# Medical Staff Peer Review Policy

Medical Staff Policies & Procedures

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<th>Medical Staff Policies &amp; Procedures</th>
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<td>Date Approved by MEC: 04/10/2012</td>
</tr>
<tr>
<td>Author: Manager of Outcomes</td>
<td>Date Last Reviewed/Updated: 10/09/2018</td>
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Jersey Shore University Medical Center
Medical Staff Peer Review Policy

Purpose:
To ensure that the hospital, through the performance improvement activities of its medical 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. This purpose is in accordance with patient safety and self-critical analysis as defined by provisions of federal and state law providing protection to peer review related activities.

Goals:
1. Monitor, evaluate, and improve the ongoing professional practice of individual practitioners with clinical privileges
2. Create a culture with a positive approach to peer review by recognizing practitioner 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 of peer review is clearly defined, fair, defensible, timely, and useful

Definitions:
Abbreviations Quick Reference List
DPRC Departmental Peer Review Committee
EBM Evidence Based Medicine
FPPE Focused Professional Practice Evaluation
HIM Health Information Management Department
MEC Medical Executive Committee
OMD Outcomes Management Department
OPPE Ongoing Professional Practice Evaluation
PRC Peer Review Committee
QI&O Quality Improvement and Outcomes Committee

Conflict of interest
A member of the medical 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 were the provider under review.
- Relative conflicts of interest are either due to a provider’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, associate, or referral source.
**Departmental Peer Review Committee (DPRC)**
The DPRC acts on behalf of the PRC in performing peer review functions (e.g. case review) at the departmental level.

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

**Health Professional Affiliate (HPA)**
As defined by the Jersey Shore University Medical Center Rules and Regulations, a health professional affiliate means an individual other than a licensed Physician, Dentist, Podiatrist or Psychologist whose patient care activities require that his/her authority to perform patient care services be processed through the usual Medical and Dental Staff channels. HPAs will be subject to this Peer Review process.

**Medical Executive Committee (MEC)**
The MEC is the governing body of the medical staff and is accountable to the Board of Trustees on all matters pertaining to appointments, reappointments, and overall quality and efficiency of care rendered.

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

**Peer**
A “peer” is an individual practicing in the same profession and who has expertise in the applicable 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 practitioner may review the care of another practitioner. For specialty-specific clinical issues, a peer is an individual who is well-trained and competent in that specialty area.

**Peer review**
The work of all practitioners granted privileges will be reviewed through the peer review process. “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, but not limited to:

1. The review of individual cases
2. The review of aggregate data for compliance with general rules of the medical staff and clinical standards
3. Use of rate indicators in comparison with established benchmarks or norms

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. The initial peer review body will be the Peer Review Committee (PRC) as described in the PRC charter (Attachment B) unless otherwise designated for specific circumstances by the MEC.

Peer Review Committee (PRC)
See above peer review body. The MEC delegates the authority to perform peer review to the PRC with activities and responsibilities outlined in the Peer Review Committee Charter (Attachment B).

Practitioner
As defined by the Jersey Shore University Medical Center Medical Staff Bylaws, a practitioner is any appropriately licensed Physician, Dentist, Podiatrist, or Psychologist applying for or exercising clinical privileges. In addition, Health Professional Affiliates will also be incorporated in this definition with respect to the Peer Review process.

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:

- Patient Care
- Medical Knowledge
- Practice-Based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems-Based Practice

These competencies are further elaborated in the Medical Staff Expectations for General Competencies (Attachment A).

Rate indicators
This type of indicator identifies cases or events that are aggregated for statistical analysis prior to review by the appropriate committee or administrative function. This type of indicator may be expressed as a percentage, average, percentile rank, or ratio. A target range should be established for each indicator. It may be based on best practice from benchmark data, statistical variation from the average, or internal targets, e.g. mortality or complication rates for surgical procedures.
**Review indicators**
This type of indicator identifies a *significant event* that would ordinarily require analysis by practitioner peers to determine cause, effect, and severity, e.g. intra-operative death or post-operative stroke.

**Rule indicators**
This type of indicator represents a general rule, standard, generally recognized professional guideline, or accepted practice of medicine where individual variation does not directly cause adverse patient outcomes. Ideally, there should always be compliance. Rare or isolated deviations usually represent only a minor problem, e.g. core measure compliance.

**Policy:**
1. All peer review information is privileged and confidential in accordance with all staff and hospital bylaws, state and federal laws, and regulations.
2. The involved practitioner will receive practitioner-specific feedback on a routine basis.
3. The medical staff will use the practitioner-specific peer review results in making its recommendation to the hospital regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.
4. The medical staff will keep practitioner-specific peer review and other quality information concerning a practitioner in a secure file. Practitioner 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 significant incidents, or near misses
   - Correspondence to the practitioner regarding commendations, comments regarding practice performance, or corrective action
5. Only the final determination of the PRC and any subsequent actions are considered part of an individual practitioner’s Quality File.
6. Peer review information in the individual practitioner’s Quality File is available only to authorized individuals enumerated below who have a need to know this information to ensure patient safety and self-critical analysis as mandated by state and federal law.
   - The practitioner
   - The president of the medical staff
   - Medical staff department chairs (for members of their departments only) to conduct OPPE
   - Members of the MEC, credentials committee, and medical staff services professionals for purposes of considering reappointment or corrective action
   - Medical 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)
• Outside individuals participating in the peer review process as outlined in paragraph 11 below.
• The hospital president when information is needed to effectuate corrective action as defined by the medical staff bylaws.

7. No copies of peer review documents will be created or distributed unless authorized by this policy consistent with state and federal mandates.

8. Peer review is conducted on an ongoing basis and reported confidentially 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 and C.

9. **Participants in the peer review process**
   Members of the PRC shall be selected in accordance with the medical staff bylaws. Staff shall participate confidentially and consistent with their roles and responsibilities in the Peer Review process. The PRC shall afford the practitioner under review the opportunity to participate in the process.

10. **Conflicts**
    It is the obligation of the individual reviewer or committee member to disclose to the committee any actual or potential conflict. If the individual believes the conflict is disqualifying, they shall state their reasons and be excused. In all other circumstances, the PRC shall decide if the reason set forth is disqualifying.

11. **External peer review**
    Either the MEC or the PRC will make determinations on the need for external peer review to fulfill the purpose of this policy. No practitioner can require the PRC to obtain external peer review.

12. **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 Medical Staff Indicator List in Attachment D.

13. **Thresholds for FPPE**
    If the results of an OPPE indicate a potential issue with practitioner performance, the PRC may initiate a FPPE to determine whether there is a 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 reached when the acceptable targets for the medical staff indicators are exceeded as exemplified in Attachment D.
14. **Individual case review**

Peer review will be conducted by the medical 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 rating system for determining results of individual case reviews is described in the Quality Indicator Case Review Rating Form (Attachment E). Feedback and response timeframes will be outlined in the request letters.

15. **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 PRC or its designee as described in Attachment B.

16. **Oversight and reporting**

Direct oversight of the peer review process is delegated by the MEC to the PRC. The responsibilities of the PRC related to peer review are described in the PRC charter (Attachment B). The PRC will report to the board of trustees through the MEC at least quarterly on a de-identified aggregate basis and provide a written report of the same to the QI&O Committee quarterly.

17. **Statutory authority**

This policy is based on state and federal authority and all minutes, reports, recommendations, communications, and actions made or taken pursuant to this policy in accordance with patient safety and self-critical analysis are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities.
Attachment A: Medical Staff Expectations for General Competencies

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

- Achieve patient outcomes that meet or exceed generally accepted medical staff standards as defined by comparative data and targets, medical literature, and results of peer review evaluations
- Use sound clinical judgment based on patient information, available scientific evidence, and patient preferences to develop and carry out patient management plans
- Demonstrate caring and respectful behaviors when interacting with patients and their families

Medical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedicine, clinical practice, and social science, and the application of their knowledge to patient care and the education of others, as evidenced by the following:

- Use evidence-based guidelines when available, as recommended by the appropriate specialty, in selecting the most effective and appropriate approaches to diagnosis and treatment

Practice-Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care, as evidenced by the following:

- Review individual and specialty data for all general competencies, and use this data for self-improvement to continuously 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, as evidenced by the following:

- Communicate clearly with other practitioners and caregivers, patients, and patients’ families through appropriate oral and written methods to ensure accurate transfer of information
**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, as evidenced by the following:

- Act in a professional, respectful manner at all times to enhance spirit of cooperation, mutual respect, and trust among members of the patient care team

- Respond appropriately to requests for patient care needs

- Respect patients’ rights by discussing unanticipated adverse outcomes and by not discussing patient care information and issues in public settings

- Participate in emergency room call coverage in accordance with medical staff rules and regulations and policy

**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, as evidenced by the following:

- Strive to provide cost-effective quality patient care by cooperating with efforts to manage the use of valuable patient care resources

- Participate in the hospital’s efforts and policies to maintain a patient safety culture, reduce medical errors, meet national patient safety goals, and improve quality
Attachment B: Peer Review Committee Charter

Purpose:
To assure that the medical staff assesses the ongoing professional practice and competence of its members and uses the results of such evaluations and assessments to identify individual and cross-disciplinary practice trends that may impact on quality of care and patient safety and to improve professional competency, practice, and care.

Structure:
A central Peer Review Committee (PRC) may coordinate the peer review activities for the medical staff but will delegate some responsibilities to Departmental Peer Review Committees (DPRC) (Attachment F: Peer Review Activities Flow Chart).

The central Peer Review Committee would support the professional practice activities for Pathology, Radiology, and the Health Professional Affiliates.

Composition of the PRC:
- The Committee shall be composed of three representatives from the medical specialties, three from the surgical specialties, and three from the departments reviewed by the PRC.
- Ideal candidates should be respected by their peers in and out of their specialty, have a broad spectrum of professional practice knowledge, and may be the chairman of a DPRC.
- The representatives shall be appointed by the President of the Medical Staff in accordance with the Bylaws – Standing Committees 13.3.1, in consultation with the Departmental Chairs and the Vice President of Clinical Effectiveness and/or Senior Vice President of Medical and Academic Affairs.
- Due to the training required to perform adequate Peer Review, a term’s duration is 3 years and Committee members may be reappointed without limitation on the number of terms.
- Administrative personnel includes: the Chief Risk Officer or designee, the Vice President of Clinical Effectiveness, CMO or Senior Vice President of Medical and Academic Affairs, and Outcomes Staff.

Individual DPRC’s for Anesthesiology, Cardiac Surgery, Cardiology, Dentistry, Emergency Medicine, Family Practice, Medicine, Obstetrics & Gynecology, Orthopedics, Pediatrics, Psychiatry, and Surgery will have the responsibility of providing indicator and case reviews.

Composition of the DPRC:
- The Committee shall be composed of 6-8 members of the Department or Section following the ideal characteristics noted for PRC membership.
- The representatives should be selected by the Department Chair with advisement from the PRC.
- DPRC members will provide initial case reviews. Secondary subspecialty reviews will be determined by DPRC protocol conforming to PRC policy.

Responsibilities:
Responsibilities for the PRC:
- Coordinate, refer, and track all incoming occurrences, peer review case referrals, and indicator outliers.
- Provide oversight for indicators including development, monitoring, and approval throughout the medical staff departments.
- Monitor the timeliness of the Peer Review process and make recommendations for improvement where work processes are lagging.
- Provide Peer Review for Departments not supported by Outcomes Management.
- Be the final common path for all correspondence leaving the peer review process, whether from delegated Departments or those it has primary responsibility to support.
- Handle disputes between Departments where patient care by multiple departments has triggered Peer Review.
- Notify administration and/or the Quality Improvement & Outcomes Committee (QI&O) of care processes noted during reviews that were affected adversely by operational issues.
- Advise Administration of resource requirements.
- Track the effectiveness and efficiency of the Peer Review Process overall.
- Provide reports to the QI&O Committee periodically relating to repetitive findings and aggregated activities.
- Meet on a regular, monthly basis, no less than nine times per year to conduct its business, and report its activities to the QI&O Committee.

Responsibilities for the DPRC:
- Accept referrals from the Peer Review Committee relating to occurrences, peer review case referrals, and indicator outliers.
- Provide Peer Review for their respective Department, completing the Quality Indicator Case Rating Form and reaching a conclusion regarding the inquiries being made.
- If the care under review was impacted by practitioners from multiple departments, the Committee may refer the case back to the Peer Review Committee for consideration of additional Departmental review but must reach a conclusion regarding the issues from their Department’s perspective.
- Prepare appropriate communication relating to the case under review to the attending practitioner notifying him/her of the conclusions reached. These conclusions shall be placed on the Quality Indicator Case Rating Form, and be referred back to the Peer Review Committee for final notification and tracking.
- Refer operational concerns raised during case review to the PRC for administrative notification.
- Meet on a regular, monthly basis, no less than nine times per year, to conduct its business and report its activities to the Peer Review Committee.

Scope:
- The Peer Review activities should be within the realm of professional practice performed by a practitioner of the medical staff or its health professional affiliates at a JSUMC facility across all levels of care.
- Practitioner behaviors relating to Disruptive Behavior and/or Practitioner Impairment should be handled according to the Administrative Policy and Procedure for Disruptive Behavior (JM-ADMIN-0008) effective 10/98 and revised 06/09.
• Routinely, the time of the PRC and DPRC, should be utilized in reviewing: cases forwarded for assessment to determine if appropriate care was rendered given the clinical circumstances, quality review forms to establish whether appropriate professional behavior was demonstrated, and rate indicator outliers and rule infringements.

**Performance Improvement:**

• The peer review process is part of a larger focus for the organization to establish performance improvement as a key part of its culture. In addition, it is a building block in developing a stronger, more cohesive medical staff which is willing to constantly assess itself and improve its delivery of care.

• Consequently, strategies to change behaviors will be utilized to correct professional practice behaviors. These include: process education, transparency with peer comparisons of performance, engagement in re-design, 1-on-1 discussions with peers, recommended experiences (e.g. hand writing instruction), chart reminders, and CME to name a few.

• Though the goal is for an appropriate change in performance, those individuals who do not respond will be referred to the MEC for further deliberation and more formal action. It is not the purview of the PRC to render disciplinary action, though it can make such recommendations to the MEC.

• The PRC looks to not only give periodic feedback through notification of routine reviews, but also to commend those members of the medical staff who deliver exemplary care as part of their routine practice. It is this additional feedback process which will ultimately begin to change the medical staff’s culture toward one of continual improvement.

**Resources:**

• Support for the Peer Review process will be provided from the Outcomes Department, Risk Management, Data Management (Corporate), and the Medical Staff Office.

• Clinical screening will be provided by Clinical Coordinators in the Outcomes Department who will also support the individual DPRC’s with case finding and rate indicator outliers.

• Clinical, clerical, and data entry support will be provided for the Peer Review Committee through the Outcomes Department.

• Partial support will be provided by the Risk Management Department through sharing of a common software for tracking occurrences, recording practitioner performance, and storing peer review related documents. (No longer needed)

• Data Management will be enlisted to help build, update, and revise the Practitioner Report Card which will be an important part of the OPPE (e.g. comparisons to Top Performers in Premier database).

• Key components for the OPPE will be provided from the files of the Medical Staff Office to allow completeness of data (e.g. Board Certification, CME credits).
## Attachment C: Case Review Process, Timeframe and Flow Chart

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<th>Activity</th>
<th>Action Steps</th>
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| Case Identification                     | The Outcomes Management Department (OMD) will utilize available resources, such as but not limited to, mortality reports, return to OR reports, Patient Safety Indicator Report, Onelinks and other reports generated from the hospital database, to identify cases for potential review.  

**Indicator work lists:** Patient case review work lists are generated from rule and rate indicators (e.g. perioperative deaths) obtained from the hospital database.  

The Outcomes Management Dept. may also receive requests for case reviews from other sources, some of which may include; the department chairs, Office of Patient Experience, Risk Management. Requests may also be received via a Quality Referral form. (Attachment G). |
| Case Screening                          | OMD reviews cases to determine the need for practitioner review based on each departments Quality Indicators that prompt a review.  

If a practitioner review is required and/or requested, the OMD will complete Part 1 of the Quality Indicator Case Rating Form and provide the reviewer with a brief case summary and reason for review.  

If a practitioner review is not required, the OMD will note the case has been screened and a review is not indicated. (Form not completed if case is not being reviewed). |
| Practitioner Review Assignment (Initial and Additional Review) | OMD facilitates the assigning of the reviewers when a case is determined to require initial or additional practitioner review.  

If the reviewer determines the case has issues outside his/her expertise or a review would result in a conflict of interest:  

1. They will notify OMD.  
2. OMD will facilitate in assigning an appropriate subspecialty peer reviewer.  
3. OMD will notify the Committee of the issue and reviewer change. (Not done for all depts.) |
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<tr>
<th>Activity</th>
<th>Action Steps</th>
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<tr>
<td>Practitioner Review</td>
<td>The reviewer performs the case review and completes the Quality Indicator Case Rating form. Only cases with completed case rating forms will be presented at the next Committee meeting.</td>
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<td>- The completed Quality Indicator Case Rating Forms will be collected by OMD (Not the standard process).</td>
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<td>- If the rating form is not completed, OMD will promptly contact the reviewer to obtain the necessary information.</td>
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| Case Review with the Committee Chair (“Agenda Meeting”) | The Committee chair may meet with the PI Coordinator from the OMD for an agenda meeting. The purpose of the Agenda meeting is to:  
  - Review the status and information on new and ongoing cases,  
  - Discuss the cases with completed practitioner reviews and Quality Indicator Case Rating forms,  
  - Develop the agenda for the next Committee meeting.  |
| COMMITTEE MEETING            |                                                                                                                                                                                                                                                                                                                                 |
| Case Presentation to the Committee | Cases with completed practitioner reviews and Quality Case Rating forms or ongoing cases that have been discussed with the Committee chair at the Agenda meeting are presented by the chair or designee. New Cases:  
  - If there are no concerns with the reviewer findings, the case is closed and the final determination is documented on the Quality Indicator Case Rating Form. The Committee may send a written response to the practitioner (see: Committee Response and Documentation).  
  - If there are any concerns with the reviewer findings  
    1. The case may be referred for an additional practitioner review (see: Practitioner Review Assignment and Practitioner Review) AND/OR  
    2. The Committee may request additional information from the practitioner (see: Practitioner Inquiry).  
  Open Cases:  
  - If the Committee has received and reviewed all of the additional requested information and there are no further concerns, the Committee may send a written response to the practitioner (see: Committee Response and Documentation). |
| Practitioner Inquiry        | If the Committee determines there is a need for additional information from the practitioner:  
  - The Committee will define the specific questions to be addressed by the practitioner.                                                                                                                                                                                                                                                |
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<tr>
<th>Activity</th>
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<td>• A certified letter will be sent to the practitioner requesting the specific questions be addressed</td>
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<td>• The practitioner will be offered the choice of providing a written response or a verbal response may be presented at the next Committee meeting.</td>
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<td>• The chair will make a courtesy call to the practitioner to inform them that the case is under review and to expect a letter requesting additional information.</td>
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<td>• If there has been no response from the practitioner after a request for additional information, the Committee will determine its next steps (See Practitioner Declined Response).</td>
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<td>Committee Response and Documentation</td>
<td>The Committee makes a final case determination when there are no concerns with the case scoring (see: Case Presentation to the Committee), all requested additional information has been received and reviewed, or if the response timeframe has lapsed. At that time, the final determination of the overall practitioner care and issues is decided by Committee consensus.</td>
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<td>• A letter to the practitioner will be composed outlining the Committee’s findings and any subsequent actions required by the practitioner (see: Improvement Plan Development).</td>
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<td>1. The letter will be sent via regular mail if the care was appropriate or by certified mail for any other conclusion.</td>
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<td>2. Copy will be sent to the department chair and a copy will be placed in the practitioner file in the OMD.</td>
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<td>• The Quality Indicator Case Rating Form will be completed by the case reviewers and signed by the Committee and/or the department chair.</td>
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<td></td>
<td>1. The form is filed within the practitioner’s Quality File.</td>
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<td>2. OMD will enter the results of all final review findings into the database for tracking.</td>
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<td>• The result of the review and practitioner’s verbal or written feedback will be documented in the Committee meeting minutes.</td>
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<tr>
<td>Improvement Plan Development</td>
<td>If the results of the case review indicate a need for individual practitioner performance improvement:</td>
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<td>• A certified letter will be sent to the practitioner outlining the Committee’s findings and any subsequent actions required by the practitioner (see: Committee Response and Documentation).</td>
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<td>• If the actions require involvement by the department chair, a separate letter will be sent to the chair outlining the Committee’s recommended course of action.</td>
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<td>• The Committee will request feedback from the practitioner and/or the department chair regarding the results of the recommended action.</td>
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<tr>
<td>Activity</td>
<td>Action Steps</td>
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<tr>
<td><strong>Referrals to QI&amp;O Committee</strong></td>
<td>For cases determined to have potential opportunities to improve system performance or potential nursing care issues:</td>
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<td>• The chair will refer the issue to the QI&amp;O Committee.</td>
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<td>• Upon receipt of the referral, the QI&amp;O Committee will discuss the issue at the following meeting and provide feedback by the next Committee meeting that includes:</td>
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<td>1. Its assessment of the issue,</td>
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<td>2. An action plan if necessary.</td>
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| 21 days AFTER Committee Meeting | In the event a practitioner fails or declines to provide a written or verbal response to the Committee by the next “Agenda” meeting, the Committee may take the following actions: |
| Practitioner Declined Response | • Send a second certified letter requesting a written request, or verbal response at the next Committee meeting. |
| | • The chair or designee may conduct a follow-up call to the practitioner requesting their response. |
| | • Arrange a “sub-committee” meeting: |
| | 1. The meeting may include: the Committee chair, Administration leader, Risk Management representative, Outcomes Management representative, and administrative support; the practitioner; the practitioner’s department chair; and/or other attendees per the discretion of the Committee. |
| | 2. The meeting will be arranged to accommodate the practitioner’s schedule, if feasible, within 30 days of the meeting request but no longer than 45 days. |
| | 3. Meeting minutes or a summary will be recorded. |
| | • If no response is received within 60 days or the practitioner still declines to respond, the next steps will be determined at the following Committee meeting. |
# Ongoing Professional Practice Evaluation

**Data Type / Source**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Data Type / Source</th>
<th>Practitioner Volume</th>
<th>Practitioner Data</th>
<th>Excellence Performance Target</th>
<th>Acceptable Performance Target</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENT CARE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Mortality Rate Index</td>
<td>Premier/Rate</td>
<td>#</td>
<td></td>
<td>&lt; 1 &gt;</td>
<td>0.85</td>
<td>1.25</td>
</tr>
<tr>
<td>Complication Rate Index</td>
<td>Premier/Rate</td>
<td>#</td>
<td></td>
<td>&lt; 1 &gt;</td>
<td>0.85</td>
<td>1.25</td>
</tr>
<tr>
<td><strong>MEDICAL KNOWLEDGE</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CME Attestation</td>
<td>Practitioner/Rule</td>
<td>N/A</td>
<td># credits</td>
<td>&gt; 50</td>
<td>&gt; 40</td>
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</tr>
<tr>
<td>Board Certification (BC) or Recertification (RC)</td>
<td>Practitioner/Rule</td>
<td>N/A</td>
<td>Y / N</td>
<td>Y</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td><strong>PRACTICE BASED LEARNING</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core Measure Non-Compliance</td>
<td>PR Letter /Rule</td>
<td># Adm.</td>
<td># letters</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>INTERPERSONAL AND COMMUNICATION</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Practitioner Satisfaction as Attending</td>
<td>Press Ganey/Rate (%ile)</td>
<td># reports</td>
<td>percentile</td>
<td>80%ile</td>
<td>50%ile</td>
<td></td>
</tr>
<tr>
<td>Abbreviation Non-Compliance</td>
<td>PRC Letter/Rule</td>
<td>N/A</td>
<td># letters</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Illegible Handwriting</td>
<td>PRC Letter/Rule</td>
<td>N/A</td>
<td># letters</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>PROFESSIONALISM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Validated Unprofessional Care or Behavior Compliant (e.g. Pt. complaint, non-availability to ER, staff non-responsiveness)</td>
<td>PR Form, Letter/Review -Rule</td>
<td>N/A</td>
<td># letters</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Inappropriate Documentation (e.g. H&amp;P, case reviews noting inadequate documentation)</td>
<td>PR Form, Letter/Review -Rule</td>
<td>N/A</td>
<td># letters</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>SYSTEM BASED PRACTICE</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Severity Adjusted Medicare LOS (needs 30 admissions) Index</td>
<td>Premier/Rate (index)</td>
<td>≥ 30 admissions</td>
<td>≥ 1 ≥</td>
<td>≤ 0.85</td>
<td>&lt; 1.25</td>
<td></td>
</tr>
<tr>
<td>Severity Adjusted Medicare Cost per Case</td>
<td>Premier/Rate (Index)</td>
<td>≥ 30 admissions</td>
<td>≥ 1 ≥</td>
<td>≤ 0.85</td>
<td>&lt; 1.25</td>
<td></td>
</tr>
<tr>
<td>Patient Safety Goal Non-Compliance (e.g. universal protocol, medicine reconciliation)</td>
<td>PR Letter/Review -Rule</td>
<td>N/A</td>
<td># letters</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
**Attachment E: Peer Review Case Rating Form**

**PART 1: OUTCOMES DEPARTMENT:**

<table>
<thead>
<tr>
<th>Case #:</th>
<th>MR #:</th>
<th>DIC Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician:</th>
<th>Physician ID#:</th>
<th>Diagnosis:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reviewer:</th>
<th>Assigned Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Referral Source:** (check one)

- HIM
- Pharmacy
- Medical Staff
- Pt. Relations
- Nursing
- Risk Management
- Other: ___________

**Indicators Prompting Review:**

- Medication Variance Review
- Suspected/Potential Adverse Event Review
- Mortality Review
- Autopsy Review

**Case Description and Key Questions for Practitioner Reviewer:**

-

**PART 2: PRACTITIONER REVIEW:**

<table>
<thead>
<tr>
<th>Patient Outcome (check one)</th>
<th>Contributing Factors (check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 - No Adverse Outcome</td>
</tr>
<tr>
<td></td>
<td>2 - Minor Adverse Outcome (complete recovery expected)</td>
</tr>
<tr>
<td></td>
<td>3 - Major Adverse Outcome (complete recovery not expected)</td>
</tr>
<tr>
<td></td>
<td>4 - Catastrophic Adverse Outcome (e.g. death)</td>
</tr>
<tr>
<td></td>
<td>5 - Unknown to Reviewer</td>
</tr>
</tbody>
</table>

**Practitioner Documentation Opportunities (check all that apply)**

- 1 - No issue
- 2 - Substantiation of clinical treatment/course
- 3 - Timeliness of documentation
- 4 - Legibility
- 5 - Other: ___________

**Overall Practitioner Care (check one)**

- 1 - Meets/Exceeds Standard of Care
- 2 - Acceptable
- 3 - Opportunity for Improvement
- 4 - Reviewer Uncertain, needs Committee Discussion

**Exemplary Findings:** (check all that apply)

- Practitioner Care
- Practitioner Documentation
- Non-Practitioner Care
- None

**Findings Description:**

-

<table>
<thead>
<tr>
<th>Reviewer Signature:</th>
<th>Date:</th>
<th>Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PART 3: DEPARTMENT PEER REVIEW:

<table>
<thead>
<tr>
<th>Practitioner Response: (check all that apply)</th>
<th>Department Peer Review Action: (check all that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No, a practitioner response is not needed</td>
<td>□ No action warranted</td>
</tr>
<tr>
<td>□ Yes, a practitioner response is needed</td>
<td>□ File for trending</td>
</tr>
<tr>
<td>If YES, what type of response is required?</td>
<td>□ Referred to the Central Peer Review Committee</td>
</tr>
<tr>
<td>□ Discussion with Chair</td>
<td>□ Referred for M&amp;M</td>
</tr>
<tr>
<td>□ Letter</td>
<td>□ Improvement letter to practitioner sufficient</td>
</tr>
<tr>
<td>□ Committee appearance</td>
<td>□ Educational letter to practitioner sufficient</td>
</tr>
<tr>
<td>□ Other</td>
<td>□ Policy/Procedure improvement identified</td>
</tr>
<tr>
<td>Practitioner Notified On:</td>
<td>□ Reinforcement of Policy/Procedure needed</td>
</tr>
<tr>
<td>Practitioner Response Date:</td>
<td>□ Practitioner self acknowledged action plan sufficient</td>
</tr>
<tr>
<td>Non-Practitioner Care Issues:</td>
<td>□ Dept. Chair to discuss the review with the practitioner</td>
</tr>
<tr>
<td>□ System Problem identified – forward to Q&amp;O</td>
<td>□ Dept. Chair to develop and implement an improvement</td>
</tr>
<tr>
<td>Date Sent:</td>
<td>plan with practitioner</td>
</tr>
<tr>
<td></td>
<td>□ Refer to MEC or appropriate officials for formal</td>
</tr>
<tr>
<td></td>
<td>corrective action</td>
</tr>
</tbody>
</table>

Findings Description:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Chairperson Signature: ___________________________ Date: _______________ Time: _______ AM / PM

PART 4: CENTRAL PEER REVIEW:

<table>
<thead>
<tr>
<th>Peer Review Committee Action:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Accepted Department Peer Review Action</td>
</tr>
<tr>
<td>□ More Information Required</td>
</tr>
<tr>
<td>□ Additional Action Required</td>
</tr>
</tbody>
</table>

Reasons for more information or additional action required:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Chairperson Signature: ___________________________ Date: _______________ Time: _______ AM / PM
Attachment G: Case Referral Form

MERIDIAN HEALTH
JERSEY SHORE UNIVERSITY MEDICAL CENTER
QUALITY REFERRAL FORM

This Quality Referral form may be used to report a quality issue you have attempted to resolve without success. It should not be used in place of an Occurrence Report or Medication Variance form. It also should not be used to address petty grievances.

Please be sure to include your name and telephone extension on the form. Please forward the completed form to the Outcomes Management Department. If you have any questions about this, please call extension 4590.

PATIENT NAME: ___________________________ MR#: ___________________________

ADMISSION DATE: ______________________ DISCHARGE DATE: __________________

ISSUE (DESCRIBE FULLY): ______________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Recommendation for Follow-Up Action: _______________________________________

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

PERSON COMPLETING REPORT: ______________________ EXT: ________________

UNIT / DEPARTMENT: ______________________ DATE: ________________
Attachment H: Department Peer Review Guidelines

The JSUMC Peer Review Committee (PRC) recommends that each medical staff department utilize the following guidelines to establish and maintain departmental peer review activities.

**Indicator Development**
Each department should establish a variety of indicators to monitor overall performance improvement (PI) and quality assurance activities. These indicators should:
1. Consist of rate (i.e. statistic), review (i.e. case review), and rule indicators (i.e. accepted practice)
2. Be measureable
3. Be based on reliable and attainable data
4. Utilize internal and external benchmarks (defined by department leaders, national societies, et. al.)
5. Measure / monitor standards of care
6. Have relevant volume
7. Monitor low volume, high risk, high volume, and problem prone procedures
8. Be tracked on at least a department dashboard and PI plan
9. Have the results reported to at least the departmental peer review committee (DPRC), department chair, Outcomes Management Department, the PRC.

**Peer Review**
When an outlier indicator signals a potential practitioner specific cause, a peer review should be conducted. The review process should:
10. Consist of multiple practitioner reviewers (varied experience, no conflict of interest)
11. Be regular and routine
12. Utilize system peers for additional review and feedback
13. If it is decided to perform an FPPE, the review process will follow the Medical Staff policy.

**Review Documentation**
The review process and its results should be documented for trending and tracking. It should document both acceptable standard of care and opportunity for improvement results. The documentation should:
14. Note the reason for the review
15. Note any developing trends
16. Summarize the review findings
17. Acknowledge acceptable standards of care were provided, if applicable
18. Define the need for improvement, if applicable
19. Define the recommended follow up actions (e.g. education, meeting, supervision, etc).
20. Record the feedback to practitioner and appropriate team leader (chair, supervisor, manager, etc.)
21. Include the final resolution once all information and actions have occurred

**Review Reports**
Periodic reports should be provided to the PRC and MEC to improve transparency and promote a culture of PI and peer review.
22. Reports to the MEC should focus on the PI dashboard and indicators in aggregate data
23. Reports to the PRC should relate to practitioner specific findings, emerging trends, and aggregated activities