SAMPLE: Peer Review Referral Policy

I. Purpose Statement

To establish a uniform and consistent method of generic screening of clinical indicators, as well as for the review and evaluation of potential medical and process errors and adverse outcomes as pertinent to the physician peer review program

II. Policy

It is the policy of [insert facility name] to conduct review of physician-related generic screens, potential medical and process errors, and adverse outcomes as part of the peer review program in a consistent and timely manner, in accordance with [insert citations to appropriate state peer review statutes].

III. Program Structures

A. DEFINITIONS

1. Generic screens of clinical indicators: Broadly defined outcomes that may or may not be an indication that a medical error was made and usually require further analysis - An example is a patient returning to the emergency department for care, but it may be for a scheduled wound check.

2. Potential medical or process errors: An event that is inconsistent with system procedures or routine patient care or results in serious physical or psychological injury or death

3. Adverse outcomes: An outcome that is inconsistent with system procedures or routine patient care, maybe due to a medical error, or involves serious physical or psychological injury or death

B. PROGRAM SCOPE

Definitions of circumstances potentially requiring peer review are listed below. This list may be revised at any time, as deemed appropriate by the performance improvement and credentialing committees of the medical staff. Revisions to the list must meet approval of both the performance improvement and credentialing committees, with final approval granted by the medical executive committee. Processes and outcomes suitable for peer review include:
1. GENERIC SCREENS, as defined in this guideline, and broadly related to a potential medical error made by a physician, but possibly also due to systems error or patient factors
   a. Moderate to severe adverse drug reactions
   b. Complications approved by the medical staff committee for review (such as CHF after patient MI)
   c. Post-operative complications as defined by the surgical services committee, such as returns to OR
2. QUALITY MONITORING RESULTS according to predefined audit criteria
   a. Operative and non-invasive procedures that are new, high-volume, low-volume, high-risk, or problem-prone are evaluated for the following elements:
      i. Selection of appropriate procedure
      ii. Patient preparation
      iii. Performance of the procedure and patient monitoring
      iv. Post-procedure care
      v. Post-procedure education
   b. Appropriateness, timeliness, completion, and legibility of medical record content
3. POTENTIAL MEDICAL OR PROCESS ERRORS
   a. Inappropriate transfer (as defined by EMTALA)
   b. Inappropriate use of medications
   c. Inappropriate use of blood and blood components
   d. Utilization issues (delay of discharge, prolonged length of stay, unsafe transfer, or discharge of patient related to clinical stability, etc.)
4. ADVERSE OUTCOMES
   a. Unexpected deaths, deaths within 24 hours of hospital admission, post-operative death, and/or any other type of patient death approved for review by the medical staff committee
   b. Preventable complications in patient condition, including those that result in major permanent loss of function and are not related to the natural course of the patient’s illness or underlying condition
   c. All transfusion reactions (hemolytic, febrile, allergic)
   d. Patient suicide
   e. Patient complaints and/or grievances against a medical staff member related to care rendered by medical staff
   f. Staff member complaints, grievances, or concerns against a medical staff member(s) related to the management of patient care
5. HOSPITAL-ACQUIRED CONDITIONS
   a. Foreign Object Retained After Surgery
   b. Air Embolism
   c. Blood Incompatibility
   d. Stage III and IV Pressure Ulcers
   e. Falls and Trauma
      i. Fractures
      ii. Dislocations
      iii. Intracranial Injuries
      iv. Crushing Injuries
      v. Burn
      vi. Other Injuries
   f. Manifestations of Poor Glycemic Control
      i. Diabetic Ketoacidosis
      ii. Nonketotic Hyperosmolar Coma
      iii. Hypoglycemic Coma
      iv. Secondary Diabetes with Ketoacidosis
      v. Secondary Diabetes with Hyperosmolarity
SAMPLE: Peer Review Referral Policy

g. Catheter-Associated Urinary Tract Infection (UTI)

h. Vascular Catheter-Associated Infection

i. Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG):

j. Surgical Site Infection Following Bariatric Surgery for Obesity

   i. Laparoscopic Gastric Bypass
   ii. Gastroenterostomy
   iii. Laparoscopic Gastric Restrictive Surgery

k. Surgical Site Infection Following Certain Orthopedic Procedures

   i. Spine
   ii. Neck
   iii. Shoulder
   iv. Elbow

l. Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures:

   i. Total Knee Replacement
   ii. Hip Replacement

m. Iatrogenic Pneumothorax with Venous Catheterization

6. SENTINEL EVENTS

   a. A patient safety event that reaches the patient and results in any of the following:

      i. Death
      ii. Permanent harm
      iii. Severe temporary harm

   b. Suicide of any patient receiving care, treatment and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital’s emergency department (ED)

   c. Unanticipated death of a full-term infant

   d. Discharge of an infant to the wrong family

   e. Abduction of any patient receiving care, treatment, and services

   f. Any elopement (that is, unauthorized departure) of a patient from a staffed around-the-clock-care setting (including the ED), leading to death, permanent harm, or severe temporary harm to the patient

   g. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)

   h. Rape, assault (leading to death or permanent loss of function), or homicide of any patient receiving care, treatment, and services while on site at the hospital

   i. Rape, assault (leading to death or permanent loss of function), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the hospital

   j. Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure

   k. Unintended retention of a foreign object in a patient after an invasive procedure, including surgery

   l. Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)

   m. Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose

   n. Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care

   o. Any intrapartum (related to the birth process) maternal death

   p. Severe maternal morbidity (not primarily related to the natural course of the patient’s illness or underlying condition) when it reaches a patient and results in any of the following: Permanent harm or severe temporary harm
7. QUALITY MEASURES
   a. Acute Myocardial Infarction (AMI)
      i. Fibrinolytic therapy received within 30 minutes of hospital arrival
      ii. Primary percutaneous coronary intervention (PCI) received within 90 minutes of hospital arrival
   b. Heart Failure (HF) – discharge instructions
   c. Pneumonia (PN)
      i. Blood cultures performed in the emergency department prior to initial antibiotic received in hospital
      ii. Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patient
   d. Healthcare-associated infections (SCIP = Surgical Care Improvement Project)
      i. Prophylactic antibiotic received within one hour prior to surgical incision
      ii. Prophylactic antibiotic selection for surgical patients
      iii. Prophylactic antibiotics discontinued within 24 hours after surgery end time
      iv. Cardiac surgery patients with controlled 6:00 a.m. postoperative serum glucose
   e. Surgeries
      i. Surgery patients on a beta blocker prior to arrival that received a beta blocker during the perioperative period
      ii. Surgery patients with recommended venous thromboembolism (VTE) prophylaxis ordered
      iii. Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 prior to surgery to 24 hours after surgery

8. UTILIZATION DATA
   Cases which may run counter to the standards of practice, as identified in utilization data, and have not been previously subjected to peer review

9. AUTHORIZED REQUEST FOR PEER REVIEW
   Cases/practitioners selected by the governing body, the medical executive committee, the chair of the medical executive committee, the chair of the peer review committee, and/or the chief executive officer (CEO), in their sole discretion

C. PEER REVIEW PARTICIPANTS
   1. A peer reviewer shall be defined as a member of the medical staff, in good standing, who has no competitive interest or economic alignment with the individual whose case is under review. A peer must be another physician, but does not necessarily have to be board certified in the same specialty as the physician whose work is being reviewed.
   2. If the question is one of general medical care, then any unbiased physician (MD or DO) may serve as the reviewer. However, if the peer review will evaluate specialty-specific clinical issues, such as the technique of a specialized surgical procedure, then the peer reviewer must be trained and competent in that specialty. Examples of peers that may offer opinions regarding medical management on a specific case include an internist who sits as a regular member on the surgical services committee, a radiologist who sits as a regular member of the internal medicine committee, etc.
   3. 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. PEER REVIEW PANELS FOR SPECIFIC CIRCUMSTANCES
   1. Peer review panels may be selected in certain circumstances when additional consideration is necessary to adequately review a specific case. Panelists may be selected for their expertise in a given subject of medicine or in a specific medical specialty.
   2. Circumstances that may call for external peer review include, but may not be limited to:
      a. The peer review cannot be conducted in accordance with the hospital’s policy for peer review by business associates.

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Updated: January 2017
SAMPLE: Peer Review Referral Policy

b. There appears to be a conflict of interest between the practitioner under review and potential peer reviewers.

c. There is a substantial difference in expertise between the practitioner under review and potential peer reviewers.

d. There is a substantial difference of opinion in the Peer Review System regarding the quality of care provided in a case or by a practitioner.

e. The review involves new technology or a new procedure and the medical staff does not have an internal resource.

f. Anticipation of a professional review action under the Fair Hearing Plan.

g. Anticipation of litigation.

h. Other reasons dictated by the circumstances.7

E. LEVELS OF SIGNIFICANCE

1. LEVEL 1: The medical care process or adverse outcome, absent recurrence or pattern, is unlikely to impact patient safety, well-being, or system operations and does not directly put patients at risk.

   This event does not require subsequent evaluation, unless there is recurrence or a pattern of similar practice behavior. The case is managed and documented appropriately.

2. LEVEL 2: The medical care process or adverse outcome is unlikely to impact patient safety or well-being or system operations.

   The case is managed appropriately, but documentation is not adequate.

3. LEVEL 3: The medical care process or adverse outcome is questionable, with minor potential for significant adverse effect on the patient or system operations.

4. LEVEL 4: The medical care process or adverse outcome is questionable, with moderate potential for significant adverse effect on the patient or systems operations.

5. LEVEL 5: The medical care process or adverse outcome has a major potential for significant, adverse effects on the patient and/or is a direct violation of clinical practice standards, professional staff bylaws/rules, or regulatory/legal requirements.

   Avoidance of reporting an error-prone medical process or adverse outcome and/or discouragement of reporting occurrences will also constitute a level 5 peer review outcome.

IV. Peer Review Procedure

A. Reports and/or data collected during the process of peer review shall be maintained in a confidential manner in accordance with state law.

B. 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.

C. In cases of immediate referral to committee, as determined by the physician advisor, the physician advisor shall notify the individual whose case is under review of the reason for review and the scheduled date of review, as soon as the physician advisor makes the determination that the case must be referred for formal peer review.

D. Participation in the peer review process by the medical practitioner whose performance is under review:

   The individual whose case is under review has the right to present his or her information regarding medical case management to the committee performing peer review.

E. Risk management staff or performance/quality improvement staff shall take the issue forward for review to the medical staff designee. If quality/risk issues or questions are identified, the medical staff department peer review committee will review the case at their next meeting. A peer physician will assign the appropriate level of significance (Level 1–5) to each occurrence (as
SAMPLE: Peer Review Referral Policy

listed above). Discrepancies on the level of significance will be reviewed by a peer review committee or the chief medical officer for final determination.

NOTE: If the level of significance is not determined, or the determination is questioned, the chief medical officer shall assist in the final determination.

F. Peer review activity time frames
1. Cases forwarded to medical staff committees for peer review are to be reviewed within one month of referral.
2. For issues believed to be of such severity or urgency that immediate action is warranted, the director of risk management or the director of performance/quality improvement, or designee, shall, upon the receipt of the report, immediately notify the medical staff leader and/or other professional staff officers and the involved physician.
3. Time frames are adhered to in a reasonable fashion. If peer review falls outside 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 in the medical staff committee meeting minutes of the reviewing committee. All efforts will be made to complete the peer review process as soon as practicable.

G. Corrective Action:
1. Level 1 issues will not require action or impact privileges. The physician will be notified, if applicable and as decided by the medical staff department chair or chief medical officer.
2. The physician will be requested to take corrective action subsequent to a level 2 evaluation, and such will be monitored periodically until resolved.
3. Recurrence or a continuing trend of level 2–4 practice patterns shall constitute a higher level of significance, thus requiring handling in a manner consistent with either level 3, 4, or 5.
4. Level 3–5 issues require contact with the physician by the medical staff department chair, chief medical officer, chief of staff, or designee. A written plan of corrective action will be required.

H. File Access:
1. A physician, after contacting the chief medical officer, may have access to his/her file of redacted reports and action/resolution summaries. These will be retained in an individual medical staff quality file, maintained separately from credentialing files, and securely kept in the medical staff office to protect confidentiality and prevent discoverability.
2. A department medical director or chief medical officer may only access the files of their members to execute responsibilities for their position.
3. The chief executive officer, chief operations officer, director of risk management, director of quality/performance improvement, or their designee(s), may access the files of all professional staff members in performance of their responsibilities.

I. Performance Improvement
1. All cases undergoing peer review will have a worksheet completed that lists the rationale for the conclusion made by the peer reviewer(s). Rationale must be based on the reason the case was reviewed and be supported by current clinical practice, practice guidelines, and/or literature. The conclusions of the review shall be defensible.
2. All opinions regarding medical management of the case under review, including minority opinions, will be considered in the ultimate determination of the case. This includes information and opinions from the individual whose case is under review. Peer review shall be balanced.
3. Results of peer review are utilized on an ongoing basis and at the time of medical staff reappointment, to improve the organization’s and physicians’ performance in individual situations, and as a whole.
4. Results of peer review activities are aggregated and reported as part of the ongoing professional practice evaluation process at least every six months to provide for a practitioner-specific appraisal of competency for continuing or renewing clinical privileges. A practitioner-specific ongoing professional practice evaluation is completed and forwarded to the credentialing committee prior to medical staff member reappointment.

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5. The chief medical officer shall provide a brief summary of de-identified peer review issues to the appropriate department chair semiannually and at reappointment.

6. Results of de-identified peer review activities, focused on corrective actions taken and process improvements that have been recommended and/or implemented, are utilized in the hospital-wide quality improvement program via quarterly reporting to the performance improvement committee, while still protecting confidentiality and preventing discoverability.

7. The peer review program is an ongoing component of the hospitalwide performance improvement program and a routine component of each medical staff service committee.

8. Peer review conclusions, outcomes, and actions are monitored for effectiveness. Results of de-identified follow-up effectiveness monitoring are reported to the performance improvement committee on a quarterly basis.

References
5. Ibid.

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