Medical Staff Peer Review Manual

1.001 Peer Review Policy

A. Purpose

The purpose of the Peer Review Policy is to define the Peer Review Process through the activities of its Medical Staff, assess the performance of individuals granted clinical privileges and use the results of such assessments to improve care.

B. The goals of the Peer Review Process are to:

- Monitor the performance of practitioners who have privileges;
- Identify opportunities for performance improvement;
- Monitor significant trends by analyzing aggregate data;
- Provide data from the evaluation of each individual member of the Medical Staff professional activity for credentialing at Union Hospital; and
- Provide educational opportunities to individual physicians and clinical departments.

C. Definitions:

- "Peer review" is the evaluation of an individual practitioner's professional performance and includes the identification of opportunities to improve care. The evaluation is conducted by an individual practicing in the same or similar discipline and has expertise in the appropriate subject matter.
- Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner's performance, rather than appraising the quality of care rendered by a group of professionals or a system. The individual's evaluation is based on generally recognized standards of care. Through this process, practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.
- A "peer" is an individual practicing in the same profession. The level of subject matter expertise required to provide meaningful evaluation of a practitioner's performance will determine what "practicing in the same profession" means on a case-by-case basis. For quality issues related to general medical care, a physician may review the care of another physician. For specialty-specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer is an

individual who is well trained and competent in that surgical procedure.

- "Physician Performance Index" or "PPI" is the summary report of the individual Medical Staff member's professional activity at Union Hospital. What activities are summarized and recorded in the Index is approved by the Medical Staff, through the Medical Executive Committee.

D. Circumstances Requiring Peer Review

Cases may be brought to peer review for educational purposes and/or may be the result of a complaint or unexpected variation from established or generally accepted healthcare indicators. Healthcare indicators include rules, standards, generally recognized guidelines or laws, hospital policies (including, but not limited to, Medical Staff Bylaws, Operations and Procedure Manual, Rules and Regulation Manual, Credentials Manual, Hearing and Appeals Manual) or this manual. "Sentinel Events" as defined by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), incident reports, patient complaints, as well as issues referred by the compliance program when issues involving medical necessity are raised.

E. Quality Indicator Classification Categories

There are three categories of quality indicators (Types I, II, and III).

Type I Indicators: Rules

Definition: This type of indicator represents the general rules, standards, or generally recognized professional guideline accepted practices of medicine where individual variation does not directly cause adverse patient outcomes. Ideally, there should always be compliance. Rare or isolated deviations usually represent only a minor problem.

Response: Occurrence of a **Rules Event** generates an automatic report of finding to the physician, sent directly by the Care Management Department, as directed by the Peer Review Council.

If a pattern of a **Rules Event** (Type I Indicator) or a potentially serious isolated event is identified, it is reported to the chief of the clinical department who will determine further action. This may be through collegial intervention or formal review in the clinical department or the Peer Review Council.

Type II Indicators: Significant Event

Definition: This type of indicator represents an unusual event within the hospital and would require analysis by peers in order to determine cause, effect, and severity.

Response: Analysis by the appropriate peer review committee. Documentation of this communication is to be maintained in a se- cure file for immediate action or such future

reference as may be necessary.

Type III Indicators: Rates

D*efinition:* This type of indicator exists only to cause a **Rate** to be created and returned to the department or committee. This type of indicator generates a record which is maintained for statistical analysis by the appropriate committee or administrative function. A target range should be established for each **Rate** indicator. This may be based on best practice from benchmark data, statistical variation from the average, or internal targets. *Response:* Feedback to individual physician and department rates will be provided on a regular basis. If the **Rate** for a particular physician falls outside of the target range, the leadership of the appropriate medical service would determine what, if any, action is warranted.

F. Where is Peer Review Done

Peer Review shall be done at the following:

- Peer Review Council.
- Department meetings.
- Investigation Committee assigned by the Credentials Committee
- During collegial intervention by Medical Staff leadership.

G. Who Can Make Referrals

The following may generate referrals:

- Medical Staff;
- Medical Staff Clinical Departments;
- Quality Improvement Department;
- Sentinel Event Investigation;
- Utilization Management;
- Risk Management;
- Hospital Clinical Departments;
- Care Management Department;
- Compliance Officer.

H. Screening of Referrals

The following individuals shall screen referrals in accordance to criteria established by the Medical Staff and the hospital and in keeping with generally accepted standards of care:

- Chairman of the Peer Review Council;

- Risk Manager; and
- Care Management Department.

I. Immediate Intervention Needed

1. If information suggests the need for immediate intervention, the case will be referred directly to the department chief of the physician involved in the case.
2. The chief of the clinical department may consult with the Medical Staff President regarding the review.
3. If the practitioner is a department chief, the case will be referred to the Medical Staff President.

J. Non-immediate Peer Review Cases

All other, non-immediate peer review cases will be referred to the clinical department or Peer Review Council.

K. Documentation

Peer review reports shall be filed in the Quality Improvement Offices with a report to Credentials Committee, if circumstance warrants.

L. Attendance by Attorneys

Attorneys shall not be allowed to participate nor attend peer review meetings.

M. Policy Regarding Peer Review Information

1. All peer review information is privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and nondiscoverability.
2. The involved practitioner will receive provider-specific feedback. If no adverse findings are made, the physician will receive feedback and the case number will be referenced in the Physician Performance Index. If a problem in care is referred for review, the involved physician will be notified in writing and given reasonable time to review the case. The case will be assigned to another member of the department, or Peer Review Council, for review.
3. The Medical Staff will use the provider-specific peer review results in its credentialing and privileging process and, as appropriate, in its performance improvement activities, including the selection of continuing medical education events.
4. Documents pertaining to provider-specific peer review and other quality information concerning a practitioner will be kept in a secure location.
5. Peer review information is available only to authorized individuals who have a legitimate need to know this information based upon their re-

sponsibilities as medical staff leaders or hospital employees. However, they shall have access to the information only to the extent necessary to carry out their assigned responsibilities. Only the following individuals shall have access to provider-specific peer review information and only for purposes of quality improvement:

- Medical Staff President;
- Clinical department chiefs;
- Members of the Peer Review Council and the Credentials Committee;
- Vice President of Medical Affairs;
- Hospital's Risk Manager to the extent necessary to follow up on referrals from that department;
- Quality Improvement Director;
- Manager, Care Management Department to the extent necessary to help and support the medical staff perform its peer review activity;
- Medical Staff Coordinator to the extent to which access to this information is necessary for the re-credentialing process;
- Individuals surveying for accrediting bodies with appropriate jurisdiction (JCAHO or state/federal regulatory bodies);
- Individuals with a legitimate purpose for access as determined by the Vice President of Medical Affairs.

6. No copies of peer review documents will be created and distributed unless authorized by the Chairman of the Peer Review Council, Vice President of Medical Affairs, or Chief Executive Officer. All copies of peer review documents created and distributed shall be marked as "Confidential Peer Review Information."

2.001 Peer Review at the Department Level

A. Chairperson

The department chief or his designee shall be the chairperson and coordinate the peer review process at the department level.

B. Membership

All members of the department shall participate in the peer review process and are obligated to adhere to the ethics of their profession by the Credentials Manual, **CR 1.001, Appointment to the Medical Staff, Specific Qualifications, 2.** All members of the department shall sign a confidentiality agreement (Exhibit K).

C. Indicators for Trending

Indicators for referrals shall be defined by the department membership with guidance from the Peer Review Council.

D. Confidentiality

The department chief, prior to beginning the peer review discussion, will review confidentiality issues of all information discussed.

E. Conflict of Interest

In any instance where a member of a department has or reasonably could be perceived as having a conflict of interest or a bias in any matter involving another department member, that member shall not participate in the discussion or vote on the matter and shall absent themselves from the meeting during that time, although he/she may be asked to answer any questions concerning the matter before leaving.

The existence of a potential conflict of interest or bias on the part of any member may be called to the attention of the chairman of the department, applicable committee chairman, or department chief by any other member with knowledge of it.

The fact that a department chair or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel a determination that a conflict exists.

The fact that a committee member or medical staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

F. Conduct at the Meeting

A member of the department shall be assigned by the chairman of the department to review the medical record in question. The Physician Reviewer Worksheet (Exhibit H) will be provided to be completed by the reviewing physician.

The chart will be provided for review at the department meeting. Additional information provided may include pertinent data and relevant authoritative articles to reflect the standard of care.

G. Review Process

If a case is referred for review as directed in 1.001, Section K, the physician assigned to review the case will find it in a preassigned area in the Medical Records Department. The physician is to review the chart and complete the Physician Review Worksheet (Exhibit H) which will accompany the chart to the department for review. If the clinical department reviews the case, the physician reviewer will present the case and all members, including the involved physician, will discuss the case.

If a concern in patient care is identified, the clinical department will make a recommendation for corrective action based on those recommendations identified on the Committee Review Form (Exhibit I).

H. Documentation

The Physician Reviewer Worksheet will be destroyed since this is merely a preliminary worksheet for individual physicians reviewing the case prior to the Peer Review meeting. Documentation on the Committee Review Form (Exhibit I) shall be completed by the Peer Review group and designated as "Confidential Peer Review Material". Documentation will be filed in the Quality Improvement Offices. The information summary will be included in the Physician Performance Index.

I. Disposition of the Case

If action is recommended by the department, the department chairman and the individual physician will meet to discuss implementation of the action plan.

J. Timelines

Cases referred for peer review shall be reviewed in a timely manner. (Peer Review Timelines - Exhibit J)

K. Referral

The chairman of the department may refer a case to the Peer Review Council if he determines that the Peer Review Council would be a better forum for review of the case. The

Peer Review Council may be judged to be a better forum for review because of a possible conflict of interest or because the nature of the case is so inflammatory as to cause acrimony within the department.

The Peer Review Council will review all cases reviewed in the clinical departments and may recommend the review of a case by the Peer Review Council if it deems that the initial review was inadequate. If, after review, it is determined that the corrective action plan is to be implemented, the Chairman of the Peer Review Council and the department chief will meet.

L. The case will be referred to Credentials Committee to review if the clinical department, or Peer Review Council, recommends restriction, reduction, or revocation of clinical privileges. The Credentials Committee will notify the Peer Review Council of actions taken as a result of the recommendations.

M. Failure to Adequately Conduct Peer Review in a Clinical Department

If the Peer Review Council determines that the clinical department has failed to adequately perform peer review, the chairman of that department will be notified by the Vice President of Medical Affairs, acting as the agent of the Peer Review Council, in writing, and the case will be reviewed at the next Peer Review Council meeting. Alternately, the Peer Review Council may recommend that the department conduct a second review of the case and address the concerns of the Peer Review Council.

N. Maternal/Fetal Committee

Composition:

The Maternal/Fetal Committee will be composed of one member from the Departments of Obstetrics, Pediatrics, and Family Practice. The member will be assigned by the chief of the respective departments. Each member will serve on a rotating basis with other members of their respective departments**.**

Review Process:

The Maternal/Fetal Committee will meet quarterly. The Maternal/Fetal Committee will be charged to review cases involving newborn infants. The charts of newborn infants will be screened by the nurse manager of Obstetrics. Cases will be designated for review according to specific criteria established by the three departments. The physician involved with the case will be notified and will be asked to attend the meeting. The Maternal/Fetal Committee will make recommendations for improvement and each member will reports its findings and recommendations to their respective departments.

3.001 Peer Review Council

A. Purpose

The purpose of the Peer Review Council is to provide centralized coordination and leadership for peer review of patient care cases that meet referral criteria established by the medical staff. The Peer Review Council shall serve as an oversight committee for the clinical departments. Referrals identified as quality issues will be reviewed by the Peer Review Committee. The Peer Review Committee may request further investigation of any case previously reviewed. Provision for educational feedback to the medical staff will be recommended and initiated as appropriate. If a concern in patient care is identified, the Peer Review Council will make a recommendation for corrective action to the physician involved.

B. Leadership and Membership

1. The Peer Review Council shall be comprised of representative members of the Active Medical Staff from each of the following departments: Internal Medicine, Family Practice, Surgery, OB/GYN, Pediatrics, Emergency Medicine, Anesthesiology, Radiology, and Pathology. The Vice President of Medical Affairs is an ex-officio member of the committee.
2. The committee members will be appointed by the President of the Medical Staff and approved by the Medical Executive Committee based on the recommendations from the committee chair. Each member will serve a two-year renewable term.
3. The chair of the committee will be appointed by the President of the Medical Staff for a three-year renewable term from committee members who have served for more than one-year and are in good standing
4. Committee members will be expected to participate in appropriate educational programs provided to increase their knowledge and skills in performing the responsibilities necessary for this committee.
5. The Committee will report at least annually to the Medical Executive Committee.
6. The Committee will meet monthly.
7. In addition to committee membership, key clinical administrative representatives and support staff, mutually agreed upon between the medical staff and administration, may participate in the committee meetings as necessary.
8. A quorum will consist of a minimum of four voting members of the Council.

C. Referrals

1. The following may generate referrals:
    - Medical Staff;
    - Medical Staff Clinical Departments;
    - Quality Improvement Department;
    - Utilization Management;
    - Sentinel Event Investigation;
    - Risk Management;
    - Hospital Clinical Departments;
    - Care Management Department.
2. Referrals shall be reviewed in a timely manner.

D. Contact

The physician whose case is being reviewed will be contacted by the Peer Review Council if any issues arise that require further discussion or explanation. Attendance by the physician may be required at the request of the Peer Review Council.

E. Confidentiality

The committee chairperson prior to beginning the discussion will review confidentiality issues of all information discussed.

F. Conflict of Interest

In any instance where a member of a committee has or reasonably could be perceived as having a conflict of interest or a bias in any matter involving another committee, that member shall not participate in the discussion or vote on the matter and shall absent themselves from the meeting during that time, although he/she may be asked to answer any questions concerning the matter before leaving.

The existence of a potential conflict of interest or bias on the part of any member may be called to the attention of the Chairman of the Peer Review Council or the President of the Medical Staff, respectively, by any other member with knowledge of it.

The fact that a committee chair or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel a determination that a conflict exists.

The fact that a committee member or medical staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

G. Conduct at the Committee Meeting

A member of the committee shall be assigned by the chairman to review the medical record in question. The Physician Reviewer Worksheet (Appendix H) will be provided to be completed by the reviewing physician.

With direction from the committee chair, copies of the Committee Review Form (Appendix I) will be provided for each member and include the summarization of the issue at the committee meeting. The chart will be provided for review at the meeting. Additional information provided may include pertinent data and relevant authoritative articles to reflect the standard of care.

H. Others Attending the Meeting

The Manager of the Care Management Department, in providing required chart and educational material, should provide support and facilitate documentation of the outcome as indicated by the committee chairperson.

I. Documentation

The action plan will also be documented as "Confidential Peer Review Material". The review material and action plan will be kept in the Quality Improvement Offices and documented in the Physician Performance Index.

J. Follow-up Communication

If action is recommended by the Peer Review Council, the chairman, department chief and individual physician involved will meet to discuss and implement the action plan. If the recommendations include reduction or suspension of clinical privileges, the case will be referred to the Credentials Committee. If the physician involved refuses to participate in an action plan, the case will be referred to the Credentials Committee.

4.001 Circumstances Requiring External Peer Review

A. External peer review will take place if deemed appropriate by the Peer Review Council or the Credentials Committee. No practitioner can require the Hospital to obtain external peer review if it is not deemed appropriate by the Peer Review Council or the Credentials Committee. External peer review may take place under the following circumstances:

- **Litigation** – When dealing with the potential for a lawsuit, such as when the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff.
- **Risk of Allegations** – When the individuals with the necessary clinical expertise would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.
- **Ambiguity** – When dealing with vague or conflicting recommendations from internal reviewers or appropriate committees and conclusions from this review will directly impact a practitioner's membership or privileges.
- **Lack of Internal Expertise** – When no one on the Peer Review Committee or on the Union Hospital Medical Staff has adequate expertise in the specialty under review; or when the only practitioners on the medical staff with that expertise are partners, associates, or direct competitors of the practitioner under review. External peer review will take place if this potential for conflict of interest cannot be appropriately resolved by the Peer Review Committee, or the Board of Trustees.
- **New Technology** – When a Union Hospital Medical Staff member requests permission to use new technology or perform a procedure new to the Hospital and the Medical Staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.

5.001 Mortality Review

A. Goal

The goal is to analyze mortality cases regarding the quality of care provided to the patient.

B. Chairperson

The Chairman of the Peer Review Council will be the chairman of the Mortality Review Committee.

C. Membership

Membership in the committee will include the following: designated chairperson, CEO or designee, Vice President of Medical Affairs, Vice President of Nursing, pathologist, radiologist if needed, department chief of the attending, the attending physician, Risk Manager and other members of the Peer Review Council as needed. Those physicians whose care during hospitalization is germane to the investigation will be invited to attend. The Medical Staff Coordinator will take the minutes of the meeting and submit them to the Risk Manager for review.

D. Referrals

Incident reports of potential mortality review shall be completed and forwarded to Risk Management. The Risk Manager will confer with the Vice President of Medical Affairs and if the referral is found to warrant review, the case shall be referred to the chairman of the Mortality Review Committee for review by the entire committee.

E. Time Frame

Time frame for review should not exceed 30 working days from date of notification and the meeting shall be called as soon as possible. (Peer Review Timelines - Appendix J)

F. Contact

Contact of all participants shall be made in a confidential manner with confirmation of attendance at the meeting required. Copies of all documentation shall be kept in the Quality Improvement Offices.

G. Confidentiality

The committee chairperson, prior to beginning the discussion, will review confidentiality issues of all information discussed.

H. Conflict of Interest

In any instance where a member of a committee has or reasonably could be perceived as having a conflict of interest or a bias in any matter involving another committee, that member shall not participate in the discussion or vote on the matter and shall absent them-

selves from the meeting during that time, although he/she may be asked to answer any questions concerning the matter before leaving.

The existence of a potential conflict of interest or bias on the part of any member may be called to the attention of the Chairman of the Peer Review Council or the President of the Medical Staff, respectively, by any other member with knowledge of it.

The fact that a committee chair or staff member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No staff member has a right to compel a determination that a conflict exists.

The fact that a committee member or medical staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

I. Conduct at the Committee Meeting

A member of the committee shall be assigned by the chairman of the committee to review the medical records in question. The Physician Review Worksheet (Appendix H) will be provided to be completed by the reviewing physician.

With direction from the committee chairperson, copies of the referral will be provided to include the summarization of the issues at the meeting. The chart will be provided for review at the meeting. Additional information provided may include pertinent data and relevant authoritative articles to reflect the standard of care. If a problem is identified, the committee will develop an action plan. The attending physician will be notified in writing regarding the committee's findings and recommendations.

If non-physician issues are identified, they will be referred to the appropriate hospital department with recommendations and requirement to submit a final report to the Vice-President of Medical Affairs within a defined timeline.

J. Documentation

Documentation shall be required and designated as "Confidential Peer Review Material". Documentation will be filed in the Quality Improvement Offices. The information will be included in the Physician Performance Index.

6.001 Sentinel Event

A. Following completion of the Root Cause Analysis and development of an action plan, identified physician issues will be referred to the Peer Review Council for further investigation.

7.001 Professional Conduct

A. Purpose

To assist the physician to accommodate the need for health care professionals to work together cooperatively and effectively to meet the goals of high-quality care. When a physician's conduct disrupts the operation of the hospital, affects the ability of others to get their jobs done, creates a "hostile work environment" for other physicians on the medical staff or hospital employees, or begins to interfere with the physician's own ability to practice competently, action must be taken. An aberrant personality pattern may interfere with effective clinical performance. As a consequence, patient safety may be placed at risk. In that event, traditional tolerance must be foregone.

B. Policy

All members of the Medical Staff shall conduct themselves in a professional and cooperative manner and shall not engage in disruptive behavior. A physician who exhibits aberrant behavior, which may reasonably appear to lead to patient endangerment either directly or because it disrupts the ability of other professionals to provide high-quality care, will be placed under observation.

C. Definitions

Disruptive conduct is more than unusual or unorthodox behavior.

Disruptive behavior includes, but is not limited to:

1. Conduct that interferes with the provision of quality patient care;
2. Conduct that constitutes sexual harassment as defined in the Union Hospital Human Resources Policy and Procedures Manual (Category # III-H);
3. Attacks leveled at other medical staff members or hospital employees which are personal, irrelevant, or go beyond the bounds of fair professional comment;
4. Making or threatening reprisals for reporting disruptive behavior, shouting or using vulgar, profane, or abusive language, physical assault, or intimidating behavior;
5. Non-constructive criticism, addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence;
6. Refusal to cooperate with other staff members, to accept medical staff assignments or participate in committee or departmental affairs on anything but his or her own terms, or to do so in a disruptive manner;
7. Impertinent and inappropriate medical records entries concerning the quality of care being provided by the Hospital or otherwise critical of the Hospital, other medical staff

members or personnel;

8. Imposing idiosyncratic requirements on the nursing staff which have nothing to do with better patient care, but serve only to burden the nurses with "special" techniques and procedures;
9. Public criticism or defamation of physicians or employees, or of the hospital, outside appropriate hospital or medical staff channels.

D. Procedure

1. Where no immediate endangerment is perceived, observation of aberrant or disruptive behavior exhibited by a physician should be recorded on an incident/variance report and forwarded to Risk Management who will discuss the issue with the Vice President of Medical Affairs.
2. The Vice President of Medical Affairs will refer the issue to chief of department to which the practitioner is assigned for immediate review.
3. The chief of the clinical department may consult with the Medical Staff President regarding the review.
4. If the practitioner exhibiting disruptive behavior is a department chief, the case will be referred to the Medical Staff President.

E. Review

1. The department chief shall oversee the review of the complaint. The review will include a discussion with the affected practitioner as well as interviews of Hospital employees or other individuals who have first-hand knowledge of the events or issues giving rise to the complaint and, if necessary, a review of the patient's medical record. The Medical Staff President or the Vice President of Medical Affairs shall oversee the review of the complaint.
2. Based on the review, the department chief shall decide whether the issues raised could be addressed through Informal Proceedings (Collegial Intervention that is intended to be educational and to elicit a voluntary, responsive course of action on the part of the affected practitioner) or should be identified as grounds for action in the investigative procedure, Credentials Manual CR 8.001 #1 and #2.

F. Documentation

1. If the department chief determines that a complaint can be resolved informally, counseling of the affected practitioner shall be completed in a timely manner. The chief shall promptly send a written report to the Risk Manager describing the actions taken.
2. Vice President of Medical Affairs shall evaluate the actions taken by the department

chief and shall determine if additional investigation and/or counseling is needed. If additional action is requested, the issue will be referred to the Peer Review Council. If additional action is required, it shall be completed and a follow-up report presented to the Medical Staff President in a timely manner.

3. When the Medical Staff President is satisfied that the complaint had been adequately addressed through the Informal Proceedings, the Risk Manager shall notify the complainant.

G. Referral to Credentials Committee

1. If the department chief believes that collegial efforts will not adequately address the issues raised by the complaint, the complaint shall be referred to the Credentials Committee for a formal investigation following Credentials Manual, CR 8.001, Procedures for Other Questions Involving Medical Staff Appointees, #1 Grounds for Action and #2 Investigative Procedure.
2. Immediately upon referring the complaint to the Credentials Committee, the department chief shall notify the Risk Manager.
3. Once the Credentials Committee has completed action on the matter and all hearings and appeals have been completed, the Risk Manager shall notify the complainant.

H. Notification of the Complainant

The notification of the complainant shall not be interpreted to mean that peer review information, which is required by state law to be kept confidential, shall be released to the complainant. The Hospital supports the full disclosure of all information necessary to inform complainants that their complaint has been resolved. Effective peer review is critical to the provision of quality health care, and that peer review is only effective when practitioners know that their evaluations of their colleagues will be kept confidential. Concerns about the precise information that may be disclosed should be referred to Hospital counsel.

I. Documentation in Physician Performance Index

Documentation of practitioner issues that have been determined to be valid will become part of the Physician's Performance Index. Documentation of practitioner issues will be maintained in the Risk Manager's Office with a summary of findings reported to Quality Improvement Council on a quarterly basis.

8.001 Informal Proceedings – Collegial Intervention

A. Purpose:

1. To encourage informal collegial and educational efforts where there is a reasonable likelihood that such steps may correct a pattern/concern before it requires formal investigation. Nothing shall preclude collegial intervention.
2. All collegial intervention efforts by medical staff leaders are part of Medical Staff peer review activities with the goal of the efforts to arrive at voluntary, responsive actions by the individual.

. Procedure:

1. Collegial efforts may involve counseling and educating colleagues when questions arise concerning their clinical practice or professional conduct and may include, but are not limited to:
    a. Educating and advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
    b. Sharing comparative quality, utilization and other relevant information in order to assist individuals in conforming their practices to appropriate norms;
    c. Follow-up on any questions or concerns raised about the clinical practice and/or conduct of staff appointees;
    d. Recommending methods to improve inappropriate behavior such as education, professional counseling, psychiatric or addiction therapy.
2. The affected individual shall be provided an opportunity to respond in writing to any written communications and the response shall be maintained in the Quality Improvement Office along with the original communication.
3. Collegial efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders depending on the circumstances. The President of the Medical Staff in conjunction with the department chief and Vice President of Medical Affairs or CEO shall determine whether to direct that a matter be handled in accordance with another Policy, such as the Policy on Physician Health or the Code of Conduct Policy, or to direct it to the Medical Executive Committee for further determination. Such efforts shall be considered to be confidential, are part of the Hospital's performance improvement and professional and peer review activities, but shall not in and of themselves give rise to any hearing rights.

C. Documentation:

If the department chief determines that the collegial intervention was successful, he will then send a written report to the Care Management Department describing the actions taken and placed in the Physician Performance Index.

D. Referrals:

If the department chief believes that collegial efforts have not adequately addressed the issues raised by the complaint, the complaint shall be referred, pursuant to the provisions of this manual, to department review, the Peer Review Council, or the Credentials Committee for further investigation.

9.001 Medical Staff Expectations

A. Purpose:

These recommendations have been created to establish a set of performance expectations for all members of the Union Hospital Medical Staff. These expectations are: technical quality of care, quality of service, resource utilization, and general contributions to the hospital and the community. The expectations are put forth in a collegial manner in order to create a more co-operative and harmonious environment in which to care for our patients. The specific expectations are as follows:

B. Technical Quality of Care

1. Maintain patient surgical and medical complication rates at or below the generally accepted standards in literature.
2. Provide appropriate patient care based upon the generally accepted standards in the medical literature.
3. Order medications, blood and blood products consistent with current medical standards.
4. Provide patient care that consistently meets or exceeds the standard of care as measured by the results of peer review activities.
5. When available, use evidence-based guidelines as approved by the medical staff in selecting the most effective and appropriate approaches to diagnose and treat patients.
6. Participate in hospital efforts to reduce adverse medication events or other adverse patient care events.
7. Provide for patient comfort including prompt and effective management of acute and chronic pain in coordination with other caregivers according to accepted standards in the medical literature.

C. Quality of Service

1. Communicate with patients and their families in a respectful manner.
2. Ensure continuous 24 hour per day, seven day per week coverage including appropriate answering service and beeper paging availability.
3. Maintain complete, accurate, timely, and legible medical records.
4. Discuss end-of-life issues including advance directives and patient and family support when appropriate to a patient's condition and honor patient's desires.
5. Provide timely and continuous care of his/her patients.
6. Maintain medical records consistent with the medical staff rules and regulations including but not limited to chart entry legibility and timely completion of history and physical ex-

amination reports, operative reports, procedure notes and discharge summaries.

7. Respond to requests for patient consultation in a timely manner.
8. When receiving information regarding patient dissatisfaction with medical staff member performance, respond to the patient or family in a timely and appropriate manner.
9. Participate in emergency room coverage as determined by the departments and the Medical Executive Committee.
10. When requesting inpatient consultation, provide adequate communication with the consultant including a clear reason for consultation. If you wish a patient to be seen as an emergency, a phone call to the consultant is in order.

D. Resource Utilization

1. Provide accurate timely discharge instructions in collaboration with other caregivers.
2. Strive to provide quality patient care that is cost effective by cooperating with the efforts to appropriately manage the use of valuable patient care resources according to the current professional standards, including, but not limited to: length of stay, operating room time, ancillary testing, supply costs, pharmaceuticals and devices.
3. Discharge patients to outpatient management when medically appropriate.
4. When general department consensus exists, utilize evidence based medicine guidelines and consider using prewritten order sets as appropriate to patient conditions.

E. Peer and Co-Worker Relationships

1. Confidential matters should not be discussed in public settings.
2. At all times, act in a professional, respectful manner with patients, other physicians, nurses, administrators, board members and other hospital personnel to enhance a spirit of cooperation and mutual respect and trust among members of the patient care team.
3. Refrain from inappropriate behavior toward fellow members of the medical staff, the Hospital staff, patients or their families as outlined in the Professional Conduct chapter.
4. Recognizing that disagreements are inevitable and can contribute to improving care, when disagreements occur, address these in an open, respectful and direct manner.
5. Recognize each medical staff member's responsibility to identify issues involving the physical and mental health of staff members in the spirit of early assistance and each staff member's responsibility to cooperate with programs designed to provide assistance.

F. General Contributions to the Hospital and Our Community

1. Abide by the bylaws, rules and regulations and other policies and procedures of the Hospital and the Medical Staff.
2. Practice medicine as a member of the Medical Staff in a manner that maintains and ad-

vances the culture of collegiality and cooperation that is the hallmark of our Medical Staff and Hospital.

3. Make positive contributions to the Hospital, its medical staff and its community by participating actively in medical staff functions or through community service.
4. Review your individual and specialty data for all dimensions of performance and utilize this data to continuously improve care.
5. When provided information on medical staff matters requesting medical staff member input, respond in a timely manner or accept decisions made by leadership.
6. Provide appropriate, timely and continuous care of patients including partnering with the Hospital staff to develop an interactive communication plan with other caregivers and patients.
7. Receive information from medical staff quality improvement activities regarding concerns about patients and respond in the spirit of continuous improvement.

Exhibit A

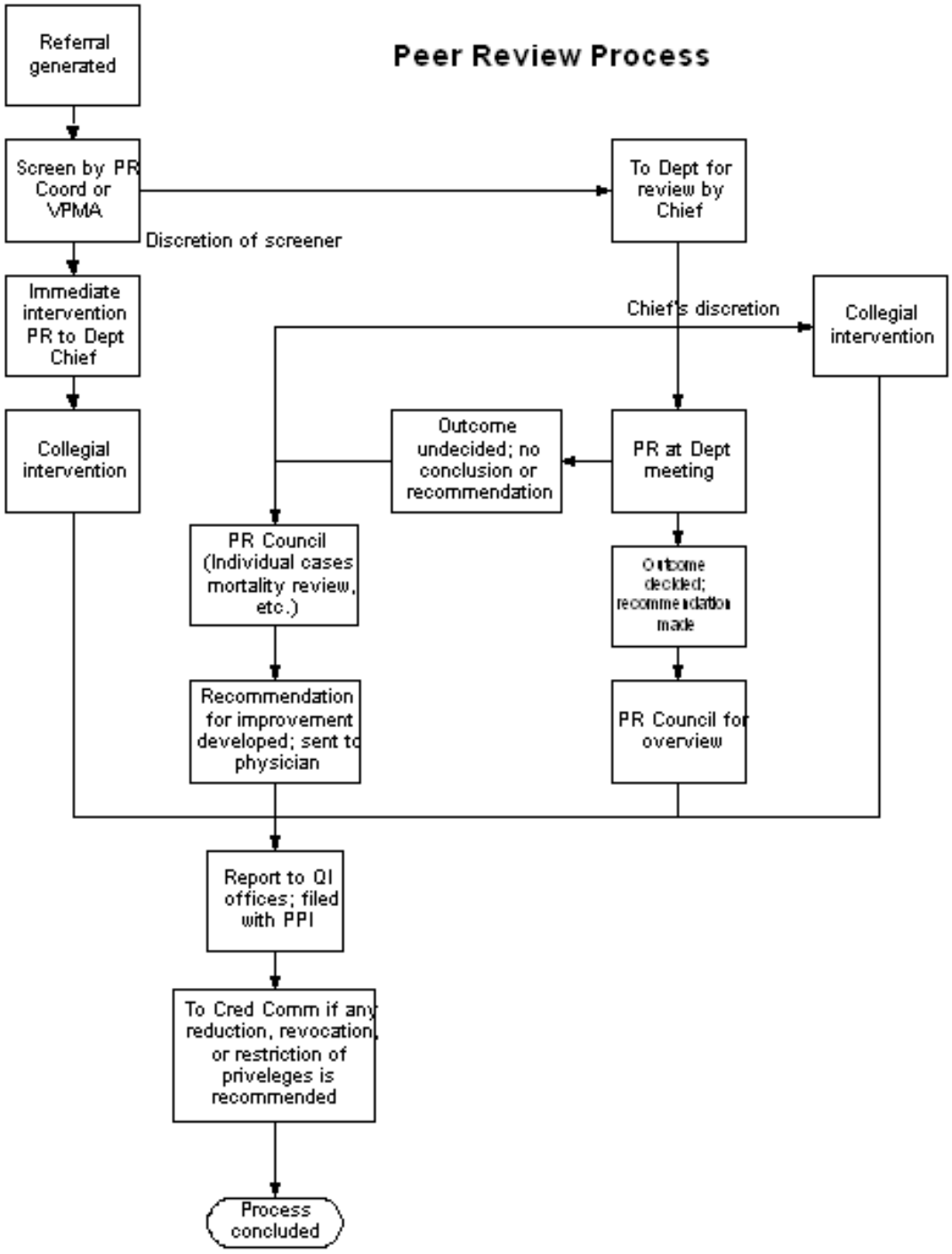
Peer Review Process
Referral generated
Screen by PR Coord or VPMA
Discretion of screener
To Dept for review by Chief
Chief's discretion
Collegial intervention
Immediate intervention PR to Dept Chief
Collegial intervention
Outcome undecided; no conclusion or recommendation
PR at Dept meeting
PR Council (Individual cases mortality review, etc.)
Outcome decided; recommendation made
Recommendation for improvement developed; sent to physician
PR Council for overview
Report to QI offices; filed with PPI
To Cred Comm if any reduction, revocation, or restriction of priveleges is recommended
Process concluded

Exhibit B

PEER REVIEW PROCESS

1. Chart identified for review
2. Chart reviewed by peer review coordinator
3. Chart reviewed with VP Medical Affairs decision to department of Peer Review Council
4. Chart reviewed with Dept. Chair or Chair Peer Review Council

5. Chart to medical staff department for review:
    a. chart assigned to reviewer by Chair
    b. physician being reviewed informed of review two weeks prior to department meeting review date, by phone call or page, then letter to office which includes chart identifiers and reason for review
    c. Physician assigned to review informed of review two weeks prior to department meeting review date, by phone call or page, and letter to office which includes chart identifiers and reason for review.
    d. Charts requested in Health Information Management and copies of review sheet place in front of chart for reviewers to use

6. Chart to Peer Review Council for review:
    a. chart assigned to reviewer by Chair
    b. physician being reviewed informed of review two weeks prior to Peer Review Council review date, by phone call or page, then letter to office which includes chart identifiers and reason for review
    c. physicians assigned to review informed of review two weeks prior to department meeting review date, by phone call or page, and letter to office which includes chart identifiers and reason for review
    d. Charts requested in Health Information Management and copies of review sheet place in front of chart for reviewers to use

7. Two days prior to Peer Review Council Meeting and Department meeting, physician reviewer reminded of chart review and meeting date and time

8. Following review of the case, letter to physician being reviewed that includes identification of concerns, and educational objectives.

UNION HOSPITAL MEDICAL STAFF
QUALITY INDICATORS

FAMILY PRACTICE

1. Death within 48 hours of admission
2. Unexpected death during hospital stay
3. Admissions not meeting intensity of service or severity of illness
4. Decubitus ulcers developed during hospital stay
5. Readmission due to clinical complications after a related previous admission, including admission
6. Development of a significant neurosensory, functional, or cognitive deficit not present on admission:
    a. major convulsion, seizure
    b. significant loss of consciousness, coma, or significant loss of mental capacity
    c. major sensory impairment (taste, sight, hearing, or touch)
    d. diminished motor function, significantly impaired use of extremity or speech
7. Readmission due to clinical complications after a related previous admission, including admission following discharge from an ED with a more serious complication or diagnosis, i.e., ruptured appendix, MI, etc. *(in 14 days)*
8. Omissions or inconsistencies in documentation or communication (e.g., to include practices related to the consultation process)
9. Illegible handwriting
10. Procedure not indicated *due to lack of medical necessity*
11. Admission with lack of intensity of service or severity of illness
12. Readmission within 14 days of discharge

Exhibit D

UNION HOSPITAL MEDICAL STAFF
QUALITY INDICATORS

INTERNAL MEDICINE

1. Death within 48 hours of admission
2. Unexpected death during hospital stay
3. Admissions not meeting intensity of service or severity of illness
4. Decubitus ulcers developed during hospital stay
5. Readmission due to clinical complications after a related previous admission, including admission
6. Development of a significant neurosensory, functional, or cognitive deficit not present on admission:
    a. major convulsion, seizure
    b. significant loss of consciousness, coma, or significant loss of mental capacity
    c. major sensory impairment (taste, sight, hearing, or touch)
    d. diminished motor function, significantly impaired use of extremity or speech
7. Readmission due to clinical complications after a related previous admission, including admission following discharge from an ED with a more serious complication or diagnosis, i.e., ruptured appendix, MI, etc. *(in 14 days)*
8. Omissions or inconsistencies in documentation or communication (e.g., to include practices related to the consultation process)
9. Illegible handwriting
10. Procedure not indicated *due to lack of medical necessity*
11. Admission with lack of intensity of service or severity of illness
12. Readmission within 14 days of discharge

Exhibit E

UNION HOSPITAL MEDICAL STAFF
QUALITY INDICATORS

OBSTETRICS

Infant:

1. Apgar score of 3 or less at five minutes
2. Brachial plexus palsy
3. Cord pH less than 7.0
4. ***Congenital deformity or birth injury leading to incapacity or disability***
5. ***Fracture of any long bone, excluding clavicles***
6. ***Fractured skull***
7. ***Intracranial bleed unrelated to prematurity***
8. Meconium aspiration
9. Neonatal seizures within the first 48 hours
10. Respiratory distress syndrome after elective induction or scheduled repeat section
11. ***Stillbirth or neonatal death in fetuses > 24 weeks or > 500gms***
12. ***Surgical injury including laceration of infant***
13. ***Term infant admitted to or transferred to Level II or III nursery***
14. Unconsented circumcision
15. ***Infant abduction (Sentinel Event)***

Maternal

16. ***Maternal death***
17. Eclampsia
18. Maternal readmission within 2 weeks of discharge
19. Return to operating room post section for unplanned procedure
20. ***Unplanned transfer to ICU***
21. ***Symptomatic uterine rupture***
22. Unconsented procedure
23. Failure to perform planned procedure
24. ***Surgery done on the wrong person or organ (Sentinel Event)***
25. ***Surgical delivery injuries, including burns and nerve injuries***
26. Retained sponge, instrument, or needle
27. Emergent Caesarean deliveries taking longer than 30 minutes from decision to incision

**** Italicized and bolded indicators have been identified for an expedited review. An expedited review includes the following: the initial investigation will occur within seven (7) days of the event by Care Management, Risk Management, Department Chair or designee, Vice President of Medical Affairs, and the case review will occur at the next scheduled department meeting.***

Exhibit F

UNION HOSPITAL MEDICAL STAFF
QUALITY INDICATORS

SURGERY

1. Death within 48 hours of admission
2. Unexpected death during hospital stay
3. Admissions not meeting intensity of service or severity of illness
4. Decubitus ulcers developed during hospital stay
5. Development of a significant neurosensory, functional, or cognitive deficit not present on admission:
    e. major convulsion, seizure
    f. significant loss of consciousness, coma, or significant loss of mental capacity
    g. major sensory impairment (taste, sight, hearing, or touch)
    h. diminished motor function, significantly impaired use of extremity or speech
6. Readmission due to clinical complications after a related previous admission, including admission following discharge from an ED with a more serious complication or diagnosis, i.e., ruptured appendix, MI, etc. *(in 14 days)*
7. Omissions or inconsistencies in documentation or communication (e.g., to include practices related to the consultation process)
8. Illegible handwriting
9. Procedure not indicated *due to lack of medical necessity*
10. Admission with lack of intensity of service or severity of illness
11. Readmission within 14 days of discharge
12. Development of a peripheral neurologic deficit within 48 hours following general anesthesia, surgery, or an invasive procedure
13. Cardiac arrest within 72 hours following general anesthesia, surgery, or an invasive procedure
14. Clinically apparent acute myocardial infarction within 72 hours following general anesthesia, surgery, or an invasive procedure
15. Fulminant pulmonary edema within 24 hours following general anesthesia, surgery, or an invasive procedure
16. Aspiration of gastric contents with development of x-ray findings of aspiration pneumonitis within 2 hours following general anesthesia, surgery, or an invasive procedure
17. unplanned hospital admission within 24 hours following outpatient procedure
18. Unplanned admission to an ICU within 24 hours following administration of an anesthetic, surgery, or an invasive procedure
19. Unplanned return to surgery or a repeat invasive procedure

Exhibit G

UNION HOSPITAL MEDICAL STAFF
QUALITY INDICATORS

PEDIATRICS

1. Death within 48 hours of admission
2. Unexpected death during hospital stay
3. Admissions not meeting intensity of service or severity of illness
4. Readmission due to clinical complications after a related previous admission, including admission
5. Development of a significant neurosensory, functional, or cognitive deficit not present on admission:
    i. major convulsion, seizure
    j. significant loss of consciousness, coma, or significant loss of mental capacity
    k. major sensory impairment (taste, sight, hearing, or touch)
    l. diminished motor function, significantly impaired use of extremity or speech
6. Readmission due to clinical complications after a related previous admission, including admission following discharge from an ED with a more serious complication or diagnosis, i.e., ruptured appendix, MI, etc. *(in 14 days)*
7. Omissions or inconsistencies in documentation or communication (e.g., to include practices related to the consultation process)
8. Illegible handwriting
9. Procedure not indicated *due to lack of medical necessity*
10. Admission with lack of intensity of service or severity of illness
11. Readmission within 14 days of discharge

Exhibit H

PHYSICIAN REVIEWER WORKSHEET
CONFIDENTIAL AND PRIVILEGED
PEER REVIEW DOCUMENT

Number: Physician Reviewer: _____

Medical Record Number: _____

Number: Physician Under Review: _____

Date of Review: _____

Date of Planned Peer Discussion: _____

Purpose of Referral: _____

_____

Please answer all of the following questions.
If the answer is "no", please provide an explanation in the space provided or on a separate sheet of paper.

1. Was the diagnosis correct? (knowledge)
   Yes: _____ No: _____ N/A: _____

_____
_____
_____

2. Was the choice of treatment appropriate? (judgment)
   Yes: _____ No: _____ N/A: _____

_____
_____
_____

3. Was the treatment properly executed? (technique)
   Yes: _____ No: _____ N/A: _____

_____
_____
_____

4. Were the services performed medically necessary?
   Yes: _____ No: _____ N/A: _____

_____
_____
_____

5. Were the services performed adequately documented?
Yes: _____ No: _____ N/A: _____

_____
_____
_____

6. Adverse outcome?
Yes: _____ No: _____

Explain:
_____
_____
_____

7. What else could have caused the adverse result?

_____
_____
_____

8. Recommendations for improvement:

_____
_____
_____

9. Other Comments:

_____
_____
_____
_____
_____
_____

Physician reviewer: _____

Signature of reviewer: _____

Date: _____

Exhibit I

UNION HOSPITAL
PEER REVIEW
COMMITTEE REVIEW FORM

For Departmental or Peer Review Committee Use

Date of case referred for review: _____ Provider Number: _____

Account number: _____ Admit Date: _____ Discharge Date: _____

Referral Source: _____

Referral Issues/Indicators: _____

Screener: _____ Date Submitted for Peer Review: _____

Case Summary of key issues: _____

Brief description of the basis for reviewer findings: _____

Physician Reviewer: _____ Date: _____

COMMITTEE REVIEW

1. Is practitioner response needed?_____Yes _____No
2. If yes to above, what questions are to be address by the practitioner?

3. Practitioner's response summary:

_____
_____
_____
_____
_____
_____
_____

Compliance with relevant evident based medicine guidelines:
Medical Specialty: _____

Guidelines: (if applicable)	Compliance	
_____	Yes	No
_____	Yes	No
_____	Yes	No
_____	Yes	No
_____	Yes	No

OUTCOME/COMMITTEE ACTION (INDEPENDENT OF MANAGEMENT OR PROBLEM IDENTIFICATION)

	A	No adverse outcome		
	B	Minor adverse outcome		Date Completed:
	C	Major adverse outcome		Date Completed:
	D	Excellent Care Provided		Date Completed:

DOCUMENTATION (SELECT ALL THAT APPLY)

	A	No issue with physician's documentation
	B	Physician's documentation does not substantiate clinical course and treatment
	C	Physician's documentation is not timely to communicate with other caregivers
	D	Physician's documentation is illegible
	E	Other:

PROBLEM IDENTIFICTION (SELECT ALL THAT APPLY)

	A	No issue with physician's overall care (outcome was result of natural history of patient's disease, patient non-compliance, etc.)
	B	No issues with the organization's systems or processes
	C	Issue with physician's diagnosis
	D	Issue with physician's judgment
	E	Issues with physician's technique/skill
	F	Issue with physician's compliance with established policies
	G	Issue with nursing practice
	H	Issue with organization's systems or processes
	I	Other:

OVERALL PHYSICIAN CARE

	1	Physician's care appropriate
	2	Physician's care controversial
	3	Physician's care inappropriate

Other Identified Needs	Where to send identified need	Notified yes	Notified no	Sent to?	Date Sent
System Problem Identified	Forward to V.P. of Medical Affairs				
Nursing Problem Identified	Forward to V.P. of Nursing				
Other:	Forward to:				

CONFIDENTIAL AND PRIVILEGED
PEER REVIEW DOCUMENT

Peer Review Committee Review Sheet

Exhibit J

Peer Review Timelines

Process	Time Period
Chart screened for indicators	Chart complete or 30 days post admission, whichever occurs first
Chart assigned to reviewer by Care Management Manager and Vice President of Medical Affairs. Reviewer shall be a member of the appropriate department or the Peer Review Council.	Initially assigned at discharge or when indicator is identified.
Reviewer examines the case then completes the Physician Reviewer Worksheet (Exhibit B)	Within 2 weeks of assignment of the chart.
Case reviewed by the Clinical Department or the Peer Review Council	At the regularly scheduled meeting.

EXHIBIT K

UNION HOSPITAL
MEDICAL STAFF PEER REVIEW ACTIVITY CONFIDENTIALITY AGREEMENT

As a member of the Medical Staff who is involved in the evaluation and improvement of the quality of patient care rendered at the Hospital, I recognize that I will be provided with, and have access to, very sensitive and confidential information regarding physician and other practitioner credentialing, quality assessment/performance improvement, and peer review activities.

I understand the vital importance of maintaining all such information, and any and all discussions and deliberations regarding the same, in strict confidence. I therefore agree to make no disclosures of this confidential information outside of appropriate meetings, except in the following very limited circumstances: (1) when the disclosures are to another authorized physician on the Medical Staff or authorized employee of the Hospital and are for the purpose of conducting legitimate Medical Staff affairs (any such disclosures shall be made only in a private setting); or (2) when the disclosures have been authorized, in writing, by the Hospital's Chief Executive Officer, Vice President of Medical Affairs, or the President of the Medical Staff.

I understand that my breach of this Agreement may not only compromise my own interests, but also the interests of the Hospital and its Medical Staff. Therefore, in the event of such a breach, I understand that my actions may result in:

(1) dismissal from my committee assignment and/or Medical Staff office;

(2) loss of available legal protections (including loss of indemnification for any litigation costs and expenses);

(3) disciplinary action as deemed appropriate by the Medical Executive Committee pursuant to the Medical Staff Credentials Policy; and/or

(4) other appropriate legal action.

_____
Signature

_____ _____
Date Printed Name