Rancho Los Amigos National Rehabilitation Center

ADMINISTRATIVE POLICY AND PROCEDURE

SUBJECT: MEDICAL STAFF PEER REVIEW

PURPOSE:

To ensure that all peer review activities are conducted in a consistent manner throughout the organization. To ensure that all peer review activities are properly designed and effectively functioning throughout the organization.

POLICY:

Rancho Los Amigos National Rehabilitation Center and the members of its medical staff are responsible for the quality of care provided to the patient population throughout the institution. Therefore, it is the policy of our organization to support the medical staff peer review process as stipulated in the PSA Bylaws. The peer review process is a non-biased activity performed by the medical staff to measure, assess and, where necessary, improve performance on an individual/organization-wide basis.

Departments: All medical staff departments
Definition: *Peer* - An individual with essentially similar or higher qualifications/privileges
External Peer Review - Referral of an issue/case to a reviewer/expert outside the organization for unbiased or specialty review and evaluation.

PROCEDURE:

A. Peer Review Program Components - The peer review process performed by the medical staff contains the following components

1. Peer review will focus on process improvement as well as on practice issues and medical management. Practice issues or circumstances requiring peer review include but are not limited to:
   - Blood utilization
   - Medication use
   - Sentinel events
   - Risk management
   - Operative and other procedure review
   - Specific department quality indicators (e.g. efficiency of clinical practice patterns, significant departures from established patterns of clinical practice)
   - Infection control
   - Proctoring of new staff (provisional) members within departments
   - Morbidity and mortality

- Medical staff committee determinations that there are problems within a department or service that are directly related to individual clinical performance
- Medical records reviews by Medical Records Committee or Department Chairs

2. Circumstances requiring external peer review:
   - Those available to review the record do not have sufficient expertise to provide a fair peer review
   - Those available to review the record have a conflict of interest, or work too closely with the staff member and do not feel comfortable performing the review
   - Ambiguous or conflicting recommendations from internal reviewers or medical staff committees, or when there does not appear to be a strong consensus for a particular recommendation

3. Peer review process participants:
   - An individual functioning as a peer reviewer will not have performed any medical management if at all possible on the patient whose case is under review.
   - The individual staff member whose practice is under review will be notified of any peer review evaluation that will potentially result in an unfavorable outcome. The staff member will be invited to provide information about the event and be given the option to participate in the evaluation.

4. Peer Review Committees
   - MSQA&I Committee
   - Executive Risk Management Committee (Patient Safety Oversight)
   - Infection Control Committee
   - Transfusion Committee
   - Pharmacy and Therapeutics Committee (Medication Use Evaluation)
   - Medical Records Committee
   - Ambulatory Care
   - Departmental PI or peer review committees
   - Surgery Department Committee
   - Tissue Committee
   - Critical Care Code Blue Sub-Committee
   - Utilization Review Committee
   - Departmental Mortality and Morbidity or other case review committees.
   - Ad hoc committees as may be needed

Members on the above standing committees are appointed by the President of the Professional Staff Association (PSA). These committees may act independently to perform peer review within the guidelines of this policy and the PSA Bylaws. Any of these committees may forward an issue for peer review to another committee as necessary for specialty review or to the Medical Executive Committee for review and evaluation.

The MSQA&I Committee, Medical Executive Committee, or Executive Risk Management Committee may form ad-hoc committees for peer review as needed for specialty or sentinel event review.

B. Peer Review Program Methodology - To provide for an effectively functioning peer review process, the following program methodology will be followed:
   1. The peer review program is consistent: - Peer review is conducted according to defined procedures outlined in this policy and the PSA Bylaws for all cases meeting the definition or reviewable circumstances.
   2. Time frames are adhered to in a reasonable fashion: - All cases that are deemed to be potential sentinel events shall be reviewed within 14 days. For all other cases, a 60-day time frame is given to submit the review. All efforts will be made to complete the peer review as soon as practical.
   3. Conclusions of review are defensible: - 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 supported by current clinical practice, practice guidelines and/or literature.
   4. Peer review is balanced: - All opinions regarding medical management, including minority opinions, of the case under review will be considered in the ultimate determination of the case. This includes information and opinions from the individual whose case is under review.
   5. Peer review is useful: - Results of peer review are utilized at the time of medical staff reappointment and to improve the organization's performance in individual situations, and as a whole.
      - Results of peer review activities are aggregated and reported at time of medical staff reappointment to provide for practitioner specific appraisal of competency and renewal of clinical privileges. A practitioner specific performance profile is completed and forwarded to the Credentials Committee prior to medical staff member reappointment by the Department chair. This profile of aggregated peer review outcomes is internal and confidential.
      - Results of peer review activities are utilized in the organizational wide performance improvement program, via quarterly reporting to the MSQAI Committee to allow for organizational improvement as necessary.
   6. Peer review is ongoing: - The peer review process is ongoing, and its conclusions are tracked over time. It plays an integral part in the organization wide performance improvement program. Conclusions, outcomes and actions resulting from peer review are monitored for effectiveness. Results of effectiveness monitoring are reported to the MSQAI Committee, the Medical Executive Committee, and the Governing Body (See attachment A).

REFERENCES: Joint Commission on Accreditation of Healthcare Organizations:
2016 Comprehensive Accreditation Manual for Hospitals
Title 22: Section 70703 (d) - California Code of Regulations
Code of Federal Regulations: Title 42 - CFR 482.22 (a) (1)

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