Addendum A
Policies & Procedures
Professional Staff
Providence Health & Services – Oregon

Professional Staff Peer Review Policy

Purpose:
To ensure that the hospital, through the activities of its professional staff, assesses the ongoing professional practice evaluation (OPPE) of individuals granted clinical privileges and uses the results of such assessments, when necessary, to perform focused professional practice evaluation (FPPE) and improve patient care.

Goals:

1. Monitor and evaluate the ongoing professional practice of individual practitioners with clinical privileges
2. Create a culture with a positive approach to peer review by recognizing physician excellence as well as identifying improvement opportunities
3. Perform focused professional practice evaluation when potential practitioner improvement opportunities are identified
4. Provide accurate and timely performance data for practitioner feedback, ongoing and focused professional practice evaluation and reappointment
5. Promote efficient use of practitioner and quality staff resources
6. Ensure that the process for peer review is clearly defined, fair, defensible, timely, and useful.

Definitions:
Peer review
"Peer review" is the evaluation of an individual practitioner's professional performance and includes the identification of opportunities to improve care. Peer review differs from other quality improvement processes 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 by a system.

Peer review is conducted using multiple sources of information including: 1) the review of individual cases, 2) the review of aggregate data for compliance with general rules of the professional staff and clinical standards, and 3) use of rate measures in comparison with established benchmarks or norms.

Practitioner competency framework
The individual's evaluation is based on generally recognized standards of care. Through this process, practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice as defined by the six Joint Commission/ACGME general competencies described below:

- **Patient Care:** Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and at the end of life

- **Medical Knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others

- **Practice-Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care

- **Interpersonal and Communication Skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams

- **Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society

- **Systems-Based Practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare

These competencies are further elaborated in the Professional Staff Expectations for Practitioners Attachment A: The Assessment of Clinical Competence.

Peer

A “peer” is an individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner’s performance will determine what “practicing in the same profession” means on a case-by-case basis. For quality issues related to general medical care, a physician (MD or DO) may review the care of another physician. For specialty-specific clinical issues, a peer is an individual who is well-trained and competent in that specialty area.

Peer review body

The peer review body designated to perform the initial review by the medical executive committee (MEC) or its designee will determine the degree of subject matter expertise required for a practitioner to be considered a peer for all peer reviews performed by or on behalf of the hospital.

Ongoing professional practice evaluation (OPPE)
The routine monitoring and evaluation of current competency for current professional staff comprises the majority of the functions of the ongoing peer review process and the use of data for reappointment.

Focused professional practice evaluation (FPPE)
FPPE is the establishment of current competency for new professional staff members, new privileges, and/or concerns from OPPE***,*** or other sources. These activities comprise what is typically called proctoring or focused review depending on the nature of the circumstances.

Conflict of interest
A member of the professional staff requested to perform peer review may have a conflict of interest if they may not be able to render an unbiased opinion.

- An absolute conflict of interest would result if the practitioner is the one under review.

- Relative conflicts of interest are either due to a practitioner's involvement in the patient's care not related to the issues under review or because of a relationship with the practitioner involved as a direct competitor, partner, or key referral source.

It is the obligation of the individual reviewer or committee member to disclose to the committee the potential conflict. It is the responsibility of the peer review body to determine on a case-by-case basis whether a relative conflict is substantial enough to prevent the individual from participating. When either an absolute or substantial relative conflict is determined to exist, the practitioner may not participate or be present during peer review body discussions or decisions other than to provide specific information requested as described in Attachment B: PHSOR Peer Review Process and Timeframe.

Policy:
1. All peer review information is privileged and confidential in accordance with professional staff policies and bylaws, hospital policies***,*** state and federal laws, and regulations pertaining to confidentiality and non-discoverability.
2. The involved practitioner will receive provider-specific feedback on a routine basis.
3. The professional staff will use the provider-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. The hospital will keep provider-specific peer review and other quality information concerning a practitioner in a secured manner. p*ractitioner*-specific peer review information consists of information related to:

    - Performance data for all dimensions of performance measured for that individual practitioner***.***

- The individual practitioner's role in sentinel events, significant incidents, or near misses
- Correspondence to the practitioner regarding commendations, comments regarding practice performance, or corrective action

5. Final determinations of the Department/Division Chair/ peer review committee and any subsequent actions are considered part of the practitioner's quality file.
6. Peer review information in the practitioner's quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a professional staff leader or hospital employee to the extent necessary to carry out their assigned responsibilities. , and may only be disclosed to:
   - The affected practitioner
   - The president of the professional staff for purposes of considering corrective action
   - Professional staff department chairs (for members of their departments only) to conduct OPPE
   - Members of the MEC HCC, and professional staff services professionals for purposes of considering reappointment or correction action.
   - Professional Staff leaders and quality staff supporting the peer review process
   - Individuals surveying for accrediting bodies with appropriate jurisdiction (e.g. The Joint Commission or state/federal regulatory bodies)
   - Individuals with a legitimate purpose for access as determined by the hospital MEC*.*
   - The hospital CEO when information is needed for the CEO's involvement in the process of immediate formal corrective action as defined by the professional staff policies and procedures.
7. No copies of peer review documents will be created and distributed unless authorized by professional staff or hospital policy.

Circumstances requiring peer review

Peer review is conducted on an ongoing basis and reported to the appropriate committee for review and action. The procedures for conducting peer review for an individual case and for aggregate performance measures are described in Attachments B: PHSOR Peer Review Process and Timeframe.

In the event that a decision is made by the MEC or designee to investigate a practitioner's performance or that circumstances warrant the evaluation of one or more practitioners with privileges, the MEC or its designee shall appoint a panel of appropriate medical professionals to perform the necessary peer review activities as described in the professional staff policies and procedures.

Circumstances requiring external peer review

The MEC, Department/Division Chair, or peer review committee will make determinations on the need for external peer review. No practitioner can require the

hospital to obtain external peer review if it is not deemed appropriate by the MEC. Circumstances requiring external peer review include the following:

- Litigation: when dealing with the potential for a lawsuit.

- Ambiguity: when dealing with vague or conflicting recommendations from internal reviewers or professional staff committees and conclusions from this review will directly affect a practitioner's membership or privileges.

- Lack of internal expertise: when no one on the professional staff has adequate expertise in the specialty under review; or when the only practitioners on the professional staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as describe above. External peer review will take place if this potential for conflict of interest cannot be appropriately resolved by the MEC, OMEC**,** and OCMB.

- Miscellaneous issues: when the professional staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the MEC, OMEC or OCMB may require external peer review in any circumstances deemed appropriate by either of these bodies.

Participants in the review process

Participants in the review process will be selected according to the professional staff policies and procedures. The work of all practitioners granted privileges will be reviewed through the peer review process. Clinical support staff will participate in the review process if deemed appropriate. Additional support staff will participate if such participation is included in their job responsibilities. The peer review body will consider the views of the practitioner whose care is under review prior to making a final determination regarding the care provided by that individual providing that individual responds in the timeframe outlined in Attachment B: PHSOR Peer Review Process and Timeframe.

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

Selection of practitioner performance measures

Measures of practitioner performance will be selected to reflect the six general competencies and will use multiple sources of data described in the Attachment C: Professional Staff Performance Indicators List.

Thresholds for FPPE

If the results of an OPPE indicate a potential issue with practitioner performance, the MEC or Department/Division Chair/ peer review committee may initiate a FPPE to determine whether there is problem with current competency of the practitioner for

either specific privileges or for more global dimensions of performance. These potential issues may be the result of individual case review or data from rule or rate indicators. The thresholds for FPPE are described in the acceptable targets for the professional staff indicators.

Individual case review
Peer review will be conducted by the professional staff in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed by the quality management staff and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability. The timelines for this process are described in Attachment B: PHSOR Peer Review Process and Timeframe. The rating system for determining results of individual case reviews is described in Attachment D: Peer Review Form.

Rate and rule indicator data evaluation
The evaluation of aggregate practitioner performance measures via either rate or rule indicators will be conducted on an ongoing basis by the Department/Division Chair, peer review committee, or a designee as described in Attachment B: PHSOR Peer Review Process and Timeframe.

Oversight and reporting
Direct oversight of the peer review process is delegated by the MEC to the Department/Division Chair or a peer review committee. Results will be reported to the OCMB through the MEC***,*** and OMEC.

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. 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.

Attachment List (Documents to be created by the individual hospital professional staff)
Attachment A: The Assessment of Clinical Competence
Attachment B: PHSOR Peer Review Process and Timeframe
Attachment C: Professional Staff Performance Indicators
Attachment D: Peer Review Form

Attachment A:
The Assessment
Of
Clinical Competence

The Assessment of Clinical Competence

Objective of Document:

To define clearly each tool/process related to the assessment of clinical competence in a user-friendly format. The document will specifically address the terms and processes of Focused and Ongoing Professional Practice Evaluation utilizing proctoring, mentoring and privilege validation assessment, and their appropriate use and limitations.

In particular, this document is intended for Professional Staff Department Chairs, Credentials Committees, Executive Committees, Privileging Criteria Development Committees, and Professional staff Office/Quality Management personnel.

Clinical Competency Assessment

Obtaining Privileges through Focused Professional Practice Evaluation	Indication	Process Mode	Definition	Evaluators	Length of Program	Responsibility
	Initial privileging - when all objective criteria have been met	**Privilege Validation Assessment**	Retrospective review or concurrent observation of a specified number of cases or for a specified time period, as recommended by Section/Department Chair/Director. Cases for review of privilege-specific competence to be representative of scope of privileges requested.	Department Chair or designee(s)	9 months; may be extended indefinitely	Department Chair with support by Professional staff Office and Quality Management. Applicant may be responsible to arrange for evaluator
	Initial privileging and re-privileging when all objective criteria have been met except minimum case volume	**Privilege Validation Assessment**	Retrospective review or concurrent observation of a specified number of cases or for a specified time period, as recommended by Section/Department Chair/Director	Department Chair or designee(s)	As needed	Department Chair with support by Professional staff Office and Quality Management. Applicant may be responsible to arrange for evaluator
	Physical Assessment	***Privilege Validation Assessment***	Physical assessment to determine the ability to exercise the privileges requested	Department Chair or designee(s)	As needed	Department Chair with support by Professional staff Office and Quality Management. Member may be responsible to arrange for healthcare professional evaluator

	Initial privileging when applicant does not meet minimum training and experience criteria	**Mentoring**	Applicant is instructed and trained to a higher level of competency	1) Training in hospital with qualified member or non-Member with temporary privileges. 2) Additional outside, postgraduate training. 3) External Training Programs, such as PEER.[A]	Until privileging criteria or Department Chair recommendations are met	Applicant to arrange for mentor or additional training. (evaluator may be compensated by applicant)
	Initial privileging for new technology (Hospital has agreed to offer privileges in the new technology) or high risk or infrequently performed procedures	**Proctoring**	Independent, objective, direct observation and evaluation of a practitioner's knowledge, skill, and expertise	Expert with privileges, free of conflicts of interest; hospital agent.	As recommended by Privileging Criteria or Department Chair	Applicant to arrange for proctor. In some cases, Hospital may arrange proctoring. (Proctor may be compensated by applicant)
Maintaining Privileges Through Ongoing Professional Practice Evaluation	Routine, ongoing monitoring as part of a departmental continuous quality assessment and improvement program	**Continuous Assessment**	Routine department activities that focus on diagnoses, procedures or processes, such as Heart Failure, SCIP and Pneumonia quality measures. Reports provided to practitioner at regular intervals	Department Chair or designee(s)	Continuous Reviewed at regular intervals and at reappointment	Department Chair with support by Quality Management
Potential To Reduce or Suspend Clinical Privileges (Evaluation & Corrective Action)	**Indication**	**Process Mode**	**Definition**	**Evaluators**	**Length of Program**	**Responsibility**
	Issues of concern or written complaints regarding a Member's clinical or professional conduct Formal process delineated in Article	**Clinical Or Professional Conduct Concerns/Corrective Action Plan**	Initial review ⇓ ⇒ NFA*	Department Chair or designee(s)		Department Chair with support by Professional staff Office and Quality Management External Review
			Informal, collegial discussion ⇓ ⇒ NFA*	Department Chair or designee(s)		

	VII of the PHSOR Professional Staff Policies and Procedures (Including Suspension)[B]		Special Appearance (opt) ⇓ ⇒ NFA*	President, Department Chair or Committee		generally covered by Professional Staff. May involve chart review and direct observation. External Practitioner Assessment and Review Program. Applicant may be responsible for external review arrangements.
			Focused Review/Investigation ⇓ ⇒ NFA*	Department Chair, designee(s), or External Review[3]		
			MEC Review/Action ⇓ ⇒ NFA*	MEC		
			OMEC Action ⇓⇑	OMEC		
			Board Action	Board		

*NFA **=** No Further Action

Focused Professional Practice Evaluation

Privilege Validation Assessment

Defined

- FPPE is defined as: (a) retrospective review of a specified number of cases, or (b) concurrent observation of a specified number of cases or for a specified period. Applicants meet all objective standards for Professional Staff Membership.

Applicability

- Appropriate for initial privileging and re-privileging when all objective criteria have been met except minimum case volume, and *on or after the age of 70*.

Role/Qualifications of Evaluators

- Department Chair or designee: Applicant may be designated as responsible for obtaining evaluator for concurrent observation.
- Independent and unbiased evaluator, with privileges in area requested, to evaluate the technical and cognitive skills of another practitioner
- Expertise to judge technical and cognitive skills, and quality of care delivered
- Represents and responsible to Hospital, Professional Staff, and OCMB, as one of the quality management activities of the Professional Staff
- Part of membership responsibilities of active members (Article III, Section 1, B.)
- Indemnification protection coverage is provided through PHS policy for Professional Staff members participating in mentoring, proctoring or other quality assurance and credentialing functions. Indemnification may be provided to non-Professional Staff members by contract. Professional liability coverage for a non-member may be provided through a part-time, non-benefited employee position or as a temporary appointment to a Quality or Credentialing Committee.

Privilege Validation Assessment Process

- Evaluator assesses all aspects of the care provided through review of medical record documentation and interviews with the care team, as appropriate, or by direct observation.
- In the event of observed substandard medical care that is harmful to the patient, the evaluator should contact the Department Chair as soon as possible and, in the case of concurrent observation, ask the practitioner to stop the substandard actions, or intervene and document the action taken.
- Clinical Competency Assessment forms are provided to the evaluator. Modifications to standardized forms, if needed, should be limited.
- Upon completion of assessment, the Clinical Competency Assessment Forms and an optional confidential report are forwarded to the appropriate Department/Committee Chair.
- Department Chair reviews documentation and makes a recommendation to continue, modify or revoke clinical privileges.
- Department Chair recommendations, based on review of the assessment documents, are reviewed by the Hospital Credentials Committee (HCC).
- Department/HCC Chair or designee meets with the Practitioner and provides feedback on the results and recommends further action to the appropriate Department Chair and HCC, as necessary.
- Recommendation forwarded to Oregon Credentials Committee (OCC).
- Applicant's right to appeal adverse decisions is defined in the Policies and Procedures, Fair Hearing Plan (Article X).

Focused Professional Practice Evaluation

Privilege Validation Assessment
Physical Assessment

Defined

- Physical assessment to determine ability to exercise the privileges requested. Applicants meet all objective standards for Professional Staff Membership.

Applicability

- Appropriate upon the request by the department chair, HCC, and/or MEC, as applicable, when there is reasonable cause.

Role/Qualifications of Evaluators

- Independent and unbiased evaluator to evaluate the technical and cognitive skills of another practitioner
- Expertise to judge technical and cognitive skills, and quality of care delivered

Privilege Validation Assessment Process

- The physical assessment "fit to work" evaluation will consist of two parts: cognitive and physical assessment including vision and hearing, as applicable.
- Practitioner may be designated as responsible for obtaining the health care evaluator, and must be approved by the HCC and/or MEC. Upon completion of evaluation, the evaluator must confirm that the practitioner has no physical or mental health issues that may interfere with the safe and effective provision of care permitted under the privileges granted.
- Department Chair reviews documentation and makes a recommendation to continue, modify or revoke clinical privileges.
- Department Chair recommendations, based on review of the result of the assessment, are reviewed by the HCC and/or MEC, as applicable.
- Department/HCC Chair or designee meets with the Applicant and provides feedback on the results and recommends further action to the appropriate Department Chair and HCC, as necessary. Recommendation forwarded to the OCC.
- Applicant's right to appeal adverse decisions is defined in the Policies and Procedures, Fair Hearing Plan (Article X).
- Failure to complete the recommended examination within 90 days of notification will be deemed as a voluntary resignation of the member's Professional Staff membership and privileges.

Focused Professional Practice Evaluation

Proctoring Guidelines

Defined

- Independent, objective, direct observation and evaluation of a practitioner's knowledge, skill, and expertise in new technology, high risk procedures or infrequently performed procedures and initially granted privileges without a current professional performance record at the hospital. Applicants meet all objective standards for Professional Staff Membership and privileges, other than proctoring requirements.

Applicability

- Initial privileging when privilege criteria require proctoring, usually in cases of new technology or for high-risk or infrequently performed procedures, when recommended on review of a concern identified through Ongoing or for Focused Professional Practice Evaluation of initially granted privilege.

Role/Qualification of Proctor

- Independent and unbiased monitor, with privileges in area requested, to evaluate the technical and cognitive skills of another practitioner. Outside experts may be granted temporary privileges for proctoring purposes when the expertise is not available within the Professional Staff.
- Expertise to judge technical and cognitive skills, and quality of care delivered
- Represents and responsible to Hospital, Professional Staff and Community Ministry Board as one of the quality management activities of the Professional Staff
- Professional Staff Policies and Procedures state that members granted privileges in new procedures are expected to assist in the training and proctoring of other members. (Article VI, Section 1, D.)
- The individual may receive a fee from the practitioner or the Hospital.

Proctoring Process

- Proctor must engage in direct observation of specified number of procedures/cases and evaluate all aspects of the care provided. Proctoring may occur at other facilities, but at least one proctored case must be performed at Providence facility.
- Proctor must be identified at time of scheduling of the case or on admission.
- Clinical Competency Assessment forms are provided to the proctor. Modifications to standardized forms, if needed, should be limited.
- Clinical Competency Assessment forms should be filled out immediately after each observed procedure/case.
- Upon completion of proctoring, the forms and an optional confidential report should be forwarded to the Department Chair, whose recommendation is forwarded to the Hospital Credentials Committee. Recommendation may be that proctoring was successfully completed or for further training or proctoring or conditions on privilege request.
- Applicant's right to appeal adverse decisions is defined in the Policies and Procedures, Fair Hearing Plan (Article X).
- In the event of observed substandard medical care that is harmful to the patient, the proctor should contact the Department Chair or designee as soon as possible and ask the practitioner to stop the substandard actions, or intervene and document the action taken.

- Presence of a proctor should be communicated to the patient and documented in the chart.

Role of *OCMB* /Hospital

- Indemnification protection and professional liability coverage may be provided through PHS policy for Professional Staff members participating in mentoring, proctoring or other quality assurance and credentialing functions. Indemnification may be provided to non-Professional Staff members by contract. Professional liability coverage for a non-member may be provided through a part-time, non-benefited employee position or as a temporary appointment to a Quality or Credentialing Committee.

Focused Professional Practice Evaluation

Mentoring Guidelines

Defined

- The mentoring process is when a Professional Staff members seeking to arrange individual informal clinical experiences or mentoring to meet privileging criteria or to enhance clinical skills. Additional clinical experience for professional development may be provided or obtained through a mentoring arrangement, either as defined in privileging criteria or with a plan developed with an experienced professional in a specific practice area or procedures. Department Chair and Credentials Committee approval is required.

Applicability

- Initial privileging when privilege criteria require mentoring, when Member seeks to obtain additional clinical experience, when recommended on review of a concern identified through Ongoing Professional Practice Evaluation or for Focused Professional Practice Evaluation of initially granted privilege. Mentee must have the ability to meet applicable clinical privilege criteria with successful clinical experience/mentoring.

Role/Qualification of Mentor

- Recognized expert, knowledgeable and skilled, in clinical area identified for additional clinical experience/mentoring. Outside experts may be granted temporary privileges for mentoring purposes when the expertise is not available within the Professional Staff.
- Mentor is responsible to provide guidance, direction and support to practitioners for professional development.
- Expertise to judge technical and cognitive skills, and quality of care delivered.
- The physician doing the material aspects of the procedure shall be identified and provide the informed consent.
- Represents and responsible to Hospital, Professional Staff and Community Ministry Board as one of the quality management activities of the Professional Staff
- Professional Staff Policies and Procedures state that members granted privileges in new procedures are expected to assist in the training and proctoring of other members. (Article VI, Section 1, D.)
- The individual may receive a fee from the practitioner or the Hospital.

Mentoring Process

- Unless specified by privilege criteria, a Clinical Experience/Mentoring Plan must be approved by the Department Chair and Credentials Committee. The plan must include the following elements: participants, goals and objectives, clinical experience specifics (include patient care responsibilities, involvement in clinical procedures (observation, assistance, and primary performance), documentation, evaluation methods/measurements of success, length of training. Mentoring may occur at other facilities, but requirements for assessment of mentoring experience may be required at Providence facility.
- Mentor must be identified at time of scheduling of cases for procedures requiring mentoring. Mentor will be listed as primary surgeon.
- Clinical Competency Assessment forms are provided to the mentor. Modifications to standardized forms, if needed, should be limited.
- Clinical Competency Assessment forms should be filled out immediately after each mentored procedure/case.

- Upon completion of mentoring, the forms and an optional confidential report should be forwarded to the Department Chair, whose recommendation is forwarded to the Hospital Credentials Committee. Recommendation may be that mentoring was successfully completed or for further training or proctoring or conditions on privilege request.
- Applicant's right to appeal adverse decisions is defined in the Policies and Procedures, Fair Hearing Plan (Article X).
- In the event of observed substandard medical care that is harmful to the patient, the mentor should contact the Department Chair or designee as soon as possible and ask the practitioner to stop the substandard actions, or intervene and document the action taken.
- Both physicians must be identified to the patient and information on the arrangements provided. The physician doing the material aspects of the procedure shall be identified and provide the informed consent.

Role of OCMB/Hospital

- Indemnification protection and professional liability coverage may be provided through PHS policy for Professional Staff members participating in mentoring, proctoring or other quality assurance and credentialing functions. Indemnification may be provided to non-Professional Staff members by contract. Professional liability coverage for a non-member may be provided through a part-time, non-benefited employee position or as a temporary appointment to a Quality or Credentialing Committee.

Disclaimer

- These clinical experience/mentoring arrangements are informal and are not in any way associated with the hospitals' medical education program. The arrangements are between a Member of the Professional Staff and another Member or a non-Member professional colleague. There is no certification of the quality or outcome of the clinical experience/ mentoring arrangement from the Hospital or Professional Staff. Neither the Hospitals nor the Professional Staff organization are involved in any way with payment or reimbursement arrangements involved in any such individual informal clinical experience/mentoring plan.

Focused Professional Practice Evaluation

Focused Review or Investigation
Internal/External Review Guidelines

Defined

- Independent, objective, evaluation of a practitioner's knowledge, skill, expertise and performance by an expert with no connection to the Member

Applicability

- As recommended by the MEC, when there are documented cases of concern regarding clinical competency and the Department Chair or designee cannot make a determination, do not have sufficient expertise in the area of concern or have a conflict of interest, or the Member under review requests external review. (Professional Staff Policies & Procedures Article VII, Section 4)

Role/Qualification of Internal/External Reviewer

- The role of an internal/external reviewer is to achieve an independent and unbiased evaluator to evaluate the technical and cognitive skills of another practitioner.
- Reviewer qualifications are specified in the recommendation for the focused review. Generally, the qualifications are comparable to the Member under review.
- Sources for reviewers include Members within PH&S facilities and Organizations specializing in external medical peer review services, such as Medical Resource Network[C].
- This individual represents and is responsible to Hospital, Professional Staff and Community Ministry Board, as one of the quality management activities of the Professional Staff.
- The individual may receive a fee from the Hospital or Member
- Indemnification may be provided to non-Professional Staff members by contract. Professional liability coverage for a non-member may be provided through a part-time, non-benefited employee position or as a temporary appointment to a Quality or Credentialing Committee.

Focused Review Internal/External Process

- Reviewer may engage in chart review, interviews with persons with information relevant to the issues, and direct observation of specified number of procedures or specified period. Reviewer should evaluate all aspects of the care provided, as requested.
- Elements essential to the focused review should be communicated, but use of a standardized form is not required for external reviewers.
- Upon completion of the focused review, the forms and/or a confidential report are forwarded to the MEC. The report should contain the type and number of cases reviewed and an evaluation of the Member's performance.
- Decision-making is further defined in Article VII of the Professional Staff Policies and Procedures.

[C] Medical Resource Network Information

Clinical Competency Assessment Form

Used for FPPE:
___ Proctoring
___ Focus Review
___ Privilege Validation Assessment

Type of Review:
____ Concurrent Observation
____ Retrospective Review
__ ___ Mentoring

Practitioner Reviewed:_____

Procedure Reviewed:_____**Date:**_____
Case # ___ of ___ Medical Record #_____
Period ___ of ____

Check Appropriate Box

I. Patient Assessment	**No Concerns**	***Some Concerns**	**Unable to Assess**
a) Appropriate History and Physical			
b) Appropriate diagnostic tests/exams			
c) Considers available evidence			
d) Considers patient preferences			
e) Develops appropriate assessment & plan			
f) Seeks consultation as appropriate			
g) Utilizes allied health professional input			
h) Modifies plans as situation warrants			
i) Interactions with staff			

II. Procedure (as applicable)			
a) Procedure indications present			
b) Patient preparation			
c) Appropriate choice of equipment			
d) Technical aspects of equipment			
e) Safety aspects of equipment			
f) Order/flow of procedure			
g) Intra-procedural decision-making			
h) Procedural technique			
i) Recognition/management of complications			
j) Interactions with staff			
k) Post procedure plan			

III. Professionalism			
Demonstrates continuous professional development, ethical practice, sensitivity to diversity, and a responsible attitude to patients, the profession and society.			
IV. Systems Based Practice			
Demonstrates an understanding of the contexts and systems in which health care is provided, and applies knowledge to improve and optimize health care.			
V. Overall Competence			

VI. Documentation			

VII. Comments/Recommendation:

If this is the last case to be reviewed, is further review needed? _____ Yes _____ No
If "Yes", provide reasons on reverse side.
Proctored Cases (evaluation of technical and cognitive skills): Did Proctor assist at procedure? □Yes □ No
If "Yes", indicate in VII above if advice or assistance was provided on the material aspects of the procedure.
Reviewer Signature:_____ Date:_____
Reviewer's Printed Name: _____
***"Some Concerns" Requires Explanation**

Attachment B: PHSOR Peer Review Process and Timeframe

Action	Case Review Process	Timeline - Guidelines
Case identification and screening	Screening work lists: Patient case review work lists for appropriate review indicators are obtained and reviewed against list of indicators.	Work lists will be generated monthly and then screened for further review.
Physician reviewer assignment	Cases will be assigned for an initial review. If the initial reviewer determines the case has issues outside of the reviewer's expertise, the reviewer will request an additional reviewer.	QM assigns initial reviewer when case is determined to require physician review or when second reviewer is requested.
Physician review	Physician reviewer performs case review and completes case rating form. If the rating form is not completed, QM will promptly contact the reviewer to obtain the additional information. Only cases with completed case rating forms will be place on the agenda.	The physician reviewer will perform the review within two weeks of assignment.
Initial reviews rated quality of care appropriate	Reviews indicating appropriate physician care are reported to the committee for summary approval. The chair will review the summary of these cases with QM prior to the committee meeting. If there are any concerns with the case scoring, the chair will discuss the case with the reviewer, and may choose to present the case for discussion.	Completed reviews indicating appropriate physician care are approved at the next meeting after the review is submitted.
Initial reviews rated controversial, inappropriate care or reviewer uncertain	Reviews indicating potential controversial or inappropriate care or reviewer uncertain regarding physician care are presented for discussion. If the care is deemed controversial or inappropriate, it will be communicated with the involved physician(s) by letter. The involved physician(s) are informed of the key questions regarding the case and asked to respond in writing.	Physician under review will respond to committee within two weeks. If no response the physician will be contacted by committee chair/designee to determine if he/she is unavailable due to special circumstances. If no response, the committee chair will finalize the rating based on the available information.
Additional clarification from the physician	After the initial written response, if the committee determines it needs further clarification, it may allow the physician to provide the second response either in writing only or in person within a specified timeframe to respond to specific, predetermined questions.	Clarification responses will be provided by the next meeting or the committee will finalize rating based on the available information. An exception would be the committee requiring a personal appearance.

Committee final disposition for cases with inquiry letters	Following receipt of the physician's response or, if the response timeframe has lapsed, the committee will make the final determination of the overall physician care and physician care issues.	Final case determinations will be made by majority vote.
Communicating findings to physicians	For cases determined to have appropriate or exemplary physician care, the involved physicians are informed annually of the results. For cases determined to be inappropriate or controversial care, physicians are informed of the decision by letter, with copies to MSOW Peer Review.	Letters regarding inappropriate or controversial care will be sent within one week of the committee meeting.
Tracking review findings	QM will enter the results of all final review findings into MSOW for tracking.	Results will be entered in the database prior to the next committee meeting.
Improvement plan development	If the results of case review indicate a need for individual physician performance improvement, the issue will be referred to the appropriate physician leadership.	If no response is received from the physician leadership within two weeks, the committee chair and President of the Professional staff will be informed.
Referrals to the hospital PI committee	For cases determined to have potential opportunities to improve system performance the committee chair will refer the issue to the appropriate hospital committee.	The hospital committee receiving the referral will discuss the issue and communicate its assessment, and action plan to hospital senior leadership.
High-risk cases	Cases meeting the organizations sentinel event criteria will have immediate review by the committee chair or designee. Additional information (such as a literature search, second opinion, or external peer review) may be necessary before making a decision on action.	Refer to Sentinel Event policy.

ATTACHMENT C: Professional Staff Performance Indicator (2013-06-15)

Indicator	Data Generated by	Medicine	Surgery	OB Gyn	Pediatrics	Anesthesia	Emergency Medicine	Pathology	Psychiatry	Radiology
Rate/Based Indicators										
Mortality: Actual Rate, Risk Adjusted Expected Rate, Observed/Expected Index (Excel Target <0.85; Actual Target <1.3)	QAR	X	X	X	X				X	
Readmissions: Actual Rate, Risk Adjusted Expected Rate, Observed/Expected Index (Excel Target <0.85; Actual Target <1.3)	QAR	X	X	X	X					
CHF core measure physician bundle	QAR	X								
AMI core measure physician bundle	QAR	X								
Pneumonia core measure physician bundle	QAR	X								
Surgical (SCIP) core physician bundle	QAR		X							
Anesth: Mortality Rate by Service Line Groups	QAR					X				
Anesth: Rate of Stroke Not POA by Service Line Groups	QAR					X				
Anesth: Rate of AMI Not POA by Service Line Groups	QAR					X				
Pathology: Significant tissue discrepancy between pre-procedure diagnosis and pathology findings	Pathology							X		
Pathology: % discrepancies between frozen section and final diagnosis	Pathology							X		
Pathology: Average report turnaround time for anatomic pathology services	Pathology							X		
Radiology: % Random case radiology interpretation correlation (Percent of Clinically Significant Discrepancies in Interpretation)	Radiology									X
Teleradiology: % Random case radiology interpretation correlation (Percent of Clinically Significant Discrepancies in Interpretation)	Radiology									X
ED: Completeness of Restraint Orders (Physicians only)	ED						X			

Indicator	Data Generated by	Medicine	Surgery	OB Gyn	Pediatrics	Anesthesia	Emergency Medicine	Pathology	Psychiatry	Radiology
ED: Admit Rate to Facility (Physicians and Nurse Practitioners)	ED						X			
ED: ED Average Length of Stay in minutes (Physicians and Nurse Practitioners)	ED						X			
ED: Return to ED within 72 hours (Physicians and Nurse Practitioners)	ED						X			
Specialty-OB: NPIC drilldown	UOR or QM Office			X						
Recommended Summary Report for Occurrence/Based Indicators										
# of case reviews deemed care inappropriate (Excel Target 0 cases/year; Actual Target 2 cases/year)	QM	X	X	X	X	X	X	X	X	X
# of case reviews deemed care controversial or inappropriate (Excel Target 0 cases/year; Actual Target 4 cases/year)	QM	X	X	X	X	X	X	X	X	X
# of cases with documentation issues identified by Peer review (Excel Target 0 cases/year; Actual Target 5 cases/year)	QM	X	X	X	X	X	X	X	X	X
# of UORs (Excel Target 0 cases/year; Actual Target 4 cases/year)	QM	X	X	X	X	X	X	X	X	X
Suspensions for delinquent medical records (Excel Target 0 cases/year; Actual Target 3 cases/year)	HIM	X	X	X	X	X	X	X	X	X

Attachment D: Peer Review Form

PH&S - Oregon Peer Review Form

Submission Date:_____

MR #:	Date of Birth:	Admit Date:	Diagnosis:	Provider:

Review Criteria:

Key questions for reviewer:

Section 1: Reviewer Scoring
[To Be Completed By Professional Staff Reviewer]

Initial Reviewer: _____ **Review Date:** _____

A		Patient Outcome related to key question
	0	No Adverse Outcome
	1	Minor Problem: Outcome not affected
	2	Problem: Potential adverse consequences
	3	Problem: Caused; Exacerbated; was allowed to
	4	Problem: Quality of life adversely affected
	5	Unexpected event-care appropriate
	U	Unknown to reviewer

B		Effect on Care related to key question
	0	Care not affected
	1	Increased monitoring/observation
	2	Additional treatment/intervention
	3	Life sustaining treatment/intervention (CPR,
	U	Unknown to reviewer

C		Overall Provider Performance related to key question: Check One
	1	Appropriate
	2	Area of Concern
	3	Inappropriate
	0	Reviewer uncertain -> Committee

D		Issue Identification related to key question
	A	No issues with provider care
		Care Issues: √ all that apply
	B	Behavioral
	C	Clinical judgment / Decision making
	D	Technique / Skills
	E	Knowledge
	F	Communication /Responsiveness
	G	Planning / Follow-up
	H	Policy Compliance
	I	Supervision (oversight of AHP, etc)
	J	Handoff or Transition of care
	O	Other:

Note: If Overall Care = 1, Issue must = A
If Overall Care = 2, 3 or 0, Issue must = (B - O), **Complete section 2**, and document who Provider will be notified by (Please select one).

___ **Reviewer or** ___ **Department Chair**

Documentation Issue Description:

E		Provider Documentation: √ all that apply
	1	No issue with provider documentation
	2	Documentation does not substantiate clinical course / treatment
	3	Documentation not timely to communicate
	4	Documentation illegible
	5	Other:

Section 2: Provider Care Comments
[To Be Completed By Professional Staff Reviewer]

Brief Description Based on Review Findings and Overall Provider Performance Score [Section 1-C]:

Overall Recommendation and if applicable, questions to be asked to the Provider or a Peer Review Committee:

Section 3: Exemplary Nominations
[To Be Completed By Professional Staff Reviewer]

Provider Care [ ] **Provider Documentation [ ]** **Non-Provider Care [ ] Brief Description:**

Section 4: Non-Provider Care Issues
[To Be Completed By Professional Staff Reviewer]

Potential or Process Issue [ ] **Potential Nursing/Ancillary Care Issue [ ] Issue Description:**

Recommendation: [If issue(s) need to be referred to another department or group, please complete Section 7.]

Section 5: Department Chair Comments and Signature (if applicable)

Department Chair Signature: _____ **Date**: _____

Comments:

Section 6: Committee Review (to be completed by Peer Review Committee)

Committee Case Review Date: _____

Provider response needed: Yes No If yes, Provider response type: In writing [ ] In person [ ]

Provider response Review Date: _____

Committee Final Scoring: (refer to sections A, B, C, D, E on Page 1)

A – Patient Outcome _____ B – Effect on Care _____ C – Overall Provider Performance _____

D – Issue Identification _____ E – Provider Documentation

	Committee Action (Check one):	**Date**
	No action warranted	
	Provider self acknowledged action plan sufficient	
	Educational letter to Provider sufficient	
	Committee chair discussion of information improvement plan with provider	
	Committee chair develops formal improvement plan with monitoring	
	Refer to Medical Executive Committee or designee	
	Comments:	

Section 7: Post Peer Review Follow Up Work (if applicable) [Reserved for Quality Management or other appropriate peer review-related authority]

General Comments: **Date:** _____

	Problem Identified (Check one or more)	**Date**
	System Problem Identified and Referred To:	
	Department Problem Identified and Referred To:	
	Other Department Problem Identified and Referred To:	