Central Maine Medical Center
Lewiston, Maine

Medical Staff Policy

SUBJECT: PEER REVIEW CLINICAL CASE REVIEW

1.0 SCOPE

This Policy applies to the Staff of the Hospital .

2.0 PURPOSE

The purpose of this Policy is to provide guidance with respect to the procedures to be followed by the Hospital's Peer Review Committee in conducting an analysis of care through clinical case review and to provide guidance with respect to the role of the Quality Department (as defined below) in supporting the Peer Review Committee.

3.0 GENERAL POLICY

Peer review is an essential, mandatory process by which clinician and systems issues are identified and analyzed in a meaningful way by Staff-colleagues. The peer review process has no punitive goal or intent. Rather, the desired endpoints are the identification of opportunities for individual clinicians or groups of clinicians to enhance their current practices and education. This can be accomplished through in-depth analysis of care, focused continuing medical education or the creation of better systems within the Hospital to support clinical care.

Peer review must be confidential and non-punitive. Clinicians are expected to participate in a meaningful way. The process needs to be timely and focused, and can produce recommendations for individual and system improvements.

All communication/work-product arising out of the performance of this Policy is protected and is strictly confidential. Correspondence with members of the Hospital's Peer Review Committee or other practitioners pursuant to a case review must not copy (e.g., "cc") or otherwise include other individuals (including physicians, patients, administrators or personal attorneys).

Peer review data is one of the criteria used by the Hospital for credentialing and privileging.

4.0 PROCEDURES

Step 1 - Case Identification:

Cases may be identified by (i) review of event reports; (ii) review of grievances from patients, families, or nursing and other professional staff; or (iii) monthly review of occurrence screens identified by chart review, utilizing for example: Mortality, Morbidity, Return to the OR, Return to ICU and Readmission Reports. Case identification then will be both concurrent and retrospective and will be based on the review of the following: (i) care management; (ii) infection prevention; (iii) risk; (iv) complications of care; (v) untoward consequences (such as early readmission); (vi) record maintenance; (vii) professional comportment; and (viii) patient or family complaints.

All practitioners will be measured against clinically relevant universal outcomes (such as unexpected death) as well as department-specific event occurrence. Each Division and Section will be responsible for developing 5 to 15 Division or Section-specific occurrence screens to measure performance against the universal outcomes.

Step 2 – Referral of Potential Case to Quality Department:

Upon identification of a potential case, the case will be referred to the Hospital's Quality Department for additional fact finding. The referral may be made via Midas remote entry or by phone or email contact with the Quality Department.

Step 3 - Case Assignment and Review:

Following the completion of additional fact finding by the Quality Department, the case will be reviewed by the leadership of the Peer Review Committee and/or Clinical Leaders to triage the case into one of the following actions: (i) conclude review, as no further action is required; (ii) conduct additional fact finding; (iii) Assign the case to Peer Review Committee; (iv) if the case is based on a trend, review the trend to date to determine whether there have been any significant changes; (iv) assign the case to the appropriate Division/Section for review; (v) assign the case to multiple Divisions/Sections for multi-disciplinary review; or (vi) implement the procedure for addressing disruptive conduct under the applicable section of Medical Staff Rules and Regulations.

Step 4 – Notification of Practitioner:

If the case is assigned to full peer review the practitioner involved will be notified of the case review and the reasons for review.

Step 5 – Preliminary Review by Assigned Practitioners:

If the case is assigned to full peer review, the case will be reviewed by a member or members of the Peer Review Committee with the goals of identifying (i) delivery of care consistent with accepted standards; (ii) systems or provider issues which if changed or augmented could enhance patient care; and (iii) opportunities to educate the involved practitioner around a particular area of practice. If appropriate, the Peer Review Committee will also screen and arrange for external review. The findings and conclusions will then be presented to the full Peer Review Committee as applicable.

External peer review: External peer review will be considered under the following conditions:

- There is no professional expertise on the Peer Review Committee to adequately address the question(s) raised during the review process;
- The assigned peer reviewer determines he/she is unable to complete the review in an objective manner;
- The physician whose case is being reviewed requests outside referral; or
- There is significant disagreement amongst peer reviewers on important points.

The chair of the Peer Review Committee will be responsible for arranging the external peer review with the external reviewer and ensuring that the external reviewer completes a confidentiality agreement.

Clinical case review: Based on the Peer Review Committee, a recommendation for leveling will be made as follows:

- Physician/Provider Care
    - Level 1 – Exemplary care

- Level 2 – Appropriate care; no issues identified with physician/provider care
- Level 3 – Opportunities for learning

- Systems of Care
  - Level 1 – Appropriate functioning of systems
  - Level 2 – Opportunities for system improvement identified

Step 6 – Additional Fact Finding by Peer Review Committee or Investigation Committee:

In the event the review determines that care did not meet acceptable standards, the Peer Review Committee will, based on initial summaries and any related committee reports, compile a list of questions and requests for the involved practitioner. The practitioner may respond to the questions and requests either in person or in writing. If the practitioner chooses not to respond to the Peer Review Committee's questions or requests, the case will be assigned a final level status in the absence of the additional information.

Step 7 – Peer Review Committee Final Recommendation:

The Peer Review Committee will meet to discuss the facts and evidence gathered in Steps 1 through 6 in order to make a final recommendation. The practitioner will be offered an opportunity to appear before the Peer Review Committee before a final recommendation is made.

Findings specific to individual provider performance will be incorporated into the provider's quality file for use in Focused Professional Practice Evaluation (FPPE), Ongoing Professional Practice Evaluation (OPPE), and re-credentialing. Findings which identify systems of care issues will be referred to Process Improvement ("PI") and Clinical Leadership for PI work.

Step 8 – Communication of the Final Recommendation:

Systems of care and other care team-based issues that were identified in the course of the process will be communicated to Division Chiefs and Section Chiefs, Staff leadership, Hospital administration, Hospital risk management, individuals responsible for the Hospital's continuing medical education, and the hospital-wide PI program.

5.0 DOCUMENT RETENTION

Any written reports and minutes of Peer Review Committee arising out of activities conducted under this Policy shall be maintained by the Peer Review Committee and shall be regularly submitted to the Medical Executive Committee.

6.0 REFERENCES

This Policy refers to the current versions of the following:

- CMMC Medical Staff Bylaws, Article 1 (Definitions);
- CMMC Medical Staff Bylaws, Article 7 (Corrective Action);
- CMMC Medical Staff Bylaws, Section 11.3.H. (Peer Review Committee); and
- CMMC Medical Staff Rules and Regulations, Section II (Code of Conduct).

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