SAINT JOSEPH
Regional Medical Center

Version #: 2

Title: MEDICAL STAFF PEER REVIEW

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Location: Saint Joseph Regional Medical Center – Plymouth		Department: Plymouth-Medical Staff Affairs

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POLICY:

1. The medical staff has a leadership role in organizational performance improvement (PI) activities. When PI findings are relevant to an individual's performance, the medical staff is responsible for determining their use in peer review for the ongoing evaluation of a licensed independent practitioner's competence.
2. Members of the medical staff should be involved in activities to measure, assess, and improve performance on an organization-wide basis. They are required to develop and conduct a properly designed peer review process that includes the following structural elements:
   A. Definition of circumstances requiring peer review.
   B. Specification of participants in the review process, including definition of "peer".
   C. Method for selecting panels for specific circumstances.
   D. Timeframes to conduct activities and report results.
   E. Circumstances where external peer review is required.
   F. Provision for participation by the individual whose performance is being reviewed.
3. Essential Functional Elements/ Process goals include:
   A. Consistent- Peer review is conducted according to defined procedures for all cases meeting the organization's definition of reviewable circumstances.
   B. Timely- the time frames specified in the peer review procedures are adhered to reasonably.
   C. Defensible- the conclusions reached through the process are supported by a rationale that specifically addresses the issues for which the peer review was conducted, including, as appropriate, reference to the literature and relevant clinical practice guidelines.
   D. Balance- Minority opinions and views of the reviewee are considered and recorded.
   E. Useful- the results of peer review activities are considered in practitioner specific credentialing and privileging decisions and, as appropriate, in the organization's performance improvement activities.
   F. Ongoing- Peer review conclusions are tracked over time, and actions based on peer review conclusions are monitored for effectiveness.
4. Members of the medical staff are also involved in:
   A. The measurement of outcomes and of processes, as defined in the Organizational Performance Improvement plan, to identify opportunities for improvement.
   B. Evaluation of individuals with clinical privileges whose performance is questioned as a result of the measurement and assessment activities.

C. Communication to appropriate medical staff members of the findings, conclusions, recommendations, and actions taken to improve organizational performance; and

D. Implementation of changes to improve performance.

5. The medical staff assumes a leadership role in the improvement of clinical processes that are dependent primarily on individuals with clinical privileges, such as surgery, physical examinations, and prescribing of medications.

6. All peer review activities will be conducted in consideration and consistent with the hospital's mission to ensure the provision of the best quality care to its patients.

7. SPECIAL PRECAUTIONS/ CONSIDERATIONS:

   A. In accordance with Indiana Statutes, Saint Joseph Regional Medical Center Plymouth maintains the strict confidentiality of all peer review information from unauthorized disclosure. Additionally, confidentiality of all information related to patients, physicians, and all other health care providers through the review and reporting process is maintained.

   B. A professional health care provider, a peer review committee, and the governing board of the Medical Center may use information obtained by peer review committees for legitimate internal business purposes. This is based on I.C. 34-4-12.6-2

   C. The activities of the Performance Improvement process are confidential and protected. They are not to be duplicated or released. This includes:

      1) Quality review and assessment
      2) Utilization review and management
      3) Risk Management and Opportunity reports and trends
      4) Safety prevention and correction
      5) Scientific, statistical and educational information
      6) Legal Defense
      7) Information for Credentialing purposes

8. CONFIDENTIALITY:

   A. Any organization that provides peer review services must demonstrate its commitment to absolute confidentiality and strict non-disclosure. Provisions pertaining to confidentiality will be routinely discussed in advance and included in any agreement, contract, or other document used to secure the services of outside consultants. Internal confidentiality will be maintained through the established hospital policies and procedures. All peer review findings will be stored in a secure file and maintained in the Risk Management Department until completed and then filed in the Medical Staff office under secured conditions.

9. OTHER CONSIDERATIONS:

   A. Minutes from all meetings where discussion of Peer Review information is a component will be maintained as confidential documents. All minutes will be maintained and secured in administrative or performance improvement offices.

   B. Access to the files containing Peer Review information will be limited to the following:

      1) Medical Staff Executive/ Credentials Committee

2) President of Medical Staff or designee
3) President of the Hospital or appropriate Vice President
4) Service chiefs of the individual practitioner
5) Risk Manager
6) Hospital Legal Counsel
7) Physician (May review own peer review file contents in the Administrative Suite. Outside legal counsel or other representatives may not be present with the physician during viewing)

C. All others listed above may examine the files only when it is necessary in the conduct of business.

D. Medical staff committee minutes containing peer review information may be reviewed in the administrative office by members of the committee. These minutes may not be copied or removed from the administrative office.

E. Any other requests for access to peer review and/or quality information shall be made in writing to the President of the Hospital for consideration.

F. All subpoenas of Medical Staff or quality records shall be referred to the President of the Hospital or her designee who may consult the President of the Medical Staff or legal counsel.

G. To assure active involvement by the individual physicians whose performance is being reviewed, the following will occur:

1) The physician will receive a letter specifying which case has been reviewed as well as the outcome of that review. The letter will outline any requested action on the part of the physician as a result of that review.
2) The physician will be provided an opportunity to respond to any identified concerns or disagreement with conclusions verbally, by appearance, or in writing. All such responses will be directed to the attention of the Medical Staff Executive Committee for consideration/ further action.

10. EXTERNAL PEER REVIEW ORGANIZATION REQUIREMENTS:

A. Availability of Clinical consultants located outside the geographic area of the practice under review;

B. The ability to ensure that the physician reviewer has no knowledge of or connection to the physician being reviewed;

C. Proof of a longstanding track record of consulting experience in the area of medical record review;

D. An extensive network of board-certified clinical consultants nation-wide that includes all specialties;

E. Availability of panel consultants who are currently in active clinical practice;

F. The ability to provide a professional final report in a timely manner; and

G. The ability to defend and support their findings if a subsequent fair hearing or litigation ensues.

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PROCEDURE:

A. Potential cases for physician peer review are identified through the following sources:
   1) Routine Performance Improvement activities/trending/data analysis/quality indicators
   2) Routine Risk Management/Patient Relations activities.
   3) By request of physicians/other professional caregivers involved with the care of a patient.
   4) By request of the Medical Staff Executive Committee.

B. All cases of concern will be entered into the quality module in MIDAS.

C. The Risk Manager will receive a SmartTrack worklist in MIDAS for all cases falling into the established criteria as being appropriate for potential peer review. The cases will be reviewed on a regular basis to evaluate the appropriateness for peer review screening/ potential peer review. The Clinical Outcomes Council Chairman may be consulted to assist in decision making/ provide screening of cases for further internal or external review measures and provide recommendations to the same.

D. On cases deemed appropriate for screening/ review, a peer review work sheet will be generated by the Risk Manager and forwarded to the appropriate physician in the HIM department with a cover sheet specifying the urgency for review.

E. The physician will review the case and enter the findings on the confidential Peer Review worksheet.

F. All findings will be returned to the Risk Manager and entered into MIDAS for trending/ data analysis purposes & reported regularly to MEC.

G. EXTERNAL PEER REVIEW PROCESS
   1) Types of cases that may be deemed appropriate for external review:
      a) Physicians unavailable within the guidelines of a defined peer.
      b) Specialty cases where conflicts of interest might result
      c) Cases of an extremely sensitive nature perhaps involving litigation or as deemed appropriate by the Risk Manager upon approval by the President.
      d) Cases referred by the Medical Staff Executive Committee upon the recommendation of the Physician reviewer.
   2) The process is essentially the same as outlined above in numbers 1-3.
   3) On cases deemed appropriate for external review, the following will occur:
      a) Risk Manager is notified to prepare the case for external review.
      b) Determination is made on which peer organization will be utilized based on above criteria
      c) Notation is made in the QAR Midas entry to status/date external review.
      d) HIM is notified to prepare the record for external review:
         (1) copy the medical record
         (2) send the record to the external review organization based on established HIM handling policies.

(3) As appropriate or when requested, a photocopy of the internal screening or review worksheet will accompany the record.

4) Upon receipt of the findings from the external review process, entry will be made to reflect the same in MIDAS under the QAR entry.

5) Appropriate circulation of findings and follow up will occur through established processes

Related Documents:

- Medical Staff Bylaws

Definitions:

- PEER: A physician licensed to practice medicine that has similar but not necessarily identical training or experience.
- PEER REVIEW: The name given to the process by which medical staff members review the performance of their peers in a particular clinical setting.
- EXTERNAL PEER REVIEW: Involves the use of a licensed physician consultant who is not affiliated with the healthcare facility requesting the review and whose specialty training and practice setting are similar to that of the physician under review and who has no personal or professional interest in the outcome of the review process.

CONFIDENTIAL MEDICAL STAFF PEER REVIEW
I.C.34-4-12.6-2

MEDICAL RECORD #: _____

DATE OF SERVICE: _____

PHYSICIAN REVIEWER:

Internal Physician: _____

External Organization: _____

REVIEW REQUESTED BY: _____

DATE REQUEST SUBMITTED: _____

URGENCY INDEX:

_____	EMERGENCT	Review within 14 days/ incomplete record if necessary
_____	URGENT	Review within 21 days/ complete record
_____	MODERATE	Review within 30 days/ complete record
_____	ROUTINE	Review as soon as conveniently possible

Saint Joseph Regional Medical Center
Plymouth, Indiana

HOSPITAL INDICATORS

Sentinel Event (specify) _____

Near Miss /Serious Event (specify) _____

Unplanned readmission within 30 days for complication of previous stay

Unplanned Readmission (other reason) _____

Inpatient admission following unscheduled return to ED within 72 hours

Cardiac or Respiratory Arrest (Code Blue) - *excludes pre-hospital codes

Unexpected death

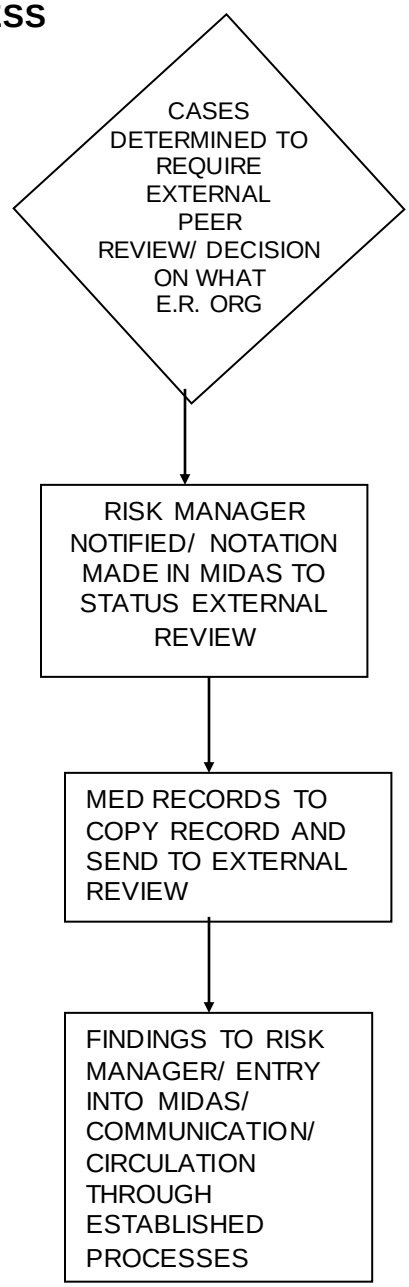
Unscheduled return to surgery

Complication related to procedure

Other event (describe) _____

MEDICAL STAFF PEER REVIEW
SAINT JOSEPH REGIONAL MEDICAL CENTER - PLYMOUTH

EXTERNAL REVIEW PROCESS



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PEER REVIEW PROCESS

SAINT JOSEPH REGIONAL MEDICAL CENTER-PLYMOUTH

INTERNAL REVIEW PROCESS