Medical Staff Peer Review and Quality Program

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Senior Manager, Clinical Operations

Agenda

- Regulatory Requirements
- Ongoing Review
- Focused Reviews
- Structure and Process
Peer Review

• **What it **IS: **(according to American Medical Association)**
  • “Medical peer review is the process by which a professional review body considers whether a practitioner’s clinical privileges or membership in a professional society will be adversely affected by a physician’s competence or professional conduct. The foremost objective of the medical peer review process is the promotion of the highest quality of medical care as well as patient safety.”
  
  - Official Website of the American Medical Association
    (last reviewed October 14, 2009).

• **What it is NOT:** a formality

The American Medical Association (AMA)

Supports the peer review process. Recommends peer review evaluations be based on:

- Appropriateness
- Medical necessity
- Efficiency of services to assure quality medical care
CMS Quality Requirements for All Hospitals

• 482.21(a)(2)
  • The hospital must measure, analyze and track quality indicators including adverse events and other’s aspects of performance that assess processes of care, hospital and operations.

• 482.21(b)(3)
  • The hospital must use the data collected to identify opportunities for improvement and changes that will lead to improvement.

CMS Quality Requirements for All Hospitals (Continued)

• 482.21(c)(1)
  • The hospital must set priorities for performance improvement activities that focus on high risk problem prone, or high volume areas and that affect patient outcomes, patient safety, and quality of care.

• 482.22(d)(1)
  • ... a hospital’s medical staff must conduct a periodic appraisal of each practitioner
  • ... must evaluate each individual practitioner’s qualifications and demonstrated competencies to perform each task or activity within the applicable scope of practice or privileges for that type of practitioner for which he/she has been granted privileges.
Accreditation Requirements

• The Joint Commission
  ▪ Major initiative in 2008
  ▪ Focused Practitioner Performance Evaluation (FPPE).
  ▪ Ongoing Practitioner Performance Evaluation (OPPE)

What Are Joint Commission’s Expectations?

• OPPE
  ▪ Review performance data for all practitioners with privileges on an ongoing basis and thus allow them to take the appropriate steps to improve performance on a more timely basis

• FPPE
  ▪ Process to evaluate the specific competence of all practitioners who do not have documented evidence of competency performing the privileges at the organization (new appointees; new privileges)
  ▪ Process to evaluate a current privileged practitioner’s ability to provide safe, high quality patient care
Accreditation Requirements:
The Joint Commission Standard MS.08.01.03

• Ongoing Professional Practice Evaluation (OPPE) – OPPE information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal
  • Reappointment
  • Between appointments
  • “Ongoing” means more than once a year – otherwise, is only “periodic”
  • There is a clearly defined process in place that facilitates the evaluation of each practitioner’s professional practice
  • Data collected is determined by individual departments
    o approved by the organized medical staff
  • OPPE data is used to determine whether to continue, limit, or revoke any existing privilege(s)

Medical Staff Quality Activities Meeting OPPE Requirements

<table>
<thead>
<tr>
<th>Example</th>
<th>Data must be collected by individual practitioners.</th>
<th>*See handout for additional data sources</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Function/Source</strong></td>
<td><strong>Responsible Department</strong></td>
<td><strong>Reported Quarterly To</strong></td>
</tr>
<tr>
<td>1. Physician Data Profile</td>
<td>Case Management</td>
<td>Quality Committee (QIC), Surgical Review Committee, Utilization Management (UM)</td>
</tr>
<tr>
<td>2. Complications Reports</td>
<td>Quality</td>
<td>Medical Review Committee, Surgical Review Committee, QIC, MEC, Board</td>
</tr>
<tr>
<td>3. Core Measures</td>
<td>Quality</td>
<td>QIC, MEC, Board</td>
</tr>
<tr>
<td>4. Blood Review</td>
<td>Laboratory</td>
<td>UM Committee, QIC, MEC, Board</td>
</tr>
<tr>
<td>5. Medication Usage Review</td>
<td>Pharmacy</td>
<td>P&amp;T Committee, QIC, MEC, Board</td>
</tr>
</tbody>
</table>
How Are the Joint Commission’s Six Areas of General Competency and CMS’ 5 Areas Included in the Process?

**Joint Commission**

- The six areas required to be evaluated are:
  1. Medical / clinical knowledge
  2. Evidence-based practice
  3. Ability to provide appropriate patient care
  4. Professionalism
  5. Systems-based practice
  6. Interpersonal and communication skills

**CMS**

- 482.12 (a)(6)
  1. Individual character
  2. Individual competence
  3. Individual training
  4. Individual experience
  5. Individual judgment

---

**Example**

**Joint Commission**

**Six General Areas of Competency**

<table>
<thead>
<tr>
<th>Area of Competency</th>
<th>CMI Volume Data</th>
<th>PI/Core Measures</th>
<th>DP Review</th>
<th>Blood Use</th>
<th>Med Use</th>
<th>BM</th>
<th>RM</th>
<th>Peer Rec 1</th>
<th>Peer Rec 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Patient Care</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>#1,2,9</td>
<td></td>
</tr>
<tr>
<td>2) Medical/Clinical Knowledge</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>#1,9</td>
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<tr>
<td>3) Evidence-Based Practice</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>#1,7</td>
<td></td>
</tr>
<tr>
<td>4) Interpersonal and Communication Skills</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>#7,4,3</td>
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<tr>
<td>5) Professionalism</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>#3,5,6</td>
<td></td>
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<tr>
<td>6) Systems-Based Practice</td>
<td>X</td>
<td>X</td>
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<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>#1</td>
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</tbody>
</table>
Example

CMS
Five Areas of Competency

<table>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Individual Character</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2) Individual Competence</td>
<td>X X X X X X X X</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>3) Individual Training</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4) Individual Experience</td>
<td>X</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Individual Judgment</td>
<td>X X X X X X X X</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>

Proprietary & Confidential

Quality Management or Peer Review Plan Defined Process

Triggers
- The medical staff should establish triggers for quality indicators being monitored that signal a peer review is needed.
- Examples of triggers are:

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>TRIGGER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANESTHESIA</strong></td>
<td></td>
</tr>
<tr>
<td><strong>PATIENT CARE</strong></td>
<td></td>
</tr>
<tr>
<td>Death Within 24 Hrs. Post Anesthesia</td>
<td>≥ 1 / Qtr</td>
</tr>
<tr>
<td>% of Cases Peer Reviewed with Outcome Classification of 2 or 3</td>
<td>≥ 1 / Qtr</td>
</tr>
<tr>
<td>Cardiac Arrest Within 24 Hrs. Post Anesthesia</td>
<td>≥ 1 / Qtr</td>
</tr>
<tr>
<td><strong>INTERPERSONAL &amp; COMMUNICATION SKILLS</strong></td>
<td></td>
</tr>
<tr>
<td>Immediate Post Op Note</td>
<td>3 Notes Not Immediate / Qtr</td>
</tr>
<tr>
<td>Validated Complaints from Patients/Family/Staff</td>
<td>≥ 1 / Qtr</td>
</tr>
<tr>
<td><strong>PRACTICE BASED LEARNING IMPROVEMENTS</strong></td>
<td></td>
</tr>
<tr>
<td>Adherence to NPGS for Abbreviations</td>
<td>3 Unacceptable Abbrev / Qtr</td>
</tr>
<tr>
<td><strong>SYSTEM BASED PRACTICE</strong></td>
<td></td>
</tr>
<tr>
<td>Packed Cell Transfusion Appropriateness</td>
<td>≥ 90%</td>
</tr>
<tr>
<td>CT Ratio</td>
<td>≥ 2.0</td>
</tr>
<tr>
<td><strong>MEDICAL KNOWLEDGE</strong></td>
<td></td>
</tr>
<tr>
<td>Number of Times Placed on Focused Review due to Performance Issues</td>
<td>&gt; 3 / Yr</td>
</tr>
<tr>
<td>New Procedure Training Obtained</td>
<td>NA</td>
</tr>
<tr>
<td><strong>PROFESSIONALISM</strong></td>
<td></td>
</tr>
<tr>
<td>OR Delay Due to Surgeon Being Late</td>
<td>≥ 3 / Qtr</td>
</tr>
<tr>
<td>Pt/Family/Staff Written Positive Feedback</td>
<td>NA</td>
</tr>
</tbody>
</table>

*See handout for additional examples

Proprietary & Confidential
Use OPPE Data as Objective Source of Information in Reappointment Process and Performance Improvement

Each department should evaluate OPPE measures and choose those that are meaningful.

Ensure collection of “zero” data (e.g., chart reviews that meet standard of care).

Department sets target (internal goal or external benchmark).

Department sets trigger (threshold for initiating FPPE).

Compare individual to cohort to promote reliability or raise performance (e.g., complications, utilization/cost, participation).

Steps to Implement OPPE

1. Identify all current criteria for each specialty
2. Identify all applicable core competencies
3. Identify the gaps
4. Meet with medical staff leaders to complete the criteria along with triggers that would signal the need for FPPE
5. Complete a matrix for sources to provide data to the Quality office
6. Define timeline for review and implement
Performance Not Meeting Expectations

• If a physician competency issue is identified in any of the ongoing peer review/quality reports, appropriate action must be initiated at that time – do not wait until reappointment

• This data will be included in the physician’s quality file for re-evaluation at reappointment – these files should NOT be located in the Medical Staff Office

• There should be no surprises when a physician is evaluated for reappointment

Ongoing Professional Practice Evaluation (OPPE) Example
What About Physicians Who Seldom Admit or Use the Hospital (Low Volume)?

• Physicians who have encounters at another hospital can authorize that hospital to complete a quality data form to be used for reappointment (see attached)
• Hospitalists may provide an evaluation for the primary care physicians for whom he/she is accepting admissions (see attached)

Determining Competency For Low Volume Or No Volume Providers

• Collect volume and performance data from facility where the practitioner actively practices
• If a facility is reluctant to release the information, you must place the burden of collecting this data on the applicant
• Request letters of reference from physicians on your medical staff whom the applicant refers patients or from the hospitalist
Determining Competency for Low Volume or No Volume Providers

• Do not confuse appointment to the medical staff with the granting of clinical privileges.
• Credentials Committee chairman can recommend medical staff membership for a low or no volume provider who desires affiliations with your hospital, who does not want or need privileges to admit or treat patients.

Never reappoint a physician to your medical staff who cannot document current clinical competency.
Accreditation Requirements:
The Joint Commission Standard MS.08.01.01

• Focused Professional Practice Evaluation (FPPE) – The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner’s professional performance
  ▪ New members
  ▪ New privileges
  ▪ Performance monitoring
  ▪ Performance issues (old “peer review”)

FPPE Requirements

• FPPE Elements of Performance:
  ▪ An FPPE is conducted for all initially requested privileges
  ▪ The organized medical staff develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified
  ▪ The performance monitoring process is clearly defined and includes each of the following elements:
    o Criteria for conducting performance monitoring
    o Method for establishing a monitoring plan specific to the requested privilege
    o Method for determining the duration of performance monitoring
    o Circumstances under which monitoring by an external source is required
FPPE Requirements

- FPPE Elements of Performance (cont.):
  - FPPE is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff
  - Triggers that indicate the need for performance monitoring are clearly defined
  - The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a practitioner’s current clinical competence, practice behavior, and ability to perform the requested privilege
  - Criteria are developed that determine the type of monitoring to be conducted
  - Measures employed to resolve performance issues are clearly defined
  - Measures employed to resolve performance issues are consistently applied

Example: Community Hospital Medical Staff Current Competency/Proctoring Criteria

<table>
<thead>
<tr>
<th>High Risk Problem Prone Procedures/Privileges</th>
<th>Experience</th>
<th>Minimum Cases to be Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angiography, Peripheral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angioplasty, Peripheral</td>
<td></td>
<td></td>
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<tr>
<td>Stenting, Peripheral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ankle Arthroscopy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angiography, Carotid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arterial Line Placement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*See handout for additional examples*
### Focused Professional Practice Evaluation (FPPE) Minimum Indicators for Review - Sample

**Emergency Department Physicians – New Appointment**

- First four encounters; two major trauma, two minor trauma
- First two pediatric encounters
- First two moderate sedation cases
- First two procedures, i.e., chest tube insertion, lumbar puncture, line placement, closed reduction (etc.)

### Minimum Indicators for Review (Sample)

- First two restraint cases
- First two psychiatric
- First two OB/GYN
- First one code management
Focused Professional Practice Evaluation (FPPE)

• The ER medical director and the ER RN director need to work with the Quality Director to operationalize the FPPE process:
  • Identification of the start date for any new practitioner in the ER
  • Identification of any cases which meet those identified for review for FPPE

Case Review Sources

• Case reviews may include (list not inclusive):
  • Deaths
  • Readmissions within 72 hours
  • Returns to surgery
  • Unexpected complications
  • Patient complaints
  • Transfers to a higher level of care
  • Cases of concern referred by other committees, Quality, or other clinicians
  • Healthcare-Acquired Infections (HAIs)
  • Failed core measures cases
  • Hospital Acquired Conditions (HACs)
  • Unattended deliveries
  • ADR’s
Sample Individual Case Review Flow Chart

Medical Review Committee
- Receive input from individual review and practitioner under review and practitioner involved in case
- Assign rating
- Look for shared learning opportunity

MEC
- Focus: Medical Staff Education and Individual Provider Improvement
- Initiate FPPE when indicated

Individual Peer Review
- No Concerns

Findings Entered in Quality Database
- Potential Systems Improvement Opportunity Identified

Quality Improvement Committee
- Focus: Systems Improvement
- Commission PI Team, RIE, RCA
- Shared Learning, Communication to Workforce

Case Origination
Screen – Quality Department
- Possible Concern

Unfavorable QOC rating

Possible Concern

Care Appropriate?

YES

NO

MEC Implement Fair Hearing Process
(See Fair Hearing Plan)

MEC Initiate FPPE Process

MEC Choices for FPPE include but are not limited to:
- Proctoring
- External Peer Review
- 100% Review of Trigger
- Mandatory consultations
- Second Assist
- Additional Education
- Initiate the Impaired Practitioner Policy
- Initiate the Discipline Practitioner Policy
- RCA with resultant changes in processes

Example: Focused Professional Practice Evaluation (FPPE) Process Flow
**Why Is External Peer Review Needed?**

- Hospital only has one physician in a certain specialty
- Joint Commission requires a peer review – Radiologists, anesthesiologists, pathologists, podiatrists, and dentists (oral surgeons)
- Only peers available may be partners in group practice
- Conflict of interest situations
- MEC may feel it is warranted

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**When Can It Be Used?**

- Initial applications
- Reappointment
- Routine OPPE
- FPPE
- Anytime MEC or Board feels it is warranted - MEC must develop indicators for referral
What External Peers Can Be Used?

- Physician peer review companies
- University medical staff members
- Some QIOs offer this service
- MEC and/or Board should select external reviewer, not physician being reviewed

Types of Routine Reviews

- Quarterly peer reviews of house-based physicians
- Radiology film over reads
- Pathology slide over reads
- Blood usage review
- Review of operative and invasive procedures
- EKG over reads
- Single specialist OPPE, i.e. OB, psych, cardiology, orthopedics, etc.
Preparing Records, Images, Slides to Submit for External Review

- Prior to submitting any records for review, a contractual agreement must be executed between the hospital and reviewer (or company). A copy of the reviewer’s credentials should be attached to the agreement.
- A request for the review should be attached to the medical records that include:
  - Information regarding review requested
  - Who is requesting review, i.e. MEC, Board or Committee

Preparing Records, Images, Slides to Submit for External Review (cont.)

- External reviewers should provide a TYPED report of the review finding to the hospital as soon as possible but no later than 30 days after receipt of the medical record
- The required turn around time should be stated in the agreement with the reviewer
Written Report of Review Findings

- The written report should include, at a minimum, any quality, standard of care, utilization review, or other issue which may have had an impact on the outcome of care provided
- A completed peer review form should be returned with the typed report that includes scoring decisions assigned by the peer reviewer

Intended (and Unintended) Effects of FPPE/OPPE

- Peer review will be more standardized/ formalized
- More likely to uncover problems early
- More likely to uncover problems, period
- More likely to lead to corrective action/peer review hearings?
## Checklist for Peer Review Program

<table>
<thead>
<tr>
<th>Content Section</th>
<th>Have</th>
<th>Do Not Have</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Definitions of Peer Review</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Definitions of Peer</td>
<td></td>
<td></td>
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<tr>
<td>3. Definitions of Peer Proctoring</td>
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</tr>
<tr>
<td>4. Ongoing Professional Practice Evaluation (OPPE) Process</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>A. Purpose</td>
<td></td>
</tr>
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<td></td>
<td>B. Patient Care</td>
<td></td>
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<td></td>
<td>C. Medical/Clinical Knowledge</td>
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<td></td>
<td>D. Interpersonal &amp; Communications Skills</td>
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<td></td>
<td>E. Professionalism</td>
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<tr>
<td></td>
<td>F. Systems – Based Practice</td>
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<tr>
<td></td>
<td>G. Responsibilities for OPPE</td>
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</tr>
<tr>
<td>5. Focused Review of a Practitioner’s Performance (FPPE)</td>
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</tr>
<tr>
<td></td>
<td>A. How Used for New Applicants</td>
<td></td>
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<tr>
<td></td>
<td>B. How Used for Existing Medical Staff</td>
<td></td>
</tr>
<tr>
<td>6. Quality Triggers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Documentation of Peer Review Activities</td>
<td></td>
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</tr>
<tr>
<td>8. Responsibilities of Quality Management Department</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Quality Reporting Pyramid - Example

- **Board of Trustees**
  - Problem statistics
  - Action recommendations from MEC
  - Problems from OPPE / FPPE
  - External / public results and hospital comparisons

- **Medical Executive Committee**
  - External Peer Review results
  - Summary of statistics-problems highlighted
  - Actions on recommendations
  - Summary of OPPE / FPPE results
  - Recommendations to board

- **Quality Improvement Council / Committee (Hospital wide)**
  - Summary of chart reviews
  - Actions on recommendations
  - Summary of statistics
  - Recommendations to MEC
  - Actions of OPPE / FPPE results

- **Review Committees**
  - Details of chart reviews
  - Problems identified
  - Recommended actions
  - Detailed statistics
  - OPPE results
  - FPPE results

- **Quality Reporting Pyramid**
  - Utilization
  - Management
  - P&T
  - Infection Control
  - Medical Records
  - Medical Review
  - HCAHPS Action Teams
  - Surgical Review
  - Ancillary Department Qd
  - Credentials
  - EOC
  - Patient Safety
Peer Review as Peer Assistance

• Oft forgotten points:
  ▪ Peer review is not simply to identify and punish “poor performers”
  ▪ After patient protection, the most important goal is practitioner improvement/assistance
  ▪ Counseling, education, referrals for mental/physical help, mentoring can avoid corrective action
  ▪ Take advantage of physician assistance committees, state programs, private programs

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THANK YOU

Intended for internal guidance only, and not as recommendations for specific situations. Readers should consult a qualified attorney for specific legal guidance.