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PEN BAY HEALTHCARE
POLICY & PROCEDURE MANUAL

POLICY# 7182-018

TITLE: Medical Staff Peer Review **PAGE 1 of 7**

SECTION: Medical Staff	**APPROVED BY:**	**DATE:**
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REFERENCES/RATIONALE:		

PURPOSE: To ensure that the hospital, through the activities of its medical staff, assesses the ongoing professional evaluation (OPPE) of individuals granted clinical privileges and uses the results of such assessments, when necessary, to perform focused professional practice evaluation (FPPE) and improve patient care.

GOALS:

1. Monitor and evaluate the ongoing professional practice of individual practitioners with clinical privileges
2. Create a culture with a positive approach to peer review by recognizing physician excellence as well as identifying improvement opportunities
3. Perform focused professional practice evaluation when potential physician improvement opportunities are identified
4. Provide accurate and timely performance data for physician feedback, ongoing and focused professional practice evaluation and reappointment
5. Promote efficient use of physician and quality staff resources
6. Ensure that the process for peer review is clearly defined, fair, defensible, timely and useful.

DEFINITIONS:

1. **Peer Review –** "Peer Review" is the evaluation of an individual practitioner's professional performance and includes the identification of opportunities to improve care. 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 by a system.

Peer review is conducted using multiple sources of information including a) the review of individual cases, b) the review of aggregate data for compliance with general rules of the medical staff and clinical standards, and 3) use of rate measures in comparison with established benchmarks or norms.

2. **Physician Competency Framework** – 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 practice as defined by the six Joint Commission/ACGME general competencies described below:

   - **Patient Care:** Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and at the end of life.
   - **Medical Knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
   - **Practice-Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate and improve patient care.
   - **Interpersonal and Communication Skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families and other members of healthcare teams.
   - **Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession and society.
   - **Systems-Based Practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare.

   These competencies are further elaborated in the Medical Staff Statement of Ethics & Goals (Attachment A)

3. **Peer –** A "peer" is an individual practicing in the same profession and who has expertise in the appropriate subject matter. 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 (MD or DO) may review the care of another physician. For specialty-specific clinical issues, a peer is an individual who is well-trained and competent in that specialty area.

4. **Peer Review Body –** The peer review body designated to perform the initial review by the Medical Staff Executive Committee (MSEC) or its designee will determine the degree of subject matter expertise required for a provider to be considered a peer for all peer reviews performed by or on behalf of the hospital. The initial peer review will be conducted by the department Chair or designee.

5. **Ongoing Professional Practice Evaluation (OPPE) –** The routine monitoring and evaluation of current competency for current medical staff. These activities comprise the majority of the functions of the ongoing peer review process and the use of data for reappointment.

6. **Focused Professional Practice Evaluation (FPPE) –** The establishment of current competency for new medical staff members, new privileges, and/or concerns from OPPE. These activities comprise what is typically called proctoring or focused review depending on the nature of the circumstances.

7. **Conflict of Interest –** A member of the medical staff requested to perform peer review may have a conflict of interest if they may not be able to render an unbiased opinion.
    - An absolute conflict of interest would result if the physician is the provider under review.
    - Relative conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner or key referral source.

It is the obligation of the individual reviewer or committee member to disclose to the committee the potential conflict. It is the responsibility of the peer review body to determine on a case-by-case basis whether a relative conflict is substantial enough to prevent the individual from participating. When either an absolute or substantial relative conflict is determined to exist, the individual may not participate or be present during peer review body discussions or decisions other than to provide specific information requested as described in the Case Review Process (Attachment C).

POLICY:

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 on a routine basis.
3. The medical staff will use the provider-specific peer review results in making its recommendations to the hospital regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.

4. The hospital will keep provider-specific peer review and other quality information concerning a practitioner in a secure, locked file. Provider-specific peer review information consists of information related to:
    - Performance data for all dimensions of performance measured for that individual physician
    - The individual physician's role in sentinel events, significant incidents, or near misses
    - Correspondence to the physician regarding commendations, comments regarding practice performance, or corrective action.
5. Only the final determinations of the MSEC and any subsequent actions are considered part of an individual provider's quality file.
6. Peer review information in the individual provider quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a medical staff leader or hospital employee 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:
    - The specific provider
    - The president of the medical staff for purposes of considering corrective action
    - Medical staff department chairs (for members of their departments only) to conduct OPPE
    - Members of the medical executive committee, credentials committee and medical staff services professionals for purposes of considering reappointment or corrective action
    - Medical leaders and quality staff supporting the peer review process
    - Individuals surveying for accrediting bodies with appropriate jurisdiction (e.g., The Joint Commission or state/federal regulatory bodies)
    - Individuals with a legitimate purpose for access as determined by the hospital board of trustees
    - The hospital CEO when information is needed for the CEO's involvement in the process of immediate formal corrective action as defined by the medical staff bylaws.
7. No copies of peer review documents will be created and distributed unless authorized by medical staff or hospital policy.

PROCEDURE:

Circumstances Requiring Peer Review

Peer review is conducted on an ongoing basis and reported to the appropriate committee for review and action. The procedures for conducting peer review for an individual case and for aggregate performance measures are described in Attachments B and C.

In the event that a decision is made by the board of directors to investigate a practitioner's performance or that circumstances warrant the evaluation of one or more providers with privileges, the Peer Review committee shall perform the necessary peer review activities as described in the medical staff bylaws.

Circumstances Requiring External Peer Review

Either the MEC or the CMO can make determinations on the need for external peer review. No practitioner can require the hospital to obtain external peer review if it is not deemed appropriate by the CMO. Circumstances requiring external peer review include the following:

- Litigation: when dealing with the potential for a lawsuit.
- Ambiguity: when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly affect a practitioner's membership or privileges.
- Lack of internal expertise: when no one on the medical staff has adequate expertise in the specialty under review; or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as described above. External peer review will take place if this potential for conflict of interest cannot be appropriately resolved by the medical executive committee or governing board.
- Miscellaneous issues: when the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the medical executive committee or governing board may require external peer review in any circumstances deemed appropriate by either of these bodies.

Participants in the Review Process

Participants in the review process will be selected according to the medical staff policies and procedures. The work of all practitioners granted privileges will be reviewed through the peer review process. Clinical support staff will participate in the review process if deemed appropriate. Additional support staff will participate if such participation is included in their job responsibilities. The peer review body will consider the views of the person whose care is under review prior to making a final determination regarding the care provided by that individual to the PRC request for participation.

In the event of a conflict of interest of circumstances that would suggest a biased review beyond that described above, the PRC and/or the MEC will replace, appoint, or determine who will participate in the process so that bias does not interfere in the decision-making process.

Thresholds for FPPE

If the results of an OPPE indicate a potential issue with physician performance, the CMO or the PRC may initiate a FPPE to determine whether there is problem with current competency of the physician for either specific privileges or for more global dimensions of performance. These potential issues may be the result of individual case review or data from rule or rate indicators.

The thresholds for FPPE will be triggered by six or more quality related events in one calendar quarter, three or more Level III events in one calendar quarter, or any Level IV case review determinations. A FPPE report will be generated for a period of eighteen (18) months to include the quarter being reported and fifteen months prior. This report will include the frequency, type, and level of the events. (See Attachment D).

Individual Case Review

Peer review will be conducted by the medical staff in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed by the quality management staff and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability. The document used for determining results of individual case review is described in the MIDAS Peer Review Form (Attachment E).

Rate and Rule Indicator Data Evaluation

The evaluation of aggregate physician performance measures via either rate or rule indicators will be conducted on an ongoing basis by the MSEC or its designee.

Oversight and Reporting

Direct oversight of the peer review process is delegated by the MEC to the PRC. The responsibilities of the PRC related to peer review are described in the PRC Charter (Attachment B). The PRC will report to the board of directors through the MEC at least quarterly.

Statutory Authority

This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, et seq. and Maine State Law. All minutes, reports, recommendations, communications, and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities.

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Attachment List

Attachment A: Medical Staff Statement of Ethics and Goals

Attachment B: PRC Charter

Attachment C: Case Review Process

Attachment D: Quarterly Review Process

Attachment E: Peer Review Form

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