LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES
HARBOR-UCLA MEDICAL CENTER

SUBJECT: PEER REVIEW PROCESS **POLICY NO.** 616A

CATEGORY: Administration	**EFFECTIVE DATE:** 1/02
POLICY CONTACT: Janine Vintch, MD	**UPDATE/REVISION DATE:** 4/22
REVIEWED BY COMMITTEE(S): Peer Review Oversight Committee (PROC)	

PURPOSE:
To maintain an effective peer review process of the Professional Staff Association of Harbor-UCLA Medical Center.

POLICY:
Harbor-UCLA Medical Center has a Professional Staff Association (PSA) peer review process that adheres to the Joint Commission and CMS standards as well as applicable state laws. All members of the PSA are subject to evaluation based on PSA peer review criteria. Evaluation results are used in privileging and appropriate actions are taken, when warranted. The peer review process is part of the Medical Center's Patient Safety Evaluation System and is therefore afforded the legal protections provided by the Patient Safety and Quality Improvement Act of 2005. Peer review proceedings are additionally protected under section 1157 of the California Evidence Code.

PROCEDURE:
Each medical staff department shall have procedures for peer review that conform to the following requirements:

1. Departments shall develop and routinely update peer review criteria based on current practices and standards of care.

2. The circumstances requiring peer review of individual cases shall include, but are not limited to:
   - cases in which significant patient injury or death may have been related to inappropriate care
   - critical clinical events reported to Risk Management
   - unexpectedly adverse outcome given severity of illness
   - performance of a procedure for inappropriate reason
   - failure to follow policy or medical staff bylaws with potential harm to a patient
   - significant patient or staff complaint/grievance concerning an individual patient

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APPROVED BY:

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Chief Medical Officer

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Chief Nursing Officer

- concerns raised by third-party payers or regulatory agencies
- specific cases meeting hospital-wide quality improvement clinical indicators

3. The Peer Review Committee (PRC) Chair for each department may become aware of cases in several ways and may use their discretion to determine which cases will appear on the PRC agenda. In general, the Chair should select cases in which there appear to be questions about the appropriateness of the care provided. If the PRC Chair reviews a case and is confident that there is no concern for inappropriate care, they may document this assessment and not place the case on the agenda or can include them as part of a consent agenda depending on the individual department preferences. The one exception will be cases which the Harbor-UCLA Risk Manager determines that peer review is required. The actual outcome of cases which the Harbor-UCLA Risk Manager determines that peer review is required will not be shared with Risk Management, but the fact that the case was reviewed by the departmental Peer Review Committee and the date of such discussion may be provided to them upon request.

4. Staff in Clinical Quality and Safety will identify cases from the Safety Intelligence (SI) or other incident reporting systems which meet screening indicators and forward them to the appropriate PRC Chair or designee for review. In addition, cases in which grievances have been filed involving providers or a patient's medical care will also be forwarded for review. In both these cases, the PRC Chair or designee may determine whether or not to place such cases on their agenda.

5. If a case is referred from one department PRC to another, the receiving PRC Chair should review the case and determine if they have enough information to respond to the referral or if the case needs to be reviewed in committee. In either case, the receiving PRC Chair should respond to the sending PRC Chair within 45 days of receipt.

6. Peer review is conducted by the PRC, or the PRC chairperson or his/her designee of the appropriate clinical department at Harbor-UCLA Medical Center. The majority of members sitting on the departmental PRC will be physician members of the medical staff with clinical privileges in the same department as the provider whose case is being reviewed. Departments may appoint other members of their PRC at the discretion of the PRC Chair.

7. Documentation of any peer review of individual cases is as provided in Policy 616B.

8. Peer review should be timely. For critical clinical events or when requested by the departmental Chair or Associate Medical Director for Quality and Safety, initial peer review of a case should be completed within 45 days of identification of the event which induced the review., All other peer review cases should be completed within 90 days of the event unless the Peer Review Chair documents the need for an extension.

9. No final adverse determination of the quality of care of an individual patient provided by a practitioner that is deemed a category 2 or 3 as defined in Policy 616B will be made until that practitioner has had an opportunity to provide input. If the involved practitioner does not respond to the notification of the category assignment within 30 days, the PRC Chair will assume that they have no additional input to the discussion of the case and the category assigned will be finalized and the case will be closed.

10. As the primary purpose of the peer review program is to evaluate the performance of members of the medical staff, any concerns about the performance of residents or fellows who are not members of the medical staff will be forwarded to their program director.

11. PEER REVIEW OVERSIGHT COMMITTEE (PROC) assists the hospital leadership in assuring that the medical staff departments have effective peer review programs by providing secondary review of the following type of peer review cases:

    - All cases in which a category 3 designation has been assigned by a department's peer review committee.
    - Any cases referred to PROC by a Departmental Chair or Peer Review Committee.
    - Any case in which a member of the medical staff wishes to formally appeal the category assignment of a department's Peer Review Committee
    - Cases in which two or more departments differ in their assessment of QI cases where those differences impact peer review.

    In addition, PROC reviews information about grievances against physicians and surgeons and assures that appropriate peer review has been performed if indicated.

12. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) is an adjunct process to individual case review that provides the medical staff with the ability to identify professional practice trends impacting quality of care and patient safety on an ongoing basis. OPPE evaluates the strengths and opportunities of a practitioner's performance and competence related to his/her privileges. This process uses multiple sources of information including, but not limited to, review of aggregate data, compliance with medical staff bylaws and hospital policies, and the conclusions from peer review of individual cases. OPPE indicators shall be developed by clinical departments and approved by the PSA Executive Committee.

    Departments may, where relevant, collect and evaluate department members' data pertaining to the following types of information:

    - Operative and other clinical procedure(s) performed and their outcomes;
    - Patterns of blood and pharmaceutical usage;
    - Requests for tests or procedures;
    - Patterns of length of stay;
    - Use of consultants;
    - Morbidity and mortality; and
    - Findings from individual case review.

    "Patient Satisfaction" survey responses shall not be used to evaluate professionals unless the methodology used is considered reliable by the PSA Executive Committee.

    The department chairperson, PRC Chair, or designee will review OPPE reports on all individuals with clinical privileges in the department at least every 6 months. Each practitioner's OPPE report will be maintained in the practitioner's peer review file (see Policy 616C) within their department.

13. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) is a process initiated when the conclusions from individual case review or OPPE raises questions or concerns regarding a practitioner's ability to provide safe, high quality patient care. The proctoring program, for initial and new privileges, as defined in the Bylaws of the Professional Staff Association (PSA Bylaws) is a component of the FPPE program. FPPE generally encompasses more than the review of a specific case. It is considered an evaluation and not a formal investigation for corrective action as defined in the PSA Bylaws and is not subject to the requirements and procedures of the investigation process. If an FPPE results in a subsequent plan to perform a formal investigation and consider corrective action, the process outlined in the PSA Bylaws would be followed.

    FPPE is initiated when any of the following criteria are met:

    - When a medical staff member has been granted initial privileges or an existing medical staff member has been granted new privileges or is returning from a leave of absence. The proctoring policies described in the PSA Bylaws and in individual departmental policies will be followed.
    - When case review determines evidence of failed professional skill or judgment or a lack of practitioner knowledge.
    - When patterns or trends of undesirable outcomes are associated with the practitioner.
    - When evidence exists of unprofessional conduct including inappropriate or disruptive behavior.

    A. When any of the above criteria (other than paragraph a.) occur, the Chief Medical Officer, an Associate Medical Director, the President of the PSA, the DHS Director, the DHS Chief Medical Officer, a departmental chairperson, Division Chief or department Quality Improvement chairperson may request that FPPE be initiated. An FPPE request should be sent to the Chair of the Department of the PSA member or, if the subject of the review is a Department Chair, to the President of the PSA. When an FPPE request is received, the Chair of the PROC must be notified after the request has been approved by the MEC and sent to the Department Chair to begin the process. If the Chair of the PROC is unavailable, the Vice Chair of the PROC or the President of the PSA should be notified.

    B. FPPE may be conducted by the PRC of the practitioner's department or by a special panel where membership is determined by the departmental chairperson or if the subject of the FPPE is the department chairperson, the PSA President. The evaluation will be specific to the individual and requested privileges, if applicable, and may include direct observation. The review body may consider information from individual case reviews, analysis of aggregate data, including but not limited to clinical indicators, outcomes, length of stay, and material submitted by the subject practitioner. The review body will provide a complete report to the departmental chairperson and the Chair of the PROC and a summary of the report to the individual or group requesting the review, if applicable, within 45 days of the requested review. FPPE pursuant to paragraph 13a which requires proctoring will be reported to the department chairperson within 90 days of the granting of initial or new privileges and again prior to the completion of the practitioner's 6-month provisional term. Within 14 days of the receipt of the report, the department chairperson or if the subject of the FPPE is the department chairperson, the PSA President must make a determination as to whether further action is warranted, and this decision must be communicated to the Chair of the PROC including a copy of the final written FPPE report. If corrective action is proposed, the President of the PSA must also be so notified.

C. Rarely, there are situations in which external peer review of a case or of a physician's performance is desirable including, but not limited to, the following:
   - Committee or department review(s) that could affect an individual's membership or privileges do not provide sufficiently clear basis for action;
   - No current PSA member can provide the necessary expertise in the clinical procedure or area under review;
   - To promote impartial peer review; and
   - Upon the reasonable request of the practitioner.

   An external peer review may be requested to the President of the PSA or Chief Medical Officer by a departmental chairperson, the Medicolegal Committee, the Credentials Committee, PROC, or the PSA Executive Committee. Such review will be arranged by the Chair of PROC in consultation with the Chief Medical Officer. Further actions taken, if any, will conform to the procedures as provided in Article VI, of the Bylaws of the Professional Staff Association on Corrective Action.

D. Findings from peer review activities are reported to the departmental chairperson and/or the departmental peer review Chair and are discussed with the individuals involved. The findings are filed in the individual practitioner's Peer Review File.

E. Information with respect to any practitioner submitted, collected, prepared, or maintained for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research, as well as any other information with respect to any Association, committee department

Reviewed and approved by:
Medical Executive Committee 04/2022

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