Policy Statement

In an effort to improve the quality of care provided to the patients and to assist the physicians providing such care, St. Joseph’s and Candler Hospital’s Medical Staffs have established, with Board approval, peer review committees as more fully described in the Joint Medical Staff Organization and Functions Manual (exceptions: Critical Care, Cancer and Continuing Medical Education committees), to evaluate the quality and efficiency of services that are performed by the physicians and other professional healthcare providers within this health system. All peer review committees referenced above serve to provide recommendations only; the Joint Credentialing Committee and Medical Executive Committee may take disciplinary action.

Entities to whom this Policy Applies

St. Joseph’s/Candler Health System, Inc., subsidiaries St. Joseph’s Hospital Inc. and Candler Hospital, Inc.

Objectives

To provide a process of peer review that is consistent, timely, defensible, balanced, useful, and ongoing.

To provide meaningful data to improve the quality of care provided within the Health System.

To provide useful data to be used in making decisions regarding appropriate reappointment to the medical staff.

Definition of Terms

Peers - active members of St. Joseph’s Hospital or Candler Hospital Medical Staffs who are licensed to provide healthcare services to individuals and who are properly complying with St. Joseph’s and/or Candler Hospital bylaws, rules and regulations applied to the Medical Staffs. In addition, they shall have clinical privileges and expertise within the medical/surgical discipline for which they are reviewing.

Procedure
I. Continuous Performance Monitoring and Peer Review

A. On a routine basis, cases are screened against criteria approved by the Medical Staff. (Such as: blood appropriateness, surgical/invasive procedure appropriateness, medical record completeness/timeliness, mortality/autopsy, and unexpected outcomes).
B. Cases that fail the screens may be sent for physician peer review and/or may be trended by case type, physician, outcome and peer review score.
C. Results of this review are reported to the appropriate committee, department chairperson, Joint Credentials Committee, MEC, and/or the Board.
D. Physician members of the peer review committees, as described above, will act as a first line review for routine monitoring and peer review.
E. Cases will be evaluated and where appropriate assigned a severity score.
F. Any evaluations that score a case as 1B or lower would serve as informational purposes only and may not be fully analyzed and evaluated by the peer review committee unless trends/patterns develop.
G. Cases evaluated and scored as a “2” or higher will be reviewed and discussed by the committee.
H. Inappropriate trends/patterns of practice may trigger a Peer Review for specific cause.
I. The information obtained through performance monitoring will be used to change policies and procedures to improve patient care.
J. Peer review committees will meet on a regular basis as described in the Medical Staff Bylaws to evaluate and review case management, identify trends and recommend improvement in patient care.

II. Time Frame

A. Each medical and/or surgical case evaluation should be reviewed in a reasonable timely manner to provide for effective monitoring and quality improvement.
B. Each case occurrence shall be screened and assigned to a single physician evaluator.
C. Within thirty (30) days of receipt of the assignment to review a case, the physician peer reviewer should complete the review.
D. The scores will range from 1A to 3 (1A designates less serious ranging to 3 which designates a serious quality issue.)

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<th>ST. Joseph’s/Candler Health System Peer Review Scoring System</th>
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<tr>
<td>Score 1- A</td>
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E. The single physician peer evaluator shall forward his/her evaluation, findings and score to the complete peer review committee.

F. If the score is 1A or 1B, the information shall be forwarded to the appropriate peer review committee for information and future tracking for opportunities to improve quality of care.

G. If the screening panel score is 2 or higher the following procedures shall be followed:
   1. Within fourteen (14) days of receiving the score, the Committee Chairman shall notify the responsible physician(s) that the case has been reviewed and request a response defining the circumstances and reasoning supporting his/her medical judgment within fourteen (14) days of notification.
   2. The physician is afforded an opportunity to appear before the committee to present his information defining the circumstances and supporting information or he may present information to the committee in writing.
   3. Within ninety (90) days of receiving the initial score, the peer review committee shall convene to evaluate, discuss and determine the proper action to take in order to improve quality; i.e. continued tracking for trends/patterns, collegial peer counseling, training, disciplinary action, etc.
   4. If the committee’s final score remains a score 2 or 3, a committee recommendation will be made to the department chairperson, MEC and/or Credentials Committee as appropriate for further review and/or action.
   5. Any minority decisions shall be recorded and forwarded to MEC and/or Credential Committee as appropriate.

III. Failure to Participate

A. The Medical Staff leadership feel strongly in the duty of the physicians’ participation in the peer review and performance improvement process.

B. If the peer physician assigned to review the occurrence fails to do so within 30 days, the committee chairman is notified and communicates with the reviewing physician to encourage the review of the record.

C. If the peer physician continues to avoid review of the occurrence, the Department Chairman and President of the Medical Staff are notified and the peer reviewer is in jeopardy of disciplinary action.

D. If additional information is requested from the involved physician(s), and they fail to respond within fourteen (14) days of the letter, a second letter is sent by certified mail.

E. If there is still no response after being given an additional fourteen (14) days, the department chairman and the President of the Medical Staff are notified and privileges are suspended until a response is received.
IV. Reporting

A. Aggregate data is reported to the appropriate medical Staff committees for analysis, looking for patterns or trends to determine opportunities for improvement and/or changes to policies and procedures to improve care.
B. Individual case review is presented to appropriate committees for review, final scoring and recommendation of actions.
C. Aggregate data compared to peers is reported to the Joint Credentials Committee for determining competence and accountability for reappointment to the medical staff.
D. Summary report of ongoing review and recommended actions is made to the Medical Executive Committee, medical staff departments, Professional Relations Committee and the Board of Trustees.

V. Events that Trigger Peer Review for Cause:

A. A peer review committee overseeing the continuous monitoring and peer review process may recommend to a department chairperson, MEC and/or Credentials Committee that further review and/or action may be necessary.
B. The Department Chairperson in collaboration with MEC and/or Credentials Committee shall convene a peer review panel wherein the following circumstances occur:
   1. in the opinion of the reviewing committee there is a trend/pattern of case reviews that indicate there is a potential deviation from the standard of care as based upon the standard evaluation utilized by SJ/CHS Health System as defined in section II, D, 4
   2. a patient suffers unexpected death, catastrophic injury or unexpected loss of organ or body part following the rendering of medical/surgical treatment or
   3. Within the sound discretion of the department's chairperson that this case is appropriate for review by the peers of the attending physician.

VI. Procedure to Review for Cause:

A. A committee of at least 3 members of the Medical staff department peers will be designated to evaluate and review case management. Additional information and/or case review may be requested. The department chairperson shall be aware of the review process and be involved as appropriate.
B. Each Peer Review for Cause should be reviewed in a reasonable timely manner to provide for effective quality improvement.
C. The committee/department chairman shall notify the treating physician that a peer review has been requested and shall request the treating physician to submit to the peer review committee a responsive statement defining the circumstances and reasoning supporting his/her medical judgment within fifteen (15) days of the request.
D. The committee/department chairman shall convene the peer review committee to evaluate the data and/or case(s);
E. Any findings or disciplinary action taken as a result of the peer review committee’s evaluation shall be documented by the peer review committee for tracking and re-evaluated
for quality improvement at the next regularly scheduled peer review committee meeting;
F. Any minority opinions shall be documented.
G. If applicable, any investigations and/or recommendations shall be forwarded to department chairman, Joint Credentialing Committee and the quality assurance file for quality improvement, tracking and evaluation of trends in patient care.
H. If applicable, any disciplinary action by the Credentialing Committee and/or Medical Executive Committee shall be forwarded to the quality assurance file for quality improvement tracking and evaluation of trends in patient care.
I. The evaluation and analysis of any cases placed before the Peer Review Committee shall be completed within one hundred and twenty (120) days of assigning the peer review for cause.
J. Results of review and actions taken by the appropriate medical staff committees are reported to the Board. The Board may agree with the actions taken or may recommend additional review and/or action. The due process procedures as outlined in the Joint credentials Manual and Bylaws shall also apply.

VII. **External Peer Review**

A. Consultants or individuals who serve in the department's healthcare field, may be retained to provide external peer review on specific cases.
B. The following procedure shall be followed when utilizing external peer review.
   1. The department chairman and a peer must concur that the medical and/or surgical case necessitates an external peer review.
   2. The recommendation shall be forwarded to the Joint Credential Committee Chairman and President of the respective Medical Staff who shall forward the recommendation to the President/CEO for approval.
   3. The Joint Credentials Committee or MEC may request external peer review. The recommendation form these committees are forwarded to the President/CEO for approval.
C. Any and all external peer reviews conducted for the benefit of this health system and its healthcare providers shall be protected under the federal and state Peer Review Confidentiality Laws and by a Peer Review Confidentiality Agreement

VII. **Healthcare Provider Participation (This section applies throughout the review process.)**

A. The attending physician shall have an opportunity to be heard and provide a written statement which shall be protected under applicable state and federal Peer Review or quality assurance laws.
B. The Peer Review Committee in their evaluation and ultimate determination of findings shall utilize the attending physician’s responsive statement.
C. The healthcare provider shall be provided notice that his/her patient's case is being reviewed and shall be provided an opportunity to be heard at each stage of the peer review process.

VIII **Peer Review Procedures**

A. Each Peer Review Committee shall convene and hold a meeting regarding the case analysis, evaluation of the patient's chart, clinical findings and analysis of the attending physician’s medical judgment.
B. Additional peer review sub-committees may be formed to evaluate specific clinical departments at the discretion and election of the department chairman and/or Joint Credentials Committee. The sub-committees shall report their evaluations and findings to the appropriate department chairman, the peer review committee referenced above and/or the Joint Credentials Committee.

C. Any and all findings of the Peer Review Committee shall be based upon clear evidence established by the record of the patient and by a statement of the licensed practicing clinicians involved in the treatment of the patient.

D. Any external authoritative literature regarding departmental procedures, policies and medical practices will also be consulted.

E. Any conclusions or findings shall be recorded including, but not limited to, the majority and minority opinions of the Peer Review Committee.

F. Any and all disciplinary action or ultimate resolutions of the case management shall be recorded and retained confidentially protected under the applicable state and federal laws.

**IX. Effectiveness**

A. Each Peer Review Committee shall be responsible for maintaining its files on the case management and cross-referencing those files with the healthcare provider's name and discipline.

B. The Peer Review Committee shall be responsible for tracking their findings and evaluations on each healthcare practitioner within the health system and shall evaluate their improvement, conflicts and outcomes.

C. Any action, which would support increasing the effectiveness and improving the quality of the treatment rendered to the patients, shall be recorded and provided to the attending physicians.

1. The Joint Commission

**Approval:**

Recommended by the Medical Executive Committee:

__________________________________  ______________
Chair, Medical Executive Committee         Date
Candler Hospital

__________________________________  _____________
Chair, Medical Executive Committee  
St. Joseph’s Hospital         Date

Approved by the Board:

__________________________________  ______________
Chairman, Board of Trustees         Date
Candler Hospital
Chairman, Board of Trustees
St. Joseph’s Hospital

Original Implementation Date: 7/20/00
Effective System Date: 7/20/00
Next Review Date:
Originating Department/Committee: Medical Staff
Reviewed: 05/02, 09/07; 12/08
Revised: 10/01, 05/02, 09/07
Rescinded:
Former Policy Number(s):