SAINT JOSEPH
Regional Medical Center

Version #: 7

Title: Occurrence Monitoring & Peer Review (Medical Staff)

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Location: Saint Joseph Regional Medical Center (SJRMC)			Department: Medical Staff Servicess

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POLICY:

1. It is the policy of SJRMC to conduct review of Medical Staff indicators, appropriateness of care, complication and/or mortality rates, and resource utilization in a consistent and timely manner. To establish a uniform and consistent method of review, evaluation, and documentation of physician occurrences and peer review for the purpose of performance improvement, risk reduction, patient safety, appropriate utilization, and reduction of morbidity and mortality. Behavior issues will follow a separate review process according to the Medical Staff Code of Conduct Policy and will also be protected under peer review.

PROCEDURE:

A. Physician Performance Weekly Reviews - Triggered by Midas Reports, Chart Review and/or verbal notification.
   1) Members Include:
      a) Chief Medical Officer
      b) Clinical Risk Manager, Clinical Operations Improvement
      c) Peer Review Coordinator, Clinical Operations Improvement
      d) Manager, Medical Staff Services
   2) Issues Include:
      a) Quality –Review the summary of quality indicators identified and analyze for trends.
      b) Risk –Review the summary of risk indicators identified and analyze for trends.
      c) Bylaws/Rules and Regulations/ Medical Staff Policies -Review the summary of Bylaws/Rules and Regulations/Medical Staff Policy violations identified and analyze for trends.
      d) Utilization –Review the summary of utilization issues and analyze for trends.

B. Reports and / or data collected shall be maintained in a confidential manner in accordance with Indiana Law. Medical staff occurrences are entered into the MIDAS+ database for trending.

C. All occurrences are summarized by occurrence type and physician for review at the weekly Physician Performance Review meeting. From there, cases or trends can be referred to Department Chairs, an integrated performance improvement committee, a special peer review committee, and/or directly to Credentials or the Medical Executive Committee.

D. Participation in the peer review process by the practitioner whose performance is under review:
   1) The individual whose case or trend is under review shall have the opportunity to present his or her information regarding case management to the committee performing peer review. The individual whose case is under review has the right to sit on the peer review committee during

the time the case is reviewed and discussed, to provide additional information to the individual(s) performing peer review as necessary.

E. All individuals whose cases are referred for committee peer review shall be notified of the medical record number and date of admission of the case to be reviewed, in addition to the reason for review, at least two weeks prior to the scheduled peer review meeting date. In cases of immediate referral to committee, as determined by the Department Chair, the Department Chair shall notify the individual whose case is under review, regarding the reason for review and the scheduled date of review, as soon as the Department Chair makes the determination that the case must be referred for formal peer review.

F. Clinical Operations Improvement staff shall take the issue forward for review to the weekly physician review meeting. If issues or questions are identified, the medical staff Department Chair or designee is notified. The peer physician will assign the appropriate level of significance (Level 1- 5) to each occurrence.

NOTE: If the level of significance is not determined, the Credentials Committee Chair shall assist in the final determination.

G. Peer review activity time frames:

1) Cases forwarded to medical staff departments or peer review committees from the weekly physician review meeting are to be reviewed within one month of referral or the next committee meeting.
2) Issues believed to be of such severity or urgency that immediate action is warranted, the Director, Clinical Outcomes Improvement and/or the Manager, Medical Staff Affairs shall, upon the receipt of the report, immediately notify the Medical Staff President and/ or Officers and the involved physician.
3) Time frames are adhered to in a reasonable fashion. All cases referred for peer review shall be reviewed within the time frames as listed above. In those instances where peer review falls out of the required time frames (medical record incomplete, practitioner under review is unavailable, reviewing committee rescheduling, etc.) the reasons for the delay will be documented. All efforts will be made to complete the peer review process as soon as practicable within the confines of the delay.

H. Action:

1) Level 1 issues will not require action. Recurrence or a pattern shall constitute a higher level of significance, thus requiring handling in a manner consistent with the level 2 or 3.
2) Level 2 – 5 issues require contact with the physician by the Department Chair or Vice Chair, with a written plan of action as applicable.

I. File Access:

1) Access by the physician will occur only during an investigation and with the appropriate approval and access granted by the person or committee involved in the investigation. (Indiana Code, Sec. 34-30-15-4). These are retained in the Medical Staff Office. Arrangements will be made for a review location on a case-by-case basis.
2) A Department Chair, Service Medical Director, and section chief may access the files of its members only for performance of the responsibilities of the position.
3) The President of the Medical Staff may have access to all Medical Staff Members' files in performance of the responsibilities of the position.

4) The Chief Executive Officer, President of the Hospital, the Director of Outcomes Management or the Chief Medical Officer, Manager of Medical Staff Affairs, the Clinical Operations Improvement Clinical Risk Manager or Peer Review Coordinators may access all professional staff members' files in performance of their responsibilities.

J. Performance Improvement

1) All cases undergoing peer review beyond the weekly physician review meeting will have a worksheet completed that lists the rationale for conclusion made by the peer reviewer(s).
2) All opinions regarding medical management, including minority opinions, will be considered in the ultimate determination of a case. This includes information and opinions from the individual whose case is under review.
3) Results of peer review are utilized at time of medical staff reappointment and to improve the organization's performance in individual situations, and, as a whole.
4) Results of peer review activities are aggregated and reported ongoing and at time of medical staff reappointment to provide for practitioner specific appraisal of competency and renewal of clinical privileges.
5) Aggregated and trended results of peer review activities are utilized in the hospital-wide performance improvement program, via quarterly reporting to the Credentials Committee, to allow for organizational improvement as necessary.
6) Peer review conclusions, outcomes and actions resulting from peer review are monitored for effectiveness. Results of follow-up effectiveness monitoring are reported to the Medical Executive Committee.

DEFINITIONS:

1. Occurrence: An incident that is inconsistent with SJRMC procedures or routine patient care or results in serious physical or psychological injury or death.
2. Peer Review Component Definitions: Definitions of circumstances requiring peer review are listed below. Clinical Operations Improvement or the Credentials Committee may suggest revision to the lists, with final approval granted by the Medical Executive Committee. Circumstances requiring peer review include:
   A. Medical Staff Indicators (see annual Indicator list)
   B. Appropriate use of blood and components, medications, tests, procedures, level of care, etc.
   C. Deviation from external benchmarks identified for comparisons in screening for opportunities for improvement in management and outcomes.
   D. Risk occurrences (see annual Indicator list)
3. Peer review participants:
   A. A peer reviewer shall be defined as a member of the medical staff in good standing. In instances for occurrences involving clinical decision-making the opinions of a physician licensed in the same medical specialty as the individuals whose case is under review should be obtained.
   B. A peer review committee is either the medical staff department to which the physician is assigned or the physician component of an integrated performance improvement committee where the members are considered experts in the function being monitored.

C. An individual functioning as a peer reviewer will not have performed any medical management on the patient whose case is under review. However, opinions and information may be obtained from participants involved in the patient's care.

D. A practitioner-focused review is defined as when a process becomes more practitioner specific and requires more in-depth review involving monitoring, analyzing and understanding individual practitioner performance.

4. External Peer Review

   A. Circumstances that require external peer review include, but may not be limited to:

      1) Need for specialty review, when there are a limited number or no medical staff members of the institution with the identified specialty within the organization.

      2) The peer review committee is unable to make a determination and requests an external review.

5. Levels of Significance:

   A. Level 1: Occurrence that did not directly put patient care at risk. The case is managed and documented appropriately.

   B. Level 2: Occurrence that may impact patient safety or well-being or hospital operations. The case is managed appropriately, but documentation is not adequate.

   C. Level 3: Occurrence or medical/ surgical case management is questionable with no potential for significant adverse effect on the patient or hospital operations.

   D. Level 4: Occurrence or medical/ surgical case management is questionable with high potential for significant adverse effect on the patient or hospital operations.

   E. Level 5: Occurrence or medical/ surgical case management with significant, adverse effects on the patient and / or is direct violation of any legal/ medical staff Bylaws/ Rules requirement.

References/Standards:

- Policy Origin Date: September 2001
- Review Date: December 2009, December 2012, December 2015, December 2018
- Revised Date: January 2008
- Effective Date: October 2001
- Reviewed/Recommended By: Medical Executive Committee
- Policy 94

INDICATORS

Quality Indicators – Medical Executive Committee	
Quality concern (reviewed)	
DVT / PE acquired after admission (trended)	
Readmission for complication within 30 days (trended)	
Unexpected death (see criteria below) (reviewed)	
Iatrogenic disorder (adverse condition induced by effects of treatment) or Iatrogenic complication (reviewed)	
Sentinel events (reviewed)	
Pathology Review: Appropriateness	Protocol deviation
Risk Indicators	
Behavior	
Confidentiality	
Privacy / Dignity	
Verbal Communication	
Documentation /Documentation not meeting Bylaws/Inappropriate documentation	
Failure to diagnose, missed diagnosis or misdiagnosis	
Utilization Indicators	
Timeliness	
Discharge issues	
Utilization issue	
Bylaws Violations	
No response to page	
Failure to provide adequate coverage	
Failure to see patient in a 24 hour period	
Bylaws issue	

Unexpected Death Criteria

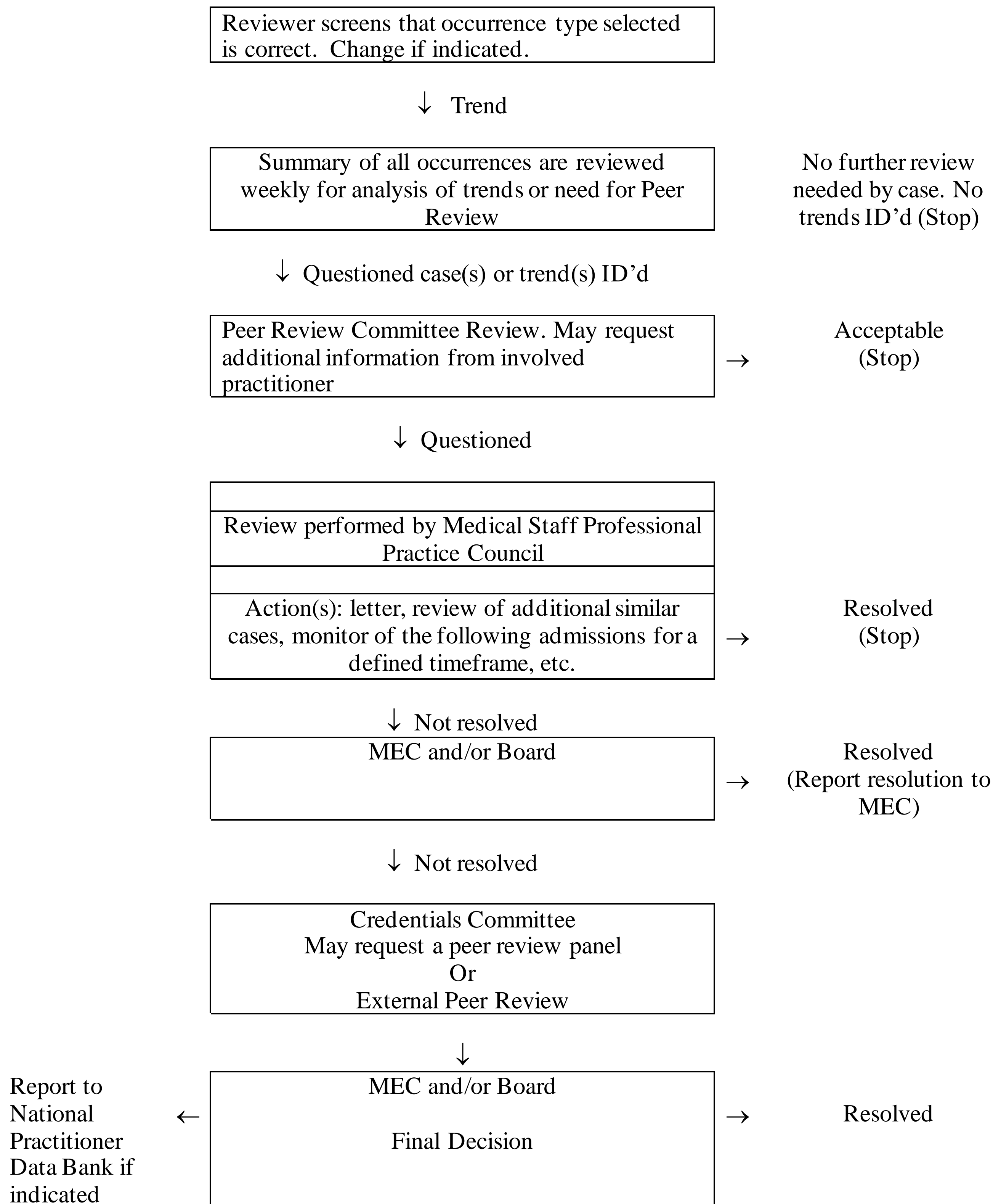
Unexplained death occurring in the hospitalized patient
Death in outpatient setting, excluding the ED
Deaths during *elective* surgical/invasive procedures
Deaths within 72 hours of *elective* surgery/invasive procedure
All pediatric deaths
Death thought secondary to:

- Medication reaction
- Blood transfusion (hemolytic reaction)
- Inpatient accident (e.g., fall)
- Potential nosocomial infection as cause of death

All indicators will be trended by physician and department.

PEER REVIEW PROCESS

High Level Flow Chart



Medical Staff Peer Review Worksheet

MR#	Date of occurrence:	Indicator:
Physician:	Specialty:	

Abstract: See attached sheet

Peer Review Committee Comments:

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PRC Level of Significance finding:

- ❑ Level 1 – Patient Care not directly at risk. Managed and documented appropriately
- ❑ Level 2 – Patient safety, well being or hospital operations *may* have been impacted. Managed appropriately, but documentation is not adequate.
- ❑ Level 3 – Case management is questionable with **no** potential for significant adverse effect of the patient or hospital operations.
- ❑ Level 4 – Case management is questionable with **high** potential for significant adverse effect of the patient or hospital operations.
- ❑ Level 5 – Case management results in significant adverse effect of the patient and/or is direct violation of any legal/ Medical Staff Bylaws / Rules requirement.

Problem Identification:	
❑ None identified	❑ Issue in documentation
❑ Issue in diagnosis	❑ Issue in technique
❑ Issue in judgement	❑ System and/or process problem
❑ Patient non-compliance	❑ Policy and procedure
❑ Natural progress of disease	❑ Other (specify):
❑ **Issue with behavior**	❑ **Communication issue**

Iatrogenic Complication:

- ❑ Grade 1 – Non-life threatening, no residual disability, no added LOS, no invasive procedure treatment required.
- ❑ Grade 2 – Potentially life threatening, no residual disability, no invasive procedure treatment required.
- ❑ Grade 3 – Potentially life threatening, no residual disability, invasive procedure treatment was required.
- ❑ Grade 4 – Complication with residual or persistence of life threatening conditions
- ❑ Grade 5 – Death due to complication(s)

Disposition:	❑ Education		
❑ Trend	❑ Counseling	❑ Letter of Concern	❑ **External** Review
❑ Closed	❑ FPPE	❑ Letter of Inquiry	❑ To Committee (specify):
			❑ Violates Standard of Code of Conduct

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PRC Chair/Designee (date)/(time)

This review is confidential and protected peer review material pursuant to Indiana Statute (I.C. §34-30-15).