# REGIONS HOSPITAL MEDICAL STAFF
## PEER REVIEW POLICY

Adopted and amended by Regions Board of Directors  
February 28, 2018

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Peer Review Policy
Section 1. In general.

1.1 Purpose and goals. The purpose of this Policy is to guide the Medical Staff as it carries out its duty to oversee activities that measure, assess, and improve the quality of health care in the Hospital and to implement Article 4 of the Medical Staff Bylaws. The goals of this policy are to:

a. Monitor and evaluate on an ongoing basis the Professional Competence of individual Practitioners.
b. Create a culture with a positive approach to peer review and identify opportunities for improvement.
c. Perform focused professional practice evaluation when opportunities for physician improvement are identified and to ensure competence before granting new or expanded privileges.
d. Provide accurate and timely performance data for physician feedback, ongoing and focused professional practice evaluation, and reappointment.
e. Promote efficient use of physician and quality staff resources.
f. Ensure that the process for peer review is clearly defined, fair, defensible, timely, and useful.

1.2 Definitions. A capitalized term used in this Policy has the same meaning as provided in Article 8 of the Medical Staff Bylaws unless a different definition is given in this Policy.

1.2.1 Peer Review means the review of the individual professional performance of a Practitioner, including feedback to the Practitioner. For purposes of this Policy, Peer Review includes OPPE, FPPE, and case review, as those terms are defined in this Policy.

1.2.2 Case Review means the assessment and evaluation of the quality of care provided by the Provider to one or more specific patients to determine whether the appropriate standard of care has been met and what, if any, action should be taken to improve or ensure high quality care in the future. Case review may result from the identification of one or more specific cases or incidents or from a review of a sample of the Practitioner’s cases.

1.2.3 Peer means a Practitioner with clinical competencies that are equal to or greater than the Practitioner whose practice is being reviewed.

1.2.4 Focused Professional Practice Evaluation (FPPE) means a time-limited, privilege-specific process of evaluating a Practitioner’s present ability to competently exercise clinical privileges the Practitioner has been granted or is seeking.

1.2.5 Ongoing Professional Practice Evaluation (OPPE) means an on-going process of identifying a Practitioner’s professional practice trends that affect the quality of care and the
safety of patients in the Hospital and clinics and for improving the quality of the care the Practitioner provides. OPPE includes the routine monitoring and evaluation of a Practitioner’s current competency to exercise clinical privileges.

1.2.6 **Peer Review Committee (PRC)** means the committee designated by the Medical Executive Committee (MEC) to conduct the review of individual practitioner’s performance of clinical duties for the medical staff.

1.2.7 **Physician** means a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, and a doctor of podiatric medicine.

1.2.8 **Practitioner** means an individual who has clinical privileges at the Hospital.

1.2.9 **Professional Competence** refers to a Practitioner’s professional competence in the following areas:

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

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

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

   d. **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 health care teams.

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

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

1.3 **Administrative assistance from the Hospital**. The Hospital may provide administrative staff services and support to all activities referred to in this Policy.

### Section 2. **Peer Review Committee (PRC)**.

2.1 **Membership.** The Peer Review Committee consists of the following:

   a. The immediate past Chief of Staff (COS-P);
   b. The vice president for medical affairs (VPMA);
   c. The medical directors of quality;
   d. The medical director of credentialing;

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2.2 **Voting members.** All members of the PRC, including its chair, have a vote except the director of performance improvement.

2.3 **Term of service; term limits.** A section head is appointed for a two year term and may not be reappointed until the section head has been off the PRC for at least one year.

2.4 **Chair.** The COS-P is the chair of the PRC. The Chair has the following duties:

a. Call and preside at PRC meetings.

b. Coordinate and manage the work flow of the PRC with the assistance of the Medical Staff Services Office.

c. Provide broad oversight of OPPE and FPPE, in cooperation with the Section and Division Heads.

d. Manage and coordinate case review.

e. Present the PRC’s findings to the MEC.

f. Attend meetings of the Board’s Quality Committee, as invited.

2.5 **Duties of the Committee.** The PRC has overall responsibility for implementing and overseeing Peer Review activities in the Hospital. The PRC has the following specific duties:

2.5.1 **Determine data that will be collected and analyzed.** The PRC must determine, in coordination with the Hospital’s performance improvement department and, as appropriate, section and division heads, what data must be collected and analyzed in the course of conducting Peer Review.

a. Hospital-wide data must be collected for all Practitioners and analyzed to assess and evaluate the quality of care provided to patients in the Hospital.

b. Section-specific data must be collected for all Practitioners practicing in each section and analyzed to assess and evaluate the care provided to patients of Practitioners in the section.

c. Practitioner-specific data must be collected for individual Practitioners as necessary to assess and evaluate the care provided by individual Practitioners and not captured by data described in the previous two paragraphs.

2.5.2 **Determine the process for collecting data.** In coordination with the Hospital’s performance improvement department, the PRC must establish a process for collecting data used in the Peer Review process. Data may be obtained from in the following categories, as appropriate to the type of review being conducted, the Practitioner, and the availability of the data:

a. Rule-based data that is routinely collected by the Hospital according to rules established jointly by the PRC and the Hospital’s data and measurement program.

b. Rate data that compare the relative frequency of certain occurrences among patients of the Hospital generally to those of the Practitioner.

c. Case data collected from the medical records of individual patients.
d. Clinical data collected from the medical records of patients of the Hospital and of the Practitioner generally.
e. Perception data collected from individuals, including patients and other Medical Staff and Hospital employees, regarding their observations of a Practitioner’s care.

2.5.3 **Communicate data and analysis.** PRC must report the results of its analysis to the Practitioner, section head, MEC, and Credentials Committee, as appropriate and as provided in this Policy.

2.5.4 **Recommend policy changes.** The PRC must review this Policy every two years and recommend changes to this Policy to the MEC as necessary.

Section 3. **Ongoing & Focused Professional Practice Evaluation (OPPE & FPPE)**

3.1 **Ongoing Professional Practice Evaluation (OPPE).** The PRC must oversee OPPE for each Practitioner with privileges in the Hospital.

3.1.1 **Data that must be collected.** Examples of data that the PRC must collect and analyze, to the extent they are available and applicable to the Practitioner, for purposes of OPPE include:

a. The Practitioner’s medical assessment and treatment of patients.
b. Adverse privileging decisions involving the Practitioner, if any.
c. The Practitioner’s clinical practice patterns.
d. The Practitioner’s adherence and departures from established patterns of clinical practice.
e. Sentinel Event data.
f. Patient safety data involving the Practitioner’s patients.
g. The Practitioner’s use of medications.
h. The Practitioner’s use of blood and blood components.
i. Information about operative and other procedures performed by the Practitioner.
j. Tests and procedures the Practitioner orders.
k. The length of stay in the Hospital of the Practitioner’s patients.
l. Morbidity and mortality data concerning the Practitioner’s patients.
m. Cases that by law or Hospital policy meet the criteria for an autopsy to be conducted or requested.
n. Other criteria developed by the Section and applicable to Practitioners who practice within the section.

3.1.2 **How data will be gathered.** The Hospital may gather the data described in the previous section from one or more of the following sources:

a. The Hospital's electronic medical record and business platform systems.
b. Direct observation of the Practitioner.
c. Monitoring of the Practitioner’s diagnostic and treatment techniques, including peer review of the Practitioner’s technique.
d. Observation of and feedback about the Practitioner’s performance with individuals involved in the care of the Practitioner’s patients, including consulting physicians, assistants at surgery, nursing and administrative personnel, and patents and their family members.
e. Publicly available sources such as the Minnesota Board of Medical Examiners and the National Practitioner Data Bank.
f. Other information technology systems, including Hospital- and clinic-based systems.

3.1.3 **Analysis and reporting of data.** The data gathered through OPPE must be analyzed by the head of the section in which the Practitioner practices and reported to the Practitioner no less frequently than once every 8 months.

3.1.4 **Use in credentialing decisions.** Information gathered and analyzed in OPPE must be communicated to the Credentials Committee to assist it in evaluating a Practitioner’s application for appointment or reappointment to the Medical Staff and for clinical privileges.

3.2 **Focused Professional Practice Evaluation (FPPE)**

3.2.1 **When conducted.** FPPE must be conducted for every Practitioner under either of the following circumstances:

a. Immediately after a Practitioner’s initial appointment to the Active or Associate Medical Staff and immediately after a Practitioner is granted new or expanded clinical privileges. FPPE under these circumstances must be completed within six months of an initial or newly requested privilege being granted by the Medical Staff. If the number of cases and/or records to be reviewed as part of the FPPE have not occurred during the six month time frame, then FPPE can be extended for an additional six months up to a maximum of twelve months. If the necessary number of observations or records cannot be completed within twelve months of the request for new or expanded privileges, the Chair of the Credentialing Committee may extend the time if; and

b. Whenever OPPE or individual case review raises a question regarding a Practitioner’s ability to exercise a privilege competently and there is no immediate threat to the health or safety of a patient. (If the case suggests that one or more patients’ health or safety may be in jeopardy, the case must be referred to the MEC for an investigation rather than the PRC for FPPE.) FPPE must continue under this circumstance for as long as necessary to determine what, if any, action by the PRC is required.

3.2.2 **Information that must be considered.** In conducting FPPE, the head of the section in which the Practitioner practices (with the assistance of the Medical Staff Services Office, where appropriate) must obtain and consider at least the following information:

a. Verification with a primary source that the Practitioner is licensed or certified to exercise the privileges being sought.

b. Verification with a primary source that the Practitioner has the formal, specific training necessary to competently exercise the privileges being sought.

c. Evidence that the Practitioner is physically and mentally able to perform the privileges being sought.
d. Data from professional practice reviews by other organizations at which the Practitioner currently has clinical privileges, to the extent the data is available.
e. Assessment, evaluation, and recommendation of the Practitioner’s peers or teachers regarding the Practitioner’s medical and clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. This input may be in the form of written documentation reflecting informed opinion of the Practitioner’s scope and level of performance, or a written Peer evaluation based on practitioner-specific data collected from various sources provided to the evaluator by the Hospital for the purpose of validating current competence.
f. The Practitioner’s performance within the Hospital if the Practitioner has practiced in the Hospital.
g. Adverse licensing actions taken against the Practitioner’s licensure or registration.
h. The Practitioner’s relinquishment for any reason of a licensure or registration, medical staff membership, or clinical privileges.
i. Disciplinary action taken by any other health care organization, including the limitation or reduction for any reason of the Practitioner’s clinical privileges.
j. Any unusual pattern or excessive number of professional liability actions in which the Practitioner was a defendant.
k. Relevant Practitioner-specific data compared to aggregate data, when available.
l. Morbidity and mortality data, when available.
m. Information from the National Practitioner Data Bank, if available.
n. Chart review.
o. Monitoring clinical practice patterns.
p. Simulation.
q. Proctoring.
r. External Peer Review.
s. Discussion with other individuals involved in the care of each patient (e.g., consulting physicians, assistants at surgery, nursing or administrative personnel).

3.2.3 Performance monitoring plan. Each section must establish a FPPE monitoring plan for Practitioners in the section. A section’s monitoring plan must include at least the following:
a. Criteria that require FPPE that includes at least the following:
   1. A request by a Practitioner for privileges that the Practitioner is not currently exercising in the Hospital;
   2. The occurrence of a “trigger” event, as defined by the section; and
   3. Trend data that indicate that the Practitioner has outcomes or occurrences that vary from the norm, as defined by the section.
b. A monitoring plan covering a time period up to six months specific to requested privileges that includes at least the direct observation of the Practitioner exercising privileges or a review of records of the Practitioner’s patients, as appropriate.
c. Performance monitoring of at least 30 days and includes chart reviews of at least 10 cases, or a longer duration if necessary to review at least 10 cases.
d. A method of assigning one or more Peers to review a Practitioner’s performance.

e. The minimum percentage of cases in which the Practitioner must be found to have provided satisfactory care and the maximum percentage of cases in which minor or major deviations from satisfactory care were observed, respectively.

f. Circumstances under which monitoring by an external source is required that are consistent with those listed in section 4.5.

3.2.4 Responsibility for conducting FPPE. The head of the section is responsible for organizing FPPE for all Practitioners who practice in the section.

a. At the end of the FPPE period (as determined by the section head), the section head must complete a form containing the section head’s evaluation and recommendations regarding the Practitioner’s competence to exercise the clinical privileges being sought. The section head may also include on the form written suggestions for the Practitioner’s personal or professional improvement.

b. If the section head determines that data collected during FPPE is sufficient to recommend granting or continuing the privileges, the section head must notify the Credentials Committee and the Practitioner. The written evaluation must be placed in the Practitioner’s credentialing file.

c. If after the FPPE is completed the section head determines that the data do not support a finding that the Practitioner is able to exercise the requested privileges competently, the section head must either

1. recommend an additional period of monitoring and evaluation and notify the PRC, Credentials Committee, and the Practitioner of the nature of the section head’s concerns and offer suggestions to the Practitioner of how to improve his or her performance; or

2. recommend to the Credentials Committee that the request for privileges be denied or privileges revoked.

Section 4. Case review

4.1 In general. Case review is conducted by a section, the PRC, the MEC, or any other body or person authorized by the MEC.

4.1.1 Section responsibility. The section head has primary responsibility for overseeing case review involving a Practitioner in the section. Oversight includes establishing, in consultation with Practitioners in the section, the criteria for identifying cases for review, designing the procedures under which the section will review the cases, and supervising the administration of the case review activities of the section to ensure conformity with the procedures and this Policy. The specific criteria and procedures may vary by section but must not be incompatible with this Policy. The section must refer to the PRC any case that its review determines needs corrective action or further review.

4.1.2 PRC responsibility. The PRC has primary responsibility for overseeing case review of cases that are referred directly to it under this Policy, and for reviewing cases referred to it by a
section, or the MEC. Oversight includes assigning one or more Peers to review a case, receiving and determining whether to accept, modify, or reject the reviewer’s report and recommendation, and forwarding the case to the MEC for further review or action as appropriate.

4.1.3 **MEC responsibility.** The MEC has primary responsibility for overseeing case review of cases for which it initiates an Investigation under the Investigation and Corrective Action Policy or that are referred to it for further review by the PRC.

4.2 **Criteria for section case review.** Each section must establish criteria that identify cases that it will review. Section case review criteria must include at least the following:

4.2.1 Any case that indicates that a Hospital or Medical Staff policy has not been followed.
4.2.2 Any case where the rate of events or processes are outside the range of acceptable frequencies, as determined by the section.
4.2.3 Any case that results in an unexpected death or serious disability.
4.2.4 Any case referred for review by another section or another medical staff or hospital committee.

4.3 **Criteria for PRC case review.** The PRC must review cases that meet the following criteria, and may establish criteria for reviewing other cases as appropriate:

4.3.1 Any adverse health event as defined by Minnesota Statutes section 144.7065.
4.3.2 Any event that the Joint Commission defines as a “sentinel event.”
4.3.3 Any case for which the MEC has initiated an Investigation under the Investigations and Corrective Action Policy. The PRC may coordinate its case review with that of the investigating committee appointed by the MEC.
4.3.4 Any case referred to the PRC by a section.
4.3.5 Any case referred for review by another section of the medical staff or other medical staff or hospital committee.
4.3.6 Any case requiring a root cause analysis.

4.4 **Method of review.** When a case is identified for review, the body responsible for overseeing the review must assign one or more Peers of the Practitioner to conduct the review. In the case of a section, the Practitioners in the section as a whole may review the case.

4.4.1 Each reviewer, or the reviewers as a body, must have the professional training and experience necessary to evaluate the Practitioner’s Professional Competence as defined in section 1.2 of this Policy.

4.4.2 The person or body assigning a case must assign the case to a reviewer(s) who is unbiased and free of economic or other conflicts with the Practitioner whose case is under review. A reviewer asked to review a case must disclose any conflict or potential conflict to the person or body assigning the review before accepting the assignment.

4.5 **External review.** The person or body responsible for overseeing case review may ask a Peer of the Practitioner who is not a member of the Medical Staff to review a case for any reason, including when

4.5.1 No Peer on the Medical Staff has sufficient expertise to evaluate the Practitioner’s care,
4.5.2 Peers on the Medical Staff with the requisite expertise have conflicts of interest that affect or could be reasonably perceived as affecting the objectivity of their review, or
4.5.3 Internal review has produced ambiguous, inconclusive, or conflicting results.

4.6 **Reviewer’s report and recommendations.** The reviewer must make a written report of the case to the body responsible for the case review using a form provided by that body. The form must ask the review to recommend any corrective action or further review that is required.

4.7 **Action on reviewer’s report.** The section, PRC, or MEC must receive, review, and take action on the reviewer’s report and recommendation by approving, modifying, or rejecting the reviewer’s recommendation. If the reviewing body determines that corrective action is required, the body must forward the recommendation to the next level of review. Only the MEC may take final action on corrective action.

Section 5. **Allied Health Professionals (AHP).** Peer review of an Allied Health Professional who has been granted privileges by the Medical Staff and the Board, including OPPE, FPPE, and case review, is conducted in the same manner as peer review of a Physician. Sections may involve other AHPs in peer review activities involving AHPs in that section as they determine appropriate.

Section 6. **Confidentiality of Review Organization activities and materials.** All activities carried out under this Policy are authorized by the Health Care Quality Improvement Act of 1986, codified at 42 U.S.C. § 11101, et seq., or Minnesota Statutes §§ 145.61 – 145.66, or both, and are subject to the provisions of these laws that prohibit or limit the disclosure of data, records, documents, and knowledge obtained or developed during the course of the activities. The PRC, MEC, and a Section when they carry out Peer Review activities, and any individual or entity that acts at their direction, are “Review Organizations” and are subject to the provisions of this section.

6.1 **Non-disclosure generally.** A person who participates in a Review Organization must not disclose what transpired at a meeting of a Review Organization except to the extent necessary to carry out one or more purposes of the Review Organization and with the authorization of the Review Organization.

6.2 **Identification of confidential material.** The Review Organization must identify all information it receives or produces as Peer Review Information. Documents, including meeting minutes and case review materials, prepared in connection with this Policy, to the extent feasible must be prominently labeled to identify them as protected Review Organization information. A label that is consistent with the following meets this requirement:

This document was acquired or prepared by or for a Review Organization in the furtherance of one or more of its functions as defined by Minn. Stat. § 145.61, subd. 5. It must be held in confidence and must not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the Review Organization and with the authorization of the Review Organization. This document is not subject to subpoena or discovery.

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6.3 **Safekeeping of confidential material.** All records prepared by, acquired by, or prepared at the request of a Review Organization must be maintained under the care and custody of the Hospital’s authorized representative on behalf of the Review Organization. Records or materials recorded on paper must be stored and locked in an office or file cabinet to which only authorized persons have access. Records or materials maintained in electronic format must be protected by password and have read/write control protections. Materials may not be removed from the Hospital for any purpose unless approved in advance by the CEO and COS.

6.4 **Access to confidential material.** Those authorized to have access to Review Organization materials include the following:

6.4.1 Members of the Review Organization and administrative staff who need to have access to the information in order to perform their functions.

6.4.2 Consultants, attorneys, or other professionals engaged by the Hospital to the extent necessary for them to assist the Review Organization in performing its function.

6.4.3 Representatives of regulatory or accreditation agencies who are entitled by law to have access to the information.

6.4.4 A Practitioner who seeks through discovery in a civil action, data, information, or records relating to the Practitioner’s medical staff privileges or membership. A Practitioner does not have a right to have access to Review Organization materials, including materials related to the Practitioner’s own practice, except as authorized by law and the Review Organization.

Section 7. **Adoption and amendment; relationship to bylaws; definitions.**

7.1 **Governing Document.** This Policy is a Governing Document of the Medical Staff and may be adopted and amended as provided in Article 7.A of the Medical Staff Bylaws. Documents adopted under this Policy (for example, a section’s performance monitoring plan under section 3.1.3 or criteria for case review under section 4.2) are Operating Documents of the Medical Staff and must be approved as provided in Article 7.B of the Medical Staff Bylaws.

7.2 **Governing Provisions.** The Governing Provisions of Article 8 of the Medical Staff Bylaws govern this Policy.

*Adopted and amended by Medical Staff Bylaws Committee: 02/12/15; 09/26/17
Adopted and amended by Regions Hospital Medical Executive Committee: 03/02/15; 12/04/17
Adopted and amended by Regions Hospital Board: 12/14/16; 02/28/18*

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