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MANUAL: MEDICAL STAFF POLICY/PROCEDURE

Effective Date: 9/24/13

Reviewed/Revised: 1/17

Approval /s/ _____

Anthony Kosinski, M.D., Medical Staff President

I. VALUES CONTEXT

Our value of Excellence requires that, through the ongoing review of data and evaluation of practitioner performance, we strive to improve the care provided to our patients.

II. PURPOSE/EXPECTED OUTCOMES

The purpose of this policy is to define the Medical Staff peer review process including ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) in order to continuously improve the quality, safety, and effectiveness of care rendered by members of the Medical Staff and Allied Health practitioners at Petaluma Valley Hospital. This policy defines procedures for data collection and event and clinical case reviews, as well as the mechanisms by which the process will assure that timely, fair, and objective assessments of practitioner competence are accomplished. When applicable, systems and process issues germane to the quality and safety of patient care will be integrated into the Hospital's performance improvement program. Responsibility and accountability for the peer review process resides with the Executive Committee (EC).

III. POLICY

All activities and records conducted as part of this policy are confidential and protected from discovery pursuant to The Healthcare Quality Improvement Act and California Evidence Code 1157. As such, all individuals participating in peer review are to abide by the confidentiality provisions of the Medical Staff Bylaws and any other agreements required participating in the Medical Staff peer review process.

The Medical Staff is responsible for performance of peer review activity under the leadership of the Department Chairpersons, with support and direction provided by the Executive Committee and the Quality Review Committee (QRC) of the Medical Staff. Peer review activities are comprised of individual case review and aggregate rate based review utilizing all available data sources to identify and assess practitioner performance. *See Addendum C. for Data Sources.*

In order to assist the Medical Staff, the Performance Improvement Department will initiate and maintain the peer review process documentation with QRC and EC oversight. The peer review process documentation shall be initiated and maintained by the Performance Improvement Department. *See Addendum B* for algorithm for case identification and peer review process.

IV. **CLINICAL COMPETENCIES SUBJECT TO REVIEW**

“Core Clinical Competencies” in this policy are defined by concepts developed by the American Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), and The Joint Commission (TJC). These competencies include:

- Patient Care and Procedural Skills
- Medical Knowledge
- Practice Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- System Based Practices

V. **TYPES OF REVIEWS**

- A. **Rate based**—Rate based reviews are generated from aggregate coded data sets. The accuracy and validity of a rate must be verified before committee presentation and/or use in evaluating a practitioner’s performance. *See Addendum G.*
- B. **Single case or event**—Single case reviews are identified by the screening and case identification elements listed in *Addendum C.* and follow the process defined in *Addendum B.*
- C. **Focused Professional Practice Evaluation (FPPE)**—FPPE is a process whereby the Medical Staff evaluated the competency of a practitioner who does not have documented evidence of competent performance of the privilege(s) in question at this hospital (i.e. new applicant or request for new privileges) or about whom questions have been raised concerning the ability to provide safe, high quality patient care (i.e. currently privileged practitioner.) A Focused Evaluation will encompass a detailed consideration and evaluation of a single event, series of cases or events, or an unexpected rate or pattern of events. A Focused Evaluation may also be an intensified proctoring or privileging decision. The FPPE process is appropriate for:
 - 1. **Proctoring:** The evaluation of practitioner without current performance documentation at the Hospital requesting new privileges. A FPPE may also be undertaken when a practitioner has requested new or

expanded privileges, upon the recommendation of the Credentials Committee.

2. Clinical FPPE: The assessment of practitioner in response to concerns regarding the provision of safe, high quality patient care. A FPPE may be initiated and performed by the QRC or the EC.
3. Behavioral FPPE: The EC or QRC may initiate and perform a Behavioral Focused Practitioner Practice Evaluation in response to reported behavioral events in accordance with the Standards of Professional Behavior.

D. **Rule Violations**—Rule violations represent a practitioner’s failure to comply with professional standards and/or patient safety standards established by regulatory requirements, statutes, and Hospital policy. Rules are documented in the Medical Staff Bylaws and Rules and Regulations, and Medical Staff and Hospital Policy and Procedure. Repeated rule violations shall be addressed as unprofessional conduct and corrective action pursued through the Behavioral FPPE processes of the QRC.

VI. CONCLUSIONS OF REVIEW

A. Aggregate Reports

1. Rate based reviews are used for generating aggregate reports
2. Trended clinical and behavioral issues shall be summarized in OPPE reports for review every eight (8) months.

B. Single Case Review

Review recommendations and scores are made at the following steps in the review process:

1. Preliminary Peer Review RN screening - The Peer Review RN provides a preliminary review of the case and assigns and refers cases pursuant to the instruction of the Committee chair.
2. Preliminary Physician review - Physician reviewer provides an out of committee review and completes the peer review document and suggests a peer review score (PR).
3. QRC conclusions and recommendations - Committee discusses case and determines the final peer review score (QRC).

VII. PRACTITIONER PARTICIPATION

- A. All members of the Organized Medical Staff are expected to participate in the peer review process in good faith.
- B. All peer review activities are confidential with discussion to occur in Medical Staff committees.
- C. Clinical Case Review
 - 1. A Department Chair or the QRC Chair may request written response from a Practitioner to clarify questions or concerns identified during the review process, or they may require a practitioner to attend a meeting in person.
 - 2. When either request is made, the Practitioner's participation is mandatory as described in Article VI, Section 6.8-7 of the Medical Staff Bylaws.
 - 3. When clinical case results in an "Educational Opportunity", the involved practitioner shall be informed of the case review and given the opportunity to provide a written response to the clinical review or to attend the Section, Department, or QRC meeting where the case will be discussed, as appropriate
- D. Physicians may review their OPPE information file in the Performance Improvement Office at any time for review of completed single case review and/or to review OPPE reports. File access is coordinated through the Peer Review Coordinator.

VII. CLINICAL REVIEW EFFICIENCY (TIMELINESS)

- A. **Routine** review is for those clinical situations where the immediate action of the Medical Staff leadership is not required. Single case review shall be conducted in a timely manner. Single cases requiring practitioner review will be assigned for review as soon as possible following identification. Whenever reasonably possible, a review will be completed by QRC action within three months after initiation.
- B. **Fast Track** review is for any circumstance in which the lack of immediate intervention would have the potential to adversely affect the health and/or safety of a patient, family, staff or visitor. Significant adverse events identified through the Medical Staff Peer Review process may be subject to accelerated "fast track" review.
 - 1. Upon determination by the Medical Staff President, Department Chair, CEO and/or CMO that a significant adverse event has occurred involving a practitioner(s), an assessment of the situation shall be

undertaken. The Medical Staff President, with the Administration Leadership, shall formulate an assessment of the event.

2. Findings from this assessment shall be summarized and, if there is an immediate threat to patient, staff, or visitors, corrective action may be taken pursuant to the Medical Staff Bylaws provisions for Summary Suspension.
3. If no immediate threat to care or safety exists, the remainder of the review shall be completed as soon as reasonably possible.
4. Findings from the “fast track” review will be summarized and reported to the Medical Staff President.
5. All cases meeting criteria for “fast track” review shall be reported to the QRC at its next regular meeting. The report shall include the timeline from concern identification to completion of “fast track” review.

VIII. EXTERNAL PEER REVIEW

External peer review may be used as part of OPPE and/or FPPE. When appropriate the QRC may recommend to the EC that external peer review be obtained for a single case review, multiple case reviews, or an FPPE. This does not preclude the EC’s direct initiation of such an external peer review.

- A. Physicians with cases submitted for external review will be notified in writing by the Medical Staff President of the external review’s scope, process and timeline.
- B. External peer review should be considered in the following circumstances:
 1. If there is difficulty in obtaining a reviewer who does not have a perceived or actual conflict of interest.
 3. If there are no peers on the Medical Staff with the appropriate clinical or technical skills to assist in peer review.
 3. When a Department Chair, the QRC or the EC requests assistance in completing a case chart review or an FPPE.

IX. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

OPPE is a review of an individual’s performance compared to peers’ performances over time using eight month intervals with trends evaluated for adequacy of clinical competence and professional conduct. *See Addendum C, Data Sources that are used.*

- A. OPPE data is evaluated every eight (8) months to identify trends or patterns of professional practice or conduct that may have an adverse impact on the quality of care and of patient safety. OPPE data shall be evaluated in the context of the type and number of privileges exercised at Petaluma Valley Hospital and other organizations. The absence of adverse outcomes/complications of care may be interpreted as acceptable performance.
- B. When an OPPE threshold or trigger is exceeded, or significant deviations from expected performance have been identified, these findings and/or results will be communicated to the appropriate Department Chair and the Medical Staff President. As appropriate, the QRC will be notified. Should the QRC conclude that a FPPE is warranted, an FPPE will be initiated and the EC informed.
- B. A summary report of OPPE trending reports shall be submitted to the EC.

X. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

- A. An FPPE may be triggered upon crossing thresholds for clinical practice and/or conduct.
- B. FPPE thresholds/triggers for clinical practice concerns and rule violations are in *Addendum F*.
- C. **FPPE PROCEDURAL STEPS**
 - 1. Verbal and written notice will be given to a practitioner subject to an FPPE. The notice will define the scope of the review.
 - 1. Notice shall include a list of the identified concerns regarding the practitioner's care and/or conduct. Specific cases, events, data, or triggers involved in the initiation of the FPPE shall be identified in the notice. The EC will receive a copy of this notice.
 - 2. Should the practitioner desire, he/she shall be provided access to medical records and other appropriate information necessary to permit the practitioner to respond to the Committee's concerns.
 - 3. The practitioner shall cooperate with the FPPE and participate in the review activities with a verbal and/or written response to any identified concerns.
 - 4. The FPPE will be completed within one hundred twenty (120) days of initiation whenever reasonably possible.
 - 5. The FPPE report shall include findings, conclusions, and

recommendations to the EC and the involved practitioner verbally and in writing at the conclusion of the FPPE.

6. Additional follow-up to any recommendations resulting from the FPPE shall be incorporated into the monitoring activities of the Medical Staff with a follow up report. The scope of report and time frames shall be communicated to the practitioner involved and the EC.

Related Policies: Medical Staff Code of Professional Behavior
 Medical Records Delinquency Policy

Replaces: Medical Staff Peer Review and Focused Professional Practice
 Evaluation Policy

Author/Department: Medical Staff	
References: References: TJC Standards, Medical Staff Bylaws, Medical Staff Rules & Regulations	
Reviewed/Revised by: Medical Staff	
Approvals: Executive Committee: 9/17/13, 1/17 Board of Trustees: 9/24/13, 1/17	Distribution: Medical Staff

ADDENDUM A. DEFINITION of TERMS

“Designee” refers to an appropriate, elected or appointed Medical Staff leader who may act on behalf of the individual described in this policy and procedure.

“Disruptive Behavior” is defined as conduct that has interfered (or has the potential to interfere) with the delivery of safe, timely, quality healthcare. A more detailed definition, with examples, is addressed in the Medical Staff Standards of Professional Behavior. Disruptive behavior and its management are not addressed in this document.

“General Clinical Competencies” in this policy are defined by concepts developed by the American Council for Graduate Medical Education (ACGME), the American Board of Medical Specialties (ABMS), and The Joint Commission. These competencies include:

Patient Care and Procedural Skills
Medical Knowledge
Practice Based Learning and Improvement
Interpersonal and Communication Skills
Professionalism
System Based Practices
Interpersonal Skills

Examples: *Patient Care & Procedural Skills*=appropriate decision making, diagnosis, treatment and procedural complications
Medical Knowledge = core measures, National Patient Safety Goal measures
Practice Based Learning & Improvements
Interpersonal and Communication Skills = patient hand-offs, documentation – legibility, medical record/ rules, appropriate behavior between colleagues, staff, patients, and families
Professionalism = satisfaction survey results, response time to ED / consults
System Based Practices

“Physician Out of Committee Review” refers to the portion of single case clinical review where a physician peer is reviewing the case on behalf of the Section/Department, QRC, or EC, completing the review worksheet, and recommending a score. Reviewers are encouraged to cite specific literature or evidence based practice references which were considered in evaluating the case under review.

“Peer Review” refers to the good faith activities utilized by the organized medical staff to conduct patient care review for the purpose of analyzing and evaluation the quality and appropriateness of care provided to patients. The term is used to reflect the activities described in this policy and includes both OPPE and FPPE.

“Peer Review Committee” of the Medical Staff consists of the Department/Section, Quality Review Committee (QRC) and the Executive Committee (EC). Routine peer review functions, as defined in this policy, are conducted by the Department/Section and the QRC.

“Peer” refers to a practitioner who has the clinical experience and training necessary to provide an assessment of the specific issues related to the clinical review of care or the investigation of conduct related to an event.

“Practitioner” refers to an individual credentialed by the Medical Staff and includes all Medical Staff Members, including those with temporary privileges, and all Allied Health Practitioners.

“Preliminary Reviewer” refers to a staff level individual such as a registered nurse, pharmacist, infection control practitioner, etc., who provide the initial case review and recommendation of a preliminary review score.

“Rate Based Review” Refers to statistical data presentations of individual peer review activities in the context of total individual clinical activities, individual performance compared to peer performance, or compared to published benchmarks reflecting generally accepted standards of medical care. Coded medical record data is utilized to generate data sets for use in aggregate reporting. When a rate exceeds a medical staff approved threshold, the EC may direct further action.

“Rule Violation” represents a practitioner’s failure to comply with Professional Standards and/or patient safety standards established by regulatory requirements, statutes, and hospital policy and reflected in the Medical Staff by Laws and Rules and Regulations and Hospital or Medical Staff Policy and Procedure. *See Addendum E.*

“Peer Review Sheet” each single case review has a Peer Review Worksheet that documents the review content and progress. The physician peer completing out of committee review may complete the review sheet by electronic, dictated or handwritten means and indicate a review score recommendation.

“Review score” refers to an alphanumeric designation for the conclusion of a single case review. These scores are defined as follows:

<p>Case Review</p> <p>Preliminary Reviewer – Peer Review RN or other appropriate staff review <u>Preliminary Staff Review recommendation:</u> PSR 0 = no educational opportunity PSR 1 = physician peer review PSR S = System / process issue(s)</p>
<p>Physician Out of Committee Reviewer and Department/Section <u>Physician Peer Review recommendation (out of committee review) and Department/Section review:</u> PR 0 = no defined educational opportunity PR 1 = identified educational opportunity for practitioner and referral to Peer Review Committee PR S = identified system/process issue(s)</p>
<p>Quality Review Committee <u>QRC Conclusions:</u> QRC 0 = no identified educational opportunity QRC 1 = at-risk clinical event offering an educational opportunity QRC 2 = an educational opportunity determined to be a potential harm event and/or represent reckless clinical practice; may warrant consideration of a FPPE* QRC S = identified system/process issue(s)</p>

”Single case Review” Cases or events requiring review are identified by the screening and case identification elements listed in *Addendum C*. During a specialty specific clinical review, whenever possible, the reviewers are individuals from the same professional discipline or a related specialty who possess sufficient training and experience to render a technically sound judgment on the clinical circumstances under review.

ADDENDUM C. DATA SOURCES

Individual Case Review may be prompted by any of the following identified data elements:

1. Assessment of operative and other clinical procedures and their outcomes
2. The use of medications, and blood and blood products
3. Documentation review for accuracy, completeness, timeliness and/or legibility. Compliance with the Medical Staff Bylaws, Rules and Regulations, and relevant hospital and medical staff policy and procedure
4. Morbidity and mortality review/Evidence-based process review/periodic case review
5. Unexpected occurrences, Unusual Occurrence Reports, sentinel events, adverse events and “near misses” including those identified by Discussions with individuals involved in the care of a patient(s) including physicians, assistants at surgery, nursing staff administrative staff, patients, and others involved in patient care processes (Event Reporting, RCA)
6. Core Measures compliance, nosocomial infections, and hospital acquired conditions
7. Length of stay, utilization review identification of avoidable days, insurance denial for lack of documented medical necessity
8. Autopsy information (Coroner Reports)
9. Patient and family complaints (AVATAR responses, grievances, complaints)
10. Coding data including complication, present on admission, procedural sequence codes,
11. Case screening by Coding Staff utilizing pre-established “**Generic Screens**”
 - a. Generic Screens are reviewed and approved annually by the Medical Staff.
 - b. See Addendum C. for complete list of Generic Screens
12. Physician referrals to Medical Staff leadership or hospital administrative or management staff
13. Cases referred from PI activities.
14. Third party payer, regulatory or accreditation agency notices specific to an individual case

OPPE

The methods for ongoing review may include, but are not limited to, assessment(s) of the following:

1. Types and volume of clinical activity
2. Conclusions of individual case review including: morbidity and mortality review
3. Conclusions of case reviews for medications, blood/blood products utilization
4. Conclusions of reviews for accuracy, completeness, timeliness and legibility of medical records
5. Summary data related to compliance with the Medical Staff Bylaws, Rules and Regulations, and relevant hospital and medical staff policy and procedure
6. Summary data for evidence-based process review (Premier)
7. Summary data for unexpected occurrences, sentinel events, adverse events and “near misses”
8. Summary data for Core Measures compliance, nosocomial infections, and hospital acquired conditions (Clinical databases, Patient Safety Indicator Reports – AHRQ Patient Safety Indicators and inpatient Quality Indicators)
9. Length of stay/UR patterns
10. Proctoring, including direct observation and retrospective evaluation reports
11. Summary data for patient and family complaints
12. Conclusions from analysis of coding data including complication, present on admission, and procedural sequence codes

FPPE

The data sources/methods for focused review may include, but are not limited to, assessment(s) of the following:

1. Medical records
2. OPPE data germane to clinical care or conduct
3. Interview and or direct observation of simulated care issues or events
4. Direct observation or retrospective review of care through the proctoring process
5. Types and volume of clinical activity
6. Interviews with others involved in care including other practitioners, nursing and ancillary staff, administrative personnel, patients, and family members.
7. Medical literature
8. Data gathering and statistical analysis
9. External peer review
10. Information from other healthcare organizations, certification and licensure organizations/agencies, the National Practitioner Data Bank, the Center for Medicare and

Medicaid Services, and the proceedings of criminal and civil legal activities directed against a practitioner.

ADDENDUM D. GENERIC SCREENS (DETERMINED BY MED STAFF)

ACC	Case Cancelled after Intubation
CAN	CNS Complication within 2 days post-op
AIN	Re-intubation of patient within 24 hours of extubation
AMI	MI within 24 hours of surgery
CEM	Embolus causing change in treatment
CNE	New Onset of Neurodeficit
COD	Cardiac or respiratory arrest – Code Blue
COM	Other Complications
CRE	New Onset Renal Failure
DAA	Death within 24 hours of admit
DGR	Drug Reaction
GIC	Unplanned Transfer
HEM	Hemolytic Transfusion Reaction
LBW	Low Birth Weight <2500 Grams
MBA	APGAR <7 at 5 minutes
MBC	Maternal Complication
MBLR	Post-Partum Transfusion
MRE	Maternal Readmit within 14 days
NBC	Newborn Complication
NBD	Newborn death
NBL	Newborn length of stay > 7 days
NBT	Unplanned transfer of newborn
NOS	Nosocomial Infection
OTH	Other
REF	Committee Referral
SED	Sedation review
SUP	Unplanned return to surgery
SWP	Surgery on wrong patient / site
UNV	Unplanned Vitrectomy

ADDENDUM E. Competency Monitoring by Indicator and Source

ADDENDUM F. Focused Professional Practice Evaluation (FPPE) TRIGGERING THRESHOLDS

Clinical Practice and Conduct Concerns

- a. A practice trend defined by an individual practitioner's accumulation of three (3) or greater QRC 1 scores in a rolling 12 months
- b. A single case or event determined by a Department Chair, QRC, or EC to require a FPPE (QRC 2)

ADDENDUM G. Rate Based Reviews

The Premier Clinical Advisor Report Builder is utilized to provide rate based reviews. Reports are provided to the QRC every eight months, and are available more frequently upon request.

Premier Clinical Advisor Reports will not be acted upon until the data is validated as accurate and appropriately attributed to the responsible individual physician or practice group.

The QRC will define the routine rate based reports the Committee wishes to receive on a routine basis.