HILLCREST
BAPTIST MEDICAL CENTER
SCOTT&WHITE HEALTHCARE

POLICY: **Medical Staff Peer Review/Professional Practice Evaluation**	POLICY NUMBER: **11004**
SECTION: Medical Staff	MANUAL: General Operating
DATE REVIEWED: June 4, 2008	EFFECTIVE DATE:
DATE REVISED: June 19, 2008; January 2009; August 19, 2011	

SCOPE: Hillcrest Medical Staff

PURPOSE: To assure that Hillcrest Baptist Medical Center, through activities of its Medical Staff, assesses the ongoing professional practice and competence of individuals granted clinical privileges and when necessary, to perform focused professional practice evaluation and improve patient care.

Goals:

1. Monitor and evaluate the ongoing professional practice of individual practitioners identifying opportunities for performance improvement and recognition of excellence.
2. Monitor for significant trends in performance by analyzing aggregate data and case findings.
3. Perform focused professional practice evaluation when potential physician improvement opportunities are identified.
4. Assure that the process for peer review is clearly defined, objective, equitable, defensible, timely and useful.
5. Provide accurate and timely performance data for physician feedback, ongoing and focused professional practice evaluation and reappointment.
6. Promote efficient use of physician and system-wide resources.

POLICY: It is the policy of Hillcrest Baptist Medical Center to comply with statutory and regulatory requirements (i.e. Joint Commission, government agencies) regarding peer review which includes ongoing professional practice evaluation and focused professional practice evaluation with the focus on improvements.

PROCESS/PROCEDURE:

Definitions:

Peer

A "peer" is an individual practicing in the same profession and who has expertise in the appropriate subject matter. All members of the medical staff will be considered "peers" pertaining to practices which are common to all practitioners. All members of a department will be considered "peers" pertaining to practices performed within that department. For practices that are specific for specialties, a "peer" will be considered one who is proficient in similar skills and practices in the specialty. When the level of subject matter expertise required is unclear, the Medical Staff Peer Review Committee will decide who constitutes a peer and if external peer review is required on a case-by-case basis.

Peer Review

"Peer review" is the evaluation of an individual practitioner's professional performance strengths and weakness and includes the identification of opportunities to improve care. The peer review process includes ongoing professional practice evaluation (OPPE) activities and focused professional practice evaluation (FPPE) activities.

Peer Review Process and Participants in the Review Process

Medical Staff Committees evaluate ongoing data review and findings regarding practitioner practice and performance and resulting performance improvement functions as set forth in the Medical Staff Bylaws, Policy on Appointment, Reappointment, and Clinical Privileges and the Medical Staff Organization and Function Manual. (*See* Appendix A).

Clinical support staff and Quality Management staff will participate in the review process if deemed appropriate and/or participation is included in their job description.

Confidentiality of all Peer Review Information

All data collected, analyzed and trended for physician performance evaluation as well as any records and proceedings of any committee relating in any manner to peer review are confidential, privileged and protected from discovery in accordance with Medical Staff Bylaws and Policy on Appointment, Reappointment and Clinical Privileges and Federal and State law and regulations pertaining to confidentiality and non-discovery. (*See* Article 8 of the Medical Staff Policy on Appointment, Reappointment and Clinical Privileges.)

Physician Competency Framework

The individual practitioner's performance evaluation is based on generally recognized standards of care. Through the peer review 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/Accreditation Council of Graduate Medical Education (ACGME) general competencies described in Appendix B. These competencies/practitioner performance expectations are further elaborated in the Medical Staff Bylaws, Policies and Rules and Regulations, Policy on Appointment, Reappointment and Clinical Privileges and Medical Staff Organization and Functions Manual.

Ongoing Professional Practice Evaluation (OPPE)

"Ongoing Professional Practice Evaluation" is the continuous evaluation of the practitioner's professional performance, rather than a cyclical or episodic evaluation. It is intended to identify and resolve potential performance issues as soon as possible, as well as foster a more efficient, evidence-based privilege renewal process. Information resulting from OPPE is considered when determining whether to continue, limit or revoke any existing privilege(s) prior to or at the time of reappointment. (*See* Medical Staff Policy on Appointment, Reappointment and Clinical Privileges).

Focused Professional Practice Evaluation (FPPE)

"Focused Professional Practice Evaluation" is a process whereby the medical staff evaluates the competency and professional performance of new medical staff members, new privileges, and/or concerns relating to the performance of a practitioner from OPPE.

A focused practice performance evaluation is not considered an investigation as defined in the Article 7 of the Medical Staff Policy on Appointment, Reappointment and Clinical Privileges and is not subject to the requirements under the investigation process.

Threshold for FPPE of Current Practitioners
If the results of an OPPE indicate a potential issue with practitioner performance for either specific privileges or for more global dimensions, the appropriate medical staff committee may initiate a FPPE to determine whether there is a problem. These potential issues may be the result of individual case reviews or data from rule or rate indicators pertaining to a practitioner exceeding thresholds established by the medical staff. (*See* Appendix B).

Conflict of Interest
Peer review is conducted in a manner that is objective, equitable and consistent. A member of the medical staff requested to perform peer review may have a conflict of interest if the member may not be able to render an unbiased opinion. See Article 7 of the Medical Staff Bylaws for specific policy/procedures concerning questions of actual or potential conflict of interest or a bias in any matter involving peer review functions.

Circumstances Requiring External Peer Review
The Medical Staff Peer Review Committee and/or the Medical Executive Committee determine when external peer review is required. Circumstances requiring external peer review include:

- 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 – 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.
- Miscellaneous issues – in any circumstances deemed appropriate by the Medical Staff Peer Review Committee, Medical Quality Improvement Committee, Medical Executive Committee or the governing board.

PROCEDURE:

ONGOING PROFESSIONAL PRACTICE EVALUATION

1. Ongoing professional practice evaluation is conducted continuously and reported on to the appropriate committees for review and action in accordance with Medical Staff Bylaws, Policy on Appointment, Reappointment and Clinical Privileges and Medical Staff, and Medical Staff Organization and Functions Manual. (*See* Appendix A). Information should be presented at intervals frequent enough- no less frequent than every 9 months- to assure timely identification of issues, patterns or trends.

2. OPPE includes review of:
   a. aggregate data on rule based indicators for individual practitioners;
   b. aggregate data on rate based indicators for individual practitioners;
   c. individual cases identified for detailed review.

See Appendix B for list of general performance indicators and practice based indicators for the Medical Staff Departments.

3. Performance Indicators (competency measures):
   a. The Medical Staff Departments identify rule and rate based performance indicators for their services and determine appropriate thresholds for each. (*See* Article 4 Medical Staff Bylaws). Rate and rule based indicators are evaluated periodically to determine if indicator(s) and threshold(s) should be modified.
   b. Rule based indicators identify individual instances of non-compliance with administrative or clinical processes.
   c. Rate based indicators identify potential performance differences among physicians using aggregated outcomes or processes of care taking into account difference in activity.
   d. Cases for individual case reviews will be based on referrals from multiple sources including but not limited to: patient/family notice; referral from medical/hospital staff; cases identified by patterns/trends of rule or rate based indicator exceeding threshold; sentinel event occurrence; and near miss occurrence with potential for major injury. See Appendix C for case review process including chart review rating scale and development of a Performance Improvement Plan.

PROCEDURE:

FOCUSED PROFESSIONAL PRACTICE EVALUATION

1. For Current Practitioners:

The Medical Staff Peer Review Committee, Medical Quality Improvement Committee or the Medical Executive Committee will consider initiating a FPPE of current practitioners in response to any of the following circumstances or events:

a. sentinel event occurrence as defined in policy;
b. near miss occurrence with potential for major or permanent injury occurs;
c. identification by medical staff peers of an unusual, adverse, individual case or clinical pattern of care; or
d. if the results of an OPPE indicate a potential issue with physician performance.

The method of focused evaluation depends on the nature of the circumstances of the case and practitioner performance issue and may include but is not limited to: multiple chart reviews; monitoring of the individual's practice patterns; proctoring; or external review and information obtained from other healthcare providers. The Medical Staff Peer Review Committee will review and make recommendations to the Medical Executive Committee regarding the appropriate focused evaluation and any indicated interventions and performance improvement actions. The Medical Executive Committee has the primary authority over activities related to the functions of the Medical Staff and performance improvement. (*See* Policy on Appointment, Reappointment and Clinical Privileges, Section 6.A. and Medical Staff Bylaws, Article 5.)

2. ***For New Clinical Privileges***:

(1) The grant of all new clinical privileges will be subject to a focused professional practice evaluation.

(2) Each department/section will recommend the number and types of cases to be evaluated to confirm the competence of a practitioner to exercise the privileges granted. For new practitioners, the evaluation will be of core privileges in the specialty and for each "special" privilege outside the "core." For an existing practitioner who has been granted additional privileges, the evaluation may be limited to the new privileges.

(3) The department/section will also recommend the process for carrying out the evaluation, including the duration. The evaluation process may include, but not be limited to:

a. chart review by internal or external reviewers;

b. concurrent proctoring;

c. review of practice patterns;

d. simulation; and or

e. discussion with other individuals involved in the care of the practitioner's patients.

(4) The recommendations made by the department/section as to the number and types of cases to be evaluated, the duration of the evaluation, and the evaluation process will be reviewed by the Credentials Committee and adopted by the Executive Committee. These committees may modify the evaluation requirements if a practitioner's credentials indicate that an additional or different evaluation may be required.

(5) When a request for privileges has been granted, the practitioner will be informed of the evaluation process that will take place and of his or her responsibility to cooperate in and/or assist in the coordination of such.

(6) The department/section chair will review the results of the focused evaluation and will report to the Credentials Committee. The report will include an assessment as to whether the evaluation confirmed that the practitioner is competent to exercise the clinical privileges granted or whether additional evaluation is required. Based on the department/section chair's assessment, and its own review of the evaluation results, the Credentials Committee will recommend to the Executive Committee any adjustments necessary to the evaluation or the privileges that were granted.

RELATED DOCUMENTS:
Medical Staff Bylaws, Policies and Rules and Regulations
Hillcrest Baptist Medical Center Policy on Appointment, Reappointment, and Clinical Privileges
Medical Staff Organization and Functions Manual

REFERRENCES/STANDARD:
2007 Joint Commission Hospital Accreditation Standards: Medical Staff
Texas Health and Safety Code § 161.032
Texas Occupational Code §§ 151.002(a)(8) and 160.007

APPENDICES:
A. Diagram for Medical Staff Peer Review
B. Joint Commission/ACGME Six General Competencies and Indicator Examples
C. Individual Case Review Process

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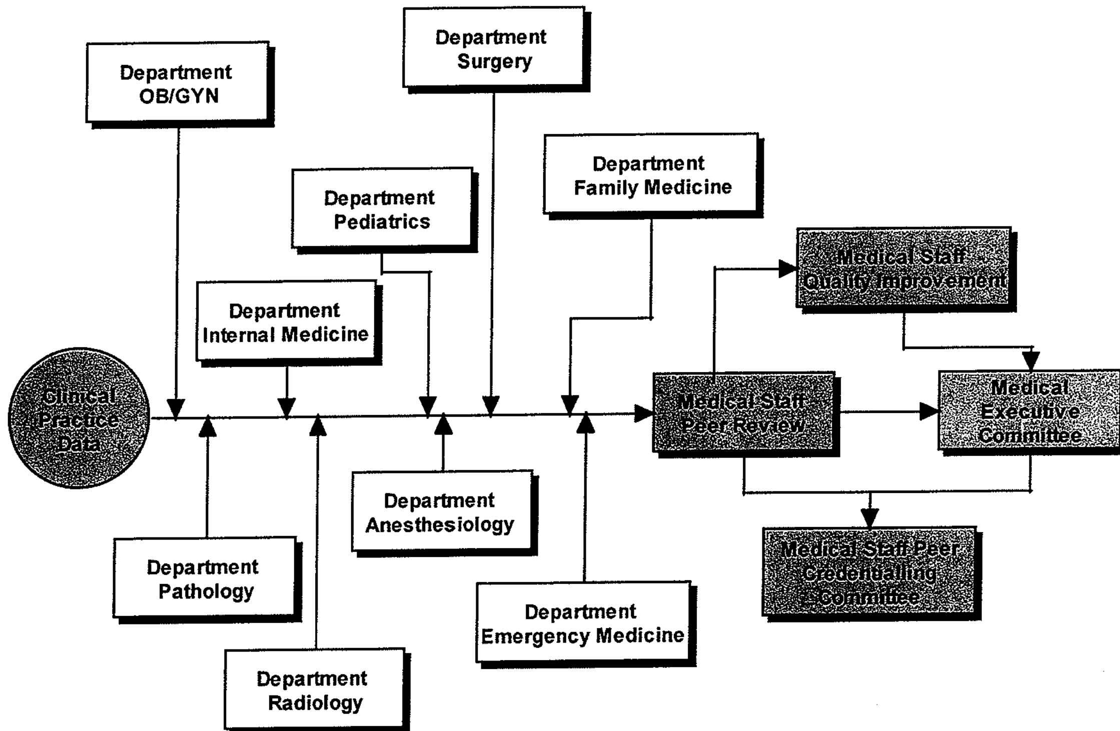
APPROVAL:

10.6.11

President, Medical Staff **Date**

APPENDIX A



APPENDIX B

JOINT COMMISSION/ACGME GENERAL COMPETENCIES

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 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 healthcare teams.

Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, and 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 healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare.

GENERIC INDICATORS EXAMPLES

Patient Care:
Review cases rated as deviating from standard of care. Threshold for individual case review described in Appendix C.
Severity adjusted Mortality Index. Threshold based on national index and peer data and peer comparison data.
Severity adjusted Complication Index. Threshold based on national index and peer comparison data.

Medical Knowledge:
Compliance with Core Measures under physician control. Threshold based on national index.
Continuing Medical Education participation.

Practice Based Learning:
Each Medical Service/Department to choose a relevant indicator based on established protocol or published evidence based on practice standard. Individual departments determine threshold.

Interpersonal Communication:
Confirmed disruptive behaviors documented by patient complaints, or reports from medical/hospital staff. Accommodations documented on patient satisfaction surveys.

Professionalism:
Involvement at medical staff activities, i.e. attendance at medical staff meetings, participation in hospital performance improvement activities.

System-based Learning:
Compliance with Medical Staff Rules and Regulation concerning medical record documentation such as timely completion of History and Physical note, legibility of entries, compliance with consent order form, completion of Medical Reconciliation Form and compliance with "time out" process prior to procedures.

APPENDIX C

INDIVIDUAL CASE REVIEW PROCESS

1. Initial case review may be performed by practitioner's peers in the appropriate Medical Staff Department/Section under the direction of the Department Chair. A case may go directly to the Medical Staff Peer Review Committee after discussion with the Chairman of the Medical Staff Peer Review Committee or Medical Staff President. All individual case review falls under the peer review confidentiality privilege.

2. Each Medical Department/Section under the direction of the Department/Section Chief shall identify opportunities to improve care noted during assessment of clinical practice of its members including opportunities identified during individual case review. The Departments/Sections shall document actions taken to improve performance. (*See* Medical Staff Bylaws Article 4 and Article 5).

3. If initial review by the Medical Department/Section results a finding of a care concern, a level 2a or greater, the case will be referred to the Medical Staff Peer Review Committee for further review. See below for rating and point system.

4. The practitioner involved will be notified by the Medical Staff Peer Review Committee of case review and the opportunity of provide additional information regarding the matter. The Committee will notify the practitioner, by certified mail, a request for information regarding the case. If a response is not received within 30 days, a second certified letter will be sent, with a response to be received within 30-60 days of the second letter. The case will be automatically reviewed by the Medical Staff Peer Review Committee if a response is not received after 90 days from the initial notification and after attempts to notify the practitioner have been made. If a Family Practice Clinic Resident is involved, copies of the information request letter will be sent to the Attending Physician of record and the Director of the Family Practice Residency Program.

5. A final severity level and points, if any, will be assigned after all information is reviewed by the Medical Staff Peer Review Committee. Involved practitioners will be notified in writing of the Committees findings and any recommended performance improvement actions.

6. An accumulation of six (6) points within a two year period or a leveling of 4a or 4b results in development of a Performance Improvement Plan by the Medical Staff Peer Review Committee Chairperson and the involved practitioner. The plan will be presented to the Medical Staff Peer Review Committee for review and comment and then to the Medical Staff Executive Committee. A Performance Improvement Plan may include focused practice performance evaluation.

** *See Medical Staff Peer Review/Professional Practice Performance Evaluation Policy for applicable Conflict of Interest and Conflict of Interest policies.*

Severity Levels:
1a-Care within the standard, no adverse patient outcome. (0 points)
1b-Care within the standard, adverse patient outcome. (0 points)
2a-Mild deviation from standard, no adverse patient outcome. (0.5 points)
2b-Mild deviation from standard, adverse patient outcome. (1 point)
3a-Moderate deviation from standard, no adverse patient outcome. (1.5 points)
3b-Moderate deviation from standard, adverse patient outcome. (2 points)
4a-Marked deviation from standard, no adverse patient outcome. (2.5 points)
4b-Marked deviation from standard, adverse patient outcome. (3 points)