POLICY

The Medical Staff shall develop, implement, and evaluate a peer review process to assure a timely and effective evaluation of care provided by its members. All members of the Medical Staff are expected to participate in, and be supportive of, the peer review process.

PURPOSE

The purpose of this policy is to assure that the hospital, through the activities of its medical staff, conducts ongoing professional practice evaluation of physicians granted clinical privileges and uses the results of such evaluations to improve care and, when necessary, perform focused professional practice evaluations.

GOALS

Through implementation of this policy, the medical staff seeks to accomplish the following goals:

1. Monitor and evaluate the ongoing professional practice of individual practitioners with clinical privileges.

2. Create a culture with a positive approach to peer review as a method for identifying improvement opportunities.

3. Perform focused professional practice evaluation when potential physician improvement opportunities are identified.

4. Promote efficient use of physician and quality assurance staff resources.

5. Provide accurate and timely performance data for physician feedback, ongoing and focused professional practice evaluation and reappointment.

6. Assure that the process for peer review is clearly defined, fair, defensible, timely and useful.
SCOPE AND APPLICABILITY
This policy addresses the full scope of the peer review process and applies to all members of the Medical Staff.

Nothing in this policy supersedes or replaces requirements, duties, or responsibilities of the Medical Staff as articulated in the bylaws or rules and regulations of the Medical Staff, or the bylaws of the Governing Body.

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-discourability.

PHILOSOPHY
The purpose of peer review is to improve patient care. Peer review is to be educational and non-punitive in nature. Peer review should serve to identify potentially major issues or problems in patient care and to provide consistent feedback to physicians regarding their performance. Ultimately, peer review should impact on and improve the completeness and quality of documentation in the medical record.

DEFINITIONS
Conflict of Interest
A member of the medical staff requested to perform peer review may have a conflict of interest that prevents him or her from rendering an unbiased opinion. A conflict of interest always exists when the physician reviewer is also the subject of the review.

Other examples of potential conflicts of interest include:
- The physician reviewer is involved in treatment of the patient whose care is under review, even if such treatment is not related to the issues under review.
- The physician reviewer has a family, business or significant personal relationship with the physician who is the subject of the review, such as being a direct competitor, being a partner, shareholder or employee in the same medical group practice or in any other venture, being a key referral source or referral recipient of the subject physician, or being related by blood or by law to the subject physician.

Whether an actual conflict of interest exists determined on a case by case basis, and depends on the facts and circumstances of the situation presented. It is also important to address the appearance of conflict, even when no actual conflict of interest exists.

It is the obligation of the medical staff member reviewer to disclose to the committee any actual or potential conflict of interest, and to remove him or herself from the review process, where appropriate. Such disclosure should be made any time prior to review or deliberations on the case or incident and before any actual decisions are made. The Committee Chair will facilitate such disclosures by asking members to identify any actual or potential conflicts of interest prior to taking up an agenda item or assigning a case for review. The Practitioner Quality Facilitators shall exclude a member from participation in peer review deliberations whenever the member is the subject of the review, except that the physician under review may participate to the same extent as any other peer review subject is allowed to participate. When there is a disagreement whether a conflict of interest exists, it is the responsibility of the peer review body to determine whether the actual or potential conflict is substantial enough to prevent the individual from participating as a reviewer.
In the event of an actual conflict of interest, the MEC will replace, appoint, or determine who will participate in the process so that the conflict of interest does not interfere in the decision-making process.

**Focused Professional Practice Evaluation (FPPE)**

“Focused professional practice evaluation” (FPPE) means the establishment of current competency for new medical staff members, new privileges and or concerns from discovered during OPPE. FPPE activities comprise what is typically called “proctoring” or “focused review” depending on the nature of the circumstances.

**Ongoing Professional Practice Evaluation (OPPE)**

“Ongoing professional practice evaluation” (OPPE) means the routine monitoring and evaluation of current competency for the active medical staff. OPPE activities comprise the majority of the functions of the ongoing peer review process and the use of data for reappointment.

**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 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, 3) clinical standards and use of rates in comparison with established benchmarks or norms.

The individual’s evaluation is based on generally recognized standards of care. Through this process, practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice as defined by the six Joint Commission General Competencies described below:

- **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 patient, 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 Medical Staff Expectations for Physicians (Attachment A).
Peer - An individual who has similar clinical competence and scope of responsibility as the reviewee, and possesses sufficient training and experience to render a judgment on the clinical circumstances under review.

Outside Review - Peer review conducted on behalf of the Medical Staff by a peer or group of peers who is not a member of the Medical Staff. Outside peer review is by an individual from the same discipline and with equal qualifications as the individual whose case is under review and who:

- Is not a full member of the hospital medical staff (although temporary privileges may be granted)
- Is not a member of the individual’s practice (directly or indirectly)
- Is not professionally affiliated or involved with the individual’s practice
- Has no financial interest

REVIEW PROCESS

Determination of Care to be Reviewed
On a routine basis, the Medical Staff (through its departments) will determine the aspects of care that will be subject to peer review. These criteria will include, but not necessarily be limited to:

1. High volume, high risk, or problem prone procedures or processes;
2. Occurrence reports and/or sentinel events that, upon initial screening, imply a quality of care concern involving a medical staff member.
3. Unexpected complications in patient conditions and/or care or treatment, including those that result in major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition
4. Patient and/or family complaints as they relate to medical staff management of care
5. Postoperative complications
6. Iatrogenic events.
7. Use of blood and blood components
8. Moderate to severe adverse drug reactions
9. Third party payer/outside regulatory or accreditation agency mandates.
10. Timeliness and appropriateness of documentation in the medical record.
11. Service-specific defined performance indicators established and approved by the specific Medical Staff Department and/or committee
12. A sentinel event or “near miss” identified during concurrent or retrospective review
13. An individual case or clinical pattern of care identified during a quality review

Determining Cases Subject to Peer Review
The Quality Services Department will screen cases against the criteria approved by the Medical Staff. The purpose of the screen is to determine if the case meets the criteria and, hence, is appropriate for review. If the case meets criteria then the peer review process will be initiated. If the case does not meet criteria, then it is closed.

Selection of a Peer Reviewer
The Quality Services Department is given the authority by the Medical Staff to assign a Physician to conduct a review of the case. The assignment must meet the following guidelines:

1. The physician must be a peer as defined in this policy.
2. The physician should not be involved in the case being reviewed.

Review by the Peer
The peer will review the facts of the case as contained in the medical record or other appropriate document(s) against the accepted standard of care. The peer will then make a determination, based on his or
her best judgment, as to the degree to which there is deviation from the standard of care. Once a case has been satisfactorily reviewed, a final determination is made. A scoring methodology has been established to quantify findings. Cases will be scored as follows:

- **Score 1**: Care and management appropriate. No issues identified.
- **Score 2**: Care and management appropriate. Documentation issues only.
- **Score 3**: Minor deviation from standard of care.
- **Score 4**: Major deviation from standard of care.

In addition to the above score, each case will also have a categorization of the outcome, as identified below:

1. No adverse outcome
2. Minor adverse outcome (e.g., transfer to ICU, increased intensity of acuity).
3. Major adverse outcome (e.g., permanent disability, death).

**Review by a Panel of Peers (Department Review)**

At times, review of a case by a panel of peers may be appropriate. This is known as department review. The individual being reviewed should be afforded the opportunity to be present at the time of the review to provide input, insight, and additional information. Department review should occur under the following conditions:

1. Any case scored 3C or 4 by the individual reviewer.
2. The individual being reviewed requests that the department review the case.
3. The Medical Executive Committee (MEC) requests the department review the case.

When a panel of peers has determined the outcome, and there is a difference of opinion within the panel, then both the prevailing opinion and the dissenting opinion should be documented in the medical staff committee minutes.

**Physician Quality Score Peer Review Reports at Time of Recredentialing and OPPE**

At time of recredentialing, a 2 year summary activity report will be presented to the Department Chairperson. The report will include:

- Individual case summaries for prior 2 years
- Individual’s total case activity and total case to committee

It will be the Department Chairman’s responsibility to review above reports and to ensure the individual practitioner’s quality score is within an acceptable range, the department chairperson will be responsible to providing written justification for recommendations for reappointment.

**Circumstances Requiring Focus Review**

If the result of OPPE or individual case reviews for a physician exceed thresholds established by the Medical staff described below, the department chair or his/her designee will review the findings to determine if further focus review is needed to identify a potential pattern of care. These potential issues may be the result of individual case review or Rule or Rate Indicators. The thresholds for FPPE are described in the acceptable targets for the medical staff indicators; however, a single egregious case may initiate a focused review by the Division.

**Thresholds:**

- Any single egregious case
- Within any 12 month period of time, any of the following criteria:
  - 3 cases rated significant deviation from standard of care
  - 5 cases rated practice within standard of care with opportunity for improvement
  - 5 cases rated as having documentation issues regardless of care rating
Outside Review

The Division Chair, the MEC or the Hospital Governing Body will make determinations on 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, Division Chair, or Hospital Governing Body. Circumstances requiring external peer review may 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 privileges.
- 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 the potential for conflict of interest cannot be appropriately resolved by the MEC or Hospital Governing Body.
- When the medical staff needs an expert witness for a fair hearing, for evaluation of a credentials file, or for assistance in developing a benchmark for quality monitoring bodies.
- In any other circumstances that the MEC or Hospital Governing Body deems appropriate.
- The individual being reviewed requests an outside review and in the opinion of the Department Chair or the MEC, there is merit to the request.
- 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 benchmark for quality monitoring

Should an outside review be deemed necessary, the following applies:

- The reviewer chosen must be a peer as defined in this policy.
- The reviewer must be acceptable to both the individual being reviewed and the Department Chair or MEC.
- When possible, the reviewer should not be familiar with the case or with the individuals being reviewed.
- For the purposes of peer review, the determination made by the outside reviewer will be considered final.

Timeliness of Review

Peer review should be completed as quickly as possible. The following are considered end-points for a review to be considered timely:

1. Routine peer review should be completed within 4 months following the screening of a case.
2. In situations where a serious issues has been identified, and the safety or welfare of a patient or other individual(s) may be at risk, an expedited review is to occur. This review is to be completed as soon as possible after the event.

Peer Review Methodology

Cases are referred for peer review from multiple sources throughout the organization to include, but not limited to Risk Management, Case Management, Infection Control, Pharmacy, Quality Management, physicians, staff and payors. Cases for review are also identified through retrospective record review following completion of medical record coding or concurrent review during quality and utilization review activities. All cases identified for potential peer review will be directed to the Quality Management Department. Case abstraction is completed through the Quality Management Department.

Conclusions of the review must be defensible. All cases undergoing peer review will have results of review documented in the Quality Management database and/or physician peer review file, including rationale for
the conclusion made by the peer reviewer(s). Rational shall be based on the reason the case was reviewed, and may be supported by current clinical practice, practice guidelines, and/or literature.

**Informing the Physician of the Results of Peer Review**

The individual being reviewed is to be informed of the results of the review. The individual should be provided with the following:

1. The reason(s) for the review.
2. The result(s) of the review (i.e. the score).
3. Actions taken as a result of the review.

*The physician being reviewed has 30 days to respond in writing to the findings of the reviewer. Should no response be received by the Quality Department within this designated time the findings of the reviewer will be documented and considered final. If the physician disagrees with the findings, the written response will be forwarded to the reviewer(s) for reconsideration in the final score.*

**Actions Taken as the Result of Department Review**

The results of peer review are to be acted upon. Such actions may include, but are not necessarily limited to, the following:

1. No action necessary (case closed).
2. Using the review as an opportunity to educate the individual (and others).
3. Forwarding the case to another committee for further review.
4. Focused review to determine if additional issues exist.

At the time of education or forwarding to another committee, the department may elect that no response is necessary (case closed), or require a response from the individual. When a peer review decision results in a specific action that action and subsequent expedited outcome is evaluated and monitored for effectiveness. Results of follow-up effectiveness monitoring are reported to the specific Medical Staff Department and may be reported to the Medical Executive Committee, and governing body as appropriate.

**Use of Peer Review Findings in Reappointment/Privileging**

A summary of peer review findings will be made available to the Department Chair at the time of a Medical Staff member’s reappointment and request for renewal of privileges. This information shall be considered in making the recommendation for reappointment and privileging.

*In determining the outcome of a case, when appropriate, both the opinion of the reviewer(s) and the individual being reviewed should be considered and documented.*

Peer review information 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, they shall have access to the information only to the extent necessary to carry out their assigned responsibilities. Only the following individuals shall have access to provider-specific peer review information and only for purposes of quality improvement:

- Medical staff officers;
- Medical staff department chairs (for membership of their departments only);
- Members of the Medical Executive Committee, Credentials and Medical Staff Quality Improvement Director
- Medical Directors when relevant (e.g. GI Lab, Pathology, etc)
- Hospital Risk Manager/ Hospital Director of Quality
- Quality Management Department for review, database entry, etc.
- Medical staff services professionals to the extent that access to this information is necessary for the re-credentialing process or formal corrective action
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o Individuals surveying for accrediting bodies with appropriate jurisdiction, e.g. JCAHO or state/federal regulatory bodies; and
o Individuals with a legitimate purpose for access as determined by the hospital board of directors
o The hospital CEO when information is needed to take immediate formal corrective action for purposes of summary by the CEO

PROCEDURE
There is a procedure for managing the peer review process. It is presented as a flow chart and is appended as ATTACHMENT B.

EVALUATION OF PROCESS
On an annual basis, the MEC shall assess the effectiveness of the peer review process and undertake such action(s) as deemed necessary to assure that the process remains timely and effective.

REFERENCES
Comprehensive Accreditation Manual, 2008, Joint Commission, Medical Staff Chapter “Medical Staff Peer Review”, Lang, Daniel M.D., American Hospital Association, American Hospital Publishing Inc. 1991

Statutory Authority
This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, et seq. and California Business and Professions Code Section 805. 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, including California Evidence Code Section 1157. Documents, including minutes and case review materials, prepared in connection with this policy should be labeled with language consistent with the following:

CONFIDENTIAL PEER REVIEW RECORDS
PROTECTED UNDER CALIFORNIA EVIDENCE CODE SECTION 1157
NOT FOR PUBLIC USE OR DISCLOSURE
DO NOT COPY OR REMOVE THIS FILE WITHOUT AUTHORIZATION
Peer Review Policy Attachment A

Expectations for General Competency of
Practitioners Granted Privileges at Oak Valley District Hospital

This document describes the expectations that physicians have of each other as members of our medical staff based on the ACGME/Joint Commission physician General Competencies framework. The expectations described below reflect current medical staff bylaws, policies and procedures and organizational policies. This document is designed to bring together the most important issues found in those documents and key concepts reflecting our medical staff’s culture and vision.

Medical staff leaders will work to improve individual and aggregate medical staff performance through providing appropriate measurement of these expectations that provides positive and constructive feedback so each physician has the opportunity to grow and develop in his or her capabilities to provide outstanding patient care and valuable contributions to our hospital.

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 as evidenced by the following:

1. Provide effective patient care that consistently meets or exceeds medical staff (or national) standards of care as defined by comparative outcome data, medical literature and results of peer review activities.

2. Plan and provide appropriate patient management based on patient information, patient preferences, current indications, available scientific evidence and sound clinical judgment.

3. Assure that each patient is evaluated by a physician as defined in the bylaws, rules and regulations and document findings in the medical record at that time.

4. Demonstrate caring and respectful behaviors when interacting with patients and their families.

5. Provide for patient comfort by managing acute and chronic pain according to medically appropriate standards.

6. Counsel and educate patients and their families

7. Cooperate with hospital efforts to implement methods to systematically enhance disease prevention.

8. If applicable, supervise residents, students and allied health professionals to assure patients receive the highest quality of care.

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 as evidenced by the following:

1. Use evidence-based guidelines when available, as recommended by the appropriate specialty, in selecting the most effective and appropriate approaches to diagnosis and treatment.

2. Maintain ongoing medical education as appropriate for each specialty
3. Demonstrate appropriate technical skills and medical knowledge using medical simulation technology where available.

**Practice Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care as evidenced by the following:

1. Regularly review your individual and specialty data for all general competencies and use the data for self-improvement of patient care.

2. Respond in the spirit of continuous improvement when contacted regarding concerns about patient care.

3. Use hospital information technology to manage information and access on-line medical information.

4. Facilitate the learning of students, trainees and other health care professionals.

**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 as evidenced by the following:

1. Communicate effectively with physicians, other caregivers, patients and families to ensure accurate transfer of information through appropriate oral and written methods according to hospital policies.

2. Request inpatient consultations by providing adequate communication with the consultant including a clear reason for consultation and direct physician-to-physician contact for urgent or emergent requests.

3. Maintain medical records consistent with the medical staff bylaws, rules, regulations and policies.

4. Work effectively with others as a member or leader of a health care team or other professional group

5. Maintain high patient satisfaction with physician care.

**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 as evidenced by the following:

1. Act in a professional, respectful manner at all times and adhere to the Medical Staff Behavior Disruptive Conduct Rules and Regulations.

2. Respond promptly to requests for patient care needs.

3. Address disagreements in a constructive, respectful manner away from patients or non-involved caregivers.

4. Participate in emergency call as defined in the bylaws, rules and regulations

5. Follow ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and discussion of unanticipated adverse outcomes.

6. Utilize sensitivity and responsiveness to culture, age, gender, and disabilities for patients and staff.
7. Make positive contributions to the medical staff by participating actively in medical staff functions, serving when requested and by responding in a timely manner when input is requested.

**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 as evidenced by the following:

1. Comply with hospital efforts and policies to maintain a patient safety culture, reduce medical errors, meet national patient safety goals and improve quality.

2. Follow nationally recognized recommendations regarding infection control procedures and precautions when participating in patient care.

3. Ensure timely and continuous care of patients by clear identification of covering physicians and by availability through appropriate and timely electronic communication systems.

4. Provide quality patient care that is cost-effective by cooperating with efforts to appropriately manage the use of valuable patient care resources.

5. Cooperate with guidelines for appropriate hospital admission, level of care transfer, and timely discharge to outpatient management when medical appropriate.

6. Advocate for quality patient care and assist patients in dealing with system complexities.
Attachment B
Medical Staff Peer Review Procedure

Indicators approved by Medical Staff

1. Quality Services screens cases against criteria
2. Screening criteria validated? Yes
   Quality Services assigns peer to review case
   Peer reviews case against standards of care.
   Case Closed
   No further action necessary

   Case referred to Department Review
   Department reviews findings and makes determination
   Department reviews case
   MD Informed of Findings *
   Minor issues only? No adverse outcome?
   Yes
   Outside reviewer needed?

   No

   No

   No

   No

   No

3. Case Closed
   Data entered into database for use at reappointment
   Care and management appropriate?
   Yes

* After physician makes written responses, case may be returned to reviewer(s) for reconsideration on final score