COVENANT CHILDREN'S HOSPITAL

PROFESSIONAL PRACTICE EVALUATION POLICY (PEER REVIEW)

Adopted by the Medical Staff: November 17, 2017

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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 Children's Hospital (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 resolution 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).

(c) The process used to evaluate a Practitioner's competence on an ongoing basis is described in the Ongoing Professional Practice Evaluation (OPPE) Policy.

(d) 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, respectively.

(e) If a matter involves both clinical and behavioral concerns, the Chairs of the Leadership Council and the Committee on Professional Enhancement ("CoPE") shall coordinate the reviews. The behavioral concerns may either be addressed by:

(i) the Leadership Council pursuant to the Professionalism Policy with a report to the CoPE; or

(ii) 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.

(3) If the Practitioner involved is also employed by the Hospital or a Covenant Health-related entity (the "employing entity"), Medical Staff Leaders will consult with appropriate representatives of the employing entity and then determine which of the following two processes will be used for the review:

(a) If the matter will be reviewed using the Medical Staff process as set forth in this Policy, a representative of the employing entity will be invited to attend relevant portions of committee meetings involving the Practitioner, as well as participate in any interventions that may be necessary following the review. Documentation from the Medical Staff process will not be disclosed to the employing entity for inclusion in the employment file, but the employing entity will be permitted access to such documentation as needed to fulfill its operational and legal responsibilities in accordance with any applicable Hospital policy related to such information-sharing; or

(b) If the matter will be reviewed by the employing entity pursuant to its policies:

(i) the Medical Staff process shall be held in abeyance and the Leadership Council notified;

(ii) the PPE Support Staff will assist the employing entity with witness interviews, document review, data compilation, and similar fact-finding. Documentation of such fact-finding will be maintained in the Practitioner's confidential Medical Staff peer review/quality file consistent with the state peer review statute, but the employing entity will be permitted access to such documentation as needed to fulfill its operational and legal responsibilities;

(iii) the Leadership Council will be kept informed of the progress and outcome of the review by the employing entity; and

(iv) the Leadership Council may choose, at any time and in its sole discretion, that the matter shall also be reviewed pursuant to this Policy. However, neither such a review by the Leadership Council nor any other provision of this Policy shall be interpreted to affect the right of the employing entity to take any action authorized by the employment contract with the Practitioner.

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 CoPE.

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

ASSIGNED REVIEWER means a physician appointed by a CoPE member, the Leadership Council, or the CoPE to review and assess the care provided in a particular case and report back to the individual or committee that assigned the review. The Assigned Reviewer will complete the *PDR, AR, Ad Hoc Committee Case Review Form*, and upon request will meet with the individual or committee that assigned the review to discuss his or her findings and answer questions. As requested, an Assigned Reviewer may also serve as a consultant to an individual or committee conducting a review, without the need for the Assigned Reviewer to complete a review form.

AUTOMATIC RELINQUISHMENT/AUTOMATIC RESIGNATION of appointment and/or clinical privileges are administrative actions that occur by operation of the Credentials Policy and/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 PROFESSIONAL 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.

CoPE MEMBER refers to a member of the CoPE who acts as an individual reviewer by receiving a case for review, obtaining input from Assigned Reviewers or Pre-Determined Reviewers as needed, completing the *CoPE Member Case Review Form*, and forwarding the review form to the CoPE for its determination.

DEPARTMENT CHAIR means the applicable Medical Staff Department Chair (e.g., Chair of Medicine) 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) 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, staff from the Medical Staff Office, quality management, human resources, and/or patient safety 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.

PRE-DETERMINED REVIEWERS means those Practitioners who are appointed by the Leadership Council, in consultation with the Department Chairs, to conduct case reviews and report their findings to a CoPE member, the Leadership Council, or the CoPE. Depending on volume, more than one Pre-Determined Reviewer may be appointed in a Department or specialty. Pre-Determined Reviewers will complete the *PDR, AR, Ad Hoc Committee Case Review Form* when asked to review a case, and upon request will meet with the individual or committee that assigned the review to discuss their findings and answer questions. They may also serve as a consultant to an individual or committee conducting a review, without the need to complete a review form. Pre-Determined Reviewers shall serve one-year terms and may be reappointed for additional terms.

PROFESSIONAL PRACTICE EVALUATION ("PPE") refers to the Hospital's routine peer review process. It is used to evaluate a Practitioner's professional performance when any questions or concerns arise. 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 Professional 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:

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

2.B ***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 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;

(b) the Leadership Council determines that an exception must be made in a particular situation to ensure an appropriate review (in these instances, the individual in question will be given prior notice that the disclosure will be made and informed that no retaliation will be permitted against the individual); or

(c) information provided by the individual is used to support an adverse professional review action that results in a Medical Staff hearing.

Retaliation (as defined in the Medical Staff Professionalism Policy) by the Practitioner against anyone who is believed to have reported a concern or otherwise provided information about a matter is inappropriate conduct and will be addressed by the Leadership Council through 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.

2.C ***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 physician review, as determined by the PPE Support Staff (in consultation with the CoPE Chair or the Chief Medical Officer);

(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 Critical Event Review Team involving an individual Practitioner's professional performance;

(6) a Department Chair or Section Chief's determination that ongoing professional practice evaluation ("OPPE") data reveal a practice pattern or trend that requires further review as described in the OPPE Policy;

(7) when a threshold number of Informational Letters identified in **Appendix A** is reached, or when a trend of noncompliance is otherwise identified with: (i) Medical Staff Rules and Regulations or other policies; or (ii) adopted clinical protocols, order sets or pathways, or other quality measures, based either on the overall number of Informational Letters sent to the Practitioner or based on other relevant factors; and

(8) concerns about the performance of a Practitioner identified through the transplant program's quality assessment and performance improvement process.

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 ***Opportunity for Input.***

(1) If any questions or concerns are identified about the care provided in a case under review, the Practitioner will be notified of the questions or concerns and offered an opportunity to provide input prior to the review being completed and any final determination made. The notice to the Practitioner shall include a time frame for the Practitioner to provide the requested input.

(2) This prior notice and opportunity for input will always occur during the initial assessment of a case if any questions or concerns are identified, but subsequent levels of review may also seek input from the Practitioner if necessary or helpful to the review.

(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 ***Manner of Providing Input.***

(1) The Practitioner shall provide input through a written description and explanation of the care provided, responding to any specific questions posed in the notice.

(2) 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 (as determined by the individual or committee conducting the review) to discuss the issues.

(3) As part of a request for input pursuant to this Policy, the person or committee requesting input may ask the Practitioner to provide a copy of, or access to, medical records from the Practitioner's office. Failure to provide such copies or access will be viewed as a failure to provide requested input.

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

(1) If the Practitioner fails to provide input requested by a CoPE member 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.

(2) If the Practitioner fails to provide input requested by the Leadership Council or CoPE 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 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.)

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.

4.A ***Informational Letter.*** The CoPE shall identify specific performance issues that can be successfully addressed through the use of Informational Letters, without the need to immediately 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 A includes:

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

(2) the number of violations that must occur before an Informational Letter will be sent; and

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

In these situations, the PPE Support Staff shall 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 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 A**; 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 A** are met.

Informational letters may be signed by: A Department Chair, a CoPE member, or the Chief Medical Officer. The Department Chair, CoPE Chair, and Chief Medical Officer shall be copied on any Informational Letter that they do not personally sign.

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 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: The Leadership Council, the Trauma Committee, or the CoPE. The Department Chair and CoPE will be informed of the substance of any Educational Letter, and may contact the PPE Support Staff to review a copy of the letter.

4.C ***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 reported to the PPE Support Staff and 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, 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 the follow-up letter, regardless of who conducts or facilitates it, and may contact the PPE Support Staff to review a copy of the letter.

4.D ***Performance Improvement Plan ("PIP").***

(1) ***General.*** The CoPE may determine it is necessary 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 should 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 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 by the CoPE.

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

(c) The CoPE 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) ***PIP at Another Covenant Health Hospital***. As set forth in the Medical Staff Credentials Policy, a PIP that is in effect at another Covenant Health hospital will automatically and immediately take effect at the Hospital.

(6) ***Reporting Obligations*.** Most PIPs that are developed by the CoPE will not require a report to any state licensing board or to the National Practitioner Data Bank. However, the CoPE must assess this reporting issue with each PIP. If the CoPE 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 to address the issues identified and to improve the care provided.

(7) ***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.

(8) ***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 CoPE. The educational activity/program may be chosen by the CoPE or by the Practitioner. If the activity/program is chosen by the Practitioner, it must be approved by 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) ***Prospective Monitoring*** 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).

(c) ***Indicators Checklist*** which means that the Practitioner must (i) research the medical literature and government publications; (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.

(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 CoPE. If there is any disagreement about the proper course of treatment, the Practitioner must discuss the matter further with individuals identified by 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 CoPE, or by an appropriately credentialed individual from outside of the Medical Staff approved by 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 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 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 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 CoPE to address any identified deficiencies in his or her practice. The Practitioner must execute a release to allow the CoPE 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 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 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 CoPE.

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

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

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

(1) ***Time Frames for Review.***

(a) ***General.*** 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.

(b) ***Pre-Determined Reviewers and Assigned Reviewers.*** Pre-Determined Reviewers and Assigned Reviewers are expected to submit completed review forms to the CoPE member, Leadership Council, or CoPE, depending on who assigned the review, within 14 days of the review being assigned.

(c) ***CoPE Members.*** CoPE members are expected to complete their reviews within 14 days of the review being assigned to them or within 14 days of the CoPE member's receipt of the findings of a Pre-Determined Reviewer or Assigned Reviewer, whichever is later.

(d) ***Leadership Council.*** The Leadership Council is expected to conduct its review and arrive at a determination or intervention within 30 days.

(e) ***External Reviewers***. If an external review is sought pursuant to Section 6.C of this Policy, those involved will use their best efforts to take the steps needed to have the report returned within 30 days of the decision to seek the external review (e.g., by ensuring that relevant information is provided promptly to the external reviewer and that the contract with the external reviewer includes an appropriate deadline for the review).

(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. A report of this determination shall be made to the CoPE. If information was sought from the Practitioner involved, the Practitioner shall also be notified of the determination.

(4) ***Exemplary Care.*** If the Leadership Council or CoPE determines that a Practitioner provided exemplary care in a case under review, the Practitioner should be sent a letter recognizing such efforts.

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

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

(i) it determines that a PIP may not be adequate to address the issues identified;

(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 toward 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) ***Notice of Referral.*** The Practitioner shall be notified of any referral to the Medical Executive Committee.

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

5.B ***PPE Support Staff.***

(1) ***Review.*** All cases or issues identified for PPE shall be referred to the PPE Support Staff, who will log the matter in some manner that facilitates the subsequent tracking and analysis of the case (e.g., a confidential database or spreadsheet). The PPE Support Staff will then review the referral, with such reviews to 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 their review, the PPE Support Staff (in consultation with the appropriate CoPE member or Chief Medical Officer, when necessary) may:

(a) determine that no further review is required and close the case;

(b) send an Informational Letter as described in Section 4.A of this Policy; or

(c) determine that further physician review is required.

(3) ***Preparation of Case for Physician Review.*** The PPE Support Staff 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 case review form;

(b) as needed, modifying the case review form to reflect specialty-specific issues, as directed by a CoPE member, the CoPE, or Chief Medical Officer;

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

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

(e) identification of relevant literature.

(4) ***Referral of Case to Leadership Council, Trauma Committee, or CoPE Member.***

(a) Cases shall be referred to the Leadership Council if they are administratively complex as described in this Section or if the PPE Support Staff, in consultation with the appropriate CoPE member

or Chief Medical Officer, determines that review by the Leadership Council would be appropriate. Administratively complex cases are defined as those:

(1) that require immediate or expedited review;

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

(3) that involve the CoPE member who would otherwise be expected to review the case;

(4) that involve professional conduct;

(5) that involve a Practitioner health issue;

(6) that involve a refusal to cooperate with utilization oversight activities;

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

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

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

(10) 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.

(b) Trauma cases will be referred to the Trauma Committee and reviewed as set forth in Section 5.D.

(c) All other cases shall be referred to the appropriate CoPE member.

5.C ***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:

(a) a CoPE member;

(b) a Pre-Determined Reviewer;

(c) an Assigned Reviewer;

(d) a committee composed of such Practitioners; or

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

The Leadership Council will then assess the matter and document its findings on the *Leadership Council Case Review Form*.

(2) ***Determinations and Interventions.*** Based on its own review and the findings of the other reviewers, if any, the Leadership Council may:

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

(b) send an Educational Letter;

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

(d) refer the matter to one of the following for review and disposition:

(i) CoPE; or

(ii) Medical Executive Committee;

(e) address the matter through the Medical Staff Professionalism Policy or through the Practitioner Health Policy; or

(f) refer the matter for review under the appropriate Hospital or Medical Staff policy.

5.D ***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. In performing its reviews, the Trauma Committee will use the standard review forms and other documents approved by the CoPE.

(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. The Trauma Committee shall also notify the CoPE when it determines that no further review is required and closes a case.

(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.E ***CoPE Member.***

(1) ***Review.*** When a matter is referred to a CoPE member, the CoPE member shall either:

(a) review it personally and complete the *CoPE Member Case Review Form*; or

(b) assign the review to any of the following, who shall evaluate the care provided, complete the *PDR, AR, Ad Hoc Committee Case Review Form*, and report his or her findings back to the CoPE member:

(i) a Pre-Determined Reviewer;

(ii) an Assigned Reviewer; or

(iii) a committee composed of such Practitioners.

In all cases, CoPE members remain responsible for completing the *CoPE Member Case Review Form*.

(2) ***Reports***. CoPE members shall report their findings to the Leadership Council for determination if that committee requested the review. Otherwise, CoPE members shall report their findings to the CoPE for determination.

5.F ***CoPE***

(1) ***Review of Prior Determinations.*** The CoPE shall review reports from the PPE Support Staff and the Leadership Council for all cases where it was determined that (i) no further review or action was required; or (ii) an Educational Letter or Collegial Intervention was appropriate to address the issues presented. If the CoPE 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 14 days; or

(b) review the matter itself.

(2) ***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 CoPE member or the Leadership Council. The CoPE may request that one or more individuals involved in the initial review of a case attend the CoPE meeting and 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 any Practitioner on the Medical Staff with the appropriate clinical expertise (e.g., a Pre-Determined Reviewer or 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;

(v) refer the matter to the Leadership Council; or

(vi) refer the matter to the Medical Executive Committee.

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 PPE Support Staff shall notify the Practitioner that the case has been referred for evaluation and that the medical record must be completed within 10 days.

If the medical record is not completed within 10 days, the Practitioner will be required to attend a meeting of the Leadership Council to explain why the medical record was not completed. Failure of the individual to either attend this meeting or complete the medical record in question prior to that meeting will result in the automatic relinquishment of the Practitioner's clinical privileges until the medical record is completed. If the Practitioner fails to complete the medical record 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.)

The 10-day time frame set forth in this section applies only to medical records that are necessary for a review being conducted pursuant to this Policy. The time frame set forth in this section supersedes any other time frames for the completion of medical records as may be set forth in the Medical Staff Bylaws, Rules and Regulations, or other policy.

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.***

(1) An external review may be appropriate if:

(a) there are ambiguous or conflicting findings by internal reviewers;

(b) the clinical expertise needed to conduct a review is not available on the Medical Staff; or

(c) an outside review is advisable to prevent allegations of bias, even if unfounded.

(2) An external review may be arranged by the Leadership Council or the CoPE, in consultation with the Chief Executive Officer or Chief Medical Officer. Those arranging for an external review shall first seek to identify an appropriate expert who is already affiliated with Covenant Health. If a decision is made to obtain an external review, the Practitioner involved shall be notified and informed of the reason for and nature of the review.

(3) If a Practitioner wishes to independently engage an external reviewer to complete a report for the CoPE's consideration, the following conditions must be satisfied:

(a) the external reviewer must provide a copy of the final report directly to the CoPE;

(b) the external reviewer must agree to communicate directly with the CoPE (both verbally and in writing) to address any questions the CoPE may have;

(c) the external reviewer's report must be completed within a reasonable time frame such that the CoPE's review is not unduly delayed;

(d) the Practitioner must enter into a HIPAA-compliant business associate agreement with the external reviewer; and

(e) the Practitioner must pay for the cost 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 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 referral shall be reported to the CoPE and will stay on the CoPE's 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 CoPE members, 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 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) ***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.

(4) ***PPE Communications.*** Communications among those participating in the PPE process, including communications with the reviewers and 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 to minimize the risk of a breach of confidentiality (e.g., conversations should not be held in Hospital hallways).

(b) 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. For all e-mails, a standard

convention, such as "Confidential PPE Communication," shall be utilized in the subject line of such e-mail.

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.

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

(d) Before any correspondence is sent to a Practitioner whose care is being reviewed (whether paper or electronic), a text message should be sent or a phone call should be attempted as a courtesy to alert the Practitioner that the correspondence is being sent and how it will be sent. The intent of any such text message or phone call is to make the Practitioner aware of the correspondence and avoid any deadline being missed. Whenever such a text message or phone call is utilized, a notation to that effect should be made on the copy of the applicable correspondence maintained in the Practitioner's confidential file or in another peer review database.

(e) 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 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 D**.

6.J ***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, 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.

6.K ***Delegation of Functions.*** When a function under this Policy is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions and requirements of this Policy. However, the delegating individual or committee is responsible for ensuring the designee performs the function as required by this Policy.

7. PROFESSIONAL PRACTICE EVALUATION REPORTS

7.A ***Practitioner Professional Practice Evaluation 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 Centralized Credentials Committee in the reappointment process.

7.B ***Reports to Medical Executive Committee and Board.*** The PPE Support Staff shall prepare reports at least annually 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, Department Chair, CoPE, Medical Executive Committee, Hospital management, or the Board.

Adopted by the Medical Staff: November 17, 2017.

Approved by the Board: December 5, 2017.

APPENDIX A

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 the CoPE at any time, without the need for approval by the Medical Executive Committee or Board. However, notice of any revisions shall be provided by the CoPE to the Medical Executive Committee and the Medical Staff.

I. Failure to Abide by Rules and Regulations

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

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

APPENDIX B

PERFORMANCE IMPROVEMENT PLAN OPTIONS

IMPLEMENTATION ISSUES CHECKLIST

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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 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 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 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 the 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: ❑ PPE Support Staff ❑ Department Chair ❑ Chief Medical Officer ❑ Other: _____ _____ ❑ Must Practitioner notify reviewer of cases subject to requirement? ❑ Yes ❑ No Other options? _____ _____ ***Documentation of Review*** ❑ Case Review Form ❑ 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.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented correctly.)*** ***(cont'd.)***	***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 on: _____ (date) _____ _____ _____ _____ ***Responsibilities of Consultant*** ***(****Information provided by CoPE; include discussion of legal protections for consultant.****)*** ❑ Review medical record prior to treatment or procedure. _____ _____ ❑ 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: ❑ Chief Medical Officer ❑ Chief of Staff ❑ CoPE Chair ❑ Department Chair ❑ 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.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented correctly.)*** ***(cont'd.)***	***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? _____ ❑ 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 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)* ❑ Case Review Form ❑ 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.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented correctly.)*** ***(cont'd.)***	***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? ❑ 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

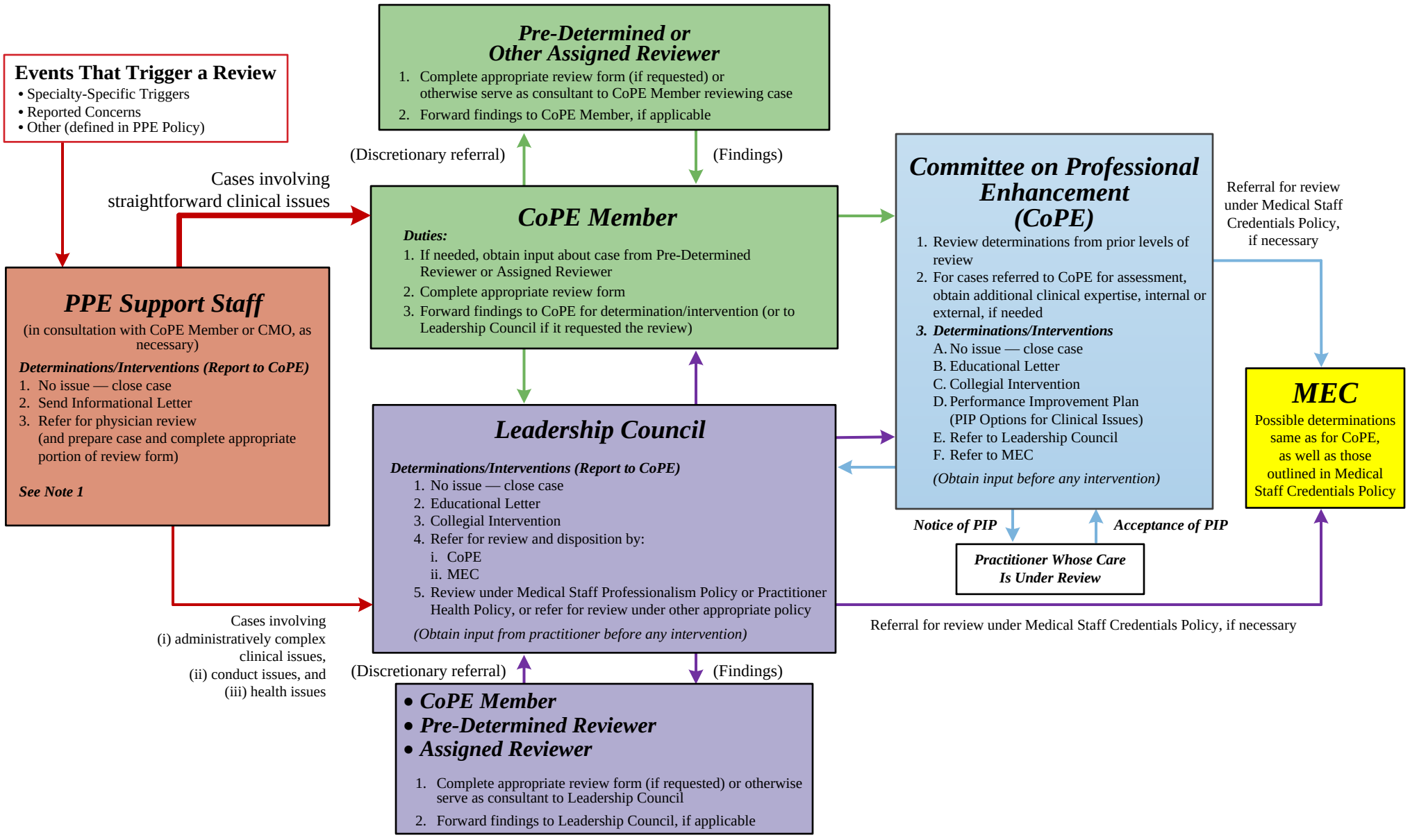
PIP OPTION	IMPLEMENTATION ISSUES
Formal Evaluation/ Assessment Program ***(Onsite multiple-day programs that may include formal testing, simulated patient encounters, chart review.)***	***Scope of Formal Evaluation/Assessment Program*** ❑ Acceptable programs include: _____ _____ ❑ CoPE approval required 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 <u>before</u> 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)? *(Review Bylaws)* _____ _____ ❑ 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 CHILDREN'S HOSPITAL
Appendix C: Flow Chart of Professional Practice Evaluation Process



Possible SYSTEM ISSUES identified at any level shall be referred to the appropriate Hospital department and reported to the CoPE, which shall monitor the issue until resolved.

The Leadership Council or the CoPE may refer a case for review during an EDUCATIONAL SESSION or request that the LESSONS LEARNED from the case be otherwise disseminated, after the review process for an individual practitioner has been completed.

Note 1: If the Practitioner involved is also employed by the Hospital or a Covenant-related entity, Medical Staff Leaders will consult with appropriate representatives of the employing entity and determine whether: (1) the review will be conducted by the Medical Staff per this Policy, with input and involvement of the employing entity; or (2) the review will be conducted by the employing entity, in which case the Medical Staff process will be held in abeyance pending the outcome of that review. In the latter situation, the Leadership Council may decide at any time to also review the matter under this Policy.

APPENDIX D

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Individual Reviewer Application/ Case	Committee Member					Hearing Panel	Board
			Credentials	Leadership Council	CoPE	MEC	Ad Hoc Investigating		
Self or family member	Y	N	R	R	R	R	N	N	R
Relevant 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
Involvement in prior PIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R

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 following guidelines:

STEP 1 Identify and confirm the conflict of interest	The Presiding Officer should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Determine whether recusal is appropriate	• The Interested Person may make a voluntary decision to refrain/recuse; or • The Presiding Officer may determine to recuse the Interested Person.
STEP 3 Plan for recusal in advance	• If the Interested Person intends to voluntarily refrain/recuse, he or she should notify the Presiding Officer prior to the meeting, if possible. • If the meeting will involve discussion of a number of matters, as a courtesy, the Presiding Officer should consider scheduling the meeting in a way that avoids inconvenience to the Interested Person (e.g., scheduling the matter to which the recusal applies as the first or last item on the agenda).
STEP 4 Obtain information from the Interested Person *(if applicable)*	When the matter implicating the conflict of interest is ready for consideration, the Interested Person will be excused from the meeting. Prior to being excused, the individual may provide information and answer any questions regarding the following: (i) any factual information for which the Interested Person is the original source; (ii) the Interested Person's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report to the MEC prior to being excused from the meeting); (iii) clinical expertise that is relevant to the matter under consideration; (iv) any policies or procedures that are applicable to the committee, department, section, or Board or are relevant to the matter under consideration; and (v) how the committee, department, section, or Board has, in the past, managed issues similar or identical to the matter under consideration.
STEP 5 The Interested Person is excused from the meeting	The Interested Person will be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's deliberation and decision-making.
STEP 6 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee, department, section, or Board. The minutes should reflect the fact that the Interested Person was excused from the meeting prior to deliberation and decision-making.