National Patient Safety Leadership Speaker Series

Peer Review: The Fundamentals

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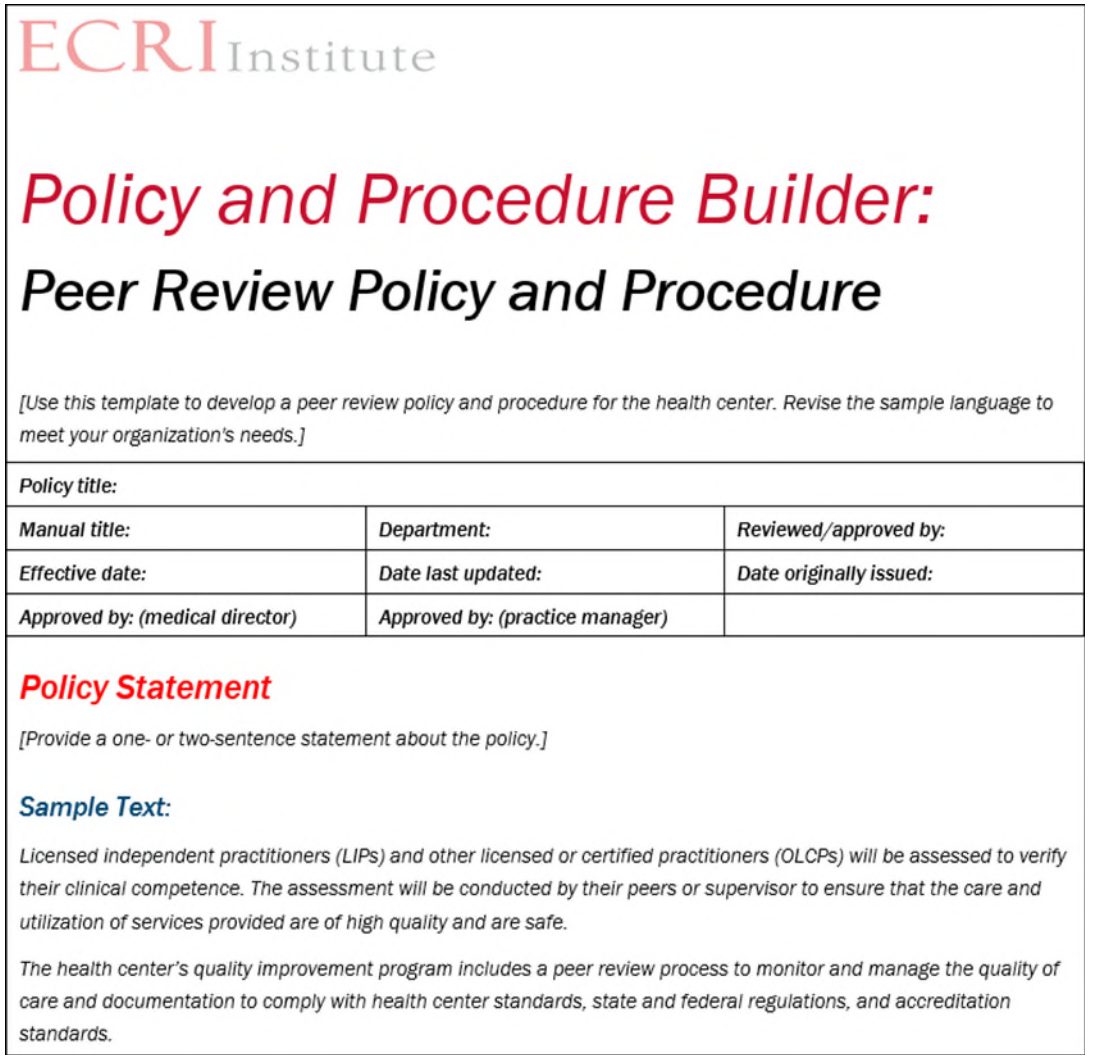
ECRI Institute

About ECRI Institute

- Independent, not-for-profit applied research institute focused on patient safety, healthcare quality, risk management
- Website for HRSA-funded entities. Log in with email address and password at: www.ecri.org
- **Have not activated your profile yet?** Email us at: Clinical_RM_Program@ecri.org
- 50-year history, 450-person staff
- AHRQ Evidence-Based Practice Center
- Federally designated Patient Safety Organization

ECRI Resources

- New! Peer Review Policy and Procedure
- Credentialing and Privileging Toolkit
  - Peer Review Checklist
  - Peer Review/Chart Review Form
  - Sample Peer Review Tracking Mechanism
  - Peer Review Acknowledgement Form



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Policy and Procedure Builder:

Peer Review Policy and Procedure

[Use this template to develop a peer review policy and procedure for the health center. Revise the sample language to meet your organization's needs.]

Policy title:		
Manual title:	*Department:*	*Reviewed/approved by:*
Effective date:	*Date last updated:*	*Date originally issued:*
Approved by: (medical director)	*Approved by: (practice manager)*	

Policy Statement

[Provide a one- or two-sentence statement about the policy.]

Sample Text:

Licensed independent practitioners (LIPs) and other licensed or certified practitioners (OLCPs) will be assessed to verify their clinical competence. The assessment will be conducted by their peers or supervisor to ensure that the care and utilization of services provided are of high quality and are safe.

The health center's quality improvement program includes a peer review process to monitor and manage the quality of care and documentation to comply with health center standards, state and federal regulations, and accreditation standards.

Katten

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Peer Review: The Fundamentals

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What Is “Peer Review”?

- Generally speaking, “Peer Review” is the process by which physicians, advanced practitioners, nurses, and other healthcare provider are evaluated by their peers and others in order to determine whether they have met, and continue to meet, stated eligibility criteria in order to demonstrate that they have the current competency to exercise clinical privileges in all health care services provided to their patients.
- The activities included under peer review include the following:
  - Initial application procedures to determine whether a practitioner meets minimum standards for membership/employment
  - A “deeper dive” review of the practitioner’s educational background, training, experience, malpractice history and other related information which is reviewed and analyzed during the appointment, re-appointment, and employment procedures of the facility
  - The development of quality standards, quality metrics, outcome criteria, and other clearly defined factors against which a practitioner’s performance is measured on an ongoing or periodic basis

What Is “Peer Review”? (cont.)

- The activities included under peer review include the following (cont.):
  - A review of a practitioner’s performance outcome to be determined by a peer review committee or other group when identifying whether performance standards and requirements had been met and, if not, what types of remedial measures should be taken
  - The provision of ongoing feedback to practitioners to keep them up to date on their performance and, when necessary, the scheduling of meetings to review adverse patient events and deviations from standards of care which have or may cause patient injury
  - The development and implementation of a “just culture” approach which moves away from the “blame game” and focuses on ways to coach, consult, and educate practitioners when quality of care concerns are identified

Applicable HRSA Standards (1)

- **HRSA Health Center Program Compliance Manual, Chapter 5: Clinical Staffing**
  - Requirements
    - The health center must provide the required primary and approved additional health services of the center through staff and supporting resources of the center or through contracts or cooperative arrangements
    - The health center must provide health services so that such services are available and accessible promptly, as appropriate, and in a matter that will assure continuity of service to the residents of the center's catchment area
    - The health center must utilize staff that are qualified by training and experience to carry out the activities of the center

Applicable HRSA Standards (2)

- **HRSA Health Center Program Compliance Manual, Chapter 5: Clinical Staffing (cont.)**
  - Demonstrating compliance
    - The health center has operating procedures for initial and recurring review (for example every two years) of the credentials for all clinical staff members and health center employees
    - The credentialing procedures would ensure verification of the following:
      - Current licensure, registration, or certification using a primary source
      - Education, training, and experience
      - National Practitioner Data Bank query
      - Identity using a government-issued picture identification for initial credentialing
      - DEA registration
      - Current documentation of basic life support training

Applicable HRSA Standards (3)

- The credentialing procedures would ensure verification of the following (cont.):
  - Verification of fitness for duty, immunization, and communicable disease status
  - For initial privileging, verification of current clinical competence
  - For renewal of privileges, verification of current clinical competence via peer review or other comparable methods (for example, supervisory performance reviews)
  - Process for denying, modifying, or removing privileges based on assessments of clinical competence and/or fitness for duty
- Related considerations
  - The health center determines how it assess its clinical competence and fitness for duty of its staff. For example, regarding clinical competence, a health center may utilize peer review conducted by its own providers or contract with another organization to conduct peer review

Applicable HRSA Standards (4)

- **HRSA Health Center Program Compliance Manual, Chapter 10: Quality Improvements/Assurance**
  - Requirements
    - The health center must have an ongoing quality improvement/quality assurance (QI/QA) system that includes clinical services and clinical management and maintains the confidentiality of patient records
    - The health center's ongoing QI/QA system must provide for periodic assessment of the appropriateness of utilization of services and quality of services provided or proposed to be provided to individuals served by the center
    - Such assessments must be conducted by physicians or by other licensed healthcare professionals under the supervision of physicians based on the systematic collection and evaluation of patient records

Applicable HRSA Standards (5)

- **HRSA Health Center Program Compliance Manual, Chapter 10: Quality Improvements/Assurance (cont.)**
  - Demonstrating compliance
    - The health center has board-approved operating procedures or processes that address:
      - Adhering to current evidence-based clinical guidelines, standards of care, and standards of practice in the provision of health center services
      - Identifying, analyzing, and addressing patient safety adverse events and implementing follow-up actions
      - Completing periodic QI/QA assessments on at least a quarterly basis to inform the modification of the provision of health center services
      - Health center's physicians or other licensed professionals conduct QI/QA assessments on at least a quarterly basis using data systematically collected from patient records to ensure providers adherence to current evidence-based clinical guideline standards of care and standards of practice and identification of any patient safety and adverse events

Example Peer Review Standards–The Joint Commission (1)

- **MS.08.01.01 - Focused Professional Practice Evaluation**
  - Focused professional practice evaluation is a process by which the organization evaluates the privilege specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization
  - This process may also be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care
  - Focused professional practice evaluation is a time-limited period during which the organization evaluates and determines the practitioner's professional performance
  - A period of focused professional practice evaluation is implemented for all initially requested privileges

Example Peer Review Standards–The Joint Commission (2)

- **MS.08.01.01 - Focused Professional Practice Evaluation (cont.)**
  - Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff
  - The triggers that indicate the need for performance monitoring are clearly defined
  - The decision to assign a period of performance monitoring to further access current competence is based on the evaluation of a practitioner's current clinical competence, practice behavior, and ability to perform the requested privilege
  - The measures employed to resolve performance issues are clearly defined

Example Peer Review Standards – The Joint Commission (3)

- **MS.08.01.03 – Ongoing Professional Practice Evaluation**
  - The ongoing professional practice evaluation allows the organization to identify professional practice trends that impact quality care and patient safety. Such identification may require intervention by the organized medical staff. The criteria used in the ongoing professional practice evaluation may include the following:
    - Review of operative and other clinical procedures performed and their outcomes
    - Pattern of blood and pharmaceutical usage
    - Request for tests and procedures
    - Length of stay patterns
    - Morbidity and mortality data
    - Practitioner's use of consultants
    - Other relevant criteria as determined by the organized medical staff

Example Peer Review Standards – The Joint Commission (4)

- **MS.08.01.03 – Ongoing Professional Practice Evaluation (cont.)**
  - Relevant information obtained from the ongoing professional practice evaluation is integrated into performance improvement activities. These activities adhere to the organization's policies or procedures intended to preserve any confidentiality or legal privilege of information established by applicable law.
  - If there is uncertainty regarding the practitioner's professional performance, the organized medical staff should follow the course of action defined in the medical staff bylaws for further evaluation of the practitioner.
  - Ongoing professional practice evaluation information is factored into the decision to maintain existing privileges, exercise existing privileges, or to revoke an existing privilege prior to or at the time or renewal (MS.08.01.03)

Example Peer Review Standards – Institute for Medical Quality (1)

- **Section 3 – Organized Medical Staff Peer Review**
  - The peer review determines the appropriateness of clinical decision-making performance of procedures specific to each practitioner's specialty or scope of practice and/or clinical privileges. Medical staff bylaws establish standards for peer review prior to conducting the review.
  - **Frequency**: The peer review body meets on a regular basis, at least quarterly, and distributes peer review findings to the appropriate physicians and committees. There is an expedited peer review of all unanticipated events (deaths, unplanned transfers to acute facilities, significant complications).
  - **Number**: Peer review covers the full scope of privileges granted to each practitioner. A minimum of ten cases per practitioner per year will be reviewed or all cases if less then ten per provider per year

Example Peer Review Standards – Institute for Medical Quality (2)

- **Section 3 – Organized Medical Staff Peer Review**
  - **Internal or external**: When there are three or more physicians in the same specialty with the same scope of practice and/or clinical privileges, an internal review is appropriate. For specialties with one or two physicians, peer review is external.
  - Peer review, at a minimum, evaluates the following elements:
    - Clinical decision making
    - Procedural or surgical techniques through review of documentation, one applicable, and
    - The area of deficiency, if identified, is clearly defined and leads to a plan of correction and evidence of implementation
  - The results of the individual peer review, as well as potential trends in peer review, are considered in the credentialing and privileging process

Example Peer Review Standards – Institute for Medical Quality (3)

- **Section 3 – Organized Medical Staff Peer Review**
  - The system for quality assessment for improvement has the active participation of the medical staff. It includes but is not limited to an ongoing program that demonstrates measureable improvement in patient health outcomes.
  - It uses quality indicators or performance measures associated with improved health outcomes to improve patient safety
  - It identifies and reduces medical errors
  - It includes chart review and utilizes information derived from other data sources, such as patient satisfaction surveys and incident reports
  - The facility measures, analyzes, and tracks quality indicators, adverse patient events, infection control, and other aspects of performance relating to patient care and services provided

Example Peer Review Indicators (1)

- Core measures/strategic initiatives
  - Clinical initiatives and reported data outliers, as applicable
- Mortality return/level of care
  - Unexpected return within 48 hours of clinic visit
  - Unplanned return to clinic within 72 hours with original or similar sign/symptoms
- Complications
  - Iatrogenic events
  - Moderate to severe adverse drug reactions
  - Consent issues
  - Nosocomial infection related to clinic procedure
  - Unexpected complications in patient condition and/or care or treatment
  - Delay in referral to emergency department or higher level of care

Example Peer Review Indicators (2)

- Referrals
  - Behavioral concerns
  - Patient complaints
  - Documentation concerns
  - Medical care
    - Medication error
    - Delay in tests or assessment of ordered procedures
    - Critical lab or diagnostic values not addressed
    - Controlled substance prescribing pattern
    - Adverse outcome or serious reportable event
    - Patient management
    - Supervision of mid-level providers

Example Peer Review Indicators (3)

- Referrals
  - Quality letter from hospitals, third party payers or regulatory agencies
  - Litigation and claim referrals

Example Peer Review Scenario (1)

- Background
  - Dr. Callahan has been a member of the medical staff at Community Health Center for 25 years and is a board certified internist
  - The Center has recently adopted a more robust peer review and QA/QI program to better track ongoing physician performance against identified indicators
  - Although Dr. Callahan's past performance has not identified any significant quality of care concerns, his last quarterly report has identified several deviations from standards and peer review indicators in the areas of:
    - Medication errors
    - Unplanned return to Center within 72 hours with original or similar signs/symptoms
    - Patient management issues

Example Peer Review Scenario (2)

- Peer review procedure
  - Under the Center's procedures, all peer review inquiries, patient complaints, deviations from standards, etc., are sent through an online reporting tool to a centralized review team made up of registered nurse specialists.
  - The specialists review the medical records in question as well as other relevant data sources to determine whether the case/cases require further review by the Center's Peer Review Committee ("PRC").
  - Because Dr. Callahan's quarterly report has identified an unexpected increase in peer review incidents as measured against established standards, the specialist has referred all of the cases to the PRC.
  - These cases are summarized and, along with the records and supporting documentation, are sent digitally and securely to the Center's CMO and Chair of the PRC.

Example Peer Review Scenario (3)

- The PRC Chair then assigns the cases to PRC members to conduct a more formal review and assessment. In addition, they have reviewed Dr. Callahan's past quality file and reports to see if there have been similar issues in the past.
- After reviewing the cases, the PRC member provides an initial written assessment as to whether deviations from standards have occurred as well as whether there were near misses or actual patient harm as a result of any deviation.
- Copies of these written assessments are sent securely to the PRC Chair.
- Based on these assessments and confirmation that standards were not followed, the PRC Chair requests a meeting between Dr. Callahan and the PRC Committee member. Copies of the written assessments are sent to Dr. Callahan in advance of the meeting in order to allow Dr. Callahan to be better prepared.

Example Peer Review Scenario (4)

- The purpose of the meeting is to review the standards, identify where, in the opinion of the reviewers, the standards were not followed, and, most importantly, to obtain Callahan's rationale for the decisions and choices he made in each case.
- After the meeting, each PRC member who met with Callahan submits a written summary along with a preliminary score to the PRC Chair for review by the entire PRC Committee.
- The PRC Committee then reviews the reports, discusses, and deliberates about the scoring process. Among the factors considered are the following:
  - Was Dr. Callahan's purpose to cause harm?
  - Did he knowingly cause harm?
  - Was the harm justified?
  - Did the behavior represent a substantial or unjustifiable risk?
  - Did his actions involve a breach of duty to produce an outcome, or the failure to follow a required rule or procedure, or to avoid an unjustifiable risk or harm to the patient?

Example Peer Review Scenario (5)

- If a breach is identified, was it based on human error or at-risk behavior?
  - If based on human error, remedial action could include consulting as to better choices in the future.
  - If at-risk behavior is involved, coach the physician and note that repeated violations could result in disciplinary action.
- If breach was purposeful or reckless with a disregard for its impact or patients, disciplinary action is appropriate.
- Or is the breach possibly based on a physical or psychological impairment?

Peer Review and Immunity Protections

- Every state has what is known as a “peer review privilege” statute which makes privileged and confidential from discovery and admissibility into evidence the minutes, reports, discussions, analyses, etc. relating to internal and external efforts to improve patient safety, reduce morbidity or mortality, or for purposes of professional discipline
- Because robust peer review efforts generate extremely sensitive information as it effects a health center and the individual providers which would be very valuable to plaintiffs attorneys and others, it is critical that the health center take steps to maximize the privilege protections, if available, under both state and federal law
- State statutes vary in terms of the scope of activities that are covered, the types of facilities and providers which can access these protections, how the privileged information can be shared or not without risking a waiver of the privilege, and if the privileged information can be shared among affiliated entities

Peer Review and Immunity Protections (cont.)

- Most state statutes require that these activities be conducted by or through a designated committee
- Hence the importance of utilizing a peer review or similar committee to conduct these peer review assessments

Patient Safety and Quality Improvement Act of 2005 ("PSQIA")

- The PSQIA is a federal law which became effective in January 2009, and provides a very broad privilege protection which is above and beyond what is provided under state laws
- PSQIA provides protection for all licensed healthcare entities and providers. In many states, HRSA healthcare facilities cannot take advantage of the state privilege protections.
- PSQIA applies to all patient safety activities relating to the improvement of patient care and reduction of risk and is not limited to activities that have to flow through designated committees.
- In order to access these privilege protections, the health center must either contract with a federally certified patient safety organization (PSO) or create its own certified PSO.
- In addition, the health center needs to develop appropriate policies and procedures consistent with the PSQIA.
- The state peer review statute and the PSQIA are not mutually exclusive–both privileges can be asserted depending on the documents in question.
- Because of the broader privilege protections afforded under the PSQIA, health centers should seriously consider contracting with a PSO (see listed PSOs at www.pso.ahrq.gov)

State Immunity Protections

- As is true with state peer review statutes, states also provide an immunity from liability when engaged in identified peer review activities as defined under state laws. This immunity applies, for example, when a terminated physician decides to sue the health center and any and all individuals involved in the disciplinary action.
- The immunity protections typically apply as long as the individuals act “in good faith and without malice” or if their actions were not considered “willful or warranted” depending on the particular state statute
- The combination of the state peer review privilege and the state immunity protections are critical when attempting to engage an open and frank discussions with peers about adverse events, behavioral issues, and other actions which can adversely affect patient care
- It is critical that healthcare centers review and modify their policies and their procedures in order to maximize both the privilege and the immunity protections under state law

The Health Care Quality Improvement Act ("HCQIA") (1)

- HCQIA is a federal law which provides that the committee and other persons involved in a professional review disciplinary action are not liable for civil monetary damages if all the required standards are met
- HCQIA is not a privilege statute
- Applicability – only applicable to peer reviews for physicians and dentists
- Requirements
  - Peer review process must be a professional review action which is an action or a recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician whose conduct affects or could adversely affect the healthcare of a patient or patients and which affects or may affect adversely the clinical privileges or membership of the practitioner in a healthcare facility
  - The action must be taken and a reasonable belief that the action was in furtherance of improving patient care

The Health Care Quality Improvement Act ("HCQIA") (2)

- Requirements (cont.)
  - The action must be taken after a reasonable effort to obtain facts of the matter
  - The action must be taken after adequate notice and hearing procedures are afforded to the physician involved or such other procedures as are fair to the physician under the circumstances
  - There must be a reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts after meeting the notice and hearing requirements
- The peer review process must be a professional review action
  - Must provide physician or dentist under review an opportunity to be heard in front of or before a mutually agreed upon arbitrator, or hearing officer who was appointed by the committee and who is not in direct economic competition with the provider involved, or a panel of individuals who are appointed by the committee and are not in direct economic competition with the provider involved

The Health Care Quality Improvement Act ("HCQIA") (3)

- In order to access via the HCQIA immunity protections the healthcare facility must query the National Practitioner Data Bank and must make appropriate reports depending on the disciplinary action taken against the practitioner
- Immunity applies to all civil liability arising out of the professional review action but does not apply in federal discrimination cases
- A healthcare facility seeking to maximize its immunity protections under state law and HCQIA must carefully review and, if necessary, modify their peer review, hearing and appeals processes in order to comply with these laws

Michael R. Callahan

A nationally recognized advisor to health care providers across the country, Michael Callahan provides deeply informed advice in all areas of hospital-physician relations and health care regulatory compliance including EMTALA, HIPAA the Medicare CoPs and licensure accreditation standards. He is widely respected for his leading work on the Patient Safety Act from a regulatory policy and litigation standpoint including the development of patient safety organizations (PSOs).

Practice focus

- Federal and state licensure and accreditation for hospitals and health systems
- Hospital-physician relations including contracts, bylaws and peer review investigation and hearings
- PSOs and participating provider policies, compliance and litigation support
- CMS and state departments of health investigations
- Assisting health systems with medical staff integration

The knowledge to identify efficient and practical solutions

- Health systems, hospitals and physician groups large and small, across the country come to Michael for practical, real-world guidance and answers to challenging legal and operational issues which Michael can provide quickly because of his many years of experience. He understands the reality of hospital quality, peer review, risk management and related operational legal and regulatory complexities and can rely on a large client base in order to also provide better and comparative solutions.

Polling Question

- How many people are in the room listening to today's presentation?
  - 1
  - 2
  - 3
  - 4
  - 5
  - 6
  - 7
  - 8
  - 9
  - 10 or more

Questions?

Please email us at Clinical_RM_Program@ecri.org.

Thank you

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