



Kalihi-Palama Health Center
Hale Ho'ola Hou

Policy and Procedure Manual

SUBJECT: Medical Staff Peer Review

SECTION OF MANUAL: Quality Improvement

DEPARTMENT/TEAM: Medical Staff

DATE: Effective: 07/01

Revised: 8/2011

Reviewed (annual):

Position Responsible For Review/Revisions: Medical Director and Director of Corporate Compliance

Committee Responsible for Final Approval: Quality Improvement Committee

Reference Standard: JCAHO LD.LD.4.40; LD.4.50; LD4.60; LD.4.70. The Health Care Quality Improvement Act of 1986, (HCQIA), 42 USC, 11101 et seq.

Policy:

It shall be the policy of KPHC to require all Medical Staff Providers to participate in Peer Review activities on a routine basis as determined and scheduled by the Medical Director. Peer Review will include routine chart review (chart audits) as well as directed review of medical cases related to sentinel events, adverse outcome, practice guideline issues, or educational value as determined relevant by the Medical Director. The end product of peer review should be improvement of patient care through provider education and health system improvement.

Purpose:

The purpose of Medical Staff Peer Review is to promote the quality and improvement of patient care by the ongoing evaluation of the performance and competency of the Healthcare Providers at KPHC. Peer review is a mechanism to:

- Assure that documentation of clinical information is appropriate and accurate;
- identify concerns in health management, the provision of medical care, or utilization;
- determine the effectiveness and efficiency of processes;
- identify opportunities for improvement;
- review outcomes related to expectations;
- take action to improve performance and;
- determine clinical competency for renewing or revising clinical privileges

Definitions:

Provider - refers to a licensed medical or behavioral health practitioner who is delivering care to clients of KPHC, including, but not limited to, physicians, nurse practitioners, nurse midwives, physician assistants, psychologists, licensed clinical social workers and licensed marriage and family therapists.

Peer - for the purpose of this policy, refers to all providers of similar skill level, job description and expected knowledge base, regardless of educational degree or level of training.

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Sentinel Event - refers to any unexpected clinical occurrence including those involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function.

Procedure:

1) Routine Chart Review

- i) Routine Chart Review will be performed monthly. Each regular staff provider will have a total of approximately sixty (60) charts reviewed over the course of a year with five (5) charts reviewed each month.
- ii) Specific disease management, treatment guidelines and outcome goals will be chosen by the Medical Director in cooperation with the Director of Corporate Compliance to include for review on a Provider Chart Review Form.
- iii) Charts for all providers will be randomly chosen by the support staff of the Director of Corporate Compliance and a list will be distributed to each Provider to review along with the *Provider Chart Review Form* to complete.
- iv) Providers working on a temporary or time-limited basis or on an as-needed basis will have chart reviews done at intervals dependent on the anticipated duration of service.
- v) In most cases, Chart Review will occur within each department (Behavioral Health, Family Medicine, Internal Medicine, Pediatrics, Women's Health). No distinction will be made in the choice of reviewer by educational degree or level of training.
- vi) Charting done by students or residents will also be reviewed, will be held to the same standard as regular staff providers, and can be used in the evaluation of the teaching provider.
- vii) Completed *Provider Chart Review Forms* will be returned to the Medical Director for review and aggregation.
- viii) A copy of the reviewed *Provider Chart Review Form* will be given to the Provider and placed in his or her Credentialing File.
- ix) If a Chart Review deficiency is reported, the provider has the right to make a written appeal to the Medical Director to be placed in the Credentialing File.
- x) General findings and discussions concerning the Routine Chart Review will be made at the monthly Medical Staff Meeting or quarterly Peer Review Meeting.
- xi) Peer review should assess the quality of care rendered and be used as a learning tool.

2) Directed Case Review Process

- i) Directed Case Review will be used to identify and review potentially problematic cases in an effort to prevent recurrences of problems, improve clinical performance, and improve patient outcomes.
- ii) Cases reviewed will be those from staff referral for review of care, case mortality review and adverse outcome review criteria/sentinel events including:
 - (1) Any unexplained, unexpected or problem death;
 - (2) Admission to the hospital within 48 hours of an outpatient visit;
 - (3) Delayed or missed diagnosis;
 - (4) Patient complaints regarding clinical performance that the Medical Director deems appropriated for discussion;
 - (5) Any unusual case determined to be of significant teaching value for other providers.

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- iii) Cases will be referred to the Medical Director by completing the *Referral for Case Review* form that includes documentation of the problem. No identifying patient data will be used during Peer Review Meetings.
 - iv) Directed Case Review activities involving all members of the medical staff will occur on a quarterly basis during the Medical Staff meeting as determined by the Medical Director.
 - v) Recommendations may be made to the provider involved in the care at the Peer Review Meeting. The intent of the recommendations is to improve performance and the quality of care for the patient if indicated.
- 3) Review of Major Deficiencies
- i) If a Routine Chart Review or a Directed Case Review reveals that a KPHC provider repeatedly fails to follow standard clinical practice guidelines then the Medical Director will direct a focused chart review of the provider. A *Medical Staff Peer Review Report* will be generated and reviewed by the Credentialing Committee.
 - ii) Findings of major deficiencies in documentation or medical decision making made by the Credentialing Committee from the Peer Review process will be presented by the Medical Director to the individual provider in writing by means of the *Medical Staff Peer Review Report*.
 - iii) *The Medical Staff Peer Review Report* will contain the following components:
 - (1) The names of the clients and visit dates reviewed;
 - (2) a review of objective findings including noted discrepancies from accepted standards of documentation and management;
 - (3) The level of deficiencies:
 - (a) Repeated minor deficiencies
 - (b) Major deficiencies in documentation with substantial risk for adverse patient outcome
 - (c) Major deficiencies in decision making with substantial patient risk
 - (d) Medical mismanagement with significant adverse patient outcome
 - (4) Instructions on providing a written or verbal response to the noted discrepancies if necessary.
 - iv) The final *Medical Staff Peer Review Report* will be presented to the Credentialing Committee with the response from the reviewed provider, if applicable. A final recommendation for remediation or counseling will be made by the Committee and presented to the provider with the following guidelines:
 - (1) Adequate review with no remediation indicated
 - (2) Minor charting errors to be reviewed at the next review cycle
 - (3) Non-preventable errors reflecting the actions of other staff or clinic systems or procedures with a report filed with the Director of Corporate Compliance
 - (4) Errors in provider judgment with a remediation plan to be developed by the provider and reviewed at the next review cycle
 - (5) Errors reflecting a lack of specific clinical knowledge with an education plan to be developed by the provider and reviewed in one month
 - (6) Errors reflecting a lack of communication skills with a remediation plan to be established by the provider and reviewed in one month
 - (7) Errors reflecting serious general knowledge, judgment and/or communication skill deficits, to be addressed immediately by the provider with the Credentialing Committee, which may include an educational program, mentorship, referral for employee assistance, professional counseling, medical referral, written warning, suspension, or termination.

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- v) A written appeal of the Credentialing Committee's findings can be made to the Chief Executive Officer for final resolution.
- vi) All final *Medical Staff Peer Review Reports* will be submitted to the Director of Corporate Compliance for review by the Quality Improvement Committee.