1.4.8 Medical Peer Review Referral and Intake

(a) Procedure Overview

This procedure describes how instances of actual or suspected substandard clinical performance are referred for non-routine or for cause peer review so that appropriate action can be taken to ensure patient safety.

(b) Responsibility

(1) Any person may submit referrals to the Professional Practice Evaluation Support Unit (PPESU) regarding the conduct, performance, or competence of licensed medical providers, but identified referral sources shall refer known or suspected instances of substandard clinical performance within five business days of discovery. All referrals, from any source, involving any potential or perceived imminent danger to the health of patient(s) and/or staff shall be made within one business day of discovery.

(2) The following referral sources are required to timely forward all suspected instances of substandard clinical practices and professional misconduct to the PPESU:

(A) Safety Assessment Panel pursuant to Health Care Department Operations Manual (HCDOM), Section 1.4.9, Safety Assessment, Summary and Automatic Privilege Modification.
(B) Institutional health care leadership.
(C) Regional health care leadership.
(D) Headquarters health care leadership.
(E) Nursing Professional Practice Council.
(F) Mental Health Peer Review Committee.
(G) Dental Peer Review Committee.
(H) Death Review Committee (DRC).
(I) Statewide Health Care Incident Review Committee.
(J) Office of Internal Affairs.
(K) Federal Receiver or designee(s).

(c) Procedure

(1) Written Referrals

(A) A referral for non-routine peer review shall be in writing.
(B) A referral shall include:

1. A concise statement about the incident, allegation, or reasonable suspicion pertaining to the medical provider(s).
2. Any and all available evidence supporting the suspicion of substandard clinical performance to the extent that the evidence is known and/or presently available. Such documentation may include, but is not limited to, documented witness statements, medical records, attendance sheets, and any other documentation which is available or may be made available.

(2) Where to Submit Referrals

(A) Referrals shall be emailed to: mprcsupport@cdcr.ca.gov
(B) In the absence of email availability, the referrals shall be sent to:

CCHCS
P.O. Box 588500
Elk Grove, CA 95758
Attn: Professional Practice Evaluation Support Unit, Bldg. E

(3) Referral Intake Package

(A) The PPESU support staff shall compile a Referral Intake Package consisting of the information from the referral, a peer review history synopsis, and all relevant documentation pertaining to the issue.
(B) The PPESU support staff shall forward the Referral Intake Package to the Peer Review Intake Screener (PRIS), with the following exceptions:

1. Referrals from the Health Care Executive Committee (HCEC) shall be scheduled directly to the Medical Peer Review Committee (MPRC) calendar without prior review from the PRIS.
2. If the licensed medical provider referred to the PPESU support staff is already under peer review at the MPRC level (i.e., non-routine or routine peer review which has been elevated to MPRC review), the case shall automatically be added to next MPRC calendar for review and incorporation into the existing peer review matter.

3. Referrals from the DRC shall be directed to the Regional Deputy Medical Executive (RDME) representing the region of the subject medical provider(s).

(C) Items that do not result in a referral for non-routine peer review or are not part of an open case shall be included on the MPRC consent calendar and provided to the HCEC.

(4) Peer Review Intake Screener

(A) The PRIS shall be a physician assigned to the subject medical provider's region or headquarters. For referrals involving a Physician Assistant or a Nurse Practitioner, the PRIS may be a physician or a provider of the same discipline as the subject provider.

(B) The PRIS shall review all Referral Intake Packages within five business days after receipt from the MPRC support staff, or sooner, as warranted by circumstances surrounding the referral to determine whether the referral meets Intake Referral Criteria.

(C) If the PRIS determines that the clinical issues identified pose potential or actual imminent danger to the health of patient(s) and/or staff, the PRIS shall immediately transmit a Request for Safety Assessment to the MPRC Chairperson pursuant to HCDOM, Section 1.4.9, Safety Assessment, Summary and Automatic Privilege Modification.

(D) If the peer review referral does not meet Intake Referral Criteria:

1. The PRIS shall provide a written summary explaining why the case does not meet Intake Referral Criteria and provide the summary and the referral package to the PPESU support staff.
2. The PPESU support staff shall place the matter on the MPRC consent calendar.
   a. If the consent calendar item is accepted by the MPRC, the case shall be closed.
   b. If the consent calendar item is not approved by the MPRC, the committee shall discuss the case(s) at the time of the disapproval or schedule the matter for the next meeting, depending on time and/or urgency.

(E) If the Peer Review Referral meets Intake Referral Criteria, the PRIS shall summarize the case and return it to the PPESU support staff which shall schedule the matter for review by the MPRC.

(5) Intake Referral Criteria

(A) Evaluation of whether a non-routine peer review referral meets Intake Referral Criteria consists of an evaluation of whether the licensed medical provider's clinical performance or conduct has or is likely to have a negative impact on or pose a risk to patient safety or the clinical environment including whether the licensed medical provider's professional performance or conduct falls below the applicable standard of care.

(6) Death Review Committee Referrals

(A) The RDME of the subject medical provider's region shall conduct the initial review of all Intake Referral Packages from the DRC within five business days after receipt from the PPESU support staff, or sooner, as warranted by circumstances surrounding the referral.

(B) The RDME's review shall determine whether the identified clinical practice or professional conduct of the subject medical provider(s) as revealed by the DRC:

1. Should be returned to the institution for handling by institution executive staff.
2. Should be placed on the consent calendar for the next MPRC meeting.
   a. The MPRC may close the matter or open the matter for discussion.
   b. The PPESU support staff shall notify the referral source of the MPRC's decision.
3. Should be addressed by the MPRC. In instances where the RDME determines that the identified clinical issue(s) pose a potential or actual imminent danger to the health of patient(s) and/or staff, the RDME shall immediately transmit a Request for Safety Assessment to the MPRC Chairperson pursuant to HCDOM, Section 1.4.9, Safety Assessment, Summary and Automatic Privilege Modification.

(C) The RDME shall summarize the reasoning for his/her determination in writing.

1. If the matter is being returned to the institution for handling, the RDME shall include recommendations for resolution of the matter in the summary and provide the summary and the Intake Referral Package to the institution and the PPESU.
2. If the matter is referred to MPRC, the RDME shall provide the summary and the Intake Referral Package to the PPESU support staff to forward to the MPRC.

References

- Federal Health Care Quality Improvement Act of 1986, Title 42, United States Code, Section 11101
- *Plata v. Newsom, et al.*, U.S. District Court of the Northern District of California, Case No. C01-1351 JST
- California Constitution, Article VII, Public Officers and Employees
- California Business and Professions Code, Section 800, *et seq*.
- California Evidence Code, Division 9, Chapter 3, Section 1157
- *Plata* Physician Professional Clinical Practice Review, Hearing and Privileging Procedures Pursuant to Order Approving, With Modifications, Proposed Policies Regarding Physician Clinical Competency, July 9, 2008*; Plata v. Newsom, et al.,* Federal Court Case No. C01-1351 published September 4, 2008, Court ordered procedures

Revision History

Effective: 12/2017