

Title:	Performance Improvement Committee		
Department:	Medical Staff Services		
Approver(s):	PI Committee, Medical Executive Committee & Board of Trustees		
Policy Number:	Medical Staff Policy MS 6 PI Committee		
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SECTION 1

1.1 Policy Statement

The Medical Staff provides leadership for measuring, assessing and improvement processes that primarily depend on the activities of one or more licensed independent practitioners (LIP) and other practitioners credentialed and privileged through the Medical Staff process.

The Medical Staff is responsible for establishing and maintaining patient care guidelines and oversight of the quality of care, treatment and services rendered by Medical Staff and Allied Health Professionals (AHPs). Relevant information developed from the sources described herein is integrated into performance improvement initiatives, consistent with hospital preservation of confidentiality and privilege of information, and monitored by the Performance Improvement (PI) Committee.

1.2 Definitions

Variances are assigned a "type" category according to the following guidelines. The type category determines data collection, review and reporting.

1. **Type 1 Rate** - indicator exists to generate a trend (e.g., mortality rate, readmission rate or infection rate). *Performance Improvement Committee*
2. **Type 2 Rule** - standard or other generally accepted practice at Hendrick Medical Center (e.g., completing the H & P within twenty four (24) hours). *Performance Improvement Committee*
3. **Type 3 Review** - indicator that suggests a significant quality of care concern or potential for adverse outcomes. *Performance Review Committee*

1.3 Purpose

- 1.3.1 The PI Committee is responsible for reviewing rates and rules which are defined as Type 1 and Type 2 variances.

- 1.3.1 The PI Committee assesses the ongoing professional practice and competence of individual practitioners with hospital privileges, identifies opportunities for practice and performance improvement of individual practitioners by analyzing aggregate data and case findings; and provides suggested areas for hospital-wide improvement.

1.4 Designation

The following standing Medical Staff committees report to the PI Committee: Critical Care; Pharmacy and Therapeutics (P&T); and Trauma Services Review (TSRC). Additionally, the PI Committee receives reports from various hospital committees such as Transfusion, Infection Prevention, and Utilization Management.

SECTION 2

2.1 Composition

- 1.2.1 Voting members of the PI Committee:

- A. Vice Chief of Staff, as Chair;
- B. Chairs of the clinical departments;
- C. Seven (7) At-Large members from the Active Medical Staff. One (1) of the seven (7) At-Large members must be on medical staff at the South Campus of Hendrick Medical Center;
- D. Three (3) hospital representatives, as assigned by the Chief of Staff.

- 1.2.2 The Performance Improvement Department with the assistance of the Medical Staff Services Department will be responsible for collection of all appropriate information for the PI Committee and will act as agents of the PI Committee.

- 1.2.3 Physician liaisons are appointed by the Chief of Staff and assigned to the Performance Improvement Committee. They are not required to attend meetings of the PI Committee and are not voting members unless assigned as a member, but provide a valuable service on behalf of their specific functions:

- A. Blood Usage
- B. Infection Prevention
- C. Medical Records
- D. Surgical Case Review
- E. Utilization Management

A physician liaison for continuing medical education (CME) is appointed by the Chief of Staff but does not report to the PI Committee. The PI Committee refers topics for potential CME presentations to the hospital's CME Committee as deemed appropriate.

2.2 Duties

2.2.1 The PI Committee is involved in the measurement, assessment and improvement related to:

- A. Coordination of the systematic and ongoing review of the appropriateness and quality of blood usage, drug usage, surgery and invasive procedures, timeliness of completion of medical records, physician-related infection data and utilization management;
- B. Prioritizing and monitoring the Medical Staff data gathering and analysis components of the Hospital's performance improvement program and coordination of the Medical Staff's activities in this area with those of the other professional and support services in the Hospital;
- C. OPPE – serves as a liaison with the Credentials and PR Committees, MEC, and the Medical Staff and plays a key role in OPPE by:
 - 1. Overseeing data gathering by the Medical Staff Office, Performance Improvement Department and Risk Management Department;
 - 2. Regularly evaluating Medical Staff Members' performance in the six areas established by the ACGME and recommending to the MEC target areas of performance and variances there from;
 - 3. Meeting on a regular basis with Medical Staff Members whose performance deviates from established targets in the area of rates and rules;
 - 4. Referring to the PR Committee Medical Staff Members or AHPs deemed in need of FPPE.
- D. Indicators used for FPPE/OPPE are approved by the Medical Executive Committee (MEC). Review may be delegated by the MEC to the Credentials or PI Committees as appropriate.
- E. Supervising the conduct of specific programs and procedures for assessing, maintaining and improving the quality and efficiency of the Medical Staff provided in the Hospital. Adopting and modifying such programs and procedures, subject to the approval of the MEC and the Board of Trustees of the Hospital. This may include developing criteria and identifying data needs for the various activities;
- F. Identifying patterns of performance within or outside the acceptable range, by receiving and evaluating explanations for patterns significantly different from the norm, and by reporting these findings and explanations;
- G. Coordinating the Medical Staff's performance improvement activities with those of other health care disciplines;
- H. Participating in evaluating the overall quality review program for its

comprehensiveness, integration, effectiveness and cost efficiency; and

- I. Reviewing and reporting to the MEC on a continuous basis other general indicators of the quality of care and of clinical performance, including unexpected patient care management events and adverse event data.

2.2.2 Performance Improvement Department

- A. The PI Department of the Hospital maintains a Medical Staff reporting schedule of essential activity reports to the PI Committee.
- B. The PI Department maintains a reporting mechanism for the PI Committee that is designed to collect information related to Medical Staff and patient care issues. Reporting may be verbal (directly or via the Physician Hot Line to the Performance Improvement Department 670-6677) or written communication.
 1. Cases that meet the criteria outlined for PR Committee review will be forwarded to the PR Committee;
 2. Cases for the PI Committee will be presented in summary form for recommendation of appropriate disposition;
 3. Behavioral and/or impairment issues involving Medical Staff members or AHPs will be reported to the Chief Medical Officer, or designee.

2.3 Meetings

The PI Committee meets as necessary but at least quarterly, maintains a permanent record of its proceedings, and reports to the MEC.

SECTION 3 – PROCEDURE

3.1 Ongoing Professional Practice Evaluation (OPPE)

3.1.1 Data Collection

- A. The Performance Improvement Department collects practitioner-specific clinical indicator data. The data will be risk adjusted when possible. Data collected will be formulated into the approved practitioner-specific OPPE report format to include both practitioner-specific and aggregate data. These reports will be generated twice annually for all practitioners holding clinical privileges.
- B. Quality management tools that pertain to possible variances by members of the Medical Staff and Allied Health Professionals Staff will be made available to the Medical Staff Office and Chief Medical Officer such as First Reports and Root Cause Analyses.

3.1.2 Distribution of Reports

The Medical Staff Office will assist in the compilation of OPPE reports twice annually for each practitioner holding clinical privileges. All OPPE reports will be available to the practitioner upon request and to the appropriate Department Chair for evaluation. If no variances are indicated, a copy of the OPPE report will be maintained in the Medical Staff Office for reappointment purposes. OPPE reports are privileged and confidential peer review documents and will be maintained as such.

3.1.3 Identification of Variances

If a variance is indicated, supporting documentation will be collected to be reviewed by the Chief Medical Officer (CMO). Documentation collected may include, but is not limited to complaints, medical records, peer references, or other PI documents.

- A. The CMO will review all reports for which a variance to the established benchmark/threshold is indicated. Any supporting documentation gathered will also be reviewed. The review will include: (i) identification of patterns/trends; (ii) determination of a relationship to other performance criteria; (iii) existence of an outlier; and (iv) determination of whether additional review is needed.
- B. As part of the variance validation process, the CMO will request input from the practitioner regarding the specific indicator. The practitioner will be asked to provide a written response within two weeks (14 calendar days) of the request.
- C. For significant variances, if the practitioner does not respond within two weeks (14 calendar days), a second request will be made to which the practitioner has one week (7 calendar days) to respond.
- D. The CMO with the assistance of the PI Committee Chair will make a determination regarding the existence of a variance. If the practitioner has not responded to the request for input, the determination of a variance will be made utilizing what information is available.
- E. If it is determined that no variance exists, the CMO will complete an OPPE recommendation. The completed form will be attached to the OPPE report and will be maintained in the Medical Staff Office for reappointment purposes.
- F. If the report of a variance concerns an AHP, the AHP's sponsor(s) will be notified by letter at the same time as noted in B, above.

3.1.4 System Issue

If the PI Committee or PI Committee Chair identify a potential system issue, it will be reported to the CMO, for possible referral to the Executive Quality Council or individual hospital management member as appropriate.

3.2 Initial Review by PI Committee

- 3.2.1 If based on a thorough review of the documentation available the PI Committee determines that a variance does exist, a review will be conducted by the PI Committee as a whole, and the following steps will be followed:
- A. If patient safety is an issue and there may be a need for immediate action, a referral will be made to the CMO or Chief of Staff;
 - B. If the nature of the variance does not raise patient safety concerns, the PI Committee will hold a collegial meeting with the practitioner to discuss the identified issue(s) and obtain practitioner feedback regarding plans for improvement. The issue(s) will be re-evaluated in three (3) months and again during the next reporting cycle;
 - C. If the review concerns a member of the PI Committee, such member will be excused from any relevant deliberations regarding his/her review;
 - D. If the review concerns the PI Committee Chair, the review will be conducted by the PR Committee.

3.3 Re-evaluation by PI Committee

- 3.3.1 Three (3) months after the initial review, the PI Committee Chair will re-evaluate the issue identified to determine if there has been any improvement.
- A. If performance is up to benchmark/threshold level, this is documented on the OPPE recommendation form and filed in the practitioner's confidential quality file located in the Medical Staff Services department.
 - B. If performance is still below benchmark/threshold level and a variance is validated, the PI Committee may, depending on the nature of the variance: (i) hold another collegial meeting with the practitioner; (ii) recommend an OPPE plan; or (iii) make a referral to the PR Committee for FPPE.

3.4 Performance Monitoring

- 3.4.1 Type of Monitoring – may include one or more of the following:
- A. Medical record review;
 - B. Direct observation;
 - C. Discussion with other individuals involved in the care of the practitioner's patients;
 - D. Monitoring of diagnostic and treatment techniques;

3.4.2 Content of Monitoring

The performance monitoring plan must include:

- A. What is being evaluated – outcomes, complications, clinical management, technique, etc;
- B. Method of evaluation – direct observation, closed chart review, quality data for specific aspects of performance, proctoring, etc;
- C. Length of evaluation – number of procedures, number of admissions, length of time, etc;

3.4.3 PR Committee Review/Recommendation

- A. Twice annual OPPE reports will be maintained in the Medical Staff Office until the practitioner's application for reappointment is due for review by the Credentials Committee unless a variance is confirmed and action recommended.
- B. If at any time an OPPE report results in the PI Committee's recommendation for FPPE, and after establishment of such a plan by the PR Committee, the recommendation and proposed performance monitoring plan will be reviewed by the Credentials Committee at their next regularly scheduled meeting.

3.4.4 MEC Review and Approval

The recommendation of the Credentials, PI and PR Committees are subject to review and approval by the MEC in accordance with Medical Staff Bylaws.

3.4.5 Practitioner Notification of Recommendations

The MEC will notify the practitioner of approved recommendations. Failure of the practitioner to cooperate with the approved recommendation(s) may result in corrective action. If corrective action is initiated, the practitioner will be afforded the hearing rights outlined in the Medical Staff Bylaws.

3.4.6 Documentation

All documentation associated with professional practice evaluation will be maintained in accordance with applicable Hospital and Medical Staff policies. Documents will be maintained in the Medical Staff Office.

3.5 Duties of Physician Liaisons and Monitoring Activities Reporting to the PI Committee

3.5.1 Blood Usage Evaluation

The medical director for transfusion services will also serve as the physician liaison for blood usage evaluation and transfusion services for the Medical Staff. The physician liaison will ensure that the Hospital's Transfusion Committee conducts periodic blood usage reviews, including evaluation of appropriateness of all transfusions (whole blood and blood components), reviews of all confirmed transfusion reactions, and reviews ordering practices for blood and blood products (including the amount requested, the amount used and the amount wasted).

- A. The Medical Director of Transfusion Services will serve as the Chair of the Hospital's Transfusion Committee and physician liaison for blood usage to the Medical Staff PI Committee. If the Medical Director is not a member of the Medical Staff, the Chief of Staff will appoint a Medical Staff member to Chair the Hospital's Transfusion Committee. The physician liaison will report a summary of items monitored by the Transfusion Committee to the PI Committee. If the physician liaison is not a member of the Medical Staff, the summary may be presented by the Hospital's Lab Director. Any item that requires intervention by the PI Committee will also be reported along with all data collected.
- B. The Transfusion Committee, consisting of Medical Staff Members, nursing representatives, quality assurance supervisor, Transfusion Services representative, and Medical Director of Transfusion Services, conducts a peer review program that monitors transfusion practices for all categories of blood and components. Data collection is conducted on all types of blood products including:
 - 1. Ordering practices;
 - 2. Patient identification;
 - 3. Sample collection and labeling;
 - 4. Usage (including discard of components);
 - 5. Appropriateness of use;
 - 6. Blood administration policies;
 - 7. The ability of services to meet patient needs;
 - 8. Compliance with peer review recommendations.
- C. Blood usage evaluation will be reported to the PI Committee on a quarterly basis.

3.5.2 Continuing Medical Education

A Medical Staff Member will be appointed by the Chief of Staff to serve as the physician liaison for continuing medical education for the Medical Staff. Such Member will have the authority to ask other Members of the Medical Staff to serve on the Hospital's Continuing Medical Education Committee subject to approval by the Chief of Staff and the Medical Executive Committee. Duties include:

- A. Working with the Hospital's Department of Education to encourage, evaluate, and sponsor educational programs consistent with the needs and interests of the Medical Staff;

- B. Incorporating the findings of performance improvement activities to determine Medical Staff educational needs;
- C. Reporting to the PI Committee as needed.

3.5.3 Infection Prevention

A Medical Staff Member will be appointed by the Chief of Staff to serve as the physician liaison for infection prevention for the Medical Staff. The Hospital's Infection Prevention Committee periodically reviews and evaluates the Hospital's infection prevention program including surveillance, prevention and control of infections. Duties include:

- A. Approving and discussing the meeting agenda with the Hospital's Infection Prevention Practitioner prior to meetings of the Infection Prevention Committee;
- B. Reviewing all new and revised Infection Prevention policies/procedures;
- C. Presenting information from the Infection Prevention Committee to the PI Committee and any other as directed by the PI Committee;
- D. Advising the Infection Prevention Practitioner regarding issues that the Infection Prevention Practitioner cannot address alone;
- E. Working with the Infection Prevention Practitioner to handle emergencies, disasters, and/or outbreaks of an infectious nature or with infection prevention/control implications;
- F. Conducting correspondence with the Medical Staff about infection prevention and control issues or important information;
- G. Advising a Medical Staff Member, or group of Medical Staff Members, about specific infection control concerns; and
- H. Reporting to the PI Committee on a quarterly basis.

3.5.4 Information Management (Medical Records)

A Medical Staff member will be appointment by the Chief of Staff to serve as the physician liaison for the medical records function to conduct ongoing medical record review for timeliness of completion and clinical pertinence. Duties include:

- A. Review at least triennially the Medical Staff Bylaws, policies and manuals pertaining to the medical record and recommend changes as appropriate;

- B. Review and approve at least triennially the policies and procedures which govern the functions of the Health Information Services department;
- C. Review and approve all forms utilized in the compilation of a medical record;
- D. Work with the Health Information Services Director to present a quarterly summary to the PI Committee of pertinent data elements such as open and closed medical record reviews, medical record delinquencies and suspensions;
- E. Reporting to the PI Committee on a quarterly basis in person or through the Health Information Services Director.

3.5.5 Surgical Case Review

A Medical Staff member will be appointed by the Chief of Staff to serve as the physician liaison for surgical case review. The surgical case review function is to conduct ongoing operative and other invasive procedure review, including tissue review, evaluation and comparison of pre-operative and post-operative diagnoses, indications for surgery, actual diagnosis of tissue removed, and situations in which no tissue was removed. Duties include:

- A. Non-Tissue Review – review of cases that did not meet screening criteria performed by the PI Department to determine if the cases meet acceptable standards of care or should be referred to the PI Committee;
- B. Tissue Review – review of all cases identified by the pathologists to determine if the cases meet acceptable standards of care or should be referred to the PI Committee;
- C. Procedural Studies – work with the PI Director and/or Performance Improvement Committee Chair to develop studies, discuss data collection and results. Such studies are presented upon completion to the PI Committee.
- D. Presentation of a report to the PI Committee at least annually.

3.5.6 Utilization Management

A Medical Staff member will be appointed by the Chief of Staff to serve as the physician liaison for utilization management. The utilization function is to review and monitor that the utilization management plan is in effect, is known to Medical Staff members and is functioning at all times. Duties include:

- A. Developing and administering an effective review plan of overall patient care as related to length of stay; admission diagnosis, discharge diagnosis, and disposition at discharge;
- B. Serving as a resource to ensure that admission criteria are met for elective and non-

emergency admissions;

- C. Serving as a resource to Case Management staff in identifying and presenting alternatives to admitting/attending physicians to optimize clinical resource utilization;
- D. Contacting admitting/attending physicians when appropriate in a review process and when there is incomplete information regarding medical necessity of admission, or continued stay;
- E. Assisting Health Information Services in coding principle diagnoses and/or sequencing events; and
- F. Reporting to the Performance Improvement Committee on a quarterly basis.

3.7 Confidentiality

3.7.1 Each proceeding or record of a Medical Staff committee is confidential. The President and/or Vice Presidents, legal counsel to the Hospital, Medical Staff Services personnel and Performance Improvement Department personnel will be considered agents of all Medical Staff committees and the Medical Staff, as applicable, when performing their respective functions and responsibilities.

3.7.2 Access to Data

Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) data may be accessed as outlined below:

A. Individual Practitioner

- 1. FPPE/OPPE data will be maintained in each Medical Staff or AHP's profile in the Medical Staff Office.
- 2. OPPE reports may be released to the individual practitioner along with comparisons of the practitioner to aggregate not individual data of others in the same specialty.
- 3. FPPE data may only be released as directed by the MEC.
- 4. Practitioners may not access data on another practitioner unless acting as an agent of a peer review committee. Comparisons will be made to established norms rather than other practitioners at the Hospital.

B. Persons performing official Medical Staff functions within the Hospital

- 1. Committees of HMC, its governing board or Medical Staff who are authorized to engage in medical peer review.
- 2. Hospital staff assisting a medical peer review committee may have access to data only to the extent necessary to perform their official functions.

C. Persons or organizations outside the Hospital

1. Facility surveyors of a national accreditation body such as the Joint Commission, appropriate state or federal agency such as Department of State Health Services or Centers for Medicare and Medicaid Services, who are on HMC's premises in the presence of appropriate Hospital or Medical Staff Office personnel will be entitled to inspect FPPE/OPPE data.
2. Outside peer review committee, organization or individual for the purpose of medical peer review or disclosure to a professional review body.