

<i>Manual</i>	Medical Staff	<i>Effective Date</i>	03/21/2001
<i>Policy #</i>	MS 102	<i>Date Revised</i>	03/31/2014
		<i>Next Scheduled Review</i>	03/31/2023
		<i>Responsible Person</i>	Director, Medical Staff Services

PURPOSE

To define the processes for Medical Staff Quality Management (QM) and Peer Review, as delineated in the Medical Staff Bylaws and consistent with the Performance Improvement and Patient Safety Plan. These processes are designed to continuously measure, assess and improve the performance and quality of care provided to patients and the clinical performance of each clinically privileged staff member. Conclusions from the peer review process are used in the continuous and ongoing evaluation of clinical competence of the medical staff, in determining reappointment of staff members, and in the renewal and revision of individual clinical privileges. In collaboration with the Medical Staff Executive Committee (MSEC), the ad-hoc Peer Review Committee (PRC) is responsible for the oversight of the peer review activities of each department. The Quality Council is responsible for the oversight of the quality management activities of each service.

POLICY

- A. The MSEC requires each medical staff service to participate in and oversee quality management activities. These activities are consistent with the Performance Improvement and Patient Safety Plan.
- B. Each service conducts consistent, timely, defensible, balanced, useful and ongoing peer review by physician peer reviewers for any clinician related quality of care issue, from any source. In addition, each medical staff service develops and approves clinically relevant quality and appropriateness criteria that identify variances, which trigger an evaluation of the care by a physician reviewer.

Definitions:

Peer is an individual from the same profession (for example, physician and physician, dentist and dentist) and with comparable qualifications.

Quality Criteria is the degree of adherence to generally recognized contemporary standards of best practice and the achievement of anticipated outcomes for a particular department, procedure, diagnosis, or clinical problem.

Appropriateness Criteria is the extent to which a particular procedure, treatment, tests, or department 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.

The peer review program includes:

- a definition of those circumstances requiring peer review;
- specification of the participants in the review process;
- a method for selecting peer review panels for specific circumstances;

- time frames in which peer review activities are to be conducted and the results reported;
- circumstances under which external peer review is required; and
- provision for participation in the review process by the individual whose performance is being reviewed.

PROCEDURE

I. SERVICE LEVEL

A. Quality Management

1. Each service identifies opportunities for improvement through individual case review, data analysis or staff reported events. These cases are reviewed with a multidisciplinary approach and focus on identifying opportunities for system improvement, clinical education and performance measurement.
2. The meetings to address QM can be held separately or combined with the Peer Review meeting.
3. Process issues are referred to the appropriate service, committee, or performance improvement team for resolution.
4. Educational opportunities are addressed individually or through group entities such as in-services or huddle messages.
5. Professional competency or medical judgment issues are referred to and managed by the service or ad-hoc Peer Review Committee and the Focus Professional Practice Evaluation Policy (FPPE).

B. Peer Review

1. Each service holds peer review meetings to discuss and evaluate cases in accordance with their service peer review criteria. The frequency of these meetings shall be determined by the service based on volume, necessity, and scope of the service.
2. The service Performance Improvement Implementation Plan shall define criteria for cases to review, guidelines for screening and review of cases, and appropriate follow-up.
3. Criteria/indicators are reviewed and approved by the service. These criteria may 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.
4. The cases are reviewed with a focus on identifying opportunities for practice or technical improvement, clinical education, and professional feedback.
5. Cases requiring action and a summary of the discussion (both supportive and critical opinions that lead to the action) are documented in the service meeting minutes. Individual practitioners under review are afforded the opportunity to participate in the peer review process. The types of actions considered may include but are not restricted to:
 - a. Education of the practitioner
 - b. Education for the members of the service (e.g., educational forum, grand rounds)
 - c. Referral to other services
 - d. Changes to clinical, administrative or operational processes for the improvement of patient safety
 - e. Initiation of the FPPE Process
 - f. Initiation of a formal corrective action

6. The service Peer Review minutes include cases reviewed, reasons for the reviews, issues identified, interventions, and any necessary follow-up. All Peer Review minutes shall be submitted to the PRC within 3 months of the meeting.
7. Cases reviewed which identify a significant professional conduct, technical, or medical judgment issue will be recorded and tracked for FPPE, credentialing purposes, and formal corrective action.
8. Each service has the option of forwarding select cases to the PRC on an ad-hoc basis, to seek the PRC's findings, conclusions, and recommendations on such cases. This may occur under circumstances including but not limited to:
 - a) When there is a lack of consensus on a case(s) within the service, and the service would like input from the PRC, to solidify its original conclusion.
 - b) When a case(s) is believed to affect a system-wide issue.
 - c) When a case(s) involves multiple services for which the PRC may be needed to facilitate inter-service communication.

II. MEDICAL CENTER LEVEL

A. Medical Staff Executive Committee

Assures that each service fulfills the following:

- Monitors the quality of care provided by privileged independent practitioners;
- Triggers FPPE as required.
- Performs adequate case review to support reappointment activities

B. Quality Council Responsibilities

1. Assures that each service fulfills the following:
 - Develops a formal structure and QM program that is consistent with the Performance Improvement and Patient Safety Plan
 - Reports annually to the Quality Council
2. Assures availability of resources to accomplish QM program goals
3. Submits service reports to Clinical Excellence Committee

C. Peer Review Committee Responsibilities

1. Reviews cases submitted by the service, in order to provide additional analysis, findings, and recommendations to the service. Make recommendations for process improvements to the individual service and the Clinical Excellence Committee.
2. Reports its findings and recommendations to the Clinical Excellence Committee specific to process improvements. Provides referrals to the Credentials Committee as appropriate. The Credentials Committee has the responsibility to ensure that peer review findings are valid and recommendations from the PRC are followed, as well as the authority to recommend remedial action.

APPROVAL

Medical Staff Executive Committee: March 27, 2014, reviewed with no revisions 3/30/2020
Governing Body: April 30, 2014, reviewed with no revisions 3/31/2020