

PHC – Medical Staff Peer Review and Professional Practice Evaluation

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Purpose: To ensure that the Providence Health Care (PHC) urban hospitals (Providence Sacred Heart Medical Center and Providence Holy Family Hospital), through the activities of their medical staffs, assess the Ongoing Professional Practice Evaluation (OPPE) of individuals granted clinical privileges and uses the results of such reviews to improve care across the urban campuses, and, when necessary, performs Focused Professional Practice Evaluation (FPPE).

As allowed by Washington State law and PHC Community Board Resolution, peer review may be shared within PHC. The Medical Staff Bylaws of both urban hospitals also allow peer review to be shared jointly across the two campuses, and each Medical Executive Committee approves this policy to jointly conduct peer review and to share peer review across the urban campuses.

Goals:

1. Monitor and evaluate the ongoing professional practice of individual practitioners with clinical privileges
2. Create a transparent culture with a positive approach to peer review by recognizing practitioner excellence as well as identifying improvement opportunities
3. Perform focused professional practice evaluation for new providers or when potential practitioner improvement opportunities are identified
4. Promote efficient use of physician leadership and quality staff resources
5. Provide accurate and timely performance data for practitioner feedback, OPPE, and reappointment
6. Assure that the process for peer review is clearly defined, fair, defensible, timely and useful
7. Promote consistent, high quality patient care services across the urban campuses
8. Involve practitioners in team and process improvement across the urban campuses
9. Promote team reviews and learnings (such as Mortality & Morbidity reviews) to create a climate of continual improvement in patient care provided by the organization

Definitions:

Peer review may include case conferences, case complication review, critical incident review, morbidity and mortality (M&M) reviews and other quality and performance reviews regarding credentialed staff; Washington State law provides legal protection for peer review as that term is defined by statute; it is the intent of the Medical Staff that those protections apply to all forms of such activities.

Practitioner 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 a system. See Attachment A for a graphic representation of the peer review process.

Peer review is conducted using multiple sources of information including:

1. The review of individual cases
2. The review of aggregate data for compliance with general rules of the medical staff
3. Clinical standards and use of rates in comparison with established benchmarks or norms

The individual practitioner's evaluation is based on generally recognized standards of care. Through this process, practitioners receive feedback for confirmation of personal achievement or for personal improvement related to the effectiveness of their professional practice. The six competencies defined by the Joint Commission [adapted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative], as described below are used in evaluating performance:

- **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 health care 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 health care is provided, and the ability to apply this knowledge to improve and optimize healthcare.

These competencies are further elaborated in the 'Code of Conduct and Professional Expectations – Medical Staff and Allied Health Professionals' (Attachment B), which is signed by each practitioner joining the medical or allied health professional staff of Sacred Heart Medical Center. See also 'Physician Performance Dimensions' (Attachment C), amplifies the core competencies listed above.

Peer – 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-basis. For example, 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, such as evaluating the technique of a specialized procedure, a peer is an individual who is well-trained and competent in that specialty. A physician may be determined to be the optimum peer reviewer for a specific mid-level provider.

Peer Review Body – Departments will establish peer review bodies and processes under the guidance of the Medical Executive Committee (MEC). Peer review may be conducted jointly across the urban campuses. Departments will:

1. Determine the degree of subject matter expertise required for a provider to be considered a peer.
2. Determine the ongoing monitors and triggers for individual case review.
3. Report cases rated 3 or 4 according to the scoring guidelines in Attachment D to the Medical Executive Committee.
4. Provide a yearly summary of the Department’s peer review process and results to the Medical Executive Committee.
5. Recommend multi-disciplinary review by one of the following:
 - a. Medical Executive Committee peer review oversight committee
 - b. A joint body established by the MEC’s
 - c. Review by practitioner/s at another hospital within the Providence Health & Services organization when either conflicts of interest exist or an appropriate expert is not available within PHC.
 - d. Complex cases may require a review by physician/s from a facility outside of PH&S where similar levels of care are provided. See section below, ‘Circumstances requiring external peer review.’

Ongoing Professional Practice Evaluation (OPPE) – The routine monitoring and evaluation of current competency for currently appointed practitioners. OPPE will be performed at approximately 6-9 month intervals. These activities comprise the majority of the functions of the ongoing peer review process and the use of data for reappointment. OPPE may also be shared across the Providence urban campuses. A summary of completed OPPE will be included on the monthly Credentials Report to the MEC.

Focused Professional Practice Evaluation (FPPE) – The establishment of current competency for newly appointed staff members who hold clinical privileges, currently credentialed staff members who request additional privileges, and/or concerns identified from OPPE. See separate policy (Attachment E) which amplifies the methods for FPPE. FPPE information may also be shared across the urban campuses, although it must include an assessment specific to the individual hospital. A summary of completed FPPE will be included on the monthly Credentials Report to the MEC.

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 practitioner 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 to disclose to the peer review committee the potential conflict. It is the responsibility of the peer review body to determine on a case-by-case basis if a relative conflict is substantial enough to prevent the individual from participating. The Medical Executive Committee may assist Department Chairs in resolving potential conflict of interest issues by appointing a multi-disciplinary review body or recommending review outside of the individual hospital, or outside of PHC.

Policy:

- 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.
- When a practitioner's specific performance is evaluated, the involved practitioner will receive provider-specific feedback at a minimum on all cases rated a 3 or 4.
- The medical staff will use the provider-specific peer review results in making its recommendations to the medical center regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.
- The medical center will maintain provider-specific peer review and other quality information concerning a practitioner in a secure, locked file or secure database. Provider-specific peer review information consists of information related to:
 - Performance data for all dimensions of performance measured for that individual practitioner
 - The individual practitioner's role in sentinel events, significant incidents or near misses
 - Correspondence to the practitioner regarding commendations, comments regarding practice performance, or corrective action
- Only summary documents and the final determinations of peer review and any subsequent actions are permanent records within an individual provider's quality file.
- Peer review information in the individual provider's 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. However, these authorized individuals shall have access to the information only to the extent necessary to carry out their assigned responsibilities. The Chief Medical Officer (CMOE) or Division Chief will assure that only authorized individuals have access to individual provider quality files and that the files are reviewed under the supervision of the Director of Medical Staff Services or designee. Only the following individuals shall have access to provider-specific peer review information and only for purposes of quality improvement:
 - Chief Medical Executive
 - Chief Medical Officer
 - Division Chief
 - The specific provider – access to all information s/he has provided to the hospital and all information within the credentials file which has already been provided to the 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 FPPE, OPPE, and peer review
 - Members of the Medical Executive Committee and Credentials Committee for purposes of considering reappointment or corrective action
 - Senior Director of Performance Improvement (PI) and his/her designated staff may have selected access for specific data collection projects and for completion of root cause analyses. .
 - Risk Management staff may have access to data as they manage the hospital's occurrence reporting program, perform proactive risk assessments, respond to patient complaints, participate in root cause analyses, and provide data related to litigation

- Individuals surveying for accrediting bodies with appropriate jurisdiction, such as Joint Commission and state/federal regulatory bodies
- Individuals with a legitimate purpose for access as determined by the hospital Board
- The medical center Chief Executive or PHC Chief Executive when information is needed for the Chief Executive's involvement in the process of immediate formal corrective action for purposes of summary suspension as defined by the medical staff bylaws
- Medical Staff Services office staff as required by their specific job functions
- No copies of peer review documents will be created and distributed unless authorized by medical staff policy or bylaws, the MEC, the Board or by mutual agreement between the President of the Medical staff and the CMOE for purposes of deliberations regarding corrective action on specific cases.
- All requests for peer review documents by the State of Washington or by subpoena will be reviewed by legal counsel

Circumstances requiring peer review:

Peer review is conducted on an ongoing basis and reported to the appropriate committee for review and action. Peer review indicators for individual case and for aggregate performance measures are described in Attachment F (being developed).

In the event a decision is made to investigate a practitioner's performance or circumstances warrant the evaluation of one or more providers with privileges, the Medical Executive Committee 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:

The Department Chair may recommend, and the Medical Executive Committee, CMO, Division Chief, or Board will make the determination regarding 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 MEC or Board.

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 impact a practitioner's membership or privilege/s.
- 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 MEC or 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 Board may require external peer review in any circumstances deemed appropriate by either of these bodies.

Participants in the review process:

Department chairs and committee representatives will comprise the core peer review team for the Department. The work of all practitioners granted privileges will be reviewed through the peer review

process. Clinical support staff and leadership may participate in the review process if their input is necessary. Performance Improvement, Risk Management, and Medical Staff Services all provide support to the peer review process. The peer review body will involve and consider the views of the person whose care is under review prior to making a final determination regarding the care provided by that individual, providing that individual responds in the requested timeframe. It is the obligation of credentialed staff members to respond to peer review inquiries within the time frame specified.

In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, 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

Measures of physician performance will be approved by the Department Chairs and MEC. The Senior Director of Performance improvement will participate in selection of the measures and provide available PI data. (Attachment F)

Thresholds for Ongoing and Focused Professional Practice Evaluation:

If the results of Ongoing Professional Practice Evaluation indicate a potential issue with physician performance, the Department Chair may initiate a focused evaluation to determine if there is a problem with current competency of the practitioner for either specific privileges or for more global dimensions of performance. These potential issues may be the result of individual case review or rule or rate indicators. The thresholds for Focused Professional Practice Evaluation are described in the acceptable targets for the medical staff indicators in Attachment F. However, a single egregious case may initiate a focused review by the Department.

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 initially reviewed by Medical Staff Services or PI. The goal for complex cases will be 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 (Attachment D).

Benchmarking databases:

Benchmarking databases, such as Premier, will be utilized as part of FPPE and OPPE whenever practitioner-specific data is available.

Oversight and Reporting:

The peer review process is delegated by the MEC to the Departments. The MEC retains oversight of the process, and cases rated 3 and 4 according to the case review rating form are reported to the MEC for their ratification.

Statutory Authority:

This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986, RCW 70.41.200 and RCW 4.24.250. 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. Documents, including minutes and case review materials, prepared in connection with this policy should be labeled with the following language:

Statement of confidentiality: "Data, records, documents and knowledge, including but not limited to minutes and case review materials, collected for or by individuals or committees assigned peer review functions are confidential and shall be used by the committee and committee members only in the exercise of proper functions of the committee, and are not available for court subpoena in accordance with RCW 70.41.200, RCW 4.24.250, all other applicable state peer review statutes, and case law."

All participants who participate in peer review processes in substantial good faith receive the protections of RCW 70.41.200 and are indemnified by PH&S.

Attachment A – Flow chart – SHMC Peer Review Process

Attachment B - Code of Conduct and Professional Expectations – Medical Staff and Allied Health Professionals

Attachment C – Physician Performance Dimensions

Attachment D – Individual case review scoring guidelines

Attachment E – Focused Professional Practice Evaluation (FPPE policy)

Attachment F - Indicators/Thresholds

Approved PSHMC and PHFH MEC November/December 2014