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| Title: Professional Practice Evaluation Policy (Peer Review) | Number: |
| Review Responsibilities: Medical Executive Committee | Origination Date: August 28, 2018 Effective Date: October 24, 2018 |

I. Purpose

The purpose of this Policy is to guide the Medical Staff as it carries out its duty to oversee activities that measure, assess, and improve the quality of health care in the Hospital, and to implement *Article 4 Professional Practice Evaluation* of the Medical Staff Bylaws.

The following core competencies, identified by the Accreditation Council for Graduate Medical Education, provide the standard of professional practice by which practitioner competency is evaluated:

- a. **Patient Care:** patient care is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and care at the end of life
- b. **Medical and Clinical Knowledge:** knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and education of others
- c. **Practice-based Learning and Improvement:** use of scientific evidence and methods to investigate, evaluate and improve patient care practices
- d. **Interpersonal and Communication Skills:** interpersonal and communication skills that support the establishment and maintenance of professional relationships with patients, families and other health-care team members
- e. **Professionalism:** behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward patients, profession and society
- f. **System-Based Practice:** understanding contexts and systems in which health care is provided and applying this knowledge to improve and optimize health care.

This policy provides the framework by which the following goals are accomplished:

- a. professional competence of all privileged practitioners is monitored and evaluated on an ongoing basis;
- b. a positive approach to peer review identifies opportunities for improvement;
- c. focused professional practice evaluations are performed (1) to ensure competence after granting new or expanded privileges; and (2) when opportunities for improvement are identified in privileged practitioners;
- d. processes for professional practice evaluation are consistent, fair, and timely;
- e. practitioner competency is evaluated at the time medical staff membership and privileges are renewed.

II. Definitions

Focused Professional Practice Evaluation (FPPE): A time-limited process to evaluate the privilege-specific competency of individual practitioners upon (1) initial appointment to the medical staff or grant of privileges; (2) when privileged practitioners request new privileges; or (3) when a professional competency concern arises.

Ongoing Professional Practice Evaluation (OPPE): A process of ongoing data collection and analysis for the purpose of assessing a practitioner’s professional practice.

Peer: A practitioner with competencies equal to or greater than the practitioner whose practice is being reviewed.

Peer Review: The review of professional competence of privileged practitioners for the purpose of performance improvement and provision of safe and quality patient care.

Peer Review Committee: Any committee designated by the medical executive committee, medical staff bylaws, or medical staff policy, to conduct review activity of privileged practitioner’s professional practice utilizing FPPE, OPPE and peer review processes.

Physician: A doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, and a doctor of podiatric medicine licensed to practice in Minnesota.

Practitioner: A person for whom the Medical Staff evaluates credentials and recommends clinical privileges

III. Policy

The Medical Executive Committee (MEC) has oversight for coordinating, monitoring, trending, reporting, evaluating and improving all Medical Staff professional practice evaluation activity in accordance with the purpose stated above.

Professional practice evaluation includes peer review, FPPE and OPPE activity.

Committee oversight

Oversight of peer review, FPPE and OPPE is assigned to the credentials committee and hospital-wide peer review committee as follows:

| Credentials committee | Hospital-wide peer review |
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| Oversee FPPE activity and reporting | Implements and oversee hospital peer review activities |
| Oversee OPPE activity and reporting | Insure peer review activity is fair, consistent and timely |
| Evaluate OPPE metrics and FPPE results relative to privileging decisions | |

Committee membership

| Credentials committee membership | Hospital-wide peer review |
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| <p>[From Credentialing policy]:</p> <ul style="list-style-type: none"> • Medical director, credentialing • 5 to 9 privileged practitioners appointed by the COS and approved by the MEC • Up to 2 members of the committee may be advance practice professionals | <ul style="list-style-type: none"> • COS-P • VPMA • Medical director, quality • Medical director, credentialing • The VPMA, COS-P, medical director of quality and medical director of credentialing jointly appoint a minimum of 5 active medical staff in good standing representing a cross section of specialties |

Peer Review

Peer review is conducted by the medical staff using its own members to perform review activity of privileged practitioner’s professional practice for the purpose of performance improvement and to insure safe and quality patient care.

Peer review activity is structured to evaluate actual or potential harm to patients resulting from circumstances that include, but are not limited to:

- a. failure to follow hospital or medical staff policy
- b. unmet standards of care
- c. unexpected death or disability
- d. referrals from a hospital or clinic, hospital committee
- e. staff or patient/family requests

Peer review findings (1) may lead to a focused professional practice evaluation for the purpose of individual performance improvement; and (2) are included in the metrics reported in ongoing professional practice evaluations (OPPE).

Peer review activity is confidential, collegial activity and not an investigation.

External review. A person or body responsible for overseeing peer review may request the services of a peer who is not a member of the medical staff for any reason, including (1) when no peer on the medical staff has sufficient expertise to evaluate a practitioner’s competence; (2) peers on the medical staff have conflicts of interest that could be reasonably perceived as affecting the objectivity of their review; or (3) internal review has produced ambiguous, inconclusive, or conflicting results. The reviewer must report to the person or body requesting the review by completing documentation provided by that body.

Focused Professional Practice Evaluation (FPPE)

Focused professional practice evaluation is a systematic, time-limited process for evaluating an individual practitioner's competence to perform the clinical privileges granted to them. Focused professional practice evaluations occur under the oversight of the section head (or designee) and medical staff services office when the following occurs:

- a. Initial or expanded privileges are granted.
- b. A question arises as to a practitioner's ability to competently exercise the privileges granted to them.
- c. Data indicating an incident or pattern in a practitioner's practice raises a question as to the practitioner's ability to competently exercise the privileges granted to them.
- d. Results of peer review activity indicate the need for performance improvement.

A focused professional practice evaluation may be requested by the VPMA, COS, division head, section head, medical director credentialing, credentials committee, or peer review committee.

The section head, or designee, in which the practitioner practices, with the assistance of the medical staff services office is responsible for overseeing the practitioner for the FPPE period and making recommendations on their competency to exercise the privileges granted. Focused evaluations will specify the competency being evaluated and identify performance indicators to measure improvement. The following methods of evaluation may be used:

- a. personal observation
- b. chart review
- c. interviews with colleagues and peers
- d. simulation

Following completion of an FPPE, results will be reported to the credentials committee.

Ongoing Professional Practice Evaluation (OPPE)

Ongoing professional practice evaluation is a systematic process that provides professional practice metrics on individual practitioners to section heads or their designee for the purpose of evaluating the individual practitioner's competence to perform the clinical privileges granted to them against standards of quality care and patient safety. Ongoing professional practice evaluations are reported to section heads or designee more frequently than every 12 months.

Data collected for ongoing professional practice evaluation is used to make decisions to maintain, revise or revoke existing privileges, or to recommend expansion of privileges, at the time of application for renewed or expanded privileges.

If, as a result of OPPE, a pattern or trend affecting quality of care and patient safety is identified, performance improvement activities may result, including an FPPE.

If a practitioner has minimal or no activity at Regions Hospital, the following sources of information may be considered:

- a. clinical practice data from another hospital or healthcare facility at which the practitioner has activity;
- b. peer reference attesting to the practitioner's competency.

Non-physician practitioners

Professional practice evaluation of non-physician practitioners granted privileges by the medical staff and hospital board is conducted in the same manner as professional practice evaluation of physicians.

Confidentiality of Review Organization activities and materials

All activities carried out under this Policy are authorized by the Health Care Quality Improvement Act of 1986, codified at 42 U.S.C. § 11101, et seq., or Minnesota Statutes §§ 145.61 – 145.66, or both, and are subject to the provisions of these laws that prohibit or limit the disclosure of data, records, documents, and knowledge obtained or developed during the course of the activities. Peer review committees, the MEC, credentials committee and Section heads when they carry out Peer Review activities, and any individual or entity that acts at their direction, are "Review Organizations" and are subject to the provisions of this section.

Non-disclosure generally. A person who participates in a Review Organization must not disclose what transpired at a meeting of a Review Organization except to the extent necessary to carry out one or more purposes of the Review Organization and with the authorization of the Review Organization.

Identification of confidential material. The Review Organization must identify all information it receives or produces as Peer Review Information. Documents, including meeting minutes and case review materials, prepared in connection with this Policy, to the extent feasible must be prominently labeled to identify them as protected Review Organization information. A label that is consistent with the following meets this requirement:

This document was acquired or prepared by or for a Review Organization in the furtherance of one or more of its functions as defined by Minn. Stat. § 145.61, subd. 5. It must be held in confidence and must not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the Review Organization and with the authorization of the Review Organization. This document is not subject to subpoena or discovery.

Safekeeping of confidential material. All records prepared by, acquired by, or prepared at the request of a Review Organization must be maintained under the care and custody of the

Hospital's authorized representative on behalf of the Review Organization. Records or materials recorded on paper must be stored and locked in an office or file cabinet to which only authorized persons have access. Records or materials maintained in electronic format must be protected by password and have read/write control protections. Materials may not be removed from the Hospital for any purpose unless approved in advance by the CEO and COS.

Access to confidential material. Those authorized to have access to Review Organization materials include the following:

- a. Members of the Review Organization and administrative staff who need to have access to the information in order to perform their functions.
- b. Consultants, attorneys, or other professionals engaged by the Hospital to the extent necessary for them to assist the Review Organization in performing its function.
- c. Representatives of regulatory or accreditation agencies who are entitled by law to have access to the information.
- d. A practitioner who seeks through discovery in a civil action, data, information, or records relating to the Practitioner's medical staff privileges or membership. A Practitioner does not have a right to have access to Review Organization materials, including materials related to the Practitioner's own practice, except as authorized by law and the Review Organization

IV. Compliance

V. Attachments

VI. Other Resources

VII. Approval(s)

Bylaws Committee (08.28.18)

Peer Review Committee (09.06.18)

Medical Executive Committee (10.01.18)

Regions Hospital Board of Directors (10.24.18)