**NORTHWEST TEXAS HEALTHCARE SYSTEM**

P. O. Box 1110
Amarillo, TX 79175



**Policy: Medical Staff Peer Review Process**

**POLICY STATEMENT**: Medical Staff Quality Improvement (QI) Committee/ Peer review is a process used to maintain quality patient care throughout the organization. This process is successful when the result is a timely objective review, evaluation, and intervention as necessary in order to protect patient safety. The Medical Staff QI Committee/Peer Review Committee and/or any other committee appointed by the Medical Executive Committee will carry out and manage the process. The committee will maintain responsibility for assigning or confirming the quality of care scores**.** The Medical Executive Committee assumes overall responsibility for the peer review process with recommendations forwarded to the Board of Governors.

**Membership:** The Medical Staff QI/Peer Review Committee will consist of the President, Immediate Past-President, or President Elect, the Credentials Committee Chairman, the Chiefs of the Medical Staff Departments and the Medical Director for Trauma. The Immediate Past-President or President-Elect will serve as the Chairman for the committee.

Each Department Chief will make recommendations to the Medical Executive Committee for one or two additional members from their departments to serve on the committee. The Board of Governors will grant final approval of membership. Two reviewers will serve one, two or three year staggered terms.

The following shall serve as members without vote: Administrative and other Hospital Representatives.

Other members of the Medical Staff with special expertise may attend at the request of the Chairman of the committee. The physician reviewer's identity shall remain anonymous.

**Meetings:** The Medical Staff QI/ Peer Review committee will meet as necessary to conduct business, but no less than monthly. If immediate review is warranted, the peer review will be obtained and a special meeting will be called as soon as possible.

**Committee Function:** Cases may be presented for peer review process through any of the following mechanisms:

1. Routine performance improvement activities;
2. Referral by a Medical Staff member, Medical Staff committee, Board of Governors member, Risk Management, patient advocate, any other hospital employee, or regulatory agency. All requests for peer review will be honored.

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a. All referrals, including all pertinent data will be forwarded to the Quality Management Department.
b. All referrals are screened initially by Quality Management personnel. The Peer Review process will be followed as outlined on the flow sheet.

The Quality Management Department may request review of a case by a specialist, such as an Infectious Disease physician. However, this consultation does not constitute peer review, and any issues identified by the physician from whom such consultation was requested shall be referred for review through the established peer review process.

Authority to refer cases for external review is given to the following:

1. The Peer Review Committee, Risk Management, with concurrence of the CEO/Managing Director, or designee, and the Chief of the Department and/or the President of the Medical Staff;
2. The Executive Committee; and/or
3. The Board of Governors.

**Procedure Guidelines**:

1. All discussions will be held in strictest confidence. The Guidelines for Conducting Confidential Executive Sessions as outlined in policy will be followed.

2. The step-by-step process outline on the attached flow sheet will be followed.

3. Per the Bylaws, Medical Staff members have the responsibility for participation in peer review activities. (Article II; 2.3, n). It is strongly recommended that peer reviewers attend the meeting at which the case(s) he/she reviewed is presented.

4. For physicians under FPPE for Cause monitoring, quality issues deemed to warrant further review will be presented at the QI/Peer Review Committee meeting. The physician under monitoring will not be requested to attend the initial discussion. If the committee determines that input from the involved physician is indicated, the physician may be requested to respond by letter or by his/her attendance. A report of the committee's review listing the physicians on FPPE For Cause monitoring is provided monthly to the Executive Committee.

5. Results of peer review are made part of a Medical Staff member's quality profile, and will be considered at the time of the Ongoing Professional Practice Evaluation (OPPE**)** and reappointment.

6. Any action that results in suspension, or reduction or loss of privileges or membership will be addressed as per Articles VI and VII Article X of the Medial Staff Bylaws and the Fair Hearing Plan. Privileges/membership decisions are ultimately the responsibility of the Board of Governors.

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7. It is recognized that variances to this process may occasionally be indicated through circumstances that cannot be foreseen. The Executive Committee or Board of Governors may therefore make modifications to this process, but only if the reason for doing so is well documented in minutes, and the decision to deviate from the established standard is not capricious.

8. Expedited review: review that has an implication on Medical Staff decision including but not limited to suspension; expected turnaround time will be shortest timeframe possible and will be placed as highest priority

Attachments:

- Peer Review Flow Sheet
- Clinical triggers for Medical Staff QI
- Quality of Care Scores
- Mortality Review Criteria
- Case Review Document – form for referral of case

References: Medical Peer Review Reporting System (“Incident Reports”) Policy #V-B.1. Medical Staff Policies, “Guidelines for Conducting Confidential Executive Sessions” and “Conflict of Interest”.

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**NORTHWEST TEXAS HEALTHCARE SYSTEM**
**Quality of Care Scores**
**Physician Peer Review**

| MIDAS Required Scores |
|---|
| **1** Good quality of care |
| **2** Documentation deficiencies |
| **4** Care varied from standard of care, no patient harm – referral to committee for final decision |
| **5** Care varied from standard of care, potential harm for patient |
| **6** Care varied from standard of care, actual harm for patient |

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Northwest Texas Healthcare System

Monthly screening of the mortality log will occur to determine which deaths will require intensive review. The following criteria will be utilized to make this determination:

| Mortality | | |
|---|---|---|
| **Trended item** | **Category** | **Source** |
| Referral from Risk | Outside standard of care | QM monthly chart review |
| Deaths of Pediatric patients | 17 years old or less without a terminal diagnosis<br>Trauma and/or deaths of patient's without terminal diagnosis | QM monthly chart review |
| Deaths related to hospital acquired infection | All | QM monthly chart review |
| Deaths of patients in observation status | All | QM monthly chart review |
| Deaths of patients at the Pavilion | All | QM monthly chart review |
| Maternal deaths | All | QM monthly chart review |
| Stillborn deaths | Apgars 0/0 | Sent to QM from OB log |
| Excluded from review:<br>1. Trauma deaths – due to review through trauma program | | |

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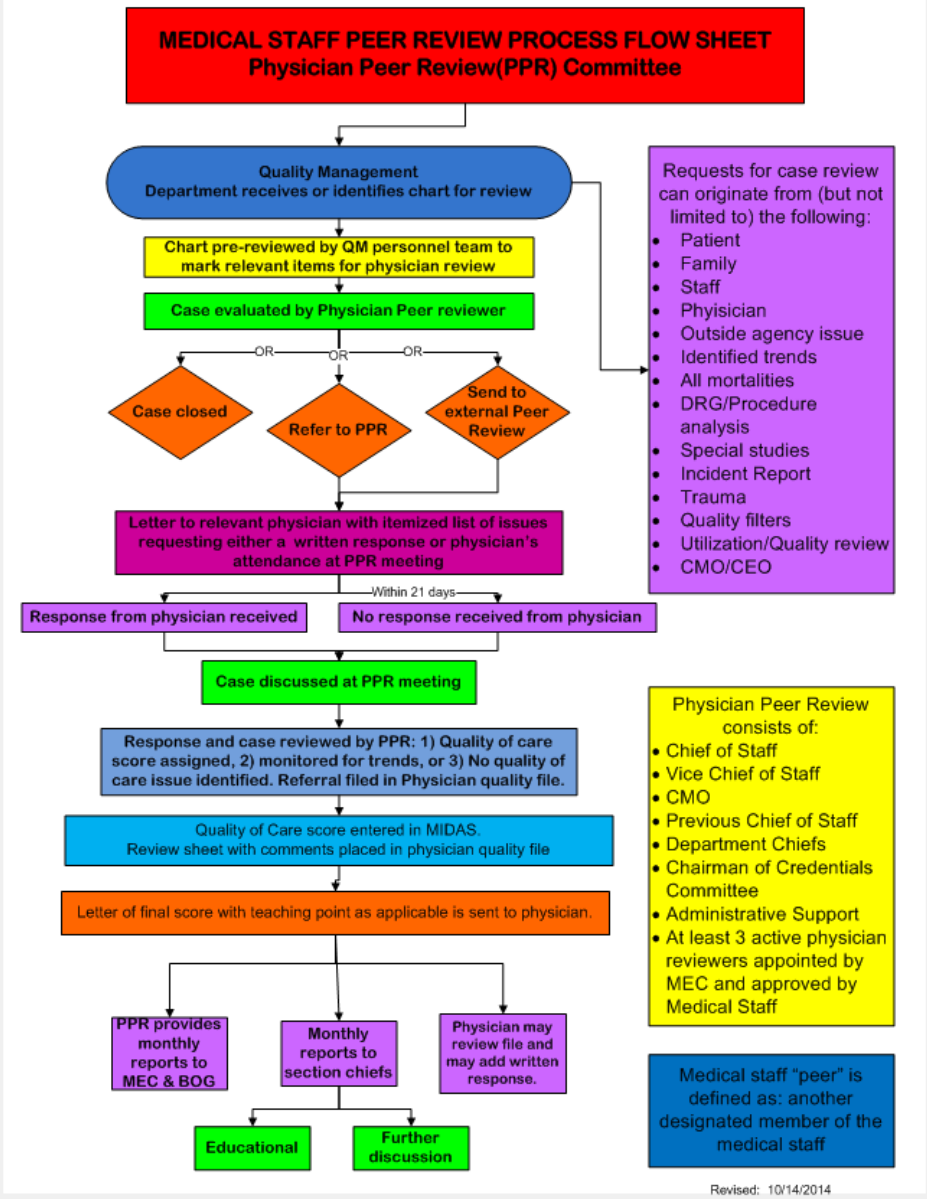


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# Peer Review Summary of Events

| Case | PEER REVIEWER | ISSUE/OUTCOME | QOC Score |
|---|---|---|---|
| **Patient-**<br>MR # | | **Date of Event-**<br><br>**Outcome-**<br><br>**Issue under review –** | |
| | | | |

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