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| **Policy/Procedure Title** | Peer Review/Professional PracticeEvaluation | **Manual Location** | Hendrick Health Website |
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| **Revised/ Reviewed** | 07/2001, 01/2004, 06/2005,1/2008, 4/20092/20178/2017, 10/2018, 10/2023 |
| **Affected Departments** | **Hendrick Medical Center Brownwood Medical Staff** |
| **Approved By** | Krista Baty | ***Title*** | CAO |
| **Approved By** | Dan Stewart, M.D. | ***Title*** | Chief of Staff |
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# POLICY STATEMENT

All Medical Staff and Allied Health Staff members will be subject to review as part of the ongoing process of performance improvement. Performance improvement activities will include measurement, collection, and analysis of data, peer review, and improvement of performance on an individual and organization-wide basis.

# SCOPE

This policy applies to all licensed independent practitioners and allied health professionals who have delineated clinical privileges. This policy also applies to all licensed independent practitioners and mid-level practitioners (i.e. Nurse Practitioners, Physician Assistants) practicing in Hendrick Medical Center Brownwood.

# DEFINITIONS

Ongoing Professional Practice Evaluation: The ongoing process of data collection for the purpose of assessing a practitioner’s clinical competence and professional behavior. Information gathered during this process is factored into decisions to maintain, revise, or revoke an existing privilege(s) prior to or at the time of the two-year membership and privilege renewal cycle.

Focused Professional Practice Evaluation: The time limited evaluation of practitioner competence in performing a specific privilege. The process is consistently implemented as a means to verify clinical competence for all initially requested privileges, for a newly requested privilege, and whenever a question arises regarding a practitioner’s ability to provide safe, high- quality patient care. FPPE is not considered an investigation or corrective action as defined in the Medical Staff Bylaws and is not subject to the Bylaws provisions related to the corrective action process.

FPPE affects only the privileges for which a relevant concern has been raised and related privileges for which the same concern would apply. Other existing privileges in good standing should not be affected by the decision to initiate FPPE.

Peer Review: Peer Review is the process by which a practitioner, committee of practitioners, examines the work of a peer and determines whether the practitioner under review has met accepted standards of care in rendering medical services. The professional personal conduct of a physician or other healthcare professional may also be investigated. Individual Case Review,

**Reviews/Revisions: 1st 2nd 3rd 4th 5th**

Date: 10/28/2014 2/28/2017 10/04/2023

By: Medical Staff Services

Medical Staff Medical Staff Services Services

Ongoing Professional Practice Evaluation, and Focused Professional Practice Evaluation are components of peer review.

# PURPOSE

To assist in the improvement of quality patient care and professional staff education, the peer review process is a part of the hospital’s overall ongoing quality improvement activity. It will involve timely evaluation/review of competence of each practitioner’s patient care for the purpose of improving care, provider education and the renewing of delineated privileges.

# PEER REVIEW

1. **Desired Effect of Peer Review**
	1. **Usefulness –** Improvement in quality of patient care. The results of peer review activities will be considered in determining practitioner competence, clinical privileges and reappointment. Results will also be used to direct hospital-wide quality improvement initiatives as well as to provide educational feedback to individual physicians and facilitate changes in practice patterns when necessary.
	2. **Timeliness -** Peer review cases will be completed promptly, according to time frames outlined in this policy.
	3. **Collegiality –** All participants will strive to make peer review constructive and maintain professionalism throughout the process.
	4. **Defensibility –** Conclusions reached throughout the peer review process will be supported by a rationale that specifically addresses the issues for which the peer review was conducted, including, when appropriate, reference to current literature and relevant clinical practice guidelines.
	5. **Balance –** Minority opinions and views of the reviewee will be considered and recorded.
	6. **Consistency –** By adherence to the guidelines listed above, the peer review process will maintain consistency and freedom from bias.
	7. **Lessons Learned** – Ensure that each case is reviewed/ assessed for opportunities to learn and improve care for the individual involved and the staff as a whole. All adverse finding will be reviewed by the individual for the opportunity to help in this determination.

# Immunity and Confidentiality

All peer review documents are protected under federal and state laws addressing peer review. The documents are the sole property of the hospital and may not be released or reviewed for any purpose other than in formal committee or departmental settings. All Medical Staff performance improvement information will be kept confidential and secured in the Quality Department.

# Circumstances Requiring Peer Review

Cases for peer review are selected based on an initial screening performed by designees of the Medical Staff Departments. The designee performs the initial screening utilizing the pre-established Medical Staff Quality Indicators, which are reviewed and approved annually by the Medical Staff. Designees include but are not limited to RN Case Managers, Risk Manager, and Director of Pharmacy. This includes:

* Ongoing monitoring of blood and medication usage
* Ongoing monitoring of operative/invasive procedures/anesthesia and other procedures that place the patient at risk
* Hospital-wide interdisciplinary DRG monitoring
* Code Blue/Mortality/Autopsy review
* Quality Management (risk, safety, infection control, and restraint)
* Utilization Review (readmissions, avoidable days) issues
* Patient complaints regarding unprofessional behavior or possible deviation from standard of care
* Peer or hospital staff complaints regarding unprofessional behavior or possible deviation from standard of care. These will be made in writing.
* Ongoing monitoring of compliance with standards for medical record content and completion.
* Sentinel Events as outlined and defined in the hospital-wide QAPI plan (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient’s illness or underlying condition).

The rationale for pulling a given chart will be clearly documented.

# Peer Review Process

* 1. The Board of Trustees delegates the supervision of the Peer Review Process to the Medical Executive Committee, and maintains final authority in all Peer Review matters.
	2. The Medicine and Surgical Departments will be responsible, subject to the approval of the MEC, for ensuring peer review of all cases meeting criteria for peer review.

Department of Medicine

The Chief of Medicine appoints physician members to the Medicine Peer Review Committee and serves as Chair. The members will serve for one year unless appointed by the incoming Chief of Medicine to serve for a second year.

Department of Surgery

The Surgery Department identified 6 sections:

Anesthesiology,

ENT to include Ophthalmology, General Surgery to include Urology, Obstetrics/Gynecology, Orthopedics to include Podiatry, Pathology

The Surgery Department’s physician members to the Surgery Peer Review Committee will rotate by section annually so that all Department members are provided the opportunity to participate in the process. The Chief of Surgery, who is elected by the Department, will serve as the seventh member of the Surgery Peer Review Committee.

* 1. Peer review will be performed as follows:
		+ There will be monthly peer review meetings.
		+ Cases for review will be determined by predetermined criteria (see Section III). The predetermined criteria should be reviewed annually by the appropriate committees and referred to the MEC and Board of Trustees for approval.
		+ The Quality Department designee will distribute a listing of cases for review to the physician reviewers.
		+ All chart review will occur prior to the meeting and only those charts requiring discussion and/or further evaluation will be brought to the meeting.
		+ The committee may choose to review additional charts as needed to confirm trends or provide data for comparison. In some instances, the Department Chief or Chief of Staff may elect to appoint a separate peer review panel to review a complex case, such as a sentinel event, identification of a trend, or deviation from standards of care.

Final case rating will utilize the following categories:

**C1** Case reviewed by a registered nurse outside of committee with

**C1A** No identified opportunity for improvement

**C1B** Opportunity for systems improvement not related to physicians

**C2** Case reviewed by a physician outside of committee with no identified opportunity for improvement

**C3** Case review by the Peer Review Committee with no identified opportunity for improvement

**C4** Case reviewed by Peer Review Committee with identified process problems or opportunities for process improvement

**C4A** Opportunity identified for process improvement- facility **C4B** Opportunity identified for process improvement- practitioner **C4C** Opportunity identified to improve communication

**C4D** Opportunity identified to improve documentation

**C5** Case identified by Peer Review Committee with:

**C5A** Alternative method to provide clinical services

**C5B** Identified violation of medical staff policy

**C6** Case identified by Peer Review Committee with identified practitioner- specific clinical concerns:

**C6A** Without adverse clinical outcome

**C6B** With adverse clinical outcome

* 1. All completed peer review forms will be filed in the Quality Department. Results of Category 5 and 6 cases will be reported to the Medical Executive Committee. Peer Review results will be included with each reappointment performance improvement profile. Any profile with 2 (two) or more final categorizations of C5 or C6 in a 12-month period will trigger an FPPE.
	2. Problems identified with nursing, pharmacy, interdisciplinary communication, etc., will be referred to the appropriate committee or supervisor. A report will be made back to the peer review committee regarding the action taken.

# Time Frame for Conducting and Reporting Peer Review Results

The reviewing practitioner will be notified by letter of charts requiring their review. If the review is not completed within 30 days of notification, a reminder letter will be sent to the reviewing practitioner. The Medical Executive Committee will be notified if a practitioner fails to complete reviews within 30 days of reminder letter (which is 60 days from initial notification).

# External Peer Review

Cases may be referred for external peer review under the following circumstances:

* 1. When the Peer Committee and MEC determine that there is no member of the Medical Staff that can serve as a ‘peer’.
	2. When the Peer Committee and MEC determine that competitive interests or other associations lend to a degree of bias sufficient to contaminate or potentially contaminate the peer review process.
	3. For confirmation of findings that remain in dispute after local peer review.
	4. Upon request of the physician under review if either of the above criteria are met. Practitioners will be notified if any cases are referred for outside review.

# Participation in Review Process by Practitioner Being Reviewed

* 1. The Peer Review Committee may request additional case information from the practitioner. If initial categorization is a C6, the practitioner will be notified of the committee’s concerns and allowed to respond to the committee either in writing or in person. The comments of the practitioner shall be recorded in the minutes or included as an attachment to the minutes and shall be considered prior to final categorization of the case.
	2. The Department Chief may request that the practitioner whose case is being reviewed attend the meeting where the case will be reviewed. If this is done, the practitioner must attend the meeting.
	3. Practitioners will be notified in writing that C5 and C6 cases will be referred to the MEC. The MEC may elect to review the case and request the practitioner to be present at this process. If this is done, the practitioner must attend the meeting.
	4. Practitioners who are asked to appear or who happen to serve on the Peer Review Committee will be asked to leave the room during final discussion and categorization of their own cases.

# Education and Corrective Action

* 1. Determinations regarding the appropriate initial steps for education, etc. will be made by the Peer Committee. Wherever possible educational efforts will be extended to the Medical Staff as a whole and to the appropriate support personnel.
	2. Comparable deficiencies will be addressed as similarly as possible across specialties. Failure to comply with requirements and recommendation of the Peer Committee will be handled in a consistent manner.
	3. If the Peer Committee determines that the clinical deficiencies or policy violations are of significant magnitude, recurrent in nature, or associated with lack of insight and/or cooperation on the part of the practitioner, the Peer Committee will forward its findings and recommendations to the MEC for further action.

# Documentation

Results of peer review finding, discussion, conclusions, and any recommendations or actions will be recorded in the minutes of the appropriate committees. Cases and practitioners will be referred to by Case Identification Number and Physician Peer Review Identification Numbers, not by names.

# Administrative Assistance

* 1. The Quality Department Designee:
		+ Coordinates the Peer Review activity,
		+ Is responsible for collecting performance data from the above sources,
		+ Maintains the practitioner’s quality files.

If a case has a variance or deviation from standard of care the case will be referred to the appropriate department for peer review. The Quality Department Designee will complete a Case Rating Form and it will be delivered to the reviewing physician.

* 1. The Quality Department Designee:
		+ Prepares the minutes of the meeting for review by the committee,
		+ Notifies the appropriate hospital departments of any referrals,
		+ Prepares the draft committee letters for the chairperson’s consideration, and
		+ Prepares a quarterly report to the Board of Trustees, and
		+ Ensures that appropriate quality assurance data is considered during the credentialing process.

# ONGOING PROFESSIONAL PRACTICE EVALUATION

1. **Timeframe for Collection and Reporting**

OPPE will be initiated and reported on all providers with clinical privileges. Results of OPPE will be reported for review and/or action every three to six months if possible, and in no event less frequently than every nine months.

# Indicators for Review

* 1. The type of data to be collected and related thresholds, or triggers, is determined by individual medical staff committees/departments and approved by the Medical Staff. Indicators may change as deemed appropriate by the department and/or medical staff and should be reviewed and approved on an annual basis. Data collected should not be limited to negative/outlier trending data. Good performance data should also be considered, as outlined in the Peer Review Section, III in this policy.

# Oversight and Reporting

The organized Medical Staff delegates the collection of the selected performance indicators to the appropriate hospital department. The overall process, data compilation and reporting is coordinated by the Quality Department.

The review of performance data and any recommendation(s) for action, if necessary, may be the responsibility of one of the following:

* The Medical Executive Committee;
* The specific Medical Staff Department;
* The Chief of the Department;
* A standing or special committee of the medical staff

# Results and Reporting of Data Analysis

Data is analyzed and reported to determine whether to continue, limit, or revoke any existing privilege(s). The results of the individualized practitioner or APP report are referenced in the MEC meeting minutes, maintained in the quality file and incorporated into the two-year reappointment process.

The outcome of the evaluation must be documented and maintained in the practitioner or APP quality file.

During the course of OPPE, an FPPE may be triggered by the following special circumstances:

* A single egregious case or evidence of a practice trend
* Exceeding the predetermined thresholds established for OPPE
* Patient/staff complaints
* Non-compliance with Medical Staff Bylaws, Rules and Regulations
* Elevated infection, mortality and/or complication rates
* Failure to follow approved clinical practice guidelines
* Behavior that undermines a culture of safety

If unprofessional behavior or disruptive conduct is identified as a possible concern, the Behavior that Undermines a Culture of Safety Policy will be initiated as a component of the OPPE.

At the completion of the review period, the results of OPPE (the practitioner or APP profile report) will be communicated to the individual practitioner or AHP. The original report will be maintained in the practitioner or AHP quality file.

# FOCUSED PROFESSIONAL PRACTICE EVALUATION

1. **Initiation of FPPE**
	1. FPPE will be initiated in the following instances:
		1. Upon initial appointment;
		2. When a new privilege is requested by an existing practitioner;
		3. When a question arises through the OPPE process, individual case review, or other peer review process regarding a currently privileged practitioner’s ability to provide safe, high-quality patient care. For example, when a trigger is exceeded and preliminary review indicates a need for further evaluation.
	2. A recommendation of FPPE may be made by:
		1. The Credentials Committee;
		2. A Department of the Medical Staff;
		3. The Chief of the Department;
		4. A special committee of the medical staff;
		5. The MEC
	3. The FPPE monitoring plan for a new practitioner, or newly requested privilege(s) will be specific to the requested privileges or group of privileges.

FPPE is not considered an investigation as defined in the Medical Staff Bylaws and is not subject to the bylaws provisions related to investigations. If FPPE results in an action plan to perform an investigation, the process identified in the Medical Staff Bylaws would be followed.

# Timeframe for Collection and Reporting

* 1. The period of FPPE must be time-limited. Time-limited may be defined by;
		1. A specific period of time;
		2. A specific volume (number of procedures/admissions)
	2. The medical staff may take into account the practitioner’s previous experience in determining the approach, extent, and time frame of FPPE needed to confirm current competence. The practitioner’s experience may be individualized based upon one of the following experience/training examples:
		1. Recent graduate from a training program affiliated with the facility, where the requested privileges were part of the training program (competence data is available)
		2. Recent graduate from a training program at another facility, where the requested privileges were part of the training program (competence data is not available)
		3. A practitioner with regular experience exercising the requested privilege of fewer than two years on another medical staff
		4. A practitioner with regular experience exercising the requested privilege of more than five years at another medical staff
	3. FPPE shall begin with the applicant’s first admission(s) or performance of the newly requested privilege. FPPE should optimally be completed within three months, or a suitable period based upon volume. The period of FPPE may be extended as necessary at the discretion of the medical staff but may not extend beyond the first biennial reappointment.

# Methods for Conducting FPPE/Communication to the Practitioner

* 1. FPPE may be accomplished by:
		1. Chart reviews, both concurrent and/or retrospective
		2. Simulation
		3. Discussion with the involved practitioner and/or other individuals involved in the

care of the practitioner’s patients

* + 1. Direct observation/proctoring
		2. For dependent’s, FPPE methods may include review or proctoring by the sponsoring physician.
		3. Internal or external peer review.
	1. The terms of all FPPE shall be communicated in writing to the affected practitioner, or including the following:
		1. The cause for the focused monitoring
		2. The anticipated duration
		3. The specific mechanism by which monitoring will occur (i.e. chart reviews, proctoring, peer observation, etc.)

# Performance Monitoring Criteria and Triggers

* 1. Monitoring criteria, including specific performance elements to be monitored, as well as thresholds or triggers, are developed and approved by the medical staff or medical staff department/committee. The triggers are defined as potentially unacceptable levels of performance. Triggers to consider include, but are not limited to:
* A single egregious case or evidence of a practice trend
* Exceeding the predetermined thresholds established for OPPE
* Patient/staff complaints
* Non-compliance with Medical Staff Bylaws, Rules and Regulations
* Elevated infection, mortality and/or complication rates
* Failure to follow approved clinical practice guidelines
* Behavior that undermines a culture of safety
	1. If the results for a practitioner exceed thresholds established by the Medical Staff, outliers may be forwarded for peer review after initial screening by the Quality Department.

# Conclusion of FPPE

At the conclusion of the initial FPPE, findings will be reviewed by the Medical Executive Committee or responsible Department, for decision and recommendation. Decisions may include moving forward with OPPE, extending the period of FPPE, development of a performance improvement plan, or recommending to limit or suspend the privilege. Such recommendations are reported to and approved by the Medical Executive Committee and Board of Trustees. For recommendations resulting in restriction, suspension, revocation of specific privileges or other limitation on privileges, the processes pursuant to the Medical Staff Bylaws Appendix A (Fair Hearing Plan) will apply.

Each practitioner will be notified of their performance and outcome(s) following FPPE. A letter is forwarded to the Medical Staff member including, but not limited to, the following:

1. Findings and outcome of FPPE
2. Specific actions, if any, that need to be taken by the practitioner to address any quality concerns and the method for follow-up to ensure that the concerns have

been addressed

1. If the focused review is complete or will continue (duration will be specific if the focused review will continue)
2. The period of initial FPPE is completed and the practitioner will move into OPPE
3. The period of FPPE for a specific privilege is completed and the practitioner will continue with OPPE
4. At the end of the period of focused evaluation, in the event that the practitioner’s activity/volume has not been sufficient to meet the requirements of FPPE:
	1. The practitioner may voluntarily resign the relevant privilege(s), or
	2. The practitioner may submit a written request for an extension of the period of focused evaluation,
	3. If the practitioner has sufficient volume of the privileges in question at another local facility, external peer references specific to the privilege/procedure may be obtained.
	4. FPPE may be extended at the discretion of the responsible medical staff department or committee.

The practitioner is not entitled to a hearing or other procedural rights for any privilege that is voluntarily relinquished.

Results of FPPE are maintained in the Practitioner Confidential Quality File.

# Performance Improvement Plan

If FPPE outcomes identify the need for an improvement plan, the plan will be drafted by the responsible medical staff department, committee or chair. The written improvement plan and supporting FPPE outcomes should be presented to the Medical Executive Committee for approval. The involved Practitioner should also be offered the opportunity to address the MEC and respond to the findings before the improvement plan is finalized and implemented.

Methods identified to resolve performance issues shall be clearly defined. Examples of improvement methods may include:

* Necessary education
* Proctoring and/or mentoring
* Counseling
* Practitioner Assistance Program
* Suspension or revocation of privilege, subject to the provisions of the Bylaws.

Following approval by the Medical Executive Committee (MEC), the Department or Committee Chair, or Chief of Staff will meet with the Practitioner to communicate the improvement plan. If the Practitioner agrees with the plan, the written document should be signed by the Practitioner and forwarded to the Quality Department. If the Practitioner does not agree with the plan and/or refuses to implement the improvement plan, the outcome will be reported to the responsible department chief and/or Medical Executive Committee for resolution.

# RESPONSIBILITIES OF THE QUALITY DEPARTMENT

* 1. The Quality Department will be responsible for compiling and reporting results of FPPE and OPPE to the Medical Staff Committee(s) every three, six, or at a maximum, every nine months. A practitioner or APP-specific profile will be utilized.
	2. In order to facilitate FPPE for Advanced Practice Provider, and/or those practitioners requesting a new privilege, the practitioner or APP must notify the Quality Department of the first scheduled procedure or encounter. The practitioner or AHP must also provide the Quality Department with a patient listing or log until the specified patient volume or FPPE requirement is met.
	3. The OPPE practitioner or APP -specific profile that illustrates performance over the two-year reappointment cycle will be utilized at the time of reappointment.

4 The Quality Department will be responsible for working with each Medical Staff Committee on an annual basis to review the continued relevance of the selected indicators and triggers.

Peer Review Form:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Patient:** |  | **Encounter#** | **MR#** | **DOS:** | **PCP:** |
| **Reason for Referral**: |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Referred to Physician Reviewer: |  |  |  |  |  |
| Case Summary/Key Issues for Di | scussion: |  |  |  |  |

|  |
| --- |
| **Please place a**  **to indicate classification of C2 or referral to peer committee:** |
|  **C2** |  | Case evaluated by physician reviewer with no identified opportunity for improvement. |
|   | Refer to Committee | Preliminary Rating:  |
| Physician Reviewer: |  Date:  |
|  |  | **\*\*All pertaining to the review, conclusions, and outcome will be attached to this form\*\*** |
|  |  | **Final classification categories listed below will be assigned by the Peer Review Committee** |
| **Case Review by Peer Review Committee with …** |
|  **C3** | No identified opportunity for improvement. |
|  **C4** | Review Committee with identified process problems or opportunities for process improvement: |
| **C4A** Opportunity identified for process improvement- facility |
| **C4B** Opportunity identified for process improvement- practitioner |
| **C4C** Opportunity identified to improve communication |
| **C4D** Opportunity identified to improve documentation |
|  **C5** | Case identified by Peer Review Committee with: |
| **C5A** Alternative method to provide clinical services |
| **C5B** Identified violation of medical staff policy |
|  | Identified physician/ practitioner-specific clinical concerns without adverse clinical outcome. |
|  **C6A** |  |
|  | Identified physician/ practitioner-specific clinical concerns with adverse clinical outcome. |
|  **C6B** |  |