Southern Maine Health Care
MaineHealth

Medical Staff Quality Monitoring Manual

*Updated 02/22/2022

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I. Purpose

The Southern Maine Health Care (henceforth referred to as "SMHC") Medical Staff Quality Assessment & Improvement Plan (henceforth referred to as "the Plan") is designed to define and describe the framework for which the Medical Staff monitor, assess, and improve the quality of patient care.

A. It shall provide the structure to ensure that the standards of quality of patient care are consistent across all clinical services and all levels and categories of the Medical Staff.
B. All privileged practitioners shall be subject to participation in the activities described in the Plan.
C. This Plan shall be integrated with SMHC Organizational Quality Assessment and Improvement Plan, encompassing a collaborative and cooperative effort to improve patient care and outcomes.

II. Objectives

The objectives of the Plan are:

A. To provide high quality medical care to patients served by the organization;
B. To fulfill the organization's obligation to comply with all applicable state and federal laws;
C. To render care that is consistent with applicable professional standards;
D. To serve as a guide in process improvement activities, peer review, focused professional practice evaluations (FPPE), and ongoing professional practice evaluations (OPPE);
E. To inform strategic planning and quality improvement activities to the SMHC Medical Staff Quality Improvement (henceforth referred to as the "MSQI") Committee;
F. To measure, assess, and improve processes;
G. To utilize data for identification of meaningful trends of care;
H. That OPPE information is factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege at the time of renewal;
I. To ensure that relevant findings, conclusions, recommendations, actions, and process improvements are communicated to the appropriate Medical Staff members.

III. Authority / Leadership / Support

A. The Maine Medical Center (MMC) and SMHC Regional Board (henceforth referred to as the "Regional Board") has ultimate responsibility and authority for the quality of patient care. The Regional Board delegates authority for the operation of the Plan to the Medical Staff.

B. The SMHC Chief Medical Officer, or designee, and the SMHC Vice President of Quality & Safety are responsible for the coordination of Medical Staff quality improvement activities and for the coordination of timely, accurate, and comprehensive reporting of quality-related data.
C. The SMHC Medical Executive Committee (henceforth referred to as the "MEC") organizes the Medical Staff's quality improvement activities and ensures that a mechanism is in place to conduct, evaluate, and revise such activities.
D. The MSQI Committee establishes and maintains an ongoing, comprehensive, and effective quality improvement program that monitors the performance of its practitioners. The Committee is responsible for coordinating, overseeing, and supporting the elements, processes, and functions related to Medical Staff performance improvement. The MSQI Committee assures performance improvement activities appropriately integrate the SMHC Organizational Quality Assessment and Improvement Program. The MSQI Committee shall be comprised of members of the Active Medical Staff who are appointed by the SMHC Medical Staff President after consultation with and approval by the MEC. The SMHC Medical Staff Quality Improvement Specialist (henceforth referred to as the "MSQIS") and representatives from the SMHC Quality & Patient Safety Department, in collaboration with the SMHC Associate Chief Medical Officer and the SMHC Vice President for Quality & Safety, provide staffing support to the Committee, which shall meet a minimum of ten times per year.
E. The SMHC Specialty Medical Directors (henceforth referred to as "SMDs") collaborate with the MSQIS and SMHC Department of Quality & Patient Safety on the development of process improvement metrics and projects that support the intent of the Plan and the work of the MSQI Committee.
F. The MSQIS and the SMHC Department of Quality & Patient Safety will play a supportive role in the development of Medical Staff quality indicators as well as the collection, analysis, and presentation of quality data. In addition, the MSQIS will assist in Committee facilitation and project management for quality initiatives.
G. By approval of the Plan, the SMHC President, the Chair of the Quality Improvement and Patient Safety Committee of the Board, the SMHC Medical Staff President, and the SMHC Vice President for Quality & Safety authorize and direct all Medical Staff members to participate in and support the implementation of the Plan in accordance with the Medical Staff Bylaws & associated manuals.

IV. Scope and Components

In developing indicators for the review and monitoring of improvement activities for the Medical Staff, the following aspects of care shall be considered:

A. Care must be safe, that is, avoiding injuries to patients from the care that is intended to help them;
B. Care must be effective, that is, providing services based on scientific knowledge to those who can benefit, and avoiding both under-use and over-use of those services;

C. Care must be patient-centered, respectful of, and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide clinical decisions;

D. Care must be timely, that is, reducing potentially harmful delays in the delivery of clinical services and interventions;

E. Care must be efficient, that is, avoiding waste of equipment and supplies;

F. Care shall be equitable with regard to personal characteristics, such as gender, race, ethnicity, sexual orientation, and/or socioeconomic status.

V. Key Aspects/Focus of Care

A. The Medical Staff offers both Inpatient and Outpatient care encompassing ALL service lines.

B. Reviews of the clinical work of the Medical Staff shall include, but not be limited to, indicators related to the following key aspects of care:

1. Patient Care
    - Operative and Invasive Procedures
    - Medication Usage
    - Documentation
    - Evidence-Based Medical Management
    - Non-Invasive Procedures
    - Tests
2. Medical Knowledge
3. Practice-Based Learning and Improvement
4. Interpersonal and Communication Skills
5. Professionalism
6. Systems-Based Practice

C. Service line and specialty-specific indicators shall be reviewed periodically for pertinence to care outlined in Section IV (Scope and Components), regulatory requirements, and national quality initiatives.

VI. Performance Improvement Activities

A. Process for review shall include:

1. Systematic process and outcome-based quality improvement analysis with indicator-based screening and quantitative review, including trending, conclusion, and quality improvement interventions with assessment of the ultimate efficacy of those interventions, such as through OPPE indicators.
2. Quality Improvement and peer review activities related to outcomes and processes of care, which are not necessarily on an individual basis.

3. Practitioner-specific FPPE, OPPE, and peer review data will be used in the periodic reappointment, re-credentialing, and re-privileging process of the Medical Staff.
4. Ethical issues beyond the scope of departments, service lines, and committees are referred to and reviewed by the SMHC Ethics Committee when deviations from ethical standards are suspected, or when issues require review and clarification.
5. SMDs are responsible for using performance data and information to continuously assess and improve care and service, and to continuously assess the performance of all who have delineated clinical privileges. Privacy protection shall be in place facilitating a thorough and credible review.

VII. Documentation / Communication Reporting

A. The MSQI Committee shall be responsible for coordinating all Medical Staffs' quality reporting, communication, and documentation.
B. OPPE and Performance Improvement Plans shall be reported to the MEC. Recommendations and action plans, as indicated, will be reported to the Regional Board by the MEC. Feedback, recommendations, and action plans will be communicated back to the Medical Staff through the MEC.
C. MSQI Committee minutes and meeting materials will be forwarded to the MEC. The minutes shall reflect discussion and recommendations for process improvements.
D. FPPE, OPPE, and peer review findings shall be documented and maintained in the Medical Staff member's individual file. Relevant findings and specific results of peer review assessments and subsequent performance improvements will be reported to relevant SMDs for dissemination to their service line(s). Peer review findings are provided to and reviewed by the SMD at time of the provider's reappointment.

VIII. Confidentiality and Conflict of Interest

Data collected through quality improvement activities is confidential and, therefore, accessible only to individuals responsible for quality improvement programs and agencies responsible for surveying the SMHC's quality improvement programs. No provider shall be assigned a peer review in which they have been professionally involved. Peer reviews will be assigned to a medical staff member of the same or similar specialty for their unbiased assessment of care provided. External peer reviews may be obtained.

IX. Review and evaluation of Medical Staff Quality Improvement Program

Evaluation of the Quality Improvement Program will be based on an analysis of the effectiveness of improvement efforts and outcomes. When ineffective or inefficient problem resolution is identified through the Quality Improvement Program appraisal, appropriate changes in organization or methods of the Quality Improvement Program will be undertaken. In addition, any portion of this Plan may be modified or amended at any time to maintain compliance with the Joint Commission, the Centers for Medicare and Medicaid Services, or other defined standards, and to ensure effectiveness of quality improvement activities.

APPROVED:

Patricia Camire RN, MSN — 1/18/22

Chairman, Quality Improvement and Patient Safety Committee of the Board
Patricia Camire, RN MSN

Date

[signature] — 1/4/2022

President
Nathan Howell

Date

William Frank, M.D — 01/14/2022

President of the Medical Staff
William Frank, MD

Date

[signature] — 1/13/2022

Vice President of Quality & Patient Safety
Helen Troy, RN MSN

Date

Approved by MSQI Committee: 12/9/2021
Approved by MEC: 12/16/2021
Approved by QI and Patient Safety Committee of the Board: 12/20/2021
Approved by SMHC Local Board: 12/30/2021

FOCUSED PROFESSIONAL PRACTICE EVALUATION PROGRAM

Focused Professional Practice Evaluation (FPPE) is used to evaluate the competence of Medical Staff providers in the following situations:

1. At the time of initial granting of privileges, for all practitioners;
2. When current Medical Staff members are granted new privileges; or
3. When questions arise regarding a practitioner's competence and/or behavior that suggest an issue with the provision of safe, high-quality care.

Triggers for additional FPPE may include, but are not limited to:

1. Atypical utilization patterns;
2. Higher than expected rates of complications, readmissions, or mortality;
3. A higher than expected number of complaints;
4. Deficiencies with documentation; or
5. When there is insufficient Ongoing Provider Practice Evaluation (OPPE) data to monitor the quality and safety of current privileges.

Background:

FPPE is intended to be a time-limited process during which the organization evaluates and determines the practitioner's professional performance. The goal is to have the process completed within 90 days from the date of his or her first encounter. If there are insufficient encounters (defined as admissions, consultations, or procedures) for a meaningful evaluation, the provider may be asked to provide data or information from other hospitals or from their office practice. Providers with unique roles in the organization, such as per diem or locum tenens, may undergo a different FPPE process than other providers in the same specialty.

FPPE Process:

A. The appropriate Specialty Medical Director (SMD) will be the physician responsible for oversight and completion of the process. He or she may designate other practitioners to assist in the review process.

B. The reviewing practitioner(s) must be a Medical Staff member in good standing in the same or similar specialty when possible. The reviewer may also be in a related specialty (i.e. anesthesia for surgery).

C. In the event that no staff member is deemed qualified to perform the review, an external source may be obtained. This determination will be made with input from the SMD, Associate Chief Medical Officer, Chair of the Credentials Committee, or Chair of the Medical Staff Quality Improvement (MSQI) Committee.

D. Triggers indicating the need for FPPE as described above may result from a single concerning incident or evidence of a concerning trend.

E. The FPPE may include, singly or in combination, medical record review, direct observation, or feedback from other individuals involved in patient care. In cases of a 360-type review, feedback from non-physician or non-APP individuals (i.e. nurses, technicians, medical assistants, etc.) may be included.

F. The results of the FPPE process will be evaluated by the SMD, who will report to the MSQI Committee, along with a recommendation, including, but not limited to:

1) The process has been successfully completed, and the practitioner will be monitored in accordance with the OPPE Program;
2) An extension of the process should be undertaken, along with the rationale for the recommendation, detailing the nature and duration of the continued FPPE, as well as the outcomes or expectations that would constitute successful completion; or
3) Privileges should be modified or withdrawn, with a written recommendation to the MSQI Committee.

G. In all cases in which privileges are restricted or withdrawn because of quality or safety issues, the practitioner will be afforded the rights of appeal as defined in the Medical Staff Bylaws.

H. The MSQI Committee will act on the recommendation of the SMD and will forward its recommendation to the Medical Executive Committee (MEC).

I. The MEC will review the recommendation and will forward its recommendation to the Quality Improvement Committee of the Board. All final authority resides with the Board.

J. Upon completion of the process, feedback will be provided to practitioner as necessary (i.e. outliers, concerns regarding quality and safety of care, or opportunities for improvement).

Please see Appendix A for specialty-specific FPPE requirements for initial granting of privileges.

05/07/2019 smc

Approved by MEC 06/20/2019
Approved by the Board 07/08/2019

ONGOING PROFESSIONAL PRACTICE EVALUATION PROGRAM

All members of the Medical Staff will be subject to Ongoing Professional Practice Evaluation (OPPE) as a means of assessing current clinical competence, and to inform the biennial reappointment and re-privileging processes. Providers must have 25 patient encounters (defined as an admission, consultation, or procedure) per year, or provide quality data from another facility or practice acceptable to the Medical Staff Quality Improvement (MSQI) and Credentials Committees, that demonstrates current clinical competence. Those who have no patient encounters, and fail to provide acceptable quality data within the prescribed timeframe, will be administratively changed to the Active or Affiliate without Privileges category. Those with a low-volume of encounters may be returned to a Focused Provider Practice Evaluation (FPPE) process.

Purpose:

OPPE allows the Medical Staff and Southern Maine Health Care to assess professional practice data to provide:

1. Evidence of current clinical competence that will inform the re-credentialing and re-privileging processes that will aide in the decision to maintain, review, or revoke existing privileges prior to or at the time of renewal;

2. Identification of opportunities for performance improvement initiatives; and

3. Identification of individual occurrences or concerning trends that may trigger a FPPE. Please refer to the FPPE Program.

OPPE Criteria:

The Medical Staff will determine a set of metrics that form the basis of the OPPE process. Metrics will be determined with input from the MSQI Committee and the Specialty Medical Director (SMD). Metrics proposed as described above will be vetted by the MSQI Committee, in consultation with the Associate Chief Medical Officer (ACMO) and the Vice President of Quality & Safety. Metrics may include process or performance measures pertaining to core competencies, such as patient care, clinical knowledge and judgement, communication, professionalism, and practice improvement.

OPPE Process:

A. All practitioners holding privileges will be enrolled in the OPPE database, which will specify their area of practice, the responsible SMD, and the assigned metrics.

B. All practitioners will have an assigned SMD.

C. The SMD is responsible, with assistance from the ACMO, the Vice President of Quality & Safety, the Quality & Patient Safety Department, and the Medical Staff Quality Improvement Specialist for oversight of the OPPE process.

D. Aggregated group data will be reported to the MSQI Committee.

E. All practitioner-specific data will be reported to the MSQI Committee.

F. OPPE reports will be presented to the MSQI Committee in accordance with the *Medical & Advanced Practice Provider Quality Assessment & Improvement Plan*.

G. Reports to the MSQI Committee will include, but are not limited to:

1) Data reporting;
2) Analysis of the data;
3) Identification of practitioner-specific issues;
4) Identification of metric-specific issues;
5) Review and discussion of peer review results; and
6) Proposed action plans and recommendation(s) for performance improvement.

H. The MSQI Committee will consider the SMD's recommendation(s) and forward them to the Medical Executive Committee (MEC).

I. The MEC will review the recommendation(s) of the SMD and the MSQI Committee, and report their recommendation(s) to the Board.

J. The Board holds ultimate responsibility for monitoring and implementation of safe, high-quality care.

K. In the event of a recommendation by the MEC to restrict or withdraw privileges based on quality or patient safety issues, the practitioner will be afforded the right of appeal as defined in the Medical Staff Bylaws.

L. Feedback will be provided to practitioners as necessary (i.e., outliers, concerns regarding quality and safety of care, or opportunities for improvement).

Please see Appendix B for specialty-specific OPPE requirements.

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Approved MEC 06/20/2019
Approved by the Board 07/08/2019

Peer Review is a component of Ongoing Professional Practice Evaluation (OPPE) that applies to all Medical Staff practitioners holding privileges at Southern Maine Health Care.

As described in the Medical Staff Bylaws (2-8 [19]), all practitioners are required to participate in the peer review process.

Purpose:

Peer Review is utilized to accomplish evaluation of practitioner performance relating to standard of care as judged by peers.

Peer Review Criteria:

Criteria may include, but are not limited to:

- Any patient care issue referred for evaluation by another provider, nursing personnel, case management, quality department reviewers, etc.;
- Isolated significant event;
- Significant patient or staff complaint; and
- Predefined select screening metrics including, but not limited to, those listed in Appendix C.

Peer Review Process:

1. Peer Review of a practitioner will be performed by a member in good standing in the same or similar specialty when possible.

2. Peer Review will generally occur under the direction of the appropriate Specialty Medical Director (SMD).

3. The SMD may be supported by the Chief Medical Officer (CMO) or designee, the Vice President of Quality, Medical Staff Leadership, including the Medical Staff Quality Improvement (MSQI), Credentials, and Medical Executive Committees, the Medical Staff Quality Improvement Specialist, and the Quality & Patient Safety Department.

4. In the event of a conflict of interest, the peer review will be directed by the CMO or designee, in consultation with Medical Staff Leadership.

5. In the absence of qualified practitioners, an external source may be utilized in consultation with the SMD, the CMO or designee, and Medical Staff Leadership.

6. The scope of the peer review process may vary to fit the nature of the purpose.

7. Peer review outcomes will be reported using a standard approach that broadly assesses:

    a. Level 1: Care Appropriate: No Departure from Standard of Care;
    b. Level 2: Care Controversial: No Clear Departure from Standard of Care;
    c. Level 3: Care Inappropriate: Significant Departure from Standard of Care.

8. All Level 2 and 3 peer review outcomes will be submitted to the Risk Management Department to undergo a multidisciplinary Risk/Quality review as appropriate, including the Vice President of Quality, to ensure that no additional actions should be taken, such as referring the case to undergo an Intensive Analysis to identify potential systems issues that should be addressed.

9. Level 2 and 3 outcomes will require identification of the issues raised and any actions recommended or taken.

10. Level 2 and 3 outcomes will be reported to the MSQI Committee by the SMD along with recommendation(s).

11. The MSQI Committee will act on the information and recommendation(s), and forward it to the Medical Executive Committee (MEC).

12. The MEC will assess the information provided and determine if further actions are warranted.

13. The MEC's conclusion will be reported to the Board of Trustees.

14. The Board holds the ultimate responsibility for the monitoring and implementation of safe, high quality care.

15. The confidentiality of the peer review process will be maintained to the fullest extent permitted by applicable law.

16. The results of the peer review will be reported back to the involved practitioner.

17. Any adverse recommendations leading to limitation or reduction in privileges will afford the rights of appeal as defined in the Medical Staff Bylaws.

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Approved by MEC 06/20/2019
Approved by the Board 07/08/2019

FPPE Requirements Per Service-Line

** all encounters/procedures proctored and w/retrospective chart reviews unless otherwise noted † all MMC providers will have retrospective reviews only

Service-Line	Physician	APP	Comments
Anesthesiology	n/a (by Spectrum)	Adult Encounter - 4	APPs- CRNAs
		Pediatric Encounter - 4	
Bariatric Surgery	Bariatric Procedures – 5	n/a	Request anesthesia input if not proctored
Breast Surgery	Breast Procedures – 5	n/a	Request anesthesia and plastic surgery input if retro reviews
Cardiology	Adult Encounter Retro Review - 3	Adult Encounter - 5	
	Invasive Procedure - 2		
Cardiology - Pediatric	Pediatric Encounter Retro Review - 5	Pediatric Encounter - 5	
Dermatology	Adult Encounter Retro Review - 2	Adult Encounter - 3	
	Biopsy - 2	Procedure – 2 (incl. Bx)	
	Misc. Procedure - 1		
Emergency Dept.	Adult Encounter Retro Review - 2	Adult Encounter - 2	Resident – 5 of anything
	Pediatric Encounter Retro Review - 2	Pediatric Encounter - 2	
	Moderate Sedation- 1	Laceration Repair - 2	
	Intubation - 1	Slit Lamp Exam - 1	
	Misc. Emerg Procedure - 2	Additional Retro Chart Reviews - 5	
ENT	Adult Misc Procedure – 2	n/a	Request anesthesia input if not proctored
	Pediatric Misc. Procedure – 2		
	Intubation - 2		

Service-Line	Physician	APP	Comments
Family Medicine	Adult Encounter Retro Review - 2	Adult Encounter – 2	
	Pediatric Encounter Retro Review - 2	Pediatric Encounter – 2	
	Misc. Office Procedure - 2	Misc. Office Procedure - 1	
General Surgery	Colon Case – 2	Patient Encounter - 2	Request anesthesia input if not proctored
	Lap Appy – 1	Procedures – 2 (independent or assist)	
	Lap Chole – 1	Discharge Summary - 1	
	Hernia Repair - 1		
Geriatric Medicine	Adult Encounter Retro Review - 5	n/a	
Gastroenterology	Colonoscopy – 3	Patient Encounter – 4 (or 5 if no inpatient encounters)	Request anesthesia input if not proctored
	Endoscopy - 2	Discharge Summary – 1	
Hospitalist	Adult Admission Retro Review - 2	Adult Admission - 2	Or 5 only of cases of no admits or dc's done
	Adult Encounter Retro Review - 2	Adult Encounter - 2	
	Adult DC Retro Review - 2	Adult DC - 2	
Intensivist/Pulmonology	Inpatient Encounter Retro Review (SCU) – 2	Inpatient Encounter (SCU) – 2	
	Intubation – 1	Intubation – 1	
	Central Line Insert – 1	Central Line Insert – 2	
	Bronchoscopy – 1		
Internal Medicine	Adult Encounter Retro Review - 3	Adult Encounter - 5	
	Misc. Office Procedure - 2		
Neurology	Adult Office Encounter Retro Review - 3	Adult Office Encounter - 5	
	EEG Over Read - 2		
Nephrology	Consults/Encounters – 5	n/a	

Service-Line	Physician	APP	Comments
OB/GYN	Vaginal Delivery - 2	C-Section Assist – 3	
	C-Section - 2	Hysterectomy Assist - 2	
	Hysterectomy - 2	OR Office Visits Only if no proc - 5	
Oncology	New Consult Retro Review - 3	Adult Encounter - 5	
	Adult Encounter Retro Review - 2		
Ophthalmology	Adult Procedure w/ Retro Review – 3 (or 5 if no pediatric cases)	n/a	Request anesthesia input if not proctored
	Pediatric Procedure w/ Retro Review - 2		
Orthopedic	Total Joint Replacement – 2	Adult Office Encounter - 3	
	Arthroscopy - 2	Intra-articular Injection - 1	
	Fracture Fixation - 1	Fracture Reduction - 1	
Pain Medicine	Adult Encounter Retro Review - 3	Adult Encounter – 3	
	Invasive Procedure - 2	Invasive Procedure – 2	
Palliative Care	New Consult Retro Review - 2	Adult Encounter – 3	
	POLST Referral Retro Review - 2	POLST Referral - 2	
Pediatric	Office Encounter Retro Review - 3	Office Encounter - 3	Neonatology: 5 hosp enc
	Newborn Delivery - 2	Office Procedure - 2	
Pediatric Dentistry	Pediatric Dental Procedure Retro Review - 5	n/a	Request anesthesia input if not proctored
Plastic Surgery	Plastics Cases Retro Review - 5	Plastic Cases (Proctored) - 5	Request anesthesia input if not proctored
Podiatry	Adult Encounter Retro Review – 3	n/a	
	Invasive Procedure - 2		

Service-Line	Physician	APP	Comments
Psychiatry	Adult Admission/Consult Retro Review – 3	Adult Admission/Consult – 3	
	Adult Discharge Retro Review - 2	Adult Discharge - 2	
Psychology	Pediatric Encounter Retro Review - 5	n/a	
Surgical Oncology	Misc Procedures Retro Review – 5	n/a	Request anesthesia input if not proctored
Urology	Surgical Procedure – 2	Adult Encounter – 3 (or 5 if no procedures)	Request anesthesia input if not proctored
	Laparoscopic Proc - 2	Procedure - 2	
	Cystoscopy - 1		
Vascular Surgery	Adult Encounter Retro Review – 5 (if no procedures)	Adult Encounter - 5	Request anesthesia input if not proctored
	Procedures – 5 (w/retro review)		
Walk-In	Adult Encounter Retro Review - 2	Adult Encounter – 2	
	Pediatric Encounter Retro Review - 2	Pediatric Encounter - 2	
	Laceration Repair - 2	I&D - 2	
		Laceration Repair - 2	
Work Well	Adult Encounter Retro Review (New EE) - 2	***	***Create APP FPPE
	Adult Encounter Retro Review (Existing EE) - 1		
	Laceration Repair - 2		

as of 12/20/2021

Service Line	Service Leader/Med Dir	2021 Measures	Targets	2022 Measures	Targets
All Service Lines	n/a	**Provider Complaints	# listed	**Provider Complaints	# listed
		**Peer Reviews	# listed	**Peer Reviews	# listed
Retired Measure		**Patient Experience (CG-CHAPS done 6/19 / NRC Real Time as of 9/19)	per report	**Patient Experience: NRC Real Time	per report
New Measure		**PMP Report Checked	95%	**PMP Report Checked	95%
**Needed for APP Measures to Report On		**Encounters closed w/in 72 hrs (for APPs)	95%	**Encounters closed w/in 72 hrs (for APPs) *retired 2/2022*	95%
		**Documentation of Current Medications in the EMR	97%	**Documentation of Current Medications in the EMR	97%
		10% Records co-signed by Physician (for APPs) (*not measured for ortho or WIC***)	10%	**10% Records co-signed by Physician (for APPs) (***not measured for ortho or WIC***)	10%
Anesthesiology (Spectrum) & CRNAS	A. Hayman (Spectrum)	QI Participation (including CRNAs)	80%	QI Participation (including CRNAs)	80%
		Documentation of Mental Status in Epic	>90%	Documentation of Mental Status in Epic	>90%
		Documentation of NPO in Epic	>90%	Documentation of NPO in Epic	>90%
		SMHC PACU Core Temp ≥36°c	>97%	PACU Core Temp ≥36°c (CRNAS)	>90%
		Provider Notes Signed within 24-hours for Discharged Patients	90%	Provider Notes Signed within 24-hours for Discharged Patients	90%
				Inadequate Reversal (CRNAs)	90%
				Post Anesthesia Antiemetic (CRNAs)	90%
				Post Anesthesia Vomiting (CRNAs)	90%
Cardiology	S. Reza	CAD: w/LVEF <40 and/or Diabetes Use of ACE or ARB	60%	CAD: w/LVEF <40 and/or Diabetes Use of ACE or ARB	60%
		HF: Beta Blocker Therapy for LVSD	84%	HF: Beta Blocker Therapy for LVSD	84%
		HTN: Controlling HBP	75%	HTN: Controlling HBP	75%
		Risk-Adjusted Mortalities Rate	2%	Risk-Adjusted Mortalities Rate	2%
		Risk-Adjusted Complications Rate	3%	Risk-Adjusted Complications Rate	3%
		Risk-Adjusted Readmission Rate	7%	Risk-Adjusted Readmission Rate	7%
				O/E Inpatient Mortalities (attending)	1.0%
				O/E Inpatient Complications (attending)	1.0%

Service Line	Service Leader/Med Dir	2021 Measures	Targets	2022 Measures	Targets
				O/E 30-day Readmissions (attending)	1.0%
Emergency Medicine	K. Perreault	ED throughput: Door to provider-(mins/admitted only)	≤30	ED throughput: Door to provider-(mins/admitted only)	≤30
		ED throughput: room to provider-(% met target)	50%	ED throughput: room to provider-(% met target)	50%
		Returns to the ED w/in 48 hrs-standard of care met	100%	Returns to the ED w/in 48 hrs-standard of care met	100%
		Telestroke:		Telestroke:	
		Door to needle tPA	≤45 min	Door to needle tPA **(chg to tNK?)**	≤45 min
		Door to Discharge (Throughput)	TBD	Door to Discharge (Throughput)	TBD
		NRC Real-Time: Provider Show Courtesy	72%	NRC Real-Time: Provider Show Courtesy	72%
		NRC Real-Time: Provider Explained Things	61%	NRC Real-Time: Provider Explained Things	61%
				Opiod Prescribing (PMP Checked?)	TBD
				Notable Events (Moderation Sedation)	TBD
Family Medicine	B. Loffredo (U. Onuhoa-WW)	Encounters closed w/in 72 hrs	95%	(as noted above)	
		Colorectal screening (50-74 yrs)	80%		
		DM-eye exam (18-75 yrs)	70%	DM-eye exam (18-75 yrs)	70%
		DM-HbA1c >9 (18-75 yrs)	<17%	DM-HbA1c >9 (18-75 yrs)	<17%
		HTN control: BP <140/90 (18-85 yrs)	76%	HTN control: BP <140/90 (18-85 yrs)	76%
WorkWell		PMP Checked	95%	Obstructive Sleep Anpea Screening (data from WW)	70%
		Tdap w/laceration	95%	APP Records Co-Signed (data from WW)	10%
		Visual acuity for eye injuries	95%		
		Follow-up to Initial Worker's Compensation Visit Ratio (days)	2.5	Follow-up to Initial Worker's Compensation Visit Ratio (days)	2.5
Gastroenterology	I. Prokopiw			Cecal Intubation to Withdrawal Time (min)	> 6 min
		Cecal Intubation to Withdrawal Time (min)	6-9	Return to OR rate (all cause)	3%
				Return to the OR (exluded expected returns)	3%
				O/E Inpatient Complications	1.0%
		Return to OR rate (all cause)	3%		

Service Line	Service Leader/Med Dir	2021 Measures	Targets	2022 Measures	Targets
Infectious Disease	T. Courtney	HIV-related measures:		HIV-related measures:	
		Care Panel Ever	90%	Care Panel Ever	90%
		Medical Visit Frequency	90%	Consult Notes Signed w/in 24 hrs	90%
		Hepatitis Screening Ever	90%	Hepatitis Screening Ever	90%
		RPR Ever	90%	RPR Ever	90%
		TB Screening Ever	90%	TB Screening Ever	90%
		Viral Load Suppression	90%	Viral Load Suppression	90%
		CPOE: Laboratory Orders	30%	CPOE: Laboratory Orders	30%
		CPOE: Medication Orders	60%	CPOE: Medication Orders	60%
		Medical Records Closed w/in 72 hours	95%	(same as listed above)	
		Zoster Vaccine for HIV Patients	90%		
Inpatient Medicine: Hospitalists	A. Goldman	Discharge Orders before 10a	35%	Discharge Orders before 10a	35%
		Discharges before 12p	35%	Discharges before 12p	35%
		Risk-Adjusted Complications	3%	Risk-Adjusted Complications	3%
		Risk-Adjusted Mortalities	2%	Risk-Adjusted Mortalities	2%
		Risk-Adjusted Readmissions	7%	Risk-Adjusted Readmissions	7%
		Clinically Adjusted LOS (days)	4.45	Clinically Adjusted LOS (days)	4.45
				O/E Inpatient Length of Stay (attending)	1.0%
				O/E Inpatient Complications (attending)	1.0%
				O/E Inpatient Mortalities	1.0%
				O/E Inpatient 30 Day Readmissions (attending)	1.0%
				PMP Checked	TBD
Nephrology		Provider Visits with CKD 4&5 template	60%	Provider Visits with CKD 4&5 template	60%
		Provider Visits with CKD stage 4 & 5	22%	Provider Visits with CKD stage 4 & 5	22%
		Provider Templates Pushed Into Progress Notes	60%	Provider Templates Pushed Into Progress Notes	60%
		Risk-Adjusted Complications	0%	O/E Inpatient Complications (attending)	1.0%
		Risk-Adjusted Mortalities	0%	O/E Inpatient Mortalities (attending)	1.0%
		Risk-Adjusted Readmissions	7%	O/E Inpatient 30 Day Readmissions (attending)	1.0%
				Hemodialysis order set usage	90%
				ESRD Questionaire Compliance	60%

Service Line	Service Leader/Med Dir	2021 Measures	Targets	2022 Measures	Targets
Oncology		Risk-Adjusted Complications	0%	Risk-Adjusted Complications	0%
		Risk-Adjusted Mortalities	0%	Risk-Adjusted Mortalities	0%
		Risk-Adjusted Readmissions	7%	Risk-Adjusted Readmissions	7%
				O/E Inpatient Complications (attending)	1.0%
				O/E Inpatient Mortalities (attending)	1.0%
				O/E Inpatient 30 Day Readmissions (attending)	1.0%
				Chemotherapy informed consent signed (ON HOLD - ISSUES WITH REPORT)	TBD
OB/GYN	P. Manning	Complication rate (inpatient; risk-adjusted)	3%	Complication rate (inpatient; risk-adjusted)	3%
				O/E Inpatient Complications	1.0%
				PC-02: C-Section	24%
				Cervical cancer screening	82%
		Cervical cancer screening	82%		
		(referenced above)			

Service Line	Service Leader/Med Dir	2021 Measures	Targets	2022 Measures	Targets
Orthopedics	D. Johnson				
		NSQIP: Surgical site infections-deep incision/organ space	2.0%	NSQIP: Surgical site infections-deep incision/organ space	2.0%
		Complication rate (inpatient; risk-adjusted)	2.0%	Complication rate (inpatient; risk-adjusted)	2.0%
		Unplanned Return to the OR	3.0%	Unplanned Return to the OR (exludes anticipated)	3.0%
				O/E Inpatient Complications	1.0%
Outpatient Medicine: Internal Medicine	W. Cullen	Encounters closed w/in 72 hrs	95%	(same as listed above)	
		Colorectal Screening (50-75 yrs)	80%	Colorectal Screening (50-75 yrs)	80%
		Tobacco Cessation Referrals	95%		
		Eye Exam for Diabetics (18-75 yrs)	62%	Eye Exam for Diabetics (18-75 yrs)	62%
		HgbA1c >9 (18-75 yrs)	17.5%	HgbA1c >9 (18-75 yrs)	18.0%
		HTN-BP Control <140/90 (18-85 yrs)	80%	HTN-BP Control <140/90 (18-85 yrs)	80%
		Tobacco Use & Cessation Intervention (≥18 yrs)	96%	Tobacco Use & Cessation Intervention (≥18 yrs)	96%
Neurology	J. Dolan (Med Dir)	Encounters Closed w/in 72 hrs	95%	(same as listed above)	
		Parkinson's Disease related measures:		Parkinson's Disease related measures:	
		Mental Status screen in past year	90%	Mental Status screen in past year	90%
		PHQ Y/N screen in past year	90%	PHQ Y/N screen in past year	90%
		Dyskinesia Y/N screen in past year	90%	Dyskinesia Y/N screen in past year	90%
Dermatology	J. Pratt (Med Dir?)	Encounters Closed w/in 72 hrs	95%	(same as listed above)	
		COPE: Laboratory Orders	30%	CPOE: Laboratory Orders	30%

Service Line	Service Leader/Med Dir	2021 Measures	Targets	2022 Measures	Targets
		COPE: Medication Orders	60%	CPOE: Medication Orders	60%
		Documentation of Current Medications in the EMR	97%	(same as listed above)	
		Secure Messaging	50%	Secure Messaging	50%
Pain Medicine	A. Khan	Encounters closed w/in 72 hrs: Office visits	90%	Encounters closed w/in 72 hrs: Office visits	90%
		Encounters closed w/in 72 hrs: Lab/DI results	90%		
		Encounters closed w/in 2 business days; RX refills	90%	Encounters closed w/in 2 business days; RX refills	90%
		Current Controlled Substance Use Contract in Place	95%	Current Controlled Substance Use Contract in Place	95%
		Pain Assessment	90%	Pain Assessment	90%
		** (noted above as metric reported by all)			
		Access to Care [TNA] (Days to Consult)	3%	Access to Care [TNA] (Days to Consult)	3%
Palliative Care	J. Slobodnjak	Inpatient PC consults performed	20	Inpatient PC consults performed	20
		Outpatient PC consults performed	20	PC Consult to date performed (hours)	30
		PC Consult to date performed (hours)	30	PC Consults with Advance Directive at Discharge	50%
		PC Consult to discharge (hours)	75	PC Consults with POLST at Discharge	50%
		Admit to PC request (hours) **language revised*	48		
		PC Consults with Advance Directive at Discharge	50%		
		PC Consults with POLST at Discharge	50%		
Pathology (Spectrum)	V. Parker	AP/CP QI Meeting Attendance	50%	AP/CP QI Meeting Attendance	50%
		Frozen Section (IntraOp) case review major discrepency	<3%	Frozen Section (IntraOp) case review major discrepency	<3%
		External retrospective case review - major discrepancy	<2%	External retrospective case review - major discrepancy	<2%
		Prospective case review - major discrepancy	<2%	Prospective case review - major discrepancy	<2%
		Provider Notes Signed within 24-hours for Discharged Patients	90%	Provider Notes Signed within 24-hours for Discharged Patients	90%

Service Line	Service Leader/Med Dir	2021 Measures	Targets	2022 Measures	Targets
Pediatrics	M. Bordeau			Annual Well Child Visits (15 months)	85%
				Trauma Screening by age 17 years	80%
				HPV Immunization	60%
		Annual Well Child Visits (15 months)	85%		
		Trauma Screening by age 17 years	80%		
		(referenced above)			
		HPV Immunization	60%		
Podiatry	*(vacant)*	Unplanned returned to the OR	3.0%	Unplanned returned to the OR	3.0%
		Surgical site infections	2.0%	Surgical site infections	2.0%
				Complication Rate (inpatient; risk-adjusted)	3.0%
		Complication Rate (inpatient; risk-adjusted)	3.0%		
Psychiatry		Discharge summaries signed w/in 72 hrs	90%	Discharge summaries signed w/in 72 hrs	90%
				O/E Inpatient Length of Stay	1.0%
		Readmissions (0-30d)	7%	Readmissions (0-30d)	7%

Service Line	Service Leader/Med Dir	2021 Measures	Targets	2022 Measures	Targets
		Metabolic Monitoring (inpatient)	36%	Metabolic Monitoring (Attending: CMS IPFQR)	80%
		Average LOS per DC provider (days)	8	Average LOS per DC provider (days)	8
				Average LOS (Days: Attending Provider)	8
Pulmonology	M. Bandara				
		Complications (Primary Phys)	3%	Complications (Primary Phys)	3%
		Mortalities (Primary Phys)	2%	Mortalities (Primary Phys)	2%
		Readmissions (Primary Phys)	7%	Readmissions (Primary Phys)	7%
		Labs/DI Closed w/in 2 business days	80%	Labs/DI Closed w/in 2 business days	80%
		Telephone Encounters Closed w/in 24 hrs	60%	Telephone Encounters Closed w/in 24 hrs	60%
		Tobacco Screening & Cessation Intervention for Tobacco Users	90%		
		Encounters Closed w/in 72 hrs	95%	(same as above)	
				O/E Ratio Complications	1.0%
				O/E Ratio Mortalities	1.0%
				O/E Ratio 30-day Readmissions	1.0%
				O/E Inpatient Length of Stay	1.0%
Radiology (Spectrum)	C. Cinelli / P. Kim	QI Participation	100%	QI Participation	100%
		Synergy QI Participation	100%	Synergy QI Participation	100%
		Provider Notes Signed within 24-hours for Discharged Patients	90%	Provider Notes Signed within 24-hours for Discharged Patients	90%
		Random Retrospective Overreads (Major Discrepancies)	# and % as listed	Random Retrospective Overreads (Major Discrepancies)	# and % as listed

Service Line	Service Leader/Med Dir	2021 Measures	Targets	2022 Measures	Targets
		OneConnect Volumes, Critical Findings, Unexpected, STAT, and Provider to Provider Comm Report	# and % as listed for 1 hr / 2 hr / 3 days	OneConnect Volumes, Critical Findings, Unexpected, STAT, and Provider to Provider Comm Report	# and % as listed for 1 hr / 2 hr / 3 days
				Mammography Inspection Case Counts (all facilities)	# as listed
		Spectrum Peer Reviews (Major Discrepancies)	<3%	Spectrum Peer Reviews (Major Discrepancies)	<1%
		Spectrum Peer Reviews (Minor Discrepancies)	<3%	Spectrum Peer Reviews (Minor Discrepancies)	<3%
		Synergy Peer Reviews (Major Discrepancies)	<3%	Synergy Peer Reviews (Major Discrepancies)	<1%
		Synergy Peer Reviews (Minor Discrepancies)	<3%	Synergy Peer Reviews (Minor Discrepancies)	<3%
		Critical Findings (Participation in One Connect Program	Y/N	Critical Findings (Participation in One Connect Program	Y/N
		vRad Peer Reviews (Major Discrepancies)	<3%	vRad Peer Reviews (Major Discrepancies)	<1%
		vRad Peer Reviews (Minor Discrepancies)	<3%	vRad Peer Reviews (Minor Discrepancies)	<3%
Surgery: General	M. Carroll (Surg); J. Kurta (Urology); K. Malka (Vasc Surgery)	Complication Rate (Surgeon/Consulting; Inpatient; Risk-adjusted)	3%		
				O/E Inpatient Complications	1.0%
				O/E Inpatient Length of Stay	1.0%
				O/E Inpatient Readmissions	1.0%
		Return to the OR (all cause; inpatient and outpatient)	3%	Return to OR (excludes anticipated)	3%

Service Line	Service Leader/Med Dir	2021 Measures	Targets	2022 Measures	Targets
		NSQIP: Deep Incision/Organ Space SSI	1%	NSQIP: Deep Incision/Organ Space SSI	1%
		Robotics metric?			
Ophthalmology					
		Complication Rate (Surgeon/Consulting; Inpatient; Risk-adjusted)	3%	Complication Rate (Surgeon/Consulting; Inpatient; Risk-adjusted)	3%
				Return to OR (excludes anticipated)	3%
		Return to the OR (all cause; inpatient and outpatient)	3%	Return to the OR (all cause; inpatient and outpatient)	3%
		Vitrectomy Rate following cataract surgeries	2%	Vitrectomy Rate following cataract surgeries	2%
		NSQIP-Deep Incision/Organ Space SSI	2%		
Oral & Maxiofacial		*no metrics reported*		NSQIP Deep Incision/Organ Space SSI	1%
				Return to OR (excludes anticipated)	3%
				O/E Inpatient Complications	1.0%
				O/E Inpatient Length of Stay	1.0%
				O/E Inpatient Readmissions	1.0%
Otolaryngology (ENT)		Complication Rate (Surgeon/Consulting; Inpatient; Risk-adjusted)	3%	Complication Rate (Surgeon/Consulting; Inpatient; Risk-adjusted)	3%
				O/E Inpatient Complications	1.0%
				O/E Inpatient Length of Stay	1.0%
				O/E Inpatient Readmissions	1.0%
		Return to the OR (all cause; inpatient)	3%	Return to OR (excludes anticipated)	3%

Service Line	Service Leader/Med Dir	2021 Measures	Targets	2022 Measures	Targets
		NSQIP-Deep Incision/Organ Space SSI	1%	NSQIP-Deep Incision/Organ Space SSI	1%
Pediatric Dentistry		Complication Rate (Surgeon/Consulting; Inpatient; Risk-adjusted)	3%	Complication Rate (Surgeon/Consulting; Inpatient; Risk-adjusted)	3%
				O/E Inpatient Complications	1.0%
				O/E Inpatient Length of Stay	1.0%
				O/E Inpatient Readmissions	1.0%
		Return to the OR (all cause; inpatient)	3%	Return to the OR (all cause; inpatient)	3%
		NSQIP-Deep Incision/Organ Space SSI	1%	NSQIP-Deep Incision/Organ Space SSI	1%
				Return to OR (excludes anticipated)	3%
Plastic Surgery		Complication Rate (Surgeon/Consulting; Inpatient; Risk-adjusted)	3%	Complication Rate (Surgeon/Consulting; Inpatient; Risk-adjusted)	3%
				O/E Inpatient Complications	1.0%
				O/E Inpatient Length of Stay	1.0%
				O/E Inpatient Readmissions	1.0%
		Return to the OR (all cause; inpatient)	3%	Return to the OR (all cause; inpatient)	3%
		NSQIP-Deep Incision/Organ Space SSI	1%	NSQIP-Deep Incision/Organ Space SSI	1%
				Return to OR (excludes anticipated)	3%

Service Line	Service Leader/Med Dir	2021 Measures	Targets	2022 Measures	Targets
Urology		Complication Rate (Surgeon/Consulting; Inpatient; Risk-adjusted)	3%	Complication Rate (Surgeon/Consulting; Inpatient; Risk-adjusted)	3%
		HAC Rate (all cause inpatient)	0%	O/E Inpatient Complications	1.0%
		Mortality Rate (risk-adjusted)	1%	O/E Inpatient Length of Stay	1.0%
		Readmission Rate (risk-adjusted)	5%	O/E Inpatient Readmissions	1.0%
		Return to the OR (all cause; inpatient)	3%	Return to the OR (all cause; inpatient)	3%
		NSQIP-Deep Incision/Organ Space SSI	1%	NSQIP-Deep Incision/Organ Space SSI	1%
				Return to OR (excludes anticipated)	3%
Vascular Surgery		(same as above)			
		(same as above)			
		Complication Rate (Surgeon/Consulting)	3%	Complication Rate (Surgeon/Consulting)	3%
				O/E Inpatient Complications	1.0%
				O/E Inpatient Length of Stay	1.0%
				O/E Inpatient Readmissions	1.0%
		Return to the OR (all cause; inpatient)	3%	Return to the OR (all cause; inpatient)	3%
		NSQIP-Deep Incision/Organ Space SSI	1%	NSQIP-Deep Incision/Organ Space SSI	1%
				Return to OR (excludes anticipated)	3%
Wound Healing		NSQIP-Deep Incision/Organ Space SSI	1%	NSQIP-Deep Incision/Organ Space SSI	1%
		Return to OR (excludes anticipated)	3%	Return to OR (excludes anticipated)	3%

Service Line	Service Leader/Med Dir	2021 Measures	Targets	2022 Measures	Targets
				O/E Inpatient Complications	1.0%
				O/E Inpatient Length of Stay	1.0%
				O/E Inpatient Readmissions	1.0%
Walk-In care	S. Gray	Encounters closed w/in 72 hrs	95%	(noted above)	
		Return to the WIC within 72 Hours	TBD	Return to the WIC within 72 Hours	3%
		Referral to the ED (from WIC) within 72 Hours	TBD	Referral to the ED (from WIC) within 72 Hours	2%
		Avoidable referrals to the ED	10%		
		Appropriate Treatment for Children w/Pharyngitis (CMS146)	90%		
		Appropriate Treatment for Children w/Upper Respiratory Infection (CMS154)	90%		

APPENDIX C: PEER REVIEW INDICATORS

PEER REVIEW INDICATORS

The following is a list of high risk conditions, known as indicators, categorized by service-line that may be subject to a peer review. The list of triggers is not intended to be all-inclusive, and may be modified at any time as trends are identified per the Criteria referred to in the Peer Review Program:

a. Cardiology:
    i. Operative Complications;
    ii. Return to the Operating Room;

b. Emergency Medicine:
    i. Returns to the Emergency Department within 48 hours with subsequent inpatient admission;
    ii. Code Blue Events (Pediatric and Adult);
    iii. Deviation from protocol;
    iv. Department specific process improvement indicators for specified durations;

c. Family Medicine:
    i. Department specific process improvement indicators for specified durations;

d. Gastroenterology:
    i. Readmission w/in 30 days;
    ii. Operative/Procedural Complications;
    iii. Return to the Operating Room;

e. Inpatient Medicine:
    i. Readmissions within 7-days of Hospital Discharges from the Hospitalist Service (non-consultative care) for Related Diagnosis;

f. OB | GYN:
    i. APGAR scores less than or equal to 4 at 1 minute;
    ii. Readmission for the same diagnosis/post procedure;
    iii. Returns to the Operating Room;
    iv. Maternal | Fetal/Neonatal transfer;
    v. Mortality (Maternal or Fetal);
    vi. Operative Complications;
    vii. OB Hypertension (165/110 at admission);

viii. Pre-term Labor;
ix. Transfer to Higher Level of Care;
x. Unplanned C-Section;

g. Ophthalmology
    i. Returns to the OR;
    ii. Operative Complications;

h. Orthopedics:
    i. Operative Complications;
    ii. Returns to the Operating Room;
    iii. Readmissions Related to Surgical Care;

i. Outpatient Medicine:
    i. Department specific process improvement indicators for specified durations;

j. Pediatrics:
    i. APGAR scores less than or equal to 4 at 1 minute, and less than or equal to 7 at 5 minutes;
    ii. Maternal | Neonatal Transfer;
    iii. Mortality;
    iv. Complications;
    v. Birth Injury;
    vi. Transfer to Higher Level of Care;
    vii. Resuscitation events;

k. Podiatry:
    i. Infections after procedure;
    ii. Returns to the Operating Room;

l. Psychiatry
    i. Inpatient Readmission within 30 Days;

m. Pulmonary/SCU
    i. Readmission within 30 Days
    ii. Bronchoscopy with Admission/Readmission within 30 Days;

n. Surgery
    i. Unplanned Readmissions Related to Surgical Care;
    ii. Operative Complications;

iii. Returns to the Operating Room;
iv. Mortality Related to Surgical Care;

o. Urology
    i. Returns to the Operating Room;

p. Walk-In Clinic
    i. Referral to the ED (Pediatrics and COPD Only);
    ii. Return to the WIC within 72 Hours;
    iii. Referral to the ED – Chest Pain;

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