## Cabinet Peaks Medical Center

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| Originating Department: | Index: | |
| **Credentials Committee** | CR-002 | |
| Affected Departments/Employees: | Original Effective Date: | Revised Date: |
| Medical Staff, Allied Health Providers, Medical Staff Services, Quality Risk Management | 08/07/01 | 02/18/15 |

Practitioner Peer Review Process

# Purpose:

To ensure that Cabinet Peaks Medical Center (CPMC), through the activities of its practitioners, assesses the performance of individuals who are granted clinical privileges, and uses the results of such assessments to improve care.

**Policy:**

1. Improve the quality of care provided by individual practitioners.
2. Monitor the performance of practitioners who have privileges.
3. Identify opportunities for performance improvement.
4. Monitor significant trends by analyzing aggregate data.
5. Assure that the process for peer review is clearly defined, fair, defensible, timely, and useful.

# Supportive Data

1. Applicability: Applies to the medical and allied health professional staff of CPMC, and others who have delineated clinical privileges.
2. Confidentiality: The peer review/quality improvement activities are protected from discoverability according to S37-2-201 and S50-16-201 of the Montana Code Annotated. All activities are to be kept confidential. Only authorized persons have access to monitoring data and/or retrieval of this information. Authorized persons include medical staff leaders, medical center administration, medical staff services personnel, and quality/risk management personnel as appropriate.
3. 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.
   1. Peer review is conducted using multiple sources of information, including the review of individual cases, the review of aggregate data for compliance with general rules of the medical staff, and clinical standards and the use of rate compared against established benchmarks or norms.
   2. The individual’s evaluation is based on generally recognized standards of care. 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.
4. Peer: A “peer” is an individual who is 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-case basis. For example, for quality issues related to general medical care, any physician may review the care of another physician. For specialty-specific clinical issues, however, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well trained and competent in that surgical specialty.
5. Conflict of Interest: A member of the medical or allied health professional staff asked to perform peer review may have a conflict of interest if he or she might not be able to render an unbiased opinion due to either involvement in the patient’s care or a relationship with the practitioner involved as a direct competitor or partner. It is the individual reviewer’s obligation to disclose the potential conflict to the appropriate committee. The committee’s responsibility is to determine whether the conflict would prevent the individual from participating and the extent of that participation. Individuals determined to have a conflict may not be present during peer review discussions or decisions, other than to provide requested information.
6. Responsibility:
   1. Each Medical Staff Department is responsible for peer review activities per the Medical Staff Bylaws Article 1 and Article 4 and the Medical Staff Rules and Regulations Part 20. Oversight is delegated to the Medical Staff Executive Committee (MSEC). The Manager of Quality Risk Management (QRM) is made aware of situations requiring intensive review through the medical staff. When variations in performance are noted, and particularly when there is an unanticipated patient outcome, it is the responsibility of the Manager of QRM to inform the department chairperson of the need to conduct a review.
   2. It is the responsibility of the medical staff departments to identify indicators for department specific quality performance measures (see applicable attachments). The QRM Department will assume responsibility for tracking this data and making it available to the appropriate Medical Staff Department Committee when indicated and at the time of reappointment.

**Procedure**

1. When the findings of the assessment process are relevant to an individual’s performance, the medical staff is responsible for determining their use in peer review and/or the periodic evaluations of a licensed independent practitioner’s competence, in accordance with the bylaw requirements on renewing or revising clinical privileges.
2. The Peer Review process involves the collection of data using a variety of methods. These methods include, but are not limited to, codes, DRGs, quality improvement screens, pathology reports, autopsy reports, internal and external databases, medical staff referral, and indicators for quality performance developed by the medical staff. This collection is done on an ongoing basis and is reported by the Director of QRM. The QRM Department screens these reports for peer review issues in confirmation with the appropriate Medical Staff Department’s review criteria.
3. The peer review or quality file containing specific peer review information on a practitioner will be archived separately from the practitioner’s credentialing file in a locked and secure cabinet. Provider specific information is considered:
   1. Quality and utilization review data
   2. Risk occurrences
   3. Sentinel events
   4. Correspondence to the physician regarding commendations or corrective action
4. Peer review information will be available to authorized staff who have a legitimate need to know such as:
   1. Quality Risk Management
   2. Medical Staff Services
   3. Credentialing and Medical Staff Executive Committee Members
   4. The medical center CEO, for purposes of summary, when information is needed to take immediate formal corrective action.
   5. Individuals with a legitimate purpose for access as determined by the organization’s legal counsel and/or board of directors.
5. No copies of peer review documents will be created and distributed unless authorized by legal counsel or unless specified in policy, with the exception of the copy given to the reviewed practitioner for feedback.
6. Circumstances requiring peer review may include, but are not limited to:
   1. Initial and current competence for privileging:
      1. Initial appointment competence reviews: 20 random cases reviewed per practitioner during his/her provisional period. For courtesy practitioners, it is understood that he/she may not have enough to satisfy this request.
      2. Current competence minimum reviews:
         1. 6 internal and 2 external (8 total) random cases reviewed per active physician and advanced practice nurse cases per year
         2. Up to 5 internal random cases reviewed per courtesy physician per year if the physician admits patients to Cabinet Peaks Medical Center

* + - 1. 10% review of all physician assistant – certified cases
  1. Invasive, operative, and noninvasive procedures that place patients at risk
  2. Blood usage
  3. Medication use and monitoring
  4. Mortality and morbidity review
  5. Safety management
  6. Risk management
  7. Infection control
  8. Utilization review
  9. Customer satisfaction and complaint review
  10. Sentinel event review
  11. Pathology and clinical laboratory/autopsy results
  12. Assessment of patients (quality of the history and physical)
  13. Education of patients and family

1. All medical and allied health professional staff peer review activities are reviewed with the applicable medical staff department committee.
2. The reviewed practitioner receives a confidential copy of each peer review report.
3. Data involving performance are assigned a score index indicating whether the information and/or case review demonstrated an acceptable standard of care.
4. The score index is defined as:
   1. 1 = Appropriate
   2. 2 = Controversial
   3. 3 = Inappropriate
5. The findings of any reviews rated a 2 or 3 by the peer practitioner are submitted to the Medical Staff Department Committee for further review. Each Department Committee member assigns a score index to the case and the overall index rating is determined in aggregate. The committee may decide on one of the following actions:
   1. Agreement that the variation was due to unforeseen circumstances and could not have been prevented. The variation will be trended by the QRM Department. Further variations, should they occur, will be brought to the attention of the Department Chief and/or Committee.
   2. Agreement that a variation occurred that might have been preventable. The Medical Staff Department Committee may recommend a change in or monitoring of a delineated privilege.
   3. The Committee and practitioner do not agree that a variation occurred. The matter is then referred to either the Medical Staff Executive Committee or the Credentials Committee. When a more extensive review of an occurrence is required, an ad hoc study group should be established per the Medical Staff Credentialing Bylaws, Article 5.
   4. Action taken as a result of the peer review may be changes in policy and procedures or processes, counseling of an employee or practitioner, sending a letter to the practitioner or trending occurrences. All cases assigned a score index by the Medical Staff Department Committee are placed in the involved practitioner’s peer review file for use in the initial or reappointment process.
   5. The practitioner may appeal the category decision of the Medical Staff Department Committee by requesting a review of the case(s) by the Credentials Committee.
   6. After committee review, a practitioner may be placed on intensified review if a trend occurs. A trend, for the purpose of peer review, is defined as:
      1. Any single egregious case
      2. Within any 12 month period of time, any one of the following criteria:
         1. 3 cases rated care inappropriate
         2. 5 cases rated either care controversial or inappropriate
         3. 5 cases rated as having documentation issues, regardless of care rating
   7. Intensified review is defined as:
      1. A thorough review of all the quality improvement monitors with deviations from standards of care, and untoward events that have been categorized in the two (2) years prior to being placed on intensified review and for six (6) months thereafter, and/or
      2. A 100% review of all admissions for performance for the next 12 months following Credentials Committee recommendation, and/or
      3. As defined by the Chief Executive Officer and Chief of the Medical Staff.
6. External Peer Review:
   1. External peer review may be utilized under the following circumstances if deemed appropriate by the Credentials Committee, the Medical Staff Executive Committee, Medical Center Leadership, or the Board of Directors:
      1. A request of the practitioner of concern who does not believe he/she may receive an unbiased review internally.
      2. The Medical Staff Department Committee cannot provide an unbiased reviewer based on issues of competitive or partnership practices. In the case that the Department Chief is the subject of the review, this case will be forwarded directly to the Credentials Committee for consideration and assignment of external peer review if there is no unbiased expert internally.
      3. When dealing with the potential for litigation.
      4. When dealing with ambiguous or conflicting recommendations from internal reviewers of medical staff committees, or when there does not appear to be a strong consensus for a particular recommendation.
      5. Lack of internal expertise when no one on the medical staff has adequate expertise in the specialty under review, or
      6. Lack of expertise when the only practitioners on the medical staff with that expertise are partners, associates or direct competitors of the practitioner under review and this potential for conflict of interest cannot be appropriately resolved by the medical staff.
      7. When a medical staff member requests permission to utilize new technology or perform a procedure new to this organization and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.
      8. Periodic random case review of the medical staff.
      9. Miscellaneous issues which may include:
         1. When the medical staff needs an expert witness for a fair hearing;
         2. For evaluation of a credential file; or
         3. For assistance in developing a benchmark for quality monitoring.
   2. On the basis of the recommended action of the outside peer review organization, the Credentials Committee or Medical Staff Executive Committee may determine a need to limit/suspend privileges by the Medical Staff Bylaws, Rules and Regulations. The medical staff may also work in cooperation with the reviewing agency to modify physician behavior in anticipation of such limitations.
7. Internal peer review shall be completed within 30 days from the date received by the reviewing physician per the Medical Staff Rules and Regulations Part 20.

# Quality Improvement Process

1. Medical Staff Departmental Chiefs may request the reviews of the performance of any practitioner whose privileges are within their scope of service. This review will be most important if there has been any detection of variant performance within the department, or the occurrence of “near miss” or sentinel events.
2. Citizenship issues that are not directly related to the quality of care are also subject to further study per the Medical Staff Credentials Bylaws Article 5.
3. The Medical Staff Department Committees shall report on peer review activities to the Medical Staff Executive Committee and Leadership to monitor peer review decisions and actions for effectiveness.

# Retention of Records

1. If there is an issue with a practitioner’s care and outcome, peer review documents should be retained permanently.
2. If there are no identified issues with a practitioner’s care and outcomes, peer review documents should be retained for three years and then destroyed. Note: The Montana Statute of Limitations is three years.

**Attachments:**

CR-002-AA Quality Improvement Program Emergency Medicine Indicators

CR-002-AB Quality Improvement Program Medicine Indicators

CR-002-AC Quality Improvement Program Obstetrics Indicators

CR-002-AD Quality Improvement Program Surgery Indicators

CR-002-AE Quality Improvement Program Anesthesia Indicators

CR-002-AF Prophylactic Antibiotic Regimen Selection Inpatient Surgery

CR-002-AG Prophylactic Antibiotic Regimen Selection Outpatient Surgery

**Forms:**

CR-002-FA Clinical Case Medical Staff Peer Review

CR-002-FB Clinical Case Review Committee Recommendations

CR-002-FC Focused Ultrasound Exam Data

CR-002-FD Clinical Case Anesthesiology Peer Review

CR-002-FE Surgical Infection Prevention Indicators for C-section Patients

CR-002-FF Transfusion Review

CR-002-FG Labor, Delivery, Recovery, and Post Partum Indicator Review

CR-002-FH Neonate Indicators Review

CR-002-FI Surgical Indicators Monitoring Review

CR-002-FJ Mortality Review

CR-002-FK Surgical Indicator Monitoring Report Summary

CR-002-FL Blood Utilization Review Process Audit

CR-002-FM Blood Utilization Quarterly Report

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| **Rule/Cite/Tag:** | | | | | |
| CMS CAH Conditions of Participation §485.641 *Periodic Evaluation and Quality Assurance Review*; S37-2-201 and S50-16-201 of the Montana Code Annotated | | | | | |
| **Medical Center Policy Cross Reference:** | | | | | |
| Medical Staff Bylaws, Medical Staff Credentialing Manual, and Medical Staff Rules and Regulations | | | | | |
| **List Historical Policy Version Dates:** | | | | | |
| Medical Staff Quality Improvement and Peer Review Process 08/07/01; Confidential Medical Staff Peer Review Form (CR-005) 02/2010; Confidential Committee Recommendations (CR-006); and Peer Review Process (CR-002) 04/16/08, 03/28/12, 01/13/14, 03/17/14 | | | | | |
| Approved By: | | | Approval Date: | | |
|  | ***See hard copy for signature*** |  |  | 02/18/15 |  |
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