

PEER REVIEW FOR QUALITY MANAGEMENT

I. PURPOSE: Robert J. Dole VAM&ROC (RJD-VAMROC) sets forth the requirements and process for initiating, conducting, and documenting protected peer review activities for quality management of care.

II. POLICY:

- A. Peer review for quality management is considered privileged and confidential.
- B. Peer review is intended to promote confidential and systematic processes that contribute to quality improvement efforts at the individual provider level with a non-punitive context. It can also be conducted to assess resource utilization issues related to individual provider decisions.
- C. Protected peer reviews involve members of the health care staff in activities to measure, assess and improve performance and utilization of resources on an organization-wide basis. Authority for protected peer reviews is found in Title 38 U.S.C. 5705, entitled Confidentiality of Medical Quality Assurance Records and its implementing regulations. VHA Directive 2004-051 "Quality Management (QM) and Patient Safety Activities That Can Generate Confidential Documents" provides detailed guidance.
- D. Peer review is intended to be an endeavor encompassing multiple disciplines.
- E. All clinical providers as defined in this center circular are required to complete Protected Peer Review training. Required training is assigned by the Education Department at time of employment. Accountability for assurance of completion rests with the employee's immediate supervisor.

III. SCOPE AND AUTHORITY:

- A. Peer review may be initiated by any of the following activities:
 - 1. Quality management assessments and activities
 - 2. Incident or occurrence reports
 - 3. Mortality and morbidity reviews
 - 4. Utilization management reviews
 - 5. Identified medical record documentation concerns
 - 6. May be initiated with claims filed for malpractice, so long as the purpose of the peer review is to identify, evaluate, and where appropriate, correct circumstances having the potential to adversely affect the delivery of care
 - 7. Executive Concerns
 - 8. Quality Concerns identified by any Health Care Worker.
- B. Essential elements of protected peer review include:

1. Determination of the necessity of specific actions recommended by the peer review process,
2. Evaluation of an episode of care, and
3. Confidential communication back to appropriate providers regarding the results and actions taken to improve performance.

C. Peer Review for Quality Management may be suspended if the review is identified as non-protected peer review. This includes the following types of reviews:

1. Reviews conducted while considering clinical privileges or clinical competency
2. Administrative investigations
3. OSHA investigations
4. Reviews performed for the purpose of consideration of tort claims or defenses
5. Management review: reviews that are other than for quality improvement and/or utilization related to individual provider decisions.

IV. DEFINITIONS:

A. Confidential documents: Documents produced by the VA in the process of conducting systematic health care reviews for the purpose of improving the quality of health care or improving the utilization of implementing regulations.

B. Peer: A peer is a health care professional who has comparable education, training, experience, licensure, or similar clinical privileges or scope of practice.

C. Provider: A provider is defined as a health care professional who is authorized to deliver health care exercising autonomous clinical judgment and whose actions are subject to review. This includes, but is not limited to: physicians, osteopaths, nurses, and other allied health care professionals who are required to exercise autonomous clinical judgment. ***NOTE: This does not apply to health care profession trainees acting within the scope of their training program.***

D. Peer Review: Peer review is defined as is defined as an organized process carried out by an individual health care professional or select committee of professionals, to evaluate the performance of other professionals. In the health care setting, peer review is applied to a broad array of activities of varying characteristics; this includes, but is not limited to: reviews done for Quality Management; Management Reviews, e.g., Administrative Investigation Boards (AIB); Clinical Practice reviews; Ongoing Professional Practice Evaluations (OPPE); Tort Claims; and National Practitioner Data Bank (NPDB) reporting.

E. Peer Reviewer: The term “peer reviewer” is defined as a health care professional who can make a fair and credible assessment of the actions taken by the provider relative to the episode of care under review. Factors to consider when selecting a peer reviewer include, but are not limited to, whether the individual has similar or more advanced education, training, experience, licensure, clinical privileges, or scope of practice.

F. Protected Peer Review: Peer review designated for the purpose of improving the quality of health care and/or improving utilization of health care resources is protected by 38 U.S.C. 5705.

V. PROGRAM RESPONSIBILITIES

A. Facility Director:

1. The Facility Director has ultimate responsibility for peer reviews for quality improvement performed within the facility as defined in accordance with VHA directive 2010-025.

2. The facility Director is responsible for ensuring a Peer Review Committee (PRC) is established in accordance with VHA Directive 2010-025.

3. Ensuring broad based education on Peer Review for quality management policy and processes is provided to appropriate individuals.

B. The Chief of Staff:

1. The Chief of Staff is responsible for providing clinical leadership, direction and for implementation of this policy.

2. Chair the Peer Review Committee and provide clinical oversight of the peer review program.

3. Review requests submitted by initial peer reviewers for extension in the established peer review completion timeline.

4. Approve cases that are to be sent to the VISN Chief Medical Officer (CMO) or designee for referral for review under the national external peer review contract.

5. Collaborate with the Clinical Practice Council, Medical Center director, and/or VISN CMO, as appropriate, to ensure follow-up actions are initiated for outlier data findings identified and interventions/outcomes are documented to closure.

C. The Quality/Risk Manager is Responsible For:

1. Obtaining a peer review on all cases identified with a health care issue, entering the findings into the peer review database, and providing quarterly aggregates of data to the Clinical Practice Council (CPC)/VISN.

2. Coordination of the communication to the provider and the peer review committee and ensuring meeting minutes reflect following action items until completed.

VI. PROCEDURES/GUIDELINES:

A. Protected peer review starts with an initial review, which should be completed within 45 days.

B. The Quality/Risk Manager or designee initiates the initial review by logging the information into the peer review tracking log and submitting the information to an appropriate peer for initial review. A format for maintaining confidentiality when documenting the review is provided to the initial reviewer.

C. The initial reviewer identifies the peer review level as identified below:

1. Level 1- most experienced, competent practitioners would have managed the case similarly.

2. Level 2 Most experienced, competent practitioners might have managed the case differently.

3. Level 3 Most experienced competent practitioners would have managed the case differently.

D. The peer reviewer must:

1. Withdraw from a case if the specialized knowledge required exceeds their expertise or when they feel uncomfortable about judging a case.

2. Abstain from review of cases in which there is a conflict of interest or, for any other reason, the reviewer is unable to conduct an objective, impartial, accurate, and informed review.

Note: In the event that there is no peer at the facility able or willing to serve as a peer reviewer, the Chief of Staff, or designee, consults with the VISN Chief Medical Officer to make arrangements to have the review conducted at another facility.

3. Agree and adhere to understanding the information they learn from their review is confidential and cannot be revealed to anyone outside the protected quality management process.

E. The findings of the initial review are logged in the peer review tracking log.

1. The practitioner is notified of the initial peer review findings and informed of the opportunity to respond in writing and/or attend the next peer review committee meeting.

2. The completed initial reviews are sent to the multi-disciplinary peer review committee.

3. The practitioner is notified of the peer review committee meeting in advance and given the opportunity to submit information regarding the issue being reviewed and/or attend the committee.

F. The peer review committee makes a final level determination and determines further actions to be taken as appropriate.

G. Outside Peer review may be requested by the peer review committee and will be submitted to the outside peer review organization or outside peer by the Quality/Risk Manager or designee when requested.

H. Peer review findings may be disclosed as long as they are aggregated and documented in a way that strictly protects the confidentiality of those involved and are communicated solely for the purposes of promoting organizational performance (including appropriate resource utilization) and optimal patient outcomes. Aggregated findings may not be released unless individual provider confidentiality is strictly protected.

I. Minutes are maintained identifying the Peer Review Committees decisions.

1. The peer review information and minutes are maintained securely in the Quality/Risk Managers office.

J. The final determination of the peer review will be conducted to conclude within 120 days.

K. Trending and activity reports from peer review activities are reported to CPC in a manner that does not identify individual practitioners on at least a quarterly basis.

L. This information (without individual practitioner identification) is shared in leadership and may be shared with other councils when determined to be pertinent to that council.

VII. THE PEER REVIEW COMMITTEE

A. The RJD-VAMROC PRC is comprised of the following:

1. Voting members:

- a. Chief of Staff/Acting Chief of Staff (Chairperson)
- b. Associate Director of Patient Care Services (Nurse Executive) or Acting
- c. Associate Chief of Staff, BH-MHC or Designee
- d. Chief of Anesthesia
- e. Chief of Pharmacy
- f. Chief of Surgery or Designee
- g. Director of Emergency Medical Services or Designee
- h. Director of Primary Care Services or Designee
- i. Director of Specialty Care Clinics, Services, and Critical Care or Designee
- j. Director of Medical Surgical Services or Designee
- k. Director of the Quality Management
- l. Quality/Risk Manager
- m. RN's (2)
- n. Ad-Hoc Members providing for appropriate peer representation on a case.

B. Quorum is comprised of Chief of Staff/Acting Chief of Staff, Associate Director of Patient Care Services (Nurse Executive) or Acting, and 50% plus 1 of the voting members. Quorum must be present for the committee to conduct business.

C. Majority vote by members in attendance will determine the final Level of Care Assignment on Peer Review cases based on the following stipulations:

1. Any committee member who lacks the knowledge base on a peer review has an ethical obligation to abstain from voting.
2. Voting for Final Level of Care Assignment should include at least 3 same discipline peers. If the standard composition of the committee does not contain 3 same discipline peers, the Chair will table the case til a future meeting when members are present or ensure the addition of needed voting adhoc members.
3. If the total committee vote is more severe than the sub-vote of same discipline peers, the vote will not be considered a valid vote. The Chair will review options including further in-house review and/or outside review.

D. Ad-Hoc Members will be assigned for PRC activities by the Risk Manager.

1. Ad-hoc duties include case presentation(s) and feedback, participation in open discussion, and representation of the discipline being reviewed. Ad-Hoc members will be able to vote on final Level of Care Assignment(s) on the case(s) they are providing representation for.

E. Substitute members are generally not permitted to participate in PRC meetings. Exceptions may include extended leave of an appointed voting member. In the event a substitute member is approved the individual must meet all the responsibilities of a regular PRC member.

F. The Peer Review Committee is granted the authority to determine the final levels of standard of care after review of the initial reviewer's findings, pertinent medical records, and other data associated with the peer review.

G. The Peer Review Committee will provide oversight for quarterly tracking of peer review activity.

H. The committee will meet a minimum of quarterly and more often as the need is identified.

I. The committee ensures that the final review of each case occurs within 120 days from the determination that a peer review is necessary (the initial review should be completed within 45 days).

J. Minutes of the activities of the committee are recorded.

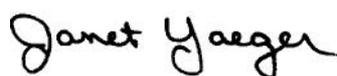
VIII. REFERENCES:

VHA Directive 2010-025, Title 38 USC 5705, Title 38 CFR Part 46, "Policy Regarding Participation in the National Practitioner Data

Bank," Title 38 C FR 17.500-17.511

VHA National Patient Safety Improvement Handbook Records, "Confidentiality of Healthcare Quality Assurance Review VHA Handbook 1050.1
VHA Directive 0700, Administrative Investigations.

IX. RESCISSIONS: Center Circular QPC -08-13, same subject, dated June 23 , 2008.



JANET YAEGAR, RN, MSN
Associate Director Patient Care



JAMES M. PARKER, DDS
Interim Chief of Staff



THOMAS J. SANDERS, FACHE
Medical Center Director