

**ST. MARY'S HOSPITAL**

**PROFESSIONAL PRACTICE  
EVALUATION POLICY**

*Adopted by the Medical Executive Committee: March 10, 2015*  
*Approved by the Board: March 31, 2015*  
*Last Reviewed: December 21, 2021*

**PROFESSIONAL PRACTICE EVALUATION POLICY**

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## PROFESSIONAL PRACTICE EVALUATION POLICY

### 1. OBJECTIVES, SCOPE, AND STATEMENT OF MUTUAL EXPECTATIONS

1.A **Objectives.** The primary objectives of the professional practice evaluation process at St. Mary's Hospital (the "Hospital") are to:

- (1) define prospectively, to the extent possible, the expectations for patient care and safety through patient care protocols and guidelines;
- (2) establish, continually review, and update triggers for focused professional practice evaluation and data elements for ongoing professional practice evaluation that will facilitate a meaningful review of the care provided;
- (3) effectively, efficiently, and fairly evaluate the quality, appropriateness, and safety of care provided, comparing it to established patient care protocols, guidelines, and benchmarks whenever possible; and
- (4) provide constructive feedback, education and improvement assistance to practitioners regarding the quality, appropriateness, and safety of the care they provide.

1.B **Scope of Policy.** This Policy applies to all practitioners who provide patient care services in St. Mary's Hospital. For purposes of this Policy, a "practitioner" is defined as any individual who has been granted clinical privileges.

1.C **Statement of Mutual Expectations.**

1.C.1 **Expectations for Practitioners.** Practitioners are expected to:

- (a) constructively participate in the development, review, and revision of clinical protocols and guidelines pertinent to their clinical specialties, including those related to national patient safety initiatives and core measures;
- (b) comply with adopted protocols and guidelines or document the clinical reasons for variance;
- (c) abide by all responsibilities outlined in the Medical Staff Bylaws, Rules and Regulations, Credentials Policy, and other Medical Staff and Hospital policies;
- (d) constructively participate in identifying the data to be collected, reviewed and analyzed for practitioners in their specialties as part of the ongoing professional practice evaluation;

- (e) constructively participate in identifying adverse outcomes, clinical occurrences, or complications in their specialties that will trigger focused professional practice evaluation;
- (f) respond appropriately to educational letters and collegial interventions by modifying the behavior or practice that triggered the letter or intervention;
- (g) participate constructively and cooperatively in the focused professional evaluation process and in any performance improvement plans that may be developed for the practitioner; and
- (h) report, through appropriate channels, any quality of care or patient safety concerns.

1.C.2 ***Expectations for Medical Staff Leaders and Hospital Management.***

Practitioners can expect Medical Staff leaders and Hospital management to:

- (a) research and develop clinically-sound protocols, guidelines, and quality measures;
- (b) openly communicate with practitioners regarding review of their professional practice within the confines of peer review confidentiality principles;
- (c) share ongoing professional practice evaluation (OPPE) reports on a regular basis, and strive to develop helpful comparative data;
- (d) use collegial, educational methods to address concerns when, in the discretion of the Medical Staff leaders and Hospital management, such methods are consistent with patient safety and quality patient care;
- (e) provide a reasonable opportunity for a practitioner to have input into the review of a particular case or cases and in the development of a performance improvement plan to which he or she will be subject; and
- (f) complete the focused professional practice evaluation process in a timely and efficient manner, adhering to the time frames as outlined in this Policy.

## 2. PROFESSIONAL PRACTICE EVALUATION COMMITTEE (PPEC)

2.A **Composition.** The Professional Practice Evaluation Committee (PPEC) shall consist of at least six members of the Medical Staff who are widely representative of the medical and surgical specialties at the Hospital. Particular consideration is to be given to Past Presidents of the Medical Staff and to other physicians knowledgeable about the quality improvement and peer review processes. The Peer Review Coordinator and the CMO shall also serve on the committee. The Committee shall meet as often as necessary to fulfill its duties.

2.B **Duties.** The PPEC shall:

- (1) oversee the implementation of this Policy;
- (2) review and approve specialty-specific data elements for ongoing professional practice evaluation and specialty-specific triggers for focused professional practice evaluation that are identified by each Department;
- (3) review and maintain familiarity with patient care protocols and guidelines developed by national organizations;
- (4) review and approve patient care protocols or guidelines adopted by Departments and the Medical Staff Peer Review Coordinator;
- (5) identify those variances from rules, regulations, policies or protocols which do not require physician review but for which the Medical Staff Peer Review Coordinator may send an educational letter to the practitioner involved in the case (as described in Section 3.B.2);
- (6) review cases referred to it as outlined in Paragraph 5.E.2 of this Policy;
- (7) develop, when appropriate, performance improvement plans for practitioners;
- (8) on a regular basis, submit reports of its actions and recommendations to the Medical Executive Committee, which shall then forward the reports to the Board;
- (9) review the effectiveness of this Policy periodically and recommend revisions or modifications as may be necessary; and
- (10) oversee the Hospital's compliance with core measures.



### 3. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

3.A **Definition.** OPPE means the ongoing review and analysis of data to identify issues in practitioners' professional performance.

#### 3.B **OPPE Data Elements.**

3.B.1 **Specialty-Specific Data Elements.** Each Department, in consultation with the Medical Staff Peer Review Coordinator, shall determine the OPPE data to be collected for each practitioner in that Department and, where appropriate and relevant, the threshold for each data element. In determining the data elements to be collected, the available information system capabilities and the type of data that would reasonably be expected to reflect clinically-significant issues for each specialty shall be considered. When possible, the thresholds for data elements shall be based on relevant clinical literature. The OPPE data elements and thresholds for each Department shall be approved by the PPEC.

3.B.2 **Non-Compliance with Medical Staff Rules, Regulations and Policies, or Failure to Follow Clinical Protocols/Guidelines.** When cases or situations are identified in which:

- (i) a practitioner failed to comply with Medical Staff Rules and Regulations or other Hospital or Medical Staff policies; or
- (ii) an adopted protocol or guideline was not followed and there is no appropriate documentation in the medical record as to the reasons for not following the protocol or guideline,

the Medical Staff Peer Review Coordinator shall prepare an informational letter reminding the practitioner of the applicable requirement and offering assistance to the practitioner in doing so. The letter shall be signed by the Department Chief or the Chair of the PPEC, a copy shall be placed in the practitioner's confidential file, and it shall be considered in the reappointment process and/or in the assessment of the practitioner's competence to exercise the clinical privileges granted. The number of letters sent shall be included on the OPPE report. If more than two letters are sent during the six-month period covered by the OPPE report, the matter shall be reviewed as outlined in Section 3.C.2 of this Policy.

#### 3.C **Review of OPPE Data Elements.**

3.C.1 **Collection of Data.** An OPPE report for each practitioner shall be prepared at least every six months. The report shall be available to the practitioner and a copy placed in the practitioner's file and considered in

the reappointment process and in the assessment of the practitioner's competence to exercise the clinical privileges granted.

3.C.2 ***Data That Do Not Meet Thresholds.*** If a practitioner's OPPE report includes data that do not meet the defined thresholds or that otherwise may indicate a practice pattern that requires further review, the report shall be forwarded to the appropriate Department Chief. The Department Chief may review the underlying cases that make up the data or other relevant information concerning the OPPE report to determine if the data reflects any clinical pattern or issue that requires focused professional practice evaluation. If the Department Chief determines that focused professional practice evaluation is required, the process outlined in Section 5 of this Policy shall be followed.

#### 4. **FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) TO CONFIRM COMPETENCE (NEW MEMBERS/NEW PRIVILEGES)**

4.A ***Definition.*** Focused Professional Practice Evaluation ("FPPE") is a time-limited period during which a practitioner's professional performance is evaluated.

4.B ***Initially-Granted Privileges.*** All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, shall be subject to FPPE. (A flow chart depicting the FPPE process for initially-granted privileges is attached as **Appendix A.**)

4.C ***Development of FPPE Requirements.*** Each Department Chief shall recommend the FPPE requirements needed to confirm the competence of a new Medical Staff member to exercise the core privileges in the specialties represented within the Department and for each "special" privilege outside the "core" in each specialty and how such FPPE is to be documented. The requirements shall specify a time frame for the FPPE to be completed.

FPPE requirements recommended by the Department shall be reviewed by the Credentials Committee and adopted by the Medical Executive Committee. Such requirements may include:

- (1) retrospective or prospective chart review by internal or external reviewers;
- (2) concurrent proctoring or direct observation of procedures or patient care practices; or
- (3) discussion with other individuals involved in the care of the new member's patients.

The Credentials Committee and Medical Executive Committee shall consider relevant FPPE requirements when making their recommendations regarding

clinical privilege requests and may modify the FPPE requirements if an applicant's credentials indicate that additional or different FPPE may be required.

4.D ***Notice of FPPE Requirements.*** When notified that a request for privileges has been granted, the practitioner shall be informed of the above FPPE clinical activity and performance requirements and of his or her responsibility to cooperate in satisfying the FPPE requirements. In addition, the practitioner shall be informed of the requirement of fulfilling all citizenship requirements, including completion of medical records and/or emergency service call responsibilities.

4.E ***Review of FPPE Results.***

4.E.1 ***Review by the Department Chief.*** The Department Chief shall review the results of the FPPE and shall report to the Credentials Committee whether the practitioner fulfilled all requirements and his or her assessment as to whether the FPPE confirmed that the practitioner is competent to exercise the clinical privileges granted or if additional FPPE is required to make a determination.

4.E.2 ***Review by Credentials Committee.*** Based on the Department Chief's assessment, and its own review of the FPPE results and all other relevant information, the Credentials Committee may make one of the following recommendations to the Medical Executive Committee:

- (a) the FPPE process has confirmed competence and no changes to clinical privileges are necessary;
- (b) some questions exist and additional FPPE is needed to confirm competence, what additional FPPE is needed, and the time frame for it (which may be coordinated by the PPEC);
- (c) the time period for FPPE should be extended because the individual did not fulfill the FPPE clinical activity requirements, thus preventing an adequate assessment of the individual's competence, but in no event shall the time frame for FPPE extend beyond 24 months after the initial granting of privileges;
- (d) there are concerns about the practitioner's competence to exercise some or all of the clinical privileges granted, the details of a performance improvement plan that would adequately address the Committee's concerns about the individual's competence or the changes that should be made to the practitioner's clinical privileges subject to the procedural rights outlined in the Credentials Policy. In developing such a performance improvement plan, the Credentials Committee may request input or assistance from the PPEC; or

- (e) the individual's clinical privileges should be automatically relinquished for failure to meet FPPE clinical activity requirements or other requirements of Medical Staff appointment (e.g., emergency call obligations and medical records completion), subject to the procedural rights outlined in Section 4.F of this Policy.

#### 4.E.3 *Review by Medical Executive Committee.*

- (a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:
  - (1) adopt the findings and recommendation of the Credentials Committee as its own; or
  - (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or
  - (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.
- (b) If the recommendation of the Medical Executive Committee is either that the FPPE process has confirmed competence or that the FPPE process should be extended to permit further review, the recommendation shall be forwarded to the Board through the President of the Medical Staff.
- (c) If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing in accordance with Article 7 of the Credentials Policy, the Medical Executive Committee shall forward its recommendation to the CEO, who shall promptly send special notice to the applicant. The CEO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

#### 4.F *Hearing Rights for Automatic Relinquishment of Privileges.*

If a determination is made by the Medical Executive Committee that an individual's clinical privileges shall be considered automatically relinquished as set forth in Section 4.E.2(e), the practitioner shall not be entitled to the hearing and appeal rights outlined in the Credentials Policy or Allied Health Practitioner

Policy. Rather, the practitioner shall be entitled to the hearing rights outlined in this section.

4.F.1 **Notice.** The practitioner shall be notified in writing before a report of the automatic relinquishment is made to the Board. The notice shall inform the practitioner of the reasons for the automatic relinquishment and that he/she may request, within 10 days, a meeting with the Department Chief, the Credentials Committee and the CMO (or designees).

4.F.2 **Meeting with Department Chief, Credentials Committee, and Chief Medical Officer.** The individual shall have an opportunity to explain or discuss extenuating circumstances related to the reasons for failing to fulfill the FPPE or other requirements. No counsel may be present at the meeting. Minutes shall be kept.

4.F.3 **Written Report and Recommendation.** At the conclusion of the meeting, the Credentials Committee shall make a written report and recommendation. The report shall include the minutes of the meeting held with the individual. After reviewing the Credentials Committee's recommendation and report, the Medical Executive Committee may:

- (a) adopt the Credentials Committee's recommendation as its own and forward it to the Board;
- (b) send the matter back to the Credentials Committee with specific concerns or questions; or
- (c) make a recommendation to the Board that is different than the Credentials Committee's and outline the specific reasons for its disagreement.

4.F.4 **Final Board Decision.** The decision of the Board shall be final, with no right to hearing or appeal under the Credentials Policy or the Policy on Allied Health Professionals, as applicable.

## 5. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) WHEN CONCERNS ARE RAISED (PEER REVIEW)

5.A **When Concerns Are Raised.** The FPPE process shall also be conducted whenever concerns are raised about a practitioner's clinical practice. (Concerns regarding a practitioner's professional conduct shall be directed for review in accordance with the Medical Staff Code of Conduct.) The process for FPPE when concerns are raised is outlined in **Appendix B-1** (Detailed Flowchart) and **Appendix B-2** (Simplified Flowchart). This Section describes each step in that process.

5.B ***FPPE Triggers.***

5.B.1 ***Specialty-Specific Triggers.*** Each Department shall identify adverse outcomes, clinical occurrences, or complications that will trigger FPPE. The triggers identified by the Departments shall be approved by the PPEC.

5.B.2 ***Reported Concerns.*** Any practitioner or Hospital employee may report concerns related to the safety or quality of care provided to a patient or the professional conduct of a practitioner to the Medical Staff Peer Review Coordinator. Concerns may be reported anonymously. Such reported concerns shall be reviewed as outlined in this Section 5, unless the Medical Staff Peer Review Coordinator determines that the concern is not related to an individual practitioner, the report cannot be substantiated, or the report is without merit.

5.B.3 ***Other FPPE Triggers.*** In addition to specialty-specific triggers and reported concerns, other events that may trigger a FPPE include, but are not limited to, the following:

- (a) identification by a Medical Staff committee of a clinical trend or specific case or cases that require further review;
- (b) patient complaints referred by the Patient Representative that the Medical Staff Peer Review Coordinator determines require physician review;
- (c) a Department Chief's determination that OPPE data reveal a practice pattern or trend that requires further review;
- (d) a trend of noncompliance with Medical Staff Rules and Regulations or other policies and/or failure to follow adopted clinical protocols or guidelines resulting in more than two educational letters being sent within a six-month period;
- (e) cases identified as litigation risks that are referred by the Risk Management Department for focused professional practice evaluation;
- (f) concerns about medical necessity referred from the Hospital's Compliance Officer or others; and
- (g) sentinel events, as defined in the Sentinel Events Policy, if they involve an individual practitioner's professional performance.

All matters identified for FPPE shall be referred to the Medical Staff Peer Review Coordinator.

5.C ***Medical Staff Peer Review Coordinator Review and Determination.***

5.C.1 ***Review.*** The Medical Staff Peer Review Coordinator shall review all matters that are identified or referred for FPPE. The review may include, as necessary, the following:

- (a) the relevant medical record;
- (b) interviews with, and information from Hospital employees, practitioners, patients, family, visitors, and others who may have relevant information;
- (c) consultation with relevant Medical Staff or Hospital personnel;
- (d) review of other relevant documentation; and
- (e) the practitioner's professional practice evaluation history.

5.C.2 ***Incomplete Medical Records.*** One of the objectives of this Policy is to review matters and provide feedback to practitioners in a timely manner. Therefore, if a matter identified for FPPE involves a medical record that is incomplete, the Medical Staff Peer Review Coordinator shall notify the practitioner that the case has been referred for evaluation and that the medical record must be completed within 10 days. If the medical record is not completed within 10 days, the practitioner's Medical Staff appointment and/or clinical privileges will be automatically relinquished until the medical record is completed.

5.C.3 ***Determination.*** After conducting its review, the Medical Staff Peer Review Coordinator shall make one of the following determinations:

- (a) ***No Further Review Required.*** If the Medical Staff Peer Review Coordinator, in consultation with the Chief Medical Officer, determines that no issue is presented in the case and no further action or review is required, the matter shall be closed. A report of the cases closed by the Medical Staff Peer Review Coordinator with no further review shall be provided to the PPEC on a monthly basis.
- (b) ***Send an Informational Letter*** regarding noncompliance with Medical Staff Rules and regulations, policies or adopted clinical protocols or guidelines, as described in Paragraph 3.B.2 of this Policy.

- (c) **Physician Review Required.** If the Medical Staff Peer Review Coordinator, in consultation with the Chief Medical Officer, determines that a case requires physician review, the case shall be prepared for review. Preparation of the case may include, as appropriate, the following:
  - (i) completion of the appropriate portions of the applicable review form (i.e., general, surgical, medical, or obstetrical);
  - (ii) preparation of a time line or summary of the care provided;
  - (iii) identification of relevant patient care protocols or guidelines; and
  - (iv) identification of relevant literature.

5.D **Review by Chief Medical Officer.** The Chief Medical Officer shall review all matters referred by the Medical Staff Peer Review Coordinator. The Chief Medical Officer may request additional information from any practitioner or Hospital employee with personal knowledge of the matter.

5.D.1 **Assignment of Review.** The Chief Medical Officer may assign the review of the case to the relevant Department Chief or to any other practitioner who has the clinical expertise necessary to evaluate the care provided. The Department Chief or assigned reviewer shall then complete an appropriate review form, if applicable, and report his or her findings to the Chief Medical Officer within 21 days.

5.D.2 **Notice to and Input from Practitioner.** The Chief Medical Officer and/or Department Chief may request the practitioner to provide input, but are not required to do so. The Chief Medical Officer or Department Chief may ask the practitioner to discuss the care with them personally, to provide a written description and explanation of the care, and/or to respond to specific questions posed by the Department Chief or Chief Medical Officer. The request shall provide a time frame for such input. If the practitioner fails to provide input within the time frame, the Chief Medical Officer or Department Chief shall proceed with the review without input from the practitioner, and shall note the practitioner's failure in a report to the PPEC.

5.D.3 **Determination.** Following review of the case, the Chief Medical Officer shall make one of the following determinations:

- (a) **No Further Review or Action Required.** If the Chief Medical Officer determines that no further review or action is required, the case shall be closed. The Chief Medical Officer's findings and



determination shall be reported to the PPEC and, if input was sought from the relevant practitioner, he or she shall be notified of the findings and determination.

- (b) ***Address Through Educational Letter.*** If the Chief Medical Officer determines that no further review or action is required, but the goal of enhancing quality of care and improving patient safety would be advanced by sending an educational letter to the practitioner involved, the Chief Medical Officer shall compose and send the letter or shall facilitate having an appropriate letter sent in a timely manner. The letter shall inform the practitioner that a copy of the letter will be included in the practitioner's file along with any response that he or she would like to offer. A copy of the letter shall also be forwarded to the PPEC.
- (c) ***Address Through Collegial Intervention.*** If the Chief Medical Officer determines that no further review or action is required, but the goal of enhancing quality of care and improving patient safety would be advanced by a collegial intervention with the practitioner involved, the Chief Medical Officer shall conduct that collegial intervention personally or shall facilitate an appropriate and timely collegial intervention. A follow-up letter shall be sent to the practitioner after the collegial intervention summarizing the discussion. A copy of the letter will be included in the practitioner's file along with any response that he or she would like to offer. A copy of the letter shall also be forwarded to the PPEC.
- (d) ***Further Review Required.*** If the Chief Medical Officer determines that further review of the matter is required, the matter shall be referred to the PPEC, including all supporting documentation and the completed review form with the Department Chief's or assigned reviewer's findings. However, if a pattern has developed despite prior attempts at collegial intervention or prior participation in a performance improvement plan, or if the matter involves a very serious incident, the Chief Medical Officer may instead refer the matter directly to the Medical Executive Committee for its review and appropriate recommendation or action pursuant to the Credentials Policy.

## 5.E ***PPEC Review.***

- 5.E.1 ***Review of Prior Determinations.*** The PPEC shall review reports from the Medical Staff Peer Review Coordinator and the Chief Medical Officer that no further action was required or that educational letters or collegial interventions were appropriate to address the issues identified. If the PPEC has concerns about any such determination, it may:

- (a) send the matter back to the Chief Medical Officer with its questions or concerns and ask that the matter be reconsidered;
- (b) ask an individual Medical Staff member, another Medical Staff committee or Hospital Department to review the matter; or
- (c) review the matter itself.

5.E.2 ***Cases Referred to the PPEC for Further Review.***

- (a) ***Preliminary Review.*** The PPEC shall review all other matters referred to it along with all supporting documentation. The PPEC may request information from any other practitioner, Hospital employee, or individual with personal knowledge of the matter.
- (b) ***Additional Clinical Expertise Needed.*** Based on its preliminary review, the PPEC shall determine whether any additional clinical expertise is needed to adequately identify and address concerns raised in the case. If additional clinical expertise is needed, the PPEC may assign the review to any practitioner with the appropriate clinical expertise or to an ad hoc committee composed of such practitioners or, in consultation with the Chief Medical Officer, may arrange for an external review.
- (c) ***External Reviews.*** An external review may be appropriate if:
  - (i) there are ambiguous or conflicting findings by internal reviewers;
  - (ii) the clinical expertise needed to conduct a review is not available on the Medical Staff; or
  - (iii) an outside review is advisable to prevent allegations of bias, even if unfounded.

If a decision is made to seek an external review, the practitioner involved shall be notified of that decision and the nature of the external review.

- (d) ***Notice to and Input from Involved Practitioner.***
  - (i) ***No Further Review Required.*** If, based on its initial review and any additional information obtained, the PPEC determines that no further review is required, the matter shall be closed. If input had been sought from the

practitioner involved at any time during the review process, or if the practitioner involved had been notified that an external review was being sought, the practitioner shall be notified of the PPEC's final determination.

- (ii) ***Request for Input.*** If, based on its initial review and any additional information obtained, the PPEC's preliminary determination is anything other than a finding that no further review is required, it shall notify the practitioner involved of the PPEC's review and its preliminary findings. The notice shall invite the practitioner to provide input by meeting with the PPEC and/or by providing a written description and explanation of the care, and responding to any specific questions posed by the PPEC. The notice shall provide a time frame for such input. If the practitioner fails to provide input within the time frame specified by the PPEC, the practitioner's clinical privileges shall be considered automatically relinquished until the requested input is provided, in accordance with the Credentials Policy.

5.E.3 ***Final Determination.*** Based on its review of all information obtained, including any input from the practitioner, the PPEC shall determine the appropriate course of action from the following:

- (a) ***No Further Review or Action Required.*** If the PPEC determines that no further review or action is required, the matter shall be closed. The PPEC shall inform the practitioner involved of its determination.
- (b) ***Address Through Educational Letter.*** If the PPEC determines that no further review or action is required, but the goal of enhancing quality of care and improving patient safety would be advanced by sending an educational letter to the practitioner involved, the PPEC will compose and send the letter itself or will facilitate having an appropriate letter sent in a timely manner. The letter shall inform the practitioner that a copy of the letter will be included in the practitioner's file along with any response that he or she would like to offer.
- (c) ***Address Through Collegial Intervention.*** If the PPEC determines that no further review or action is required, but the goal of enhancing quality of care and improving patient safety would be advanced by a collegial intervention with the practitioner involved, it will facilitate an appropriate and timely collegial intervention and document the collegial intervention taken. A follow-up letter

shall be sent to the practitioner after the collegial intervention summarizing the discussion. A copy of the letter will be included in the practitioner's file along with any response that he or she would like to offer.

- (d) ***Address Through Performance Improvement Plan ("PIP")***. If the PPEC determines that quality care and patient safety could be enhanced and the practitioner's practice improved through a performance improvement plan, it shall develop such a plan. The performance improvement plan will be presented to the practitioner in person and in writing, and a copy will be placed in the practitioner's file.

To the extent possible, the performance improvement plan shall be for a defined time period or for a defined number of cases. The plan shall specify how the practitioner's compliance with, and results of, the performance improvement plan shall be monitored. As deemed appropriate by the PPEC, the practitioner shall have an opportunity to provide input into the development and implementation of the performance improvement plan.

Until the PPEC has determined that the practitioner has complied with all elements of the performance improvement plan and that concerns about the practitioner's practice have been adequately addressed, the matter shall remain on the PPEC's agenda and the practitioner's progress on the PIP shall be monitored.

A performance improvement plan may include, but is not limited to, the following (additional guidance regarding performance improvement plan options and specific implementation issues is found in **Appendix C**):

- (i) ***Additional Education/CME*** which means that, within a specified period of time, the practitioner must arrange for education or CME of a duration and type specified by the PPEC. The educational activity/program may be chosen by the PPEC or by the practitioner. If the activity/program is chosen by the practitioner, it must be approved by the PPEC. If necessary, the practitioner may be asked to voluntarily refrain from exercising all or some of his/her clinical privileges or may be granted an educational leave of absence while undertaking such additional education.
- (ii) ***Focused Prospective Review*** which means that a certain number of the practitioner's future cases of a particular

type will be reviewed (e.g., review of the next 10 similar cases performed or managed by the practitioner).

- (iii) ***Second Opinions/Consultations*** which means that before the practitioner proceeds with a particular treatment plan or procedure, he/she must obtain a second opinion or consultation from a Medical Staff member(s) specified by the PPEC. The practitioner providing the second opinion/consultation must complete a Second Opinion/Consultation Report form for each case, which shall be reviewed by the PPEC.
- (iv) ***Concurrent Proctoring*** which means that a certain number of the practitioner's future cases of a particular type (e.g., the practitioner's next five vascular cases) must be personally proctored by a Medical Staff member(s) approved by the PPEC or by an appropriately credentialed individual from outside of the Medical Staff approved by the PPEC. The proctor must be present before the case is started and must remain throughout the duration of the case or must personally assess the patient and be available throughout the course of treatment. The proctor(s) must complete the appropriate review form, which shall be reviewed by the PPEC.
- (v) ***Participation in a Formal Evaluation/Assessment Program*** which means that, within a specified period of time, the practitioner must enroll in an assessment program identified by the PPEC and must then complete the program within another specified time period. The practitioner must execute a release to allow the PPEC to communicate information to, and receive information from, the selected program. If necessary, the practitioner may be asked to voluntarily refrain from exercising all or some of his/her clinical privileges or may be granted an educational leave of absence while undertaking such formal assessment.
- (vi) ***Additional Training*** which means that, within a specified period of time, the practitioner must arrange for additional training of a duration and type specified by the PPEC. The training program must be approved by the PPEC. The practitioner must execute a release to allow the PPEC to communicate information to, and receive information from, the selected program. The practitioner must successfully complete the training within another specified period of

time. The director of the training program or appropriate supervisor must provide an assessment and evaluation of the practitioner's current competence, skill, judgment and technique to the PPEC. If necessary, the practitioner may be asked to voluntarily refrain from exercising all or some of his/her clinical privileges or may be granted an educational leave of absence while undertaking such additional training.

- (vii) ***Educational Leave of Absence*** which means that the practitioner voluntarily agrees to a leave of absence during which time the practitioner completes an education/training program of a duration and type specified by the PPEC.
- (e) ***Refusal of Performance Improvement Plan.*** The practitioner must agree in writing to constructively participate in the performance improvement plan that is developed by the PPEC. If the practitioner involved in the case refuses to participate in the performance improvement plan that is developed by the PPEC, the matter shall be referred to the Medical Executive Committee for appropriate review and recommendation under the Credentials Policy.
- (f) ***Refer to the Medical Executive Committee.*** If the PPEC determines that an educational letter, collegial intervention, or a performance improvement plan may not be adequate to address the issues identified, or if a pattern has developed despite prior attempts at collegial intervention or prior participation in a performance improvement plan, the PPEC shall refer the matter to the Medical Executive Committee for appropriate review under the Credentials Policy.

## 6. PRINCIPLES OF REVIEW AND EVALUATION

6.A ***Confidentiality.*** Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process.

6.A.1 ***Documentation.*** All documentation that is prepared in accordance with this Policy shall be appropriately marked as confidential and privileged pursuant to Ga. Code Ann. §31-7-15, §31-7-131 et seq., and §31-7-140 et seq. and maintained in appropriate Medical Staff files. This documentation shall be accessible to authorized officials and Medical Staff leaders and committees having responsibility for credentialing and professional practice evaluation functions, and to those assisting them in those tasks. All such information shall otherwise be deemed confidential

and kept from disclosure or discovery to the fullest extent permitted by Georgia or federal law.

6.A.2 ***Participants in the PPE Process.*** All individuals involved in the professional practice evaluation process (Medical Staff and Hospital employees) will maintain the confidentiality of the process. All such individuals shall sign an appropriate Confidentiality Agreement.

6.A.3 ***PPE Communications.*** Communications among those participating in the professional practice evaluation process, including communications with the individual practitioner involved, shall be conducted in a manner reasonably calculated to assure privacy. Telephone and direct communications shall take place at appropriate times and locations, and correspondence shall be conspicuously marked with the notation “Confidential, to be Opened Only by Addressee” or words to that effect.

6.B ***Conflict of Interest Guidelines.*** To protect the integrity of the review process, all those involved must be sensitive to potential conflicts of interest. It is also important to recognize that effective peer review involves “peers” and that the PPEC does not make any recommendation that would adversely affect the clinical privileges of a practitioner (which is only within the authority of the Medical Executive Committee). As such, the conflict of interest guidelines outlined in Article 8 of the Credentials Policy shall be used in assessing and resolving any potential conflicts of interest that may arise under this Policy.

Additional guidance pertaining to conflicts of interest principles can be found in **Appendix D.**

6.C ***Protection for Reviewers.*** It is the intention of the Hospital and the Medical Staff that the professional practice evaluation process outlined in this Policy be considered patient safety, professional review, and peer review activity within the meaning of the Patient Safety Quality Improvement Act of 2005, the federal Health Care Quality Improvement Act of 1986, and Georgia law. In addition to the protections offered to individuals involved in professional review activities under those laws, such individuals shall be covered under the Hospital’s Directors’ and Officers’ Liability insurance and/or will be indemnified by the Hospital when they act within the scope of their duties as outlined in this Policy and function on behalf of the Hospital.

6.D ***Collegial Efforts and Progressive Steps.*** This Policy encourages the use of collegial efforts and progressive steps to address issues that may be identified in the professional practice evaluation process. The goal of those efforts is to arrive at voluntary, responsive actions by the practitioner. Collegial efforts and progressive steps may include, but are not limited to, counseling, informal discussions, education, mentoring, letters of counsel or guidance, sharing of comparative data, and performance improvement plans as outlined in this Policy.

All collegial efforts and progressive steps are part of the Hospital's confidential performance improvement, OPPE, FPPE, and peer review activities. These efforts are encouraged, but are not mandatory, and shall be within the discretion of the CMO, the Department Chief, and the PPEC.

- 6.E ***Findings and Recommendations Supported by Evidence-Based Research/Clinical Protocols or Guidelines.*** Whenever possible, the findings of assigned reviewers and the PPEC shall be supported by evidence-based research, clinical protocols or guidelines.
- 6.F ***System Process Issues.*** Quality of care and patient safety depend on many factors in addition to practitioner performance. If, during OPPE or FPPE, system processes or procedures that may have adversely affected, or could adversely affect, outcomes or patient safety are identified, the issue shall be referred to the appropriate Hospital Department and/or the Medical Staff Peer Review Coordinator. The shall also be reported to the PPEC so that the PPEC can monitor the successful resolution of these issues.
- 6.G ***Tracking of Reviews.*** The Medical Staff Peer Review Coordinator shall track the processing and disposition of focused professional practice evaluations conducted pursuant to this Policy. The CMO, Department Chief, and PPEC shall promptly notify the Medical Staff Peer Review Coordinator of their determinations and dispositions. The number of cases identified or referred for review and the dispositions of those cases shall be included on each practitioner's OPPE report.
- 6.H ***Educational Sessions.*** If a specific case is identified as part of the focused professional practice evaluation process that would have educational benefit for all members of a particular Department or for members of several Departments, the relevant Department Chief(s), the CMO, or the PPEC Chair may direct that the case be presented in an educational session and that members of the relevant Departments be invited to attend the session. The particular practitioner(s) who provided care in the case shall be informed that the case is to be presented in an educational session at least 10 days prior to the session. Information identifying the practitioner(s) shall be removed prior to the presentation, unless the practitioner(s) request otherwise. Documentation of the educational session shall be forwarded to the PPEC for its review.

## 7. PROFESSIONAL PRACTICE EVALUATION REPORTS

- 7.A ***Ongoing Professional Practice Evaluation Reports.*** An ongoing professional practice evaluation report shall be generated for each practitioner as described in Section 3.
- 7.B ***Practitioner FPPE History Reports.*** A practitioner history report showing all cases that have been reviewed for a particular practitioner within the past 2 years and their dispositions shall be generated for each practitioner for consideration



and evaluation by Department Chief and the Credentials Committee in the reappointment process.

7.C ***Reports to Medical Executive Committee and Board.*** The Medical Staff Peer Review Coordinator shall prepare reports at least quarterly showing the aggregate number of cases reviewed through the FPPE process, the timeliness of the reviews, the dispositions of those matters, and, when applicable, the effect of the process on patient outcomes.

7.D ***Reports on Request.*** The Medical Staff Peer Review Coordinator shall prepare reports as requested by the CMO, Department Chiefs, PPEC, Medical Executive Committee, or the Board.

Originally adopted by the Medical Executive Committee: November 8, 2011.

Reviewed & approved as is by the Medical Executive Committee: November 11, 2014.

Revisions adopted by the Medical Executive Committee: March 10, 2015.

Reviewed & accepted As Is by the Medical Executive Committee: November 10, 2015

Reviewed & accepted As Is by the Medical Executive Committee: December 11, 2018

Reviewed & accepted As Is by the Medical Executive Committee: December 14, 2021

Originally approved by the Board of Directors: November 29, 2011.

Revisions approved by the Board of Directors: March 31, 2015.

Reviewed & accepted As Is by the Board of Directors: November 19, 2015

Reviewed & accepted As Is by the Board of Directors: December 21, 2018

Reviewed & accepted As Is by the Board of Directors: December 21, 2021