of patients or employees reporting quality issues, may be redacted before the physician may review the file.

Summaries of Peer Review, by category of Peer Review and by individual practitioner will be presented, at least quarterly, to the Quality Council, MEC and Board. (Attachments Three and Four)

### **V. IMPLEMENTATION OF CHANGES TO IMPROVE PERFORMANCE**

-The Quality Council is responsible for the implementation of changes to improve performance.

-Reports will be forwarded to the MEC and Board at least quarterly.



## CRITERIA FOR PEER REVIEW

1. ORYX Data (Core Measures)
2. QIO Reports
3. Data Advantage Reports
4. Surgery Review Indicators:
  - Morbidity/Mortality
  - Code Blue Review
  - Autopsy Criteria Met
    - If YES – chart contains documentation of discussion with family requesting autopsy
  - Surgical Consent not obtained as per policy
  - H&P not on chart prior to procedure
  - Normal tissue
  - Cases with no surgical specimen (specimen expected)
  - Discrepancy pre-op and post-op
  - Frozen / permanent section discrepancy
  - Post-op infection
  - Post-op complications related to surgery
    - Excessive bleeding (> 400 cc blood loss)
  - Intra-operative variances related to surgery:
    - Injury to another organ during surgery
    - Excessive bleeding (> 400 cc blood loss)
    - Foreign body retained
    - Intra-operative CPR / mortality
  - Immediate Post-operative note not written
  - Unplanned out-patient admission due to complication of surgery
  - Unplanned return to OR
  - Unplanned admission to ICU post-operatively related to surgery
  - Unplanned transfer to a higher acuity level of care / facility post-operatively related to surgery
  - Readmission < 30 days for surgical related problem
  - Operative mortality related to surgery

- < 48 hours post-operatively
- Within 30 days post-operatively
- Patient Complaint

5. Anesthesia Indicators:

- No anesthesia consent
- Immediate pre-induction assessment not documented
- Reintubation / laryngospasm (Rx)
- Difficult airway / intubation
- Tooth damage
- Eye injury
- Hyperthermia > 101 degrees
- Hypothermia < 94 degrees
- Surgery cancelled after induction
- Pulmonary edema (Intra / post op)
- Prolonged hypoxia (SaO<sub>2</sub> > 10% of baseline)
- Codes in OR / PACU
- MI peri-op / post-op (within 24 hours)
- Post dura puncture (H/A requiring Rx)
- Unplanned ICU admission
- Unplanned outpatient admission
- Unplanned readmission due to complication of anesthesia
- CVA within 24 hours related to anesthesia
- Neurological complications within 24 hours related to anesthesia
- Mortality within 24 hours related to anesthesia
- Unexplained change in patient condition in PACU
  - Prolonged nausea / vomiting
  - Prolonged PACU (> 2 hours)
  - Aspiration
  - Post operative infection related to anesthesia
  - Pneumonia
  - Patient Complaint

6. Department of Medicine:

- Morbidity/Mortality
- Code Blue Review
- Autopsy Criteria Met
  - If YES – chart contains documentation of discussion
- AMI after non-cardiac admission
- Neurological deficit after non-neurological admission
- Nosocomial pneumonia / septicemia
- Non-Surgical Invasive Procedure Complication (central line, Swan Ganz, cut-down, chest tube, etc.)
- Unplanned transfer to ICU
- Readmission within 7 days of hospital discharge related to previous admission
- Readmission within 31 days of hospital discharge related to previous admission
- Patient Complaint

7. Radiology:

- Procedure Correlation (High Volume, High risk, Problem Prone)
  - Gall Bladder
  - MRI
  - CAT Scan (etc.)
- Unplanned admission following outpatient procedure
- Patient injury during procedure
  - Neurological deficit due to procedure
  - Seizure or convulsion
  - Severe headache requiring Rx
  - Pneumothorax secondary to lung biopsy
  - Arachnoiditis after myelogram
  - Extra Arachnoid Tap necessary after myelogram
- Aspiration during procedure
- Allergic reaction to contrast dye
- Viscus Perforation
- Unplanned return to radiology for additional films

8. Pharmacy and Therapeutics:

- Medication errors with ‘serious’ score per medication variance report
- Patient received any of the drugs listed:

- Phenytoin / Digoxin / Theophylline / etc.
  - If YES, then serum level measured
- Drug exceeds specified limit
- DUE results
- ADRs
- Drug ordered and not in formulary
- Over 3 antibiotics administered concurrently or over 5 antibiotics administered in same hospital stay
- 3<sup>rd</sup> generation antibiotic administered

9. Blood Utilization:

- Transfusion criteria not met (PRBC, FFP, platelets)
- Patients with suspected / confirmed reactions
- C/T ratio – trend over time
- Single unit transfused

10. Pathology:

- Frozen Section / Histology Correlation (# of frozens / FNA's with significant discrepancy with final diagnosis. Goal < 5%)
- Number of frozens / FNAs deferred (Goal < 5%)
- # of amended diagnoses (Goal < 1%)
- Cytology / Histology correlation
- Peer Congruence:
  - External Consultations
  - Internal / Blind Review

11. Infection Control:

- Nosocomial infections
- Wound infections post op
- Infections following insertion of a central line
- Pneumonia following surgical episode
- Death where nosocomial infections may have contributed

12. Utilization Review:

- Failure to meet admission criteria
- Re-admissions within 30 days
- Inappropriate transfers
- QIO Denial
- LOS > established norm for diagnosis

13. Medical Records:

- Clinical pertinence
- Legibility studies
- Delinquency in completions of medical records (H&P, immediate post-op note, verbal orders, etc).