Lakeview Hospital
Physician Peer Review Process
ADM-MED-708

Approval Body:	Administration Medical Executive Committee Credentialing Committee of Board of Directors	**Effective Date:** 4/2010	**Date of initial approval:** 7/1994
Sponsor:	Manager Medical Staff Services	**Reviewed Date:**	6/98, 11/01, 11/03, 3/04, 3/05, 10/05, 12/07-3/08, 4/12, 4/14, 5/18
Manual:	Administrative Manual Medical Staff Chapter	**Revised Date:**	4/96, 3/01, 11/01, 11/03, 1/04, 3/05, 10/05, 3/08, 4/10, 4/16

Policy Statement:

The purpose of peer review activity at Lakeview Hospital is to identify opportunities for improvement, eliminate errors, and provide practitioner education in a manner that fosters respect and professional growth.

1. When an unfavorable outcome is identified, our first emphasis is examining and improving the system and care processes.
2. We provide consistent and accurate feedback to physicians about their performance compared to the entire medical staff.
3. We strive to have complete and quality records.
4. We consider peer review information during the credentialing process.

Procedure or Special Instructions:

1. Performance Improvement Activities:
   Members of the medical staff are involved in activities to measure, assess, and improve performance on an organization-wide basis. Examples include:
   a. Medical Staff, representation on the Lakeview Hospital Quality Steering Committee, Medical Staff Department Committees and/or HealthPartners system-wide performance improvement groups.
   b. Documentation & Clinical indicators identified by Medical Staff Department Chairs, Medical Staff Committees, Medical Directors, Peer Review Director and/or the Medical Executive Committee (MEC).
   c. Monitoring Joint Commission/CMS identified indicators.

   Reports will be routinely presented to the MEC.

2. Department Review:
   Departments may define circumstances that require peer review. Reviews should be consistent, timely, defensible, balanced, useful and ongoing. The review criteria may change at the discretion of the Medical Staff Leadership. Examples include but are not limited to:

   <u>Surgery examples:</u>
   Complications of surgery
   Infection Rates
   Readmissions within 48 hours

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Normal tissue not meeting surgical indications

<u>OB examples:</u>
Elective Deliveries < 39 weeks
Cesarean Sections
Neonates <34 weeks
Neonates 1500 grams
Neonatal APGAR less than 7 @ 5 minutes
Post Partum Hemorrhage requiring transfusion
Eclampsia
Cord prolapse
Meconium aspiration
Neonatal transfers
Maternal readmissions within 48 hours
Uterine rupture
Neonatal injury

<u>Peds Examples</u>
Pediatric Transfers
Unexpected death

<u>Medicine/ICU examples:</u>
Unexpected transfers
Unexpected death
Readmission for same diagnosis within 48 hours
Ventilator management greater than 72 hours
Unexpected organ failure related to medication
Core Measure failed charts

<u>ED examples</u>:
AMA
Cardiac arrest in ED
Core measures failed charts

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Sepsis
Time to Imaging (stroke)
Time to Transfer for Acute Coronary Intervention

Anesthesia examples: **As a result of Anesthesia*
Central nervous system complications post-operatively*.
Peripheral neurologic deficiencies post-operatively*
Aspiration pneumonitis during or w/i one post procedure/day*
Cardiac/respiratory complication within 48 hours of anesthetic*
Dental injury*
Ocular injury*
Anaphylaxis*

Resolution may include:

a. When a problem is identified through the normal departmental review process, the Department Chair, or his designee, is responsible to notify the involved physician to discuss concern.
b. A CME program may be useful to initiate system improvement to prevent errors from recurring.
c. If a concern cannot be resolved by the department chair/designee and involved physician, it may be forwarded to the Peer Review Director and/or the Professional Practice Evaluation Committee for resolution;
d. If no resolution is achieved it will be forwarded to the Medical Executive Committee for resolution.
e. If no resolution is achieved, Corrective Action as defined by Article VII of the Bylaws of the Medical Staff will be followed.

3. Incidents, patient, family, or staff complaints.
Complaints are considered opportunities for improvement. When an incident involving the Medical Staff is received, it is referred to the Medical Staff Services Manager who will in turn contact medical staff leadership to schedule a review. The Department Chair, Medical Director, Chief of Staff, Vice President of Medical Affairs or the Medical Executive Committee may address the issue. Interactions concerning incidents/complaints are considered confidential.

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Fact-finding discussions, necessary to clarify an incident or complaint are protected under *Minnesota Peer Review Statutes 145.64.*

Interactions may include:

- Discussion with physician involved;
- Discussion with other involved hospital and medical staff members;
- Physician attendance at a Professional Practice Evaluation Committee meeting;
- Physician attendance at a Medical Executive Committee meeting;
- Recommendation for a Case Conference;
- Credentialing Committee members may be included in discussions

4. The physician will be invited to respond to the incident/complaint. If a response is received, a copy of the incident/complaint, along with the response, will be placed in the practitioner's credentialing file. If no response is received, the lack of response will be noted and filed in the practitioner's credentialing file.

5. Focused Review:
   Focused review is an extension of the aforementioned processes. If a trend or problem is identified a focused review may be implemented as noted above.

6. External Peer Review:
   In the event a determination cannot be reached through the internal process the information will be referred to an outside peer review organization. The reviewer selected will be knowledgeable and experienced with the procedure being reviewed.

7. Focused Professional Practice Evaluation (FPPE):
   FPPE is an identified period of time during which the organization evaluates and determines a new practitioner's professional performance. Refer to ADM-MED 740 OPPE & FPPE for details.

8. On-going Performance Practice Evaluation (OPPE):
   Ongoing professional evaluation is a process whereby an individual practitioner's performance, ethical behavior, utilization, competency, professionalism, and compliance with established policies and best practices is continuously examined through review of compiled data. Refer to

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ADM-MED 740 OPPE & FPPE for details.

Considerations:

TJC Medical Staff Standards
Lakeview Hospital Bylaws and Rules and Regulations
ADM-MED 740 OPPE & FPPE