COVENANT MEDICAL CENTER

PROFESSIONAL PRACTICE EVALUATION POLICY (PEER REVIEW)

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

1.A Objectives. The primary objectives of the Professional Practice Evaluation ("PPE") process of Covenant Medical Center (the "Hospital") are to:

(1) establish a positive, educational approach to performance issues and a culture of continuous improvement for individual Practitioners, which includes:

(a) fairly, effectively, and efficiently evaluating the care being provided by Practitioners, comparing it to established patient care protocols and benchmarks whenever possible; and

(b) providing constructive feedback, education, and performance improvement assistance to Practitioners regarding the quality, appropriateness, and safety of the care they provide;

(2) effectively disseminate lessons learned and promote education sessions so that all Practitioners in a relevant specialty area will benefit from the PPE process and also participate in the culture of continuous improvement; and

(3) promote the identification and correction of system process issues that may adversely affect the quality and safety of care being provided to patients (e.g., protocol or policy revisions that are necessary; addressing patient handoff breakdowns or communication problems).

1.B Scope of Policy.

(1) The Hospital's PPE process includes several related but distinct components:

(a) The PPE process described in this Policy is used when questions or concerns are raised about a Practitioner's clinical competence. This process has traditionally been referred to as "peer review."

(b) The process used to confirm an individual's competence to exercise newly granted privileges is described in the FPPE Policy to Confirm Practitioner Competence and Professionalism (New Members/New Privileges). The process used to evaluate a Practitioner's competence on an ongoing basis is described in the Ongoing Professional Practice Evaluation (OPPE) Policy.

(c) 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.

(d) If a matter involves both clinical and behavioral concerns, the Chairs of the Leadership Council and the CoPE shall coordinate the reviews. The behavioral concerns may either be addressed by the Leadership Council pursuant to the Professionalism Policy with a report to the CoPE, or may be addressed by the CoPE pursuant to this Policy with the provisions in the Professionalism Policy being used for guidance.

(2) This Policy applies to all Practitioners who provide patient care services at the Hospital.

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 PPE 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 activities. These efforts are encouraged, but are not mandatory, and shall be within the discretion of the Leadership Council and the CoPE.

1.D Definitions. The following definitions apply to terms used in this Policy:

ASSIGNED REVIEWER means a physician appointed by the Leadership Council or the CoPE to review and assess the care provided in a particular case and to report back to the individual or committee that assigned the review. Duties and responsibilities of Assigned Reviewers are described more fully in **Appendix A**.

AUTOMATIC RELINQUISHMENT/AUTOMATIC RESIGNATION of appointment and/or clinical privileges are administrative actions that occur by operation of the Credentials Policy or this Policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any state licensing board or agency, nor do they entitle the Practitioner to a hearing or appeal.

COMMITTEE ON PERFORMANCE ENHANCEMENT ("CoPE") is a multi-specialty peer review and quality assurance committee under Texas law that oversees the professional practice evaluation process, conducts case reviews, and develops Performance Improvement Plans as described in this Policy. This committee possesses no disciplinary authority. Only the Medical Executive Committee has the authority to conduct non-routine, formal Investigations and to recommend restrictions of clinical privileges. The composition and duties of the CoPE are described in the Medical Staff Organization Manual.

DEPARTMENT CHAIR means the applicable Medical Staff Department Chair (e.g.,

Department of Medicine or Surgery) at the Hospital.

LEADERSHIP COUNCIL is a peer review and quality assurance committee under Texas law that:

(1) conducts reviews of, or determines the appropriate review process for, clinical issues that are administratively complex, as described in this Policy;

(2) handles issues of professional conduct pursuant to the Medical Staff Professionalism Policy; and

(3) in conjunction with the Physician Health and Wellness Committee, handles issues of Practitioner health pursuant to the Practitioner Health Policy.

This committee possesses no disciplinary authority. Only the Medical Executive Committee has the authority to conduct non-routine, formal investigations and to recommend restrictions of clinical privileges. The composition and duties of the Leadership Council are described in the Medical Staff Organization Manual.

MEDICAL STAFF LEADER means any Medical Staff Officer, department chair, section chief, and committee chair.

PPE SUPPORT STAFF means the clinical and non-clinical staff who support the professional practice evaluation process as described more fully in this Policy. This may include, but is not limited to, persons from Medical Staff Services or the Quality Improvement Department.

PRACTITIONER means any individual who has been granted clinical privileges and/or membership by the Board including, but not limited to, members of the Medical Staff and Allied Health Professionals.

PROFESSIONAL PRACTICE EVALUATION ("PPE") refers to the Hospital's routine and ongoing peer review processes. It is used to evaluate a Practitioner's professional performance for a time-limited period. The PPE process outlined in this Policy is applicable to all Practitioners and is not intended to be a precursor to any disciplinary action, but rather is designed to promote improved patient safety and quality through continuous improvement.

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

FPPE Focused Professional Practice Evaluation
OPPE Ongoing Professional Practice Evaluation
PIP Performance Improvement Plan
PPE Professional Practice Evaluation (Peer Review)
CoPE Committee on Performance Enhancement
MEC Medical Executive Committee

2. PPE TRIGGERS. The PPE process set forth in this Policy may be triggered by any of the following events:

2A ***Specialty-Specific Triggers.*** Each Section and Department shall identify adverse outcomes, clinical occurrences, or complications that will trigger PPE. The triggers shall be approved by the CoPE and the MEC.

2B ***Reported Concerns.***

(1) ***Reported Concerns from Practitioners or Hospital Employees.*** Any Practitioner or Hospital employee may report to the PPE Support Staff 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 reviewed and addressed in accordance with the Medical Staff Professionalism Policy;

(c) potential Practitioner health issues, which 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 and/or in accordance with the Medical Staff Professionalism Policy, whichever the Leadership Council 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, committee, or hospital department for review. Such referral shall be reported to the CoPE, which shall monitor the matter until it is resolved.

(2) ***Anonymous Reports.*** Practitioners and employees may report concerns anonymously, but all individuals are encouraged to identify themselves when making a report. This identification promotes an effective review of the concern because it permits the PPE Support Staff to contact the reporter for additional information, if necessary.

(3) ***Follow-up with Individual Who Filed Report.*** The PPE Support Staff and/or the Chief Medical Officer shall follow up with individuals who file a report by:

(a) thanking them for reporting the matter and participating in the Hospital's culture of safety and quality care;

(b) informing them that the matter will be reviewed in accordance with this Policy and that they may be contacted for additional information;

(c) informing them that no retaliation is permitted against any individual who raises a concern and to report any retaliation or any other incidents of inappropriate conduct; and

(d) informing them that, due to confidentiality requirements under state and Federal law, no further information can be provided regarding the outcome of the review.

(4) ***Unsubstantiated Reports or 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. False reports will be grounds for disciplinary action. False reports by Practitioners will be referred to the Leadership Council. False reports by Hospital employees will be referred to human resources.

(5) ***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 or otherwise provided information about the matter will be provided to the Practitioner unless: (a) the individual specifically consents to the disclosure; or (b) the Leadership Council determines that an exception should be made in a particular situation. Retaliation (as defined in the Medical Staff Professionalism Policy) by the Practitioner against anyone who is believed to have reported a concern is inappropriate conduct and will be addressed by the Leadership Council as provided in the Professionalism Policy.

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

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

(1) identification by a Medical Staff committee or work group of a clinical trend or specific case or cases that require further review. The review and deliberations of such a committee or work group and any documentation prepared are confidential peer review information and shall be used and disclosed only as set forth in this Policy;

(2) patient complaints that are referred by the patient representative and that require further review, as determined by the Initial Reviewer;

(3) cases identified as quality risks that are referred by the risk management department. However, confidential information generated pursuant to this Policy may not be disclosed as part of any risk management activities;

(4) unresolved issues of medical necessity referred through the utilization management committee, case management department, compliance officer, or otherwise;

(5) referrals from the CERT Review Team or sentinel events involving an individual Practitioner's professional performance;

(6) a Department Chair's determination that ongoing professional practice evaluation ("OPPE") data or focused professional practice evaluation ("FPPE") data reveal a practice pattern or trend that requires further review as described in the OPPE Policy or the FPPE Policy and to Confirm Practitioner Competence and Professionalism, respectively;

(7) when a threshold number of Informational Letters identified in **Appendix C** is reached or when there is a trend of nonevidence based medicine.

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.

3A Notice.

(1) No intervention (Educational Letter, Collegial Intervention, or Performance Improvement Plan as defined in Section 4 of this Policy) 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 of any referral to the Medical Executive Committee.

3B Input. The Practitioner shall provide input through a written description and explanation of the care provided, responding to any specific questions posed in the notice. Upon the request of either the Practitioner or the person or committee conducting the review, the Practitioner shall also provide input by meeting with appropriate individuals to discuss the issues.

3C Failure to Provide Requested Input.

(1) If the Practitioner fails to provide input requested by the Leadership Council, the CoPE or the Trauma Committee within the time frame specified, the review shall proceed without the Practitioner's input. The entity requesting the information shall note the Practitioner's failure to respond to the request for input in the report to the CoPE regarding the review and determination.

(2) If the Practitioner fails to provide input requested by the Leadership Council or within the time frame specified, the Practitioner will be required to meet with the Leadership Council to discuss why the requested input was not

provided. Failure of the Practitioner to either meet with the Leadership Council or to provide the requested information prior to the date of that meeting will result in the automatic relinquishment of the Practitioner's clinical privileges until the information is provided. If the Practitioner fails to provide input requested by the Leadership Council or CoPE within thirty (30) days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned. (See Section 1.D for additional information about automatic relinquishment/resignation.) If the Practitioner wishes to continue to practice at the Hospital they must reapply for privileges pursuant to the Credentials Policy.

4. INTERVENTIONS TO ADDRESS IDENTIFIED CONCERNS. When concerns regarding a Practitioner's clinical practice are identified, the following interventions may be implemented to address those concerns.

4A Informational Letter. The CoPE shall identify specific performance issues that can be successfully addressed through the use of Informational Letters, without the need to proceed with more formal review under this Policy. The performance issues that may lead to an Informational Letter are often referred to as "rate and rule" measures. Informational Letters are a non-punitive, educational tool to help Practitioners self-correct and improve their performance through the use of feedback.

As determined by the CoPE, performance issues that may be addressed via Informational Letters include, but are not limited to, noncompliance with:

- specific provisions of the Medical Staff Rules and Regulations or Hospital or Medical Staff policies;
- an adopted protocol, without appropriate documentation in the medical record as to the reasons for not following the protocol;
- core or other quality measures; or
- care management/utilization management requirements.

Appendix C includes:

(1) a list of issues that may result in an Informational Letter being sent;

(2) the number of Informational Letters in an OPPE period that will lead to further review under this Policy.

In these situations, the CoPE Chair shall direct the PPE Support Staff to prepare an Informational Letter reminding the Practitioner of the applicable requirement and offering assistance to the Practitioner in complying with it. The purpose of this feedback is to increase awareness of the requirement and to permit the Practitioner to improve his/her practice on a self-improvement basis. However, nothing in this

Policy prohibits any authorized individual or committee from forgoing the use of an Informational Letter and responding to a particular incident in some other manner as warranted by the circumstances.

A copy of the Informational Letter shall be placed in the Practitioner's confidential file. It shall be considered in the reappointment process and in the assessment of the Practitioner's competence to exercise the clinical privileges granted.

A matter shall be subject to review by the Leadership Council in accordance with Section 5 of this Policy if: (i) the threshold number of Informational Letters to address a particular type of situation is reached as described in Appendix C; or (ii) a trend of noncompliance is otherwise identified based on the overall number of Informational Letters sent to a Practitioner or other relevant factors, even if none of the thresholds for a particular category in **Appendix C** are met.

Informational letters may be signed by: the Chair of the CoPE.

4B 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 specific 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: Leadership Council, the Trauma Committee, the CoPE, or their designees. The Department Chair and CoPE will be copied on any Educational Letter that is sent to a Practitioner.

4C Collegial Intervention. Collegial intervention means a face-to-face discussion between the Practitioner and one or more Medical Staff Leaders. If the Collegial Intervention results from a matter that has been reviewed through this Policy, it shall be 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 the Practitioner would like to offer.

A Collegial Intervention may be personally conducted by: One or more members of the Leadership Council, Trauma Committee or CoPE (when directed to do so by the full committee), or these committees may facilitate an appropriate and timely Collegial Intervention by one or more designees (including, but not limited to, a Department Chair). The Department Chair, Leadership Council, and CoPE shall be informed of the substance of any collegial intervention and provided a copy of the follow-up letter, regardless of who conducts or facilitates it.

4D Performance Improvement Plan ("PIP").

(1) ***General.*** The CoPE or the Leadership Council may determine if it would be beneficial to develop a PIP 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 should specify how the Practitioner's compliance with, and results of, the PIP

will be monitored. One or more members of the CoPE or Leadership Council (or their designees) will personally discuss the PIP with the Practitioner to help ensure a shared and clear understanding of the elements of the PIP. The PIP will also be presented in writing, with a copy being placed in the Practitioner's file, along with any statement the Practitioner would like to offer.

(2) ***Input.*** As deemed appropriate by the Leadership Council or the CoPE, the Practitioner may have an opportunity to provide input into the development and implementation of the PIP. The Department Chair shall also be asked for input regarding the PIP, and shall assist in implementation of the PIP as may be requested.

(3) ***Voluntary Nature of PIPs.*** If a Practitioner agrees to participate in a PIP developed by the CoPE or the Leadership Council, such agreement will be documented in writing. If a Practitioner disagrees with the need for a PIP, the Practitioner is under no obligation to participate in the PIP. In such case, the Leadership Council or the CoPE cannot compel the Practitioner to agree with the PIP. Instead, the Leadership Council or the CoPE will refer the matter to the Medical Executive Committee for its independent review and action pursuant to the Medical Staff Credentials Policy.

(4) ***Ongoing Assessment of PIP Results.***

(a) All PIPs will stay on the CoPE's or the Leadership Council's agenda and will be periodically assessed so the committee can determine whether any modifications to the PIP are appropriate. Such modifications may include, but are not limited to, additional education, monitoring requirements, or a decision that the elements of the PIP have been satisfied and no additional action is needed. The CoPE or the Leadership Council will obtain input from the Practitioner before making any modification to a PIP other than a determination that the elements of the PIP have been satisfied.

(b) The CoPE's or Leadership Council's assessment of the PIP will continue until it determines that either: (i) concerns about the Practitioner's practice have been adequately addressed; or (ii) the Practitioner is not making reasonable progress toward completion of the PIP in a timely manner, in which case the CoPE or Leadership Council shall refer the matter to the Medical Executive Committee for its independent review pursuant to the Medical Staff Credentials Policy. The CoPE or the Leadership Council will inform the Credentials Committee of the satisfactory completion of the PIP or the practitioner's failure to make reasonable progress.

(c) The CoPE or the Leadership Council will communicate with the Practitioner:

(i) periodically regarding the Practitioner's progress under the PIP;

and

(ii) prior to any referral of the matter to the Medical Executive Committee.

(5) ***Reporting Obligations.*** Most PIPs that are developed by the CoPE or the Leadership Council will not require a report to any state licensing board or to the National Practitioner Data Bank. However, the CoPE or Leadership Council must assess this reporting issue with each PIP. If the CoPE or the Leadership Council determines that any element of a PIP must be reported, the resulting report will be shared with the Practitioner first. The report will explicitly state that the Hospital does not consider the PIP to be a disciplinary matter and, to the extent applicable, that the Practitioner is working constructively with the CoPE or the Leadership Council to address the issues identified and to improve the care provided.

(6) ***Participation in PIPs by Partners.*** Consistent with the conflict of interest guidelines set forth in this Policy, partners and other individuals who are affiliated in practice with the Practitioner may participate in PIPs through chart review and monitoring, proctoring, and providing second opinions. In any such instance, these individuals shall comply with the standard procedures that apply to all other individuals who participate in the PPE process, such as the use of Hospital forms and the requirements related to confidentiality. To the extent possible, individuals who are not partners or affiliated in practice with the Practitioner will also be sought to perform these functions, consistent with the conflict of interest guidelines in this Policy.

(7) ***PIP Options.*** A PIP may include, but is not limited to, the following (used individually or in combination):

(a) ***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 Leadership Council or the CoPE. The educational activity/program may be chosen by the Leadership Council or the CoPE or by the Practitioner. If the activity/program is chosen by the Practitioner, it must be approved by the Leadership Council or the CoPE. 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.

(b) ***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 ten similar cases performed or managed by the Practitioner).

(c) ***Indicators Checklist*** which means that the Practitioner must:

(i) research the medical literature;

(ii) identify evidence-based guidelines that address when a test or procedure is medically-indicated; and

(iii) prepare a checklist, flow chart, or similar document that can be used to document in the medical record the medical necessity and appropriateness of a test or procedure for a specific patient. The checklist will be reviewed and approved by the Leadership Council or the CoPE.

(d) ***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 approved by the Leadership Council or the CoPE. If there is any disagreement about the proper course of treatment, the Practitioner must discuss the matter further with individuals identified by the Leadership Council or the CoPE, before proceeding further. The Practitioner providing the second opinion/consultation must complete a Second Opinion/Consultation Report form for each case, which shall be reviewed by the CoPE.

(e) ***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 approved by the Leadership Council or the CoPE, or by an appropriately credentialed individual from outside of the Medical Staff approved by the Leadership Council or the CoPE. The proctor must be present during the relevant portions of the operative procedure or must personally assess the patient and be available throughout the course of treatment. Proctors must complete the appropriate review form, which shall be reviewed by the Leadership Council or the CoPE.

(f) ***Participation in a Formal Evaluation/Assessment Program*** which means that, within a specified period of time, the Practitioner must enroll in a program approved by the Leadership Council or the CoPE that is designed to identify specific deficiencies, if any, in the Practitioner's clinical practice. The Practitioner must then complete the assessment program within another specified time period. The Practitioner must execute a release to allow the Leadership Council or the CoPE to communicate information to, and receive information from, the selected assessment 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.

(g) ***Additional Training*** which means that, within a specified period of time, the Practitioner must complete additional training in a program approved by the Leadership Council or the CoPE to address any

identified deficiencies in his or her practice. The Practitioner must execute a release to allow the Leadership Council 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 Leadership Council. 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.

(h) ***Educational Leave of Absence or Determination to Voluntarily Refrain from Practicing during the PPE Process*** which means that the Practitioner voluntarily agrees to a leave of absence ("LOA") or to temporarily refrain from some or all clinical practice while the PPE process continues. During the LOA or the period of refraining, a further assessment of the issues will be conducted or the Practitioner will complete an education/training program of a duration and type specified by the Leadership Council or the CoPE.

(i) ***Other*** elements not specifically listed may be included in a PIP. The Leadership Council and the CoPE have 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 PIP options and implementation issues is found in **Appendix D**.

5. STEP-BY-STEP PROCESS. The process for PPE is outlined in **Appendix E** (Flow Chart of Professional Practice Evaluation Process). This Section describes each step in that process.

5A 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 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) ***Exemplary Care.*** If the Leadership Council or the CoPE determines that a

Practitioner provided exemplary care in a case under review, the Practitioner will be sent a letter recognizing their efforts. A copy of the letter shall be placed in the Practitioner's confidential file.

(4) ***Referral to the Medical Executive Committee.***

(a) ***Referral by the CoPE.*** The Leadership Council or the CoPE may refer a matter to the Medical Executive Committee if:

(i) it determines that there are quality issues that cannot be resolved with the practitioner;

(ii) the individual refuses to participate in a PIP developed by the CoPE;

(iii) the Practitioner fails to abide by a PIP; or

(iv) the Practitioner fails to make reasonable and sufficient progress on completing a PIP.

(b) ***Pursuant to the Credentials Policy.*** This Policy outlines collegial and progressive steps that can be taken to address clinical concerns about a Practitioner. However, a single incident or pattern of care may be of such concern that more significant action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter to the Medical Executive Committee pursuant to the Credentials Policy when deemed necessary under the circumstances.

(c) ***Review by Medical Executive Committee.*** The Medical Executive Committee shall conduct its review in accordance with the Credentials Policy.

(5) ***Role of Department Chairs in PPE Process.*** Active participation of Department Chairs is an essential element of an effective PPE process under this policy. The Department Chair plays an important role in the PPE process by:

(a) overseeing the Department's development of specialty-specific triggers for reviews under this Policy;

(b) participating with the Leadership Council and the CoPE in Collegial Interventions with Department members;

(c) advising the Leadership Council and the CoPE in the development of effective PIPs for Department members and assisting in their implementation;

(d) reviewing copies of Informational Letters, Educational Letters, follow-up letters after Collegial Intervention, and composite reports of cases of

Department members reviewed through the process. If the Department Chair has any concern regarding the disposition of a case involving a member of the Department, the Chair shall document those concerns and forward them to the Leadership Council or the CoPE Chair for review under this Policy;

(e) consulting with the Leadership Council or the CoPE regarding the selection of one or more Clinical Specialty Reviewers;

(f) recommending to the Leadership Council or the CoPE in writing, through its Chair, modifications to make the PPE process more effective and efficient; and

(g) working with PPE Support Staff to present educational case review sessions as described more fully in Section 6.G of this Policy.

5.B PPE Support Staff.

(1) ***Organization.*** All cases or issues identified for PPE shall be referred to the PPE Support Staff for organization. Such organization by the PPE Support Staff may include, as necessary, the following:

(a) the relevant medical record;

(b) preparation of a time line or summary of the care provided;

(c) identification of relevant patient care protocols or guidelines; and

(d) identification of relevant literature.

(2) ***Preparation of Case for Physician Review.*** The PPE Support Staff shall prepare cases for physician review. Preparation of the case may include, as appropriate, the following:

(a) completion of the appropriate portions of the applicable review form (e.g., general, surgical, medical, obstetrical, or other review form);

(b) preparation of a time line or summary of the care provided;

(c) identification of relevant patient care protocols or guidelines; and

(d) identification of relevant literature.

5.C Initial Review

(1) **Review.** All matters may be initially reviewed by RL Committee, the Chief of Staff, the Vice Chief of Staff, or the immediate past Chief of Staff.

(2) **Determination.** The purpose of the Initial Review is to determine whether the

matter requires substantive review. The Initial Review may result in any of the following:

(a) No issue – matter closed. If a matter is closed that fact will be noted on the RL or other form. A copy will NOT be placed in the Practitioner's file. If there is a matter in a Practitioner's file that has not been acted upon by the Chief of Staff, the CoPe, or the Leadership Council, it cannot be considered or otherwise used for any purpose.

(b) Possible quality issue – submit for a Clinical Specialty Review.

(c) Possible conduct issues, heath issues, or multiple complex clinical issues – submit to Leadership Council.

5.D Clinical Specialty Review

(1) **Review.** For cases referred to them, Clinical Specialty Reviewers shall review the medical record and all supporting documentation assembled by the PPE Support Staff and complete the appropriate review form. Clinical Specialty Reviewers shall report their findings to the Leadership Council for determination if that committee requested the review. Otherwise they shall report their findings to the CoPE.

(2) **Additional Expertise.** As needed, a Clinical Specialty Reviewer may assign a review to one or more Assigned Reviewers, who will report back to the Clinical Specialty Reviewer. The Clinical Specialty Reviewer remains responsible for completing the review form and reporting his or her findings to the appropriate committee.

(3) **Time Frames.** Clinical Specialty Reviewers and Assigned Reviewers, as applicable, shall complete their reviews within 30 days of the review being assigned. If a review is not completed within this time frame, the PPE Support Staff shall send a reminder and a request for immediate review. If the individual in question fails to complete the review within one week of the reminder, the matter shall be reported to the Chief of Staff or the CoPE Chair.

5.E Referral of Case the Leadership Council or the Trauma Committee.

(1) Cases shall be referred to the Leadership Council if they are administratively complex as described in this Section or if the RL Committee, the Clinical Specialty Reviewer, the CoPE Chair, or the Chief Medical Officer determines that review by the Leadership Council would be appropriate. Administratively complex cases are defined as those:

(a) that require immediate or expedited review;

(b) that involve Practitioners from two or more specialties or Departments;

(c) that involve a Clinical Specialty Reviewer;

(d) that involve professional conduct;

(e) that involve a Practitioner health issue;

(f) for which there are limited reviewers with the necessary clinical expertise;

(g) where there is a trend or pattern of Informational Letters as described in Section 4.A of this Policy;

(h) where an unacceptable pattern of clinical care appears to have developed despite prior attempts at Collegial Intervention/education; or

(i) where a Performance Improvement Plan is currently in effect, or where prior participation in a Performance Improvement Plan does not seem to have addressed identified concerns.

(2) Trauma cases meeting the above criteria will be referred to the Trauma Committee and reviewed as set forth in Section 5.G. The committee's findings and recommendations will be submitted to the CoPE for review on a quarterly basis.

5.F Leadership Council.

(1) **Review.** The Leadership Council shall review all matters referred to it, including all supporting documentation assembled by the PPE Support Staff. Based on its preliminary review, the Leadership Council shall determine whether any additional clinical expertise is needed for it to make an appropriate determination or intervention.

If additional clinical expertise is needed, the Leadership Council may assign the review to one or more of the following, who shall evaluate the care provided, complete an appropriate review form, and report their findings back to the Leadership Council within 30 days:

(a) a Clinical Specialty Reviewer;

(b) an Assigned Reviewer;

(c) a committee composed of such Practitioners; or

(d) an external reviewer, in accordance with Section 6.C of this Policy.

5.G Trauma Committee.

(1) The Trauma Committee will review cases based on the criteria required for accreditation by the American College of Surgeons and Texas law.

(2) The Trauma Committee may address concerns that are identified through its review by sending the Practitioner an Educational Letter as Described in Section 4.B of this Policy or by conducting a Collegial Intervention as described in Section 4.C. In such case, the Trauma Committee shall provide the CoPE with a copy of the Educational Letter or the Collegial Intervention follow-up letter.

(3) If the Trauma Committee determines that a concern cannot be adequately addressed through either an Educational Letter or a Collegial Intervention, it shall refer the matter to the CoPE for review. The Trauma Medical Director or another member of the Trauma Committee may be requested to attend a CoPE meeting to discuss the Trauma Committee's findings and answer questions.

5.H CoPE

Cases Referred to the CoPE for Further Review.

(a) ***Review.*** The CoPE shall consider review forms, supporting documentation, findings, and recommendations for cases referred to it by a Clinical Specialty Reviewer or the Leadership Council. The CoPE will require the Clinical Specialty Reviewer who conducted the review to submit their findings in writing and may require the reviewer to attend a CoPE meeting and to present the case to the committee.

Based on its preliminary review, the CoPE 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 CoPE may:

(i) invite a specialist with the appropriate clinical expertise to attend a CoPE meeting as a guest, without vote, to assist the CoPE in its review of issues, determinations, and interventions;

(ii) assign the review to an Assigned Reviewer;

(iii) appoint a 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 of this Policy, the CoPE may:

(i) determine that no further review or action is required;

(ii) send an Educational Letter;

(iii) conduct or facilitate a Collegial Intervention with the Practitioner;

(iv) develop a Performance Improvement Plan; or

(v) refer the matter to the Medical Executive Committee or the Leadership Council.

6. PRINCIPLES OF REVIEW AND EVALUATION

6.A ***Incomplete Medical Records.*** If the medical records needed to conduct a review under this Policy are incomplete, the matter shall be governed by the incomplete medical records policy as outlined by the Medical Staff Rules and Regulations.

6.B ***Forms.*** The CoPE shall approve forms to implement this Policy. Such forms shall be developed and maintained by the PPE Support Staff unless the CoPE 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 CoPE 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 or restraint of trade, even if unfounded.

An external review may be arranged by the Leadership Council or the CoPE, in consultation with the Chief of Staff and the Chief Medical Officer. Those arranging for an external review shall first seek to identify an appropriate expert who is already affiliated with Covenant Health System. If a decision is made to obtain an external review, the PPE staff will inform the Practitioner 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, the Leadership Council and the CoPE 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 or committee and/or the PPE Support Staff, the Chief Medical Officer or Chief Executive Officer. The referral shall be reported to the CoPE and will stay on the CoPE agenda until it determines, based on reports from the Hospital department or individuals charged with addressing the system issue, that the issue has been resolved.

6.F ***Tracking of Reviews.*** The PPE Support Staff shall track the processing and disposition of matters reviewed pursuant to this Policy. The Clinical Specialty Reviewers, Leadership Council, and CoPE shall promptly notify the PPE Support Staff of their determinations, interventions, and referrals.

6.G ***Educational Sessions/Dissemination of Educational Information.***

(1) ***General Principles.***

(a) Educational sessions as described in this section, as well as the dissemination of educational information through other mechanisms, are integral parts of the peer review process and assist Practitioners in continuously improving the quality and safety of the care they provide. These activities will be conducted in a manner consistent with their confidential and privileged status under the Texas peer review protection law and any other applicable federal or state law.

(b) Cases that reflect exemplary care, unusual clinical facts, or would be of educational value for any other reason, shall be referred to the appropriate Department Chair for discussion during an educational session or for the dissemination of "lessons learned" in some other manner.

(c) Medical Staff members, residents, medical students, and appropriate Hospital personnel are encouraged to participate in educational sessions in order to assess and continuously improve the care they provide.

(d) Educational sessions may also serve as a triage mechanism for the review process set forth in this Policy in certain circumstances. If any case is identified in an educational session that:

(i) may raise questions or concerns with the clinical practice or professional conduct of an individual Practitioner, and

(ii) has not already been reviewed as part of the process set forth in this Policy, the case should be referred for review in accordance with this Policy to evaluate whether the potential concern has merit, and to address any concerns that exist. Following the conclusion of that review process, the case may be referred back to the Department

Chair for purposes of conducting an educational session as described in this section.

(2) ***Rules for Educational Sessions.***

(a) For purposes of this section, "educational sessions" include morbidity and mortality conferences, Tumor Board conferences, and any other session conducted in a manner designed to promote quality assessment and improvement.

(b) Educational sessions will be supported and facilitated by the PPE Support Staff, whenever possible.

(c) Any Practitioner whose care of a patient will be reviewed in a session shall be notified at least seven days prior to the educational session. Such Practitioners shall be encouraged to attend and participate in the discussion.

(d) Information identifying specific Practitioners shall be removed prior to any presentation, unless the Practitioner requests otherwise or it is impossible to de-identify the information.

(e) All individuals who attend routine educational sessions that occur in designated specialty areas shall sign a Confidentiality Agreement annually.

(f) All attendees at an educational session will also be required to sign a confidentiality reminder for each session (e.g., as part of the sign-in process). In addition, a confidentiality reminder should be made verbally at the beginning of each session.

(g) Minutes are not required to be kept for educational sessions, but each session will have a standardized agenda that includes:

- a header in large, bold print identifying the agenda as a "Confidential Peer Review Document," and a reference to the Texas peer review statute (including the citation of the statute);
- the date of the educational session;
- cases reviewed (i.e., medical record numbers); and
- participants involved.

All such agendas shall be filed securely in confidential PPE Support Staff files.

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 Hospital personnel 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 Texas or federal law.

(2) ***Participants in the PPE Process.*** All individuals involved in the PPE 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 shall be conducted in a manner reasonably calculated to assure privacy.

(a) Hospital e-mail may be used to communicate between individuals participating in the professional practice evaluation process, including with those reviewing a case and with the Practitioner whose care is being reviewed. Except as set forth below, personal e-mail accounts shall not be used other than to direct recipients to check their Hospital e-mail. If an individual who is participating in a review under this Policy does not have a Hospital e-mail account, e-mails may be sent to a private account, but only if: (i) the e-mail is encrypted; and (ii) the individual is the only person who has access to the private account. For all e-mails, a standard convention, such as "Confidential PPE Communication," shall be utilized in the subject line of such e-mail. Notwithstanding this subsection, e-mail should not be utilized to present a PIP to a Practitioner. As noted previously in this Policy, one or more members of the CoPE (or their designees) should personally discuss the PIP with the Practitioner and present a copy to the Practitioner in person.

(b) All correspondence (whether paper or electronic) shall be conspicuously marked with the notation "Confidential Peer Review," "Confidential PPE Communication" or words to that effect.

(c) Before any correspondence is sent to a Practitioner whose care is being reviewed (whether paper or electronic), a courtesy call may be attempted to alert the Practitioner that the correspondence is being sent and how it will be sent. The intent of any courtesy call is to make the Practitioner aware of the correspondence and avoid any deadline being missed.

(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.

(4) ***Practitioner under Review.*** The Practitioner under review must maintain all information related to the review in a strictly confidential manner, as required by Texas law. The Practitioner may not disclose information to, or discuss it with, anyone outside of the review process set forth in this Policy without first obtaining the permission of the Leadership Council, except for any legal counsel who may be advising the Practitioner.

(5) There will be no recordings of the PPE communications. Any recording of a PPE communication will result in the Practitioner's automatic relinquishment of the Practitioner's privileges. Any recordings of a PPE communication cannot be used for any purpose.

(6) ***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 CoPE does not make any recommendations 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 the Medical Staff Credentials Policy shall be used in assessing and resolving any potential conflicts of interest that may arise under this Policy. Those conflict of interest guidelines are summarized in **Appendix F**.

6.I ***Legal Protection for Reviewers.*** It is the intention of the Hospital and the Medical Staff that the PPE process outlined in this Policy be considered patient safety, professional review, peer review, and quality assurance activity within the meaning of the Patient Safety Quality Improvement Act of 2005, the federal Health Care Quality Improvement Act of 1986, and Texas law. In addition to the protections offered to individuals involved in review activities under those laws and the Hospital's bylaws, such individuals shall be indemnified and covered under the Hospital's general liability and/or directors' and officers' insurance policies 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 Professional Practice Evaluation History Reports.*** The PPE Support Staff will prepare 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 Centralized Credentials Committee in the reappointment process.

7.B ***Reports to Medical Executive Committee and Board.*** The PPE Support Staff will prepare annual reports showing the aggregate number of cases reviewed through the PPE process and the dispositions of those matters.

7.C ***Reports on Request.*** The PPE Support Staff shall prepare reports as requested by the Leadership Council, a Department Chair, the Centralized Credentialing

Committee, the CoPE, the Medical Executive Committee, Hospital management, or the Board.

Adopted by the Medical Executive Committee on _____, 2019.

Adopted by the Board on _____, 2019.

APPENDIX A

RESPONSIBILITIES OF ASSIGNED REVIEWERS

From time to time, a Clinical Specialty Reviewer, the Leadership Council, or the CoPE may assign to a physician with the necessary clinical expertise to review and assess the care provided in a particular case. Assigned Reviewers must have obtained board certification in their specialty.

The duties and responsibilities of such Assigned Reviewers include the following:

- Initial Review and Documentation

  Upon request by a Clinical Specialty Reviewer, the Leadership Council or the CoPE, an Assigned Reviewer shall review the pertinent parts of the medical record and all supporting documentation and document their assessment and findings using the specific review form provided by the PPE Support Staff. These forms have been developed by the CoPE to facilitate an objective, consistent, and competent review of each case.

- Time Frame

  The Assigned Reviewer shall submit a completed review form to the Clinical Specialty Reviewer, the Leadership Council or the CoPE within 30 days of the review being assigned. A reminder will be sent if the review is not completed within this time frame.

- PPE Review Process Following the Assigned Reviewer Assessment

  The Assigned Reviewer will be contacted if additional information and expertise are necessary to facilitate the review. In certain cases, the Assigned Reviewer may be requested to attend a Leadership Council or a CoPE meeting in order to discuss their findings and to answer questions.

- Confidentiality

  The Assigned Reviewer must maintain all information regarding a review in a strictly confidential manner. Specifically, this is a peer review-protected activity, and the reviewer may not discuss matters under review with anyone outside of the process. An external reviewer must sign a Confidentiality Agreement before he or she performs the review.

- Legal Protections

  When performing a review, the Assigned Reviewer is acting at the direction and on behalf of the Hospital and the Medical Staff Leadership. As such, they have significant legal, bylaws, insurance, and indemnification protections.

APPENDIX B

RESPONSIBILITIES OF CLINICAL SPECIALTY REVIEWERS

ELIGIBILITY CRITERIA AND APPOINTMENT

The Leadership Council, in consultation with the Department Chairs, shall appoint physicians to serve as Clinical Specialty Reviewers for a Department or a specialty. In order to be appointed and continue to serve in this role, Clinical Specialty Reviewers must:

(a) be a member of the Active Medical Staff and be experienced or interested in credentialing, privileging, PPE/peer review, and Medical Staff activities;

(b) be sensitive to, and supportive of, evidence-based medicine protocols and system initiatives;

(c) participate in PPE training;

(d) review the expectations and requirements of this position and affirmatively accept them;

(e) be board certified in their specialty; and

(f) not be a member of the CoPE or the Leadership Council.

The Leadership Council may appoint Department Chairs to serve as Clinical Specialty Reviewers, or may appoint other physicians who satisfy the above qualifications. The Leadership Council may also appoint a Departmental committee, specialty committee, service line committee, or similar committee to fill this role. The Leadership Council may choose to appoint more than one Clinical Specialty Reviewer for a Department or specialty, depending on its size and volume of cases. A Clinical Specialty Reviewer's term of service is three years. A reviewer may serve a second term. A reviewer may also may also serve two additional terms after one year off.

DUTIES UNDER THE PPE POLICY

The basic duties of a Clinical Specialty Reviewer are as follows, which supplement the provisions contained in the PPE Policy:

(a) Engage in Case Review by either:

(i) personally reviewing cases referred by the RL Review Committee, the Chief of Staff, the Vice Chief of Staff, the immediate past Chief of Staff, the Leadership Council, or the CoPE. The responsibilities of Clinical Specialty Reviewers when

directly reviewing a case are the same as those outlined in **Appendix A** for Assigned Reviewers; or

(ii) assigning the review to one or more Assigned Reviewers. In accordance with **Appendix A**, these reviewers will complete the appropriate review form and report the findings back to the Clinical Specialty Reviewer.

(b) Report to Leadership Council or CoPE

Clinical Specialty Reviewers shall complete the appropriate review and report their findings to the Leadership Council for determination if that committee requested the review. Otherwise, they shall report their findings for determination to the CoPE. Clinical Specialty Reviewers may be requested to attend a CoPE or Leadership Council meeting to discuss their findings and answer questions.

APPENDIX C

PERFORMANCE ISSUES THAT TRIGGER INFORMATIONAL LETTERS

This Appendix lists specific performance issues that can be successfully addressed by Practitioners via Informational Letters as described in Section 4.A of this Policy, rather than a more formal review. More formal review is required if a threshold number indicated below is reached within an OPPE period, or if a pattern or trend of noncompliance with Medical Staff Rules and Regulations or other policies, adopted clinical protocols, or other quality measures is otherwise identified.

This Appendix may be modified by recommendation of the CoPE approval by the Medical Executive Committee.

I. Failure to Abide by Rules and Regulations

Specific Rule/Regulation	***Number of Violations Permitted Before Informational Letter***	***Number of Informational Letters that Result in Review Under PPE Policy***
e.g., failure to respond to non-critical consult within 24		

II. Failure to Abide by Hospital or Medical Staff Policies

Hospital/Medical Staff Policy	***Specific Requirement***	***Number of Violations Permitted Before Informational Letter Sent***	***Number of Informational Letters that Result in Review Under PPE Policy***
e.g., On-Call Policy	Failure to respond timely when on call		

III. Failure to Abide by Clinical Protocols with No Documentation as to the Clinical Reasons for Variance

Specific Protocol	*Number of Violations Permitted Before Informational Letter*	*Number of Informational Letters that Result in Review Under PPE Policy*
e.g., insulin protocol		

IV. Failure to Abide by Quality Measures

Specific Protocol	*Number of Violations Permitted Before Informational*	*Number of Informational Letters that Result in Review Under PPE Policy*
e.g., SCIP Measures		
e.g., DVT Prevention Measures		

V. Failure to Abide by Care Management/Utilization Management Requirements

Specific Requirement	*Number of Violations Permitted Before Informational Letter*	*Number of Informational Letters that Result in Review Under PPE Policy*
e.g., failure to appropriately document intensity of services provided		

APPENDIX D

PERFORMANCE IMPROVEMENT PLAN OPTIONS
IMPLEMENTATION ISSUES CHECKLIST

TABLE OF CONTENTS

Note: Issues related to the development and monitoring of Performance Improvement Plans ("PIPs") are described in Section 4.D of the PPE Policy. The Implementation Issues Checklists in this Appendix may be used by the CoPE or Leadership Council to effectuate PIPs. Checklists may be used individually or in combination with one another, depending on the nature of the PIP.

A copy of a completed Checklist may be provided to the Practitioner who is subject to the PIP, so that the CoPE or Leadership Council and the Practitioner have a shared and clear understanding of the elements of the PIP. While Checklists may serve as helpful guidance to the CoPE/Leadership Council and the Practitioner, there is no requirement that they be used. Failure to use a Checklist or to answer one or more questions on a Checklist will not affect the validity of a PIP.

PIP OPTION	IMPLEMENTATION ISSUES
Additional Education/CME ***(Wide range of options)***	***Scope of Additional Education/CME*** ❑ Be specific – what type?
	❑ Acceptable programs include:
	❑ CoPE approval required before Practitioner enrolls. ❑ Program approved: _____ ❑ Date of approval: _____ ❑ Time frames ❑ Practitioner must enroll by: _____ ❑ CME must be completed by: _____ ❑ Who pays for the CME/course? ❑ Practitioner subject to PIP ❑ Medical Staff ❑ Hospital ❑ Combination: _____ ❑ Documentation of completion must be submitted to CoPE.
	❑ Date submitted: _____ ***Additional Safeguards*** ❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges until completion of additional education? ❑ Yes ❑ No
	Follow-Up ❑ After CME has been completed, how will monitoring be done to be sure that concerns have been addressed/practice has improved? (Focused prospective monitoring? Proctoring?)

PIP OPTION	IMPLEMENTATION ISSUES
Prospective Monitoring ***(100% focused review of next X cases (e.g., obstetrical cases, laparoscopic surgery))***	***Scope of Monitoring*** ❑ How many cases are subject to review? _____ ❑ What types of cases are subject to review? _____ _____ ❑ Based on Practitioner's practice patterns, estimated time for completion of monitoring?
	❑ Does monitoring include more than review of medical record? ❑ Yes ❑ No If yes, what else does it include?
	❑ Review to be done: ❑ Post-discharge ❑ During admission ❑ Review to be done by: ❑ The CoPE ❑ Other: _____
	❑ Must Practitioner notify reviewer of cases subject to requirement? ❑ Yes ❑ No Other options?
	Documentation of Review ❑ General Case Review Worksheet ❑ Surgical Review Worksheet ❑ Medical Review Worksheet ❑ Specific form developed for this review ❑ General summary by reviewer ❑ Other: _____
	Results of Monitoring ❑ Who will review results of monitoring with Practitioner?
	❑ After each case ❑ After total # of cases subject to review (unless sooner discussions are necessary based on case findings)

PIP OPTION	IMPLEMENTATION ISSUES
Indicators Checklist ***(Research the medical literature, identify evidence-based guidelines addressing when a test or procedure is medically indicated, and develop a Checklist that can be included in the medical record to document medical necessity and appropriateness.)***	***Completion of the Checklists*** ❑ Checklists will be developed for the following procedures (in order of priority, if more than one): _____ _____ ❑ The Practitioner will consult with the following subject matter experts in developing the Checklists: _____ ❑ The following CoPE member will serve as the point of contact to assist the Practitioner with questions about the Checklists: ❑ The first draft of the Checklists will be submitted to the CoPE by: ❑ The CoPE will submit the Checklists to the following individuals/ committees for their review and comment, prior to final approval by the CoPE: ❑ The target date for final completion of the Checklists is: ***Additional Safeguards*** ❑ Until the Checklists have been approved, what steps will be taken to monitor the medical necessity/appropriateness of the Practitioner's tests/procedures? ❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges until the Checklists have been approved? ❑ Yes ❑ No ***Follow-Up*** ❑ Once Checklists are completed and being used to document medical necessity/appropriateness of the Practitioner's procedures/tests for individual patients, describe the monitoring of completed Checklists that will occur (who will monitor, how often, and who will discuss with Practitioner):

PIP OPTION	IMPLEMENTATION ISSUES
Second Opinions/ Consultations ***(Before the Practitioner proceeds with a particular treatment plan or procedure, he or she obtains a second opinion or consultation.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented correctly.)***	***Scope of Second Opinions/Consultations*** ❑ What types of cases are subject to the second opinions/consultations?
	❑ How many cases are subject to the second opinions/consultations?
	❑ Based on practice patterns, estimated time to complete the second opinions/consultations? _____
	❑ Must consultant evaluate patient in person prior to treatment/ procedure? ❑ Yes ❑ No
	Responsibilities of Practitioner ❑ Notify consultant when applicable patient is admitted or procedure is scheduled and ensure that all information necessary to provide consultation is available in the medical record (H&P, results of diagnostic tests, etc.).
	❑ What time frame for notice to consultant is practical and reasonable (e.g., two days prior to scheduled, elective procedure)?
	❑ If consultant must evaluate patient prior to treatment, inform patient that consultant will be reviewing medical record and will examine patient.
	❑ If consultant must evaluate patient prior to treatment, include general progress note in medical record noting that consultant examined patient and discussed findings with Practitioner.
	❑ Discuss proposed treatment/procedure with consultant.

PIP OPTION	IMPLEMENTATION ISSUES
Second Opinions/ Consultations ***(Before the Practitioner proceeds with a particular treatment plan or procedure, he or she obtains a second opinion or consultation.)***	***Qualifications of Consultant*** ❑ Consultant must have clinical privileges in_____. ❑ Possible candidates include: _____ _____ _____ ❑ The following individuals agreed to act as consultants and were approved by the CoPE (or designees) on: _____ (date)
	Responsibilities of Consultant (*Information provided by CoPE; include discussion of legal protections for consultant.****)*** ❑ Review medical record prior to treatment or procedure.
(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented correctly.) ***(cont'd.)***	Evaluate patient prior to treatment or procedure, if applicable.
	❑ Discuss proposed treatment/procedure with physician. _____ ❑ Complete Second Opinion/Consultation Form and submit to PPE Support Staff *(not for inclusion in the medical record).*
	Disagreement Regarding Proposed Treatment/Procedure If consultant and physician disagree regarding proposed treatment/procedure, consultant notifies one of the following so that an immediate meeting can be scheduled to resolve the disagreement: ❑ The Leadership Council ❑ Other: _____

PIP OPTION	IMPLEMENTATION ISSUES
Second Opinions/ Consultations ***(Before the Practitioner proceeds with a particular treatment plan or procedure, he or she obtains a second opinion or consultation.)***	***Compensation for Consultant*** *(consultant cannot bill for consultation)* ❑ No compensation ❑ Compensation by: ❑ Practitioner subject to PIP ❑ Medical Staff ❑ Hospital ❑ Combination ***Results of Second Opinion/Consultations*** ❑ Who will review results of second opinions/consultations with Practitioner?
(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented correctly.) ***(cont'd.)***	❑ After each case ❑ After total # of cases subject to review (unless sooner discussions are necessary based on case findings) ❑ Include consultants' reports in Practitioner's quality file. ***Additional Safeguards*** ❑ Will Practitioner be removed from some/all on-call responsibilities until the second opinions/consultations are completed? ❑ Yes ❑ No

PIP OPTION	IMPLEMENTATION ISSUES
Concurrent Proctoring ***(A certain number of the Practitioner's future cases of a particular type (e.g., vascular cases, management of diabetic patients) must be directly observed.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented correctly.)***	***Scope of Proctoring*** ❑ What types of cases are subject to proctoring? _____ ❑ How many cases are subject to proctoring? _____ ***Time Frames*** ❑ Based on practice patterns, estimated time to complete the proctoring? ***Responsibilities of Practitioner*** ❑ Notify proctor when applicable patient is admitted or procedure is scheduled and ensure that all information necessary for proctor to evaluate case is available in the medical record (H&P; results of diagnostic tests, etc.). _____ ❑ What time frame for notice to proctor is practical and reasonable (e.g., two days prior to scheduled, elective procedure)? ❑ ***Procedures***: Inform patient that proctor will be present during procedure, may examine patient and may participate in procedure, and document patient's consent on informed consent form. _____ _____ ❑ ***Medical***: If proctor will personally assess patient or will participate in patient's care, discuss with patient prior to proctor's examination. _____ _____ ❑ Include general progress note in medical record noting that proctor examined patient and discussed findings with Practitioner, *if applicable*. ❑ Agree that proctor has authority to intervene, if necessary. ❑ Discuss treatment/procedure with proctor.

PIP OPTION	IMPLEMENTATION ISSUES
Concurrent Proctoring ***(A certain number of the Practitioner's future cases of a particular type (e.g., vascular cases, management of diabetic patients) must be directly observed.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented correctly.)*** ***(cont'd.)***	***Qualifications of Proctor*** *(CoPE must approve)* ❑ Proctor must have clinical privileges in_____. *(If proctor is not a member of the Medical Staff, credential and grant temporary privileges.)* ❑ Possible candidates include: _____ _____ _____ ❑ The following individuals agreed to act as proctors and were approved by the CoPE (or designees) on_____: (date) _____ _____ _____ _____ ***Responsibilities of Proctor*** *(information provided by CoPE; include discussion of legal protections for proctor)* ❑ Review medical record and: ❑ ***Procedure***: Be present for the relevant portions of the procedure and be available post-op if complications arise. ❑ ***Medical***: Be available during course of treatment to discuss treatment plan, orders, lab results, discharge planning, etc., and personally assess patient, if necessary. ❑ Intervene in care if necessary to protect patient and document such intervention appropriately in medical record. ❑ Discuss treatment plan/procedure with Practitioner. _____ _____ ❑ Document review as indicated below and submit to PPE Support Staff. ***Documentation of Review*** *(not for inclusion in the medical record)* ❑ General Case Review Worksheet ❑ Surgical Review Worksheet ❑ Medical Review Worksheet ❑ Obstetrical Review Worksheet ❑ Specific form developed for this PIP ❑ Other: _____

PIP OPTION	IMPLEMENTATION ISSUES
Concurrent Proctoring ***(A certain number of the Practitioner's future cases of a particular type (e.g., vascular cases, management of diabetic patients) must be directly observed.)***	***Compensation for Proctor*** *(proctor cannot bill for review of medical record or assessment of patient and cannot act as first assistant)* ❑ No compensation ❑ Compensation by: ❑ Practitioner subject to PIP ❑ Medical Staff ❑ Hospital ❑ Combination
	Results of Proctoring ❑ Who will review results of proctoring with Practitioner?
(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented correctly.) ***(cont'd.)***	❑ After each case ❑ After total # of cases subject to review (unless sooner discussions are necessary based on case findings) ❑ Include proctor reports in Practitioner's quality file ***Additional Safeguards*** ❑ Will Practitioner be removed from some/all on-call responsibilities until proctoring is completed? ❑ Yes ❑ No

PIP OPTION	IMPLEMENTATION ISSUES
Formal Evaluation/ Assessment Program ***(Onsite multiple-day programs that may include formal testing, simulated patient encounters, chart review.)***	***Scope of Formal Evaluation/Assessment Program*** ❑ Acceptable programs include: _____ _____ ❑ CoPE approval required before Practitioner enrolls ❑ Program approved: _____ ❑ Date of approval: _____ ❑ Who pays for the evaluation/assessment? ❑ Practitioner subject to PIP ❑ Medical Staff ❑ Hospital ❑ Combination: _____ ***Practitioner's Responsibilities*** ❑ Sign release allowing CoPE to provide information to program (if necessary) and program to provide report of assessment and evaluation to CoPE. ❑ Enroll in program by: _____ ❑ Complete program by: _____ ***Additional Safeguards*** ❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges until completion of evaluation/assessment program? ❑ Yes ❑ No ❑ Will Practitioner be removed from some/all on-call responsibilities until completion of evaluation/assessment program? ❑ Yes ❑ No ***Follow-Up*** ❑ Based on results of assessment, what additional interventions are necessary, if any? _____ _____ ❑ How will monitoring after assessment program/any additional interventions be conducted to be sure that concerns have been addressed/practice has improved? (Focused prospective review? Proctoring?)

PIP OPTION	IMPLEMENTATION ISSUES
Additional Training ***(Wide range of options from hands-on CME to simulation to repeat of residency or fellowship.)***	***Scope of Additional Training*** ❑ Be specific – what type? _____ _____ ❑ Acceptable programs include: _____ ❑ CoPE approval required before Practitioner enrolls. ❑ Program approved: _____ ❑ Date of approval: _____ ❑ Who pays for the training? ❑ Practitioner subject to PIP ❑ Medical Staff ❑ Hospital ❑ Combination: _____ ***Practitioner's Responsibilities*** ❑ Sign release allowing CoPE to provide information to training program (if necessary) and program to provide detailed evaluation/assessment to CoPE before resuming practice. ❑ Enroll in program by: _____ ❑ Complete program by: _____ ***Additional Safeguards*** ❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges until completion of additional training? ❑ Yes ❑ No ❑ Will Practitioner be removed from some/all on-call responsibilities until completion of additional training? ❑ Yes ❑ No _____ _____ ❑ Will LOA be used for the additional training? ❑ Yes ❑ No _____ _____ ***Follow-Up*** ❑ After additional training is completed, how will monitoring be conducted to be sure that concerns have been addressed/practice has improved? (Focused prospective review? Proctoring?)

PIP OPTION	IMPLEMENTATION ISSUES
Educational Leave of Absence or Determination to Voluntarily Refrain from Practicing during the PPE Process	❑ Who may grant a formal LOA (if applicable)? *(ReviewBylaws)* _____
	❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges while the PPE process continues? ❑ Yes ❑ No
	❑ Specify the conditions for reinstatement from the LOA or for the resumption of practice following the decision to voluntarily refrain: _____ _____ ❑ What happens if the Practitioner agrees to LOA or to voluntarily refrain, but: ❑ does not return to practice at the Hospital? Will this be considered resignation in return for not conducting an investigation and thus be reportable? ❑ Yes ❑ No ❑ moves practice across town? Must Practitioner notify other Hospital of educational leave of absence or the determination to voluntarily refrain from practicing? ❑ Yes ❑ No

PIP OPTION	IMPLEMENTATION ISSUES
"Other" ***Wide latitude to utilize other ideas as part of PIP, tailored to specific concerns.*** ***Examples:*** • ***Participate in an educational session at section or Department meeting and assess colleagues' approach to case.*** • ***Study issue and present grand rounds.*** • ***Design and use informed consent forms approved by CoPE.*** • ***Design and use indication forms approved by CoPE.*** • ***Limit inpatient census.*** • ***Limit number of procedures in any one day/block schedule.*** • ***No elective procedures to be performed after____p.m.*** • ***All patient rounds done by certain time of day – timely orders, tests, length of stay concerns.*** • ***Personally see each patient prior to procedure (rather than using PA, NP, or APRN).*** • ***Personally round on patients – cannot rely solely on PA, NP, or APRN.*** • ***Utilize individuals from other specialties to assist in PIPs (e.g., cardiologist experiencing difficulties with TEE technical complications mentored by anesthesiologists).***	

COVENANT HEALTH
COVENANT MEDICAL CENTER
Appendix E: Flow Chart of the Professional Practice Evaluation Process

Events That Trigger a Review

- RL Solutions
- Statistical issues generated by a Section or a Department
- Concerns expressed by Medical Staff Members or Hospital Employees
- Concerns expressed by patients
- Significant events
- Any member of Medical Staff Leadership or the Chief Medical Officer may refer a matter directly to CoPE

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PPE Support Staff will assemble documents and any other relevant data.

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Initial review by the RL Review Committee, the Chief of Staff, the Vice Chief of Staff, or the immediate past Chief of Staff.

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No issues – matter closed	Possible quality issues – Submit for Clinical Specialty Review	1. Possible conduct issues; 2. health issues; or 3. multiple or complex clinical issues – Submit to the Leadership Council

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Clinical Specialty Review conducted by a Department Chair, a CoPE member, or a Trauma Committee Member.

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No issues – matter closed	Possible quality issues – submit to the CoPE or back to the Leadership Council if it requested the review.

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CoPE

No issues – matter closed	Quality issues that can be resolved with the physician – •Educational letter •Collegial intervention •Performance Improvement Plan	Pattern that indicates emotional or health issues – refer to Leadership Council	Significant quality issues that cannot be resolved with the physician – • consider outside review •refer to MEC

Leadership Council

- Review determinations from previous reviews
- Obtain additional clinical or other professional expertise as needed

No issues – matter closed	Issues that can be resolved with the physician – • Educational letter • Collegial intervention •Performance Improvement Plan	Emotional or health issues – • Obtain assistance from the Physical Health and Wellness Committee • Prepare voluntary treatment plan up to and including leave of absence with specified actions.	Significant conduct, health or quality issues that cannot be resolved with the physician – •Refer to MEC

MEC

No issues – matter closed	Options outlined in the Credentials Policy.

APPENDIX F

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Committee Member								
	Provide Information	Individual Reviewer Application/ Case	Credentials	Leadership Council	CoPE	MEC	Ad Hoc Investigating	Hearing Panel	Board
Self or family member	Y	N	R	R	R	R	N	N	R
Treatment relationship*	Y	N	R	R	R	R	N	N	R
Employment relationship with hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Reviewed at prior level	Y	Y	Y	Y	Y	R	N	N	R
Raised the concern	Y	Y	Y	Y	Y	R	N	N	R

* A "treatment relationship" exists where an individual participating in a review has a significant and ongoing role in providing health care services to the Practitioner under review (e.g., as a primary care practitioner or consultant).

Y– (green "Y") means the Interested Member may serve in the indicated role; no extra precautions are necessary.

Y – (yellow "Y") means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Centralized Credentials Committee, Leadership Council, and CoPE have no disciplinary authority. In addition, the Chair of the Centralized Credentials Committee, Leadership Council, or CoPE always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would inhibit the full and fair discussion of the issue before the committee, skew the recommendation or determination of the committee, or otherwise be unfair to the Practitioner under review.

N– (red "N") means the individual may not serve in the indicated role.

R– (red "R") means the individual must be recused in accordance with the rules for recusal.

Rules for Recusal

- Interested Members must leave the meeting room prior to the committee's or Board's final deliberation and determination, but may answer questions and provide input before leaving.

- If an Interested Member is recused on a particular issue, the recusal shall be specifically documented in the minutes.

- Whenever possible, an actual or potential conflict should be raised and resolved prior to the meeting by the committee or Board chair, and the Interested Member informed of the recusal determination in advance.

- No Medical Staff member has the RIGHT to demand the recusal of another member – that determination is within the discretion of the Medical Staff Leaders in accordance with these guidelines.

- Voluntarily choosing to refrain from participating in a particular situation is not a finding or an admission of an actual conflict or any improper influence on the process.