

Medical Staff Peer Review Policy / To provide a mechanism that enables the hospital, through the activities of the medical staff, to assess the ongoing professional performance and competence of the medical staff.

Template: Policy
Version: 4 (08/19/2010)
Expiration Date: 02/28/2011
Approvers:
Administrators:
Editors:
Viewers: Phoenix Children's Hospital↔; Internal↔;
Folders: Medical Staff; Medical Staff;

POLICY OWNER:	Medical Staff/Cindy Corsbie
Policy Expiration Date:	02/15/2013
Scope:	Department Specific
If departmental, which:	Medical Staff
Effective Date:	02/15/2010
Dates Revised:	3/13/01, 10/01/04; 02/05, 9/05, 11/05, 01/06, 6/06, 1/06, 12/07, 2/10
Reviewed By:	Speciality Committee / Speciality Chair

Body:

For Internal Use Only

Phoenix Children's Hospital

Scope: Department

Medical Staff Policy

MEDICAL STAFF PEER REVIEW POLICY

Effective Date: February 15, 2010

REASON FOR POLICY

1. To provide a mechanism that enables the medical staff and the Hospital Board of Directors, to assess the professional performance and competence of privileged by the medical staff. This may include conducting professional practice evaluations and using the results of such assessments and evaluations to improve professional competence, practice and patient care.

GOALS

1. To monitor the clinical performance of privileged providers.
2. To monitor trends in performance by analyzing aggregate data and case findings, utilizing comparative data when available.
3. To identify any existing opportunities for practice and performance improvement of individual practitioners, provide feedback, and develop plans for improvement/correction to improve the quality of care provided by the practitioner(s).
4. To assure that the processes for Focused Professional Practice Evaluations (FPPE) are clearly defined, objective, equitable, timely and appropriate.

DEFINITION(S)

1. **Data**

Data means any measurements related to clinical processes, outcomes or steps in the performance of a clinical process.

2. **Events**

An event means an undesirable or unexpected occurrence or behavior identified by PCH or the Medical Staff organization. Information regarding an event may be aggregated and considered data.

3. **Focused Professional Practice Evaluation (FPPE)**

Process used to assess current competency of privileged providers, and competency for newly requested or granted privileges. This process may also be used to investigate concerns arising from Ongoing Professional Performance Evaluations.

4. **Privileged Provider**

The term "Privileged Provider" shall include Physicians and Allied Health Practitioners who are credentialed for independent practice by the Medical Staff. The clinical care and behavior of Allied Health Practitioners credentialed by the Medical Staff shall be evaluated pursuant to this Policy.

5. **Ongoing Professional Practice Evaluation (OPPE)**

A mechanism whereby the medical staff can identify professional practice trends that affect quality of care and patient safety on an ongoing basis. The ongoing process continually evaluates individual practitioners for performance and competence-related issues using multiple sources of information.

6. **Peer**

A peer is defined as a practitioner who has similar expertise in the appropriate specialty area.

7. **Peer Review Committee (PRC)**

The Peer Review Committee is designated to provide oversight of the overall peer review process, that includes the OPPE and the FPPE processes,, The PRC is also responsible for providing oversight of case rating assignments for consistency across Sections, Departments and Committees. Any and all deliberations discussed and conducted at the Peer Review Committee are protected by ARS. Section 36-441 and 36-445.

POLICY STATEMENT(S)

1. **PEER REVIEW/ OPPE**

- A. The OPPE is a continuous process. The Medical Executive Committee (MEC) shall establish reporting requirements for each Section/Department. The report shall include ongoing professional practice evaluation for each member of the Section/Department.
- B. The data used in the OPPE may include the following:
 - i. Aggregate data on hospital rule based indicators for individual practitioners, using comparative data when available.
 - ii. Aggregate data on rate based indicators for individual practitioners, selected by and/or agreed upon by the specialty section using comparative data when available;
 - iii. Data collected and assessed through the hospital quality improvement indicators which may include, but are not limited to:
 - a. Review of operative and other clinical procedure(s) performed and their outcomes.
 - b. Patterns of Blood and Pharmaceutical usage
 - c. Length of stay patterns
 - d. Morbidity and mortality data
 - e. Practitioner's use of consultants
 - f. Department specific process audits or clinical guidelines audits.
 - g. Compliance with hospital and medical staff rules and policies
- C. OPPE data will be evaluated by the PRC on a regular basis. When statistically significant data suggests that a privileged provider's performance deviates from his/her colleagues, by a magnitude of one standard deviation in an unfavorable direction, the PRC may recommend further evaluation by means of an FPPE to the MEC.
- D. Additional evaluations will be conducted when any of the following occurs:
 - i. Sentinel event or near miss with potential for major or permanent injury that occurred as a result of the practitioner's practice and/or performance.
 - ii. An unusual adverse individual case or clinical pattern of care including substantiated staff concerns related to a practitioner's clinical skill and performance.
 - iii. Significant trends or events identified based on review of aggregate data or individual case review.

- iv. Any event that has the potential for, or results in an untoward patient outcome or that involves clinical practice that may lie outside acceptable standards directly related to practitioner-specific issues. This includes events reported by individuals having knowledge of them and reports originating from patient/family complaints.
- v. Occurrence reports that identify a pattern of practice or behavior that is outside of acceptable standards.
- vi. Behavior concerns related to disruptive or unprofessional behavior including sexual harassment. (Refer to the Board Resolution regarding Conduct within the Hospital).

2. **GENERAL PROCEDURES**

A. **Individual Case Peer Review:**

- i. If concerns are identified by any committee, team or staff member in the organization regarding clinical performance or behavior of a privileged providers that concern will be forwarded to the appropriate Department Chair, the President of the Medical Staff, and the Chief Medical Officer (CMO). If an objective peer review trigger, approved by the section or department, has been identified, then this shall also be referred to the appropriate Department Chair, the President of the Medical Staff, and the CMO. If the concern involves the President of the Medical Staff, that concern will be forwarded to the Vice President of the Medical Staff as well as to the President's Section chair and CMO.
 - a. The Chair of the Department will, if appropriate, request that the head of the appropriate Section or Sections perform the initial review.
 - b. The Section(s) and /or Department may utilize the case as the basis of a Morbidity and Mortality (M&M) conference, which will be protected by ARS. Section 36-441 and 36-445.
 - c. After individual review or M&M, the Section Head will submit an assessment as to whether *care was appropriate* or there was an *opportunity for improvement*
 - d. All instances where it is determined that the provider had an *opportunity for improvement* will be referred on to the Peer Review Committee.

B. **Department-level Committee Review:** [If a department chooses to perform department-level review]

- i. Any individual review where it was determined that the provider has an *opportunity for improvement* shall be referred to the respective Department committee for review and action. Any issues identified as systems or process issues or nursing related issues will be referred to Quality Management, the Quality Council or, Nursing Administration as appropriate.
 - a. The practitioner involved in the event shall be invited to the meeting where the case will be presented.
 - b. Adequate notice shall be at least two weeks prior to the case review at the Departmental level.
 - c. The Chair of the Section/Department may contact the practitioner to discuss the case prior to the meeting if deemed necessary.

- d. The practitioner has the right to review the chart prior to the committee meeting and be advised of the specific concerns being addressed.
 - e. The practitioner has the right to attend the meeting in person or address the concerns via written correspondence.
 - f. Under special circumstances, practitioners who are unable to attend the meeting in person due to practice location may ask for permission to participate in the peer review process via conference call. The practitioner must agree to maintain peer review confidentiality statute AZ 36-445.01 and a member of the Medical Staff must agree in advance to attest to the identity of the individual who is participating via conference call.
- C. Peer Review Committee:**
- i. The PRC will review all cases in which it was determined at earlier steps of the Peer Review process that the Provider has an opportunity for improvement. The Committee may opt to invite the involved practitioner for another review of the case. If the Committee agrees with the prior reviews, the data will be tracked and trended (E below). The Committee may determine that the care was appropriate. In either case, the chair of the Committee will communicate with the provider to inform him or her of the outcome of the deliberations.
 - a. If a provider wishes to appeal the decision of the Committee, he or she may request to appear at a subsequent Committee meeting to present his/her basis for appeal. If the provider does not agree with the decisions of the Committee at that point, he or she may then follow the Fair Hearing/Grievance processes as they apply to the Medical Staff and the Allied Health Staff.
 - b. The PRC shall review the files on providers who have accumulated 3 or more “opportunity for improvement” assessments within a 2-year period.
 - c. An FPPE may be triggered by an isolated event or by an accumulation of “opportunity for improvement” assessments.
- D. Time frame:**
- i. Routine professional performance evaluation/peer review are generally initiated and completed at the departmental level within forty-five (45) business days of receipt of notification of the event by the Quality Office. Peer Review Committee shall have an additional 45 days to complete its review (90 days from receipt by the Quality Office).
- E. Tracking/Trending:**
- i. After receiving the report from the section/department, the PRC may evaluate the quality information submitted for review and determine that no action is indicated or that action is indicated. If action is indicated, the report and recommendation will be forwarded to the MEC. Even if no specific action is taken by the Peer Review Committee, if the Committee agrees that the provider has an *opportunity for improvement*, it will be tracked in the quality database.
- F. FPPE:**

- i. When the Peer Review Committee has recommended that an FPPE be initiated, the processes related to an FPPE shall proceed as per Section 3.

G. Reappointments:

- i. As per 2.C.b above, three months prior to reappointment the provider's profile will be reviewed. If a provider has more than 3 events over a two-year period in which it was determined that there was an "opportunity for improvement," the profile will be reviewed by PRC Chair, who will present the profile to the PRC. The PRC may make recommendations about the continuation of privileges to the Department Chair, the Credentials Committee and MEC.

3. FOCUSED PROFESSIONAL PERFORMANCE EVALUATION

A. CRITERIA:

- i. The Medical Executive Committee is ultimately responsible for evaluating reports regarding any Practitioner's conduct, performance or competence. When reliable information indicates a Practitioner may have displayed acts, demeanor, or conduct which may be:
 - a. Detrimental to patient safety or to the delivery of quality patient care within the hospital,
 - b. Unethical,
 - c. Contrary to the Medical Staff Bylaws, Rules and Regulations,
 - d. Below applicable professional standards,
- ii. The MEC may direct that certain actions be taken or recommendations be made. It is expected that said reliable information will most often be received by MEC from the Peer Review Committee. Such actions or recommendations shall be made in the reasonable belief that the action or recommendation is warranted by the facts and is in furtherance of quality health care. These actions or accommodations will only be made after a reasonable effort to obtain the facts of the matter, including soliciting relevant information from the practitioner and other involved parties.

B. MEC EVALUATION

- i. A request for an investigation or corrective action and any report referenced in 3.A above must be submitted to the MEC, in writing, supported by reference to specific activities or conduct.
 - a. If, based on the evaluation of the information received, the MEC decides no investigation or corrective action, as defined in the Medical Staff Bylaws is necessary, the President of the Medical Staff shall so inform the Section/Department Chair who initiated the request and the practitioner in writing.
 - b. The MEC may request the Peer Review Committee, a Department or a Section to initiate a FPPE in order to determine whether any basis exists to request corrective action or initiate an investigation. A FOCUSED REVIEW SHALL NOT BE CONSTRUED AS NOR SHALL IT CONSTITUTE AN INVESTIGATION.
 - c. Focused review will be used only in circumstances where questions

have been raised about a practitioner's performance, in the judgment of the Peer Review Committee or MEC.

1. Once it has been decided to implement a focused review, a "Focused Review Committee" shall be formed consisting of three members of the practitioner's department who will be selected by the Chair of the practitioner's Department, the Chair of the PRC and the President of the Medical Staff. At least one of the three physicians must be a member of the practitioner's section and have similar clinical privileges as the practitioner and, if necessary, one or more external reviewers may participate in the focused review.
2. MEC or the PRC may direct that the focused review be conducted in whole or in part, by one or more external reviewers in circumstances where there are few specialists on staff with sufficient knowledge of the area being reviewed or when other circumstances exist such that, in the judgment of the MEC or the Peer Review Committee, the assistance of an external reviewer would be advantageous to the focused review process. The external reviewer shall be board certified in the sub-specialty of the practitioner under review.
3. The Chair of the Peer Review Committee shall notify the Practitioner that a focused review will be conducted. The Practitioner shall have the right to participate in the review process. The "Focused Review Committee" performing the focused review shall determine the level of Practitioner participation, i.e. written, through personal meetings, or any other form appropriate to the circumstances.
4. The focused review shall be completed within 45 days of the appointment of the "Focused Review Committee". That time may be extended for good cause by the chair of the Peer Review Committee upon the request of the "Focused Review Committee". If an extension is necessary, the Chair of the Peer Review Committee will notify the president of the medical staff in writing.
5. Focused review requires the cooperation of the Practitioner. When the "Focused Review Committee" finds the practitioner uncooperative, it may report back to the Peer Review Committee and request termination of the focused review. In these circumstances, the Peer Review Committee shall notify the MEC which shall determine whether to initiate an investigation, which may lead to corrective action.
6. Upon concluding the focused review, the "Focused Review Committee" shall make a written report to the Peer Review Committee and to the practitioner with recommendations that may include, but not limited to, a recommendation for no further monitoring, a recommendation for continued monitoring, periodic meetings with a clinical section or department chief, referral to the Professional Health Committee, where applicable, or that the MEC proceed with a formal investigation and consider corrective action. The Practitioner, may, within five business days of receiving a copy of the recommendations, provide his or her input to the MEC for its consideration.

7. A case summary including all peer review and committee comments and ratings is entered into the involved practitioner's quality profile and is incorporated into the Medical Staff reappointment process.

4. **GENERAL PRINCIPLES REGARDING PEER REVIEW**

- A. When the case involves subspecialty specific practice, the review of cases will be conducted by physicians who have appropriate expertise in the specialty and subject matter involved. Physicians who have direct involvement in the case under review may not participate as reviewers.
- B. The appointed membership of the Medical Staff Departments and Sections serve as the peer review panel that, in executive session, either conducts the initial review or provides oversight of the review performed outside of the meeting.
- C. Nursing and ancillary staff may participate in the review of events related to care and services provided by their respective discipline. Nursing and ancillary personnel may be present for any case discussion at the discretion of the PRC Chair and/or Committee.
- D. Results of the OPPE will be forwarded to the Section/Department Chairs and to the MEC on a regular basis to review the findings.
- E. OPPE information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s) or to revoke an existing privilege prior to or at the time of reappointment.
- F. Detailed documentation of all communications related to the proceedings with the involved practitioner(s) must be filed with the case summary in the Quality Management Office.

5. **CONFIDENTIALITY**

- A. The Hospital Board of Directors has delegated to the Medical Staff the authority to ensure that high quality medical care is maintained in accordance with the Medical Staff Bylaws, and the Medical Staff Fair Hearing and Grievance processes. Reports of case reviews, records, documents, and committee minutes are maintained as confidential and are subject to the protection under Arizona Statutes Section 36-441 and 36-445 et seq.
- B. Confidential minutes, reports and discussions held in executive session meetings are kept on file in a designated and secured place in the medical staff and quality management offices and are not stored with other health care records that are not covered by the state peer review laws. Copies are not distributed unless authorized by the chairperson of the respective committee or the President of the Medical Staff. The minutes are available for review in the medical staff office by any committee member, officer of the medical staff, or designated administrative representative. Cases should not be discussed outside of the peer review process.
- C. Except for required reports and action items, the confidential business, documents, and confidential discussions of the committee meetings may not be communicated in any way to individuals not serving on the committee without prior authorization from the chairperson or the President of the Medical Staff.
- D. The President of the Medical Staff or Chief Medical Officer or designee, may

review the results of any case or peer review activity, or any individual practitioner file. The Department Chairpersons and Section Chiefs may review any activity within their respective Departments or Sections. Individual practitioners may review their own information in accordance with established Medical Staff Policy and Procedure.

PHOENIX CHILDRENS HOSPITAL

PEER REVIEW RATINGS

Effective: January 2010

PHYSICIAN SCORE: Overall Physician Care	
Rating	Defined
A	Physician Care Acceptable
B	Opportunity for Improvement
R1	Resident expected to provide care appropriate for their level of training.
R2	Resident's level of training would not have prepared them adequately.

ISSUE IDENTIFICATION: Physician Related	
Rating	Definition
1	Issue with physician's diagnosis
2	Issue with physician's judgment
3	Issue with physician's technique and skill
4	Issue with physician's policy compliance
5	Issue with supervision of house staff or Allied Health Professionals
6	Issue with documentation

FINAL OUTCOME OF HOSPITALIZATION	
Rating	Definition
1	No adverse outcome
2	Short term sequela
3	Long term sequela
4	Death

Policy Information/History:	
Manual:	<i>MEDICAL STAFF</i>

Dates Created/Reviewed/Revised:	<i>3/13/01, 10/01/04; 02/05, 9/05, 11/05, 01/06, 6/06, 1/06, 11/06, 01/08, 12/09, 2/10</i>
Policy Owner:	<i>Cindy Corsbie Director of Medical Staff</i>

Overall Outline of Peer Review Process

1. Issues identified via OPPE or reported event.
2. Issue reported to Dept Chair, President Medical Staff, and CMO
3. Dept Chair has section chair or appropriate designee perform initial review. Event may serve as basis for M&M. – Practitioner is rated: care appropriate or opportunity for improvement
4. Department Chair reviews. If Dept performs peer review, case will be presented at Department Committee meeting. Department Committee rates practitioner. If not Departmental review, case will be sent on to PRC.
5. Chair of PRC reviews all ratings. All “opportunities for improvement” ratings will be reviewed by PRC
6. Trends, 1 standard deviation above the rest of section or more “opportunities for improvement,” or significant lapses will be the basis for PRC to recommend FPPE to MEC
7. MEC acts on recommendations from PRC.
8. If investigation necessary, investigation will be managed by MEC