CANYON VISTA
MEDICAL CENTER

Medical Staff Bylaws

Appendix E

Professional Review Policy

CANYON VISTA MEDICAL CENTER
MEDICAL STAFF BYLAWS

I N D E X

APPENDIX "E"
PROFESSIONAL PERFORMANCE REVIEW POLICY

1.1 PURPOSE

1.1(a) To define the process for conducting performance evaluations, establish the method and duration of monitoring, and circumstances under which monitoring by an external source or focused review may be required.

1.1(b) To define the type of data (criteria/indicators), to be collected for the ongoing and focused professional practice evaluation and ensure this information is integrated into performance improvement initiatives and used to determine whether to continue, limit or revoke any existing privilege(s).

1.1(c) To ensure reported concerns regarding a privileged practitioner's professional practice are uniformly investigated and addressed as defined by the organization and applicable laws.

1.1(d) To measure, assess, and resolve clinical performance issues on an organization-wide basis and to promote high quality patient care; and

1.1(e) To conduct an effective peer review process that is evidence-based, consistent, timely defensible, balanced, useful, and ongoing.

2.1 SCOPE

This policy applies to all Medical Staff and Allied Health Professionals privileged through the medical staff credentialing process of the Hospital. However, providers who, by virtue of staff category (e.g., consulting, honorary, affiliate, etc.), have not been granted privileges and have no volume at the facility are exempt from the OPPE and FPPE requirements contained herein.

3.1 DEFINITIONS

3.1(a) **Focused Professional Practice Evaluation (FPPE)** – A time-limited (for a specific period of time OR a specific volume/number of procedures, admissions, encounters, etc.) evaluation of practitioner or AHP's competence in performing a specific privilege. This process is implemented for (1) all newly requested privileges, and (2) whenever recommended by the applicable committee or department when a question arises regarding a practitioner's ability to provide safe, high quality patient care, or a "trigger" event occurs.

3.1(b) **Ongoing Professional Practice Evaluation (OPPE)** – A documented summary of ongoing data collected for the purpose of assessing a practitioner or AHP's clinical competence and professional behavior. The information gathered during this process factors into the decision to maintain, revise or revoke existing privilege(s).

3.1(c) **Peer** – An individual who possesses the same or similar medical specialty knowledge and training as the individual being reviewed. ***Note that an individual functioning as a peer reviewer will not have performed any medical management on the patient whose case is under review. However, opinions and information may be obtained from participants that were involved in the patient's case.***

3.1(d) **Practitioner** – The definition of "practitioner" shall be the same as in the Medical Staff Bylaws.

4.1 POLICY

The Medical Staff, through the activities of departmental and committee review, will monitor and evaluate the quality and appropriateness of patient care provided by all medical staff licensed independent practitioners and allied health professionals with delineated clinical privileges and/or scopes of practices.

The review process involves monitoring, analyzing, and understanding those special circumstances of practitioner performance which require further evaluation. If there is uncertainty regarding the practitioner's professional performance, the course of action defined in the Medical Staff Bylaws for further evaluation should be followed. It is not intended that this Policy supersede any provisions of the Medical Staff Bylaws. If the performance of the practitioner is sufficiently egregious, the Chief of Staff or CEO shall determine, within his/her sole discretion, whether the provisions of this Policy need not be followed, whereupon the provisions of the Medical Staff Bylaws, and not this Policy, shall govern.

If behavior that undermines a culture of safety or practitioner wellness is identified as a potential concern, the Behavior that Undermines a Culture of Safety Policy or Practitioner Wellness Policy, as appropriate, may be implemented in conjunction with this Policy. However, nothing herein limits the appropriate committee, MEC or Board's obligations or authority under either Policy. When findings of this process are relevant to an individual's performance the Medical Staff is responsible for determining their use in ongoing evaluation of a practitioner's competence, in accordance with Joint Commission standards on renewing or revising clinical privileges.

5.1 SCREENING

A qualified reviewer will be assigned by the Department Chair or his/her designee will perform concurrent and retrospective chart reviews as part of the routine peer review process, which shall not be considered an "investigation" as that term is contemplated by the Medical Staff Bylaws. Any individual (including patients/family, medical staff, allied health professional or Hospital staff) may report any concerns regarding the professional performance of a practitioner. If a case meets the screening indicator criteria, the screener will refer the case to an appropriate physician peer reviewer for evaluation and scoring.

6.1 RESPONSIBILITIES

The Medical Staff Services Director or his/her designee is responsible for coordinating and facilitating review activities, forwarding cases to the designated Department Chairperson or his/her designee, as appropriate, per the criteria/indicators for review identified in Addendum A, trending data related to individual practitioner performance, and providing periodic summary reports for review by the Department, applicable peer review committees and MEC of patterns/trends identified.

Each department chairman responsible for the ongoing review of patient care rendered by the members of his/her department may, at his/her discretion, designate other members of the department to collaborate with him/her or conduct FPPE as appropriate.

The department chairman, or his/her designee peer review screener, will review the medical record, score the case using the rating scale contained herein, identify opportunities for improvement and make recommendations whether any further intervention/action is needed. All cases scored as 3, 4 or 5 will be referred for a higher level of departmental review or by a special panel of peers assigned by the Department Chairperson, Chief of Staff, applicable peer review committee or MEC.

The MEC will serve as the oversight committee for all medical staff performance improvement activities, review findings of ongoing and focused practice evaluations, and take action as appropriate. The MEC will consider all documented cases which meet the criteria for review at the time of renewing, revising, limiting or revoking existing privileges, and make recommendations to the Board of Trustees regarding ongoing and focused professional practice reviews, as appropriate.

The MEC reviews and modifies this Policy at least every two (2) years and peer review indicators as needed, but at least annually, with input from the individual departments and the Quality Department.

7.1 CRITERIA/INDICATORS FOR REVIEW

The following are six (6) areas of general competence that may be considered in review:

- Patient care.
- Medical/clinical knowledge.
- Practice-based learning and improvement.
- Interpersonal and communication skills.
- Professionalism; and
- Systems-based practice

***The Medical Staff, in conjunction with the applicable departments, will develop and update the criteria/indicators to be collected for OPPE and the "triggers" for FPPE* 8.1**

8.1 REVIEW PROCESS

8.1(a) Professional performance reviews, which include OPPE and FPPE, may include, but shall not be limited to:

- Periodic chart reviews.
- Use of external peer review.
- Simulation.
- Proctoring by direct observation.
- Extension of monitoring period to further evaluate competency and/or performance evaluation.
- Evaluation of medical assessment and treatment of patients.
- Consultations/discussions with other individuals involved in the care of the patient.
- Adverse privileging decisions.
- Use of medications.
- Use of blood and blood components.
- Operative and other procedures.
- Appropriateness of clinical practice patterns.
- Significant departures from established patterns of clinical practice.
- Use of developed criteria for autopsies.
- Monitoring of diagnostic and treatment techniques.
- Discussion with other individuals involved in the care of each patient, including consulting physicians, assistants at surgery, nursing, and administrative personnel.

8.1(b) Evaluation is accomplished through a review of various data sources, which may include, but are not limited to the following:

- Monitoring clinical practice patterns
- Complications
- Complaints/Compliments
- Volume
- Length of stay patterns
- Morbidity and mortality data
- Peer review cases/chart reviews
- Suspensions
- Medical record deficiencies

- Patient, peer, family, staff complaints
- Pharmacy, Therapeutics/Infection Control Committee
- Medical Records/Utilization Review Committee
- Patient Care Conferences
- Blood and Tissue Reviews
- Patient Safety data
- Quality Core Measures
- Occurrence reports
- Sentinel event data
- Mortality Reviews
- Other relevant criteria as determined by the organized medical staff

9.1 OPPE

OPPE is used to assess the competence of those practitioners privileged through the medical staff process. All OPPE data will be reviewed by the applicable department or service chairperson or his/her designee/reported for review/action at least every nine (9) months for overall performance and comparison purposes or to determine whether there are any performance improvement initiatives that need to be addressed further, which are related to organizational processes or clinical practices.

All reviews shall be considered a part of the confidential peer review activity of the medical staff, and the written results of OPPE shall become part of the practitioner or AHP's quality file and will be included in the decision to maintain existing privileges, revise existing privileges or to revoke existing privileges prior to or at the time of renewal. Results of OPPE shall be communicated in writing to the practitioner or AHP at least every nine (9) months.

10.1 FPPE

FPPE is implemented (1) for all newly requested privileges, and (2) whenever a question arises regarding a practitioner's ability to provide safe, high quality patient care, or a "trigger" event occurs. The Credentials Committee, a Department, a Department Chairperson, a Section Chairperson, any peer review committee, the MEC, or the Board may recommend FPPE.

Periods of FPPE implemented for reasons other than for a newly requested privilege must be time-limited (for a specific period of time or a specific volume/number of procedures, admissions, encounters, etc.). The terms of the FPPE must be communicated to the affected practitioner or AHP in writing, which shall include the reasons for the FPPE; the specific period of time or specific volume/number of procedures, admissions, encounters, etc.; and the method for monitoring specific to the privileges giving rise to the review.

Cases reviewed pursuant to an FPPE may be selected either by ongoing monitoring of clinical practice patterns using the criteria/indicator "triggers" outlined in Addendum A, attached, or when there is an unexpected patient outcome. Such FPPE may be accomplished through:

10.1(a) Review of certain cases/procedures (e.g., all laparoscopic cholecystectomy cases; or all cesarean sections) during an identified period of time.

10.1(b) Review of an identified number of cases or procedures performed: or

10.1(c) Review of a randomly selected percentage of cases during a specified time period.

All reviews shall be considered a part of the confidential peer review activity of the medical staff, and the written results of FPPE shall become part of the practitioner or AHP's quality file and will be included in the decision to

maintain existing privileges, revise existing privileges or to revoke existing privileges prior to or at the time of renewal.
Results of FPPE shall be communicated in writing to the practitioner or AHP upon conclusion of review.

11.1 RATING SCALE

The peer reviewer uses the following rating scale to assess the cases:

Rating Score	Definition
0	Quality of care, treatment, or services meet or exceeds medical standards of practice
1	Medical management in variance with acceptable standards of practice but it is without potential for: Anatomical or physiological impairment, disability, or death Unnecessary prolonged treatment, complications, or readmissions
2	Medical management in variance with standards of medical practice and it is with the potential for adverse consequence: Anatomical or physiological impairment, disability, or death Unnecessary prolonged treatment, complications, or readmissions
3	Medical management does not meet acceptable standards of practice (disease, or symptoms caused, exacerbated or allowed to progress) resulting in: Anatomical or physiological impairment or disability Unnecessary prolonged treatment, complications, or readmissions
4	Medical management does not meet acceptable standards of practice resulting in: Adverse Outcome
5	Medical management does not meet acceptable standards of practice resulting in: Death

The Code of Conduct reviewer uses the following rating scale to assess the cases:

Rating Score	**Definition**
1	Dismissed with no further action
2	Send the subject provider a certified return receipt letter of guidance about the incident. Subject provider will be made aware that the document action of the incident will be in the quality file, separate from the credentialing file. Track and Trending will begin.
3	**Initial Incident:** • Send the subject provider a certified return receipt letter of guidance about the incident. Subject provider will be made aware that the letter will be in the quality file, separate from the credentialing file • If deemed appropriate by the COCC, assigned member(s) of the COCC will meet with the subject provider to counsel and educate him/her about concerns and the necessity to modify the behavior in question.
	Repeat Incident: • If there have been prior incidents and a pattern may be developing, the COCC will notify the subject provider that a series of reports have been received and invite the subject provider to meet with the COCC. The subject provider will be informed that documentation regarding the incidents will be filed in the quality file and included, along with the documentation of any previous incidents in the credentialing process. • The subject provider will also be informed that additional incidents will be referred to the MEC. • If the COCC receives additional complaints regarding the subject provider after the above measures have been performed, the COCC may escalate the issue to the next level of classification and will result in a zero-tolerance policy/behavioral agreement contract recommendation being made to the MEC. Track and trending will continue.

4	Notify the subject provider that a report or series of reports have been received and invite the subject provider to meet with the COCC. After the provider has been interviewed by the committee, it will be determined whether a recommendation for corrective action should be sent to the MEC. An initial corrective recommendation may consist of but not be limited to anger/stress management, psychiatric counseling or other training deemed appropriate to the situation. • A recommendation for a behavioral agreement contract may be appropriate
5	This will be referred directly to the MEC for corrective action.

12.1 ACTIONS BASED ON THE RATINGS

The criteria utilized to determine the type of action/intervention imposed are based on severity, frequency of occurrence, and trigger threshold parameters. The following actions/interventions are taken based upon the rating assigned:

LEVEL 1—DEPARTMENTAL CHAIR REVIEW (or designated initial peer reviewer)

RATING	ACTION
0, 1	Case approved. Results used for trending only Case review sheet to Medical Staff Coordinator for physician's reappointment file

LEVEL 2—REVIEW BY APPROPRIATE CLINICAL DEPARTMENT

2, 3	Further review indicated Department Chair may decide to track and trend Presented at appropriate department meeting <u>Recommendation of the department may include</u> Case found to be acceptable – No further action needed Results used for trending only Case review sheet to Medical Staff Coordinator for physician's reappointment profile Further review indicated—Refer to MEC A focus review plan is proposed

LEVEL 3—MEDICAL EXECUTIVE COMMITTEE REVIEW

2, 3, 4, 5	Further review indicated by the department. Responsible physician notified case to be reviewed by MEC and given notice of the meeting <u>Recommendation of the MEC may include:</u> Require additional education A review of additional cases Assignment of proctor for certain procedures Require consultation for specific diagnoses Institute a focused professional practice evaluation (FPPE) or specified scope and duration Limit, modify, restrict, suspend, or revoke existing privilege(s) MEC notifies responsible physician by certified mail of recommendation(s) made Case review sheet to Medical Staff Coordinator for physician's reappointment file

13.1 PEER REVIEW PROCESS

- The MSD or his/her designee will receive materials from various locations for review.
- The MSD or his/her designee will record the cases on the Excel spread sheet created for tracking purposes.
- The MSD or his/her designee will prepare materials to be given to the Department Chairperson or designee for review.

- Once the MSD or his/her designee receives the review back from the Department Chairperson or designee s/he will prepare the review (if indicated) for committee.
- The MSD or his/her designee will review the confidential quality file for any information that may indicate a trend.
- Trends will be prepared for committee review.
  - A trend will be any like issue that has occurred three times or more during the previous/current reappointment cycle.
- The MSD or his/her designee may ask the peer reviewer to be available during the meeting for discussion if the peer reviewer is not a part of the committee.
- Meeting minutes will be recorded at all meetings.
- The MSD or his/her designee will perform all follow-up requested from committee.

14.1 EXTERNAL PEER REVIEW *(see Medical Staff policy External Peer Review for detailed procedure)*

The Board of Trustees, the Medical Executive Committee, the Chief of Staff, the Medical Staff Quality Improvement Committee, the CEO, or a Department Chairperson has the authority to request external peer review. Circumstances that may indicate an external review may include, but are not limited to:

- There is no member who qualifies as a "peer," or expertise is lacking.
- Conflict of interest exists that cannot be appropriately resolved by the MEC or Board.
- Professional standards are not clear, non-existent, or inconsistent.
- Need for opinion from an impartial, expert outsider due to confusing, ambiguous, or conflicting internal review opinion.
- There is potential for medical malpractice suit or significant compliance issue, legal counsel or risk management may recommend external review.
- When a matter has the potential to lead to an action that would require a hearing pursuant to the Health Care Quality Improvement Act of 1986.

Practitioners or AHPs may request the Hospital to obtain external peer review; however, the determination as to whether to grant said requests rests solely with the Board of Trustees, the Medical Executive Committee, the Chief of Staff, or the Department Chairperson.
An external reviewer may, but is not required to, be appointed to the reviewing committee as an ad hoc member for the purpose of completing a case review. The decision to appoint an external reviewer to a committee shall be in the sole discretion of the Board of Trustees, the Peer Review Committee, or the MEC.

15.1 DOCUMENTATION

Cases presented at meetings will be referred to and referenced by the medical record number/patient account number and not by the patient's name. The physician's ID# will be used rather than the name of the physician. The reason the case is being reviewed (i.e., mortality review, blood criteria not met, complications, etc.), and results of peer review findings, recommendations to continue, limit, modify or restrict privileges, will be recorded in meeting minutes.

16.1 REPORTING

Department-specific case review results are reported quarterly in aggregate to the respective clinical department. Composite case review ratings for all departments are presented to the Medical Executive Committee and Board quarterly.

17.1 CONFIDENTIALITY & MAINTENANCE OF FILES

No copies of peer review documents will be created or distributed, unless required and authorized by applicable law or allowed the Medical Staff Bylaws or Fair Hearing Plan. A practitioner or AHP may review his/her quality file

by making an appointment with the Medical Staff Office and Chief of Staff, provided that the Chief of Staff and CEO may, in their sole discretion, redact any personal information (e.g., reviewer, patient, or employee identities) from the file before the practitioner or AHP reviews the file.

Practitioners or AHPs shall be permitted to submit written responses to any peer review matter for which he/she is being reviewed for placement in his/her peer review/quality file.