Kettering Health Main Campus
Medical Staff Services
3535 Southern Blvd.
Kettering, OH 45429
(937) 395-8324

ketteringhealth.org

Notification of Focused Professional Practice Evaluation (FPPE)

Dear Practitioner:

Per our Medical Staff Bylaws and HFAP guidelines, we are required to perform a Focused Professional Practice Evaluation (FPPE) on all practitioners granted initial privileges. Below, you will find the initial appointment Focused Professional Practice Evaluation (FPPE), Case Evaluation and the FPPE Policy.

For physicians, your Evaluator will be a peer that is qualified to evaluate your skills. For AHPs, your Evaluator will be your Collaborating Physician. You will be evaluated based on direct observation, discussion, and retrospective review of your patient's record(s) in accordance with the specialty-specific plan.

Please return your **completed forms (2)** to Medical Staff Services within **six months** of your appointment. You may mail to the address below or email them to MedicalStaffServices@KetteringHealth.org.

Thank you for your continued cooperation with this quality improvement process. Should you have any questions regarding the enclosed documents, please feel free to contact our office at 937-395-8324.

Medical Staff Services
Kettering Medical Center System
3535 Southern Blvd.
Kettering, Ohio 45429

Enclosures

Kettering HEALTH

Initial Appointment Focused Professional Practice Evaluation

NAME:

SPECIALTY:

Focused Area of Review: Five (5) review or direct observation **HOSPITAL ACTIVITY:**	***KEY: 2 = meets; 1 = partially meets; 0 = does not meet; NA = not applicable, no activity or not observed***				
Evaluate in terms of completeness, accuracy and appropriateness	**Pt #1**	**Pt #2**	**Pt #3**	**Pt #4**	**Pt #5**
Basic Medical Knowledge					
Professional Performance					
Professional Judgment					
Professional/Ethical Conduct					
Competence - Clinical Skills					
1. Assessment of Patient including, but not limited to, history and physical exams. This also includes ongoing assessment, daily rounds on patients, etc.					
2. Patient Management with the scope of delineated privileges					
3. Prescribe, initiates, monitor or alters any and all medications. Appropriately utilizes medications within the scope of practice/privileges					
4. Initiates and completes orders and order sets per policy or protocol					
Competence - Technical Skills					
1. Uses appropriate techniques for core privileges or scope of practice (i.e. insertion central lines, catheters, sutures, chest tubes, anesthesia care, etc.)					
2. Uses appropriate universal precautions including handwashing, exposure, infectious substances					

CITIZENSHIP:

Cooperativeness, ability to work with others **[ ] yes [ ] no**

Timeliness/Accuracy of documentation of Medical Records which includes progress notes, discharge summaries, etc. **[ ] yes [ ] no**

Efficiency and use of hospital resources **[ ] yes [ ] no**

Interpersonal/communication skills with patients, hospital staff, colleagues **[ ] yes [ ] no**

What are the practitioner's strengths/weaknesses?

Is there anything this practitioner needs to change to be a better practitioner?

Has this practitioner been subject to any health, substance abuse, behavioral or other problems that may affect the practitioner's performance or ability to perform the privileges requested? [ ] yes* [ ] no * Please provide explanation in the box below

Have this practitioner's clinical privileges been:
a) subject to any internal focused monitoring or review? **[ ] yes [ ] no**
b) reduced/limited - either voluntarily or involuntarily? **[ ] yes [ ] no**

Evaluator Signature: _____ **Date:** _____

Clinical Service Chair Signature: _____ **Date:** _____

STOP!

This form MUST be submitted along with the Case Evaluation

Initial Appointment Focused Professional Practice Evaluation

NAME:
SPECIALTY:

Maintain HIPAA Compliance – Please do not list patient names

PATIENT 1 MEDICAL RECORD #:
DIAGNOSIS:
PRIMARY PROCEDURE (if applicable):
PATIENT 2 MEDICAL RECORD #:
DIAGNOSIS:
PRIMARY PROCEDURE (if applicable):
PATIENT 3 MEDICAL RECORD #:
DIAGNOSIS:
PRIMARY PROCEDURE (if applicable):
PATIENT 4 MEDICAL RECORD #:
DIAGNOSIS:
PRIMARY PROCEDURE (if applicable):
PATIENT 5 MEDICAL RECORD #:
DIAGNOSIS:
PRIMARY PROCEDURE (if applicable):
During the review period, the reviewer shall conduct a concurrent review a minimum of five (5) medical records. The records reviewed must be of differing diagnoses (identified above).
Upon completion, the evaluation form must be returned to: **Medical Staff Services** **3535 Southern Blvd.** **Kettering, Ohio 45429** **(937)395-8324 phone** **(937)395-8357 fax**

STOP!
This form MUST be submitted with the Evaluation

PURPOSE:

The purpose of this policy is to define the peer review process of the Medical Staffs of Kettering Health Main Campus System, (each of the aforementioned Medical Staffs hereinafter individually referred to as "Medical Staff"). The Kettering Health Main Campus System Board of Directors (Board) has delegated to the Medical Staff, through its committees and those committees' agents, the responsibility for evaluating, maintaining, and monitoring the quality of the Medical Staff's health care services at, as applicable, Kettering Health Main Campus System, and their provider-based locations (each of the aforementioned hospitals/medical centers hereinafter individually referred to as "Hospital"). As such, whenever a Practitioner, an Advanced Practice Practitioner (APP), a member of the Hospital's staff, or a committee engages in activities pursuant to this Policy, the individual/entity shall be acting as, or on behalf of, a Peer Review Committee (PRC) as that term is recognized in Ohio Revised Code Section 2305.25, et seq.

To provide a comprehensive framework whereby the Medical Staff can assess the quality and appropriateness of care provided by Practitioners and APPs who have been granted Clinical Privileges at the Hospital in order to:

1. Improve the Quality of Care provided by Practitioners and APPs.
2. Create a culture with a positive approach to Peer Review.
3. Identify opportunities for Quality-of-Care improvement on the part of Practitioners/APPs.
4. Assist in providing accurate and timely performance data for feedback to Practitioners/APPs.
5. Monitor significant trends by analyzing aggregate data.
6. Assure that the process for Peer Review is clearly defined, objective, timely, and useful.

DEFINITIONS:

This Policy describes the committee structure and routine processes by which the Medical Staff monitors, evaluates, and improves its Practitioners' and APPs' performance. This Policy is not intended to be confrontational or adverse. Rather, this Policy's primary focus is educational, recognizing that early detection of concerns and a prompt response to them benefits the patient as well as the caregiver. All actions between a Practitioner/APP and PRC pursuant to this Policy shall be voluntary and informal in nature. Nothing in this Policy supersedes any provision of the Medical Staff governing documents or otherwise precludes the referral of a matter to an alternative forum (e.g., the Medical Executive Committee (for initiation of formal corrective action pursuant to the Medical Staff Bylaws or APP Policy, as applicable), the Practitioner Wellness Committee (for impairment issues), or the Credentials Committee (for conduct matters), etc.) should a PRC determine such referral is appropriate. Rather, the purpose of this Policy is to describe the general routine processes that are followed for practice evaluation.

Use of Designee: Whenever an individual is authorized to perform a duty by virtue of his/her position, then the term shall also include the individual's designee.

Committee Agents: Whenever a committee is authorized to engage in an activity, the committee may designate one (1) or more agents to act on its behalf.

Focused Professional Practice Evaluation (FPPE): This term means the focused evaluation of a Practitioner's/APP's competence in exercising a specific Privilege. This process is implemented for (1) all newly granted Privileges (initial grants as well as grants of additional Privileges during the term of an existing Privilege period); and (2) whenever a question arises regarding a Practitioner's/APP's ability to provide safe, quality care. This process is part of the Hospital's routine evaluation process and allows the Medical Staff to focus evaluation on a specific aspect of a Practitioner's/APP's performance.

Clinical Quality Review Committee (CQRC): This term means a PRC established by the MEC, and subject to the authority of the MEC, that provides overall jurisdiction for the operation of the Peer Review program. To the extent additional PRCs are established, they are subject to the authority of the CQRC.

Ongoing Professional Practice Evaluation (OPPE): The term means a documented compilation of ongoing data collected for the purpose of assessing a Practitioner's/APP's Quality of Care. The information gathered during this process factors into decisions to maintain, revise, suspend, or revoke existing Clinical Privilege(s) prior to or at the end of a designated appointment/Privilege period. This process not only allows any potential problems with a Practitioner's/APP's performance to be identified and resolved as soon as possible; but, also, fosters a more efficient, evidence-based Privilege regrant process.

Peer: This term means an individual practicing in the same or similar profession as the individual under review with equal or greater education, training, or current competence. A determination as to who constitutes a Peer will be made on a case-by-case basis, as appropriate. All external Practitioner reviewers must agree to maintain confidentiality consistent with Ohio's peer review privilege prior to engaging in Peer Review activities.

Peer Review: This term means a prospective, concurrent, or retrospective review of patient care management, interaction, and/or consultation by a PRC (or one of its agents) in order to evaluate the Quality of Care provided by a Practitioner/APP. Peer Review is conducted using multiple sources of information. The individual's evaluation is based on generally recognized standards of care. Through this process, Practitioners/APPs receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their medical, technical, and interpersonal skills in providing patient care.

Peer Review Committee (PRC): This term means a committee subject to the oversight of the CQRC (as well as the CQRC) that is responsible for evaluating and improving Practitioner/APP performance as it relates to:

1. Patient care

2. Medical/clinical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. System-based practice

All members of a PRC, and individuals requested to act as an agent of a PRC, must sign a confidentiality statement, a copy of which is attached hereto as Addendum A and incorporated by reference herein, prior to engaging in peer review activities.

All PRCs must follow the minutes' format as may be specified by the CQRC.

Quality of Care: For purposes of this Policy only, this term refers to issues related to a Practitioner's/APP's professional conduct or clinical competency.

Quality Department (QD): This is the Hospital department responsible for oversight, development, evaluation, and ongoing monitoring of quality improvement, peer review, and patient safety processes and initiatives. QD is a designated Peer Review agent of all PRCs.

POLICY:

1. Scope: The CQRC is charged with evaluating the care provided by Practitioners/APPs at the Hospital.
   a. Depending upon the scope of issues presented, the CQRC may provide such evaluation through the CQRC or it may establish PRCs, consistent with the Medical Staff governing documents, that are specialty specific and that report up to the CQRC.
   b. The composition, term, and duties of the CQRC and the PRC(s) are set forth in the Medical Staff Organization Manual or other applicable Medical Staff documents.

2. Education: All participants in the Hospital's Peer Review program will be educated as to the responsibilities of the members and their respective committees.

3. Manner of Activities: Peer Review activities are conducted in the following manner:
   a. Cooperatively: A PRC (or agent on behalf of the PRC) may request to meet with a Practitioner/APP to discuss cases or issues under review or to request that the Practitioner/APP respond, in writing, to cases or issues under review. Practitioners/APPs are expected to reasonably participate in this process. A failure to do so will result in the matter being resolved without the Practitioner's/APP's input and will be considered in the context of whether the Practitioner/APP is acting in a professional manner consistent with his/her responsibilities pursuant to the Medical Staff governing documents.
   b. Courteously: Participants are to be courteous and respectful to each other.

c. Impartially: Activities are to be fair, impartial, and conducted in an appropriate manner designed to protect patient safety and the integrity of the program. Activities are to be performed in good faith and without bias, prejudice, personal gain, or malice.

d. Peer to Peer: The Peer Review program is designed to foster collegial engagement. As such, neither a Practitioner nor an APP shall have the right to have legal counsel present at a PRC meeting at which the Practitioner/APP is requested by a PRC to attend.

4. Performance Improvement Activities: Performance improvement activities related to systemic issues are not a part of this Policy. Rather, to the extent a performance improvement issue is identified by a PRC, the issue will be referred to the appropriate Hospital committee. Correspondingly, if a Hospital committee identifies an individual Practitioner/APP issue, that committee will refer the matter to the QD for review and referral, as appropriate, to the CQRC or a PRC.

5. Conflicts of Interest:
   a. The fact that a PRC member or PRC agent is in the same specialty as the Practitioner/APP under review does not, in and of itself, require recusal of that person.
   b. In the event a Practitioner/APP believes that a PRC member/agent has a conflict of interest that precludes him/her from acting in an impartial manner, the Practitioner/APP must submit his/her objections, in writing, to the chair of the applicable PRC. The PRC, at its sole discretion, will make the final determination as to the whether the contested individual may continue to participate. In the event that a PRC member/agent is determined by the PRC to have a conflict of interest that precludes participation, the PRC member/agent must be excused while the PRC conducts its deliberation and votes.
   c. A member of a PRC who is under review must be recused from participating in the peer review matter as a PRC member. Once the Practitioner/APP has responded to any questions by the PRC, the Practitioner/APP must be excused from the room prior to any discussion, decisions, or votes related to the Practitioner's/APP's case(s).

6. Confidentiality:
   a. Peer Review information includes all information collected for, generated by, or otherwise under the oversight of a PRC. Peer Review information shall only be used for Peer Review purposes as that term is defined in Ohio Revised Code §2305.25, et seq. in the absence of a decision on the part of the Hospital President/CEO or Chief Medical Officer that it is appropriate for certain information to be used for alternative purposes.
   b. Peer Review information shall be maintained in a secure location. Although not required as a means of assuring Peer Review protection, any or all of the following processes may be implemented as an additional means of assisting in maintaining confidentiality as deemed appropriate based upon the situation:
      i. Identifying Practitioners/APPs by code number.

ii. Identifying patients by code number.
iii. Distributing minutes and related materials at committee meetings and recollecting such minutes and related materials at the conclusion of a meeting.
iv. Making information available only on a secure computer site.

Peer Review Process:

1. Process
   a. The process for conducting individual Practitioner/APP case reviews is set forth in Addendum B, attached hereto and incorporated by reference herein.
   b. Case review may be triggered by any number of factors including, but not limited to: sentinel events/serious safety events, near misses, specialty specific clinical screens, benchmarks, practice patterns, professional liability cases, resource utilization data, requests for peer review, safety reports, etc.
   c. Mortalities, with a designation of Do Not Resuscitate – Comfort Care (DNRCC) or Do Not Resuscitate – Comfort Care Arrest (DNRCC-Arrest) at the time of the hospitalization order, may be reviewed and closed by the QD provided that the following did not occur during the admission:
      i. The patient received a full code.
      ii. There was a medical error or serious reportable event.
      iii. There was a major complication.
      iv. The death was unexpected.

Ongoing Professional Practice Evaluation:

1. Process. The Medical Staff conducts continuous ongoing quality oversight of Practitioners/APPs intended to provide useful information in the areas of patient care, professionalism, practice-based learning and improvement, interpersonal and communication skills, system-based practice, and medical/clinical knowledge. This information assists the Medical Staff, Practitioners, and APPs in identifying individual practice trends that may affect patient care and safety. The data generated by OPPE is a factor in the decision as to whether to permit a Practitioner/APP to maintain Clinical Privileges.

2. Data. Data compiled for purposes of OPPE may include, but is not limited to, the following:
   a. Review of indications for, and performance of, operative and other clinical procedure(s) performed and their outcomes.
   b. Pattern of pharmaceutical usage.
   c. Appropriateness of clinical practice patterns.
   d. Significant departures from established patterns of clinical practice.
   e. Medical assessment and treatment of patients.
   f. Morbidity and mortality data.

g. Sentinel event data.
h. Patient safety data.
i. Core indicators and specialty-specific indicators as determined by the CQRC in collaboration with the applicable Medical Staff leaders.
j. Other relevant criteria as determined by the CQRC.

3. Compilation of Data. Data may be acquired through the following:
   a. Periodic medical record review.
   b. Direct observation.
   c. Monitoring of diagnostic and treatment techniques.
   d. Discussion with other individuals involved in the care of each patient including consulting Practitioners/APPs, surgical assistants, nursing, and administrative personnel.

4. Criteria
   a. Criteria are reviewed annually by the QD after obtaining input from the Medical Staff leaders.
   b. The developed criteria are forwarded to the applicable PRC for review and recommendation to the CQRC. Following review, the CQRC shall forward and makes its recommendation to the MEC which, in turn, shall make a final recommendation to the Board for approval.

5. Distribution
   a. The QD generates OPPE reports that are provided, or made available, to each Practitioner/APP. Reports are summarized at least three (times) in a two-year appointment/privilege cycle. These reports are intended to reflect individual performance that can be compared to prior reports.
   b. The QD provides the Department Chair with the OPPE reports of each Practitioner/APP in his/her Department. In the event a Department Chair believes that an OPPE indicates concerns, the Department Chair is encouraged to meet with the affected Practitioner/APP to provide mentoring and direction. A memorandum of such meeting shall be made by the Department Chair and maintained in the Practitioner's/APP's Peer Review file. The Credentials Committee chair shall act as the Department Chair for purposes of a Department Chair's OPPE.
   c. The QD provides a Practitioner's/APP's OPPE report to the CQRC or other applicable PRC when the data:
      i. Establishes that thresholds have been exceeded.
      ii. Establishes that there are opportunities for improvement.
      iii. Is negative.

Focused Professional Practice Evaluation:

1. Purpose. FPPE, by its very term, is a review of a particular Practitioner/APP, and is an integral component of this Policy's routine peer review processes. At the time that a Practitioner/APP is initially granted Privileges, there is insufficient data upon which to make a determination of competency; and, therefore, a period of FPPE is implemented. In addition, even when the OPPE process is in place, the data generated may be insufficient to determine Quality of Care. As such, an FPPE implemented by the CQRC/PRC solely because of the inability to obtain needed data (e.g., low volume providers) does not constitute an investigation antecedent to a professional review action. Instead, it is part of the Peer Review Program designed to supplement data in order that appropriate determinations may be made. However, in the event an FPPE is initiated due to potential competency/conduct concerns, it shall be deemed an investigation in the event a Practitioner/APP resigns while such FPPE is in place.

2. Grounds. An FPPE is implemented:
   a. For all new grants of Privileges (initial grants as well as grants of additional Privileges during the term of an existing Privilege period).
      i. For low volume Practitioners/APPs, an FPPE may remain in place for more than one (1) Privilege period.
      ii. For newly appointed Practitioners whose residency/training was at the Hospital, consideration will be given to using the data collected during training to satisfy the FPPE requirement.
   b. When concerns arise regarding a currently privileged Practitioner's/APP's Quality of Care.

3. FPPE for New Grants of Clinical Privileges. The scope of the FPPE for new grants of Privileges is set forth in an applicable Medical Staff policy and/or the applicable Clinical Privilege set. The assigned Peer monitors the completion of the requisite number of cases or other selected evaluation method. Upon completion, the assigned Peer notifies the Medical Staff Office who, in turn, notifies the Practitioner's/APP's Department Chair. The Department Chair determines whether the FPPE has been successfully completed. A Department Chair may extend an FPPE once for a period not to exceed six (6) months. The Credentials Committee must be notified when an individual's FPPE has been extended. If the Department Chair continues to have concerns following an extension, he/she must notify the Credentials Committee who shall refer the matter to the CQRC. The Credentials Committee chair shall perform the Department Chair's duties with respect to a Department Chair's FPPE. If any concerns arise during an FPPE, the matter is handled consistent with this Policy and related Medical Staff governing documents.

4. FPPE for Quality-of-Care Concerns Identified During a Privilege Period. An FPPE for Quality-of-Care concerns may be triggered by the CQRC or the MEC when any of the following occurs:
   a. Egregious single event.
   b. Pattern of concern identified pursuant to an OPPE.
   c. Concerns identified by a PRC (other than the CQRC), the CQRC, or the MEC.
   d. Significant complaints by patients, Hospital staff, Practitioners, or APPs.

e. Other patterns of quality trends of concern.

5. Elements of a FPPE Based upon Quality-of-Care Concerns
   a. The establishment of an FPPE based upon Quality-of-Care concerns during a Privilege period is generally the responsibility of the CQRC. A PRC should refer such matters to the CQRC. An FPPE is to be designed in a manner that best provides oversight of the care being provided by a Practitioner/APP relative to the issue under review.
   b. An FPPE that is managed by the CQRC is not deemed adverse and, therefore, does not trigger any procedural due process rights pursuant to the Medical Staff governing documents nor, in the absence of a resignation while in place, is an FPPE reportable to federal or state authorities.
   c. An FPPE may consist of any or all of the following:
      i. Prospective, concurrent, or retrospective case review.
      ii. Direct observation.
      iii. Proctoring.
      iv. Education.
      v. External Peer Review.
      vi. In the event the CQRC implements an FPPE, the Practitioner/APP will be notified, in writing.
      vii. Although not required, it is the expectation that the CQRC will meet with the Practitioner/APP to review the reason for the FPPE and its scope.

6. External Peer Review
   a. Purpose. External Peer Review is used to assure that an objective and fair evaluation of the care delivered (as documented in the medical record) is afforded to the Practitioner(s)/APP(s) involved; and to resolve any issues remaining from internal Peer Review. As such, external Peer Review is considered whenever it is determined that:
      i. An internal review may not be perceived as objective or unbiased.
      ii. An internal review cannot be performed due to a conflict of interest.
      iii. Similarly trained Practitioners/APPs are not available to conduct a review.
      iv. There is a substantial difference of opinion regarding the care provided.
      v. The review involves a new technology or procedure for which the Medical Staff does not have the requisite expertise.
      vi. There is a possibility of a future professional review action.
      vii. Other appropriate reason as dictated by circumstances.
   b. Authority. The following have the authority to initiate an external review:
      i. The MEC or Chief of Staff (with approval of the Hospital President/CEO or CMO).
      ii. The CQRC or CQRC chair (with approval of the Hospital President/CEO or CMO).
      iii. The Board.
      iv. The Hospital President or Chief Executive Officer (on behalf of the Board).A Practitioner/APP cannot require the Hospital to obtain an external peer review.

c. Qualifications. An external Practitioner reviewer must meet the following qualifications:
   i. Possess skills needed at the Hospital for a specific peer review project or for peer review consultation on an occasional basis when requested by Hospital administration, the Board, or an authorized Medical Staff committee.
   ii. Practice either locally or in another city and/or state in which he/she has a current, valid, unrestricted license to practice and be a member of the active medical staff in good standing at another accredited hospital; OR, be a Practitioner who is a recognized expert in his/her field who has retired from active practice at another accredited hospital within the last twelve (12) months
   iii. Satisfy the Hospital's Professional Liability Insurance coverage requirements.
   iv. Be board certified in the specialty under review and engaged in the active practice of such specialty for at least five (5) years.
   v. Not have, or be perceived as having, a conflict of interest with the affected Practitioner/APP. Preference will be given to external peer reviewers who have no personal relationship with the Practitioner/APP.
   vi. Be able to provide a timely, written, objective opinion based on the care delivered (as documented in the medical record and pertinent related components such as radiographs, referral facility records, etc.). The opinion must include decision rationale, any national or organizational standards utilized, and opportunities for improvement (if any).
   vii. Be willing to continue to participate in the Peer Review process through fair hearing and litigation if the matter extends to these proceedings.
   viii. Enter into an appropriate agreement for consulting peer review services to include a Business Associate Agreement.
   ix. Such other qualifications as are deemed appropriate by the appointing committee.

7. Process Following Receipt of External Peer Review Report
   a. If the CQRC has any concerns or questions relative to the review after receipt of an external Peer Review report, the CQRC is expected to follow up with the external reviewer either by letter or conversation documented by minutes.
   b. Because Peer Review is part of the routine ongoing checks and balances of the Hospital's quality assessment process, a Practitioner or APP is not required to be notified of an external review. However, recognizing the value that such a report has in assessing patient care, in all but exceptional circumstances (as determined by the CQRC following consultation with Hospital legal counsel), the affected Practitioner/APP will be given access to the results of an external Peer Review (whether favorable or unfavorable) as well as the opportunity to participate in, or respond to, any concerns, as soon as reasonably appropriate. The Practitioner/APP is not required to be, and should not be, given a copy of the report unless the report becomes part of an investigation conducted by the MEC that results in the initiation of the fair hearing process (or such other process as may be available for an APP). Nothing in this paragraph shall be construed as precluding the imposition of a summary

suspension, pursuant to the process set forth in the Medical Staff Bylaws or APP Policy, as applicable, prior to such review if circumstances so warrant.

c. Thereafter, the applicable CQRC shall:
   i. Close the matter.
   ii. Continue with the FPPE.
   iii. Enter into a voluntary remediation agreement with the Practitioner/APP.
   iv. Refer the matter to the MEC for initiation of formal corrective action. Thereafter, the process set forth in the Medical Staff Bylaws or APP Policy, as applicable, shall apply.

d. Upon completion of an external Peer Review, the determination as to what information will be shared; and when, how, and with whom, shall be decided by the CQRC (or the Board if the Board or the Hospital President/CEO initiated the review); provided, however, that to the extent the review establishes the need for remediation and/or corrective action, legal counsel should be brought in to assist the CQRC in such determination.

Results of Professional Practice Evaluation (Ppe):

1. Based upon the analysis of the information resulting from PPE activity (FPPE or OPPE), several actions may occur including, but not limited to:
   a. Determination that the Practitioner/APP is performing in accordance with established expectations and that no action is necessary/warranted.
   b. Determination that an issue(s) exists that requires a period of FPPE.
   c. Determination that an issue(s) exists that requires informal remediation.
   d. Determination that an issue exists that requires referral to the Medical Executive Committee for formal corrective action.

Assessment of Medical Practice Evaluation:

Not less than every two (2) years, the CQRC, in conjunction with the QD, will evaluate the effectiveness of the Peer Review program and determine what changes, if any, should be made to the Peer Review process as set forth in this Policy.

Access to Peer Review Information:

1. Committee Activities
   a. Peer Review files are Hospital property and are maintained for credentialing, privileging, and related peer review purposes. The information maintained in these files is privileged pursuant to Ohio Revised Code §§2305.25, et seq.
   b. All Peer Review committee minutes are maintained as protected peer review documents. A Practitioner/APP who is under review is not entitled to access to these minutes unless they

are produced as part of a fair hearing proceeding (or similar proceeding as applicable to APPs).

c. All correspondence between a PRC and a Practitioner/APP, final determinations, related records, and related information are maintained in a Peer Review file.

d. The Hospital maintains one or more Peer Review files for each Practitioner/APP who maintains, as applicable, an appointment and/or Clinical Privileges at the Hospital. Peer Review files contain information including credentials, privileging, OPPE, FPPE, and other Quality of Care Data. Peer Review files may also be developed for other Peer Review activities (e.g., formal corrective action proceeding, etc.).

   i. Consistent with Medical Staff policy, a Practitioner/APP has the right to review his/her credentials file and quality file (subject to certain information, such as references or other third-party documentation, not being disclosed as determined by the Hospital).

   ii. A request to review one's credentials or quality file should be made to the Medical Staff Office. Requests should be made at least five (5) business days in advance. The review will be held at the Medical Staff Office, as applicable, in the presence of a designated Peer Review agent.

e. Peer Review information is otherwise available only to (a) authorized individuals/committees who require access to such information as part of the protected Peer Review process; or (b) appropriate accrediting/regulatory organizations.

SPONSORING DEPT:	KHMCS Medical Staff Services
DEPARTMENTS AFFECTED:	KHMCS Medical Staff Services
DATE OF ORIGIN:	5/8/19

ADDENDUM A

PEER REVIEW PROGRAM MEMORANDUM OF UNDERSTANDING AND STATEMENT OF CONFIDENTIALITY

Thank you for agreeing to serve as a member of a Peer Review Committee (PRC) or otherwise participate in the peer review process at the Hospital. Practitioners/Advanced Practice Practitioners (APPs) who participate in peer review must be viewed by their colleagues as fair, collegial, confidential, clinically competent, and professional. Peer review is ultimately the responsibility of the Hospital Board as part of maintaining the quality of medical care. The Board delegates this responsibility to the Medical Staff through the Chief of Staff and MEC which, in turn, authorizes the PRCs to act. As a member of a PRC or participant in the peer review process, it is your shared responsibility in return to make sure that the peer review program is effective.

The ultimate goal of peer review is to continuously improve the skills of Practitioners and APPs with Privileges at the Hospital through identification, analysis, and practice improvement recommendations for problematic events. In order for these interventions to successfully improve patient care, the process of peer review has to be just and fair. This leads to a number of behavior expectations for members of PRCs and other peer review participants, as follows:

- Have a professional and collegial demeanor in all activities.
- Keep deliberations frank, honest, accurate, unbiased, and non-inflammatory.
- Be trustworthy. Keep the deliberations confidential the way you would expect if your case was under review.
- Seek additional input if the issue is outside the expertise of the PRC members. Sometimes determining whether or not a particular action was within the standard of care requires detailed knowledge of current practice that only a group of peers from within the involved specialty can provide.
- Do not use the peer review process to discredit, embarrass, undermine, discourage, or unseat a colleague. Cases should be selected without bias.
- Do not protect a colleague or friend from peer review. If you perceive that this needs to be done, you are indicating that you believe the peer review process is either not fair; or, is being used to do something other than improve the Quality of Care. It is your obligation to bring these concerns to the PRC chair.
- If you have a conflict of interest with the Practitioner/APP being discussed (*e.g.*, competitor, partner, refers patients to you or vice-versa, financial relationship, employed in the same group, *etc.*), you are expected to disclose that conflict to the PRC. The PRC is responsible for determining whether the conflict rises to the level of precluding you from participating in the pending peer review matter. For purposes of this Policy, the fact that Practitioners/APPs are competitors, partners, or employed in the same group shall not, in

and of itself, automatically disqualify such Practitioners/APPs from participating in the peer review process with respect to his/her colleagues.

All peer review information is privileged and confidential in accordance with the Medical Staff Bylaws/Manuals, Hospital and Medical Staff policies, and state and federal laws and regulations pertaining to confidentiality and non-discoverability. In Ohio, peer review discussions and documents are protected from discovery by Ohio law. As long as the Hospital has a prescribed process for peer review and follows that process, efforts to protect patients and improve Practitioner/APP performance cannot be used as evidence in a state civil lawsuit.

To preserve the confidentiality of quality management data, it is imperative that Practitioners and APPs involved in peer review observe the following instructions in the performance of peer review:

- The case review form should never be shared with individuals who are not authorized to access this information. When the review is completed, please submit the form (either in hard copy or electronically) to the designated Medical Staff/Hospital personnel or office. The form is not to be part of the patient's medical record.
- Once the case review form is completed, making additional copies of the form is prohibited.
- Discussing peer review cases or data with other Practitioners or APPs outside of the PRC meeting is prohibited unless specifically requested by the PRC.
- Discussing any peer review case or data with anyone in a public setting is prohibited.
- Discussions of PRC reviews with Hospital employees other than those involved in the peer review or performance improvement process are prohibited.

I understand the expectations for a member of a PRC/participant in the peer review process, and I agree to comply with these expectations. I further understand and agree to comply with the requirements for confidentiality of peer review deliberations. I also understand and acknowledge that failure to comply with these expectations and requirements may result in my removal as a member of a PRC/participant in the peer review process and/or may be grounds for corrective action pursuant to the Medical Staff Bylaws or APP Policy, as applicable.

NAME (Print)	SIGNATURE	DATE SIGNED

ADDENDUM B
PRACTITIONER/APP PEER REVIEW PROCESS

Cases presented for peer review are evaluated and outcomes are ranked according to the following scale:

- No Quality Variance: Care rendered was appropriate but may be tracked to evaluate any developing trends.
- Minor Variance from Expected Practice: Care rendered is deemed to be outside of benchmarks/established standards/standard of care. The variance is considered minor or standards of care for the case are controversial.
- Major Variance from Expected Practice: Care rendered is deemed to be substantively outside of benchmarks/established standards/standard of care.

1. Cases identified though Quality Department

   Nurse/Practitioner reviewer initiates case evaluation and reviews findings with the Medical Director of QD

   a. No Quality Variance is determined. Case may be tracked/trended.

   b. Minor and Major Variances to Expected Care are referred to CQRC.

2. Cases identified by a departmental Peer Review Committee (with notice provided to QD)

   a. No Quality Variance is determined. Case may be tracked and trended.

   b. Minor and Major Variances to Expected Care are referred to CQRC.

3. Cases identified by administrative processes, typically through the Medical Staff Office, and may include communication or behavioral concerns (with notice provided to QD)

   a. Case/situation reviewed by the Chief Medical Officer and/or Medical Staff leadership.

   b. No Quality Variance or Minor Variations from Expected Practice are closed with appropriate coaching and entered into the QD database for tracking and trending.

   c. Major Variances from Expected Practice are referred to the appropriate Peer Review Committee which may include CQRC or Credentials Committee for review pursuant to the procedure for disruptive conduct set forth in the Medical Staff Bylaws.

4. Cases referred to CQRC

   a. Summary prepared and case assigned by CQRC chair to an appropriate peer for case review.

   b. CQRC peer reviewer determines No Quality Variance. Case may be tracked and trended.

   c. CQRC peer reviewer determines concern for Minor or Major Variance in Expected Practice. Referred for presentation to the CQRC members.

   d. CQRC full committee initial case review presented by peer reviewer

      i. No Quality Variance is determined. Letter of education provided and tracking and trending may occur.

      ii. Concerns are identified and a letter sent to the Practitioner/APP. The letter will also include a due date for expected response.

e. CQRC full committee review of written response from Practitioner/APP:

i. If Practitioner/APP responds, information presented is considered and a determination made. In addition to a written response a Practitioner/APP may request to meet with CQRC to discuss the case under review.

ii. If Practitioner/APP fails to respond within time requested, CQRC makes a determination of care based on available information.

1. No Quality Variance is determined. Letter of education provided and tracking and trending may occur.

2. Minor Variances and Major Variances from Expected Practice are determined by vote of the committee members present. A letter of education and notification is sent to the Practitioner/APP and results in tracked and trended

f. Reconsideration of CQRC determination

i. The Practitioner/APP may submit a written request to the CQRC to reconsider the determination. The request must specifically identify the findings with which the Practitioner/APP disagrees and the basis for such disagreement.

ii. In addition to a written response, a Practitioner/APP may request to meet with the CQRC to discuss the case.

iii. After review of the written request and meeting, if any, with the Practitioner/APP, the CQRC may:

1. Determine that the additional information presented adequately addresses concerns and revise determination to No Quality Variance. Letter of education provided and tracking and trending may occur.

2. Uphold the initial determination and notify the Practitioner/APP in writing.

3. Recommend external review as outlined in the Policy.

5. Impact of determination

a. The CQRC determination (*i.e.*, a case rating assigned by the CQRC) is not deemed adverse nor does it trigger any procedural due process rights pursuant to the Medical Staff Bylaws or APP Policy. Rather, the case rating/determination is part of the ongoing informal peer review/professional practice evaluation process

b. Aggregate data from Minor and Major Variances from Expected Practice will be reviewed as part of the departmental OPPE process as well as during the Practitioner's/APP's biennial reappointment and/or regrant of Privileges by the Credentials Committee.

c. Three (3) or more Minor and/or Major Variances from Expected Practice by a Practitioner/APP in a rolling twelve (12) month time period will prompt additional review by CQRC for consideration of FPPE or additional appropriate intervention.

6. Responsibility of QD

a. The QD maintains all case review findings in its peer review database.