


**GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL**

APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.	PAGE
 Peter John D. Camacho, MPH Hospital Administrator/CEO	GMHA Medical Staff Medical Staff Office Compliance Office Risk Management	January 23, 2017	A-MS500	1 of 13
TITLE: MEDICAL STAFF PEER REVIEW				
LAST REVIEWED/REVISED: 01/2017				
ENDORSED: MEC 8/2016, EMC 12/2016, JCPAC 01/2017, BOT 01/2017				

PURPOSE

To define the process and describe the activities in the Peer Review process as they relate to the improvement of healthcare quality, performance, effectiveness and efficiency of patient care by the healthcare practitioner.

Peer review may result from cases identified through quality indicators as well as the investigation of significant, potential and/or actual adverse patient events. The goal of the peer review process is to provide a review process that is educational, consistent, timely, defensible, balanced, fair, useful and ongoing. Peer review will be included in the credentialing and privileging process for practitioners.

POLICY

1. The members of the Guam Memorial Hospital Authority (GMHA) organized medical staff will be involved in activities designed to measure, assess and improve performance that includes a peer review process. This policy does not include the detailed provisions found in the Appendix to the Bylaws of the Medical Staff: Fair Hearing Plan for Medical Staff Members and Initial Applicants.
2. The Medical Staff Peer Review criteria are evaluated at least annually and as needed by the Department.
3. The same peer review process is followed by all Departments. Overall responsibility for the peer review process lies with the Department Chair.
4. It is the responsibility of the Department Chair to ensure timeliness of peer review and assign a rotation of an adequate number of physicians to conduct peer review. All active members of the Medical Staff are required to participate in peer review activities. Physician reviewers will be assigned alphabetically within the Department, and according to specialty as needed. Cases that are not reviewed by a physician may be brought to the peer review meeting where the Chair may assign a physician to review at the meeting. Overall responsibility for the peer review process lies with the Department Chair.
5. At the Medical Executive Committee (MEC), the Department level recommendation can only be "accepted" or "rejected". All "rejections" will be sent back to the originating entity with recommendations and/or questions. If a case remains unresolved following subsequent review, the MEC will be asked to consider the need for external peer review.
6. Physician behavior issues will be forwarded directly to the Board of Trustees Joint Conference and Professional Affairs Committee for follow-up with the Department Chair.

7. Members of the active Medical Staff are required to participate in the peer review process. Failure to participate in the peer review process may result in the practitioner's review at the MEC level for further action.
8. Any negative information (i.e., peer review rating level 3) regarding the peer review of a practitioner must be approved by the Department before adding it to the physician's file. A copy of this documentation will be sent via certified mail to the practitioner.
9. The peer review process will include ongoing review and evaluation that contributes to the preservation and improvement of quality, performance, effectiveness, efficiency and safety of patient care and clinical practice patterns provided at GMHA. These include but are not limited to: medical assessment and treatment of patients, use of medications, use of blood and blood components, use of operative and other procedures, efficiency of clinical practice patterns and significant departures from established patterns of clinical practice.
10. All activities related to peer review are protected by Guam Rules of Evidence Article IV, Rule 417 and will remain confidential.
11. Participants in peer review confine all discussions and information to the department meetings, to maintain confidentiality and to protect information from discovery.
12. The medical staff will provide leadership for review and improvement of processes dependent primarily on the activities of physicians.

DEFINITIONS

1. Peer Review – An activity that involves case evaluation by an unbiased practitioner to measure, assess, and improve professional practice and the quality of patient care. The results of peer review activities are used to identify opportunities that include, but are not limited to: improving patient care, improving clinical judgment and technical skill, providing information related to clinical competency determination for reappointment, and as necessary, for implementing corrective action.
2. Peer Reviewer – A member of the medical staff or individual with clinical privileges, who practices in the same or related medical specialty as the individual whose case is under review, with experience to render a judgment on the clinical circumstances that may be under review.
3. Peer – A peer is a practitioner who has expertise in the appropriate subject matter. If the question is one of general medical care, then any unbiased practitioner can serve as a peer reviewer. If there are specialty-specific clinical issues, then the peer reviewer must be of the same specialty or have like privileges. Additionally, the peer reviewer must have sufficient clinical experience and training to provide an evaluation of the significant issues involved in the review of either the individual case or an undesirable pattern of care.
4. Case – An event during a patient's hospital stay that corresponds to medical staff approved criteria for peer review, but is not limited to those criteria. A case may be derived from generic or departmental screens, medical staff indicators, sentinel events, third party complaints, or other sources that suggest undesirable processes or outcomes of care.
5. Committee – One or more members of the medical staff who review individual cases or aggregate practitioner data for the purpose of peer review under the auspices of a clinical department, the Medical Executive Committee, or an interdisciplinary body established especially for the review. Members to conduct a review shall be selected based upon their professional knowledge,

lack of bias and availability. The chief of Staff, the Department Chair or their designee may appoint members.

6. Conflict of Interest – A practitioner who is requested to perform peer review may have a conflict of interest if he/she may not be able to render an unbiased opinion. It is the obligation of the individual practitioner or committee member to disclose to the Committee a potential bias. It is the responsibility of the peer review committee, on a case-by-case basis, to determine if a conflict of interest is substantial enough to preclude the individual from participating in the peer review process. Regardless of the nature and/or extent of the conflict, the practitioner may not participate or be present during peer review committee discussions or decisions, other than to provide specific information as requested.
7. ACGME – Accreditation Council for Graduate Medical Education
8. Ongoing Professional Practice Evaluation (OPPE) – The ongoing professional practice evaluation allows the organization to identify professional practice trends that may impact on the quality of care and patient safety. Early identification of problematic performance allows for timely intervention.
9. Concurrent Review Circumstances – Issues that are identified before the patient has been discharged from the hospital, during routine quality improvement reporting and utilization review activities.
10. Retrospective Review Circumstances – Issues that are identified after the patient has been discharged from the hospital, during routine medical records coding and/or quality review activities.
11. External Peer Review – Special circumstances where review is completed by a physician (or peer review organization) who was not a member of the organization but who may be appointed for the purpose of assisting with peer review.
12. Medical Staff Committee – For purposes of this policy, “Medical Staff Committee” refers to any medical staff standing or ad hoc body, or individual authorized to act on behalf of such body, that conducts peer review and performance improvement activities in accordance with the Bylaws and/or this policy.
13. Fallout – A case meeting an indicator for peer review.
14. Review Indicators – Identifies a significant event that would ordinarily require analysis by physician peers to determine cause, effect and severity; requires analysis by appropriate peer review committee.
15. Rule Indicators – Represents a general rule, standard, generally recognized professional guideline, or accepted practice of medicine where individual variation does not directly cause adverse patient outcomes. Occurrence of a rule event generates an automatic report of findings from the Quality Services Department (i.e., core measure outlier). A target number of events is set based on the criticality of the rule, to determine the threshold for follow-up.
16. Rate Indicators – Identify cases or events that are aggregated for statistical analysis prior to review by the appropriate committee. Data are expressed as a percentage, average, percentile rank or ratio. A target range may be based on best practice from benchmark data. Feedback to individual physician’s rates is provided on a regular basis. If a rate falls outside of the target range, leadership of the appropriate service/department would determine what action, if any, is required.

GUIDELINES

1. The peer review process should promote quality of practice by providing education and counseling, issuing letters of commendation, warning, or censure as necessary.
2. All cases referred for peer review should consistently follow the peer review process as outlined in this policy.
3. All cases referred for peer review should be reviewed in a timely manner as specified in this policy, to the extent responsibly possible.
4. The peer review process may assess behavior, judgment, medical or psychological health, resource management, clinical knowledge or technical performance.

PHILOSOPHY

To provide for an effectively functioning peer review process, all committees and medical staff members conducting peer review should adopt the following philosophy.

1. *Consistency*: All cases referred for peer review will follow the peer review procedure components listed in this policy.
2. *Timeliness*: All cases referred for peer review will be reviewed within the time frames specified in this policy, to the extent reasonably possible. All reasonable efforts will be made to complete the peer review process as soon as practicable.
3. *Conclusions of review are defensible*: All cases undergoing peer review will have a *Peer Review Form* work sheet completed, which captures the rationale for the conclusion made by the peer reviewer(s). The *Form* should address the reason the case was reviewed, and should be supported by current clinical practice, rules and regulations, practice guidelines and/or literature.
4. *Results of peer review activities are aggregated and reported* at time of medical staff reappointment to provide for practitioner-specific appraisal of competency and renewal of clinical privilege.
5. *The peer review program is an ongoing component* of the hospital-wide performance improvement program and a routine component of each Medical Staff Department.
6. *Peer review conclusions, outcome, actions and timeliness resulting from peer review are monitored for effectiveness*. Results of follow-up effectiveness monitoring are reported to the appropriate Medical Staff Departments on a regular basis.

PROGRAM COMPONENTS

I. Responsibility:

It will be the responsibility of the physician Department Chair to ensure peer review within their department is conducted according to this policy and procedure.

II. Review by the Quality Improvement Specialists:

- A. Cases are identified for review through various methods, including but not limited to:

1. Referrals from medical staff committees
2. Patient Safety Event Form (Blue Form) and/or patient/family complaints
3. Referrals from Risk Management
4. Referrals from members of the Medical Staff
5. Case identification through concurrent and/or retrospective record review based on criteria established and approved by the medical staff
6. Trended data indicative of the type and quality of patient care provided
7. Cases identified through quality indicators or screening criteria
8. Significant, potential or actual adverse patient occurrences

III. Circumstances Requiring Peer Review:

A. Circumstances that may trigger peer review are listed below. This list may be revised as deemed appropriated by the responsible Medical Staff Departments:

1. Mortality review (trended data unless criteria for individual review met)
2. Complications (trended data unless criteria for individual review met)
3. Unplanned removal, injury or repair of organ or structure
4. Commitment to quality indicators
5. Infection issues (trended data unless criteria for individual review met)
6. Medical record and documentation issues
7. Blood and blood components review (trended data unless specific clinical issue identified)
8. Criteria established by specific departments and committees
9. Cases as identified by the Department Chair, Chief of Staff, or Associate Administrator of Medical Services where opportunities to improve may be addressed
10. Moderate sedation reversals
11. Core measure fallouts
12. Utilization management issues
13. Referrals from other Medical Staff departments or committees

B. Circumstances that trigger mandatory peer review:

1. Event resulting in a significant adverse outcome
2. Cases meeting criteria for mortality review
3. Unplanned returns to surgery
4. Consent issues
5. ED call panel concerns
6. Complaints involving medical care or physician behavior
7. Other cases as deemed by the Department Chair, Chief of Staff or at the discretion of the Associate Administrator of Medical Services

C. Physician behavioral issues will be forwarded directly to the Board of Trustees Joint Conference and Professional Affairs Committee.

IV. Peer Review Participants:

- A. Selection of a physician reviewer to complete a case review will be selected in alphabetical order, or as needed, based on the specialty required, in alphabetical order.
- B. All active Medical Staff are required to participate in peer review activities.
- C. Upon the request of the Department or the Medical Executive Committee, fully proctored Allied Health Professionals may also participate in peer review activities.

- D. A physician shall not review his/her own case.
- E. Unless not feasible under circumstances, an individual functioning as a peer reviewer should not be in partnership with, or related to, the individual whose case is under review.
- F. Unless not feasible under the circumstances, an individual functioning as a peer reviewer should not have performed any medical management on the patient whose case is under review. However, opinions and information may be obtained from participants that were involved in the patient's care.

V. Multi-disciplinary or ad hoc peer review panels (committees):

At the request of a Medical Staff Department Head to the Medical Executive Committee Chairperson, a multidisciplinary or ad hoc peer review panels/committees may be selected by the Medical Executive Committee in certain circumstances, including controversy, when additional consideration is necessary to adequately review a specific case. Panelists may be selected for their expertise in a given subject of medicine or in a specific medical specialty.

VI. Medical Staff Responsibilities:

- A. Each department will conduct regular patient care reviews and studies of practice in conformity with the Hospital's general performance improvement plan. Results of actions will be reported to the Departments, the Medical Executive Committee and the Board of Trustees, with such detail as is appropriate for such group to fulfill its function.
- B. All active Medical Staff are required to participate in peer review activities.
- C. Annually, each department approves quality indicators which define those circumstances requiring peer review and establish thresholds for indicators based on criticality that will trigger either tracking and trending, or physician case review and committee discussion and rating.
- D. Peer Review activities may include, but are not limited to:
 - 1. Review and aggregate all similar cases
 - 2. Review and aggregate all cases with identified problems or outcomes
 - 3. Compare practitioner outcomes measurements to internal or external standards
 - 4. Interview the practitioner to assess knowledge base when questions arise
 - 5. Perform direct observation of clinical or technical skills
 - 6. Utilize internal peer reviewer or an external peer reviewer in specialty relevant to the practitioner's specialty.
- E. Peer review actions include, but are not limited to:
 - 1. Take no action when no problems or concerns are identified
 - 2. Trend findings or outcomes
 - 3. Letter of inquiry requesting further information or explanation
 - 4. Letter of education with notification of opportunities for improvement
 - 5. Invitation of individual to Department Meeting to discuss case
 - 6. Letter of warning or reprimand
 - 7. Referral to other Department
 - 8. Recommendation for disciplinary action (MEC only) any actions restricting or limiting a practitioner's privileges or ability to schedule procedures may be reportable to the Guam Board of Medical Examiners under the Physicians

Practice Act. Recommendations for corrective actions resulting in a report to the Guam Board of Medical Examiners shall be approved by the MEC.

VII. Situations which may trigger a referral to the Department/Credentials Committee for possible FPPE include, but are not limited to:

- A. Two instances of Rating Level 3 in the same indicator or physician issue within the past twelve (12) months;
- B. Three instances of Rating Level 3 in any combination of indicator or physician issue within the past twelve (12) months;
- C. Four instances of a Rating Level 2 in the same indicator or physician issue within the past twelve (12) months;
- D. Greater than 90 cumulative days of suspension for delinquent medical records within the past twelve months;
- E. When adverse trends are identified

VIII. Individual Participation in the Peer Review Process:

Except in unusual situations when it is not feasible under the circumstances, such as when summary action is determined to be reasonable and warranted, any physician whose performance is under review will be afforded the opportunity to respond to the Department's findings, recommendations and stipulations. Such response may be in person at a Department Meeting, by letter or other methods that are consistent with the Medical Staff Bylaws and/or Rules and Regulations.

PROCEDURE

- A. Using indicators/guidelines approved by the Medical Staff, the Quality Improvement Specialists will complete the Peer Review Case Rating Form, including the committee referral, a brief case summary and reason(s) for review, and key questions for the physician reviewer.
 - 1. The Quality Improvement Specialists screens records according to department established quality indicators (i.e., readmissions, complications, return to surgery and mortalities), issues identified from other Medical Staff committees and other pertinent sources of medical information relating to patient care. Each review includes problem identification documentation of corrective action and follow-up monitoring.
 - 2. Identifiers for the physician reviewee and physician reviewer are blinded to the extent possible at all levels subsequent to the initial physician review in the peer review process to ensure an unbiased review, in compliance with Joint Commission and regulatory requirements.
- B. Quality Improvement Specialists assign a physician reviewer, based on alphabetical order, availability, and specialty, if applicable.
- C. Pursuant to the Medical Staff General Rules and Regulations, all active members of the medical staff are required to participate in the peer review process. The physician reviewer is given 14 days to complete the case review.

1. If the physician reviewer has not completed the review within 14 days the Department Chair is notified and the physician will be notified by facsimile that he/she has 7 additional days to complete the peer review or will be placed on the Medical Records Suspension List if the review is not done.
 2. If the physician reviewer fails to complete the case review within 21 days, the physician will be placed on the Medical Records Suspension List and the procedures outlined in the GMHA Medical Records Department policy for Medical Record Delinquency will be followed. As such, the physician's admitting and operative/invasive privileges are suspended until the peer review is completed and associated fines will be administered.
 - a. The Medical Staff Office will notify the physician of the suspension via a confirmed facsimile. A certified, return receipt requested letter will then be sent to the physician if the delinquency is not corrected within the first 24 hours of notification.
- D. All peer review shall be completed within the target time frames to the extent possible. If the case qualifies as a sentinel event, the Sentinel Event policy and procedure will take precedence. However, the peer review process will continue in an expedited fashion.
- E. Additional information may be requested from the physician being reviewed at any time during the review process, for the purpose of seeking and obtaining necessary additional information.
- F. Peer review should be conducted in an environment where a careful and thorough review can occur. The physician reviewer is charged with the task of reviewing the reason(s) for review along with the case summary and medical record and making a determination regarding his/her evaluation of the care provided.
- G. The physician peer reviewer will be assigned charts to review, assign a rating level and identify all applicable physician care issues once his/her initial review is completed. The reviewer will select one of the following Rating Levels:
- Level 1** – Care Appropriate: No departure from Standard of Care.
Level 2 – Care Controversial: No Clear Departure from Standard of Care.
Level 3 – Care Inappropriate: Significant Departure from Standard of Care.
- H. In addition, the reviewer will identify and check off on the "Peer Review Case Rating Form" any physician care issues identified in the review. Physician issues include:
1. Diagnostic work-up
 2. Diagnosis
 3. Clinical Judgment/Decision-making
 4. Technique/Skills
 5. Knowledge
 6. Communication/Responsiveness
 7. Treatment Plan
 8. Follow-up/Follow-through
 9. Policy Compliance
 10. Documentation (Legibility, Timeliness, Completeness)
 11. Other

- I. If the reviewer concludes there was no departure or no clear departure from the Standard of Care and recommends a Level 1 or Level 2, the case is sent to the Department for approval.
- J. If the reviewer concludes there was a significant departure from the Standard of Care and recommends a Level 3, a seven-day (certified mail) notification is sent to the reviewee, advising him/her that the case is expected to be discussed at the Department meeting. Only one notification shall be sent.
- K. The Department may agree with or modify the conclusion and/or rating level recommended by the physician peer reviewer. Case discussion may include response letters and/or the physician reviewee's presence.
- L. The reviewee has the opportunity to respond, either in person or in writing, whichever the practitioner prefers. If the practitioner of record fails to either appear or submit a written response, the review will be completed and a level will be assigned at that time. No other opportunities to respond shall be granted except under extenuating circumstances.
- M. Following the reviewee's case presentation and discussion, the reviewee shall be excused at the discretion of the Chair to allow appropriate deliberation and case conclusion. Upon the conclusion of the discussion, the members of the Department shall vote on the Level to be assigned to the case.
- N. The final case outcome reached by the Department shall be supported by a rationale that addresses issues for which the peer review was conducted, including, as appropriate, references to the evidence-based literature and/or relevant clinical practice guidelines.
- O. The appropriate members of the Department shall vote on a rating level by secret ballot. Determination of the peer review rating and any recommended actions shall be made by department consensus, not an individual reviewer. Assignment of a rating level will be Level 1, Level 2 or Level 3, as previously described.
 - 1. Average rating levels will be calculated as follows:
 - Up to 1.5 = 1
 - Greater than 1.5 up to 2.5 = 2
 - Greater than 2.5 = 3
- P. The Department shall use the mean or average of the secret ballot rating levels to calculate the committee rating level. The final rating as determined by the department will stand. The total number of physicians rating the case will be recorded with the rating level.
- Q. After the Department votes and determines the rating level, the reviewee is invited back. The Department Chair notifies the reviewee of the rating level.
- R. If the reviewee is not present, he/she will be notified of the Department's determination within seven (7) days of the meeting.
- S. Only case reviews concluded at the Department with rating level of 3, indicating a potential issue with physician performance and without further request for information will be forwarded to the Medical Executive Committee.

- T. At the discretion of the Medical Executive Committee, cases may be sent back to the Department for re-review or re-consideration, or further action taken, as deemed necessary.
- U. Cases associated with corrective action must be reviewed according to the Medical Staff Bylaws and the practitioner shall be afforded the procedural rights as described in Appendix to the Bylaws of the Medical Staff: Fair Hearing Plan for Medical Staff Members and Initial Applicants.as appropriate.
- V. When the Medical Executive Committee confirms a recommendation for a Level 3, the reviewee is notified by certified letter (within seven days following the committee meeting) and the Medical Executive Committee's recommendation.
- W. If the Department Chair is unavailable, then the responsibility defers to the Vice Chair, Chief of Staff or designee.
- X. If a letter of response is requested from the reviewee by the Department, the reviewee shall have 15 days to reply from the date of the certified letter to the Medical Staff Office. Failure to respond will result in a final request to respond within 10 days. If the response is still not received, the case shall be sent to the Department for review and level rating based on the information available in the medical record. The case shall also be taken to MEC and subsequently the physician will be notified of any action taken.
- Y. Quality trending reports which represent physician performance and patterns of care are compiled and presented to the Department Chair for review. Summary reports are presented at the Department Medical Executive Committee and to the Board of Trustees.

X. Circumstances Under Which External Peer Review is Used:

- 1. When there is no local expertise on the Medical Staff to adequately review the case, as determined by the Department Chair
- 2. When a limited number of peers exist on the Medical Staff, making it difficult for the medical staff leadership to obtain an objective review, free from special interest or conflict of interest
- 3. When there is known conflict among physicians which would impact fairness of the review
- 4. As requested, or suggested by a regulatory or accrediting agency (CMS, TJC)
- 5. As requested by the governing body
- 6. As requested by a physician appealing the results of review due to alleged unfairness

XI. Timeliness of Peer Review Process:

- A. Peer review will be conducted by each department on an ongoing basis and reported not less than quarterly. Whenever possible, the peer review process is initiated within 15 working days after identification of the event and completed within 90 days from the initiation of the review for routine cases, or prior to the next scheduled Department meeting, whichever is later. A time frame of 120 days is permitted for completion of complex cases after initiation of the peer review process.
- B. The Quality Improvement Specialists will advise the Chief of Staff, the Department Chair and the Associate Administrator of Medical Services if the timeliness of completion falls below 90% compliance.
- C. Following the department/committee meeting the final action(s) and any follow up

required will be documented in the peer review summary. The peer review summary will be appended to and included as part of the department meeting minutes.

- D. Peer review findings relevant to an individual physician's performance are incorporated into the ongoing professional practice evaluation for that individual. Outcomes of peer review actions will be tracked and specific practitioner summaries will be available for review at reappointment.

RELATED POLICIES:

Policy No. A-PI100, Performance Improvement Plan of the GMHA Administrative Manual

Policy No. A-PS700, Root Cause Analysis for Sentinel Events of the GMHA Administrative Manual

Policy No. 6170-15, Ongoing Professional Practice Evaluation of the GMHA Administrative Manual

Policy No. 6170-16, Focused Professional Practice Evaluation of the GMHA Administrative Manual

RESCISSION:

Policy No. 6432-5, Medical Staff Peer Review Process of the GMHA Administrative Manual made effective July 12, 2000

REFERENCES:

The Joint Commission Comprehensive Accreditation Manual (2016). Evaluation of Practitioners: MS.08.01.01, MS.08.01.03

Centers for Medicare and Medicaid Services (2016): Code of Federal Regulations. Chapter IV Part 482.22 Condition of Participation: Medical Staff

CA Code of Regulations Title 22 (2006) Division 5, Chapter 1, §71501(a)(1)(F)(4)(6) Governing Body; §71503(a)(e) Organized Medical Staff

ATTACHMENT:

- I. [PEER REVIEW CASE RATING FORM](#)

Peer Review Case Rating Form

MR #: _____ PT#: _____ Service Date: _____ Referral Date: _____ MD #: _____

Referral Source: Check the corresponding box

Screen Risk MRD Nursing Pharm Gst Relations Physician Other:

Event Date: _____

Review Criteria/Referral Issue: _____

Quality Screener/Date: _____ Date Submitted for Physician Review _____

Case Summary _____

Key Questions/Points for Physician Reviewer:

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

To be completed by Physician Reviewer (Please write legibly)

Physician Reviewer: _____ Review Date: _____

Patient Outcome

<input type="checkbox"/>	No adverse outcome
<input type="checkbox"/>	Minor adverse outcome (complete recovery expected)
<input type="checkbox"/>	Major Adverse Outcome (complete recovery NOT expected)
<input type="checkbox"/>	Catastrophic Adverse Outcome (e.g. death)
<input type="checkbox"/>	Unknown to Reviewer

Overall Physician Care: Rating Levels: Check One

<input type="checkbox"/>	Level 1: Care Appropriate: No Departure from Standard of Care
<input type="checkbox"/>	Level 2: Care Controversial: No Clear Departure from Standard of Care
<input type="checkbox"/>	Level 3: Care Inappropriate: Significant Departure from Standard of Care

Note: If overall care = 1 **then** physician issue must = A
If overall care = Level 2, or 3 **then** physician issue must = B through 0

On initial presentation the patient's risk for this adverse outcome was:

High Intermediate Low

Indicate your level of certainty around preventability

Definitely Possibly None

Issue Identification

A No issue with physician care

Physician Issue: Check all that apply

- B Diagnostic work-up
- C Diagnosis
- D Clinical Judgment/Decision-making
- E Technique/Skills
- F Knowledge
- G Communication/Responsiveness
- H Treatment Plan
- I Follow-up/Follow-through
- J Policy Compliance
- K Documentation:
 - Legibility
 - Timeliness
 - Completeness
- O Other: _____

Peer Review Case Rating Form (Cont.)

If Overall Physician Care rated level 1, provide a **brief description** of the basis for reviewer findings:

If Overall Physician Care rated level 2, or 3, please complete the following:

A. **Brief description** of the basis for reviewer concerns: _____

B. **What questions** are to be addressed by the physician or Department:

1. _____
2. _____
3. _____
4. _____
5. _____

Exemplary Nominations: Physician Care Physician Documentation Non-Physician Care

Brief Description: _____

Non-Physician Care Issues: Potential System or Process Issue Potential Nursing/Ancillary Care Issue

Issue Description: _____

Department Review

Is physician response needed? Yes No

Practitioner response: Discussion with Chair Letter Department Appearance

Department Final Scoring: Refer to page 1 for level rating and physician issue scales.

Level 1 Level 2 Level 3
 Physician Issue must be A Physician Issue (B-O): _____ Physician Issue (B-O): _____

Department Action (Check One)

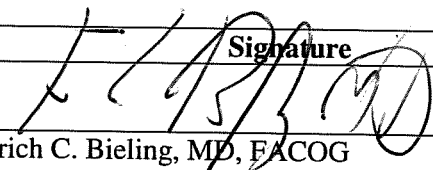
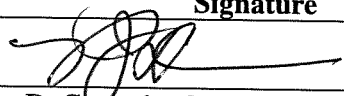
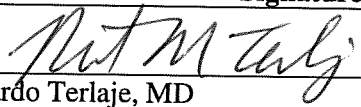
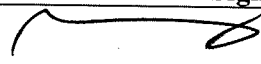
	Letter for response
	Letter for information
	Letter for reprimand
	Collegial intervention
	Letter to MD of Departmental findings
	Refer to MEC for recommendation
	System or Process Problem Identified Date Sent: _____ Forwarded to: _____ Describe system/process problem: _____
	Refer to Nursing: Associate Administrator of Nursing Services Date Sent: _____ Response Date: _____ Describe nursing concern: _____
	Referral for CME Date Sent: _____ State topic or reason for referral: _____
	Trend Date Submitted for Trending to Compliance Office: _____

Department Chair Signature: _____ Date: _____

**GUAM MEMORIAL HOSPITAL AUTHORITY
REVIEW AND ENDORSEMENT CERTIFICATION**

The signatories on this document acknowledge that they have reviewed and approved the following:

- Bylaws Submitted by Department/Committee: Administration
- Rules & Regulations Policy No.: A-MS500
- Policies & Procedures Title: Medical Staff Peer Review

Reviewed/Endorsed	Date	Signature
	24 August 2016	
Title	Friedrich C. Bieling, MD, FACOG Chairperson, Medical Executive Committee	
Reviewed/Endorsed	Date	Signature
	12/02/16	
Title	Peter John D. Camacho, MPH Chairperson, Executive Management Council	
Reviewed/Endorsed	Date	Signature
	1/19/17	
Title	Ricardo Terlaje, MD Chairperson, BOT-Joint Conference and Professional Affairs Committee	
Reviewed/Endorsed	Date	Signature
	1/19/17	
Title	Eloy Lizama Chairperson, Board of Trustees	

***Use more forms if necessary. All participating departments/committees in developing the policy should provide signature for certification prior to submitting to the Compliance Officer.**