

**YALE-NEW HAVEN HOSPITAL
DEPARTMENT OF PHYSICIAN SERVICES
MEDICAL STAFF POLICY
PEER REVIEW &
ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)**

Purpose: To set forth the policy for conducting peer review and ongoing professional practice evaluation of members of the Yale-New Haven Hospital Medical Staff

Scope: All Members of the Medical Staff and “Affiliated Health Care Professionals”

Policy:

Members of the Yale-New Haven Hospital Medical Staff and Affiliated Health Care Professionals are involved in activities to measure, assess, and improve performance on an ongoing, organization-wide basis. In addition, Medical Staff members are responsible for conducting peer review and mortality and morbidity review processes (referred to below jointly as “peer review”) that assess the performance of individual staff members. These reviews are also used for medical and hospital staff and resident education.

Medical staff members and affiliated healthcare professionals must render high quality patient care and demonstrate competent professional performance, sound judgment, clinical and technical skills, ethical integrity and participate in medical education opportunities that may benefit their patients and patient care processes.

It is the policy of the Medical Staff to encourage and support peer review. In order to promote consistency of the peer review process, the Medical Staff has established the Institutional Practice Quality and Peer Review Committee (IPQPRC) to oversee all Departmental, Sectional and other specially constituted committees that conduct peer review activities under the auspices of the Yale-New Haven Hospital Medical Staff Bylaws, and to permit the processes to occur in many different formats as long as the principles set forth below are followed.

Connecticut general statutes section 19a-25 protecting the confidentiality of morbidity and mortality reviews and section 19a-17b protecting the confidentiality of peer review are critical to the honest and thorough case examinations required to perform meaningful case evaluation. The Hospital and Medical Staff intend to protect peer review proceedings and findings to the fullest extent of the law.

PEER REVIEW

Components:

- A. The peer review process must be consistent. Each Department and/or Section that conducts peer review must establish criteria for determining how cases are selected and reviewed.
- B. The peer review process must be timely. The Departments and/or Sections must establish time frames for reviews. However, the need for flexibility is understood: that is, while one type of case with an unexpected outcome might require immediate review, review of another outcome might wait until a more formal meeting can be organized.
- C. The peer review process must be rational and defensible. Conclusions reached through peer review should be supported by a rationale that encompasses relevant literature and clinical guidelines.
- D. The peer review process must be balanced. In some cases, the conclusions reached during the peer review process will not be unanimous. In those cases, conclusions of the minority and of the staff involved in the case should be considered and recorded.
- E. The peer review process must be useful. The results and conclusions of peer review in its various forms will be used as appropriate in recertifying and performance improvement activities.
- F. Peer review recommendations, when they are made, must be tracked over time and monitored for clinical effectiveness. This will be accomplished under the authority of the IPQPRC.

G. Peer review is defined by the process, not by the name that the Department, Section or Hospital applies to the group that conducts and/or directs the review. For example, a Department may refer to peer review as a case conference, case complication review, critical incident review or M&M. Connecticut state law provides legal protection for peer review as that term is defined by statute; it is the intent of the Medical Staff that those protections apply to all Departmental and Sectional peer review activities even if such activities are not specifically referred to as peer review.

Procedure:

How Cases are Chosen: Cases may be identified for review through a variety of methods, including but not limited to: chart review, direct observation, monitoring of diagnostic and treatment techniques, committee discussion, the variance reporting system, physician/nurse/staff phone calls or confidential conversations, patient or family complaints, and internal review and monitoring required by regulatory and/or accreditation standards. Clinical Departments and Sections may designate automatic review of cases meeting pre-determined criteria: for example, all in-patient maternal deaths are reviewed.

In addition to Departmental/Sectional Committees such as Morbidity & Mortality, information collected and evaluated under the authority of the IPQPRC may include the following:

Practice Screens:

- Review of payment denials by insurers (trigger for appropriateness of care)
- Specialty adjusted mortality rates
- Specialty adjusted re-admission rates
- Complications from moderate sedation

Screening to evaluate the detail of the performance of specific practitioners:

These are conducted via established Medical Staff / Medical Board Committee structures as indicated.

- Qualifications and ongoing/current competence of Medical Staff Members (Credentials Committee, Medical Board, Medical Board Administrative Committee)
- Appropriateness of interventional/surgical case selection (Tissue/Cath Lab/GI Procedure Committees)
- Issues in transfusion practice (Transfusion Committee)
- Medical record documentation (Medical Records Committee)
- Clinical review of Code 5/Code 7 and Rapid Response Team calls (Resuscitation and Rapid Response Committee)
- Autopsy results (Autopsy Committee)
- Malpractice experience (Institutional Claims and Risk Management Committees)
- Appropriateness of treatment (Cancer Committee/Tumor Board)
- Denied insurance days (Utilization Review Committee)

Diagnostic and treatment performance on National Quality Indicators:

- Antibiotic prescribing patterns
- Acute myocardial infarction treatment
- Pneumonia treatment
- Congestive Heart Failure treatment
- Intensive Care Unit quality indicators
- Surgical Infection Prevention
- Prevention of deep vein thrombosis

Individual practitioner and/or case or procedure-specific peer review may be affirmatively requested when:

- a. levels of performance, patterns, or trends vary significantly and undesirably from those expected;
- b. performance varies significantly and undesirably from that of other organizations;
- c. performance varies significantly and undesirably from recognized standards,
- d. a serious sentinel event or near miss occurs;

or a Medical Staff or Hospital Committee, Department or Section, acting in its peer review capacity and in the course of peer review, otherwise deems review appropriate.

For example, if an elevated wound infection rate is associated with a particular type of surgery, cases done by all relevant surgeons may be reviewed. If a particular physician has an unexpected level of procedural complications, cases done by that particular

physician may be reviewed. When the detailed practice of a specific physician is reviewed, this is considered Focused Professional Evaluation and is governed by the Focused Professional Practice Evaluation Policy.

Who Participates in the Review: The Committee or group doing the review may decide who must participate. There is considerable latitude in this format. For example, review may be conducted at a Grand Rounds in some Departments and will be attended by Departmental and other staff. Other Departments may review unexpected outcomes immediately, and may choose to assemble all caregivers without the rest of the service. Evaluation of specific practitioners must be sent to the IPQPRC.

Outside Reviewers: Peer reviews may also be done, in whole or in part, by health care professionals or other professionals not associated with the Hospital when directed by the IPQPRC. Generally, there are two ways these reviews are done.

The first occurs when a Hospital Department invites a care giver who is not a credentialed member of the Medical Staff to provide input during a grand rounds or other forum.

The second occurs when the IPQPRC commissions the participation of an outside, non credentialed reviewer in the focused review of the practice of a specific member of the Medical Staff or of all or portions of a particular service. This type of peer review can be requested for many reasons, including but not limited to: risk management concerns, administrative or leadership issues, or patient safety risks.

In either case described above, when invited by duly authorized Committees, the participation of outside reviewers does not diminish the peer review protection of the Committees.

How is the Review Done: Reviews may, but need not, take place at routine scheduled committee meetings. If it is impractical or undesirable to review and/or evaluate a particular matter at a regularly scheduled committee meeting, the committee responsible for the review may designate an individual or a sub-committee of individuals to perform the review by chart review, discussions with appropriate individuals and other appropriate means, and to report the results and any evaluation of the review back to the committee.

Peer Review Records: Records of the reviews, regardless of how they are designated or labeled, are to be kept confidential. They are not included in patient records. It is recognized that reviews may be conducted in meetings that also review non-peer review material; in such cases, minutes of peer review matters will be documented separately from non-peer review minutes.

How will Review information be used: Information gathered during peer review proceedings described in this policy may be used for purposes of the Medical Staff reappointment and privileging process, pursuant to the Medical Staff Bylaws.

If at any time, a peer review process identifies individual performance that is not or may not be satisfactory, the Committee, Department or Section responsible for the review will designate the IPQPRC to review the deficiencies with the staff member. This discussion will detail the deficiencies noted and the desired changes in behavior or performance and the time frames or expectations by which behavior and/or performance is expected to improve. The details of this discussion will be documented in confidential files.

If performance deficiencies raise urgent questions about patient safety, summary suspension of all or some clinical privileges pursuant to the Medical Staff Bylaws may occur. In such cases, the affected individual shall have access to the Fair Hearing and Appeals policy as outlined in the Medical Staff Bylaws.

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

In addition to the peer review process described above, Ongoing Professional Practice Evaluation allows the identification of practice trends that impact on quality of care and patient safety between reappointment cycles.

Department Chiefs, Clinical Vice Chairs and Section Chiefs are involved in the identification of the performance measures that are used to evaluate members of the Medical and Affiliated Medical Staff assigned to their Department.

Depending upon the type of practice and available data, measures are quantitative, qualitative or a combination of both. All members of the Medical Staff are evaluated on a measure entitled "professionalism". This includes the appropriateness of their interactions with each other, hospital employees and trainees as well as patients and their families consistent with the expectations set forth in the Medical Staff Code of Conduct as outlined in Article V., Section C. of the Medical Staff Bylaws.

The OPPE evaluation measures for each clinical Department are identified in Attachment A.

OPPE is conducted every six months encompassing activity that occurs in two time periods:

- January 1st through June 30th
- July 1st through December 31st

The Department Chief or his/her designee (Vice Chair, Section Chiefs, Associate Section Chiefs) are provided with practitioner specific data relative to the quantitative measures outlined in Attachment A. The relevant medical staff leader responsible for completing OPPE is responsible for reviewing the information and identifying any areas of concern. Any matters of concern which have been documented and resolved within the Department are so noted as are issues that have been raised to the level of the IPQPRC. The IPQPRC will follow and document issues to conclusion or refer them to the Credentials Committee as applicable and outlined in the responsibilities of the IPQRC outlined in Article XV, Section F. of the Medical Staff Bylaws.

Similarly, in the event that a medical staff leader identifies a practitioner specific issue *as a result of* OPPE, it is expected that it will be reviewed, addressed and resolved and documented within the Department / Section to the extent possible. Patterns of concern or serious matters are referred to the IPQPRC.

Information obtained about members of the Medical Staff during OPPE may factor into the decision to maintain or revise existing privileges or revoke an existing privilege at the conclusion of OPPE or at the time of the practitioners next reappointment as applicable.

Fair Hearing and Appeals processes apply as outlined in Article VI of the Medical Staff Bylaws apply to adverse decisions made as a result of OPPE.

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OPPE Measures

Every Medical Staff member who requires an Ongoing Professional Practice Evaluation is reviewed for clinical judgment/competence as well as professionalism/patient complaints. From there, Yale-New Haven Hospital distinguishes between hospital based departments, which use their own metrics, and all other departments, which use hospital data that is provided by UHC. UHC is an alliance of 116 leading academic medical centers. Each member institution sends their cases to UHC's Clinical Database. Yale-New Haven Hospital benefits from sending its data to UHC because it allows us to compare our performance, or an individual physician's performance, against comparable hospitals or physician groups.

When UHC receives the hospital's case data, they produce an expected length of stay, cost, and mortality rate for each patient. Using the data from individual member institutions, UHC develops risk models for adults and pediatrics.

This risk adjustment process is especially helpful when looking at physician performance for OPPE because it allows for a like comparison. Each provider's actual practice can be compared to an expected value for certain metrics that are adjusted for patient attributes such as severity of illness, age, and various comorbidities.

The following table shows the metrics that are tracked broken out by group.

Group	Metrics
All Departments/Sections (Affiliated Staff and Medical Staff)	<ul style="list-style-type: none"> • Clinical judgment / competence • Professionalism / patient complaints
Dermatology Internal Medicine Neurology Neurosurgery OBGYN Ophthalmology Orthopedics Pediatrics Psychiatry (Inpatient) Surgery	<ul style="list-style-type: none"> • Inpatient/Outpatient Cases • Length of stay • Mortality • Cost • Complications • Case Mix Index • Number of consultations • Re-admissions • Medical record suspensions • Timeliness of operative notes (where applicable)
Affiliated Medical Staff (all departments)	<ul style="list-style-type: none"> • # of orders in Epic (where applicable)
Anesthesiology	<ul style="list-style-type: none"> • Attending notes: pre anesthesia assessment
Child Psychiatry	<ul style="list-style-type: none"> • Acceptable participation in teaching program • Appropriate consultations
Dentistry	<ul style="list-style-type: none"> • Attendance at clinic • Resident feedback
Diagnostic Radiology	<ul style="list-style-type: none"> • Number of cases sent to peer review • Report turn-around time • % of reports signed within 24 hours
Emergency Medicine	<ul style="list-style-type: none"> • ED length of stay
Laboratory Medicine	<ul style="list-style-type: none"> • Standardized National Competency Review • Laboratory Certification
Pathology	<ul style="list-style-type: none"> • Turn-around time • Frozen section vs. permanent discrepancies
Psychiatry (CIU)	<ul style="list-style-type: none"> • Demonstrates appropriate interaction with trainees
Therapeutic Radiology	<ul style="list-style-type: none"> • Timeliness of treatment summaries