

## Medical Staff Peer Review Policy

### I. Purpose

This Policy is established to define the peer review process at the Hospitals (including their provider-based locations) that are a part of the Mount Carmel Health System (MCHS). The MCHS Board of Directors (the “Board”) has delegated to its Medical Staffs, through their committees and those committees’ agents, the responsibility for evaluating, maintaining, and monitoring professionalism and the quality of the health care services provided at MCHS. As such, whenever a Practitioner, a member of the Hospital’s staff, or a committee engages in activities pursuant to this Policy, the individual/entity shall be acting as or on behalf of a peer review committee as that term is defined in Ohio Revised Code Section 2305.25, *et seq.*

This Peer Review policy does not apply to Summary Suspensions; refer to the Medical Staff Bylaws for additional information.

### II. Goals

1. Create a performance improvement focused culture for peer review by recognizing Practitioner excellence as well as identifying improvement opportunities;
2. Perform a Focused Professional Practice Evaluation (“FPPE”) when potential Practitioner improvement opportunities are identified;
3. Promote efficient use of Practitioner and quality staff resources;
4. Provide accurate and timely performance data for Practitioner feedback, Ongoing Professional Practice Evaluation (“OPPE”) and FPPE, and reappointment;
5. Support Medical Staff educational goals to improve patient care; and
6. Assure that the process for peer review is clearly defined, fair, timely and useful.

### III. Definitions

*Advanced Practice Professional (“APP”)*: An Advanced Practice Registered Nurse, Physician Assistant, or Ph.D. Psychologist who is granted clinical privileges pursuant to the Medical Staff process.

*Chief Clinical Officer (“CCO”)*: The physician responsible for providing leadership and oversight of all MCHS clinical programs and physicians.

*Chief Executive Officer (“CEO”)*: The individual appointed by the MCHS Board to serve as the Board's representative in the overall administration of the Hospital(s).

*Chief Medical Officer (“CMO”)*: The physician responsible for providing clinical leadership and oversight at the Hospital level.

*Clinical Quality Management Department (“CQM”)*: The Hospital department responsible for oversight, development, evaluation, and ongoing monitoring of the quality

improvement, peer review, and patient safety processes and initiatives. CQM is a designated peer review agent of all Peer Review Committees and peer review activities.

*Core competencies:* The six core competencies for evaluation are as follows:

- patient care
- medical knowledge
- interpersonal and communication skills
- professionalism
- systems based practice
- practice based learning and improvement

The core competencies are further defined and explained in Exhibit B, Practitioner Competency Expectations.

*Focused Professional Practice Evaluation (FPPE):* The confirmation of current competency based on either 1) concerns from OPPE (i.e. focused review) or 2) newly credentialed Practitioner or new privileges, (e.g. proctoring). This policy only addresses FPPE based on concerns.

*Hospital:* MCHS' acute care hospital facilities and their provider-based locations commonly known as Mount Carmel East, Mount Carmel Grove City, and Mount Carmel St. Ann's, as well as MCHS' specialty hospital Mount Carmel New Albany.

*Ongoing Professional Practice Evaluation (OPPE):* The routine monitoring and evaluation of current competency for Practitioners with granted privileges primarily through the use of aggregate data and systematic case review. This is accomplished through the peer review process.

*Peer:* An individual practicing in the same or similar profession, but not necessarily in the same specialty, who has the appropriate expertise to evaluate the Practitioner competency issue under review. An individual in a related field, but not of the same specialty, who has sufficient training, experience and knowledge of the subject matter as a result of practice or teaching may be qualified to perform peer review. The level of subject matter expertise required will be determined on a case-by-case basis related to the nature of the issues under review. For the evaluation of APPs with delineated privileges, a physician with equivalent or greater privileges is considered a peer for purposes of peer review.

*Peer Excellence Committee (“PEC”):* The committee designated by the Hospital’s Medical Executive Committee (“MEC”) to conduct the review of individual Practitioner performance for the Medical Staff, unless the MEC designates another entity for specific circumstances. Each PEC is described in the PEC Charters. Members of the peer review body may render judgments of Practitioner performance based on information provided by individual reviewers with appropriate subject matter expertise.

*Peer review:* The evaluation and improvement of an individual Practitioner's professional performance by other duly authorized Practitioners for the six core competencies. This process may use multiple sources of data for evaluation and includes both the identification of opportunities to improve care and the recognition of Practitioner excellence. During the peer review process, a Practitioner is not "under investigation," for the purposes of reporting requirements under the Healthcare Quality Improvement Act.

*Peer Review Data:* Sources of peer review data may include case reviews and aggregate data based on review, rule and rate indicators in comparison with generally recognized standards, benchmarks or norms. The data may be objective or perception-based (e.g. incident reports, patient satisfaction survey data) as appropriate for the competency under evaluation.

*Peer review support staff/Designated peer review agent:* An individual, department and/or committee other than a MCHS Medical Staff member or MCHS Medical Staff committee who works for or on behalf of a PEC and/or a practitioner or medical reviewer functioning in a peer review capacity.

*Practitioner:* A physician, dentist, podiatrist, psychologist or APP who is granted clinical privileges pursuant to the Medical Staff credentialing process.

#### **IV. Conflict of Interest**

A member of the Medical Staff requested to perform peer review may have a conflict of interest if he/she may not be able to render an unbiased opinion. An *absolute* conflict of interest would result if the individual requested to perform peer review is the Practitioner under review, a first degree relative by consanguinity or affinity of the Practitioner under review, or a current/former spouse or civil union/domestic partner of the Practitioner under review. *Potential* conflicts of interest would result if the individual requested to perform peer review was: 1) directly involved in the patient's care but not related to the issues under review, 2) a direct competitor, partner or key referral source of the Practitioner under review, 3) involved in a perceived personal conflict with the Practitioner under review or 4) a relative of the Practitioner under review other than those defined as having an absolute conflict.

#### **V. Process**

##### **A. Peer Review Information Management**

1. All peer review information is privileged and confidential in accordance with the MCHS Medical Staff Bylaws, state and federal laws, and regulations pertaining to confidentiality and discoverability.
2. The Practitioner under review will receive Practitioner-specific feedback.
3. The Medical Staff will use the Practitioner-specific peer review results in making its recommendations to the Hospital regarding the credentialing and

privileging process and, as appropriate, in its performance improvement activities.

4. All written documents related to Practitioner-specific peer review information will be kept by the Hospital in a secure, locked file in the CQM Office. Practitioner-specific peer review information may include:
  - a. *Individual case review findings*: The final ratings of the PEC and any written correspondence with the Practitioner including letters of inquiry, Practitioner responses, commendations, improvement opportunities, or documentation of any follow up action such as collegial counseling.
  - b. *Aggregate Practitioner performance data*: Practitioner-specific data for all of the core competencies measured for that Practitioner and any written correspondence with the Practitioner including letters of inquiry, practitioner responses, commendations, improvement opportunities, or documentation of any follow up action such as collegial counseling.
  - c. *Peer review data retention*: Peer review data will be retained in accordance with the MCHS document retention policy. Information related to formal MEC investigations and corrective actions will be retained indefinitely in the individual Practitioner's credentialing file.
  
5. Peer review information in a Practitioner's quality file, which is retained in the CQM electronic file, is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities. The Hospital CMO and CCO will assure that only authorized individuals have access to individual Practitioner quality files and that the files are reviewed under the supervision of the CQM Vice President or designee. The following individuals may have access to Practitioner quality files:
  - a. The individual Practitioner;
  - b. Members of the MEC, Department Chairs and Medical Directors;
  - c. Hospital CMO or CCO, Trinity Health CCO, Medical Staff Services staff, CQM Vice President and peer review support staff;
  - d. Chairs of the MCHS Credentialing Committee and the Credentialing Subcommittee of the MCHS Board;
  - e. Individuals surveying for accrediting bodies with appropriate jurisdiction, e.g. Joint Commission or state/federal regulatory bodies;
  - f. Individuals with a legitimate purpose for access as determined by the MCHS Board of Directors;
  - g. The CEO for purposes of any potential professional corrective action as defined by the Medical Staff Bylaws;
  - h. Regional Chief Nursing Officer (CNO) or Hospital CNO for review of Advanced Practice Registered Nurses (APRNs); and
  - i. Hospital legal counsel for purposes of any potential corrective action as defined by the Medical Staff Bylaws.

6. No copies of peer review documents will be created or distributed unless in the normal course of conducting business pursuant to this policy, the Medical Staff Bylaws or policies, the MEC, or the Board.

**B. Internal Peer Review (IPR) General Guidelines**

1. IPR is conducted by the Medical Staff using its own members as the evaluation source of Practitioner performance. The procedures for conducting IPR for an individual case and for aggregate performance measures are described below.
2. Participants in the peer review process will be selected according to the Medical Staff policies and procedures as described in the Peer Review Charters and this document. All participants will sign a Confidentiality and Conflict of Interest Attestation prior to participating in peer review activities (Appendix A). PEC members will sign a Confidentiality and Conflict of Interest Attestation on appointment and at each meeting attended via the sign-in sheet attestation. Reviewers who are not committee members will sign a Confidentiality and Conflict of Interest Attestation for each requested review. Invited guests will sign a Confidentiality and Conflict of Interest Attestation at each meeting attended via the sign in sheet.
3. It is the obligation of a PEC member to disclose to the PEC an absolute or potential conflict of interest as defined above. It is the responsibility of the PEC to determine on a case by case basis if a potential conflict of interest is substantial enough to prevent the individual from participating either in case review as described in this document, or in the evaluation of aggregate data as described in the OPPE/FPPE Policy.

In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, the PEC or the MEC will replace, appoint or determine who will participate in the peer review process so that bias does not interfere in the decision-making process.

4. **Performance Measurement and OPPE/FPPE**
  - a. Performance measures for Practitioners under review will be selected by the Medical Staff and approved by the MECs to reflect the six core competencies, using the multiple sources of data described in the Medical Staff Indicator List, which is maintained in the CQM department and reviewed by the Medical Staff and the CQM department annually.
  - b. OPPE will be conducted by the Department Chair as described in the OPPE/FPPE Policy based on the results of case reviews or by rate or rule indicators.
  - c. If the results of OPPE indicate a potential issue with a Practitioner's performance, the PEC may initiate FPPE as described in the OPPE/FPPE Policy. The thresholds for FPPE are described in the Medical Staff

Indicator List; however, the PEC may initiate FPPE based on a single egregious case.

C. **Internal Individual Case Triage Process and Timelines**

1. Cases are identified by screening worklists or referral sources (e.g., Incident Reports, Case Management, patient relations, HIM). Cases received by CQM are entered into a tracking database/spreadsheet, and CQM determines the need for Practitioner review and type of review, based on Medical Staff-defined criteria. See the Case Identification Flow Diagram attached as Appendix B.
2. If Practitioner case review is required based on Medical Staff-approved criteria, CQM completes the initial section of the case review form within two (2) weeks of receipt (unless the case has been identified as needing Immediate Review as described below). Case review for routine cases should be completed within ninety (90) days from the date the chart is reviewed by the CQM staff. Case review for complex cases should be completed within one hundred twenty (120) days. Exceptions to the timeframes above may occur based on case complexity or reviewer availability. See the Case Review Flow Diagram attached as Appendix C.
3. If CQM needs clarification regarding whether a case meets review criteria, CQM will contact the PEC Chair or designee. If it is determined that the case meets review criteria, CQM will assign a Practitioner reviewer as described below. If the PEC Chair determines the case does not meet criteria but is of concern, the issue raised by the case will be presented to the PEC to decide if it should be reviewed and to discuss whether a new or modified review indicator should be adopted to handle similar cases in the future.
4. Potential Serious Safety Events, Serious Reportable Events, Sentinel Events, and/or any other significant events requiring peer review will have immediate review by the PEC Chair or designee. The Hospital CMO will be notified as soon as the case is identified and will immediately notify the CCO and the appropriate medical staff president. Initial review in these circumstances should be performed within forty-eight (48) hours of case identification. The PEC Chair should consider convening an *ad hoc* meeting unless the next regularly scheduled PEC meeting is within seven (7) days of case identification. Absent extenuating circumstances, case review should be completed within ten days. Additional information (such as literature search, second opinion, or external peer review) may be necessary before making a decision on further action. Timelines may be extended if approved by the CCO or designee.
5. CQM may receive cases which carry the potential risk of recurrent harm to patients, colleagues, or providers. If CQM believes there is a significant potential risk, CQM should seek guidance from the department chair. The

Department Chair will notify the Hospital CMO who will notify the CCO and the appropriate medical staff president to make a determination as to whether the case should be handled through the immediate review process as described above in Section V.C.4.

**D. Internal Review Individual Case Assignment**

1. Cases will typically be assigned for initial review to a PEC member on a rotating basis unless CQM identifies an issue requiring a specific specialty expertise. In addition, if the initial reviewer determines the case has a technical issue outside of his/her expertise, he/she will request that CQM obtain a specialty review. Reviewer assignment may also be modified due to a conflict of interest as described below. If either CQM or the initial reviewer feels the case needs specialty review, the reviewer will be the PEC member from that specialty, if available. Otherwise, CQM will contact the PEC Chair to determine the appropriate reviewer. If an individual outside the PEC is needed to conduct a review, he/she will be made an *ad hoc* member of the PEC for that review.
2. If CQM or a reviewer identifies an absolute conflict of interest, the case will be assigned to the next member in the rotation or an alternate specialist. The reviewer will disclose any potential conflict on the case review form. If CQM or a reviewer identifies a potential conflict, the PEC Chair will be informed in advance and decide if a substantial conflict exists. All decisions regarding whether a conflict exists will be disclosed to the PEC.

If the PEC Chair determines that an absolute or substantial potential conflict exists, the individual with the conflict may not participate in the review or be present during the case presentation, discussion, or decision other than to provide information when requested.

**E. Internal Review Process**

1. The reviewer completes the case review and submits it to CQM via the electronic peer review database. The rating system for determining results of individual case reviews is described in the Case Review Rating Form (Appendix D). If the form is incomplete, CQM will contact the reviewer to obtain the information necessary to complete the review. Only cases with completed forms will be presented at the PEC meeting. Case reviews should be completed within two (2) weeks of assignment. Completed case reviews received five (5) or more working days prior to the meeting will be on the agenda.
2. If the case reviewer has questions or concerns about a case while conducting a review, he/she may contact the Practitioner under review to schedule a meeting to discuss the case. The case reviewer will document the conversation with the Practitioner on the electronic Case Review Rating Form. If the Practitioner declines to meet with the case reviewer, the case

reviewer will document the declination on the Case Review Rating Form and will continue to review the case with the information available.

3. The PEC Chair will review the Case Review Rating Forms for all cases where the case reviewer rates the care as appropriate. If the PEC Chair concurs with the rating of appropriate care, these reviews are reported to the PEC for summary approval. The PEC Chair will review a summary of these cases with CQM prior to the meeting for rating concerns. For any cases in which the PEC Chair has concerns with the rating by the case reviewer, he/she will discuss the rating concerns with the reviewer. If concerns persist, the case will be presented to the PEC for discussion.
4. When a case requires PEC discussion, the initial reviewer will present the case to the PEC. All reasonable efforts will be made to avoid disclosing the identity of the Practitioner under review during the initial case presentation and discussion. If the case reviewer is not available for the meeting, he/she will contact the PEC Chair to discuss the case and the PEC Chair will present it to the PEC. For specialty reviews conducted by an ad hoc peer review member, the ad hoc peer review member will be invited to attend the PEC meeting for the case presentation and discussion.
5. **Initial Reviews Rated as Care Not Appropriate**
  - a. When a case is presented for discussion and the PEC has concerns or is uncertain, it will communicate the key questions to the involved Practitioner(s) via secure email. A member of the CQM team will send the email to the involved Practitioner copying the PEC Chair. The involved Practitioner(s) will be asked to respond to the PEC's questions via secure email within two (2) weeks. At the Practitioner's request, he/she may attend the next PEC meeting to answer the specific questions raised. Legal counsel for the Practitioner under review is not permitted to participate in the discussion between the Practitioner and the PEC. If there is no response, a second secure email will be sent to the Practitioner asking him/her to respond within one (1) week. CQM will also contact the Practitioner to determine if he/she did not respond due to special circumstances. The PEC Chair will make the final determination regarding the validity of special circumstances. If there is no response, PEC will finalize the rating based on available information at the next meeting.
  - b. After the initial response, if PEC determines it needs further clarification, it will ask the Practitioner to attend the next PEC meeting to respond to specific questions. The practitioner may not be present for the PEC discussion. Legal counsel for the Practitioner under review is not permitted to participate in the discussion between the Practitioner and the PEC. If the Practitioner does not attend the PEC meeting to respond to the



questions raised, the PEC will finalize the rating unless the Practitioner has a valid previous commitment.

6. Final case determinations will be made by majority vote of the PEC members in attendance at the meeting. If the care is rated as less than appropriate, the PEC will develop a course of action to address the concern(s). Action could include providing the Practitioner with recommendations to assist with improving his/her practice or referral to the MEC, if warranted by the circumstances.
7. Practitioners are notified via secure email when they receive a rating of appropriate or exemplary care. For cases involving exemplary care, a copy of the email will be placed in the Practitioner's quality file and his/her Department Chair will be informed. For cases involving appropriate care, a copy of the email will be placed in the Practitioner's quality file. The Department Chair is not routinely notified of when care is rated as appropriate; however, the information is available on the OPPE report.

Practitioners are notified via letter when they receive a rating of care with minor improvement opportunity. Practitioners are notified via letter when they receive a rating of care with major improvement opportunity. Letters advising Practitioners of care with minor or major improvement opportunity should be hand delivered or delivered via overnight delivery with delivery confirmation. A copy of the letter will be placed in the Practitioner's quality file and the Department Chair will be informed.

The rating letters described above will be sent to Practitioners within seven (7) working days of the PEC meeting.

8. If the PEC determines that an improvement plan is required to address the Practitioner's quality of care, the plan will be developed and implemented pursuant to the OPPE/FPPE Policy.

**F. External Peer Review**

1. External peer review is used to assure that an objective and fair evaluation of a Practitioner's care (as documented in the medical record) is afforded. External peer review is considered when it is determined that:
  - a. No one on the Medical Staff has adequate expertise in the specialty under review; including new procedures or technology;
  - b. An internal review cannot be performed due to a conflict of interest;
  - c. A similarly trained Practitioner is not available to conduct an internal review;
  - d. Internal reviewers or Medical Staff committees have a substantial difference of opinion regarding the care provided;
  - e. The MEC or Governing Board requests external peer review for circumstances deemed appropriate by either of these bodies; or

- f. Other appropriate reason as dictated by circumstances.
2. The following have the authority to initiate external peer review:
    - a. PEC
    - b. MEC
    - c. CCO
    - d. CEO (on behalf of the Board)
    - e. MCHS Board of Trustees
    - f. While a Practitioner may request external peer review (at his/her own cost), a Practitioner cannot require external peer review. Similarly, the Practitioner under review cannot determine how or by whom the external review is conducted. The results from external peer review will not be considered definitive for purposes of Medical Staff peer review until the report is reviewed by the appropriate Medical Staff body or its designee.

If external peer review is obtained for purposes of peer review, the results of the review are protected from discovery under peer review statutes.

3. When the results of the external peer are available the report will be reviewed by the PEC at its next regularly scheduled meeting unless the MEC or the Board requests an expedited review. As with cases reviewed internally, the PEC will determine if there are any improvement opportunities. If improvement opportunities exist, they will be handled in the same manner as improvement opportunities identified through an internal review. If the external review is requested directly by the MEC or the Board the requesting body will review the report.
4. When a decision is made to send a case for external peer review, the involved Practitioner will be notified of the reason for the external review as well as the case being sent for review. The Practitioner will be given a copy of the external peer review report and will be given an opportunity to provide input regarding the findings in the same timeframes as forth above for an internal review prior to the PEC making any determinations. The identity of the external reviewer will be blinded from the Practitioner.

**G. Disruptive Physicians**

The PEC will not address issues related to unprofessional and disruptive behaviors. Rather, those issues will be addressed using the process set forth below.

1. Members of the Medical Staff must treat others with respect, courtesy and dignity and conduct themselves in a professional and cooperative manner. Peer review processes may be utilized to address conduct that does not meet the MCHS Respectful Work Environment policy or the Trinity Health Code of Conduct.

2. Reported unprofessional/disruptive behavior may be referred to and investigated by the Department Chair, Medical Staff President, PEC Chair, MEC, CMO or the CCO. If the conduct is not investigated by the Department Chair, the results of the investigation will be sent to the Department Chair for appropriate action. If the Department Chair declines to act, the matter will be referred to the appropriate Medical Staff President and CMO.
3. Medical Staff leadership may:
  - a. Once the first occurrence of unprofessional/disruptive behavior is substantiated, the Department Chair, PEC Chair or PEC Chair's designee will initiate a collegial discussion with the Practitioner and this intervention will be documented including the participants, date, time, discussion and action plan. The documentation related to this collegial discussion will be placed in the Practitioner's quality file. A copy will also be given to the Practitioner.
  - b. If a second occurrence of unprofessional/disruptive behavior is substantiated, the Department Chair and Medical Staff President (or Medical Staff President Elect or CMO) will initiate a discussion with the Practitioner. The discussion will be documented including the participants, date, time and action plan. The documentation related to this discussion will be placed in the Practitioner's quality file. A copy will also be given to the Practitioner.
  - c. If a third occurrence of unprofessional/disruptive behavior is substantiated, the CMO and Medical Staff President will meet with the Practitioner and give the Practitioner a final warning for misconduct. The final warning for misconduct will be documented including the participants, date, time and action plan. A copy of the final warning for misconduct will be placed in the Practitioner's quality file. A copy will also be given to the Practitioner.
  - d. If there are no further instances of substantiated unprofessional/disruptive behavior for a period of one year from the first substantiated occurrence, the process outlined above will start at the beginning.
  - e. If there are any further instances of substantiated unprofessional/disruptive behavior, the CMO will refer the matter to the PEC.
  - f. If a Practitioner is referred to the PEC due to substantiated unprofessional/disruptive conduct, the PEC will send the Practitioner a letter requesting that the Practitioner attend the next regularly scheduled PEC meeting to discuss the behavioral concerns. A summary of the behavioral concerns will be included in the letter. After the Practitioner attends the PEC meeting, he/she will receive a follow up letter summarizing the discussion and the recommendations of the PEC.
  - g. If the Practitioner chooses not to appear before the PEC, the PEC has the option of issuing recommendations to the Practitioner or referring the matter to the MEC for possible corrective action pursuant to the Medical Staff Bylaws.

- h. If the PEC receives notice of additional substantiated occurrences of unprofessional/disruptive behavior within a twelve (12) month time frame from meeting with the PEC or if the Practitioner disregards the PEC's recommendations, the Practitioner will be referred to the MEC for possible corrective action pursuant to the Medical Staff Bylaws. The PEC will provide the Practitioner with written notice that a referral was made to the MEC.
- i. Letters sent Practitioners from the PEC regarding behavioral concerns and recommendations should be hand delivered or delivered via overnight delivery with delivery confirmation. A copy of the letter will be placed in the Practitioner's quality file.
- j. While the intent is to address and resolve issues of unprofessional/disruptive conduct in the progressive manner described above, this policy does not preclude the referral of a matter, at any time, to an alternative forum (PEC or MEC, etc.) for action, including corrective action under the Medical Staff Bylaws.

**H. Oversight and Reporting**

The PEC reports to the MEC. No changes can be made to the PEC Charters and peer review policies without MEC approval. The PEC Chair will provide bi-monthly reports to the MEC.

**I. Statutory Authority**

This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, et seq. and state statutes and Ohio Revised Code §§2305.24, 2305.25, 2305.252, and 2305.253. All peer review conducted under this policy is subject to peer review privilege and immunity provided under state and federal law.

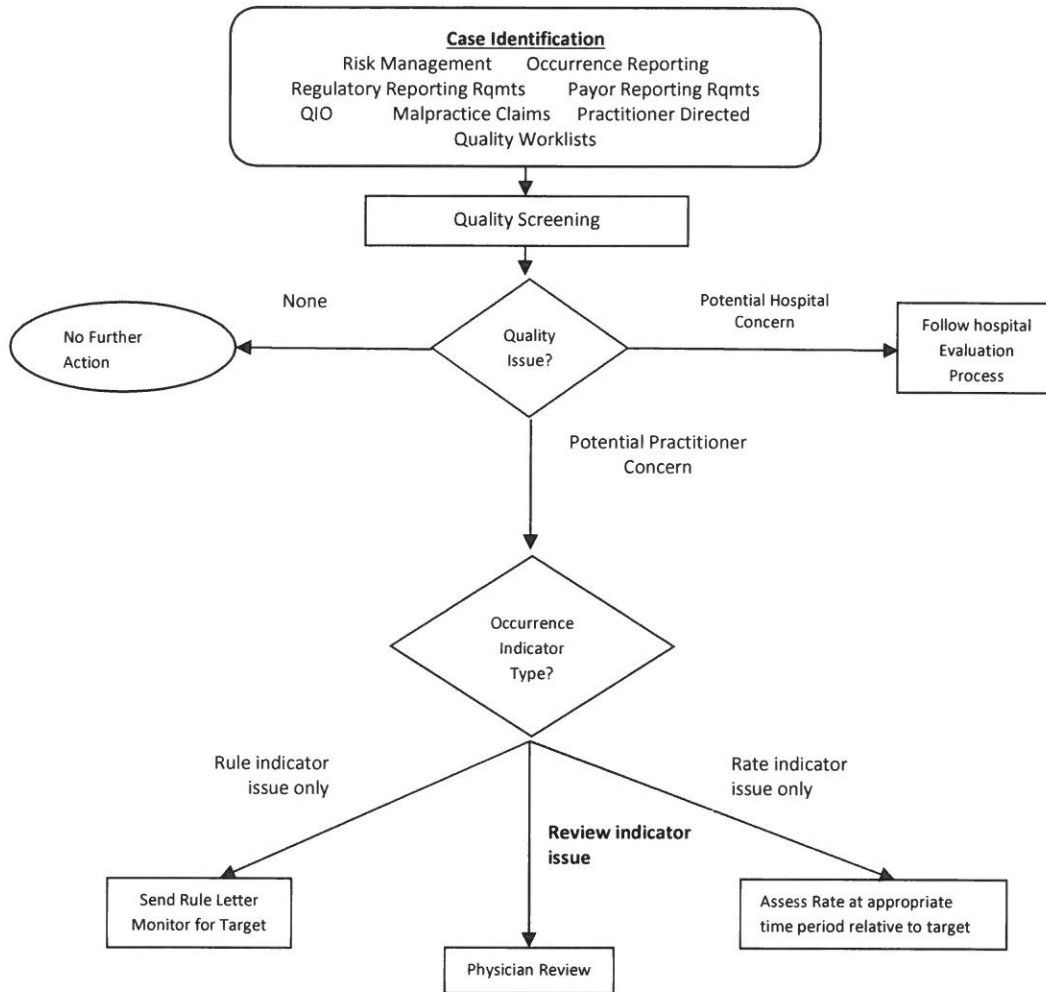
All minutes, reports, recommendations, communications and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities. Documents, including minutes and case review materials, prepared in connection with this policy should be labeled consistent with the following confidentiality statement:

"Data, records, documents, and knowledge, including but not limited to minutes and case review materials, collected for or by individuals or committees assigned peer review functions are confidential, are not public records, and shall be used by the committees and individuals only in the exercise of committee's scope of responsibility."

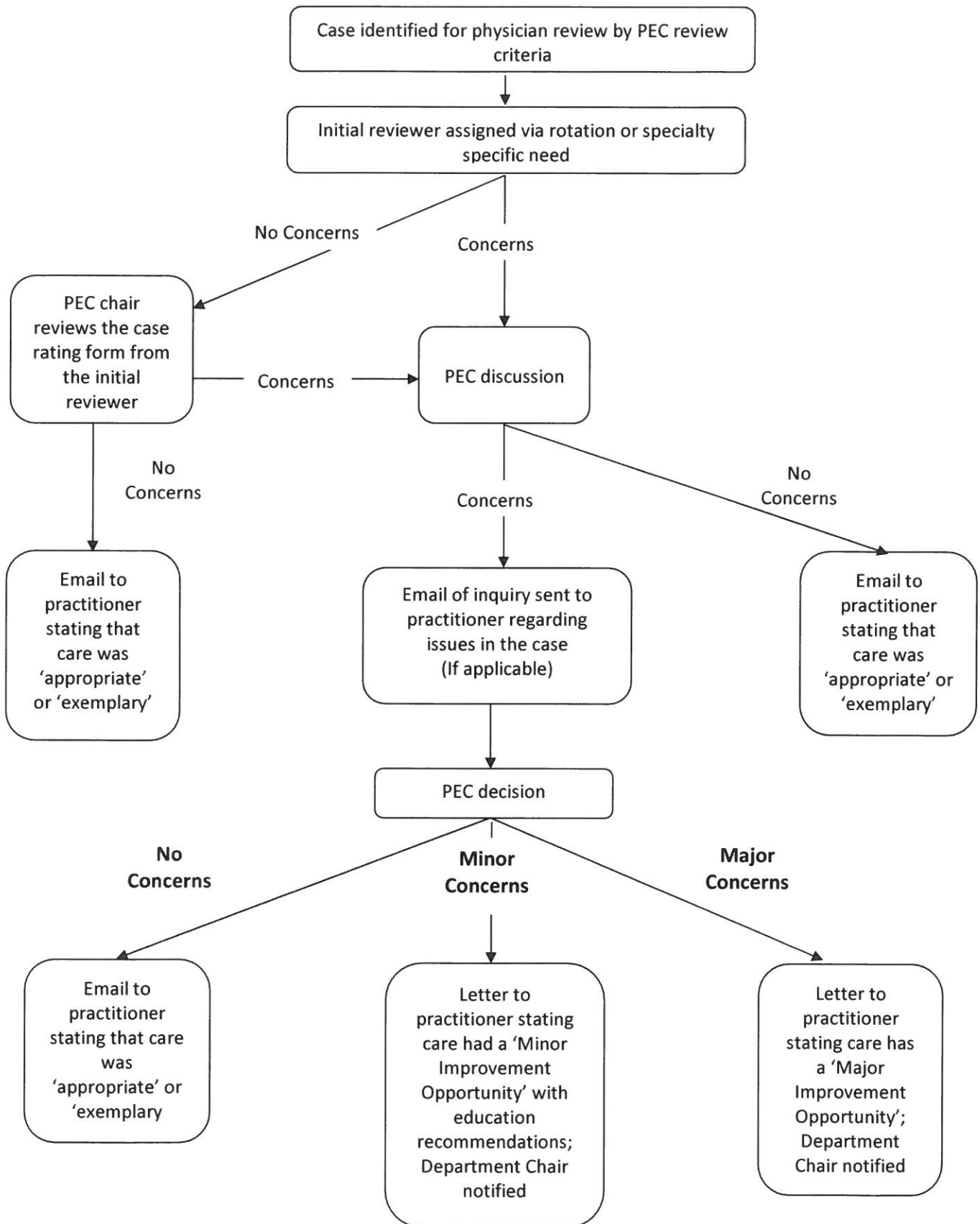


# Appendix B

## Case Identification Flow Diagram



### Appendix C Case Review Flow Diagram



## Appendix D Peer Review Case Rating Form

MR #: \_\_\_\_\_ D/C Date: \_\_\_\_\_ Referral Date: \_\_\_\_\_ Provider #: \_\_\_\_\_ Type: \_\_\_\_\_

Referral Source: Check the corresponding box

|        |      |     |         |       |               |           |             |
|--------|------|-----|---------|-------|---------------|-----------|-------------|
| Screen | Risk | HIM | Nursing | Pharm | Pt. Relations | Med Staff | Other _____ |
|--------|------|-----|---------|-------|---------------|-----------|-------------|

Review Criteria/Referral Issue: \_\_\_\_\_

Quality Screener/Date \_\_\_\_\_ Date Submitted for Review \_\_\_\_\_

Case Summary \_\_\_\_\_

Key Questions for Reviewer: \_\_\_\_\_

**General Questions for Reviewer:** Were appropriate tests, treats, medications or consults ordered/done? Were they done in a timely manner? Were appropriate preventive measures taken? Were care decisions/plan communicated?

### To be completed by Physician Reviewer

Reviewer: \_\_\_\_\_ Date: \_\_\_\_\_ Conflict of Interest?  No  Potential \_\_\_\_\_

| Overall Practitioner Care: Check one |  |
|--------------------------------------|--|
| 0                                    | Appropriate                                    |
| 1                                    | Minor Improvement Opportunity                  |
| 2                                    | Major Improvement Opportunity                  |
| U                                    | Reviewer Uncertain, needs Committee discussion |

**Note:** If Overall Care = 0, then Issue must = (A);  
If Overall Care = 1, 2, or U,  
then Issue must = (B) through (O)

| Issue Identification                                  |  |
|---|--|
| A   | No issues with practitioner care               |
| <b>Practitioner Care Issues: Check all that apply</b> |  |
| B   | Diagnosis ( Pt Care)                           |
| C   | Clinical Judgment/Decision-making ( Pt Care)   |
| D   | Technique/Skills ( Pt Care)                    |
| E   | Planning ( Pt Care)                            |
| F   | Supervision: House Physician or AHP ( Pt Care) |
| G   | Knowledge (Medical Knowledge)                  |
| H   | Timely/Clear Communication (Comm/IP Skills)    |
| I   | Responsiveness (Professionalism)               |
| J   | Follow-up/Follow-through (Professionalism)     |
| K   | Policy Compliance (System based Practice)      |
| O   | Other:   |

### Complete on all cases

| Practitioner Documentation: Check all that apply |  |
|--|--|
| 1  | No issue with practitioner documentation                       |
| 2  | Documentation does not substantiate clinical course/ treatment |
| 3  | Documentation not timely to communicate with other caregivers  |
| 4  | Documentation unreadable                                       |
| 9  | Other:   |

### Documentation Issue Description:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If Overall Practitioner Care rated **Appropriate**, provide a **brief description** of the basis for reviewer findings:

\_\_\_\_\_

\_\_\_\_\_

If Overall Practitioner Care rated **Minor / Major Improvement Opportunity** or **Uncertain**, complete the following:

**A. Brief description** of the basis for reviewer concerns: \_\_\_\_\_

\_\_\_\_\_

**B. What questions** are to be addressed by the practitioner or the Committee? \_\_\_\_\_

\_\_\_\_\_

**Exemplary Nominations:** \_\_\_ Practitioner Care \_\_\_ Practitioner Documentation \_\_\_ Non-Practitioner Care

**Brief Description:** \_\_\_\_\_

**Non-Practitioner Care Issues:** \_\_\_ Potential System or Process Issue \_\_\_ Potential Nursing/Ancillary Care Issue

**Issue Description:** \_\_\_\_\_



## Appendix D

### To Be Completed by the Committee

**Committee initial Review**

Is practitioner response needed? \_\_\_ Yes \_\_\_ No (Care Appropriate, no issues or concerns)

Practitioner response: \_\_\_ Letter \_\_\_ Committee appearance

**Committee Final Scoring:**

Overall Practitioner Care: \_\_\_ Issue Identification: \_\_\_ Documentation: \_\_\_

**Committee Recommendation/Action (Check One)**

|                          |  |
|--------------------------|--|
| <input type="checkbox"/> | No action warranted  |
| <input type="checkbox"/> | Practitioner self-acknowledged action plan sufficient                                      |
| <input type="checkbox"/> | Educational letter to practitioner sufficient  |
| <input type="checkbox"/> | Educational letter + Dept. Chair discussion of informal improvement plan with practitioner |
| <input type="checkbox"/> | Communication letter + Dept. Chair develops formal improvement plan with monitoring        |
| <input type="checkbox"/> | Communication letter + Refer to MEC  |

\_\_\_ System Problem Identified – forward to: \_\_\_\_\_ Date sent: \_\_\_\_\_ Date Response: \_\_\_\_\_

Describe system issue: \_\_\_\_\_

\_\_\_ Referral to Nursing Review Date sent: \_\_\_\_\_ Date Response \_\_\_\_\_

Describe nursing concern: \_\_\_\_\_

\_\_\_ Referral to CME Committee Date sent: \_\_\_\_\_

|                          | <b>Patient Outcome</b>  |
|--------------------------|---|
| <input type="checkbox"/> | 1 No Adverse Outcome  |
| <input type="checkbox"/> | 2 Minor Adverse Outcome (complete recovery expected)            |
| <input type="checkbox"/> | 3 Major Adverse Outcome (complete recovery <b>NOT</b> expected) |
| <input type="checkbox"/> | 4 Catastrophic Adverse Outcome (e.g. death)                     |
| <input type="checkbox"/> | 0 Unknown to Reviewer   |

|                          | <b>Effect on Care</b>  |
|--------------------------|--|
| <input type="checkbox"/> | 1 Care not affected  |
| <input type="checkbox"/> | 2 Increased monitoring/observation (e.g. vital sign checks)                      |
| <input type="checkbox"/> | 3 Additional treatment/intervention (e.g. IV fluids)                             |
| <input type="checkbox"/> | 4 Life sustaining treatment/intervention (e.g. intubation, pressor support, CPR) |
| <input type="checkbox"/> | 0 Unknown to Reviewer  |

\*A box should be placed on this form reflecting the peer review protection language that is appropriate for the state

**Appendices**

**Appendix A: Confidentiality and Conflict of Interest Attestation**

**Appendix B: Case Identification Flow Diagram**

**Appendix C: Case Review Flow Diagram**

**Appendix D: Case Review Rating Form**

**Other Related Documents**

**Confidentiality Statement**

**PEC Charters**

**Medical Staff Competency Expectations**

**Medical Staff Indicator List**

**OPPE/FPPE Policy for Current Medical Staff Members**

**FPPE Evaluation for Initial Appointment or New Privileges**