UCLA Santa Monica - UCLA Medical Center
and
Orthopædic Hospital

PEER REVIEW **MS 130**

Manual	Medical Staff	***Effective Date***	01/31/1990
Policy #	MS 130	***Date Revised***	03/28/2017
Responsible Person	Director, Medical Staff Administration	***Next Scheduled Review***	06/30/2023

PURPOSE

This policy defines the process for peer review by the medical staff. The process measures, assesses and improves the performance and quality of services provided to patients and the clinical performance of each medical staff member. Conclusions from the peer review process are used in the ongoing practitioner performance evaluation of the medical staff, the reappointment of staff members, and the renewal and revision of individual privileges.

POLICY

The Medical Staff establishes through its individual departments and medical staff committees effective functioning peer review that is consistent, timely, defensible, balanced, useful and ongoing. This process includes:

- A definition of those circumstances requiring peer review
- Specification of the participants in the review process, including a definition of "peer" which shall be as follows: a "peer" is defined as an individual from the same profession (for example physician and physician, dentist and dentist) and with comparable qualifications.
- 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
- Provision for participation in the review process by the individual whose performance is being reviewed

PROCEDURE

A. Each Department selects criteria for cases to review relevant to its scope of service. Cases are screened by the Quality Management Department using criteria established by the Department. Cases not meeting criteria are reviewed by a medical staff member.

B. Processes and outcomes on which each Department collects data may include:
   a. Operative, other invasive and noninvasive procedures that place patients at risk
   b. Medication usage
   c. Appropriateness of admissions and hospital stays
   d. Needs, expectations and satisfaction of patients
   e. Physician performance
   f. Behavior management procedures
   g. Autopsy results
   h. Risk Management activities

i. Quality Control activities
j. Mortalities
k. Patient safety issues

C. Cases are screened for potential peer review from the following resources:
   a. Internal screening processes
   b. Confidential Event Reports
   c. Findings from Mortality & Morbidity Reviews
   d. Medical Records data – complications
   e. Utilization Management data
   f. Physicians
   g. Hospital Departments
   h. Patient Relations
   i. Referrals from clinical services/departments and external agencies and providers

D. Cases requiring action and a summary of the discussion (both supportive and critical opinions that lead to the action) are documented in the Department meeting minutes. Individual practitioners under review are afforded the opportunity to participate in the peer review process. Actions considered may include:
   a. Education of the practitioner
   b. Education for the members of the department (i.e. educational forum)
   c. Referral to other departments

E. The Department, with the Medical Staff Executive Committee, will select peer review panels for specific circumstances.

F. Time Frame Guidelines:
   a. Cases for specific reviews, e.g. deaths, sedation, operative and invasive procedures are reviewed every 90 days and presented quarterly to the Department.
   b. Cases regarding risk or untoward events are reviewed as soon as reported and presented within 30 days of review to the Department.
   c. A physician reviews the case and presents the case to the Department within 30 days.
   d. A physician's response to a review is presented at the next Department meeting.
   e. Unresponsive physicians are presented to the Medical Staff Executive Committee for review and intervention. Possible administrative action may include suspension of privileges while awaiting a response.

G. The Department, with the Medical Staff Executive Committee, shall define the circumstances and the process whereby an external peer review will be conducted when no appropriate peer is internally identified.

H. Department reviews and meeting minutes shall be submitted to the Medical Staff Executive Committee monthly.

I. **Medical Staff Peer Review Ranking System**

Rank	Interpretation
0	A QM RN screened the chart using Medical Staff approved quality criteria. All standards were met. The relevant Medical Staff Committee was informed.
1	A physician reviewed the chart and all standards were met. No Medical Staff Committee action is indicated.
2	A physician reviewed the chart and found opportunities for clinical improvement. Medical Staff Committee action is indicated.
3	A physician reviewed the chart. There was a significant deviation from usual clinical standards. Medical Staff Committee action is indicated.
T	Temporary ranking
Outcome Modifiers	
A	Without adverse patient outcome
B	With adverse patient outcome
MD-specific Modifiers	
C	Diagnostic concerns
D	Treatment concerns
E	Documentation, communication or coordination of care concerns
F	Concerns about adherence to rules, regulations, policies or professional standards
Non-Medical Staff Modifiers	
G	Concerns about the performance of non-physician providers
H	Policy, procedure or process concerns
R	Cases where the resident's independent action initiated the review. Refer to residency program for action. Even though the attending may be unaware of the resident's independent action, the attending is still responsible for the resident's actions and it should be determined if the attending's supervision was found appropriate or inappropriate. "R" is not used when the ranking was due to the inappropriate supervision of the resident by the attending.

APPROVED

Medical Staff Executive Committee 06/23/2020

Governing Body 06/30/2020