MISH

POLICY NAME: OPPE Procedural Manual Ongoing Professional Practice Evaluation	Policy #: 179-304
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DEFNITIONS:

Peer:

Another practitioner, who has similar clinical responsibility as the reviewee and, when appropriate and possible, is in the same specialty or related specialty with experience to render a judgment on the circumstances under review.

Peer Review:

The process by which the medical staff evaluates the care, documentation, conduct and other matters potentially affecting patient care to maintain and improve the quality of care.

Reviewee:

A medical staff Member or Members whose care, documentation, conduct and other matters potentially affecting the quality of care is evaluated during the peer review process.

Peer Review Officer or Committee

An individual employed, designated or appointed by, or a committee of or employed, designated or appointed by, a health care provider group and authorized to perform peer review.

Medical Staff Clinical categories:

Within each clinical specialty a minimum threshold criteria will be maintained in order to delineate an approach to match competency with privileges granted. The criteria thresholds would serve as a trigger to identify the low-volume/ no-volume practitioners. Practitioners will be classified as:

- Clinically Active: this category should apply to physicians who are committed to the medical staff and fulfillment of the hospital's mission, and actively practice in the hospital. Clinically active meet minimum threshold criteria or required volume of quality data for specialty-specific privileges to perform a meaningful competency assessment.
  Active (adequate clinical data) - clinically active (meet minimum threshold criteria or required volume of quality data for specialty-specific privileges)

- Clinically Less Active (Low-volume/No-volume): physician primarily active at another hospital and only has privileges at MISH to provide coverage to another physician, or fulfill a specific or necessary service to the hospital. Clinically less active practitioners are below minimum threshold criteria, with some meaningful data to perform a meaningful competency assessment.
  Less active (sufficient quality data) - clinically less active (below minimum threshold criteria, with some meaningful data)

- Clinically In-Active: Only may be referring patients to the hospital. The only privileges that may be needed are refer and follow. There is no meaningful data available for collection and to perform a meaningful competency assessment.
  Inactive (no quality data) – clinically inactive (without any meaningful quality data).
  This creates a potential opportunity for medical staff and leaders to match competency with privileges granted to each practitioner.

POLICY

Ongoing routine quality review of patient care will be performed pursuant to the Risk Management and Performance Improvement Plans. The Medical Staff approve indicators/triggers for review. Initial screening will be performed either by physician or non-physician staff. All medical staff related issues identified by initial screening using established and approved indicators/triggers are reviewed by a member of the medical staff and discussed in appropriate medical staff committees. Results of peer review activities are considered in practitioner-specific credentialing and privileging decisions and, as appropriate, in the organization's performance improvement activities.

OPPE identifies professional practice trends that may impact the quality and safety of care and applies to all practitioners granted privileges via the Medical Staff Bylaws. The process supports early detection and response to performance issues that could negatively impact patient outcomes.

The goals include:

- A qualitative and quantitative data-driven process to identify performance trends that may require taking steps to improve performance (e.g. implementing an FPPE review).
- Establishing an objective, data-driven foundation for making re-privileging decisions.

The information resulting from the evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s) at the time the information is analyzed. Based on the analysis, several possible actions could occur, for example:

- determining that the practitioner is performing well or within desired expectations and that no further action is warranted
- determining that a performance issues exists and requires a focused evaluation (FPPE)
- revoking the privilege because it is no longer required
- suspending the privilege, which suspends the data collection, and notifying the practitioner that if they wish to reactivate it, they must request a reactivation

MISH will follow the general competency assessment that follows 6 general competencies as set by TJC and endorsed by most medical and professional organizations when reviewing practitioners performance:

1. Patient Care
2. Medical Knowledge
3. Practice Based Learning & Improvement
4. Interpersonal Communication
5. Professionalism
6. Systems Based Practice

PURPOSE

1. To provide a framework for hospital and medical staff to conduct ongoing routine peer review for the purpose of analyzing, evaluating, and improving the quality and appropriateness of care provided to patients at Minimally Invasive Surgery Hospital.
2. To establish the mechanism for incorporating relevant information from ongoing routine performance improvement peer review activities as they relate to medical staff appointment, reappointment and clinical privileging.
3. To define the reporting of ongoing routine medical staff peer review activities to the medical staff leadership and the governing body.
4. To ensure ongoing routine peer review is conducted according to defined procedures and established clinical and administrative indicators/triggers.

FREQUENCY OF REVIEW

The organized medical staff defines the frequency for data collection. However, the timeframe for review of the data cannot exceed every 12 months.

DATA

Qualitative and quantitative criteria (data) that have been approved by the medical staff, is used for the OPPE process.

Qualitative Data:

Qualitative or 'categorical' data, may be described as data that 'approximates and characterizes' and is often non-numerical in nature. This type of data may be collected through methods of observations, discussion with other individuals, chart review, monitoring of diagnostic and treatment techniques, etc.

Examples may include, but are not limited to:

- Description of procedures performed
- Periodic Chart Review
  - quality/accuracy of documentation
  - appropriateness of tests ordered / procedures performed
  - patient outcomes
- Types of patient complaints
- Code of conduct breaches
- Peer recommendations
- Discussion with other individuals involved in the care of patient(s), e.g. consultants, surgical assistants, nursing, administration, etc.

When the data being collected is related to the quality of performance, e.g., appropriate management of a patient's presenting condition, or the quality of the performance of a procedure, then the organized medical staff should determine that someone with essentially equal qualifications would review the data.

Quantitative Data

Quantitative data often reflects a certain quantity, amount or range and are generally expressed as a unit of measure. Contrasted with qualitative data, quantitative data generally relates to data in the form of numerical quantities such as measurements, counts, percentage compliant, ratios, thresholds, intervals, time frames, etc.

Examples may include, but are not limited to:

- Length of stay trends
- Post-procedure infection rates
- Periodic Chart Review
- Dating/timing/signing entries
- T.O./V.O. authenticated within defined time frame
- Presence/absence of required information (H & P elements, etc)
- Number of H & P / updates completed within 24 hours after inpatient admission/registration
- Compliance with medical staff rules, regulations, policies, etc.
- Documenting the minimum required elements of an H & P / update.
- Compliance with core measures

TRIGGERS

A key principle of OPPE is the use of Triggers – noticeable drops in performance. The trigger level is a predetermined baseline level of performance within an established criteria that is approved by the medical staff and executive committee.

Staff members who are below the trigger level then move into Focused Professional Practice Evaluation (FPPE). FPPE is used to evaluate and act upon concerns regarding a privileged practitioner's clinical

practice and/or competence. FPPE acts as an extension of OPPE when concerns about a practitioners performance is raised.

Executive committee and Board approve the list of triggers to be used to monitor provider performance. Chief Medical Officer and Department directors work with MEC and Board to determine triggers that will effectively assess provider performance. Triggers are periodically reviewed when quality indicators change and patient safety issues and/or trends are identified.

LOW-VOLUME PRACTITIONERS

When practitioners activity level at MAIH is low or none, supplemental data may be used from another CMS-certified organization where the practitioner holds the same privileges. The use of supplemental data may NOT be used in lieu of the OPPE process. When supplemental data is used the data is reviewed by the CMO and/or Department Director of clinical service to assess and determine the supplemental data's relevance, timeliness, and accuracy.

Examples where supplemental data could be used may include, but are not limited to:

- activity is limited to periodic on-call coverage for other physicians or groups
- occasional consultations for a clinical specialty

I. PEER REVIEW FUNCTIONS/ACTIVITIES

OPPE involves a peer review process, where practitioners are reviewed by other practitioners in the same discipline when possible and have personal knowledge of the applicant. The assessment should have both quantitative and qualitative performance data, preferably given by more than one fellow practitioner.

A. Included but are not limited to:

1. Establish and enforce guidelines designed to keep within reasonable bounds the cost of health care;
2. Determine if a hospital's facilities are being properly utilized;
3. Supervise, discipline, admit, determine privileges or control members of a hospital's medical staff;
4. Review the professional qualifications or activities of health care providers;
5. Evaluate the quantity, quality and timeliness of health care services rendered to patients in the facility; and
6. Evaluate, review or improve methods, procedures or treatments being utilized by the medical care facility or by health care providers in a facility rendering health care.

B. Privileged and Confidential

1. The records of all such committees or officers relating to such report shall be privileged as provide.
2. The reports, statements, memoranda, proceedings, findings and other records submitted to or generated by peer review committees or officers shall be privileged and shall not be subject to discovery, subpoena or other means of legal compulsion for their release to any person or entity or be admissible in evidence in any judicial or administrative proceeding.
3. Information contained in such records shall not be discoverable or admissible at trial in the form of testimony by an individual who participated in the peer review process.
4. The peer review officer or committee creating or initially receiving the record is the holder of the privilege established by this section.
5. This privilege may be claimed by the legal entity creating the peer review committee

or officer, or by the commissioner of insurance for any records or proceedings of the board of governors.

6. A peer review committee or officer may report to and discuss its activities, information and findings to other peer review committees or officers or to a board of directors or an administrative officer of a health care provider without waiver of the privilege provided.

II. Ongoing routine peer review

A. Initial indicators/triggers for routine peer review will include but not be limited to the following mechanisms:

1. Any occurrence that meets the initial indicators/triggers for review as defined by medical staff (approved indicators/triggers for review);
2. Trend and aggregate data through Chief Medical Officer;
3. Aggregate (quantitative) or trended quality metrics are encouraged (SSI rates, complications, etc…)
4. Qualitative or chart review data. Data is relevant to the specialty or privilege granted
5. Any risk management indicator that, upon initial screening, may indicate a concern involving the conduct, performance or competence of a practitioner, including incident reports;
6. Any act or practice that may be a deviation from the standard of care or act or practice that is or may be grounds for disciplinary action by licensing or accrediting agency or body;
7. Patient and/or family complaints related to quality of care; and
8. Third party payer, regulatory or accreditation agency notices related to the conduct, performance or competence of a practitioner.
9. When there is no other way to collect data or assets, then peer recommendations may be used such as in the case of Low or no volume providers.

B. Circumstances in which external peer review may be requested:

1. When there are no peers on the medical staff as determined by the designated peer review committee;
2. When a limited number of peers exist on the medical staff making it difficult for the medical staff leadership to obtain a reviewer who may not have conflict of interest, potential conflict of interest or perceived conflict of interest;
3. To verify effectiveness of internal peer review processes; and
4. At the request of MEC and/or governing body under the Medical Staff Bylaws, Rules and Regulations and/or Credentialing procedures.
5. The reviewee will receive written notice of any external review.

III. Process:

A. Preliminary Review

1. After initial screening, case reviews are assigned to physician peers for preliminary review and standard of care determination.
2. The CMO will delegate peer review activities to at least one physician in the department and that physician will conduct peer review for at least 2 years.
3. Physician peer reviewers conducting the preliminary review will be trained to conduct review in accordance with the Health Care Quality Improvement Act, Medical Staff Bylaws and Credentialing, Risk Management Plan and Performance Improvement Patient Safety Plans.
4. Preliminary determinations that the standard of care was met will be reviewed and

approved through the designated peer review entity for that department, which may include Mortality and Morbidity or Governance Councils or Committees.

5. Absent the need for immediate discipline or other special circumstances, preliminary review results indicating an act or practice is or may be a deviation from the standard of care and/or grounds for disciplinary action by the State Board of Healing Arts and/or corrective action pursuant to the Medical Staff Bylaws and other medical staff governing document are referred to the Executive Committee of the Medical Staff.

B. Chief Medical Officer - MEC review of preliminary findings of deviation from standard of care and/or grounds for disciplinary action.

1. Assure good faith review of the facts.
2. All issues reasonably presented by the facts are identified.
3. SOC determination for each issue identified.
    a. Is or may be deviation from soc?
    b. If yes, is there a reasonable le probability of harm associated with the SOC deviation?
    c. Clinically justifiable rationale for the SOC determination.
4. Recommended PI activities
5. Accept the preliminary SOC determination.
6. If preliminary review (any source) standard of care not met,
    a. Refer for more comprehensive review; AND
    b. Refer to MEC if may be grounds for corrective action per MEC governing documents OR
    c. Refer to Subcommittee for comprehensive review.
7. Don't accept preliminary review and conduct more comprehensive review.
8. Possible corrective action?, if so, referral to MEC per governing documents

C. Where the preliminary review indicates a deviation from the standard of care, possible grounds for disciplinary action by the State Board of Healing Arts or corrective action under the Medical Staff Bylaws and/or other governing documents the case may be referred directly to MEC.

1. The reviewee may be notified of case under review and will be provided an opportunity to be heard prior to any final determination.
2. If there is the potential for disciplinary action, or where approved preliminary review indicates an act or practice is or may be a deviation from the standard of care with a reasonable probability of harm and/or grounds for disciplinary action, the reviewee will be afforded the opportunity to meet with the designated peer review entity prior to the commencement of disciplinary action as defined in the medical staff bylaws.
3. The designated peer review entity will sign off peer review worksheets after completion by the physician peer reviewer and on approval of any recommended action. After completion, the peer review worksheet will be filed in Risk Management and a report will be included in the reviewee's credentials file.
4. The results of peer review activities are considered in practitioner-specific credentialing and privileging decisions. Peer review findings are aggregated without practitioner-specific information and, as appropriate, used for performance improvement, risk management and medical staff credentialing purposes.
5. Information regarding peer review activities is forwarded to the Executive Committee of the Medical Staff and the Board in accordance with the Medical Staff Bylaws.
6. The medical staff entities engaged in peer review recommend the outcome(s) and actions(s) to be taken. These may include, but are not limited to:
    a. Trending for performance improvement;
    b. Physicians education;
    c. Additional monitoring and/or other appropriate interventions'
    d. Written/verbal counseling and/or other disciplines;
    e. Submission to the MEC on system issues identified; and

f. Corrective action as defined by the medical staff.

7. Notwithstanding the provisions of this policy, at any time deemed appropriate by the clinical service chief, medical director or designee, director or designee may appoint an ad hoc committee and/or designate an alternative process to review and address concerns provided that the process is in compliance with the Medical Staff Bylaws.
8. The decision and process to perform FPPE for current practitioners with existing privileges is based on trends or patterns of performance identified by OPPE is not an adverse action triggering fair hearing processes.

IV. Reporting

A. Behavioral

1. Following initial review and after consultation with the CMO, medical director or designee, a peer review behavioral issue may be referred for review by Risk Management. The RM committee may, on a case-by-case basis, choose to refer issues regarding a member to a specific peer review entity for review and recommendation.

B. MEC/Board of Directors

1. Risk Management and/or Organization Improvement will track and trend all occurrences identified for review. Risk Management is responsible for reporting to KDHE and/or Board of Healing Arts.
2. The peer reviewer will be available to the MEC to discuss the reviewer's findings when the finding is of standard of care with probability of harm and/or grounds for corrective action pursuant to the medical staff bylaws, credentialing and rules and regulations. It is the responsibility of the peer reviewer to contact the medical staff office or Risk Management prior to the MEC meeting to discuss the case to be reviewed if the peer reviewer will not be available to attend the MEC meeting.

C. Ongoing/Trended and Aggregate Reporting

1. The medical staff committees involved with Ongoing Professional Practice Evaluation (OPPE) will provide the Credentials Committee with data systematically collected for OPPE that is appropriate to evaluate and confirm current competence for these practitioners during the FPPE period.
2. Quarterly and/or Bi-annual performance data will be provided to individual medical staff members on hospitalized patients.
3. CMO will receive data on all department members for use in conducting a comprehensive evaluation of the practitioner's performance and provide expectations to each member of the department. This data will also be considered as part of evidence-based privilege renewal process.
4. The decision and process to perform FPPE for current practitioners with existing privileges is based on trends or patterns of performance identified by OPPE are outside the scope of this policy