Policy and Procedure
Policy #: 2573
Status: Active
Version #: 1
Effective Date: 8/1/2005
Revised Date:
Scope: Banner Good Samaritan Medical Center
Population: Medical Staff

Title: *Peer Review, Medical Staff*

I. Purpose:

A. To continually seek to improve quality of care, treatment and services for all patients through an effective and efficient peer review process

II. Policy:

A. Each medical staff department conducts timely peer review by physician peer reviewers of any identified quality of care issue or concern, from any source. In addition, each medical staff department develops and approves clinically relevant quality and appropriateness criteria that identify variances, which trigger an evaluation of the care by a physician reviewer.

Definitions:
Quality is the degree of adherence to generally recognized contemporary standards of good practice and the achievement of anticipated outcomes for a particular service, procedure, diagnosis, or clinical problem.
Appropriateness is the extent to which a particular procedure, treatment, tests, or service is efficacious, is clearly indicated, is not excessive, is adequate in quantity, and is provided in the setting best suited to the patient's needs.

B. Criteria/indicators are reviewed annually and approved by the department committee. These include: medical assessment and treatment processes including medication use, blood use, operative/invasive procedure review , unexpected deaths, and identification of known or potential problems that have an adverse effect on the patient. Variations in care identified by the medical staff will be reviewed in order to identify opportunities to improve care.

Definition:
Indicators are often standards of care or practice that include objective clinical criteria from authoritative sources such as the clinical literature and consensus panels

III. Procedure/Intervention(s):

A. Each medical staff department is responsible for review and evaluation of identified cases.
B. The department determines the review mechanism. Peer review activities may result in trend and physician profiling and/or referral to the appropriate medical staff chairman/designee or the medical staff committee.

Definition:
A Peer is a person(s) who have equal standing with another person(s) in education and training with equal privileges granted by the medical staff. BGSMC physician peers are professionals in the same sub-specialty, specialty or a closely related specialty in the same department as the professionals whose services are being reviewed.

C. All peer review results may be trended to the individual physician and medical staff department after review by designated peer reviewers.
D. Practitioner specific variations, peer review findings and actions are utilized in the recredentialing and privileging process. Aggregated physician performance data is utilized in performance improvement process by the department and hospital wide, when appropriate.
E. Review Process:

1. Level One- Initial screening of all variations by Quality Management Services (QMS) within 5 calendar days of referral. QMS staff reviews all available information and refers to medical staff peer review as appropriate.
2. Level Two- Physician Peer Review - physician peers review all information available to confirm variation (not result of disease or condition) or decides if care was appropriate and consistent with current clinical guidelines, standards, or protocols. Physician peer determines if:
   a. Management of care was appropriate, and/or
   b. Variation should be trended to physician profile or department, and/or
   c. Referral for further review and/or action is indicated
3. Level Three- Committee Review
   a. Committee chairperson reviews all peer review issues and determines how to proceed with committee review. Committee reviews and evaluates care and may discuss with physician peer reviewer, request information from physician, invite physician to attend meeting, review literature, second review by a peer and take appropriate action and follow-up. Department chairman/designee reevaluates at later time to determine if action was effective and resulted in improvement.
4. Level Four- Procedures for Initiating an Investigation Leading to Possible Corrective Action – per Medical Staff Bylaws Article 6.

F. Timeframes of Peer Review
1. All identified cases are screened by the QMS staff for necessity of further review. After review of information, if it is determined by medical staff criteria that the variation is not clinically significant or is a natural consequence of disease or patient's condition, no further peer review is required and may be auto-trended. Otherwise a further evaluation is required.
2. This evaluation includes assessing the timing of the review by a peer. This may include identification of the case~~s~~ as a possible sentinel event (SE).
   a. If QMS staff determines that a case is a possible SE, it will refer the case for peer review, and the case will be peer reviewed within 5 days after referral.
   b. If not a SE, prioritization occurs. This includes deciding how timely a review is needed and if the patient outcome is known.
   c. If urgent, i.e. unexplained by patient condition or disease, the peer review needs to occur within 90 days.
   d. If not urgent, then peer review is extended to no more than 180 days.
3. At the time of the peer review, a determination is made. (Attachment I).
   a. If reviewer agrees with care and no significant variation, the review ends and the information is entered into the database and tracked.
   b. If the reviewer agrees with the care and the variation is a known variance, complication of this type of illness, or surgery, and the management is deemed adequate the variance is tracked only in the database, OR,
   c. If the reviewer does not agree with the care or there may be an educational opportunity, he/she may decide to forward the case to the committee level. At that point, the degree of the variation should be assessed. If the variation is significant, i.e. does not meet the standard of care in the community, or is deemed an education issue for the department, the case is referred to the committee for further evaluation and/or discussion. The information in the review is discussed with the respective chair of the committee prior to being forwarded to the committee.
4. At the committee level in executive session the case is evaluated and/or discussed and follow-up action/education is provided as needed.
5. Date and interval elements to be tracked include:
   i. Event date
   ii. Date referred/received by QMS and event triaged < 30 days
   iii. Peer review date

iv. Committee review date
v. Closing date

G. Circumstances Requiring External Peer Review – The following items outline circumstances where external peer review may be deemed appropriate and may be requested by the Department Chairman:
1. When the Medical Staff does not have adequate expertise or if the only other practitioners on staff with that expertise are partners or associates of the practitioner under review.
2. When, for any reason, the Medical Staff desires to have an expert witness for a fair hearing, evaluation of a credentials file, for assistance in developing a benchmark for quality monitoring or for any other purpose.

IV. Documentation (Documents & Forms):

Attachment I- Peer Review Coding
Attachment II-Flow diagram-Peer Review Process

V. Additional Information:

A. Delays
1. Timeframes for review are approximate. Delays to completing the peer review process include: medical record availability, completeness of medical record, peer reviewer availability, and other priorities in the department.

B. Sources of Referrals
1. Sources include written transmittals, phone calls, and letters from physicians, hospital staff, payers, patients, AMB, OBEX, Quality Improvement Organization (QIO), DHS, CMS, and/or risk management.

VI. References:

Comprehensive Accreditation Manual for Hospitals: The Official Handbook. August 2004. Joint Commission on Accreditation of Healthcare Organizations.

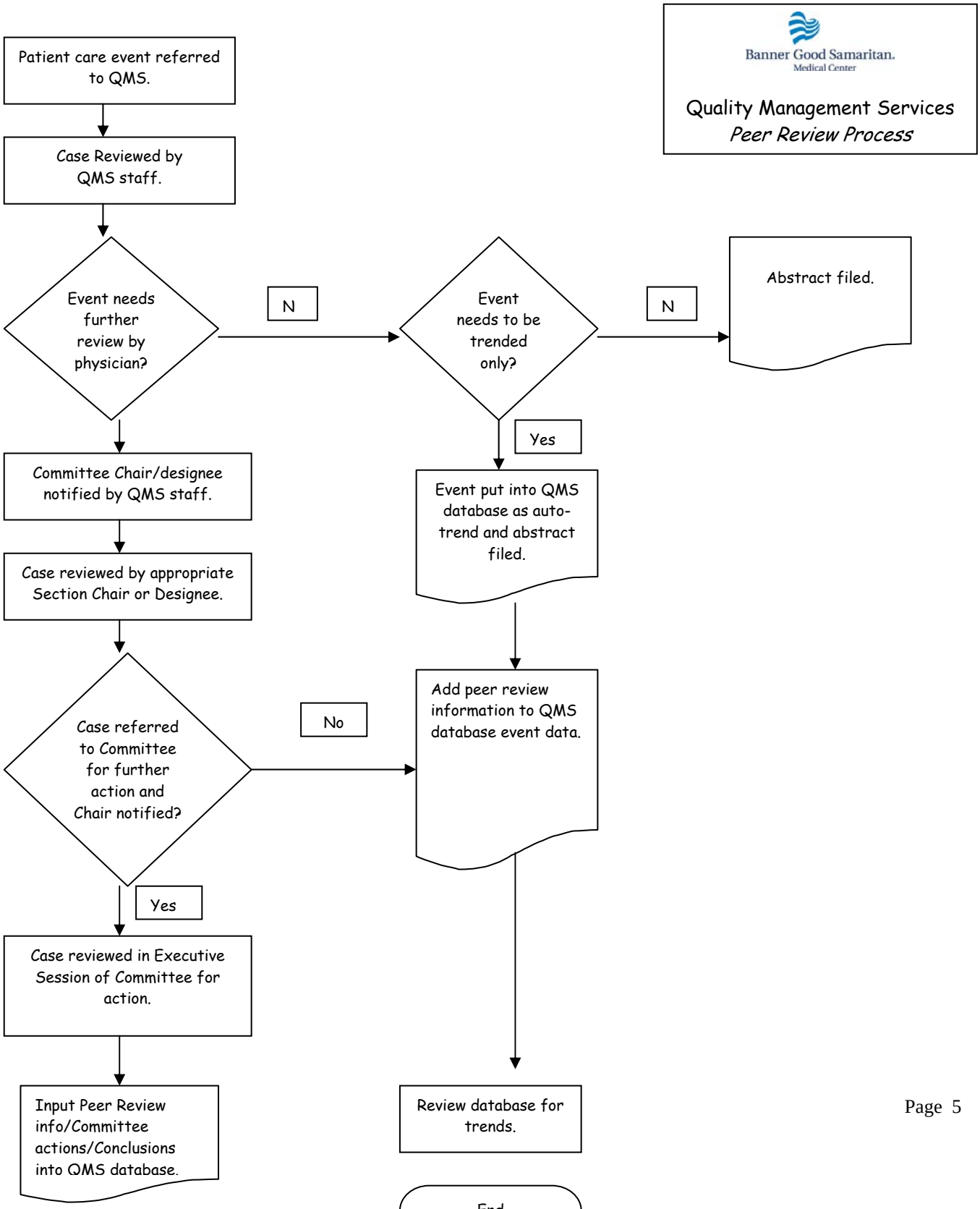
VII. Other Related Policy/Procedures:

A.

VIII. Cross Index As:

A.

Not Practitioner Related	S	Systems	This category may demonstrate trends useful for departmental or hospital wide management, but would not enhance or identify opportunities to improve practitioner-specific performance.
Practitioner Related	B	Practitioner etiquette, ethics, and conduct	Includes written and verbal communication issues. These stylistic behavioral matters do not represent clinical judgment, and may, or may not, be connected to an individual patient.
Practitioner Related	D	Documentation	Incidents where the medical record lacks clear documentation of the medical evaluation, treatment, changes in condition and prognoses, discrepancies between reports and written notes, missing, inconsistent or incomplete documentation and non-compliance with medical staff rules, regulations or policies
Practitioner Related	I	Predictable Event within the expected level of care	Within the expected level of care. These events are anticipated, well-known, widely reported in the literature, and relatively frequent.
Practitioner Related	II	Unpredictable Event within the expected level of care	Events are infrequent and unanticipated, but have been described in the literature to occur in cases.
Practitioner Related	III	Marginal Deviation from the expected level of care	Events are minimally outside of the contemporary levels of expected care of the specialty, or the expected levels of the departmental medical staff.
Practitioner Related	IV	Significant Deviation from the expected level of care	Events represent gross departures from expected standards.


Banner Good Samaritan Medical Center
Quality Management Services
Peer Review Process
Patient care event referred to QMS.
Case Reviewed by QMS staff.
Event needs further review by physician?
N
Event needs to be trended only?
N
Abstract filed.
Yes
Committee Chair/designee notified by QMS staff.
Event put into QMS database as auto-trend and abstract filed.
Case reviewed by appropriate Section Chair or Designee.
Case referred to Committee for further action and Chair notified?
No
Add peer review information to QMS database event data.
Yes
Case reviewed in Executive Session of Committee for action.
Input Peer Review info/Committee actions/Conclusions into QMS database.
Review database for trends.
End