Davis HealthSystem
812 Gorman Avenue • Elkins, WV 26241 • 304.637.3767 • Fax 304.637.3435 • davishealthsystem.org

DEPARTMENT: Hospital/Medical Staff	**POLICY DESCRIPTION: Medical Staff Peer Review Process**
PAGE: 1 of 5	**REVISED: 06/02, 01/03, 09/05, 09/08, 10/10, 01/12, 04/12, 07/13, 09/14, 11/16, 6/19, 10/19, 02/21**
REVIEWED: September 2017; October 2019	**RETIRED:**
EFFECTIVE DATE: September 2017	**REFERENCE NUMBER: TJC MS.08.01.01; MS.08.01.03**

Purpose:
The purpose of this policy is to guide the Medical Staff through an objective peer review process to maintain quality patient care throughout Davis Health System.

I. Peer Review Committee:

The Peer Review Committee will be a subcommittee of the Quality/Medical Management Committee. The Peer Review Committee will be chaired by the chairman of the Quality/Medical Management Committee and will consist of seven (7) voting medical staff members, including representation from Broaddus Hospital, other than the chairman as well as the non-voting members: Quality Improvement Specialist, and Chief Medical Officer. The Peer Review Committee should consist of a good general cross section of the medical staff who agrees to prepare for and attend at least 75% of the monthly meetings.

II. Committee Reporting/Actions:

The Peer Review Committee will present a general report to the Medical Executive Committee on a monthly basis. All peer review material will be forwarded to the credentials committee and will be placed in the protected peer review folder within the physician's credentials file. The Peer Review Committee will provide both positive and negative feedback to the involved physician on each case reviewed. The Peer Review Committee may make recommendations for quality/performance improvement or corrective action plans that may be monitored by the Medical Executive Committee, Chief of Staff, Peer Review Committee or the respective Service Chief.

III. Committee Procedures/Protection:

The following procedures will be adhered to in insuring integrity of the peer review process:

a. Appoint credible/respected members
b. Adhere to conflict of interest policy
c. Members will be excused during review of cases in which they were involved
d. Use of external review when indicated
e. Members will not be permitted to do an initial review of cases of a partner.

The following procedures will be adhered to in insuring protection of information from the peer review process:

a. Only members of the committee will be permitted in the meeting.
b. Copies of reviews, charts, etc., will be numbered and returned before leaving the meeting.
c. Tape recordings will not be permitted.
d. Any notes written during the peer review process will not be permitted to be removed from the meeting.
e. The physician involved in the case for review will provide a written response directly to the Peer Review Committee Chairman or DHS Chief Quality Officer/Risk Manager within two weeks.
f. Peer Review Committee members will sign a confidentiality attestation, prohibiting discussion of the results of the case review outside of the committee meeting.

IV. Screening:

The Quality Department will perform a concurrent review utilizing medical staff approved indicators including quality of care issues, compliance with policies and documentation. Cases may be referred for review by nursing, administration, other staff members. Patient Relations will forward all patient complaints for review through MIDAS.

V. Physician Review:

A. Cases that fall out of the screening process will be referred to the department chair, or member of the peer review committee for initial physician review. External review may be considered in some circumstances if there are issues of conflict or expertise.
   - Cases will be referred to the following:
     - Emergency Department: ER Medical Director
     - Medicine/Hospitalist: Director of Hospitalists
     - OB/GYN: Director of Women's Health Services
     - Outpatient Physician Practices: Chief Medical Officer
     - Surgery and GI: Chief of Surgery
     - Pediatric and Newborn: Pediatric Representative

B. The physician reviewer will initially classify the case as appropriate, questionable or inappropriate care and recommend questions to the physician or discussion by the committee before questions are sent.

VI. Committee Review:

A. The Chairman of the Quality/Medical Management Committee, Chief of Staff or department chair will refer all charts deemed with questionable or inappropriate care to the Peer Review Committee for a confidential peer review session, where the reviewers can present in a confidential manner the opinions and views related to the care.
B. Additional information may be required of physician or recommendations will then be made with performance improvement as the goal.
C. When review forms are complete and action follow-up has occurred, the review

forms will be filed in the physician's peer review/quality file report within their credentials file.

D. The peer review process will be managed efficiently and effectively, with determinations and follow-up being completed within 2 months of initiation of the process. Exemption to this time frame for completion will only be given to special circumstances requiring outside review, and a time frame for completion will be determined by the medical executive committee.

E. Involved physicians will be given the opportunity to participate in the peer review process at the committee level through written response to questions posed by the peer review committee reviewer. Failure to respond within that time frame will result in a committee decision based solely on the facts presented through chart/document review.

F. Recommendation for review under special circumstances will be made by the Quality/Medical Management Committee Chairman to the Medical Executive Committee, who will determine participation in a special review process. Any recommendations for outside review will be done with Medical Staff and Chief Executive Officer concurrence.

G. Appropriate criteria for external peer review may include:
- Single-specialty peer review issues
- Unique privilege issues (no one in organization with similar training or privileges)
- Unresolved peer review issues with significant differences of opinion on disposition, which cannot be resolved at the Executive Committee level.
- Conflict of interest

VII. Non Medical Issues Review:

A. Any major non medical issues such as inappropriate management of the medical record or non compliance with medical staff by-laws and/or rules and regulations or any issues related to disruptive behavior will also be referred to the Quality/Medical Management Committee Chairman, Chief of Staff or department chair for review. If complaints are validated, they will be forwarded to the peer review committee for evaluation, tracking/trending and recommendations for performance improvement.

B. These issues will also be placed in the physician's confidential peer review/quality file within their credentials file. A summary of the issues/concerns will be forwarded to the physician for their files.

VIII. Reappointment:

At time of reappointment and any time during the reappointment period should patterns or trends be recognized, the file will be referred to the department chair for review and appropriate action.

IX. Medical Executive Committee Review:

Any trended issues that are unable to be resolved at the department or Quality/Medical Management Committee level will be referred to the Medical Executive Committee for appropriate actions and recommendations.

X. Physician Feedback Reports:

The Peer Review Committee will be responsible for setting and monitoring indicators of

quality across the spectrum of care for all medical staff. These indicators will be reviewed and revised as necessary yearly.

The Peer Review Committee, with the assistance of Hospital Quality/Risk Management and Medical Staff Office, will set targets of achievement for these indicators of "acceptable" and "excellent" quality of care.

Feedback will be provided to the medical staff at least twice yearly in the form of a formal physician feedback report. This report will give the staff member their personal data, as well as, benchmarks for each indicator.

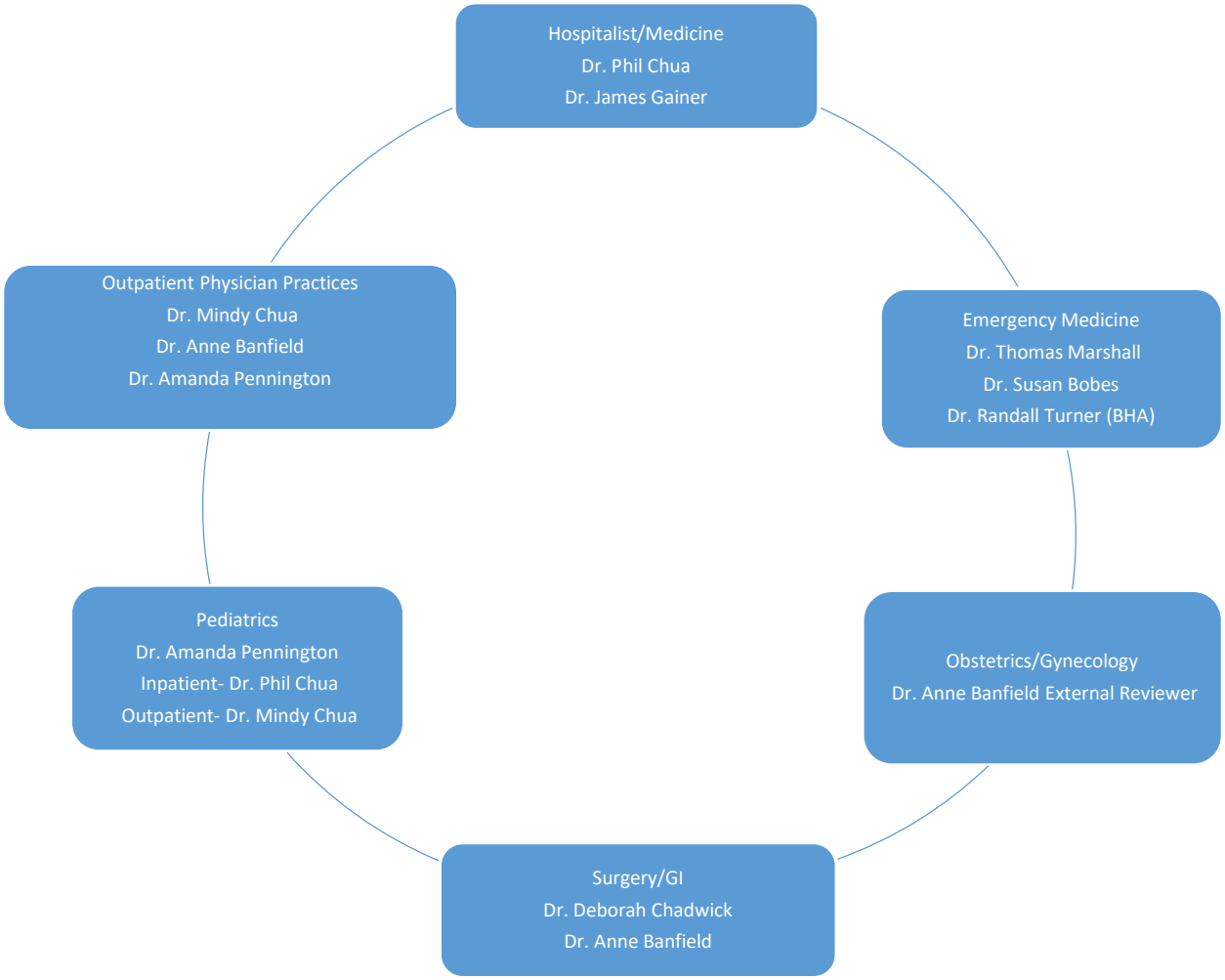
For each specific indicator, in which quality of care data falls below the acceptable threshold, data will be reviewed by the Peer Review Committee and a corrective plan of action will be developed and monitored. This may include education, tracking and trending with the opportunity for self-correction, proctoring within the department, required use of standing order sets or pathways, Chief of Service, or Medical Executive Committee depending on the indicator and severity of the deficiency identified.

Distribution - All Medical Staff

Approvals:

_____	_____
Chairman, Quality Management Committee	Date
_____	_____
CMO, Davis Health System	Date
_____	_____
Chief of Medical Staff	Date
_____	_____
Director of Quality/Risk Management	Date

Physician Review Referral



External Review can be requested at any time due to conflict or need for second opinion.