Peer Review

What are the Risk Exposures?

While the legal and professional duty to monitor and evaluate the quality of patient care has received renewed attention in this age of patient safety, the ethical responsibility to do so is not a new concept. The Hippocratic Oath, reportedly written by Hippocrates in the fourth century B.C. and traditionally taken by physicians, states in part, "I will prescribe regimens for the good of my patients and never do harm to anyone." Born from this statement is the often-used phrase, "first, do no harm."

One of the most important and difficult tasks a healthcare organization undertakes is determining the qualification and competency of medical practitioners to provide high-quality and safe patient care. The Joint Commission and other accrediting bodies require healthcare facilities to have a process in place to review physician performance.

According to the American Medical Association (AMA):

> Peer review is the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice. It is the mechanism by which the medical profession fulfills its obligation to ensure that its members are able to provide safe and effective care. The responsibility assigned to and scope of peer review is the practice of medicine; i.e. professional services administered by a physician and the portion of care under a physician's direction. Therefore, elements of medical care, which describe the knowledge, skills, attitudes, and educational experiences of physicians and provide the foundation of physician activities, are subject to peer review and its protections. Those elements include, but are not limited to the following: patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice. Activities that comprise medical care are subject to the scope and rigor of peer review and entitled to the protections and privileges afforded by peer review law.[1]

The elements referenced above are also referred to as the six general areas of competency, and are recognized by the American College of Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) to evaluate practitioners. Peer review results may be used to assess several of the six general areas of competency, depending on the circumstances. For example, if a case is reviewed because there is a concern regarding clinical skills, the review would essentially evaluate the practitioner's "medical/clinical knowledge;" if the case is reviewed because the practitioner did not comply with established evidence-based best

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practices, the review would evaluate the practitioner's "practice-based learning and improvement."[2]

When Is This a Risk Issue?

Historically, there has been concern that information gathered in the peer review process could become discoverable and used against providers in medical professional liability actions. This could cause many providers and organizations to hesitate conducting honest and complete peer review.

Plaintiff attorneys continue with their attempts to gain access to peer review information, and courts are considering the discoverability of individual documents more frequently.[3] Judges may decide that peer review information is discoverable if they find that the state laws are in conflict and/or are overridden by federal regulations, or if they decide that the information/documents were not created in a manner that affords them protection under the law.[4]

Physician Reviewers

A peer must be another physician. However, depending on the circumstances, the peer does not have to be board-certified in the same specialty as the physician being reviewed.[5] If the concern is related to general medical care, responsiveness, or communication, any physician could be considered a peer for peer review purposed.[6] Conversely, if the concern is directly related to a specialized technique or procedure, the peer reviewer must be a physician with expertise in that area.[7]

Physicians selected as peer reviews should be impartial, fair, honest, and objective. They should not have any conflicts of interest with respect to the party being reviewed. Keep in mind that conflicts of interest are not always obvious or clear cut.

Hospital Conditions of Participation (CoPs)

The Hospital Conditions of Participation (CoPs) are federal standards which must be met by all hospitals that participate in the Medicare and Medicaid programs. Several of the CoP standards for hospitals include requirements to evaluate physician performance.

Critical Access Hospitals

Although the CoP standards pertinent to medical quality and peer review for critical access hospitals (CAHs) are broader and less specific than those found in the hospital CoP standards, any CAH will be well-served and better protected in medical professional liability actions if the more specific hospital requirements have been implemented. Furthermore, there is sufficient general language in the CAH CoPs to obligate CAH facilities to do what is necessary to provide safe care.

Peer Review Protection Laws

There are two types of peer review protection laws:

1. Those granting immunity from lawsuits to institutions and individuals participating in the peer review process
2. Those declaring peer review discussions and documents to be confidential, privileged, and inadmissible in court

Physician peer reviewers should be aware that a facility's insurance policy (usually their directors and officers coverage) typically covers all who participate in peer review in good faith. Most states also have laws providing immunity for peer review participants; however, these laws vary from state to state.

Peer Review Immunity

Concern regarding the rise in medical professional liability claims and the ease with which incompetent practitioners were able to move from state to state prompted Congress to pass the Health Care Quality Improvement Act of 1986 (the Act). The Act has two objectives:

1. To promote good faith professional review activities of practice (Part A), and
2. To provide a system for disclosure of professional competence or conduct deficiencies of physician, dentists, and other healthcare professionals to healthcare entities making privileging decisions (Part B).

Physicians have historically been reluctant to participate in the peer review process, citing the possibility of being sued by the practitioner under scrutiny.[8] The Act intends to encourage peer review by granting broad immunity for hospitals, medical staffs, and other entities for their good faith peer review actions (e.g., adverse medical staff privileging decisions or corrective/disciplinary actions).

The National Practitioner Data Bank (NPDB)

The NPDB was created to make it more difficult for incompetent or unprofessional practitioners to move between jurisdictions without discovery of their professional history. To achieve this, hospitals and other healthcare entities are required to report any adverse action against the clinical privileges of physicians, dentists, and other healthcare professionals taken for a period longer than 30 days to the NPDB. Malpractice judgments or settlements made on behalf of a practitioner must also be reported by the entity making the payment, typically a professional liability insurance company.

In 2010, NPDB reporting requirements expanded. This change enhanced the ability of healthcare entities to perform due diligence investigations prior to hiring a new employee. While it has always been the case that healthcare entities could verify licensure through their own state boards, this new procedure gives hospitals access to licensing information in any of the 50

states in which the practitioner has held a license, even if the entity was unaware that the practitioner had even been licensed in the state.

Accrediting bodies require healthcare organizations to query the NPDB when granting or renewing privileges.[9, 10] If the organization fails to query appropriately, information in the NPDB may be made available to a plaintiff's attorney in litigation arising out of the practitioner's care.[11]

NPDB Limitations

In terms of payment reports, only final malpractice judgments and settlements must be reported to the NPDB.[12] As the resolution of a claim frequently takes several years, the NPDB will not be aware of claims which are pending at the time of the request. An informed risk assessment will require analysis of both the NPDB report and supplemental information (e.g., open claims data, internal/external quality assessment, a claims history/loss run from the applicant's professional medical liability insurance carrier, and risk information).

In addition, the Medical Malpractice Payment Report from the NPDB does not allow for extensive narrative regarding claim allegations; therefore, reports must be interpreted very carefully and in conjunction with other information sources.

It is recommended that medical staff bylaws address NPDB reporting and querying requirements, as well as the responsibility of the medical staff to consider claims history when making privileging decisions.

Peer Review Privilege/Confidentiality

Policies should address the mechanisms used to ensure confidentiality of peer review information. Simply marking a document "confidential" may not be adequate to convince the court that the document is protected. Hospitals must be able to prove that the documents were created solely for the peer review or quality improvement process.

Federal Confidentiality Protection

The Patient Safety and Quality Improvement Act of 2005 (PSQIA) set the stage for the first federal confidentiality protection of peer review. It allows hospitals and other healthcare providers to voluntarily report medical events for the purpose of learning from their own mistakes and the mistakes of others. Following passage of the PSQIA, the Patient Safety Rule was published in the *Federal Register* on November 21, 2008, and became effective January 19, 2009.[13]

The rule provides a framework for a voluntary reporting system that allows hospitals and healthcare providers to report medical errors, near-misses, and other patient safety events to a

certified patient safety organization (PSO) on a privileged and confidential basis. The purpose of the program is to improve patient safety nationally by aggregating and analyzing patient safety data in order to provide guidance to healthcare providers on minimizing risks in the delivery of patient care.[14]

Although there is no mandate for hospitals to contract with a PSO, beginning January 1, 2017, those hospitals with greater than 50 beds who wish to participate in a health insurance exchange need to demonstrate participation. Additionally, there are benefits to participating in a program that provides analysis and feedback on patient safety initiatives. The obvious benefit is improved patient safety. Enhanced confidentiality protection is another advantage. Any organization reviewing options for contracting with a PSO should become familiar with the confidentiality provisions and limitations.

Patient Safety Work Product

In order for information to be protected under the rule, it must be "patient safety work product," which includes any data, memoranda, reports, records, and analysis, written or oral, that could be used to improve patient safety, healthcare quality, or healthcare outcomes. This definition is intentionally very broad and provides protection for a wide range of information.

These protections are notably greater than protections under any other patient safety or quality movement. It is also significant that these protections apply in federal court, where state protections are often ineffective.

There are limitations on what information is considered PSWP. Protected information is information that is collected for the purpose of reporting it to a PSO. Medical records and information collected and used for the purpose of meeting external reporting requirements or other purposes are generally not protected.

Patient Safety Evaluation System

The rule also requires patient safety work product to be part of a "patient safety evaluation system" – meaning the "collection, management, or analysis of information for reporting to or by a PSO."[15] However, the rule does not contain specific requirements about how a patient safety evaluation system must be designed. It is apparent that the organization must independently determine the structure and clearly define that structure in its policies and procedures.

PSWP information is protected when it is entered into the patient safety evaluation system, so there is incentive to enter it as soon as practical. However, it may be difficult to determine whether information will be needed for other purposes that are inconsistent with the definition of PSWP, such as external reporting of an adverse event to a state agency or external reporting of

processional disciplinary actions. One solution is to enter information into the patient safety evaluation system and hold it there for a time before sending it to the PSO. The rule does not specify a timeframe within which information must be sent from the patient safety evaluation system to the PSO; it only requires that the intent is to send the information in a "timely" manner. If it becomes apparent that the information may be needed for other purposes, the information may be removed from the patient safety evaluation systems and thereby de-designated as PSWP. This is not an option once the information is sent to the PSO.[16]

Organizations may choose to share PSWP between the patient safety evaluation system and the risk management/quality management system or to create a separate but parallel patient safety evaluation system to the existing risk management/performance improvement system.

The final rules states, "Some institutional providers may, for example, make it a condition of employment or privilege that providers agree to the disclosure of patient safety work product to accrediting bodies."[17] Organizations may, therefore, require all providers to sign an acknowledgement that certain information obtained during a root cause analysis (RCA) will be communicated to other specific organizations.

Although it will take some work to implement such a system and contract with a PSO, many organizations will find that the enhanced confidentiality protection and the potential for improving patient safety will be well worth the investment.

Protection under PSOs will likely be challenged. In 2012, Walgreens was sued by the Illinois Department of Financial and Professional Regulation (IDFPR) for refusing to release incident reports of medical errors.[18] Walgreens claimed that the information was created as part of their patient safety evaluation system and was therefore protected under the Patient Safety and Quality Improvement Act.[19] The Litigation Center of the American Medical Association, the State Medical Societies, and the Illinois State Medical Society filed a joint court brief in support of Walgreens.[20] The trial judge found that the incident reports were privileged from discovery under the Patient Safety Act, sustained Walgreens' objection, and dismissed the case.[21] The IDFPR appealed, but the Illinois Appellate Court affirmed the lower court's ruling.[22]

Performance Improvement

One human resource management tool, *The Performance Pyramid*, has been taught for years by the American College of Physician Executives and the Greeley Company; it has also been applied to hospital medical staffs.[23] Making peer reviews a part of a facility's performance improvement process and not individualized punitive events can increase physician acceptance while strengthening patient safety. Organizations do not achieve outstanding results by accident.

Quality data should be adjusted for severity of the patient's illness and risk factors to counter the statement, "but my patients are sicker," that is sometimes made by physicians when presented with data. However, clinical risk factors need to be clearly documented in order to adjust for them. The Centers for Medicare & Medicaid Services and several proprietary vendors provide software to help entities risk-adjust their mortality data.

Peer Review Program Structure and Protocols

The goal of peer review is to have a reliable, efficient process that is free of bias. In departmentalized organizations, peer review is often accomplished by individual department members or by the department chair. Committees are developed around each service line, such as maternal/child services, or units, such as the emergency department or intensive care.

A single, centralized multi-specialty peer review committee model functions differently. It performs all case reviews and provides an oversight function for various measures of physician performance. In this model, cases for peer review committee discussions are identified; the single, central committee makes recommendations regarding improvement strategies; and the department chair or chief of staff is responsible for working directly with the physician under review to improve performance as needed.[24]

The centralized model may have less individual and specialty bias, fewer reviewers to train, and reduced variability, as there is only one peer review committee.[25] This committee reports directly to the medical executive committee to consolidate the quality reporting process.[26]

Setting the number of specialties and number of committee members is left to the individual organizations to determine, based on facility size and culture. Multi-disciplinary membership and participation in peer review are decided upon based not only on the organization's culture, but also on state law.

It is best to consult with legal counsel to ensure that any participation by non-physicians does not compromise peer review legal protections. In addition to a nursing perspective on this committee, quality support staff and risk managers can add to the discussion. If multidisciplinary members are present on the committee, only physician members may vote and the confidentiality of the proceedings must be stressed. The committee must agree on the basic methods of care review and the scoring mechanisms that are to be implemented.

Peer Review Barriers

Misunderstanding the requirements of accreditation and regulatory agencies, poor system development, and fear of litigation have all contributed to physician mistrust and reluctance to participate in the review process. Poorly conducted committee meetings and lack of focus contribute to frustration.

Peer Review

There may be some general disdain for the documentation requirements that the peer review process entails. It must also be remembered that the review process can be an uncomfortable experience for physicians. It requires critical clinical evaluation skills, personal objectivity, and tact. It also must be supported by facility staff members who are knowledgeable in accreditation and regulatory requirements, clinical assessment, criteria development, and group dynamics.

Peer review is especially difficult when the medical staff is small and has few specialists. A member may not have a "peer" (a practitioner with similar training and experience) on the staff to review his/her work. If there is a peer, the practitioner may be a practice partner, a personal friend, or a competitor. These situations can seriously hinder effectiveness.

Disruptive Behavior

Disruptive physician behavior can lead to medical errors, dissatisfied patients and staff members, and preventable adverse outcomes.[27] However, hospital and medical staff leaders are often hesitant to conduct peer review for disruptive behavior. Lack of an internal review structure and concern about the subjectivity of the complaint contribute to this reluctance.[28]

Code of Conduct

A code of conduct should be developed with clear expectations that all staff members must treat others with respect. The code should be adopted and distributed organization-wide, and education concerning the code of conduct should be provided.

Measuring Compliance

The next step in managing disruptive behavior is measuring compliance.[29] Measurement helps track whether staff member behavior is consistent with the organization's policies, puts people on notice that the organization is monitoring unacceptable behavior, and conveys the importance of maintaining positive and respectful collegial interactions. Problem-prone individuals who know that aberrant behavior is being monitored are less likely to act out. Monitoring unacceptable behavior conveys the message that the organization takes appropriate conduct seriously, also making transgressions more likely to be reported.

The measurement tools used to track compliance must protect staff members from retaliation. Ideally, the system will protect the person who is reporting, ensuring confidentiality.

Feedback

Feedback needs to be provided once compliance is measured with accurate and verified data. Studies of human behavior have shown that individual performance improves significantly when positive performance feedback heavily outweighs negative comments. Unfortunately, this approach is not always implemented in healthcare settings. Keep in mind that confidentially

surrounding disruptive behavior is essential, and that occasionally the level of behavior warrants a formal response system.

Formal Mechanisms

Without a doubt, the best way to deal with practitioner behavior that has been identified as disruptive is to meet with the practitioner informally and reach an amicable agreement to discontinue the objectionable behavior. Other options include obtaining professional counseling services or otherwise trying to resolve the problem without recourse to disciplinary action. However, disciplinary action is always a possibility and must be kept in mind. If the possibility of disciplinary action is allowed to become an idle threat, all efforts to manage disruptive behavior will collapse. For formal intervention, a foundation must be laid and then the requisite steps taken.

Peer Review Report

The essential element in the peer review process is the peer review report.[30] Whether the report results from internal or external peer review, the report should be unambiguous and provide the basis for determining of additional action is necessary.[31] Confidentiality and identities must be protected. Experienced legal counsel can help ensure compliance with the HCQIA and medical staff bylaws.

Practitioner Impairment

Impairment among licensed independent practitioners has long been recognized as a problem. Impairment has been defined by the Federation of State Medical Boards (FSMB) as the inability of a licensee or physician to practice medicine with reasonable skill and safety as the result of:

- A mental disorder;
- A physical illness or condition, including but not limited to those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills; or
- Substance-related disorders including abuse and dependency of drugs and alcohol.[32]

Before 1974, impaired providers were disciplined. Then, in 1974, model legislation was developed that recognized alcoholism and other drug addictions as illnesses and offered treatment programs as an alternative to discipline.[33] Since then, every state has passed regulations and developed programs in impairment identification, recovery, and monitoring.[34]

The Joint Commission's Standard MS.11.01.01 addresses provider impairment by stressing that the health of licensed independent practitioners must be addressed separately from disciplinary purposes. Organizations and facilities must create processes that protect patients and make their well-being the primary consideration, while also providing practitioners with compassionate help should they need it.

Corrective Disciplinary Action

While the courts are increasingly reluctant to second-guess adverse decisions of a peer review panel, they continue to be willing to examine the process by which peer review decisions are made. To protect the integrity of an adverse decision, reviewers must diligently focus on clinical issues and concerns, analyzing the effect of practitioner performance and/or conduct on the quality of care or the potential for patient injury.

Corrective action is defined as "formal or informal steps a disciplinary authority can take to limit, restrict, or impose conditions on a healthcare professional's practice. The terms *corrective action* and *disciplinary action* are interchangeable.[35] Bylaws and policies should clearly address the steps the organization will take when considering corrective actions, always being mindful of the practitioner's due process rights. For example, corrective actions may limit, modify, restrict, or reduce medical staff membership or privileges.

Bylaws

Medical staff bylaws are the foundation of any program designed to deal with disruptive behavior. Bylaws should include the definitions of disruptive behavior, while stressing that such conduct can impair the quality of care delivered within the facility.

It is essential that medical staff bylaws clearly outline an appropriate process for negative privileging decisions and corrective or disciplinary action. They should also include general categories of behavior that will result in corrective action and also provide specific examples.

Focused Professional Practice Evaluations

While focused professional practice evaluations (FPPEs) are implemented by organizations in the case of newly appointed physicians without current evidence of competence for their newly granted privileges, FPPEs can also be implemented when a provider's performance or competence elicits questions or concerns.[36] This process may include chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussions with staff members who work with the provider being evaluated.[37]

Fair Hearing/Due Process

The decision to take formal action against a practitioner's privileges should not be taken lightly. It is a serious step, the repercussions of which may follow a practitioner for the rest of their working lifetime in the form of a report to the NPDB. It is a step of last resort, but one that may be necessary if informal attempts to modify behavior are ineffective.

The most likely challenge to any corrective or disciplinary action is to its *fairness*. Practitioners under review must be afforded due process. The peer review immunity provisions of the Health

Care Quality Improvement Act (HCQIA) extend immunity if an adverse decision is made with the reasonable belief that the action was in the furtherance of quality healthcare, after a reasonable effort to obtain facts, after the physician receives adequate notice about the hearing and its procedures, and in the reasonable belief that the action was warranted by the facts known. If these four elements are met, the facility will obtain the qualified immunity.

Improving Patient Care

While a goal may be to avoid litigation, it should never be the primary goal. Disciplinary action should always have the primary goal of improving patient care. If there are underlying motivations to which the disciplinary action can be ascribed, it casts doubt on the facility's stated desire to improve the quality of patient care. Courts have held that disruptive conduct can have an impact on the quality of patient care, and can be dealt with appropriately through a fair hearing process.[38]

HCQIA does allow for summary suspensions that may be taken without a thorough investigation under certain circumstances. If the suspension is necessary so that concerns about a practitioner's care can be investigated, his or her privileges can be summarily suspended for a period not to exceed 14 days.[39] If the failure to take immediate action could result in imminent danger to the health of an individual, the practitioner's privileges may be summarily suspended.[40] However, in this case the facility would be required to provide subsequent notice and hearing processes, or do whatever else may be fair.[41]

Adequate Notice and Hearing Procedures

There are a number of steps specified in HCQIA that must be undertaken in order for the notice and hearing process to be fair and adequate. The steps eventually outlined in the recommendation section that follows are not difficult to follow, despite appearing complicated. However, even if the steps are not followed precisely, such failure does not automatically mean that the facility will lose the protection of the statute.[42] As long as the process is fair, minor imperfections may be overlooked.

Reasonable Belief of Warranted Action

There is no test or assessment specified by HCQIA to determine whether the facility reasonably believed that disciplinary action was warranted. However, legal judicial history suggests that the assessment will be satisfied if reviewers use the available information at the time of the professional review, and reasonably conclude that such action will help protect patients while containing harmful behavior.[43]

Post-hearing Process

HCQIA provides protection for facilities that report information on actions taken against

practitioners. HCQIA specifically provides that, "No person or entity…shall be held liable in any civil action with respect to any report made under this subchapter…without knowledge of the falsity of the information contained in the report."[44] This is an "actual knowledge" standard which requires that the facility knew (as opposed to "knew or should have known") that the information was false when reporting it. This is a high threshold to overcome.

How Can I Reduce Risk?

Identifying opportunities for improvement and implementing corrective action plans are part of the peer review process. It is important to understand that routine quality monitoring and trending of physician practice patterns, mortality and morbidity conferences, root cause analyses, and quality improvement projects do not constitute peer review.

Although many peer review activities are routine, hospitals should consider the possibility that a hearing and/or litigation may result, and the hospital will have to defend their peer review action. The recommendations that follow are offered to assist medical staff in addressing their legal duty, professional responsibility, and ethical call to keep patients safe through the process of peer review.

Conduct Ongoing Professional Practice Evaluations (OPPE)	
Conduct OPPE	• Understand that The Joint Commission, as one accrediting agency, requires accredited organizations to continuously monitor and evaluate practitioner performance so that performance concerns can be identified and corrected as soon as possible.[45] • Understand that the results of ongoing professional practice evaluations (OPPE) must be considered by the medical staff on an ongoing basis, and by the medical staff and governing body. • Recognize that OPPE must be considered when making recommendations and decisions to revise, revoke, or renew medical staff membership and privileges.[46] • Please see the ***Credentialing and Privileging Processes*** chapter for additional information on ongoing professional practice evaluations (OPPEs). It is available in the Healthcare Facility Tool Chest on the Risk Management Policyholder Resources Portal.

Avoid Conflicts of Interest in Peer Review

Avoid conflicts of interest

- Educate physician reviewers on what may be conflict of interest, as well as their responsibility to report a potential conflict to the peer review committee.
- Understand situations that may constitute a conflict, such as:
  - Business relationship – e.g., partners or members of the same practice;
  - Social relationship – e.g., members of the same club;
  - Financial interest – e.g., business manager, stockholder/investor;
  - Referral relationship – e.g., refer patients to each other;
  - Involved in care of patient/case under review.

Recognize Regulatory Standards and Liability

Recognize standards

- Understand that hospitals participating in Medicare and Medicaid programs must meet Conditions of Participation (CoPs).
- Recognize that several of these standards involve the evaluation of practitioner performance.
- Realize that comparable standards may be found in the CoPs for critical access hospitals (CAHs).
- Please see the ***Credentialing and Privileging Processes*** chapter and the CoPs from Centers for Medicare & Medicaid Services for additional information. It is available in the Healthcare Facility Tool Chest on the Risk Management Policyholder Resources Portal.

Understand Peer Review Protection Laws

Understand peer review immunity

- Be aware that the immunity offered by the Act is broad, but conditional, and that the review must be focused on practitioner competence and/or conduct and be performed in good faith.

Understand Peer Review Protection Laws

- Recognize that to receive immunity, a peer review action must be taken:
  - In the reasonable belief that the action was in the furtherance of quality healthcare,
  - After reasonable effort to obtain the facts of the matter,
  - After adequate notice and hearing procedures are afforded to the physician or after such other procedures as are fair to the physician under the circumstances, and
  - In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain the facts.[47]
- Understand that immunity does not apply to civil rights claims brought under 42 U.S.§§ 1981 and 2000.[48]
- Ensure that peer review decisions are non-economic, non-discriminatory, and in accordance with the bylaws of the medical staff.
- Make sure that medical staff bylaws clearly outline an appropriate process for negative privileging decisions and corrective/disciplinary action.
- Be certain that those participating in peer review are familiar with and strictly follow bylaw directives.
- Recognize that the review panel must avoid any appearance of conflict of interest and diligently focus on its review on the relationship between practitioner performance, competence, and/or conduct and the quality of care.
- Determine the scope of state law in regards to peer review immunity. Consult with counsel if you have questions regarding this.

Recognize role of NPDB

- Realize that it applies to all negative actions or findings taken by state licensing boards, peer review organizations, and private accreditation organizations against any provider, not just physicians and dentists.
- Query the NPDB prior to granting or renewing medical staff privileges and when new privileges are requested, as

Understand Peer Review Protection Laws

required by all accrediting bodies, through the two options below:

- A one-time query, also known as traditional querying, allows an entity to submit the name of a practitioner or organization and receive a query response that includes all the information that the NPDB has received on the practitioner or organization that the NPDB has received on the practitioner or organization.
- A Continuous Query, formerly known as Proactive Disclosure Service (PDS), allows an entity to receive an initial query response and automatically receive notification within 24 hours of the NPDB's receipt of new information during the 12-month enrollment for each practitioner. Continuous Query enrollment must be renewed every 12 months.

- Understand that the NPDB has limitations.
- Ensure that the medical staff bylaws address NPDB reporting and querying requirements, as well as medical staff responsibility when considering claims history.
- Please see the ***Credentialing and Privileging Processes*** chapter for additional information about querying the NPDB. It is available in the Healthcare Facility Tool Chest on the Risk Management Policyholder Resources Portal.

Create Mechanisms to Enhance Peer Review Privilege/Confidentiality

Enhance Protection

- Recognize that organizations must understand the privileges in their state.
- Understand that organizations must design guiding documents and processes in a way that provides the greatest protection.
- Ensure that bylaws, plans, and/or policies clearly address the peer review committee(s), as well as any peer review documents that will be created, such as:
  - Meeting minutes;
  - Reports;

Create Mechanisms to Enhance Peer Review Privilege/Confidentiality	
	○ Worksheets; ○ Memoranda; ○ Correspondence. • Ensure that peer review documents are confidential and are prepared pursuant to state statutes for the purpose of peer/professional review. • Seek guidance from legal counsel to assess documents and processes to ensure compliance with state law.
Create mechanisms	• Create mechanisms that strengthen peer review confidentiality, including the following: ○ Patients and physicians are identified in documents by code number only. ○ Documents reproduced and circulated at meetings are for use only during the meeting and are collected at the end of each session and destroyed. Each document is numbered to ensure that each document is retrieved at the end of the meeting. ○ Original documents are maintained in a secure location (e.g., under lock and key in the quality, risk, or medical staff office). ○ Access to documents is limited to the peer review process and is for committee use only. ○ Disclosure is made only with the authorization of the peer review committee for which the information was collected. ○ Strict access and control of all peer review documents is maintained. ○ Records related to committee professional review activity, such as reports, meeting minutes, and memoranda, are identified as records subjected to statutory confidentiality provisions. An appropriate statement, prepared/approved by counsel, is printed or stamped on each record.

Understand Federal Confidentiality Protection and Patient Safety Rule

Understand federal protections

- Recognize that hospitals with greater than 50 beds who wish to partake in a health insurance exchange need to demonstrate participation with a patient safety organization (PSO).

Understand patient safety rule

- Recognize that information to be protected under the patient safety rule must be "patient safety work product (PSWP)," which includes any data, reports, records, memoranda, and analysis, written or oral, that could be used to improve patient safety, healthcare quality, or healthcare outcomes.
- Know that the following documents ARE considered PSWP:
  - Peer review documents;
  - Clinical practice protocols;
  - Staff evaluations;
  - Equipment review logs;
  - Root cause analyses;
  - Quality and safety reports; and
  - Committee minutes, deliberations or recommendations, checklists, notes, or outcome data.
- Know that the following documents are NOT considered PSWP:
  - Patient records;
  - Billing information;
  - Mandatory reporting data;
  - Discharge information;
  - Information related to a criminal act; nor
  - Original patient or provider information.

Create a patient safety evaluation system

- Determine the structure of the patient safety evaluation system.
- Clearly describe the structure in policies and procedures.

Understand Federal Confidentiality Protection and Patient Safety Rule

- Consider the following components when developing a system:
  - A description of the patient safety evaluation system:
    - What kind of data will be collected;
    - What activities will be conducted;
    - What equipment will be used.
  - A process for managing, investigating, and reporting adverse events;
  - Procedures for entering data into the patient safety evaluation database;
  - Authorized access;
  - Procedures for reporting to the PSO;
  - Use of standardized formats for reporting to the PSO.[49]
- Determine and outline, if applicable and appropriate, the systems and processes for managing the flow of information between the patient safety evaluation system and the risk management/performance improvement programs in policies and procedures.
- Understand that PSWP information is protected when it is entered into the patient safety evaluation system.
- Understand that information obtained during a root cause analysis may be patient safety work product and may be shared with an accreditation organization if one of the two following stipulations is met:
  - Identified providers must agree to the disclosure.
  - Provider identifiers are eliminated from the information.[50]

Create Peer Review Program with Protocols and Structure

Create an infrastructure

- Create a strong, standardized infrastructure for effective peer review, that:

Create Peer Review Program with Protocols and Structure

- Is defined in writing, with sufficient detail to provide guidance to medical staff leaders and administrative personnel;
- Is based upon adherence to evidence-based standards of clinical practice and standards of conduct established by the medical and hospital administrators;
- Provide for peer review process education/training for the peer review participants;
- Ensures that the legal parameters of peer review activities are understood by the peer review process participants;
- Is uniformly conducted for all members of the medical staff;
- Is integrated into the ongoing professional practice evaluation and reappointment process;
- Incorporates data gleaned from updated information systems that provide meaningful, accurate, and timely internal and external data;
- Is established as a hospital system process that is not subject to personnel or medical staff leadership turnover;
- Is supported by medical staff and hospital leadership willing to act decisively;
- Is audited routinely for breakdowns in the system.

- Consider these essential elements of an effective peer review infrastructure, courtesy of the National Peer Review Corporation's publication *Taking Control of Peer Review*:
  - A Peer Review System Manual – A comprehensive peer review manual provides the information needed and a road map for the peer review process, outlining detailed, unambiguous instructions for the performance of day-to-day peer review. The manual should minimally include a description of and responsibilities of the peer review committees, protocols for day-to-day peer review, policies, the

Create Peer Review Program with Protocols and Structure

training elements for participants, and the details of the audit process.

- A Centralized Peer Review Structure – Many hospitals have a decentralized peer review structure in which cases are referred to a department peer review committee. The decentralized peer review committee may have drawbacks, including, but not limited to, little oversight from the medical executive committee, lack of uniformity among the various departments, lack of a multidisciplinary component to peer review, and lack of oversight by hospital administration. The establishment of a centralized multidisciplinary peer review committee system can eliminate the drawbacks of the decentralized peer review structure. Oversight rests with the medical executive committee. The administration's burden of peer review is delegated to a peer review coordinator.
- Established and Enforced Standards of Practice – Without clinical practice guidelines/standards of practice, each individual physician determines his/her own level and quality of practice. Establishing clinical practice guidelines allows the facility to screen cases, review cases, and request the practitioner's rationale for deviation from practice guidelines. Incorporating adherence to evidence-based practice guidelines into the peer review process lessens the subjectivity of medical quality review.
- Protocols for the Conduct of Clinical Peer Review and Peer Review Action – Detailed protocols for conducting peer review and taking actions provide uniformity in the peer review process across specialties. If scoring systems are used, detailed definitions of each score should be in place.
- Established and Enforced Standards of Professional Conduct – The hospital should be proactive in instituting standards of professional conduct and fully implementing these standards through the peer review process. When standards of conduct are in place, physicians are notified that certain behavior(s)

Create Peer Review Program with Protocols and Structure

cannot be tolerated, compliance is required, and each physician will be held to the same standards.

- Protocols for the Conduct of Professional Conduct, Peer Review and Peer Review Action – Professional conduct standards should be incorporated into the peer review process. Detailed protocols for conducting professional conduct peer review and taking peer review actions for violations must be included in the peer review manual.
- Protocols for Referral into Peer Review System – A protocol should provide that a referral into the peer review system will occur whenever a practitioner "engages in, makes or exhibits acts, statements, demeanor, or professional conduct, either within or outside of the hospital", which is reasonably likely to be any of the following:
  - Below the defined clinical standards of practice or indicative of poor clinical judgment;
  - A violation of the standards of professional conduct (as incorporated in the peer review system manual);
  - Contrary to the medical staff bylaws or the peer review system manual;
  - Detrimental to patient safety or to the delivery of patient care within the hospital;
  - Detrimental to the safety of others in the hospital;
  - A violation of state or federal criminal statutes.

- Protocols for referral to the peer review system should include that referral into the peer review system will occur based on sentinel events, clinical screens, benchmarks, practice patterns, malpractice cases, utilization data, compliance hotline, authorized requests for peer review, and complaints. Complaints may be verbal or written. Verbal complaints need to be investigated by the peer review coordinator and if verified, brought for review.
  - An Effective Policy for External Peer Review – The policy should outline who in the organization may request external peer review, require that the request

Create Peer Review Program with Protocols and Structure

be in a writing that states the perceived need for external peer review, and identify who grants final authority for the external peer review process.

- Useful and Sufficient Data – Physicians conducting peer review in the hospital setting must have complete confidence in the information provided to them before taking action. The data must be timely, functional, and reliable.
- Analyze "Trended" Data – Often, internally reviewed cases are "trended" and then forgotten. Instead, produce practice pattern summary reports in a format approved by the medical executive committee and review the reports at the peer review committee and/or the medical executive committee.
- Integrate Peer Review Information into Reappointment – It has not been uncommon at times for hospitals to reappoint practitioners without considering the peer review information contained in the practitioner's quality file. Peer review information is a vital component in the periodic evaluation of each practitioner.
- Use Peer Review as Education – Approaching peer review as an opportunity to educate physicians and improve clinical performance, thereby increasing patient safety and the quality of patient care, promotes an atmosphere of collegiality rather than one of adversity.
- Approach Peer Review with a Sense of Urgency – The failure to act quickly may result in adverse consequences. If a hospital's peer review committees act promptly and avoid delays when the event is fresh in the minds of the reviewers, the peer review process is typically more effective, and acceptance of any corrective action by the reviewed physician and the medical staff is enhanced.
- Audit the Peer Review System – To remain effective, the peer review system must have a routine internal, and even external, audit procedure. The audit confirms that the peer review system is operating and

Create Peer Review Program with Protocols and Structure

monitoring the quality of care rendered by medical practitioners.

- Establish a Peer Review System with Positive Medical Staff Leadership – Without physician leadership, peer review is likely to be ineffective. The peer review system should be a joint venture by the medical staff and administration to achieve the infrastructure that addresses their respective concerns.[51]

Develop a peer review protocol

- Obtain data sources
  - There are many sources for individual case review in the organization. Cases may be identified from generic screens of clinical indicator, occurrence reports, medical record abstracts, patient complaints, patient satisfaction surveys, and surveys of hospital department staff members and case managers, to name a few. Agreement on a timeline to get the identified cases into the peer review process is very important to keep the review timely. Some example of focus areas of risk identified and possibly suitable for individual case review include:
    - Patient-related risk, e.g., identification of risk associated with a particular diagnosis, presentation, or behavior;
    - Diagnostic/treatment-related risk, e.g., risk associated with frequency of misdiagnosis, delayed diagnosis, or the inherent risk of certain interventions;
    - System-related risk, e.g., risk associated with the care delivery system, staffing, available resources, or circumstances which affect patient care;
    - Outcome-related risk, e.g., risk associated with an unexpected outcome or adverse event leading to patient harm;
      - Practitioner-related risk and quality assessment - it is recommended that ongoing monitoring and evaluation consider the following:

Create Peer Review Program with Protocols and Structure

- Incompetent, negligent, and impaired practitioners;
- Performance on the “fringes” of acceptable practice (standard of care);
- Practice beyond training and experience or outside the scope of delineated privileges, e.g., unqualified practitioner;
- Failure to respond to a request for care; and
- High-risk practices and/or behavioral patterns, such as inadequate documentation, lack of communication skills, and personality disturbances.

- Utilize case screening:
  - Once a case is identified for review, it should be screened by a quality analyst, preferably with a clinical background such as nursing, to ensure that the quality issues are physician-related.
- Begin physician review:
  - Once a case is identified and screened, the case must promptly reach the physician reviewer who is assigned by the peer review committee chair. The case should be reviewed as quickly as possible, ideally within one week after identification. Time frames should be established for the physician reviewer. If the reviewer cannot complete the review within the established time frame, the peer review committee chair should be notified to reassign the review. If the initial reviewer is uncertain about the case, it should go to the full peer review committee for review.
- Complete committee review:
  - If the case review indicates appropriate care, these results should be reported at the committee level. As noted above, if the initial reviewer finds the care is inappropriate or questionable, the case should be placed on the agenda for full committee review.

Create Peer Review Program with Protocols and Structure

- Obtain involved physician input:
  - In cases of potentially inappropriate care, input from the involved physician should be obtained either before or after the committee meets. Most peer review committees prefer input after they meet to review the case. Communication with the involved physician does not come from the reviewer, but from either the quality staff or committee chair. This will preserve the anonymity of the reviewer.
  - A letter of inquiry should be sent to the involved physician, advising that a written response is expected within two weeks. If a response is not received within the requested time frame, a reminder letter is sent. The involved physician may respond in writing, meet with the committee chair, or appear before the committee. These options should be included in the peer review policy and letter.
- Communicate committee decision:
  - After deliberations are undertaken and a decision is made by the committee regarding the case, the involved physician should be notified in writing by the committee. Physicians who provide exemplary care should also be notified; notification should not be just to those physicians whose care was questionable or inappropriate.
- Create an action plan and conduct a follow-up as needed:
  - Action plans should be formulated for care that is deemed inappropriate or controversial. A formal or informal plan should be developed, as appropriate to the concern. Recommendations that result in adverse actions need to be addressed according to the medical staff bylaws and rules and regulations. A focused practice evaluation may be considered as recommended in The Joint Commission's Standard MS.08.01.01.[52] Action plans may also include external peer review, proctoring, simulation, chart review and discussions with others involved with the care of the patient review, and discussions with others involved with the care of the patient.

Create Peer Review Program with Protocols and Structure

- Provide the physician with feedback:
  - Providing relevant and timely feedback to the involved physician regarding his/her performance issues is necessary to ensure that the quality of care, treatment, and patient safety are improved. As an example, The Joint Commission addresses this in Standard MS.08.01.03, which states, "Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal."[53]
  - The key to providing feedback is that it is "ongoing." Reporting should no longer be done just at the time of reappointment, but continuously throughout the year. Reports ideally include "excellent," "acceptable," and "needs improvement" as current ratings and targets for each indicator.

Address barriers

- Understand that there may be some general disdain for the documentation requirements of the peer review process.
- Be aware that the review process can be uncomfortable for physicians.
- Consider the advantages of contracting for external peer review:
  - The review would be conducted by a disinterested (economically and professional) third party using objective criteria based on accepted standards of care.
  - The review would be anonymous and confidential.
- Track and trend aggregate external peer review findings to identify aberrant patterns of care.
- Consider a cooperative arrangement between the medical staffs of two or more small facilities or organizations to conduct analysis of aggregate peer review data:
  - By "trading" identity-protected data and conducting professional review for another medical staff, the

Create Peer Review Program with Protocols and Structure

physicians from each of the organizations fulfill the obligation to provide ongoing monitoring of professional practice and avoid expense and potential conflicts of interest.

- See the following website for a sample of an external peer review policy: http://www.nationalpeerreview.com/external-peer-review-services/.

Include Peer Review as Part of Performance Improvement

Delineate expectations

- Consider the six areas of general competence developed by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS):
  - Patient Care;
  - Medical/clinical knowledge;
  - Practice-based learning and improvement;
  - Interpersonal and communication skills;
  - Professionalism;
  - System-based practice.[54]
- Consider The Joint Commission's Elements of Performance for MS.05.01.01:
  - Medical assessment and treatment of patients;
  - Use of medications;
  - Use of blood and blood components;
  - Operative and other procedure(s);
  - Appropriateness of clinical practice patterns;
  - The use of developed criteria for autopsies;
  - Sentinel event data;
  - Patient safety data.[55]

Include Peer Review as Part of Performance Improvement

- Create performance improvement activities for organized medical staff, such as these highlighted in Elements of Performance for MS.05.01.03:
  - Education of patients and families;
  - Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment and services of an individual patient;
  - Accurate, timely, and legible completion of a patient's medical records;
  - Review of findings of the assessment process that are relevant to an individual's performance - the organized medical staff is responsible for determining the use of this information in the ongoing evaluations of a practitioner's competence;
  - Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.[56]

Communicate expectations

- Ensure that medical staff leaders communicate a set of expectations to medical staff, addressing what dimensions of physician performance are important.
- Create a leadership role for the organized medical staff to measure practitioner performance.

Measure against expectations

- Measure practitioner's performance against expectations.
- Adjust quality data for severity of the patient's illness and risk factors.
- Provide feedback to each practitioner in order to facilitate self-improvement.
- Have medical staff leaders assist in developing and following through with performance improvement plan if practice concerns continue.

Consider corrective action

- Initiate formal process that may involve limitations on privileges or loss of medical staff membership, if necessary.

Include Peer Review as Part of Performance Improvement

- Seek legal counsel for this step, if practice concerns require it.

Address Disruptive Physician Behavior

Address behavior

- Develop a code of conduct or policies/procedures with clear expectations that all staff members treat other with respect, courtesy, and dignity, and conduct themselves in a professional manner at all times.
- Develop the code with input from medical staff and internal and external experts in the areas of law, the impairment of physicians, and changing behaviors.
- Ensure that the code of conduct identifies the types of behaviors that are considered acceptable and unacceptable.
- Understand that examples of disruptive behavior may include:
  - Profane or disrespectful language;
  - Demeaning behavior, e.g., referring to hospital staff as “stupid”;
  - Sexual comments or innuendo;
  - Inappropriate touching, sexual or otherwise;
  - Racial or ethnically oriented jokes;
  - Outbursts of anger;
  - Throwing instruments or charts;
  - Criticizing a hospital staff member in front of patients or other staff members;
  - Negative comments about another physician’s care;
  - Boundary violations with staff or patients;
  - Comments that undermine a patient’s trust in a physician or the hospital;
  - Inappropriate chart notes, e.g., criticizing a patient’s hospital treatment;
  - Unethical or dishonest behavior;

Address Disruptive Physician Behavior

- Difficulty in working collaboratively with others;
- Failure to respond to repeated calls;
- Inappropriate arguments with patients, family members;
- Poor response to corrective action.[57]

Measure compliance

- Use a measurement tool such as event reporting, documented complaints, anonymous complaints, patient satisfaction surveys, or staff member questionnaires.
- Encourage staff members to report disruptive events using this system.
- Protect the confidentiality of hospital employees and safeguard against retaliation.
- Consider using the steps The American College of Physician Executives has recommended for changing the "culture of intimidation" in healthcare, including:
  - Establish a steering committee drawn from all levels of the organization to explore and define intimidation.
  - Develop a code of conduct to be signed by all providers when hired and again each year.
  - Survey staff members on their attitudes about intimidation and how they respond to it, in order to raise awareness.
  - Establish an assertive communication process and educate all staff members and physicians.
  - Establish a conflict resolution process and educate all staff members and physicians.
  - Encourage confidential reporting.
  - Enforce zero tolerance and present offenders with "data, authority, and compassion," avoiding punitive measures if possible.
  - Reward outstanding examples of collaborative teamwork and a communication style that facilitates mutual understanding and respect between providers.
  - As always, lead by example.[58]

Address Disruptive Physician Behavior	
Provide feedback	• Share the verified and accurate behavioral data once it has been collected. • Be sure to provide positive as well as negative feedback. • Utilize the basic principle of praising publicly and criticizing privately. • Ensure that physician feedback is provided by another physician – either a department chair, chief of staff, vice president of medical affairs, or chair of the physician quality committee. • Keep all materials concerning disruptive physician behavior confidential. • Understand that especially egregious behavior may necessitate a formal response mechanism.
Utilize bylaws	• Ensure that the medical staff bylaws address the behaviors that are considered disruptive and set forth steps that will be taken when such behaviors occur. • Define disruptive behaviors broadly so that all disruptive conduct can be captured. • Be certain that the bylaws explain how the quality of care can be impaired by disruptive behavior, as can the efficacy of communication channels within the facility.
Create formal response mechanism	• Understand that disciplinary action is always a possibility and must be kept in mind. • Do not allow such action to become an idle threat. • Lay the foundation for formal intervention and follow the requisite steps. • Adhere as closely as possible to the guidance afforded by the Health Care Quality Improvement Act (HCQIA) in order to make tis protections available. • Consider the following approach suggested by The American College of Physician Executives: ○ **Step I: Make Rapid Initial Assessment**

Address Disruptive Physician Behavior

- Examine each report of disruptive behavior immediately; triage and get additional information if situation looks serious or urgent.
- Maintain confidentiality at all times; insist upon it from everyone.
- Make an initial determination:
  - Is immediate action needed?
  - Is patient care affected or is the potential for same too great?
  - Is the physician too distressed or out of control to be safe?
  - Are there serious effects upon staff members, others?
  - Is there unacceptable legal liability?
- If "yes" to any of the above, shorten the time frame of the steps below.
  - Consider immediate actions when patients or others at risk.
  - Intervene at the level of the data.
  - The initial action need not be definitive; by taking initial action, the right to take additional actions later is not given up.
- Consider a very prompt meeting with the doctor.
  - Inform the physician of your initial concerns; tell him or her you will meet again soon.
  - Communicate the seriousness and urgency to the physician.
  - Use this meeting as an opportunity to get the physician's attention.
  - Consider immediate suspension in egregious cases.
- Involve hospital/group PHC and state PHP (Physician's Health Program) when appropriate

(e.g., when alcohol or drug addiction is suspected or when physician might be ill or needs support).

- **Step II: Collection Additional Data and Complete Investigation**
  - Maintain confidentiality.
  - Establish time frame for completion of the investigation.
    - In days, not weeks.
  - Get information from multiple sources when possible.
    - Consult nurses, other staff members (usually best sources of information).
    - Involve physicians as appropriate (not usually best sources).
  - Collect objective data regarding behavior, not opinions such as what is “wrong” with him or her.
  - Review incident reports and other documentation of the past behavior.
  - Search for any evidence of problematic alcohol or drug use.
- **Step III: Assess Clinical Performance**
  - Assess routinely in all cases; may be brief in some excellent performers.
  - Review for any clinical performance problems, documented or suspected.
    - Check with QA, UR, risk management, clinical department.
    - Look for any recent change or deterioration in performance.
  - Include quality of communication, relationships with patient, staff members, others.
  - Evaluate the physician’s workload (i.e., is workload too great to maintain quality?).

- If evidence of clinical performance problems, refer to appropriate department or committee for investigation and action.
  - Do not delay – clinical performance problems take precedence.
  - Do not allow clinical performance problems to be lost in the controversy about a disruptive behavior problem.

- **Step IV: Define the Behavior Problems**
  - Write behavioral problems down in clear, detailed language.
    - Make sure you understand the problems and have adequate data to proceed.
  - Use behavioral descriptions to describe the physician's actions.
  - Use objective, nonjudgmental, respectful language.
    - Include date, time, witnesses, etc.
    - Always refer to the behavior, not the person.
    - Eliminate emotionally charged words.
    - Do not impugn motives (assume good intentions).
    - Put in form that could be reviewed by the physician, his or her attorney, etc.
- **Step V: Determine Whether the Behavior Requires Action**
  - Decide whether or not the behavior is disruptive and why.
    - Ensure that you are comfortable with any decision before it is finalized.
  - Make a decision promptly and prepare to follow quickly with appropriate action.

- Take some action in almost all cases if the behavior is truly disruptive.
  - May be only to inform physician of your concerns and warn him or her to avoid similar behavior in the future.
    - "We don't want you to get into any trouble."
- Make sure the specific action fits the infraction and level of the data.
- Do not take any action with which you do not agree or that you do not support.

- **Step VI: Plan and Rehearse Intervention Meeting(s)**
  - Use a group (two to four, usually) of people who are significant to the physician to intervene.
    - Use only physicians, unless there is a good reason to involve others.
    - Balance group when possible so physician will not feel railroaded.
      - Consider including a colleague whom the physician would see as supportive (as long as the physician agrees with need to take action).
  - Make sure the intervention team agrees with the assessment of the problem and the need to take this action.
  - Determine the following in advance:
    - Goals of the meeting.
    - Outcomes that are acceptable.
    - Who should attend the meeting and who will lead.
    - Roles of those participating.

- Where the meeting will take place (based on what you want to communicate to the physician).
- When meeting should be held,
- How long, approximately (set upper limit, e.g., 1 to ½ hours).

• Rehearse beforehand.

- Decide who will say what, and in what order.
- Ask everyone to write down what they will say and bring it to the meeting.
- Chairperson should have a practiced response to diversions.
  - "I know you are concerned about the quality of nursing on the unit. We can set up a separate meeting to take about that. Right now we are here to talk about your behavior."
- Take enough time to get it right; good preparation is key to success.

• Decide consequences before the meeting.

○ **Step VII: Take Action**

• Thank the physician for coming to the meeting.

• Always act in a respectful manner.

• Explain the purpose of the meeting.

• Assume miscommunication will occur.

- Paraphrase frequently

• Ask the physician to hear you out first.

- "We called this meeting to discuss some concerns with you. We want you to hear us out first, and then you will get a chance to respond. OK?" (Get the physician's agreement.)

Address Disruptive Physician Behavior

- Start by communicating the physician's worth and value.
  - "Dr. Smith, you are a valuable member of this medical staff. We know that you have a strong commitment to your patients."
  - Elaborate with more examples, statements of value, and positive regard.
- Then state your concerns about his behavior.
  - Focus on defining problems behaviors.
  - Give several examples of problem behavior if possible.
  - Deal with problem behavior; do not make diagnoses.
  - Do not impugn motives; assume that the physician has good intentions.
  - Label behavior as "unacceptable" and explain why.
- Empathize with the physician, but remain firm that the behavior must change.
- Do not get angry or accusative with the physician.
- If relevant, indicate that no retribution will be tolerated.
- At the end of the meeting, summarize and plan the next steps.
- Tell the physician the consequences of no behavior change.
- Maintain control; stop the meeting if it starts to get out of control.
  - Do not permit the physician to be abusive in the meeting.
- Remember the power of the written word.
  - Write a summary letter of the meeting to the physician.

Address Disruptive Physician Behavior

- Ask the physician to acknowledge that the summary is accurate.

- **Step VIII: Follow Up and Monitor Progress**
  - Always monitor the situation and have follow-up meetings.
    - Good monitoring improves the chances for maintaining positive change.
  - Regular, frequent follow-up meetings are usually best.
    - Meetings can be short; frequency is more important than length.
    - Initial meeting frequency should be every one to four weeks; err on the frequent side.
  - Do the following in meetings:
    - Tailor follow up to the nature and severity of the problems.
    - Balance positive and negative feedback.
      - Tell the physician when things are getting better.
      - Remember that positive feedback is more powerful than negative feedback in influencing behavior.
    - Summarize and agree on next steps, if any.
    - Confirm next meeting date.
    - Always encourage the physician.[59]

Document Peer Review and Quality Improvement Activities Appropriately

Document appropriately

- Understand that it is the responsibility of the medical staff office, clinical division, or committee/team chair to ensure that peer review reports and meeting minutes include documentation of discussions, conclusions, and recommendations in appropriate detail.

Document Peer Review and Quality Improvement Activities Appropriately

- Be certain that peer review report is unambiguous and provides the basis for determining if additional action is necessary.[60]
- Be sure that the report provides a mechanism to improve the quality of patient care, offers legal protection by adhering to HCQIA elements, and provides a defense against any action taken by the physician reviewed.
- Ensure that the peer review report is focused solely on clinically applicable issues related to the competency and professional conduct of the physician being reviewed.
    - The peer review report should reference the medical records and current literature and standards.
    - The peer review report should not include unnecessary or extraneous issues which distract from the focal issues of the peer review process.
- Include a description of actions taken and any further follow up or plans for continued monitoring in the peer review committee meeting minutes.
- Ensure that documents are confidential, identity-protected, appropriately handled, and properly secured.
- Consider consulting with experienced legal counsel early in the peer review process to ensure compliance with HCQIA and the medical staff bylaws.

Address Physician Impairment

Address impairment

- Understand that impairment can refer to a physical condition, a mental disorder, or a substance-abuse disorder, and that all can interfere with a provider's ability to safely care for patients.
- Act to ensure the protection of patients, but understand that physicians deserve compassionate care.
- Ensure that individual physicians understand their obligation to respond to an impaired colleague by:

Address Physician Impairment

- Intervening in a timely manner to ensure that impaired colleagues cease practicing and receive appropriate assistance from a physician health program;
- Reporting impaired colleagues in keeping with ethical guidelines and applicable law;
- Assisting recovered colleagues when they resume patient care.[61]

- Understand that physicians collectively have an obligation to ensure safe and effective care by their fellow colleagues, and should:
  - Promote health and wellness among physicians.
  - Establish mechanisms to ensure impaired physicians promptly cease practice.
  - Support peers in identifying physicians in need of help.
  - Establish or support physician health programs that provide a supportive environment to maintain and support health and wellness.[62]

- Ensure the management of individual health for licensed independent practitioners is separate from action taken for disciplinary reasons, and that it addresses the following:
  - Education of licensed independent practitioners about illness and impairment recognition issues specific to licensed independent practitioners;
  - Self-referral by a licensed independent practitioner;
  - Referral by others and maintaining confidentiality;
  - Referral to an appropriate professional for evaluation, diagnosis, and treatment;
  - Maintaining confidentiality, except as limited by applicable law, ethical obligation or when the health and safety of a patient is threatened;
  - Evaluation of credibility of a complaint, allegation, or concern;
  - Monitoring rehabilitation;

Address Physician Impairment

- Reporting unsafe treatment;
- Initiating appropriate actions when a licensed independent practitioner fails to complete the required rehabilitation program;
- Implementation, by the medical staff, of its process to identify and manage matters regarding the individual health of licensed independent practitioners;[63]
  - Visit the website of the Federation of State Physician Health Programs (FSPHP) to understand and comply with state reporting requirements: https://www.fsphp.org/.

Outline Process for Corrective or Disciplinary Action

Outline process

- Understand that some administration actions can lead to automatic suspension of privileges *without* due process, such as:
  - Failure to maintain a current state license;
  - Failure to maintain require professional liability insurance coverage;
  - Failure to complete medical records in a timely manner;
  - Failure to maintain current state/federal narcotics registration;
  - Failure to maintain current required health immunizations (for organizations that require annual vaccines).[64]
- Understand that the following types of disciplinary actions typically do not afford the practitioner due process rights:
  - A letter of censure, reprimand or warning – The practitioner is generally permitted to respond in writing.
  - Collegial interventions such as proctoring, CME requirements and mentoring or coaching.[65]

Outline Process for Corrective or Disciplinary Action

- Ensure that the medical staff bylaws address general categories of behavior that will lead to corrective behavior, for example:
  - Inadequate or substandard clinical performance, e.g., improper surgical technique, improper diagnosis, failure to call for an appropriate consultation;
  - Inability to work with others, e.g., disharmony that adversely impacts patient care; or
  - Violation of healthcare facility policy or medical staff rules, e.g., failure to document appropriately, failure to respond when on call.

Consider FPPEs

- Understand that FPPEs can be utilized on newly appointed physicians as well as providers whose performance is being questioned.
- For a provider who is not new to the organization, limit the review to the privileges in questions.
- Understand that any other privileges held by the provider should not be affected.
- Be certain the medical staff understands their responsibility to clearly define the performance monitoring process, including with regard to the following:
  - Criteria for conducting performance monitoring;
  - Method for establishing a monitoring plan specific to the requested privilege;
  - Method for determining the duration of performance monitoring; and
  - Circumstances under which monitoring by an external source is required.[66]
- Utilize criteria developed by the medical staff to consistently implement and document professional evaluations.
- Document the resolution of performance issues.
- Please refer to the ***Credentialing and Privileging*** chapter for more information on focused professional practice evaluations.

Outline Process for Corrective or Disciplinary Action

Use bylaws

- Define the following terms (or their equivalent) in the medical staff bylaws:
  - Termination of privileges – withdrawal or refusal to reappoint;
  - Temporary suspension – may apply only to specified privileges and typically relates to the time required for hearing or related procedures; may be protective and often summary in nature;
  - Reduction of privileges – may relate to the reduced competence or inadequate skill preparation of the practitioner;
  - Protection of probation – to monitor performance deficiencies, usually accompanied by supervision or proctoring;
  - Letters of reprimand or admonition.

Meet the Fair Hearing/Due Process Requirements

Meet requirements

- Make decisions in good faith and without consideration of professional affiliations, associations, or economic competition.
- Utilize the four threshold elements that must be considered in any fair hearing process, which require that the action be taken:[67]
  1. *In the reasonable belief that the action was in the furtherance of quality health care*:
     The primary motivation for any disciplinary hearing must be to improve the quality of patient care. Economic motivations, such as business competition, should have no place in the decision to undertake a fair hearing. Similarly, a desire to protect a facility from litigation due to a provider's practices should not be the primary motivation for disciplinary action.
  2. *After a reasonable effort to obtain the facts of the matter*:
     Nothing in HCQIA specifies the manner in which the investigation should be carried out in order

to obtain immunity under the act. In this, as in many things in the law, the concept of "reasonableness" is front and center. According to one definition, reasonable means "fair, proper to moderate under the circumstances."[68] A "fair" investigation is one that is fair to the practitioner, to the facility, and to the practitioner's patients. It is an investigation that is undertaken without preconceived biases one way or the other. A "proper" investigation is one in which all potential causes for an event or events are reviewed carefully and appropriately. A "moderate" investigation might be one that is thorough and all of the evidence is weighed dispassionately.

3. *After adequate notice and hearing procedures are afforded to the physician involved, or after such other procedures as are fair to the physician under the circumstances:*

   There are a number of steps specified in HCQIA that must be undertaken in order for the notice and hearing process to be fair and adequate. First, the practitioner needs to be notified that a professional review action has been proposed against his or her privileges.[69] The notice needs to specify the practitioner's right to a hearing, including the time frame within which one may be requested (cannot be less than 30 days).[70] If the practitioner does not request a hearing within the specific time frame, he or she may be deemed to have waived the right to a hearing. Similarly, the right to a hearing is forfeited if the practitioner fails to appear at the time and place specificed.[71]

   If the practitioner requests a hearing within the specified time frame, the practitioner must then be given notice of the time, date, and place of the hearing.[72] Again, the date of the hearing cannot be less than 30 days after the notice.[73] The notice also must state who will be called as witnesses by the facility.[74]

Meet the Fair Hearing/Due Process Requirements

If a hearing is held, it must be held before a neutral decision-maker. This may be an arbitrator who is mutually acceptable to both parties. It may also be before a hearing officer or panel of individuals appointed by the facility, but in this case none of the decision-makers can be in economic competition with the practitioner involved.[75]

- Understand that the practitioner has a number of rights at the hearing, including:
  - Representation (this can be by an attorney, but does not need to be);
  - Have a record made of the proceedings;
  - Receive a copy of the record at a reasonable charge;
  - Call and examine witnesses;
  - Present relevant evidence (does not have to be admissible in a court of law as long as it is relevant);
  - Submit a written statement.[76]
- Understand that at the completion of the hearing, the practitioner has a right to:
  - Receive the written recommendation(s) of the decision-maker(s), including a statement of the basis for the recommendation(s);
  - Receive a written copy of the hospital's decision, including a statement of the basis for the decision.[77]

4. *In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph 3*:

   The HCQIA does not specify how to test whether the facility reasonably believed that the action was warranted nor the necessary level of proof (e.g., a preponderance of the evidence,

Meet the Fair Hearing/Due Process Requirements

	evidence beyond a reasonable doubt) for a facility to act. The legislative history indicates that this test will be satisfied "if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients."[78]
Follow post-hearing steps	• Take certain steps need to be taken after the hearing has concluded if actions are taken against a practitioner's privileges. • Report any action to the state medical board if the facility restricts, suspends, or revokes a practitioner's privileges for more than 30 days (for other than administrative reasons, such as medical record delinquency), as the state medical board is then required to report it to the National Practitioner Data Bank.[79] • Understand that the action is also reportable if the facility accepts the surrender of privileges in exchange for a promise not to investigate the practitioner's care, or while an investigation is underway.[80]

References:

1. American Medical Association (AMA*). H-375.962 Legal Protections for Peer Review*. AMA Policy. http://archive.li/HgN77. Accessed December 18, 2018.
2. Buczkowski E, Handunge V, Crimp WR. *The Complete Guide to OPPE – Strategies for Medical Staff Professionals, Physician Leaders, and Quality Directors*. Danvers, MA: HCPro, Inc.; 2011. Page 20.
3. Gallegos A. Challenges to peer review confidentiality rising. *American Medical News*. May 28, 2012.
4. Ibid.
5. Marder RJ. *Effective Peer Review: The Complete Guide to Physician Performance Improvement.* Third Edition. Danvers, MA: HCPro, Inc.; 2013. Page 7.
6. Ibid.
7. Ibid.
8. Lawson RH, Lewis NB, Blanchard CJ, Ryan E. *Credentialing and Peer Review of Health Care Providers: The Process and Protections*. Carrington Coleman. April 19, 2012.
9. U.S. Department of Health and Human Services, Health Resources and Services Administration. *Fact Sheet on Section 1921*. NPDB-00930.06.02. June 2012.

10. The Joint Commission. *Accreditation Requirements – Hospital Program*. Oakbrook Terrace, IL: The Joint Commission, Joint Commission Resources; Effective January 1, 2019, Standard MS.06.01.05, Elements of Performance 7.
11. Carroll R (Series Ed.) Troyer GT (Volume Ed.). *Risk Management Handbook for Healthcare Organizations*. Sixth Edition, Volume 3: Business Risk. San Francisco, CA: John Wiley & Sons, Inc.; 2011. Page 30.
12. U.S. Department of Health and Human Services, Health Resources and Services Administration. *NPDB Guidebook*. October 2018. Page E-20. Available at: https://www.npdb.hrsa.gov/resources/NPDBGuidebook.pdf
13. U.S. Department of Health and Human Services. Understanding patient safety confidentiality. https://www.hhs.gov/hipaa/for-professionals/patient-safety/index.html. Accessed December 18, 2018.
14. U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ). Patient safety organization (PSO) program – frequently asked questions. https://pso.ahrq.gov/faq. Accessed December 18, 2018.
15. U.S. Department of Health and Human Services. Patient safety and quality improvement: final rule. *Federal Register*. 73(226). Friday, November 21, 2008. Page 70798, https://www.govinfo.gov/content/pkg/FR-2008-11-21/pdf/E8-27475.pdf, Accessed December 18, 2018.
16. O'Connell A. *Working with CHPSO: Navigating Privileges, Protection and Reporting Requirements*. Teleconference Presentation. August 6, 2009. Slide 9. Available at: http://www.nossaman.com/files/23777_AHO_CHPSO%20Teleconference_8.6.09.pdf
17. U.S. Department of Health and Human Services. Patient safety and quality improvement: final rule. Pages 70782-70783.
18. Gallegos A.
19. Ibid.
20. Ibid.
21. Law 360. Preempting state law to protect patient privilege. https://www.law360.com/articles/352261/preempting-state-law-to-protect-patient-privilege. July 18, 2012. Accessed December 18, 2018.
22. Ibid.
23. The Greeley Company. *Managing Disruptive Behavior: Balancing Patient Safety with the Rights and Dignity of Physicians*. White Paper. Danvers, MA: The Greeley Company; April 2015. Page 3.
24. Marder RJ. Pages 56-57.
25. Ibid. Page 57.
26. Ibid.
27. The Joint Commission. Behaviors that undermine a culture of safety. *Sentinel Event Alert*. Issue 40. July 9, 2008.
28. National Peer Review Corporation. *Hospital Peer Review Guide III: Handling the Disruptive Physician*. Northbrook, IL: National Peer Review Corporation; 2011.
29. The Greeley Company. Page 4.
30. National Peer Review Corporation. Page 17.
31. Ibid.
32. Federation of State Medical Boards (FSMB). *Policy on Physician Impairment*. Adopted as policy by the House of Delegates of the Federation of State Medical Boards April 2011. Page 7.

Available at: https://www.fsmb.org/media/default/pdf/fsmb/advocacy/grpol_policy-on-physician-impairment.pdf
33. Federation of State Physician Health Programs (FSPHP). History. https://www.fsphp.org/history. Accessed December 18, 2018.
34. Ibid.
35. Roberts A. *Legal Strategies for MSPs & Physician Leaders – Prevent Negligent Credentialing and Protect Review*. Danvers, MA: HCPro, Inc.; 2012. Page 105.
36. The Joint Commission. *Accreditation Requirements – Hospital Program*. Standard MS.08.01.01.
37. Roberts A. Page 61.
38. *Gordon v. Lewistown Hospital*. 423 F.3d 184 (3rd Cir. 2004).
39. 42 USC §11112(c)(1)(B).
40. 42 USC §11112(c)(2).
41. Ibid.
42. 42 USC §11112(b)(3).
43. H.R. Rep. No 99-903 at 10, reprinted in 1986, U.S.C.C.A.N. at 6393. As quoted in *Gordon v. Lewistown Hospital*. 423 F.3d 184 (3rd Circ. 2004).
44. 42 USC §11137(c).
45. The Joint Commission. *Accreditation Requirements – Hospital Program*. Standard MS.08.01.03.
46. Ibid.
47. 42 USC §11112(a).
48. Carroll R (Series Ed.) Troyer GT (Volume Ed.). Page 29.
49. ECRI Institute. New federal patient safety initiative launched for providers. *Healthcare Risk Control Special Advisory*. July 2009.
50. U.S. Department of Health and Human Services. Patient safety and quality improvement: final rule. Pages 70782-70783.
51. National Peer Review Corporation. Page 1.
52. The Joint Commission. *Accreditation Requirements – Hospital Program*. Standard MS.08.01.01.
53. Ibid. Standard MS.08.01.03
54. Ibid. Standard MS.06.01.01
55. Ibid. Standard MS.05.01.01
56. Ibid. Elements of Performance for Standard MS.05.01.03
57. Neff KE. Understanding and managing physicians with disruptive behavior. In: American College of Physician Executives (ACPE). *On Target – Managing Disruptive Physician Behavior*. Tampa, FL: ACPE; Pages 50-51. Available at: https://www.quantiamd.com/q-qcp/OnTargetDisruptivePhysician.pdf
58. Weber DO. For safety's sake disruptive behavior must be tamed. In: American College of Physician Executives (ACPE). *On Target – Managing Disruptive Physician Behavior*. Tampa, FL: ACPE; Page 20 Available at: https://www.quantiamd.com/q-qcp/OnTargetDisruptivePhysician.pdf
59. Neff KE. Appendix 2: managing physicians with disruptive behavior – checklist of steps. In: American College of Physician Executives (ACPE). *On Target – Managing Disruptive Physician Behavior*. Tampa, FL: ACPE; Pages 72-76. Available at: https://www.quantiamd.com/q-qcp/OnTargetDisruptivePhysician.pdf
60. National Peer Review Corporation. Page 17.

61. American Medical Association (AMA). Chapter 9: opinions on professional self-regulation. In: *2016 AMA Code of Medical Ethics*. Available at: https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-9.pdf
62. Ibid.
63. The Joint Commission. *Accreditation Requirements – Hospital Program*. Elements of Performance for Standard MS.11.01.01
64. Roberts A. Page 107.
65. Ibid. Page 111.
66. The Joint Commission. *Accreditation Requirements – Hospital Program*. Standard MS.08.01.01, Element of Performance 3.
67. 42 USC §11112(a).
68. Garner BA. *Black's Law Dictionary*. (Abr. 10th Ed.). St. Paul, MN: Thomson-West Publishing; 2014.
69. 42 USC §11112(b)(1).
70. Ibid.
71. 42 USC §11112(b)(3)(b).
72. 42 USC §11112(b)(2).
73. Ibid.
74. Ibid.
75. 42 USC §11112(b)(3)(A).
76. 42 USC §11112(b)(3)(C).
77. 42 USC §11112(b)(3)(D).
78. H.R. Rep. No 99-903 at 10, reprinted in 1986 U.S.C.C.A.N. at 6393.
79. 42 USC §11133(a)(1)(A).
80. 42 USC §11133(a)(1)(B)(i) and (ii).