UC San Diego Health

This policy applies to: UCSD Health	Last Approval Date: 08/26/2025
Name of Policy: **Medical Staff Peer Review**	**Page 1 of 8**
Policy Number: MSP 029	
Departments Affected: All Departments	

PURPOSE: The Medical Staff Executive Committee (MSEC) and the members of the UCSDH Medical Staff (Medical Staff) are responsible for the quality of care provided to the patient population throughout UCSDH. The purpose of peer review is comprehensive, unbiased review by the Medical Staff and Medical Staff Committees of patient care, with the intent of insuring quality and patient safety, monitoring and evaluating practitioners' professional practice and identifying areas requiring improvement. At UCSDH, peer review includes review of both Members and APPs (Practitioners) who are exercising their Clinical Privileges.

To ensure that the organization, through the activities of its Medical Staff, assesses the Ongoing Professional Practice Evaluation ("OPPE") of Practitioners granted Clinical Privileges and uses the results of such assessments to improve care and, when necessary, performs Focused Professional Practice Evaluations ("FPPE").

Goals:

1. Monitor and evaluate the OPPE of Practitioners with Clinical Privileges;
2. Create a performance improvement focused culture for peer review by recognizing Practitioner excellence, as appropriate, as well as identifying improvement opportunities;
3. Recommend and collaborate with MSEC for FPPE when potential Practitioner improvement opportunities are identified;
4. Promote efficient use of Practitioner and quality staff resources;
5. Provide accurate and timely performance data for Practitioner feedback, OPPE, FPPE, and reappointment;
6. Support Medical Staff educational goals to improve patient care;
7. Provide a link with the UCSDH performance improvement structure to assure responsiveness to system improvement opportunities identified by the Medical Staff; and
8. Assure that the process for peer review is clearly defined, fair, defensible, timely, and useful.

PROCEDURE:

Peer Review Procedures

A. Information Management

1. All peer review information is privileged and confidential in accordance with Medical Staff Bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.

2. The involved Practitioner will receive Practitioner-specific feedback on a routine basis.

3. The Medical Staff will use the Practitioner-specific peer review results in making its recommendations to the Executive Governing Body ("EGB") regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.

4. Any written documents that the Medical Staff determines should be retained related to Practitioner-specific peer review information will be kept by UC San Diego Health in a secure, locked file (physically or electronically) in Medical Staff Administration. Other peer review related documents will be maintained securely within UCSDH's Peer Review management software. Practitioner-specific peer review information may include:
    a. *Individual case review findings:* The final ratings of the QRC, East Campus Medical Staff Council ("ECMSC") or PCPRC and any written correspondence with the Practitioner including letters of inquiry, Practitioner responses, commendations, improvement opportunities, or corrective action.
    b. *Aggregate practitioner performance data:* Practitioner-specific data for all of the general competencies measured for that Practitioner and any written correspondence with the practitioner including letters of inquiry, Practitioner responses, commendations, improvement opportunities, or corrective action.
    c. *Peer review data retention:* Peer review data will be retained for a period of time as determined by UCSDH policy after the most recent reappointment of the Practitioner. Information related to formal investigations and corrective actions will be retained indefinitely.

5. Electronic Practitioner-specific peer review documents or data will be retained in secure electronic files with access limited to the appropriate individuals defined below.
    - Peer review information in a Practitioner's quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities. The President of the Medical Staff (POMS) and/or Director of Medical Staff Administration, or their designees, will assure that only authorized individuals have access to individual practitioner files and that the files are reviewed under the supervision of the individuals noted in the Credentials Policy.

6. No copies of peer review documents will be created or distributed unless authorized by Medical Staff policy or Bylaws, the MSEC, or the EGB.

B. Internal Peer Review (IPR)

1. **Circumstances:** IPR is conducted by the Medical Staff using its own Members as the evaluation source of Practitioner performance. It is performed as part of OPPE and reported to the appropriate committee for review and action. The procedures for conducting IPR for an individual case and for aggregate performance measures are described below.

2. **Participants:** Participants in the review process will be selected according to the Medical Staff policies and procedures as described in Attachments A and C.

3. **Conflict of Interest Procedure**: It is the obligation of a QRC, ECMSC, or PCPRC member to disclose to the QRC, ECMSC, or PCPRC any Conflict of Interest. Committee members must identify any Conflict of Interest relating to a particular subject matter when that subject is discussed by the committee. Prior to participation in any discussion and/or vote regarding the issue, the member shall confer with the committee Chair to discuss the Conflict of Interest and determine what actions, if any, are necessary to address the Conflict. The member may recuse themselves from any discussion or action that may be impacted by the Conflict of Interest. Additionally, the Chair or members of the committee may request that the member recuse themselves. To the extent the committee members request that the individual member recuse themselves, a majority vote of the voting members is required to mandate the recusal.

   In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, a combination of the POMS, PCPRC Chair, and QIR will meet to determine who will participate in the process so that bias does not interfere in the decision-making process.

4. **Performance Measurement and OPPE/FPPE**

   a. ***Selection of Practitioner Performance Measures***
   Measures of Practitioner performance will be selected to reflect the six general Practitioner Competencies using the multiple sources of data. The PCPRC, in conjunction with the SQIRs/QIRs, East Campus Representatives, and Service Chiefs, will develop indicators for peer review. Copies of the current indicators will be maintained by the Quality and Patient Safety Department and any changes will be presented to MSEC and EGB on a quarterly basis.

   b. ***Individual Case Review***
   Case review will be conducted based on review indicators determined by the Medical Staff. Case review will be conducted in a timely manner with the goal of routine cases to be completed within 30 days from the date the chart is reviewed by the Quality Management staff and complex cases to be completed within 90 days. Exceptions may occur based on case complexity or reviewer availability. If a case review is not complete within 90 days, the Chair of the PCPRC will be notified and will work with the SQIR to ensure the case review is expedited. If the review is not complete within 120 days, the Chair will notify the President of the Medical Staff, including a description of why the case review has not been completed. The President of the Medical Staff will take any

action, as they deem appropriate, to ensure that the case is appropriately and expeditiously reviewed.

The procedure and timelines for this process are described in Attachment C. The rating system for determining results of individual case reviews is described in the Case Review Rating Form (Attachment D). Both Members and APPs (Practitioners) will have their care reviewed as part of the individual case review process.

c. Indicator Data Evaluation for Ongoing Professional Practice Evaluation (OPPE)
The evaluation of Practitioner performance measures from either the results of case reviews, or by rate or rule indicators will be conducted on an ongoing basis by Division Chiefs, Service Chiefs, QRCs, EC Representatives, the ECMSC, the Credentials Committee, and/or the MSEC based on information received from the QRCs, ECMSC, or PCPRC as described in the OPPE/FPPE policy.

d. Thresholds for Focused Professional Practice Evaluation (FPPE)
If the results of OPPE indicate a potential issue with practitioner performance, the Division Chief, Service Chief, ECMSC, or Credentials Committee may recommend FPPE. The thresholds for FPPE are described in the acceptable targets for the Medical Staff indicators. However, a single egregious case may initiate the need for a focused review. FPPE may also be authorized as described in OPPE/FPPE policy.

e. ***Multidisciplinary Review***
When multiple Services are involved in the same matter that is under review in a case before the PCPRC, the Chair of the PCPRC may appoint a multidisciplinary review team to perform a synchronized review. The Chair may designate the SQIR, or other Medical Staff Officer, Service Chiefs, or Division Chiefs, to participate in on the review team. The review will be presented in the same manner as an individual case review.

f. Cases Reviewed By the Significant Events Committee
If the UCSDH Significant Events Committee or Sentinel Event Committee refers a case to peer review, that case will be presented by the SQIR at PCPRC, regardless of the recommendation by the SQIR and/or Committee.

C. External Peer Review (EPR):

1. **Circumstances:** Pursuant to the Medical Staff Bylaws, circumstances for EPR may include but are not limited to the following:

- When a committee or Service performs a review(s) that could affect a Practitioner's Membership or Privileges, and in the committee or Service's view, would benefit from external input or expertise in the clinical procedure(s) or area(s) under review;
- When no current Practitioner can provide the necessary expertise in the clinical procedure or area under review;
- To help promote an impartial peer review; or
- As deemed necessary by the MSEC or the President of Medical Staff (POMS)

2. **Authorization:** Either the MSEC or POMS will make determinations on the need for EPR. No Practitioner can require UCSDH obtain EPR if it is not deemed appropriate by the determining bodies indicated above. Similarly, the Practitioner under review cannot determine the specific external reviewer or review organization. The results from EPR will not be considered definitive for purposes of Medical Staff peer review until the report is reviewed by the appropriate Medical Staff body or its designee.

   If EPR is obtained by UCSDH Risk Management outside of the Medical Staff peer review process it will be potentially available to the Medical Staff, if it would not affect any privilege for concerns regarding potential or actual litigation. The appropriate Medical Staff body will determine if it wishes the findings to be used in the peer review process. If EPR is obtained by the Medical Staff for purposes of peer review, such reviews are protected from discovery under peer review statutes.

3. **Review:** Once the results of EPR are obtained, the report will be reviewed by the body who requested it. If improvement opportunities exist as determined by the reviewing body, they will be handled through the same mechanism as IPR unless the issue is already being addressed in a corrective action process.

4. **Practitioner Involvement**: The POMS and/or the MSEC, in its sole discretion, will determine the nature of the involvement for the Practitioner under review, including whether the Practitioner will be made aware of the EPR. At the sole discretion of the MSEC, the Practitioner may be given a copy of the report and/or an opportunity to provide input regarding its findings prior to the committee's final decision.

D. Oversight and Reporting

The oversight of the peer review process is described in the QRC charter (Attachment A), the PCPRC charter (Attachment A1), and the East Campus Medical Staff Peer Review Subcommittees (Attachment A2).

E. Statutory Authority

This policy is based on the statutory authority of Business and Professions Code Section 805 *et seq*., Section 809 *et seq*., Evidence Code Section 1157, the Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, *et seq*. and any other applicable Federal and California statutes and case law. All peer review conducted under this policy is subject to any available peer review privilege(s) and immunities provided under both state and federal law.

All minutes, reports, recommendations, communications and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities. Documents, including minutes and case review materials, prepared in connection with this policy, should be labeled consistent with the following language:

"Privileged & Confidential--Protected by California law, including, but not limited to Evidence Code Section 1157"

DEFINITIONS:

Peer review: The process employed to review the basic qualifications, Privileges, medical outcomes, or professional conduct of Practitioners in order to assess and improve the quality of care rendered by Practitioners and, when appropriate, to determine whether the Practitioners may practice or continue to practice at UCSDH, and, if so, to determine the parameters of that practice.

Ongoing Professional Practice Evaluation (OPPE): The routine monitoring of the current competency of Practitioners who have been granted Privileges. As part of OPPE, data is collected for the purpose of assessing each Practitioner's clinical competence and professionalism.

Focused Professional Practice Evaluation (FPPE): The process used to evaluate, for a time-limited period, a specific Practitioner's clinical performance and/or professionalism. FPPE may include an evaluation of a Practitioner's quality of care, patient safety, and/or professionalism.

Peer Review Body: The committee designated by the MSEC to conduct the review of individual Practitioner performance for the Medical Staff. The peer review body will be the QRC as described in the QRC Charter (Attachment A), the Patient Care and Peer Review Committee (PCPRC) as described in the PCPRC Charter (Attachment A1) and the and the East Campus Medical Staff Peer Review Subcommittees as described in the EC Medical Staff Peer Review Subcommittees Charter (Attachment A2) unless the MSEC designates another entity for specific circumstances. Members of the peer review body may render judgments of Practitioner performance based on information provided by individual reviewers with appropriate subject matter expertise.

Peer: A Member of the Medical Staff, or an Advanced Practice Professional (APP), who has the appropriate expertise to evaluate the Practitioner competency issue under review. This may include a Practitioner from another specialty who has training experience and knowledge of the subject matter. The level of subject matter expertise required will be determined on a case-by-case basis related to the nature of the issues under review. For the evaluation of APPs with delineated privileges, a physician with equivalent or greater privileges is considered a peer for purposes of Medical Staff evaluation.

Advanced Practice Professional (APP) means an individual, other than a licensed physician (M.D. or D.O.), dentist, clinical psychologist, or podiatrist, who exercises independent judgment within the areas of their professional competence and the limits established by the Executive Governing Body, the Medical Staff, and the applicable state practice act, who is qualified to render direct or indirect medical, dental, or podiatric care under the supervision or direction of a Member possessing Privileges to provide such care at UCSDH in conformity with the Bylaws, Policies, Plans, and Rules. The following categories of professionals have been designated as APPs eligible for Privileges at UCSDH: Certified Registered Nurse Anesthetist (CRNA); Certified Nurse-Midwife (CNM); Nurse Practitioner (NP); Physician Assistant (PA); Clinical Genetics Counselor; and Naturopathic Doctor (ND).

Practitioner means, unless otherwise expressly limited, any currently licensed physician (M.D. or D.O.), dentist, clinical psychologist, podiatrist, or Advanced Practice Professional (APP).

Peer Review Data: Data sources may include case reviews and aggregate data based on review, rule and rate indicators in comparison with generally recognized standards, benchmarks or norms. The data may be objective or perception-based (*e.g.* incident reports, patient satisfaction survey data) as appropriate for the competency under evaluation.

Practitioner Competencies: The six general Practitioner Competencies for evaluation are as follows:

- Patient Care
- Medical Knowledge
- Interpersonal and Communication Skills
- Professionalism
- Systems Based Practice
- Practice Based Learning and Improvement

Conflict of Interest: Every committee member, regardless of whether the person serves as an *ex officio* member, must disclose any Conflict of Interest. Committee members will be required to disclose in writing to the MSEC, those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a Conflict of Interest with their activities or responsibilities on behalf of the Medical Staff and/or committee.

A Member of the Medical Staff requested to perform peer review may have a Conflict of Interest if they may not be able to render an unbiased opinion. For purposes of this Policy, Conflicts of Interest may include, but are not limited to, being: 1) the provider under review, 2) a relative, by consanguinity or affinity, of the provider under review, or 3) a current/former spouse or civil union/domestic partner of the provider under review.

FORMS:

CASE REVIEW RATING FORM (ATTACHMENT C) – *TO BE USED ONLY IF ELECTRONIC APPLICATION IS UNAVAILABLE*

REFERENCES/RESOURCES/RELATED DOCUMENTS:

NONE

ATTACHMENTS:

Attachment A – QRC Charter
Attachment A1- EC MS PR Subcommittee Charter
Attachment A2 – PCPRC Charter
Attachment B – Case Review Process
Attachment B1 – Case Identification Flow Diagram
Attachment B2 – Case Review Flow Diagram
Attachment C – Case Review Rating Form
Attachment D- Case Review Process Involving an SQIR

RELATED POLICIES:
Medical Staff Professionalism Policy (MSP 024)

CONTACT(S):

APPROVALS: 6/25/2024; 8/26/2025

REVISION HISTORY: 8/21/2025

ORIGINAL: 6/25/2024

UC-San Diego Health Medical Staff
Quality Review Committee (QRC) Charter

Goal
To establish a Service oriented, multi-specialty approach for the Medical Staff to evaluate and improve Practitioner performance and help create a performance improvement focused culture for peer review and assist UC San Diego Health (UCSDH) to improve systems affecting Practitioner performance.

Scope
- The Quality Review Committees (QRCs) will be responsible for measuring and evaluating all areas of Practitioner competency for Members and other Practitioners with delineated privileges providing care at UC San Diego Health under the responsibilities of the Medical Staff unless otherwise indicated in this charter.
- Although the QRC will be a source of competency data, credentialing and privileging decisions are the responsibility of the Service Chiefs, Credentials Committee, the Medical Staff Executive Committee ("MSEC"), and the Executive Governing Body ("EGB").
- While performance measurement and evaluation for UC San Diego Health systems and processes are the responsibility of the appropriate committee or Service, the QRC will identify and communicate those system and process issues affecting Practitioner performance.

Responsibilities
The primary responsibilities of the QRC are:
1. Measurement System Management
2. Evaluation of Practitioner Performance
3. Improvement Opportunity Accountability
4. Oversight of Other Medical Staff Practitioner Performance Evaluation Committees

These responsibilities are described in detail below:

1. Measurement System Management
   - At least every two years, and as needed, review for effectiveness Medical Staff indicators, targets, Practitioner attribution and screening methods and recommend changes to the PCPRC and MSEC. This will be done in collaboration with the Service Chiefs.
   - The QRC will have the authority to develop and implement specialty-specific indicators if not provided by the Services.
   - Design and approve studies when necessary, to analyze aggregate Practitioner performance.

2. Evaluation of Practitioner Performance
   A. Evaluation of Individual Cases
      - Assign the appropriate reviewer(s), or need for external review, for cases identified for peer review as described the Medical Staff Bylaws, Policies, Plans, and Rules.
      - Make determinations regarding individual Practitioner improvement opportunities based on individual or multiple case reviews.
      - Recommend focused evaluations to the PCPRC and/or MSEC when necessary, to further define if an improvement opportunity exists.
      - Recognize Practitioner excellence under difficult clinical circumstances, as appropriate.

   B. Evaluation of Rate and Rule Data for OPPE
      - Assure systematic, timely review of Medical Staff rule or rate indicator OPPE data for individual Practitioner outliers.
      - When outliers are identified, assure that the data is adequately analyzed and potential improvement opportunities are appropriately identified.
      - Evaluate rule and rate data for Medical Staff wide improvement opportunities or UC San Diego Health system issues affecting Practitioner performance.

C. Evaluation for System Improvement Opportunities
   - Identify potential UC San Diego Health systems affecting Practitioner practice or other professional practice improvement opportunities.

3. Improvement Opportunity Accountability
   - When individual improvement opportunities are identified through case review or OPPE data, assure that the appropriate individuals are notified and a reasonable improvement plan is developed.
   - Monitor and evaluate the effectiveness of Practitioner improvement plans.
   - When authorized by the PCPRC and/or MSEC, develop, implement and monitor performance improvements for Medical Staff wide improvement opportunities.
   - When UC San Diego Health system issues affecting Practitioner performance are identified, the QRC, through the SQIR, will communicate the concern to the appropriate system leader or committee and request a response regarding efforts to address the issue.

4. Oversight of Other Medical Staff Practitioner Performance Evaluation Committees
   - Some committees or specialties within a Service may continue to evaluate Practitioner performance for professional quality control or to collect data for OPPE. These committees will report to the Service QRC any relevant Practitioner specific rule or rate data through the OPPE process. Cases meeting review indicator criteria will be referred to the QRC for evaluation.
   - Evaluation of Practitioner performance for educational purposes (*e.g*. M&M conferences) will be protected pursuant to the applicable California Law. However, the discussion results are not placed in the Practitioner's quality file and any Practitioner specific concerns are referred to the QRC for formal evaluation through the Medical Staff.

Membership

QRC Composition

The QRC will be comprised of no fewer than three (3) voting members who are members of the Medical Staff of the main specialty area. Practitioners from other specialties may be invited to the meeting as needed.

Support Staff

The Administrative Assistant or other delegate serves as support staff to the QRC.

Appointment

The Service Chief will appoint the voting QRC members.

QRC Chair/Service QIR

The QRC Chair/Service QIR will be appointed by the President of Medical Staff, in consultation with the Service Chief, and approved by the MSEC.

The Chair will be appointed for a two (2) year term, renewable up to two (2) times, total of six (6) years.

Member Responsibilities

To maintain membership, QRC members will be expected to attend at least seventy-five percent (75%) of the scheduled QRC meetings over a twelve-month period and perform assigned case reviews according to QRC policies. Members failing to fulfill their responsibilities will be replaced by the process used for committee appointment. Members are expected to participate in appropriate educational programs provided by the Medical Staff to increase their knowledge and skill to perform their responsibilities.

If a member of the Medical Staff who is not a QRC member is requested to perform a case review, it is that individual's responsibility to perform that review in a timely manner according to QRC policies.

Meetings
The QRC will meet at least four (4) times per year. A quorum for purposes of making final determinations or recommendations for individual case reviews or improvement opportunities based on aggregate data will require the presence of 50% of the voting QRC members at a regularly scheduled meeting. The manner of action is defined as a majority vote of the voting QRC members present.

QRC Oversight
The QRC reports to the PCPRC. No changes can be made to the QRC charter and policies without PCPRC, MSEC, and EGB approval. The QRC Chair/QIR or designee will provide a report to the PCPRC for each QRC meeting.

Attachment A1

UC-San Diego Health Medical Staff
East Campus Medical Staff Peer Review Subcommittee Charter

Goal
To establish a Service line oriented, multi-specialty approach for the UC San Diego Health (UCSDH) Medical Staff at East Campus to evaluate and improve Practitioner performance and help create a performance improvement focused culture for peer review. The Subcommittees will also assist UCSDH to improve systems affecting Practitioner performance.

Scope
- The East Campus Representatives, in coordination with the East Campus Peer Review Subcommittees ("Subcommittees"), will be responsible for measuring and evaluating all areas of Practitioner competency for Members and other Practitioners with delineated privileges providing care at UCSDH East Campus under the responsibilities of the Medical Staff unless otherwise indicated in this charter.
- Although the East Campus Representatives will be a source of competency data, credentialing and privileging decisions are the responsibility of the Service Chiefs, Credentials Committee, the Medical Staff Executive Committee ("MSEC"), and the Executive Governing Body ("EGB").
- While performance measurement and evaluation for UC San Diego Health systems and processes are the responsibility of the appropriate committee or Service, the East Campus Representatives and their associated Subcommittees will identify and communicate those system and process issues affecting Practitioner performance.

Responsibilities
The primary responsibilities of the East Campus Representatives and their associated Subcommittees are:
1. Measurement System Management
2. Evaluation of Practitioner Performance
3. Improvement Opportunity Accountability
4. Oversight of Other Medical Staff Practitioner Performance Evaluation Committees

These responsibilities are described in detail below:

1. Measurement System Management
   - At least every two (2) years, and as needed, review for effectiveness Medical Staff indicators, targets, Practitioner attribution and screening methods and recommend changes to the ECMSC, PCPRC, and MSEC. This will be done in collaboration with the Service Chiefs.
   - The East Campus Representatives will have the authority to develop and implement specialty-specific indicators if not provided by the Services.
   - Design and approve studies when necessary, to analyze aggregate Practitioner performance.

2. Evaluation of Practitioner Performance
   A. Evaluation of Individual Cases
      - Assign the appropriate reviewer(s), or need for external review, for cases identified for peer review as described the Medical Staff Bylaws, Policies, Plans, and Rules.
      - Make determinations regarding individual Practitioner improvement opportunities based on individual or multiple case reviews.
      - Recommend focused evaluations to the ECMSC, PCPRC, and/or MSEC when necessary, to further define if an improvement opportunity exists.
      - Recognize Practitioner excellence under difficult clinical circumstances, as appropriate.

   B. Evaluation of Rate and Rule Data for OPPE
      - Assure systematic, timely review of Medical Staff rule or rate indicator OPPE data for individual Practitioner outliers.
      - When outliers are identified, assure that the data is adequately analyzed and potential improvement opportunities are appropriately identified.

- Evaluate rule and rate data for Medical Staff wide improvement opportunities or UCSDH system issues affecting Practitioner performance.

C. Evaluation for System Improvement Opportunities
   - Identify potential UCSDH East Campus systems affecting Practitioner practice or other professional practice improvement opportunities.

3. Improvement Opportunity Accountability
   - When individual improvement opportunities are identified through case review or OPPE data, assure that the appropriate individuals are notified and a reasonable improvement plan is developed.
   - Monitor and evaluate the effectiveness of Practitioner improvement plans.
   - When authorized by the ECMSC, PCPRC, and/or MSEC, develop, implement and monitor performance improvements for Medical Staff wide improvement opportunities.
   - When UCSDH East Campus system issues affecting Practitioner performance are identified, the East Campus Representatives, through the ECMSC and the Chief Medical Officer, will communicate the concern to the appropriate system leader or committee and request a response regarding efforts to address the issue.

4. Oversight of Other Medical Staff Practitioner Performance Evaluation Committees
   - Some committees or specialties within a Service may continue to evaluate Practitioner performance for professional quality control or to collect data for OPPE. These committees will report to the East Campus Representative any relevant Practitioner specific rule or rate data through the OPPE process. Cases meeting review indicator criteria will be referred to the East Campus Representative for evaluation.
   - Evaluation of Practitioner performance for educational purposes (*e.g*. M&M conferences) will be protected pursuant to the applicable California Law. However, the discussion results are not placed in the Practitioner's quality file and any Practitioner specific concerns are referred to the East Campus Representative and their associated Subcommittee for formal evaluation through the Medical Staff.

Membership

East Campus Peer Review Subcommittee Composition
Each Subcommittee will be comprised of no fewer than three (3) voting members who are members of the Medical Staff with privileges in one of the specialties being reviewed by the Subcommittee. Practitioners from other specialties may be invited to the meeting as needed.

Support Staff
The Administrative Assistant or other delegate serves as support staff to the Subcommittee.

Appointment
Any Member with privileges will be a voting member of the Subcommittee.

East Campus Representative
The East Campus Representative will be appointed by the President of Medical Staff, in consultation with the Service Chief, and approved by the MSEC.

The East Campus Representative will be appointed for a two (2) year term, renewable up to two (2) times, total of six (6) years.

Meetings
The Subcommittee will meet at least four (4) times per year. A quorum for purposes of making final determinations or recommendations for individual case reviews or improvement opportunities based on aggregate data will require the presence of at least five (5) Members with privileges in the specialties

being reviewed at a regularly scheduled meeting. The manner of action is defined as a majority vote of the voting members present.

East Campus Peer Review Subcommittee Oversight
The Subcommittee reports to the ECMSC. No changes can be made to the Subcommittee charter and policies without PCPRC, MSEC, and EGB approval. The East Campus Representative or designee will provide a report to the ECMSC for each Subcommittee meeting.

Attachment A2

Patient Care and Peer Review Committee (PCPRC) Charter

Goal

To provide oversight for the structure, policies, procedures, and results of Practitioner performance improvement as performed by the Medical Staff peer review committees at the University of California San Diego Health, and help create a positive culture for peer review.

Scope

- The PCPRC will oversee the accountability and effectiveness of the Service QRCs and East Campus Representatives when performing peer review
- The PCPRC will develop systematic approaches to evaluating and improving Practitioner performance for all General Competencies as described the Peer Review Policy and Medical Staff Expectations.

Responsibilities

1. Measurement System Management
    - At least every two years, and as needed, review all Medical Staff indicators and targets, Practitioner attribution designations, screening tools and referral systems for effectiveness in collaboration with the Service Quality Improvement Representatives (SQIRs) / Quality Improvement Representatives (QIRs)/EC Representatives and recommend changes to the Medical Staff Executive Committee (MSEC). The PCPRC will have the authority to develop and implement specialty-specific indicators if not provided by the Clinical Service or the SQIRs/QIRs/EC Representatives.
    - As needed, evaluate requests for additions or deletions to the indicators, criteria or targets used by the Medical Staff to evaluate Practitioner performance and make recommendations to the MSEC.
    - Review and recommend focused studies by the SQIRs/QIRs/EC Representatives to further analyze aggregate Practitioner performance (FPPE).
    - Define the appropriate content and format for Practitioner performance feedback reports and reappointment profiles (OPPE).

2. Evaluation of Practitioner Performance
    A. Evaluation of Individual Cases
        - Recommend to the MSEC general policies and procedures for PCPRC, ECMSC, and QRC performance of individual case review and external peer review.
        - Review and approve QRC and ECMSC specific approaches for individual case review to assure that they comply with general policies and regulatory requirements.
        - Provide oversight to assure all QRCs and EC Representatives are conducting and reporting the results of peer review on a systematic and timely basis.
        - Perform the review of cases and determine the final rating of Practitioner performance as described in the Case Review Process and Timeframes procedure under the following circumstances:
            - Assure cases with specialty technical issues are assigned to the appropriate Clinical Service SQIR/QIR and/or EC Representative for initial review and rating.
            - Conduct secondary review of cases where concerns are raised regarding the basis of the rating.
            - Review of cases where substantial Conflict of Interest or procedural error of the peer review process occurred at the QRC/ECMSC.
            - Determine if there is a need to recommend external peer review when requested either by a QRC, ECMSC, or by the PCPRC unless the need for external review has been determined by the MSEC or the Executive Governing Body (“EGB”).
        - If a Practitioner disagrees with the SQIR/QIR, EC Representative, ECMSC, or QRC decision, they may appeal that decision to the PCPRC.

    B. Evaluation of Rate and Rule Indicators

- Perform regular review of Medical Staff Rule or Rate indicator data for OPPE for individual Practitioner outliers for all Practitioner competencies within the QRC/ECMSC scope. This function may be delegated by the QRC/ECMSC to an individual committee member, a subcommittee or Medical Staff Service Chief, Clinical Service SQIRs/QIRs, or EC Representative.
- Assure the QRCs/EC Representatives perform effective evaluation of Practitioner competency measures within their patient care scope.
- Review QRC/ECMSC findings of individual Practitioner outliers for Practitioners with the QRC/ECMSC scope.
- Recommend FPPE when necessary, to further define if an improvement opportunity exists as described in the OPPE/FPPE policy.

3. Improvement Opportunity Accountability

- Identify potential individual Practitioner or Medical Staff wide opportunities for improvement based on evaluations performed by either the QRCs/EC Representatives or the PCPRC on case reviews or aggregate data.
- Identify potential non-Practitioner clinical practice or UCSDH system opportunities for improvement based on evaluations performed by either the QRCs or the PCPRC on case reviews or aggregate data.
- Review focused studies performed by the QRCs to further analyze Practitioner performance and assist in the design of those studies when necessary.
- Design and conduct focused studies to further analyze Practitioner performance for issues outside of the QRC's scope.

The role of the PCPRC is to assure when opportunities for improvement are identified, the appropriate individuals are notified of the issues and a reasonable improvement plan is developed and implemented. This will be accomplished through the QRCs for issues within their patient care scope unless otherwise determined by the PCPRC.

4. Oversight of Other Forums of Medical Staff Practitioner Performance Evaluation

- Some Medical Staff Clinical Services or committees may continue to evaluate Practitioner performance for professional quality control or to collect data for OPPE. These committees will report to the QRC/EC Representative any relevant Practitioner specific rule or rate data through the OPPE process. Cases meeting review indicator criteria will be referred to the QRC/EC Representative for evaluation.
- Evaluation of Practitioner performance for educational purposes (*e.g*. M&M conferences) will be protected pursuant to the applicable California Law. However, the discussion results are not placed in the Practitioner's quality file and any Practitioner specific concerns are referred to the QRC for formal evaluation.
- Any committee that is mandated to do peer review for compliance with specialty certification status, will perform case review functions as required by the specialty certification standards and report these findings to the PCPRC.

Membership

PCPRC Composition

The PCPRC will be comprised of all the SQIRs from each Service on the MSEC, the Chair of the ECMSC, and an APP representative designated by the President of Medical Staff. Practitioners from other specialties may be invited to the meeting as needed.

Ex-Officio Members

The CMO and/or their designee, the Chief Quality and Patient Safety Officer, the CNO and/or their designee.

Support Staff
Peer Review Coordinators/Quality & Patient Safety delegates supporting the PCPRC meeting, as determined by the Chair, may attend the PCPRC meetings. Additionally, Legal or other UCSDH Executives may attend upon invitation and as appropriate.

Appointment
The voting PCPRC members will be appointed by the President of the Medical Staff based on the recommendations from the Medical Staff Service Chiefs and the PCPRC Chair, and approved by the MSEC.

Selection of PCPRC Chair
The PCPRC Chair will be appointed by the President of the Medical Staff, and approved by the MSEC and EGB.

To be eligible for appointment as Chair, the individual must be a current voting PCPRC member and have served as a voting PCPRC member at some point in time for at least one year. The Chair will serve for a term of two years, renewable up to two times, for a total of six years. The PCPRC Chair will be an ex-officio member of the MSEC without vote. If the Chair position is vacant, the President of the Medical Staff will serve as interim chair until a chair is appointed.

SQIR Responsibilities
Voting PCPRC members will be expected to attend at least seventy-five percent (75%) of the scheduled PCPRC meetings over a twelve month period and perform assigned case reviews according to PCPRC policies to maintain membership. If a member fails to fulfill their responsibilities, they will be replaced by the process used for initial appointment to the PCPRC. PCPRC members will be expected to participate in appropriate educational programs provided by UCSDH and/or Medical Staff to increase their knowledge and skills in performing PCPRC responsibilities.

If a Member of the Medical Staff who is not a PCPRC member is requested to perform a case review, it is that individual's responsibility to perform that review in a timely manner according to PCPRC policies.

Meetings
The PCPRC will meet at least four (4) times per year. A quorum for purposes of making final determinations or recommendations for individual case reviews or improvement opportunities based on aggregate data will require the attendance of at least fifty percent (50%) of the voting PCPRC members. A majority will consist of a majority of voting PCPRC members present at the meeting.

PCPRC Oversight
The PCPRC reports to the MSEC. No changes can be made to the PCPRC charter and policies without MSEC and EGB approval. The PCPRC Chair will provide a report to the MSEC as necessary but at least four (4) times per year.

Attachment B

Case Review Process and Timeframes

Case Identification and Screening	Cases are identified by Screening Worklists or Referrals (*e.g.,* Incident Reports, Case Management, patient relations, HIM). The Quality & Patient Safety Team will review cases received to determine if the Medical Staff Peer Review indicator threshold is met. If Practitioner case review is required based on Medical Staff approved criteria, the Quality Patient Safety delegate completes the initial section of the peer review module case review form with a goal of completing the form within fourteen (14) days of receipt. A SQIR/QIR/EC Representative may review a case when identified and if defined by Medical Staff/indicator criteria.
Cases potentially not meeting review criteria	If the Quality Patient Safety delegate needs clarification whether the case meets review criteria, they will contact the SQIR, QIR, EC Representative, or designee. If it is determined that the case meets review criteria, a Peer Review Coordinator/Quality Patient Safety delegate assigns a Practitioner reviewer per the Peer Review Policy. If the Chair feels the case does not meet criteria but is of concern, the issue raised by the case will be presented to the SQIR/EC Representative to determine if it should be reviewed and to determine whether a new or modified review indicator should be adopted to handle similar cases in the future.
Practitioner Reviewer Assignment	Cases will typically be assigned for initial review to a SQIR/QIR/EC Representative. If the initial reviewer feels the case needs specialty review, the reviewer will be the peer review member from that specialty, if available. Otherwise, the Quality Patient Safety delegate will contact the QRC Chair/SQIR/EC Representative to determine the appropriate reviewer. If someone outside the committee is needed for a review, they will be made an ad-hoc member of the QRC for the intended case review only. If the review is regarding the SQIR/QIR/EC Representative, the PCPRC Chair shall designate another Practitioner to review the case. The alternate reviewer may be the Chair, SQIR/QIR/EC Representative or another qualified Practitioner.
Conflict of Interest (See Peer Review Policy for definitions)	If a reviewer identifies a conflict of interest, the reviewer will follow the process outlined in the *Peer Review Policy* to disclose any such conflict.
Practitioner Review	The reviewer <u>may</u> review the case with the involved Practitioner verbally, by phone, or by internal e-mail. The Practitioner <u>may</u> respond to the reviewer either verbally or via written communication (letter or internal e-mail). When feasible and available, communication from the practitioner should be attached to the respective case review. The reviewer completes and submits the case review form in the RL Datix Peer Review Module. If the form is incomplete, a Quality Patient Safety delegate will contact the reviewer to obtain the additional information for the review. Only cases with completed forms will be presented at the meeting. The goal is for reviews to be completed within 30 days of assignment. Completed reviews received 5 or more business days prior to the meeting will be on the agenda.
Initial Reviews Rated Appropriate Care	The QRC Chair/SQIR/EC Representative will review the case rating forms for all cases deemed to have appropriate care by the initial reviewer. If the Chair concurs with the appropriate rating, these reviews are reported to the QRC/ECMSC for summary approval.

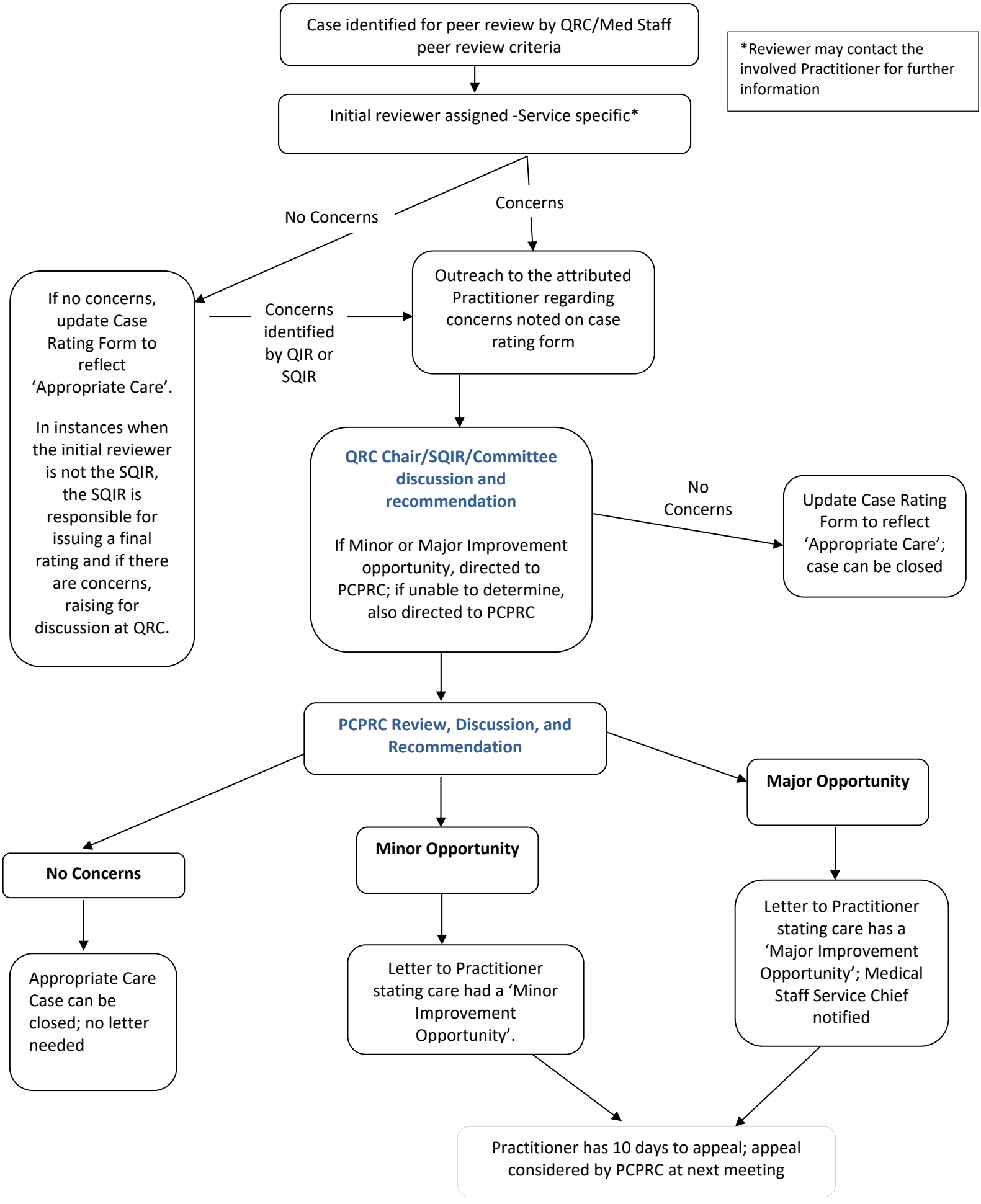
Attachment B

	For any cases in which the Chair has concerns with the rating by the initial reviewer, they will discuss the rating concerns with the reviewer. If any concerns remain following that discussion, the case will be presented to the QRC/ECMSC for discussion.
Case Presentation	For cases requiring PCPRC discussion the SQIR/ECMSC Chair or their designee will present the case. For cases being presented at QRC/ECMSC, the initial reviewer may present the case. All reasonable efforts will be made to avoid disclosing the identity of the Practitioner under review during the initial case presentation and discussion. For specialty reviews by ad-hoc peer review members, the findings will be provided to the initial reviewer or Chair (if only a technical issue) prior to the meeting to present the case.
Initial Reviews Not Rated as Care Appropriate	For cases requiring QRC/ECMSC discussion, the SQIR/QIR/EC Representatives will communicate the key questions to the involved Practitioner(s) by internal e-mail or phone. The involved Practitioner(s) will be asked to respond, within a specified timeframe, to specific predetermined questions. The Practitioner under review should respond within 10 working days*. If there is no response, the case will move forward for QRC/ECMSC discussion and the QRC/ECMSC will finalize the rating based on available information. *If the Practitioner is on vacation, the 10 working days will begin the day of their return.
Additional Clarification from the Practitioner	After the initial written response, if the QRC, ECMSC, or PCPRC determines it needs further clarification, it may ask the Practitioner for a second response in person at the next PCPRC, ECMSC, or QRC meeting to respond to specific predetermined questions but not be present for any committee discussion. If the Practitioner does not address the QRC, ECMSC, or PCPRC concern and respond to the questions raised, the PCPRC, ECMSC, or QRC committee will finalize the rating. If the practitioner cannot attend the next scheduled meeting, the Practitioner may request a one-time extension and attend the following scheduled meeting.
Peer Review of APPs	After initial review of a case, if the QRC, ECMSC, or PCPRC determines it needs further clarification from the APP's Supervising Physician, it may ask the APP's Supervising Physician for a written response or to attend an in person meeting with the PCPRC, ECMSC, or QRC to respond to specific questions but not be present for any committee discussion. Additionally, if the QRC, ECMSC, or PCPRC determines that the Supervising Physician is responsible for some or all of the care rendered by the APP, the Supervising Physician can be added to the case review.
Disposition of Cases	Final case determinations will be made by majority vote as described in the PCPRC, ECMSC, or QRC Charter. If the care is rated less than Appropriate, the QRC, ECMSC, or PCPRC will determine the Recommendations/Action. If a practitioner leaves the UCSDH Medical Staff before the case review can be completed, the SQIR and Chair will meet to determine whether the case review should proceed or whether the case review should be closed. If the case is closed without a rating due to a practitioner leaving the UCSDH Medical Staff, this information will be included as part of the closure.
Communicating Findings to Practitioners	*Exemplary care*: Practitioners informed by routine letter. A copy of the Exemplary care letter will be sent to Practitioner's peer review file and the Medical Staff Service Chief informed. Appropriate care cases are recorded and available for review. *Care with Minor or Major Improvement Opportunities*: Practitioners informed by internal e-mail with copy sent to Practitioner's peer review file and the Medical Staff Service Chief informed as above. Decision letters will be sent within 10 working days of the PCPRC Meeting.

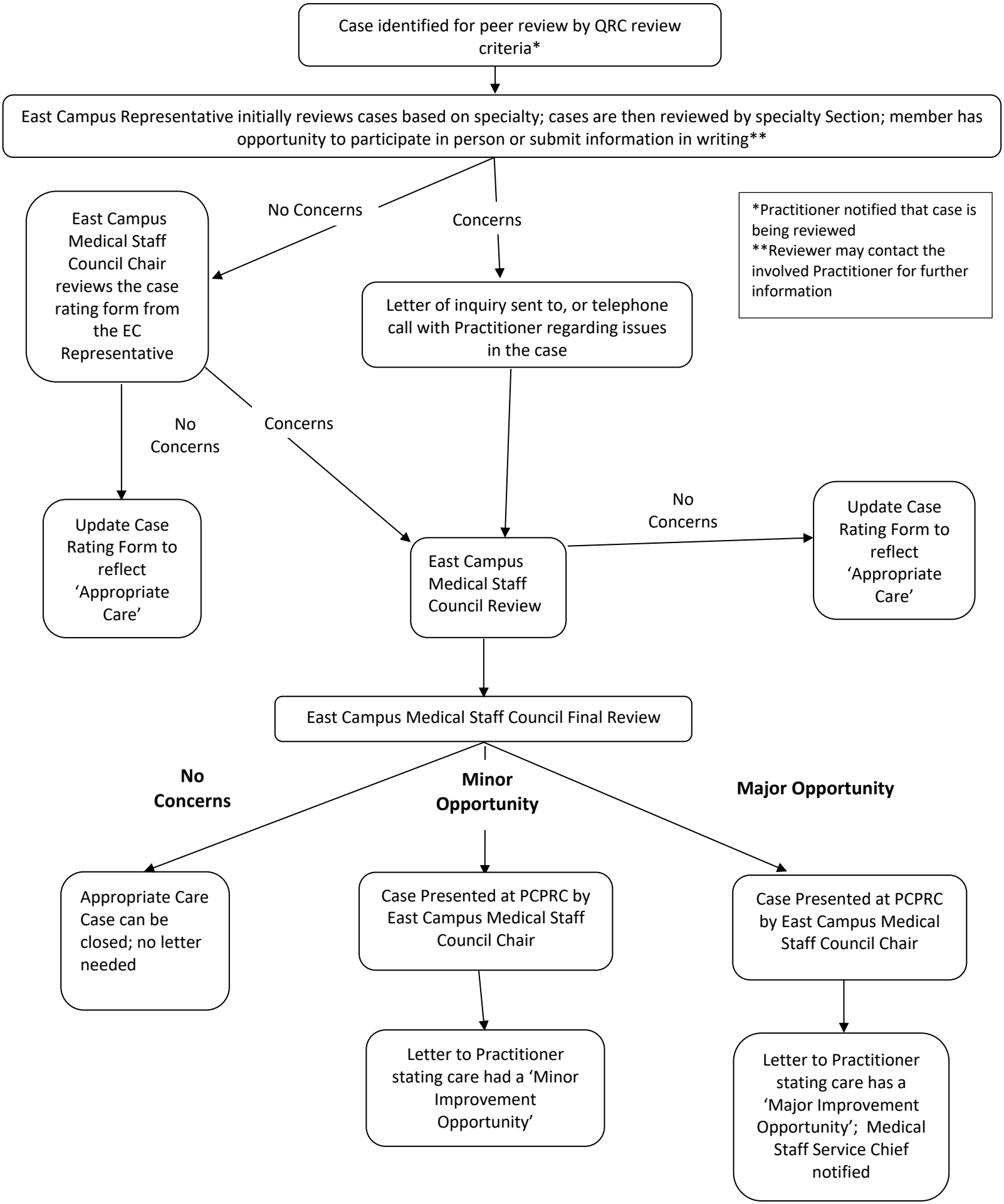
Attachment B

Appeal Process	Practitioner will be notified of the QRC's decision as it relates to their care in the case. Practitioner has the option of appealing the QRC or ECMSC's decision to the Patient Care and Peer Review Committee (PCPRC). If Practitioner desires to appeal the decision, they must submit any relevant information, in writing within 10 days of notification for the PCPRC to consider. They shall also identify the basis for the appeal. The PCPRC shall review the information submitted by the Practitioner and any information reviewed by the QRC when considering the appeal. The PCPRC may affirm the decision of the QRC or ECMSC, may reverse the decision, or, if necessary, may seek additional clarification from the Practitioner and/or QRC/ECMSC.
Improvement plan	As per the OPPE and FPPE policy.
High-risk Cases	Sentinel Events or Significant Event Committee referred events with defined external review timeframes requiring peer review, will have immediate review by the Chair, or designee. Additional information (such as a literature search, second opinion, or external peer review) may be necessary before making a decision on action. Initial review is to be performed within 3 working days of case identification, and discussed at next scheduled PCPRC, ECMSC or QRC meeting or within 30 days of the event. If additional information is needed, timelines may be extended if approved by the Executive Governing Body, its designee or the MSEC.
Suspensions	This policy does not apply to suspensions and/or Summary Suspensions; refer to the Medical Staff Bylaws.

Case Review Flow Diagram



East Campus Case Review Flow Diagram



Attachment C

Peer Review Case Rating Form

MR #:_____ **D/C Date:** _____ **Referral Date**: _____ **Provider #:** _____ **Type:**_____

Referral Source: Check the corresponding box

	Risk		iReport		Reg Rptng Req		Payor Report Req		QIO		Malpractice Claims		Practitioner Referred		Hosp Comm.
	M&M Conference		Patient Experience		Other										

Review Criteria/Referral Issue:_____

Quality Screener/Date_____ **Date Submitted for Review** _____

Case Summary _____

_____

Key Questions or Findings to Clarify for Reviewer:

_____

_____

General Questions for Reviewer: Were appropriate tests, treats, medications or consults ordered/done? Were they done in a timely manner? Were appropriate preventive measures taken? Were care decisions/plan communicated?

To be completed by Reviewer

Reviewer:_____ **Review Date**: _____ **Conflict of Interest? __No __ Potential**

		Overall Practitioner Care: Check one
	0	Appropriate
	1	Minor Improvement Opportunity
	2	Major Improvement Opportunity
	U	Reviewer Uncertain, needs QRC discussion

Note: If Overall Care = 0, **then** Issue must = (A);
If Overall Care = 1, 2, or U,
then Issue must = (B) through (O)

		Issue Identification
	A	No issues with Practitioner care
		Practitioner Care Issues: Check all that apply
	B	Diagnosis (Pt Care)
	C	Clinical Judgment/Decision-making (Pt Care)
	D	Technique/Skills (Pt Care)
	E	Planning (Pt Care)
	F	Supervision: House Physician or APP (Pt Care)
	G	Knowledge (Medical Knowledge)
	H	Timely/Clear Communication (Comm/IP Skills)
	I	Responsiveness (Professionalism)
	J	Follow-up/Follow-through (Professionalism)
	K	Policy Compliance (System based Practice)
	L	Health Disparity – REAL/SOGI/Other
	O	Other:

Documentation Issue Description:

_____

_____

_____

Complete on all cases

		Practitioner Documentation: Check all that apply
	D1	No issue with Practitioner documentation
	D2	Documentation does not substantiate clinical course/ treatment
	D3	Documentation not timely to communicate with other caregivers
	D9	Other:

If **Overall Practitioner Care** rated **Appropriate**, provide a **brief description** of the basis for reviewer findings:

_____

_____

If **Overall Practitioner Care** rated **Minor / Major Improvement Opportunity** or **Uncertain**, complete the following:

A. Brief description of the basis for reviewer concerns:_____

_____

_____

B. What questions are to be addressed by the Practitioner or the Committee?

_____

_____

Exemplary Nominations: ___Practitioner Care___ Practitioner Documentation ___Non-Practitioner Care
Brief Description:_____

Non-Practitioner Care Issues: __ Potential System or Process Issue __ Potential Nursing/Ancillary Care Issue
Issue Description:_____

To Be Completed by the Quality Review Committee

Committee initial Review
Was case reviewed with practitioner? Yes No

Committee Final Scoring (See above for Scoring Levels):
QRC Agree with Reviewer Ratings

- **Yes**
- **No** *(If disagreement, reassign ratings below)*
  Overall Practitioner Care:____ Issue Identification:____ Documentation:____

Committee Recommendation/Action (Check One)

	No action warranted
	Practitioner self-acknowledged action plan sufficient
	Minor – Practitioner notification (Practitioner only)
	Major – Practitioner Notification letter + recommend/refer to Service Chief discussion of informal improvement plan with Practitioner (CC'd Service Chief, PCPRC Chair, POMS)
	Defer to PCPRC for further review

Other Optional Referrals

___System Problem Identified – forward to: _____ Date sent: _____

Describe system issue: _____

___Referral to Nursing Review Date sent: _____

Describe Nursing concern: _____

___Referral to CME Advisory Committee Date sent: _____

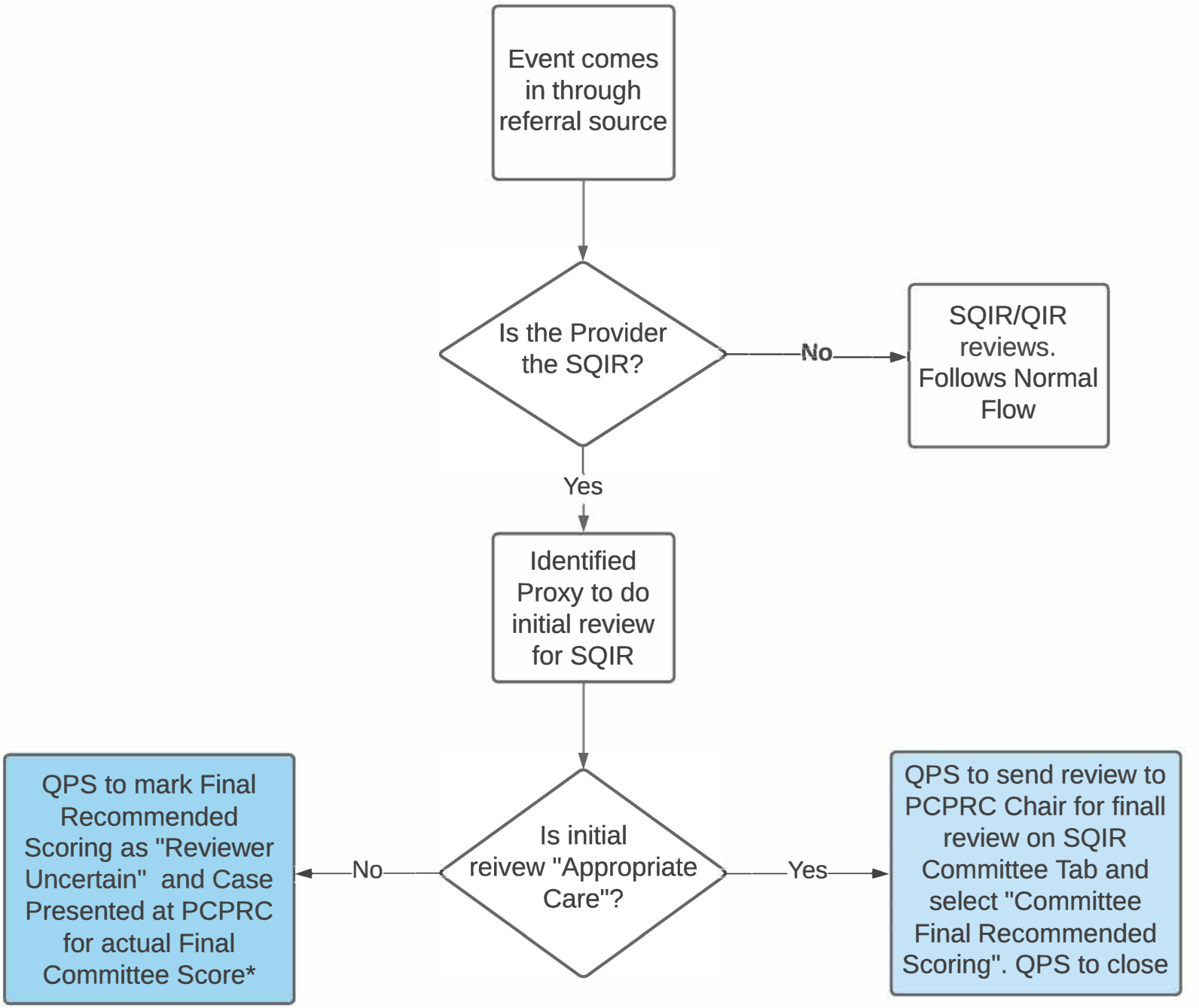
___Referral to Medical Staff Professionalism Committee Date sent: _____

___Referral to Residency/Fellowship Program Director Date Sent:_____

___Referral to Another Service – Forward to appropriate QRC Date Sent:_____

Attachment D

Cases Requiring Proxy for SQIR



*For those initial Minor/Major or Undetermined finding by proxy needing PCPRC review and scoring, the SQIR will recuse themself from the discussion until it is completed and final score identifed.