The University of Kansas Hospital
POLICY AND PROCEDURE MANUAL
Subject: Ongoing Professional Practice Evaluation

Signature _________________________________________________________
Tammy Peterman, Executive VP COO and Chief Nursing Officer

Formulation ______  Revised 11/03, 4/05, 2/08, 11/2010 Reviewed 6/07, 6/09, 11/12
Date Date Date

Position Responsible for Updates _________________________________________________
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DEFINITIONS:

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.

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 or subcommittees. Results of peer review activities are considered in practitioner-specific credentialing and privileging decisions and, as appropriate, in the organization’s performance improvement activities.

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 The University of Kansas 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.
I. Peer Review Functions/Activities

A. Include but are not limited to:

1. Establish and enforce guidelines designed to keep within reasonable bounds the cost of health care;
2. Conduct of research;
3. Determine if a hospital's facilities are being properly utilized;
4. Supervise, discipline, admit, determine privileges or control members of a hospital's medical staff;
5. Review the professional qualifications or activities of health care providers;
6. Evaluate the quantity, quality and timeliness of health care services rendered to patients in the facility; and
7. 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 provided.
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 office;
3. Any risk management indicator that, upon initial screening, may indicate a concern involving the conduct, performance or competence of a practitioner, including incident reports;
4. 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;
5. Patient and/or family complaints related to quality of care; and
6. Third party payer, regulatory or accreditation agency notices related to the conduct, performance or competence of a practitioner.

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 ECMS 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 Clinical Service Chief of each Department 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 Physician Performance Improvement Committee and/or the Executive Committee of the Medical Staff.

B. PIC 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 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 ECMS if may be grounds for corrective action per ECMS 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 ECMS 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 ECMS.

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 (“ECMS”) 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 ECMS 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 clinical service chief, Medical Staff Officer, medical director or designee, a peer review behavioral issue may be referred for review by the Medical Staff Physician Health Committee. The Physician Health Committee or its designee 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. ECMS/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 ECMS 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 ECMS meeting to discuss the case to be reviewed if the peer reviewer will not be available to attend the ECMS meeting.

C. Ongoing/Trended and Aggregate Reporting

1. Through the Physician Performance Improvement Committee to Clinical Service Chiefs at least quarterly.
2. 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.
3. Quarterly performance data will be provided to individual medical staff members on hospitalized patients.
4. Clinical Service Chiefs 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.
5. 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.