

## KENNEDY UNIVERSITY HOSPITAL

<b>POLICY:</b> Peer Review	<b>MANUAL:</b> Medical Staff
<b>FUNCTION:</b> Medical Staff	<b>POLICY NO:</b> 400
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**PURPOSE:** To ensure that Kennedy University Hospitals (KUH), through the activities of its medical staff, assesses the performance of individuals who are granted clinical privileges and uses the results of such assessments to improve care

### **Goals:**

- Provision of safe patient care
- Improve the quality of care provided by individual physicians
- Monitor the performance of practitioners who have privileges
- Assure that the process for peer review is clearly defined, fair, defensible, timely and useful
- Identify opportunities for performance improvement
- Monitor significant trends by analyzing aggregate data

### **POLICY:**

All peer review information will be treated as privileged and confidential to the fullest extent possible permitted by medical staff and KUH bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability

The involved practitioner will receive provider specific feedback on a routine basis

KUH will use the provider-specific peer review results in its credentialing and privileging process and, as appropriate, in its performance improvement activities

KUH will keep provider specific peer review and other quality information concerning a practitioner in a secure file. Provider specific peer review information includes information related to:

- Performance data for all dimensions of performance measured for that individual physician
- The individual physician's role in sentinel events, significant incidents, or near misses
- Correspondence to the physician regarding commendations, comments regarding practice performance, or corrective action

Peer review information is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a medical staff leader or hospital employee. However, they shall have access to the information only to the extent necessary to carry out their assigned responsibilities. Only the following individuals shall have access to provider-specific peer review information, and only for purposes of quality improvement:

- Medical staff officers
- Chief Medical Officer
- Medical staff department chairs/section chiefs (for members of their departments only)
- Members of the Medical Executive Board, credentials committee and medical staff peer review committee (PRC)
- Health system VP of Performance Improvement, Corporate Director of Clinical Initiatives, Corporate Director, Risk Management, AVP Medical Staff Administration
- Medical staff services professionals to the extent that access to this information is necessary for the re-credentialing process or formal corrective action
- Performance improvement staff for the purpose of reviewing, preparing, analyzing data in support of peer review activities
- The CEO, for purposes of summary, when information is needed to take immediate formal corrective action
- Individuals with a legitimate purpose for access as determined by the Board of Trustees
- Individuals surveying for accrediting bodies with appropriate jurisdiction (e.g. JCAHO, HFAP or state/federal regulatory bodies)

#### **Circumstances requiring peer review**

Peer review is conducted on an ongoing basis and reported to the appropriate committee for review and action. The procedure for conducting peer review is described in the Process and Timelines Procedure document (Attachment A). Additional evaluation will be conducted when one of the following occurs:

- A sentinel event or near miss identified during concurrent or retrospective review
- An unusual individual case or clinical pattern of care identified during a quality review

#### **Circumstances requiring external peer review**

The departmental peer review committee will make recommendations on the need for external peer review to the Chief Medical Officer and/or MEB. External peer review will take place under the following circumstances if deemed appropriate by the CMO or MEB. No practitioner can require the hospital to obtain external peer review if it is not deemed appropriate by the MEB, CMO or Board of Trustees. Circumstances requiring external peer review include the following:

- Litigation – when dealing with the potential for a lawsuit
- Ambiguity – when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees when conclusions from this review will directly affect a practitioner's membership or privileges
- Lack of internal expertise – when no one on the medical staff has the expertise in the specialty under review or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under

review as described above. External peer review will take place if this potential for conflict of interest cannot be resolved appropriately by the MEB or governing board

- New technology – when a medical staff member requests permission to use new technology or perform a procedure new to the organization and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved
- Miscellaneous issues - when the medical staff needs an expert witness for a fair hearing; for evaluation of a credentials file; or for assistance in developing a benchmark for patient safety/ quality monitoring. In addition, the MEB or governing board may require external peer review for any circumstances deemed appropriate by either of these bodies

### **Participants in the review process:**

Participants in the review process will be selected according to the medical staff policies and procedures. The work of practitioners granted privileges will be reviewed through the peer review process. Clinical support staff will participate in the review process if deemed appropriate. Additional support staff will participate if such participation is included in their job responsibilities. The peer review body will consider and record the view of the person whose care is under review prior to making a final determination regarding the care provided by that individual, providing that individual responds within the appropriate time frame.

In the event of a conflict of interest or circumstances that would suggest a biased review, the departmental PRC or the MEB will replace, appoint, or determine who will participate in the process so that bias does not interfere in the decision making process.

### **Thresholds for intensive review**

If the results of individual case reviews for a physician exceed thresholds established by the medical staff described below, the PRC will review the findings to determine whether further intensive review is needed to identify a potential pattern of care.

Thresholds:

- Any single egregious case
- Performance outside generally accepted benchmarks for evidence based care

### **Peer review for specific circumstances**

In the event that the Board of Trustees decides to investigate a practitioner's performance or circumstances warrant the evaluation of one or more providers with privileges, the MEB or its designee shall appoint a panel of appropriate medical professionals to perform the necessary peer review

### **Peer review time frames:**

Peer review will be conducted by the medical staff in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed by the quality management coordinator and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability

### **Oversight and reporting**

Direct oversight of the peer review process is delegated by the MEB to the department PRC's. The departmental PRC will report to the Board of Trustees via the MEB at least biannually

### **Statutory authority:**

The above policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101, et seq

## **RESPONSIBILITIES:**

### **Definitions of Terms:**

**Peer Review** "Peer Review" is the evaluation of an individual practitioner's professional performance and includes the identification of opportunities to improve care. Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner's performance rather than appraising the quality of care rendered by a group of professionals or by a system.

Peer Review is conducted using multiple sources of information, including the review of individual cases, the review of aggregate data for compliance with general rules of the medical staff, clinical standards and the use of rates compared against established benchmarks or norms.

The individual's evaluation is based on generally recognized standards of care combining both community standard as well as literature based information. This process provides practitioners with feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

**Peer** A 'peer' is an individual who is practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner's performance will determine what "practicing in the same profession" means on a case-by-case basis. For example, for quality issues related to general medical care, any physician (MD or DO) may review the care of another physician. For specialty-specific issues, however, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well-trained and competent in that surgical specialty.

**Peer review body** The "peer review body" designated to perform the initial review by the Medical Executive Board (MEB) or its designee will determine the degree of subject matter expertise required for a provider to be considered a peer for all peer reviews performed by or on behalf of the health system. The initial peer review body will be the departmental medical staff committee unless otherwise designated for specific circumstances by the CMO or MEB.

**Conflict of interest** A member of the medical staff asked to perform peer review may have a conflict of interest if he or she might not be able to render an unbiased opinion due to either involvement in the patient's care or a relationship with the physician involved as a direct competitor or partner. It is the individual reviewer's obligation to disclose the potential conflict to the department chair or Chief Medical Officer. The department chair or Chief Medical

Officer's responsibility is to determine whether the conflict would prevent the individual from participating and the extent of that participation. Individuals determined to have a conflict may not be present during peer review body discussions or decisions, other than to provide requested information.

**PROCEDURE:**

See Attachment A: Peer Review Procedure and Timelines

**REFERENCES:**

Marder RJ, Smith MA (2005). Effective Peer Review: A Practical Guide to Contemporary Design. HC Pro, Inc.