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| Title: | Performance Review Committee | | |
| Department: | Medical Staff Services | | |
| Approver(s): | Medical Executive Committee | | |
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**Section 1**

**1.1 Policy Statement**

The Board of Trustees of Hendrick Medical Center has the ultimate responsibility for performance improvement. The organized Medical Staff provides leadership for measuring, assessing and improving processes that primarily depend on the activities of one or more members of the Medical Staff and Advanced Practice Providers (APP) Staff. The Medical Executive Committee (MEC) has the responsibility of oversight of implementation of this policy.

The Performance Review (PR) Committee is responsible for the evaluation of medical peer review including evaluation of qualifications or professional conduct of professional health care practitioners and of the patient care they provide.

**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

The PR Committee is responsible for reviewing Type 3 variances. Medical peer review is the evaluation of medical and health care services, including evaluation of qualifications or professional conduct of professional health care practitioners and of patient care they provide. Evaluation of an individual practitioner's professional performance includes the identification of opportunities to improve care. Peer review differs from other quality management activities in that it evaluates the strengths and weaknesses of an individual practitioner's performance, rather than appraising the quality of care rendered by a group of professionals or a system.

The Medical Staff peer review process supports the continuous improvement and safety of patient care at Hendrick Medical Center through the ongoing and focused monitoring of key quality indicators. The Medical Staff leadership identifies key quality indicators, analyzes trends in patient outcomes and provider practice, reaches conclusions and takes actions for quality improvement. Additionally, the Medical Staff leads or actively participates in interdisciplinary quality improvement activities as a key contributor to the Hendrick quality improvement programs.

**SECTION 2**

#### 2.1 Composition

2.1.1 The voting members of the Performance Review (PR) Committee include eight (8) members of the Medical Staff as follows:

A. The Vice Chair of the Department of Medicine (1);

B. The Vice Chair of the Department of Surgery (1);

C. Three At-Large members of the Department of Medicine, appointed by the Chief of Staff (3); and

D. Three At-Large members of the Department of Surgery, appointed by the Chief of Staff (3).

E. One (1) At-Large member from the South Campus of Hendrick Medical Center, appointed by the Chief of Staff (1)

2.1.2 Ad hoc members may be appointed by the Chief of Staff (COS), Vice Chief of Staff, or Department Vice Chairs, or Chief Medical Officer (CMO) as needed to conduct reviews.

2.1.3 The PR Committee is chaired by the Department Vice Chair who is in the second year of his/her Department Vice Chairmanship. The Department Vice Chair who is in his/her first year, will be the Committee Vice Chair. In the event that no Department Vice Chair has tenure, the Chief of Staff will appoint from the Department Vice Chairs the positions of Committee Chair and Committee Vice Chair, subject to ratification by the MEC.

2.1.4 The Quality Department will act as the delegated agent of the Committee and be responsible for collection of all appropriate information for the PR Committee and will act as agents of the Committee.

#### 2.2 Duties

The PR Committee is responsible for conducting reviews, defined as Type 3 variances.

2.2.1 Referrals to the PR Committee for chart review or for focused professional practice evaluation (FPPE) may be initiated by a Medical Staff Department or Section, the PI Committee, Credentials Committee, MEC, the COS, or the CMO. The PR Committee works in collaboration with the Credentials and PI Committees and MEC in matters of FPPE and conducts quality review issues in two areas: (1) any area of Medical Staff quality where a review of medical care is deemed to include review of relevant patient chart(s); and (2) any area of Medical Staff quality where it has been deemed necessary for a Medical Staff Member to be in the category of FPPE.

2.2.2 The PR Committee, based on FPPE for a practitioner, is responsible for reporting findings to the MEC, reaching conclusions and recommending actions relative to the individual case or trends identified. The findings include the objective review of all records pertinent to the variance(s) that generated the review. The conclusion is the decision reached by the PR Committee after reviewing the findings and addresses the practitioner's management of the patient's care. Each conclusion must also have an action determined. The conclusion and action recommendations are described below.

1. **Conclusions**

**1 -- System Issue -** An occurrence that is unrelated to the medical management of the patient.

**2 -- Expected Event: medical management appropriate -** An occurrence that may be anticipated based on the patient's presenting/pre-existing condition or co-morbid factors.

**3 -- Unexpected Event: medical management appropriate -** An occurrence that, although adverse, was sequelae of the patient's underlying disease, surgery, or illness, AND was accurately recognized, treated promptly and appropriate by the provider.

**4 – Expected Event: Medical Management not appropriate -** An occurrence that may be anticipated based on the patient's presenting/pre-existing condition or co-morbid factors but event may have been exacerbated or impacted by timeliness, accuracy or appropriateness of the provider’s management.

**5 -- Unexpected Event: medical management not appropriate -** An occurrence that, although adverse, was sequelae of the patient's underlying disease, surgery or illness AND was exacerbated or extended related to the timeliness, accuracy or appropriateness of the provider's management.

**6 -- Significant Deviation from appropriate medical management -** An occurrence that caused or had the potential to cause significant harm to the patient directly as side/site verification related to the provider's care, treatment or management.

1. **Action Recommendations**

Based upon analysis of information collected during an evaluation, the recommendations of the PR Committee may include, but are not limited to:

1. No further action warranted – practitioner is performing within desired expectations

2. Referral to CMO due to System Issue

3. Referral to the Code of Conduct Committee

4. Referral to the Physician Health and Rehabilitation Committee

5. Route to Quality Department for Process Improvement/critical event review

6. Recommend case to Medical Staff Department (Surgery or Medicine) or appropriate Section for review

7. Educational Letter

8. Summary Suspension as outlined in the Medical Staff Bylaws due to patient safety concern

9. Focused Professional Practice Evaluation (FPPE)

10. Revoke privilege: no longer needed or level activity does not support continuation of privilege(s)

11. Continue to trend

12. Completion of Performance Monitoring Plan

#### 2.3 Meetings

The PR Committee meets monthly, or as needed, but at least quarterly to transact pending business. A permanent record of its proceedings and actions is maintained and recommendations are reported to the Medical Executive Committee.

Each Member of the PR Committee must attend at least fifty percent (50%) of the meetings held each calendar year. Members not meeting the attendance requirement may be removed and replaced by the COS.

**SECTION 3 – PROCEDURE**

**3.1 Criteria for Reviews by the PR Committee**

3.1.1 A single event in one of the following categories that is **physician-related** includes but is not limited to:

1. Suicide of any patient on the campus
2. Unanticipated death of an infant, except stillborns
3. Abduction of any patient
4. Discharge of an infant to the wrong family
5. Assault of a patient while on campus, excluding persons who present for treatment of an assault
6. Assault, homicide or other crime resulting in patient death or major permanent loss of function while on campus
7. Hemolytic transfusion reaction – major blood group incompatibilities
8. Surgical or non-surgical invasive procedure on the wrong patient, wrong site or wrong procedure
9. Unintended retention of a foreign object in a patient after surgery or procedure
10. Severe neonatal (to 28 days) hyperbilirubinemia (total bilirubin > 25 mg/dl) in a normal newborn
11. Prolonged fluoroscopy with cumulative dose > 1500 rads to a single field, or to the wrong region, or > 25% more than planned
12. Medication error resulting in death, paralysis, coma or other major permanent loss of function
13. Intrapartum maternal death
14. Patient fall resulting in death or major permanent loss of function as a direct result of the fall
15. Intraoperative or immediately post-operative sedation event resulting in unanticipated death
16. Root Cause Analysis results when forwarded by the COS or CMO.
    * 1. Pattern of events (three or more in six months) in one or more of the following categories
    1. Same surgical/procedural complication
    2. Treatment delay
    3. Medication Ordering Errors
    4. Diagnostic Errors in Diagnosis/Treatment
    5. Medical Complications
       1. Citizenship/behavioral issues referred by the COS or CMO.
       2. Potential impairment issues referred by the COS or CMO.

3.1.5 Rate of compliance for timeliness of care or consultation referred by the COS or CMO.

**3.2 Focused Professional Practice Evaluation (FPPE) for Questionable Performance and/or Outcomes**

3.2.1 FPPE will be implemented by the PR Committee for evaluation of performance by credentialed providers when issues affecting the provision of safe, high quality patient care are identified. FPPE will also be implemented when there is a pattern of events in one or more of the above listed categories. In general, if a practitioner’s performance falls below a particular threshold on an OPPE Report, or a specific incident(s) raises concerns about clinical competence, the medical staff may conduct a focused review to identify the root cause.

3.2.2 If at any time during FPPE evaluation for new privileges, information is received that suggests problems with a credentialed provider’s ability to safely and competently perform the privileges granted, the Performance Improvement Committee or the Credentials Committee may refer the issue to the PR Committee.

3.2.3 The PR Committee will review the facts surrounding the request for FPPE and will forward recommendations to MEC for final approval.

**3.3 Review Process**

3.3.1 Type 3 Variances

Practitioners will be notified by written letter when a peer review is returned with a Level 4, 5, or 6 Outcome. Practitioners may provide additional written explanation regarding the case or may appear before the PR Committee. This information will be incorporated into the PR process. If no provider response is received, the committee review is conducted based on available data. The provider is notified of the PR Committee's final determination of the review.

3.3.2 Practitioner Interview

In the event the PR Committee invites a practitioner for an interview, the interview does not constitute a hearing and will not be conducted according to procedural rules afforded under a hearing. No legal or outside representative will be permitted to participate for any party.

3.3.3 Peer Reviewers

A. Peer review should be conducted by a peer within the same specialty within the same section or department whenever possible. If the reason for the review is not related to specialty care, then an appropriate Medical Staff member in good standing may be assigned the review.

B. If necessary, the need for external peer review will be determined by the PR Committee, MEC, CMO, or the Board of Trustees of the Hospital. No practitioner can require the hospital to obtain external peer review if not deemed appropriate by the aforementioned committees or the Board of Trustees of the Hospital. Examples of circumstances that may warrant external review include but are not limited to the following:

1. Case(s) under review is/are not performed by any other member of the Medical Staff;

2. Cases with potential or actual litigation;

3. Cases involving vague or conflicting conclusions from internal reviews that may directly impact the practitioner's membership or privileges;

4. Lack of internal expertise;

5. Potential conflict of interest;

6. Economic competition;

7. Miscellaneous issues such as developing a benchmark for quality monitoring.

C. Peer reviewers may be assigned by the COS, Department Chair, or CMO.

D. Peer review for APPs will be assigned to the APP Committee, COS, or CMO. The sponsoring Medical Staff member will be held accountable for the APP's patient care management.

E. No actions related to an involuntary change in privileges, suspensions, referral to the Physician Health and Rehabilitation Committee or reports to external agencies may be conducted without MEC review and approval. The MEC is the final authority in all peer review activities. In all peer review activities, the Medical Staff will adhere to all Medical Staff and Hospital Bylaws, policies and procedures. The MEC will report significant findings or changes in membership status or privileges to the Board of Trustees of the Hospital.

3.3.4 PR Committee/Review/Recommendation

Based upon analysis of information collected during the evaluation of each case, the PR Committee will come to a conclusion with action recommendation(s) for each case as listed in Section 2 of this policy.

3.3.5 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.

3.3.6 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.

3.3.7 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.

**3.4 Confidentiality**

Each proceeding or record of a medical peer review committee is confidential including communications to the peer review committee, with the exception of those gratuitously submitted. The information is not subject to subpoena or discovery and not admissible in civil or administrative proceeding unless privilege is waived or unless disclosure is required or authorized by law.

3.4.1 The President and/or Vice Presidents, legal counsel to the Hospital, Medical Staff Services personnel and Quality Department personnel will be considered agents of all Medical Staff committees, services, and the Medical Staff as applicable when performing their respective functions and responsibilities. A medical peer review committee includes an employee or agent of the committee, including assistant, investigator, intervener, attorney and any other person or organization that serves the committee.

3.4.2 Medical Staff committee members will excuse themselves from meetings during review and deliberation of cases in which they are involved.

3.4.3 Access to Data

FPPE data may be accessed as outlined below:

1. Individual Practitioner

1. FPPE/OPPE data will be maintained in each Medical Staff or APP’s profile in the Quality Department.

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.

1. 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.

1. 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.