

Policy: Medical Staff

MEDICAL STAFF PEER REVIEW POLICY

Effective Date: March, 2001, Revised: January, 2008

I. PURPOSE

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. This may include conducting professional practice evaluations and using the results of such assessments and evaluations to improve professional competence, practice and patient care. This policy is subject to and consistent with the Medical Staff Bylaws to the extent that if there are inconsistencies between this policy and the Medical Staff Bylaws, the Medical Staff Bylaws shall prevail.

II. GOALS

- A. To monitor the clinical performance of all Medical Staff members including Allied Health practitioners to ensure that appropriate care is being provided.
- B. Monitor trends in performance by analyzing aggregate data and case findings. Utilizing comparative data when available.
- C. When opportunities for practice and performance improvement of individual practitioners are identified, provide feedback and develop plans for improvement/correction to improve the quality of care provided by the practitioner(s).
- D. Assure that the process for Focused Professional Practice Evaluation (FPPE) is clearly defined, objective, equitable, timely and appropriate.

III. DEFINITIONS

- A. Data
Data means any measurements related to clinical processes, outcomes or steps in the performance of a clinical process.
- B. 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 as noted in III A above.
- C. Focused Professional Practice Evaluation (FPPE):
Assesses current competency of medical staff members, new privileges and/or concerns from Ongoing Professional Performance Evaluation.
 - 1. The proctoring program is a component of FPPE (see the Medical Staff Proctoring Policy)
 - 2. FPPE is used when questions arise regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

- D. **Medical Staff Member**
For purposes of this Policy only, the term “Medical Staff Member” shall include Physicians and Allied Health Practitioners who are credentialed 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.
- E. **Ongoing Practice Evaluation**
Ongoing professional practice evaluation provides a mechanism for the medical staff to identify professional practice trends that impact 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 including internal data and studies, aggregate, comparable data and clinical standards as well as the use of rates compared against internal and/or external benchmarks. This process provides practitioners with feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical and interpersonal skills in providing patient care.
- E. **Peer**
A peer is defined as a practitioner who meets the requirements for medical staff membership who has similar expertise in the appropriate specialty area. .
- F. **Peer Review Committee**
The Peer Review Committee is designated to provide oversight of the overall peer review process including the Ongoing Professional Performance Evaluation and the Focused Professional Performance Evaluation process including 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.

IV. PEER REVIEW/ON-GOING PROFESSIONAL PRACTICE EVALUATION

- A. The ongoing professional practice evaluation is a continuous process. The Medical Executive Committee 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 criteria used in the ongoing professional practice evaluation may include the following:
 - 1. Aggregate data on rule based indicators for individual practitioners, using comparative data when available;
 - 2. Aggregate data on rate based indicators for individual practitioners using comparative data when available;
 - 3. Data collected and assessed through the hospital quality improvement indicators which may include:
 - 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. Practitioners use of consultants
 - f. Department specific process audits or clinical guidelines audits.
 - g. Compliance with hospital and medical staff rules and policies
- C. Additional evaluations will be conducted when any of the following occurs:
1. Sentinel event or near miss with potential for major or permanent injury that occurred as a result of the practitioners practice and/or performance.
 - a. Sentinel event information dealing with practitioner-specific issues.
 2. An unusual adverse, individual case or clinical pattern of care including substantiated staff concerns related to a practitioner's clinical skill and performance.
 3. Significant trends or events identified based on review of aggregate data or individual case review.
 4. 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.
 5. Occurrence reports that identify a pattern of practice or behavior that is outside of acceptable standards.
 6. Behavior concerns related to disruptive or unprofessional behavior including sexual harassment. (Refer to the Board Resolution regarding Conduct within the Hospital).
 7. Possible failure of a Medical Staff member to follow Medical Staff Bylaws, Rules and Regulations or Medical Staff or Hospital Policies.

D. GENERAL PROCEDURES

1. If concerns are identified by any committee, team or staff member in the organization regarding clinical performance or behavior of a Medical Staff member, that concern will be forwarded to the appropriate Section/Department Chair and Chief Medical Officer (CMO). If the concern involves a Department Chair, that concern will be forwarded to the President of the Medical Staff in addition to the Chair's Section chair and 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.
2. The Chair of the Department/Section and/or their designee shall perform the initial review. The results of the following principals of data collection may be considered if available.
 - a. Data aggregation and assessment;
 - b. Data stratification;
 - c. Use of statistical process control; and/or
 - d. Use of the organizational PDCA (plan, do, check, act) performance improvement model.

Any case reviews where ratings may lead to further action such as a "Overall Physician Care of a **"B" (Opportunity for Improvement)** or **"D" (Deviation from Standard of Care)** shall be referred to the respective Department/Section committee for review and action. Any issues identified as a system or process issue or nursing related are referred to Quality Management , the Quality Council or, Nursing Administration as

appropriate.

3. The practitioner involved in the event shall be notified and invited, with adequate notice, to the meeting where the case will be presented.
 - a. Adequate notice shall be at least one week prior to the case review at the Section level.
 - b. If the section did not review the case, notice shall be prior to the Departmental review.
 - c. The Chair of the Section/Department may contact the practitioner to discuss the case prior to the meeting if the chair feels it necessary.
 - d. The practitioner has the right to review the chart and be advised of the specific concerns being addressed prior to the committee meeting.
 - 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.
4. Routine professional performance evaluation/peer review is generally initiated and completed within forty-five (45) business days of notification of the event.
6. The results of the individual case reviews for a practitioner that exceeds thresholds established by the Medical Staff, shall be reviewed by the Section/Department to determine if a focused review is needed to identify a potential pattern of care. If a focused review is felt to be indicated, the MEC will be notified prior to any action as outlined in Section V.
7. After receiving the report from the section/department, the Peer Review Committee 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. Such actions, as included in the attached rating system, will be entered into the Midas tracking and trending database.
8. The attached rating system is used during the initial case review. Both practitioner conduct and outcome must be considered when a rating is assigned.
9. When a Focused Review is initiated, the following events related to a Focused Professional Performance Evaluation shall occur as noted in Section V below.

V. FOCUSED PROFESSIONAL PERFORMANCE EVALUATION

- A. **CRITERIA:**

The Medical Executive Committee is responsible for evaluation reports regarding any Practitioner's conduct, performance or competence. When reliable information indicates a Practitioner may have exhibited acts, demeanor, or conduct which may be:

 - 1) Detrimental to patient safety or to the delivery of quality patient care within the hospital,
 - 2) unethical,
 - 3) contrary to the Medical Staff Bylaws, Rules and Regulations,
 - and 4) below applicable professional standards,the MEC may direct that certain

actions be taken or recommendations be made. Such actions or recommendations shall be made:

1. In the reasonable belief that the action or recommendation is warranted by the facts and is in furtherance of quality health care;
2. 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

A request for an investigation or corrective action and any report referenced in "A" above must be submitted to the MEC, in writing, supported by reference to specific activities or conduct.

1. If the MEC decides no investigation or corrective action, as defined in the Medical Staff Bylaws, Article VI, based on the evaluation of the information received, is necessary, the President of the Medical Staff shall so inform the Section/Department Chair who initiated the request and the practitioner in writing.
2. The MEC may request the Peer Review Committee to initiate a focused review of the practitioner's performance in order to determine whether any basis exists to request corrective action or initiate an investigation. **FOCUSED REVIEW SHALL NOT BE CONSTRUED OR CONSTITUTE AN INVESTIGATION.**
3. 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.
 - a. 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 and the President of the Medical Staff to perform the review. 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 to conduct the focused review.
 - b. The Peer Review Committee 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 other circumstances exist such that, in the judgment of 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.
 - c. The Chair of the Peer Review Committee shall notify the Practitioner that a focused review will be conducted of his or her performance. 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.
 - d. 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".
- e. 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.
 - f. Upon concluding the focused review, the "Focused Review Committee" shall make a written report to the Peer Review Committee and the practitioner with recommendations which may include, but are not limited to, 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 days of receiving a copy of the recommendations, provide his or her input to the MEC for its consideration.
 - h. 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.

VII. GENERAL PRINCIPALS REGARDING PEER REVIEW

- A. The review of cases will be conducted by physicians who have 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 in 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 Chair and Committee.
- D. Results of the on-going professional performance review will be forwarded to the Peer Review Committee and the MEC on a quarterly basis to review the findings of the ongoing professional practice evaluation.
- E. Ongoing professional practice evaluation 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.
- G. When conducting a peer review, the Committee members should consider the principals of the Joint Commission related to properly designed and effectively functions peer review processes. These Principals include but are not limited to:

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1. Assuring that the individual whose performance is being reviewed is allowed to participate in the peer review process.
2. Utilizing objective data, objective standards, reference literature and relevant clinical practice guidelines in the peer review process whenever possible.
3. Considering and recording minority opinions and the views of the reviewed.

VIII. CONFIDENTIALITY

- A. The 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. Open, honest communication is essential to this goal. To encourage and protect all communications and activities related to peer review, 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 not covered by the state peer review laws. Copies are not distributed unless authorized by the chairperson of the respective committee or the Chief of 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.
- E. The President of the Medical Staff or Chief Medical Officer or designee shall review the results of any case that needs additional direction or intervention, as well as trends in peer review activity which falls outside the standard of care. The Department Chairpersons and Section Chiefs (if applicable) shall review activity within their respective Departments or Sections, which may fall outside the standard circumstances requiring Peer Review.

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PHOENIX CHILDRENS HOSPITAL

PEER REVIEW RATINGS
Effective: August 2007

PHYSICIAN SCORE: Overall Physician Care	
Rating	Defined
A	Physician Care Acceptable
B	Opportunity for Improvement
D	Deviation from Standard of Care
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