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## Commonwealth of Massachusetts Board of Registration in Medicine

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**MARTIN CRANE, MD**  
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### MEMORANDUM

**TO:** President/CEO, CMO and PCA Coordinator  
**FROM:** Patient Care Assessment Committee  
**DATE:** February 16, 2006  
**RE:** Guidelines for Collection, Analysis and Reporting of Performance Data

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A health care facility's Patient Care Assessment (PCA) Program must include systems for peer review and credentialing that are integrated and overseen by the facility's corporate and physician leadership.<sup>i</sup> In an effort to assess the strength of these systems at your facility, the PCA Committee, when it reviews Major Incident Reports, often asks for de-identified information about the individual credentialed practitioners involved in the incident.<sup>ii</sup>

The PCA Committee does not request this information for the purpose of identifying the involved individuals, but to assure that an assessment by the health care facility of individual practitioner performance was part of the investigation of an adverse or unexpected event. The PCA Committee needs to be assured that the health care facility is ensuring that its professional staff is competent and meeting all applicable patient care standards.

As you know, the information submitted in the Major Incident Reports is confidential and not shared with the public.<sup>iii</sup> Further, the PCA Committee does not disclose information contained in the Major Incident Reports to other divisions within the Board, including the Board's Enforcement Division.<sup>iv</sup>

We understand that health care facilities in the Commonwealth have different processes for analyzing individual practitioner performance and that there is variation in these processes depending on the size of the facility and available resources. We are eager to collaborate with you to continuously improve these processes, as we make strides toward enhancing PCA Programs at all health care facilities in the Commonwealth.

Based upon the PCA Committee's review of over 1,000 Major Incident Reports during the past two years, and in an effort to clarify the information that the PCA Committee would like to see in these reports, we are providing the following guidelines.





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### **Guidelines for Collection, Analysis and Reporting of Performance Data**

For credentialed practitioners involved in a Major Incident, the PCA Committee recommends that the health care facility submit the following information.<sup>v</sup>

1. A brief description of the practitioner's education, training, and experience, including Board Certification, if applicable. The name of the practitioner is not required.
2. A description of the criteria that is used to assess the individual practitioner's performance. The specific criteria will depend on the particular specialty of the involved practitioner. (Examples of performance criteria are provided below and based upon review of data from hospitals. However, this list is not intended to exclude other criteria that a particular hospital uses to measure performance.)<sup>vi</sup>
3. An analysis of the individual practitioner's performance, as measured by the applicable criteria. This analysis should comprise an assessment of the data for the three years prior to the incident, if available. (Hereinafter this data will be referred to as "Performance Data.")<sup>vii</sup>

The analysis of Performance Data should include:

- A numerator (practitioner data) and denominator (department/service data), and rate per year. The data provided should be relevant to the analysis of the case.<sup>viii</sup>
- A comparison of the individual's Performance Data to internal benchmarks (the department/service) and available external benchmarks. (Please indicate the benchmarks used.)
- An account of whether the individual was involved in other Major Incidents (identify the MIRs) and/or whether there are other performance issues that may be relevant to the analysis.
- An indication of whether the practitioner met applicable performance based credentialing/recredentialing requirements.
- An assessment of whether any corrective actions or performance improvement measures are necessary, taking into account the review of both the reported event and the practitioner's Performance Data. (For example, further education training, monitoring or other actions necessary to assure that any identified concerns about a practitioner are addressed, and that the practitioner is practicing competently and safely.)





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We hope that this clarification will be of assistance to you and we are available for consultation. If you have any questions about these guidelines, please feel free to contact Maureen Keenan, RN, JD, Associate Director of the PCA Program at (617) 654-9855 or by email at [maureen.keenan@state.ma.us](mailto:maureen.keenan@state.ma.us), or Charlene DeLoach, JD, CISR, Director of the PCA Program at (617) 654-9892 or by email at [charlene.deloach@dph.state.ma.us](mailto:charlene.deloach@dph.state.ma.us).

If you have specific questions about the applicability of the guidelines to any specific Major Incident Reports, please contact the Nurse Reviewer assigned to your facility. Thank you for your willingness to work with the PCA Committee. We share your objectives: patient safety and excellence in health care for all patients in the Commonwealth.

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<sup>i</sup> See PCA Regulations 243 CMR 3.00, et seq. (The regulations are available at the Board's website: <http://www.massmedboard.org/regs/243cmr.htm>.)

<sup>ii</sup> The term "credentialed practitioners" includes the medical staff, Advanced Practice Nurses (CRNAs, CNMs, NPs), and Physician Assistants.

<sup>iii</sup> See MGL c. 111, § 205

<sup>iv</sup> Since the beginning of the PCA Program in 1987, information submitted by health care facilities to the Board's PCA Division has never been shared with the Board's other divisions. In order to provide further reassurance to health care facilities, the Board is proposing that a prohibition against sharing be included in the PCA Regulations. (See proposed regulation 243 CMR 4.04 (3), available at the Board's website: [www.massmedboard.org](http://www.massmedboard.org).)

<sup>v</sup> This only applies to the practitioners whose involvement in the incident is such that one would expect they would be reviewed during the facility's investigation. We are not asking that you submit this information for those practitioners who had limited involvement with the case.

<sup>vi</sup> *Examples of Performance Criteria.*

Surgical services usually track returns to the OR; wound interruption; enterotomies or lacerations; hemorrhage; patients requiring mechanical ventilation for greater than 5 days; and patients requiring tracheostomy and G-tube. Anesthesia services usually track intraoperative cardiac or respiratory arrest; aspiration; reintubation 12 to 24 hours following extubation; perioperative MIs; and CVAs. Internal medicine services usually track readmissions within 15-30 days with the same diagnosis; and performance with criteria monitored by the ORYX indicators (e.g., CHF, Community Acquired Pneumonia; and AMI.) Some complications are tracked on a hospital-wide basis. (For example central line infections are tracked by Infection Control departments).





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<sup>vii</sup> In prior communications to many of you, we have often referred to “complication data” and “complication rates.” We believe that the term “Performance Data” better describes the type of information that we are requesting from your facility.

<sup>viii</sup> Medical and Surgical data should be broken down by sub-specialty (e.g. Gyn, Ortho, GI or Cardiology) and should be specific enough so that it is meaningful and relevant to the particular investigation or review. For example, when reviewing a case involving a laparoscopic procedure, we suggest that you look at the comparative data for laparoscopic surgeries and not group it together with open procedures.

