

**EMORY JOHNS CREEK
HOSPITAL**

**PROFESSIONAL PRACTICE
EVALUATION POLICY**

(PEER REVIEW)

Adopted by the Medical Staff: August 8, 2017

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PROFESSIONAL PRACTICE EVALUATION POLICY

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PROFESSIONAL PRACTICE EVALUATION POLICY

1. OBJECTIVES, SCOPE OF POLICY, COLLEGIAL EFFORTS AND ACRONYMS

1.A **Objectives.** The primary objectives of the professional practice evaluation process of Emory Johns Creek Hospital are to:

- (1) effectively, efficiently, and fairly evaluate the care being provided by practitioners, comparing it to established patient care protocols and benchmarks whenever possible;
- (2) provide constructive feedback, education, and performance improvement assistance to practitioners regarding the quality, appropriateness, and safety of the care they provide;
- (3) establish and continually 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; and
- (4) define prospectively, to the extent possible, the expectations for patient care and safety through patient care protocols.

1.B **Scope of Policy.**

- (1) **Practitioners Subject to Policy.** This Policy applies to all practitioners who provide patient care services at Emory Johns Creek Hospital. For purposes of this Policy, a “practitioner” is defined as a Medical Staff member or an allied health professional who has been granted clinical privileges.
- (2) **Nature of Concerns Subject to Policy.** Focused Professional Practice Evaluation (“FPPE”) is a time-limited period during which a practitioner’s professional performance is evaluated. When concerns are raised about a practitioner’s clinical practice, FPPE shall be conducted in accordance with this Policy. Concerns regarding a practitioner’s professional conduct or health status shall be reviewed in accordance with the Medical Staff Professionalism Policy or Practitioner Health Policy.

1.C **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, informational letters, counseling, informal discussions, education, mentoring, educational 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 and professional practice evaluation/peer review activities. These efforts are encouraged, but are not mandatory, and shall be within the discretion of the Leadership Council, the Department Chairs, and the PPEC.

1.D **Acronyms.** Definitions of the acronyms used in this Policy are:

CMO Chief Medical Officer
CQO Chief Quality Officer
FPPE Focused Professional Practice Evaluation (Peer Review)
OPPE Ongoing Professional Practice Evaluation
PPE Professional Practice Evaluation
PIP Performance Improvement Plan
PPEC Professional Practice Evaluation Committee
MEC Medical Executive Committee

2. **FPPE TRIGGERS.** The FPPE process may be triggered by any of the following events:

2.A **Specialty-Specific Clinical Triggers.** Each Department shall identify adverse outcomes, clinical occurrences, or complications that will trigger FPPE. The specialty-specific clinical triggers identified by the Departments shall be approved by the Professional Practice Evaluation Committee ("PPEC"). At least annually, the Quality Department shall report to the PPEC the number of cases identified by each specialty-specific clinical trigger and the dispositions of those cases to aid the PPEC in determining whether any specialty-specific clinical triggers need to be modified or deleted or new triggers should be added.

2.B **Reported Concerns.**

(1) **Reported Concerns from Practitioners or Hospital Employees.** Any practitioner or Hospital employee may report to the Quality Department concerns related to:

- (a) the safety or quality of care provided to a patient by an individual practitioner, which shall be reviewed through the process outlined in this Policy;
- (b) professional conduct, which shall be referred to the Behavioral Subcommittee or, if the matter involves urgent patient care or safety issues that require immediate review, to the Leadership Council. Concerns regarding professional conduct shall be reviewed and addressed in accordance with the Medical Staff Professionalism Policy;
- (c) potential practitioner health issues, which shall be referred to the Behavioral Subcommittee or, if the matter involves urgent patient

care or safety issues that require immediate review, to the Leadership Council. Concerns regarding potential practitioner health issues shall be reviewed and addressed in accordance with the Practitioner Health Policy;

- (d) compliance with Medical Staff or Hospital policies, which shall be reviewed either through the process outlined in this Policy or in accordance with the Medical Staff Professionalism Policy, whichever the Quality Department, in consultation with the Director of Medical Staff Services, the CMO and the CQO, as necessary, determines is more appropriate based on the policies at issue; or
- (e) a potential system or process issue which shall be referred to the appropriate individual or Hospital department for review. Such referral shall be reported to the PPEC, which shall monitor the matter until it is resolved.

(2) **Anonymous Reports.** Concerns may be reported anonymously. Receipt of reported concerns that are not submitted anonymously will be acknowledged.

(3) **Unsubstantiated Reports/False Reports.** If a report cannot be substantiated, or is determined to be without merit, the matter shall be closed as requiring no further review and shall be reported to the PPEC. False reports will be grounds for disciplinary action.

(4) **Sharing Reported Concerns with Relevant Practitioner.** The substance of reported concerns may be shared with the relevant practitioner as part of the review process outlined in Section 5, but neither the actual report nor the identity of the individual who reported the concern will be provided to the practitioner. Retaliation against an individual who reports a concern will be addressed through the Medical Staff Professionalism Policy.

(5) **Self-Reporting.** Practitioners will be encouraged to self-report to the CQO their cases that involve either a specialty-specific or other FPPE review trigger or that they believe would be an appropriate subject for an educational session as described in Section 6.G. Self-reported cases will be reviewed as outlined in this Policy. A notation will be made that the case was self-reported.

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

- (1) identification by a Medical Staff committee of a clinical trend or specific case or cases that require further review;

- (2) patient complaints that the Quality Department and CQO determine require physician review;
- (3) cases identified as litigation risks that are referred by the Risk Management Department;
- (4) questions regarding utilization or medical necessity;
- (5) sentinel events involving an individual practitioner's professional performance;
- (6) a Department Vice Chair's determination that ongoing professional practice evaluation ("OPPE") data reveal a practice pattern or trend that requires further review as further described in the OPPE Policy; and
- (7) a trend of informational letters regarding noncompliance with Medical Staff Rules and Regulations or other policies, adopted clinical protocols, or Core Measures or other quality measures, as described in Paragraph 4 and in the OPPE Policy.

3. NOTICE TO AND INPUT FROM THE PRACTITIONER. An opportunity for practitioners to provide meaningful input into the review of the care they have provided is an essential element of an educational and effective process.

3.A Notice.

- (1) No intervention (educational letter, collegial intervention, or Performance Improvement Plan as defined in Section 4) shall be implemented until the practitioner is first notified of the specific concerns identified and given an opportunity to provide input. The notice to the practitioner shall include a time frame for the practitioner to provide the requested input.
- (2) The practitioner shall also be notified when the Leadership Council refers a matter to the MEC.
- (3) Prior notice and an opportunity to provide input are not required before an informational letter is sent to a practitioner, as described in Section 4.A of this Policy.

3.B Input. The practitioner may provide input through a written description and explanation of the care provided, responding to any specific questions posed by the Leadership Council or PPEC, and/or by meeting in person with individuals specified in the notice.

3.C ***Failure to Provide Requested Input.***

- (1) If the practitioner fails to provide input requested by the Leadership Council within the time frame specified, the review shall proceed without the practitioner's input.
- (2) If the practitioner fails to provide input requested by the PPEC within the time frame specified, the practitioner will be required to attend the next meeting of the Leadership Council. Failure of the individual to either (i) attend the Leadership Council meeting, or (ii) respond to the PPEC's request prior to the date of the Leadership Council meeting will result in the automatic relinquishment of the practitioner's clinical privileges until the requested input is provided to the satisfaction of the PPEC, in accordance with the Credentials Policy.

4. **INTERVENTIONS TO ADDRESS IDENTIFIED CONCERNS.** When concerns regarding a practitioner's clinical practice are identified through the process outlined in Section 5, the following interventions may be implemented to address those concerns.

4.A ***Informational Letter.*** For specific situations that are identified by the PPEC and listed in **Appendix A** (e.g., noncompliance with specified Medical Staff Rules and Regulations or other policies, clinical protocols, or quality measures), the Quality Department shall prepare an informational letter reminding the practitioner of the applicable requirement and offering assistance to the practitioner in complying with it. 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. If a pattern or trend of noncompliance is identified, the matter shall be subject to more focused review in accordance with Section 5 of this Policy.

Informational letters may be signed by: The CQO, CMO, Department Vice Chair, or the Chair of the PPEC.

4.B ***Educational Letter.*** An educational letter may be sent to the practitioner involved that describes the opportunities for improvement that were identified in the care reviewed and offers recommendations for future practice. 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.

Educational letters may be sent by: The Leadership Council or the PPEC. If the letter is sent by the Leadership Council, a copy shall be sent to the PPEC.

4.C ***Collegial Intervention.*** Collegial intervention means a face-to-face discussion between the practitioner and one or more Medical Staff Leaders, followed by a letter that summarizes the discussion and, when applicable, the expectations regarding the practitioner's future practice in the Hospital. A copy of the follow-up

letter will be included in the practitioner's file along with any response that he or she would like to offer. If the collegial intervention is conducted or facilitated by the Leadership Council, a copy of the follow-up letter shall be sent to the PPEC.

A collegial intervention may be conducted by: The Leadership Council or the PPEC may conduct a collegial intervention itself or it may facilitate an appropriate and timely collegial intervention by designees. The Leadership Council and PPEC shall be informed of the substance of any collegial intervention and the follow-up letter, regardless of who conducts or facilitates it.

- 4.D ***Performance Improvement Plan ("PIP").*** The PPEC may determine that it is necessary to develop a Performance Improvement Plan for the practitioner.

To the extent possible, a PIP 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 PIP 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 PIP.

One or more members of the PPEC (or their designees) will personally discuss the PIP with the practitioner. The PIP will also be presented in writing, with a copy being placed in the practitioner's file, along with any statement he or she would like to offer. The practitioner must agree in writing to constructively participate in the PIP. If the practitioner refuses to do so, the matter shall be referred to the MEC for appropriate review and recommendation pursuant to the Credentials Policy.

Until the PPEC has determined that the practitioner has complied with all elements of the PIP 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. In the event the practitioner is not making reasonable and sufficient progress on completion of the PIP in a timely manner, the PPEC shall refer the matter to the MEC.

A practitioner who is subject to PIP may not serve as a Supervising Physician for an Allied Health Professional who is performing duties outlined in the PIP until such time as the PPEC has confirmed that the practitioner has completed the PIP.

A Performance Improvement Plan may include, but is not limited to, the following:

- (1) ***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 or her clinical privileges or may be granted an educational leave of absence while undertaking such additional education.

- (2) ***Focused Prospective Review*** which means that a certain number of the practitioner's future cases of a particular type will be subject to a focused review (e.g., review of the next 10 similar cases performed or managed by the practitioner).
- (3) ***Second Opinions/Consultations*** which means that before the practitioner proceeds with a particular treatment plan or procedure, the practitioner must obtain a second opinion or consultation from a Medical Staff member(s) approved 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.
- (4) ***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. Proctor(s) must complete the review form specified by the PPEC.
- (5) ***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 or her clinical privileges or may be granted an educational leave of absence while undertaking such formal assessment.
- (6) ***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 or her clinical privileges or may be

granted an educational leave of absence while undertaking such additional training.

- (7) ***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.
- (8) ***Other*** elements not specifically listed may be included in a PIP. The PPEC has wide latitude to tailor PIPs to the specific concerns identified, always with the objective of helping the practitioner to improve his or her clinical practice and to protect patients.

(Additional guidance regarding Performance Improvement Plan options and implementation issues is found in **Appendix B.**)

5. **STEP-BY-STEP PROCESS.** The process for FPPE when concerns are raised is depicted in **Appendix C-1** (Detailed Flowchart) and **Appendix C-2** (Simplified Flowchart). This Section describes each step in that process.

5.A ***General Principles.***

- (1) ***Time Frames for Review.*** The time frames specified in this Section are provided only as guidelines. However, all participants in the process shall use their best efforts to adhere to these guidelines, with the goal of completing reviews, from initial identification to a final disposition, within 90 days.
- (2) ***Request for Additional Information or Input.*** At any point in the process outlined in this Section, information or input may be requested from the practitioner whose care is being reviewed as described in Section 3 of this Policy, or from any other practitioner or Hospital employee with personal knowledge of the matter.
- (3) ***No Further Review or Action Required.*** If, at any point in this process, a determination is made that there are no clinical issues or concerns presented in the case that require further review or action, the matter shall be closed. If information was sought from the practitioner involved, the practitioner shall be notified of the determination.
- (4) ***Referral to the MEC.***
 - (a) The Leadership Council may refer a matter to the MEC if it determines that review under the Medical Staff Credentials Policy is required.

- (b) The PPEC may refer a matter to the MEC if it determines that:
 - (i) a PIP may not be adequate to address the issues identified;
 - (ii) the practitioner refuses to participate in a PIP developed by the PPEC;
 - (iii) the practitioner fails to abide by a PIP;
 - (iv) the practitioner fails to make reasonable and sufficient progress on completing the PIP; or
 - (v) review under the Medical Staff Credentials Policy is required.

The MEC shall conduct its review in accordance with the Medical Staff Credentials Policy.

5.B ***Quality Department and CQO.***

- (1) ***Review.*** All cases or issues identified for FPPE shall be referred to the Quality Department and CQO for review, which 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) other relevant documentation; and
 - (e) the practitioner's professional practice evaluation history.
- (2) ***Determination.*** After conducting its review, the Quality Department and CQO may:
 - (a) determine that no further review is required and close the case;
 - (b) send an informational letter as described in Paragraph 4.A; or
 - (c) determine that further physician review is required.

- (3) ***Preparation of Case for Review.*** The Quality Department shall prepare cases that require physician review. Preparation of the case may include, as appropriate, the following:
 - (a) completion of the appropriate portions of the applicable review form (i.e., general, surgical, medical, or obstetrical);
 - (b) preparation of a timeline or summary of the care provided;
 - (c) identification of relevant patient care protocols or guidelines;
 - (d) identification of relevant literature; and
 - (e) review of the practitioner's professional practice evaluation history.
- (4) ***Referral of Case.*** The CQO shall determine where to refer cases that require physician review. Cases shall be referred to the Leadership Council if they involve urgent patient care or safety issues that require immediate review. All other cases shall be referred for Clinical/Specialty Review, which may be conducted by the CMO, a practitioner who has the necessary clinical expertise, or the appropriate PPEC member as described in Section 5.D.

5.C ***Leadership Council.***

- (1) ***Composition and Duties.*** The function of the Leadership Council is to review and address cases involving urgent patient care or safety issues that require immediate review and intervention and to review matters referred to it directly. The composition and duties of the Leadership Council are included in the Medical Staff Organization Manual.
- (2) ***Immediate Interventions.*** When an urgent clinical issue is referred to the Leadership Council, it shall review all supporting documentation assembled by the Quality Department and CQO. Following its review, the Leadership Council may take whatever action is necessary to address the immediate patient care or safety issue.
- (3) ***Further Review.*** Once the clinical issue that presents an urgent patient care or safety risk is addressed, the Leadership Council may:
 - (a) determine that no further review or action is required;
 - (b) determine that the matter should also be reviewed through the Medical Staff Professionalism Policy, Practitioner Health Policy, Corporate Compliance Policy, Sentinel Event Policy, or other relevant policy.

If the Leadership Council makes such a determination, it shall either handle the matter itself in accordance with the relevant policy or shall refer the case to the appropriate individual or committee for disposition in accordance with the relevant policy and shall document its actions or the referral for review by the PPEC;

- (c) send the practitioner an educational letter;
- (d) conduct a collegial intervention with the practitioner; or
- (e) refer the matter for further review to:
 - (i) the appropriate PPEC member or to any practitioner(s) on the Medical Staff who has the appropriate clinical expertise to evaluate the care provided, who shall complete an appropriate review form, if applicable, and report his/her findings to the PPEC within 21 days;
 - (ii) the PPEC; or
 - (iii) the MEC.

5.D ***Clinical/Specialty Review.*** Individuals conducting clinical/specialty review (the CMO, a practitioner with necessary clinical expertise assigned by the CQO or the Leadership Council, or the appropriate PPEC member) shall review the medical record and all supporting documentation prepared by the Quality Department and shall complete an appropriate review form. The review form and the reviewer's findings shall be presented to the PPEC. As a general rule, clinical/specialty review should be conducted within 21 days of the referral.

5.E ***Professional Practice Evaluation Committee (PPEC).***

- (1) ***Review of Determinations/Interventions by Leadership Council.*** The PPEC shall review determinations that no further review or action is required, as well as educational letters and collegial intervention follow-up letters sent by the Leadership Council. If the PPEC has concerns about any such determination, it may:
 - (a) send the matter back to the Leadership Council with its questions or concerns and ask that the matter be reconsidered and findings reported back to it within 21 days; or
 - (b) review the matter itself.
- (2) ***Cases Referred to the PPEC for Review.***

- (a) **Review.** The PPEC shall review the findings and results of clinical/specialty review, as well as matters referred to it from the Leadership Council along with all supporting documentation. 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:
 - (i) invite a specialist(s) with the appropriate clinical expertise to attend a PPEC meeting(s) as a guest, without vote, to assist the PPEC in its review of issues, determinations, and interventions;
 - (ii) assign the review to any practitioner on the Medical Staff with the appropriate clinical expertise;
 - (iii) appoint an ad hoc committee composed of such practitioners; or
 - (iv) arrange for an external review in accordance with Section 6.C of this Policy.

- (b) **Determinations and Interventions.** Based on its review of all information obtained, including input from the practitioner as described in Section 3, the PPEC may:
 - (i) determine that no further review or action is required;
 - (ii) send an educational letter;
 - (iii) conduct a collegial intervention with the practitioner;
 - (iv) develop a Performance Improvement Plan;
 - (v) refer the matter to the Leadership Council;
 - (vi) refer the matter to the Behavioral Subcommittee; or
 - (vii) refer the matter to the MEC.

6. PRINCIPLES OF REVIEW AND EVALUATION

6.A **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 referred for review involves a medical record that is incomplete, the CQO

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 this time frame, the practitioner will be required to attend the next meeting of the MEC. Failure of the individual (i) to attend the MEC meeting, or (ii) to complete the medical record in question prior to the date of the MEC meeting will result in the automatic relinquishment of the practitioner's Medical Staff appointment and clinical privileges until the medical record is completed.

In the event a practitioner is referred to the PPEC more than once in a 24-month period for incomplete medical records, the practitioner will be required to: (1) complete the medical record(s) within 10 days of a notification of subsequent incomplete records; and (2) attend the next meeting of the MEC to discuss incomplete medical records and compliance with medical record requirements. Failure to complete the medical record(s) in question or attend the next MEC meeting will result in the automatic relinquishment of the practitioner's Medical Staff appointment and clinical privileges.

6.B ***Forms.*** The PPEC shall approve forms to implement this Policy. Such forms shall be developed and maintained by the Quality Department, unless the PPEC directs that another office or individual develop and maintain specific forms. Individuals performing a function pursuant to this Policy shall use the form currently approved by the PPEC for that function.

6.C ***External Reviews.*** An external review may be appropriate if:

- (1) there are ambiguous or conflicting findings by internal reviewers;
- (2) the clinical expertise needed to conduct a review is not available on the Medical Staff; or
- (3) an outside review is advisable to prevent allegations of bias, even if unfounded.

An external review may be arranged by the PPEC. 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.

6.D ***Findings and Recommendations Supported by Evidence-Based Research/Clinical Protocols or Guidelines.*** Whenever possible, the findings of reviewers and the PPEC shall be supported by evidence-based research, clinical protocols or guidelines.

6.E ***System Process Issues.*** Quality of care and patient safety depend on many factors in addition to practitioner performance. If system processes or procedures that may have adversely affected, or could adversely affect, outcomes or patient safety are identified through the process outlined in this policy, the issue shall be referred to

the appropriate Hospital Department and/or the Quality Department and CQO. The referral shall be reported to the PPEC and shall remain on the PPEC's agenda until the PPEC determines that it is successfully resolved, based on reports from individuals or Departments responsible for addressing the issue.

- 6.F ***Tracking of Reviews.*** The Quality Department shall track the processing and disposition of matters reviewed pursuant to this Policy. The Leadership Council, individuals conducting clinical/specialty review and the PPEC shall promptly notify the Quality Department of their determinations, interventions and referrals.
- 6.G ***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 CQO, the CMO, the Leadership Council, or the PPEC 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 seven 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.
- 6.H ***Confidentiality.*** Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process.
- (1) ***Documentation.*** All documentation that is prepared in accordance with this Policy shall be 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.
- (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.
- (3) ***PPE Communications.*** Communications among those participating in the PPE process, including communications with the individual practitioner involved, shall be conducted in a manner reasonably calculated to assure privacy.
- (a) Telephone and in-person conversations shall take place in private at appropriate times and locations.

- (b) E-mail may be used to communicate between individuals participating in the peer review process, including with assigned reviewers and with the practitioner whose care is being reviewed. However, as noted previously in this Policy, any Performance Improvement Plan that is developed for a practitioner shall be hand-delivered and personally discussed with the practitioner.
- (c) All correspondence (whether paper or electronic) shall be conspicuously marked with the notation “Confidential Peer Review,” “Confidential, to be Opened Only by Addressee” or words to that effect.
- (d) If it is necessary to e-mail medical records or other documents containing a patient’s protected health information, Hospital policies governing compliance with the HIPAA Security Rule shall be followed.

6.I ***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 MEC). 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.J ***Legal 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.

7. PROFESSIONAL PRACTICE EVALUATION REPORTS

7.A ***Practitioner FPPE History Reports.*** A practitioner history report showing all cases that have been reviewed for a particular practitioner within the past two years and their dispositions shall be generated for each practitioner for consideration and

evaluation by the appropriate Department Chair and the Credentials Committee in the reappointment process.

- 7.B ***Reports to MEC and Board.*** The Quality Department shall prepare reports at least quarterly showing the aggregate number of cases reviewed through the PPE process and the dispositions of those matters.
- 7.C ***Reports on Request.*** The Quality Department shall prepare reports as requested by the CQO, CMO, Leadership Council, PPEC, MEC, Hospital management, or the Board.

Adopted by the MEC on September 10, 2013.

Approved by the Board of Trustees on September 17, 2013.