Suburban Hospital
Medical Staff Peer Review Policy and Procedure

PURPOSE

The purpose of peer review is to promote continuous improvement of the quality of care provided by the Medical staff at Suburban Hospital. The role of the Medical Staff in peer review is to provide evaluation of performance to ensure the effective and efficient assessments of the work of physicians.

RESPONSIBILITY

Each medical staff department is responsible for peer review activities. Oversight is delegated to the Medical Executive Committee. The physician members of the Quality and Patient Safety Council shall perform peer review functions including following trends and overall clinical activities of the Medical Staff.

CONFIDENTIALITY

The peer review/quality assurance activities are immune to discoverability according to state statutes. All activities are to be kept confidential. Only authorized persons have access to the monitoring data and/or retrieval of this information. Authorized persons include medical staff leaders, Hospital Administration, Medical Staff Services personnel, and Quality Management and Risk Management personnel, as appropriate.

MEDICAL STAFF PEER REVIEW

The Medical Staff uses an effective mechanism designed to involve medical staff members in activities to measure, assess, and improve performance on an organizational basis. This mechanism is designed to:

- Collect data on processes and outcomes and to assess performance in relation to design specifications of processes, assess level of functioning of processes, identify opportunities for improvement, and review outcomes in relation to expectations.

- Communicate to appropriate medical staff members the findings, conclusions, recommendations, and actions taken to improve organizational performance.

- If relevant, identify individual performance as a result of the assessment process. When such a determination has been made, steps for further review, final recommendations, any actions taken, and follow-up are required.

- When the findings of the assessment process are relevant to an individual's performance, the medical staff is responsible for determining their use in peer review and/or the periodic evaluations of a licensed independent practitioner's competence, or in connection with any corrective action, in accordance with the procedures and standards set forth in the Medical Staff Bylaws, Credentialing Procedures Manual and Corrective Action and Fair Hearing Plan.

Data collection is performed on an ongoing basis and is reported to or by the Quality and Patient Safety Office. The QM Department, in consultation with appropriate Medical Staff Departmental Chair or designee, screens these reports for peer review issues.
Peer review activities of the Medical Staff shall include, but are not limited to, reviewing and making recommendations concerning the following:

- Credentials/Competency
- Invasive, Operative, and Non-invasive Procedures that place patients at risk
- Blood Use
- Medication Use and Monitoring
- Mortality & Morbidity Review
- Safety and Risk Management
- Infection Control
- Utilization Management (UM) – (e.g. timeliness of discharge; daily visit and progress note)
- Customer Satisfaction & Complaint Resolution
- Sentinel/Adverse Event or “Near Miss” Review
- Pathology & Clinical Laboratory/Autopsy Results
- Assessment of Patients
- Management of Information (including documentation)

Medical Staff peer review and performance improvement activities are reviewed in the Medical Staff department or section quality committees and the results are reported to the Medical Staff Quality and Patient Safety Council as appropriate.

Definition:

Peer review is the review of the clinical activities of members of the Medical Staff by other qualified practitioners with comparable training and experience who can render an unbiased opinion on the quality of care.

Process:

Cases included in the peer review process are identified through the following means:

- QCCR (incident reports)
- Referrals from medical staff committees, members or hospital departments
- Mortality Reports
- Complication Reports
- Readmission Reports
- Reports on unscheduled returns to the OR, to the Critical Care Unit or to the ED
- Requests for review by external regulatory agencies or payors
- Patient/Family Complaints

Identified cases are screened by the appropriate department or section quality committee chair or designee prior to each department or section quality committee meeting. The chair reviews the medical record and other relevant information and selects those requiring review by the department or section quality committee.

The department or section quality committee meets to review the cases:

- If the information presented is sufficient to make a decision about the quality of care, treatment or services, such decision is made at the meeting.

- If additional information is required from the physician of record, a letter is sent asking for a written response prior to the following meeting, or the physician may be invited to the next meeting. If the
information is not received by the date requested, a second reminder is sent. If there is no response, the chair will take necessary steps to obtain the information. Once additional information is received, a second review by all members of the peer review committee is performed and a final decision is made.

- Once the committee has sufficient information to make a disposition/conclusion, the case will be assigned a category as follows:
  - Care within the accepted standard of care
  - Marginal deviation from the standard of care
  - Significant deviation from the standard of care

Action is then determined as follows:
  - No action
  - No action required but trend
  - Variance discussed with physician verbally
  - Variance discussed with physician by letter
  - Refer to Chairman
  - Refer to another department/subsection quality committee
  - Other as appropriate to the situation

The Department or section quality committee may also recommend changes in policies, procedures, or processes, or referral to another hospital department, section or committee for review of aspects of the case relevant to their involvement.

- In cases where there is action taken, or where acknowledgement of receipt of additional information is needed, a letter is sent to the physician notifying him/her of the final decision. The physician may appeal the decision by requesting a second review of the case by the quality committee or by the Medical Executive Committee (MEC).

- The case write-up and supporting documentation of cases assigned a category other than No Action are placed in the physician's peer review file for use in the reappointment process or in connection with any recommended corrective action. Any corrective action related to a practitioner’s medical staff membership or clinical privileges shall be handled in accordance with the procedures set forth in the Medical Staff Bylaws and the Corrective Action and Fair Hearing Plan.

  A physician may be subject to a focused review, which may include an external review, in accordance with the criteria and procedures set forth in the MS rules and regulations.

The criteria and process for Focused Review is described in the Medical Staff Rules and Regulations

Issues involving conduct that are not directly related to the quality of care are also subject to disciplinary action. These are handled by a separate process by which the issue is referred to the Subsection and/or Department Chair; the Chair or Chair-Elect of the Medical Staff and the Senior Vice President for Medical Affairs as appropriate to the situation. These individuals determine the best venue for addressing the issue, which usually involves meeting with the physician, obtaining his or her feedback, and either dismissing the case or outlining specific recommendations for required change in behavior or for other resolution. A written record of the meeting and its outcome is sent to the physician, and a copy is placed in the physician’s peer review file for use in the reappointment process or in connection with any recommended corrective action.

**Structure of Medical Staff Quality (Peer Review) Committees**
<table>
<thead>
<tr>
<th>Department</th>
<th>Quality Committee</th>
<th>Meeting frequency</th>
<th>Responsible for screening and case review</th>
<th>Case Review and PI Indicators include but are not limited to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia</td>
<td>Anesthesia QA</td>
<td>Bimonthly</td>
<td>Dep’t Chair or MD designee</td>
<td>• Mortalities&lt;br&gt;• Complications&lt;br&gt;• Targeted/focused studies prn</td>
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<tr>
<td>Cardiac Surgery</td>
<td><strong>TBD</strong></td>
<td><strong>TBD</strong></td>
<td><strong>TBD</strong></td>
<td><strong>TBD</strong></td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>ED QA</td>
<td>Monthly</td>
<td>Dep’t Chair and MD designee</td>
<td>• Returns w/in 72 hours&lt;br&gt;• Admission rate of patients who return by MD&lt;br&gt;• Mortalities&lt;br&gt;• Complications&lt;br&gt;• X-ray variances&lt;br&gt;• Lab variances&lt;br&gt;• Patient satisfaction with MD care</td>
</tr>
<tr>
<td>Medicine and Family Practice</td>
<td>Departments of Medicine and Family Practice QA (reviews cases of all medical subsections)</td>
<td>Bimonthly</td>
<td>Chair, MFPQA Committee</td>
<td>• Mortalities&lt;br&gt;• Unscheduled Readmissions&lt;br&gt;• UM variances&lt;br&gt;• End of Life Issues&lt;br&gt;• Core Measures: AMI; HF; CAP&lt;br&gt;• Medication Issues&lt;br&gt;• Blood Use&lt;br&gt;• Targeted/focused studies prn</td>
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<tr>
<td>Cardiology</td>
<td>Bimonthly</td>
<td>Chair, Cardiology</td>
<td></td>
<td>• Primary angioplasty – all cases&lt;br&gt;• Mortalities&lt;br&gt;• Complications&lt;br&gt;• Emergency transfers</td>
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<tr>
<td>Critical Care QA</td>
<td>Monthly</td>
<td>Designated</td>
<td></td>
<td>• Mortalities&lt;br&gt;• Complications&lt;br&gt;• Returns to ICU&lt;br&gt;• VAP/Vent Use&lt;br&gt;• Central line-related bacteremias&lt;br&gt;• Peptic Ulcer Disease&lt;br&gt;• UTI’s&lt;br&gt;• LOS&lt;br&gt;• Blood Use&lt;br&gt;• Targeted/focused studies prn</td>
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<tr>
<td>GI QA</td>
<td>Quarterly</td>
<td>Chair, GI Section</td>
<td></td>
<td>• Mortalities&lt;br&gt;• Complications&lt;br&gt;• Blood Use&lt;br&gt;• Targeted/focused studies prn</td>
</tr>
<tr>
<td>Stroke QA</td>
<td>Biweekly</td>
<td>Designated MD</td>
<td>Designated member of Stroke Team</td>
<td>• Mortalities&lt;br&gt;• Complications&lt;br&gt;• Outcomes of cases involving T-PA and non-tPA management&lt;br&gt;• Diagnostic imaging issues&lt;br&gt;• Protocols per NIH</td>
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<tr>
<td>Pathology</td>
<td>Path./Transfusion</td>
<td>Quarterly</td>
<td>Chair Pathology</td>
<td>• Transfusion reactions</td>
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<tr>
<td>Section</td>
<td>QA</td>
<td>Frequency</td>
<td>Chair</td>
<td>Topics</td>
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<tr>
<td>Pediatrics</td>
<td>Pediatric QA</td>
<td>Monthly</td>
<td>Chair Pediatrics</td>
<td>Mortalities, Complications, Bounce-backs, Transfers out, ICU admissions, Pt/family satisfaction, Communication w/PMD, Documentation</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>Behavioral Health QA</td>
<td>Bimonthly</td>
<td>Chair, Psychiatry</td>
<td>Mortalities, Suicides post discharge, Restraint/seclusion episodes, Compliance w/H&amp;P (partial and inpatient programs), Crisis Service data</td>
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<tr>
<td>Radiology</td>
<td>Radiology QA</td>
<td>Quarterly</td>
<td>Designated MD</td>
<td>Teleradiology: accuracy of overnight readings, RadPeer Data, Complications (Interventional and minor procedures)</td>
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<tr>
<td>Surgery</td>
<td>Plastic Surgery QA</td>
<td>Quarterly</td>
<td>Chair Plastic Sgy Section</td>
<td>Mortalities, Complications, Unscheduled readmissions, Unscheduled returns to OR, Core Measure: SIP Data, Prophylactic Antibiotic Use, Blood Use, Medication Use, Targeted/focused studies prn</td>
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<tr>
<td>Orthopedic QA</td>
<td>Quarterly</td>
<td>Chair Ortho Section</td>
<td></td>
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<tr>
<td>Neurosurgery QA</td>
<td>Quarterly</td>
<td>Chair N-Sgy Section</td>
<td></td>
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<tr>
<td>Urology QA</td>
<td>Quarterly</td>
<td>Chair Urology Section</td>
<td></td>
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<tr>
<td>Gyneocology QA</td>
<td>Quarterly</td>
<td>Chair GYN Section</td>
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<tr>
<td>Ophthalmology QA</td>
<td>Quarterly</td>
<td>Chair Ophth.Sect</td>
<td></td>
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<tr>
<td>Oral, Otolaryngology and Podiatry</td>
<td>As needed</td>
<td>Chair, Section</td>
<td></td>
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<tr>
<td>General and Colorectal QA</td>
<td>Monthly</td>
<td>Chair General Surgery Section</td>
<td></td>
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<tr>
<td>Thoracic and Vascular and Interventional Rad QA</td>
<td>Monthly</td>
<td>Chair Vascular Surgery Section</td>
<td></td>
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<tr>
<td>Trauma</td>
<td>Monthly</td>
<td>Medical Director, Trauma</td>
<td></td>
<td>Mortalities, Complications, Readmissions, Transfers, Variances ACS / regulatory req’s.</td>
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</tbody>
</table>

**PERFORMANCE IMPROVEMENT**
Performance improvement activities designed to improve processes and procedures should be conducted by each Medical Staff Department or section in addition to the review of individual performance by case review. Such targeted or focused review activities may be undertaken based on adverse event occurrence; problems trended over time; review of evidence based practice; identified need for development of standardized order sets and protocols; or other identified need to improve performance related to patient care and safety.

COMMUNICATION

General process or procedural findings of peer review activities are communicated within the individual Medical Staff Departments. A regular aggregated report regarding the types of cases reviewed and any findings related to a focus study (e.g. procedure or medication use) is forwarded to the Peer Review arm of the Quality and Patient Safety Council and then to the MEC at least quarterly to monitor peer review activities and actions for effectiveness. This information is reported to the Medical Affairs Committee of the Board of Trustees as part of the regular Quality and Patient Safety Council Report.

PHYSICIAN SPECIFIC DATA FOR REAPPOINTMENT

The following information is trended for individual physicians, as appropriate to the scope of practice, for reappointment purposes:

Utilization: LOS, CMI; Denials
Blood Use
Medication Use (Interventions; ADR’s; non-formulary use; legibility; Do Not Use Abbreviations)
Morbidity and Mortality
Surgical/Invasive Procedure Review (appropriateness, complications, returns to OR)
Relevant practitioner specific data as compared to aggregate data, to the extent available
Trauma Specific:
- Timely response to trauma alerts
- Active participation in Trauma Call Roster
- Maintenance of current ATLS certification
- Attendance at Trauma Subsection meetings (Peer Review, PI).
- Attendance at special CME related courses (one half being external every three years)