

Peer review process

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Introduction

Patient safety and quality medical care are the central focuses underlying all Fallon Health peer review activities. All peer reviews are conducted using evidence-based guidelines, when available, or practice parameters developed by national medical specialty societies, which have been vetted and approved locally when feasible.

Peer review may be intensified in response to the circumstances of a single case, or the review may examine broader trends in the performance of systems and/or processes of delivery. If incident based, the review should ensure that principles of fairness and due process are afforded by any practitioner involved. Since the demarcation between quality improvement and corrective action can be problematic, strong effort must be focused to achieve the goal of quality improvement, while being objective, fair, transparent and credible.

A peer review to examine system issues should result in suggestions for system improvement. Such efforts to ensure the preservation of quality care activities are an important function of the Peer Review Committee, separate from individual practitioner review. Such review should be based on appropriateness, medical necessity and efficiency of services to assure quality medical care.

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Steps in the Peer Review Process

These policies and procedures shall be applicable for all practitioners credentialed by Fallon Health including, but not limited to, MDs, DOs, Oral Surgeons, Dentists, DPMs, DCs, optometrists, psychologists, practitioner assistants, nurse practitioners and nurse midwives.

1. Case Identification and Initial Review

All cases identified as quality of medical care issues are reviewed through the organization's Peer Review Process. The Peer Review Process is coordinated by Fallon Health Quality Programs department. Cases identified with quality-of-care issues are referred to the department for case review. Such cases may be identified through member services, concurrent review, case management, risk management, audits, sentinel events, clinician referrals, allegations of substance abuse and other sources. Any clinical quality issue regarding patient care will be initially reviewed by a nurse in the Quality Programs department with oversight from a Fallon Health Medical Director. The nurse will retrieve all pertinent medical information regarding the case in question and will enter this information into a database. If there are no quality-of-care issues identified following this quality management review, the case is closed, the findings are documented, and tracking/trending is performed in the Quality Programs department. Results of peer review cases concerning medical care complaints are tracked for individual practitioners and incorporated into the practitioner's re-credentialing process.

2. Responsibilities of Peer Review Committee and Chairman

Cases requiring further evaluation for clinical quality issues are referred to the Chair, Peer Review Committee for further review and for grading of the severity of the alleged substandard care, utilizing the protocol identified as Attachment QM-007 (page 11). Cases resulting in minor or temporary negative consequences for the member, graded as Level 1 or 2, may be handled by the Peer Review Committee Chairman without formal convocation of the Peer Review Committee, following the guidelines specified in the Fallon Health Procedure for Peer Review Corrective Action Program (page 8).

Cases graded as Level 3 or higher severity are referred to the Peer Review Committee for an informal review. The Peer Review Committee is a practitioner peer review group that includes the Chief Medical Officer, Medical Directors and contracted specialist practitioners on an ad hoc basis, as appropriate for the specific specialty care review (Attachment QM-008, page 12). All relevant information should be obtained promptly and then made available to the subject practitioner. After the information has been obtained, the issues should be discussed with the

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subject practitioner, and alternative courses of action should be considered before proceeding to the formal Peer Review Process. The Health Care Quality Improvement Act (HCQIA) of 1986 was enacted to encourage practitioners to participate in peer review committees by granting limited immunity from civil liability (claims from monetary damages). HCQIA is codified in Section 11101 et seq. of Title 42 of the United States Code. HCQIA also established a national reporting system (National Practitioner Data Bank) intended to restrict the ability of incompetent practitioners to move from state to state, by requiring disclosure of the practitioner's previous disciplinary or peer review action.

3. Formal Peer Review Committee Process

The practitioner under review must receive appropriate notice of the hearing. Written notification of the date, time and place of the hearing as well as the composition of the hearing panel, shall be sent to the practitioner under review within fifteen (15) calendar days of the Peer Review Committee's decision to move to a formal process. The hearing must be held before an arbitrator, hearing officer or hearing panel not in direct economic competition with the practitioner involved. In the hearing, the accused practitioner is entitled to representation by an attorney, to a record of the proceedings, to call, examine, and cross-examine witnesses, to present relevant evidence, regardless of its admissibility in a court of law, and to submit a written statement at the close of the hearing. Upon completion of the hearing, the practitioner has the right to receive the written recommendation of the arbitrator, hearing officer, or the hearing panel and the right to receive a written decision from the health care entity. The recommendation and the decision are to include the basis for the conclusions reached. The practitioner shall be informed of the decision of the Peer Review Committee within ten (10) days of the hearing. This decision will be sent via certified mail.

Certain of the procedural protections can be relaxed in the event of a threatened health care emergency. A hearing is not required in the case of a suspension or restriction of clinical privileges for a period not longer than fourteen (14) days, during which an investigation is conducted to determine the need for a professional review action. Clinical privileges can be immediately suspended or restricted where the failure to take such action may result in an imminent danger to the health of an individual, provided that the practitioner receives subsequent notice and the right to a hearing or other procedures.

Direct economic competitors of the subject practitioner are barred from serving on the peer review panel. The Peer Review Committee may also choose to obtain an external expert opinion for specialty review. The Peer Review Committee will summarize its findings and make written recommendations regarding the outcome of the review process, including suggested corrective actions.

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Corrective actions will be selected appropriately for the level of severity, as specified in the Fallon Health Procedure for Peer Review Corrective Action Program (page 8).

The finding and recommendations from the Peer Review Committee shall be communicated to the individual contracted practitioner if the care reviewed was identified as sub-standard. Such communication shall be by certified mail, sent within ten (10) days of the Peer Review Committee action. Information will also be filed in the practitioner's credentialing files and reviewed at the time of the practitioner re-credentialing process. The Chief Medical Officer or his/her designee will then be responsible for relaying the findings of the Peer Review Committee to the practitioner in question, with implementation of the Corrective Action Program. Documentation of this counseling and corrective action shall then be relayed back to the Peer Review Committee for inclusion in the case file.

4. Documentation of Activities

All results of evaluation of medical care by the Peer Review Committee are documented in confidential minutes, and the documentation is secured in the Quality Programs department. Final reviews by external practitioner experts or the Peer Review Committee are also tracked in the clinical quality database. All medical peer review results shall remain confidential and shall not be subject to subpoena or discovery in compliance with Massachusetts General Laws, Chapter 111 Sections 1, 203, 204 and 205. Evaluation of practitioner-specific medical care is not shared with other departments, patients, patient families, external agencies or other committees, except for the Credentials Committee, and the Board of Registration in Medicine, as required by statute. The Chief Medical Officer may decide to follow up with member complaints on medical quality directly with members or delegate a Medical Director to follow up with complaint resolution. Results of peer review activities are not shared during these communications.

5. Appeal Rights

Within ten (10) days of receipt of the decision, the practitioner under review has the right to request an appeal from the Peer Review Committee. The request must be in writing and shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for the appeal shall be:

- a) Substantial non-compliance with the procedures of the Peer Review Committee;
- b) Insufficient evidence in the hearing record to support the decision.

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The Fallon Health Board of Directors' Service and Quality Oversight Committee (SQOC) will sit as the appeal board. The Fallon Health Board of Directors' SQOC will convene for the appeal hearing within thirty (30) days of receipt of the written request from the practitioner under review. Then Fallon Health Board of Directors' SQOC will review the appeal request and any other material it deems relevant and will recommend to the Peer Review Committee whether the Peer Review Committee should affirm, modify or reverse the original finding and recommendations. After Review of the Fallon Health Board of Directors' SQOC recommendation, the Peer Review Committee will issue a determination. This decision shall be considered final.

6. Reporting to Credentials Committee and Massachusetts Board of Registration in Medicine

Minutes of the Peer Review Committee are not shared with other quality committees except for the Credentials Committee. The Chief Medical Officer or his/her designee may also share with the Clinical Quality Improvement Committee and the Fallon Health Board of Directors' SQOC to identify opportunities and report quality issues. The Fallon Health Board of Directors' SQOC has the responsibility to make recommendations and revise policies that have a direct impact on members' medical care and services. A summary of the Peer Review Committee activities shall be presented quarterly to the Clinical Quality Improvement Committee (CQIC), to include documentation of trends by health care option and level of severity, and status reports regarding corrective action plans, as part of the Peer Review Process.

The Peer Review Committee shall also send notice to the Credentials Committee documenting the occurrence of all peer reviewed cases regarding a specific practitioner. The detailed findings of the Peer Review Committee shall be made available to the Credentials Committee on request, after the Committee has been notified of the Peer Review Committee findings. Results of the Peer Review Committee are not released to the Member Relations Department or any other intramural or extramural department, except for the Massachusetts Board of Registration in Medicine, for those cases rated as Level 3 or higher severity which result in a Corrective Action Program that includes any of the following: mandatory CME; written admonition, proctoring, change in credentialed status or privileges, resignation, or termination.

7. Additional Corrective Action

Additional corrective actions may also be implemented by mutual agreement of the supervising practitioner (as defined in the Correction Action Program section,

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page 8) and the Peer Review Committee Chairman, with recognition given to recurrent events and trends documented for the practitioner in question. When feasible, the corrective action should include terms that permit measurement and validation of the completed remediation process. In the case of a practitioner with a documented substance abuse problem, one of the required corrective actions shall be referral to an approved substance abuse treatment program, such as the Physician Health Service (PHS) program of the Massachusetts Medical Society, with documentation of ongoing compliance with such a program. A practitioner's health and impairment issues should be identified and managed separately from the disciplinary process.

8. Credentials Committee

The Credentials Committee, based on findings of the Peer Review Committee, may take action to reduce, suspend or terminate a practitioner's credentialing privileges. Because such action is based on acceptable corrective action established by the Peer Review Committee, it shall be deemed consequent to the original action of the Peer Review Committee, and not subject to a second and separate appeal process.

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Corrective Action Program

1. Problem Identification

All substandard clinical care identified through the Fallon Health Peer Review Process and Quality Programs shall be categorized by severity in accordance with the Peer Review Policy and Procedures. Problems identified shall include both acts of commission and omission, deficiencies in the clinical quality of care, and any instances of practitioner impairment documented to be a result of substance abuse.

2. Corrective Actions

Following a determination by the Peer Review Committee that a practitioner has rendered sub-standard care, the Committee will recommend a list of acceptable corrective actions appropriate to the severity of the substandard care, using the guidelines identified as Attachment QM-009 (page 13), in support of their recommendations. The final recommendations of the Committee may also take into consideration other pertinent quality data regarding the practitioner in question, including but not limited to the following:

- Trended patient complaints specific to that practitioner during the previous two years.
- Additional quality reviews specific to that practitioner, documented in the Quality & Health Services Department.
- Any data or quality metrics maintained by a state or federal agency.
- Any patient and peer satisfaction survey results specific to that practitioner during the previous two years.
- For primary care practitioners, data from the prior two years summarizing the frequency of patient requests to change to a different PCP because of dissatisfaction with the practitioner.
- Any credentials file information documenting current limitations of clinical privileges or disciplinary actions, current or past substance abuse or mandated treatment for same, and records of malpractice proceedings.

3. Supervising Practitioner

The recommendations for corrective action shall be implemented by a practitioner in the Fallon Health provider network who is directly accountable for the clinical supervision of the practitioner in question. In the case of a Reliant Medical Group or UMass Memorial Health practitioner, the supervising practitioner shall be the

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department chief. In the case of a department with subdivisions and with the approval of the department chief, the division chief may also be designated as the supervising practitioner.

If neither the department chief nor the division chief is an appropriate designee because of their personal involvement in the care of the patient in question, then the group's medical director or associate medical director for clinical quality will function as the supervising practitioner.

In the case of a Fallon Health contracted practitioner who is not directly accountable to any department or division chief, the Peer Review Committee may consider other alternatives, such as the hospital Vice President of Medical Affairs, Chief of Medical Staff, or other Fallon Health contracted practitioner to function as the supervising practitioner.

4. Implementation of Corrective Action Plan

The supervising practitioner shall, in each case, review personally with the practitioner in question the results of the Peer Review Committee. The supervising practitioner shall also establish with the practitioner in question the Corrective Action Plan, using as a guideline the specific recommendations of the Peer Review Committee. The supervising practitioner shall notify the chairman of the Peer Review Committee confirming the completion of a feedback session with the practitioner in question, as well as the agreed upon Corrective Action Plan and a timetable for its accomplishment.

It is the responsibility of the chairman of the Peer Review Committee, working with the supervising practitioner, to document that the Corrective Action Plan has been implemented in accordance with the specific timetable. If the Corrective Action Plan is not implemented within the specified timetable, the chairman of the Peer Review Committee shall request from the supervising practitioner a written summary of any explanations for the failure to complete the Corrective Action Plan (practitioner termination, practitioner illness, etc.) as well as a revised timetable. If the explanations offered are not acceptable, or if the revised timetable also results in non-compliance, then the chairman of the Peer Review Committee shall recommend to the Credentials Committee appropriate alteration of the practitioner's clinical privileges, commensurate with the severity of the substandard care. Such alteration may include a probationary status for low-risk deviations from the standard of care (severity Level 1 or 2), as well as more aggressive restriction of privileges, up to and including termination for substandard care graded as severity Level 4 or 5.

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5. Oversight of Corrective Actions and Peer Review Activities

The Peer Review Committee shall report quarterly to the Fallon Health CQIC, including a summary activity by health care option, and a status report regarding all Corrective Action Plans. Peer review activities which identify practitioners who are impaired by virtue of substance abuse shall also be reported to the Massachusetts Board of Registration in Medicine and the Massachusetts Medical Society's Physician Health Services Program. Practitioners whose privileges are suspended, altered or revoked shall also be reported by the Credentials Committee to the National Practitioner Databank and to the Massachusetts Board of Registration in Medicine.

6. Distribution of Minutes and Notice Regarding Peer Review Committee Meetings

Minutes of the Peer Review Committee shall be distributed to the Credentials Committee, documenting the occurrence of a peer review meeting regarding a specific practitioner, with a notice also to the Appeals & Grievances Department if the case in question originated as a complaint to that department. The detailed findings of the Peer Review Committee shall be made available to the Credentials Committee upon request but shall not be released to the Appeals & Grievances Department or any other intramural or extramural department, in keeping with Massachusetts General Laws, which confirm the protected and confidential nature of all peer review activities.

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Attachment QM-007 - SEVERITY RATING FOR ADVERSE CLINICAL EVENTS

Note: Cases with relatively minor negative consequences for the member may require upgrading to a higher level of substandard care if the potential hazard to the member was clearly severe.

<i>Category 0</i>	No substandard care. No identifiable patient injury.
<i>Category 1</i>	Minor substandard care with benign consequences for the patient requiring no specific treatment or intervention.
<i>Category 2</i>	Moderate substandard care with modest clinical intervention required to reverse or treat the condition. No hospitalization or invasive therapy required (excepting routine venipuncture).
<i>Category 3</i>	Serious substandard care with temporary impairment. Aggressive medical intervention required to treat or reverse the condition. May involve hospitalization or invasive corrective therapy. No permanent irreversible patient disability attributable.
<i>Category 4</i>	Serious substandard care with permanent patient impairment. Irreversible injury or serious impairment resulting from substandard care. May involve loss of limb or permanently impaired bodily function.
<i>Category 5</i>	Fatal substandard care with death directly related to the clinical misadventure. This may involve acts of commission as well as acts of omission.

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Attachment QM-008 - PEER REVIEW COMMITTEE MEMBERSHIP

Permanent members:

- Fallon Health Chief Medical Officer (Chairman, may delegate to a medical director)
- Fallon Health Medical Directors

Ad Hoc Members - Chosen by the Committee Chairperson

Fallon Health Specialty Practitioner (May be external consultant practitioner)

Ex-officio members:

Fallon Health Vice President of Quality and Population Health, the Director of Quality and a notetaker.

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Attachment QM-009 - APPROPRIATE CORRECTIVE ACTION OPTIONS BY LEVEL OF SEVERITY OF SUBSTANDARD CARE

Note: Cases with relatively minor negative consequences for the member may require upgrading to a higher level of substandard care if the potential hazard to the member was clearly severe.

	Description	Acceptable Corrective Actions
Level I Minor Severity	Temporary negative consequences for member not requiring corrective medical treatment.	<ul style="list-style-type: none"> • Practitioner counseling • Targeted CME requirement • Probationary status, time limited with outcomes monitoring. • CME presentation by practitioner.
Level II Moderate Severity	Temporary negative consequences for member, corrective medical treatment required, not including hospitalization or invasive intervention.	As for Level I, plus: <ul style="list-style-type: none"> • Clinician mentor relationship for specific medical problems, possibly including but not limited to mandatory consultation or second opinions for specified medical conditions.
Level III Serious Severity	Temporary negative consequences for member, possibly including invasive treatment or hospitalization.	As for Levels I & II plus: <ul style="list-style-type: none"> • Limitation of clinical privileges, pending documentation of improved outcomes and/or specific CME.
Level IV Serious Severity	With permanent negative consequences for member, including permanent disability and/or disfigurement.	As for Levels I, II, & III plus: <ul style="list-style-type: none"> • Loss of clinical privileges and revocation of contract, depending also on mitigating circumstances and other trends regarding substandard quality performance for the practitioner in question.
Level V	Fatal substandard care with death directly related to clinical acts of commission or omission.	As for Level IV plus: <ul style="list-style-type: none"> • Loss of clinical privileges and revocation of contract.