

Policy #	Performance Improvement (Peer Review) Committee	Approval Date: 02/17/2009 MEC Revision Dates: 10/28/09 Review Dates: 02/23/10
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Purpose:

To assess through the activities of its medical staff, the ongoing professional practice evaluation (OPPE) of individuals granted clinical privileges and use the results to perform focused professional practice evaluation (FPPE) and improve patient care.

Goals:

1. To monitor and evaluate the OPPE of individual practitioners with clinical privileges [includes Allied Health Professionals AHP's];
2. To create a positive peer review culture by recognizing physician excellence as well as identifying improvement opportunities;
3. To perform FPPE when potential physician improvement opportunities are identified;
4. To provide accurate and timely performance data for physician feedback, professional practice evaluations and reappointment;
5. To promote efficient use of physician and quality staff resources;
6. To ensure that the process for peer review is clearly defined, fair, defensible, timely, and useful.

Definitions:

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:

- 1) Review of individual cases,
- 2) 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.

Physician competency framework

Use generally recognized standards of care on which to base individual evaluations. Through this process, practitioners receive feedback for personal improvement or confirmation of achievement related to the effectiveness of their professional practice as defined by the six Joint Commission general competencies described below:

- **Patient Care:** Practitioners will 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 will demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and apply their knowledge to patient care and the education of others.

- **Practice-Based Learning and Improvement:** Practitioners will be able to use scientific evidence and methods to investigate, evaluate, and improve patient care.
- **Interpersonal and Communication Skills:** Practitioners will demonstrate interpersonal and communication skills to establish and maintain professional relationships with patients, families, and other members of healthcare teams.
- **Professionalism:** Practitioners will 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 will demonstrate an understanding of the contexts and systems in which healthcare is provided, and apply this knowledge to improve and optimize healthcare.

Peer

A “peer” is an individual practicing in the same profession and who has expertise in the appropriate subject matter. Determine on a case-by-case basis the level of subject matter expertise required to provide meaningful evaluation of a practitioner’s performance. 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.

Peer review body

The Peer Review Committee (PRC) performing the initial review will be designated by medical executive committee (MEC) as a subcommittee comprised of the Credentials Committee membership unless otherwise designated for specific circumstances by the MEC. The peer review body will determine the degree of subject matter expertise required for a practitioner to be considered a peer for all peer reviews performed by or on behalf of the hospital.

Ongoing professional practice evaluation (OPPE)

Is 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.

Focused professional practice evaluation (FPPE)

Is 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.

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 practitioner under review.

- Relative conflicts of interest are either due to a practitioner'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 Peer Review Process.

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 non-discoverability.**
2. The involved practitioner will receive practitioner-specific feedback on a routine basis.
3. The medical staff will use peer review results in making its recommendations to the hospital regarding the credentialing and privileging process and in performance improvement activities.
4. The hospital will keep secure practitioner-specific peer review and other quality information concerning a practitioner. Practitioner-specific peer review information consists of information related to:
 - Performance data for all dimensions of individual physician performance.
 - The individual physician's role in sentinel events, significant incidents, or near misses.
 - Correspondence to the physician regarding commendations, comments regarding practice performance, and corrective action.
5. Only the final determinations of the Performance Improvement Committee and subsequent actions are part of an individual practitioner's quality file.
6. Individual practitioner quality file information is available to authorized individuals only on a need to know basis to the extent necessary to carry out their assigned responsibilities. *Only the following individuals shall have access to practitioner-specific peer review information and only for purposes of quality improvement:*
 - The specific practitioner;
 - The chief of the medical staff when considering corrective action;
 - Medical staff department chairs to conduct OPPE for their department members;
 - Members of the MEC, credentials committee, and medical staff services professionals for purposes of considering reappointment or correction 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 directors;
 - The hospital CEO when information is needed for immediate formal corrective action as defined by the medical staff bylaws;

7. Medical staff or hospital policy authorization is required to produce and distribute copies of peer review documents.

Circumstances requiring peer review

Procedures are defined for conducting peer review for an individual case and for aggregate performance measures. Peer review is ongoing and reported to the appropriate committee for review and action.

When a decision is made by the board of directors to investigate a practitioner's performance or when circumstances warrant the evaluation of one or more practitioners with privileges, the MEC or its designee shall appoint a panel of appropriate medical professionals to perform the necessary peer review activities as described in the medical staff bylaws.

Circumstances requiring external peer review

Only the MEC or Performance Improvement Committee may make determinations on the need for external peer review. Circumstances requiring external peer review include:

- 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: External peer review will take place 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 (as describe above) regarding the practitioner under review that cannot be appropriately resolved by the MEC 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 MEC 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. When the person whose care is under review responds within 120 days, the peer review body will consider those views prior to making a final determination regarding the care provided by that individual. In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, the Credentials Committee 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.

Selection of physician performance measures

The MEC will select measures of physician performance to reflect the six general competencies and will use multiple sources of data described by the Medical Staff.

Thresholds for FPPE

If the results of an OPPE indicate a potential issue with physician performance, the Credentials Committee may initiate FPPE to determine whether there is a 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 are described in the performance targets defined by the medical staff.

Individual case review

The medical staff will conduct peer review 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 Performance Improvement Department staff and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability. The rating system for determining results of individual case reviews is described in the Case Review Rating Form.

Rate and rule indicator data evaluation

Ongoing evaluation of aggregate physician performance measures via either rate or rule indicators will be conducted by the Credentials Committee or its designee.

Oversight and reporting

Direct oversight of the peer review process is delegated by the MEC to the Credentials Committee. The Credentials Committee will report to the board of directors on peer review activity 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.

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.