NCH HEALTHCARE SYSTEM

PROFESSIONAL PRACTICE EVALUATION POLICY

- **FPPE TO CONFIRM PRACTITIONER COMPETENCE (FPPE-CC)**
- **OPPE**
- **FPPE WHEN CONCERNS ARE RAISED (PEER REVIEW) (FPPE-EC)**

Approved by the Medical Executive Committee: October 14, 2014

Horty, Springer & Mattern, P.C.

TABLE OF CONTENTS

PAGE

PAGE

PROFESSIONAL PRACTICE EVALUATION POLICY

PART A: GENERAL PRINCIPLES AND OBJECTIVES

1. OBJECTIVES

The primary objectives of the professional practice evaluation ("PPE") process of NCH Healthcare System ("NCH") are to:

(a) define prospectively, to the extent possible, the expectations for patient care and safety through patient care protocols;

(b) establish and continually update triggers for focused professional practice evaluation and data elements for ongoing professional practice evaluation that will facilitate a meaningful review of the care provided;

(c) effectively, efficiently, fairly, and reasonably evaluate the care being provided by practitioners, comparing it to established patient care protocols and benchmarks whenever possible; and

(d) provide constructive feedback, education, and performance improvement assistance to practitioners regarding the quality, appropriateness, and safety of the care they provide.

2. SCOPE OF POLICY

The PPE process has three stages: focused professional practice evaluation to confirm competence, ongoing professional practice evaluation, and focused professional practice evaluation to evaluate questions or concerns. This Policy addresses all three stages of the PPE process.

3. TIME FRAMES

Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated. Participants will use their best efforts to adhere to these guidelines. With respect to the review outlined in Part D of this Policy, the goal is to complete reviews, from initial identification to final disposition, within 90 days.

4. INPUT

At any point in the PPE process, information or input may be requested from the practitioner whose care is being reviewed or from any other practitioner or NCH employee with personal knowledge of the matter.

5. COLLEGIAL EFFORTS

(a) In all stages of the PPE process, the use of collegial efforts and progressive steps to address issues that may be identified is encouraged. The goal of those efforts is to arrive at voluntary, responsive actions by the practitioner. Collegial efforts and progressive steps may include, but are not limited to, counseling, education, mentoring, letters of counsel, education or guidance, sharing of comparative data, and performance improvement plans.

(b) These efforts are encouraged, but are not mandatory, and will be within the discretion of the Leadership Council, the Physician Advisor, and the Practitioner Excellence Committee.

(c) All collegial efforts and progressive steps are part of the Hospital's confidential performance improvement and professional practice evaluation activities. While collegial efforts are encouraged, a single incident or pattern of care may be so unacceptable that more significant action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter to the Medical Executive Committee.

6. CONFIDENTIALITY

(a) Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process.

(b) All documentation that is prepared in accordance with this Policy will be maintained in appropriate Medical Staff files. This documentation will be accessible to authorized officials and Medical Staff Leaders and committees having responsibility for credentialing and professional practice evaluation functions and to those assisting them in those tasks. All such information will otherwise be deemed confidential and kept from disclosure or discovery to the fullest extent permitted by Florida or federal law, including but not limited to the Patient Safety Quality Improvement Act of 2005.

(c) Individuals involved in the professional practice evaluation process (Medical Staff and NCH employees) must maintain the confidentiality of the process and will be requested to sign an appropriate Confidentiality Agreement at least every two years.

7. DEFINITIONS

The definitions set forth in the Credentials Policy apply in this Policy. The following definitions also apply in this Policy:

"Leadership Council" means the committee that determines the appropriate review process for clinical issues as described in this Policy and handles issues of professional

conduct pursuant to the Medical Staff Code of Conduct and handles health issues pursuant to the Practitioner Health Policy. The composition and duties of the Leadership Council are described in the Medical Staff Organization and Functions Manual.

"Physician Advisor" means the individual appointed by the Leadership Council to perform the duties and responsibilities set forth in this Policy and as described more fully in **Appendix G**.

"Physician Reviewer" means a physician who is appointed by the Practitioner Excellence Committee to conduct case reviews and report his or her findings to the relevant Practitioner Excellence Committee as described more fully in **Appendix F**.

"Professional Practice Evaluation ("PPE") Support Staff" means the clinical and non-clinical staff who support the professional practice evaluation process as described in this Policy.

"Practitioner" means a member of the Medical Staff or a member of the Allied Health Staff.

"Practitioner's File" includes both paper files containing confidential credentialing and peer review documents and confidential electronic files, including, but not limited to, quality profiles and peer review databases.

"Practitioner Excellence Committee" ("PEC") means the multi-specialty committee that oversees the professional practice evaluation process and reviews care provided within NCH as described in this Policy. The composition and duties of the PEC are described in the Medical Staff Organization and Functions Manual.

PART B: FOCUSED PROFESSIONAL PRACTICE EVALUATION TO CONFIRM COMPETENCE

All practitioners who provide patient care services at the Hospital will participate in a process to confirm that they are competent to exercise the clinical privileges that have been granted. This process is referred to as focused professional practice evaluation to confirm competence ("FPPE-CC"). FPPE-CC is a time-limited period during which a practitioner's professional performance is evaluated. All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to FPPE-CC. FPPE-CC is expected to be completed within six months after privileges are granted. Extensions may be granted as outlined in Paragraph 3.B (3) of this Part. A flow chart of the FPPE-CC process is set forth in **Appendix A**.

1. CLINICAL ACTIVITY AND PERFORMANCE REQUIREMENTS

A. Development of Requirements

Each department will recommend the following requirements:

(1) the number and types of procedures or cases that will be subject to review to confirm a practitioner's competence to exercise the core and special privileges granted; and

(2) how those reviews are to be documented; and

(***Example***: Two vaginal deliveries, two C-sections, and two abdominal surgeries will be directly observed to confirm a new member's competence to exercise OB/GYN privileges. The reviews will be documented on the Obstetrical or Surgical Review Form.)

The FPPE requirements will be reviewed by the Credentials Committee and approved by the Medical Executive Committee.

B. Mechanism for FPPE-CC Review

The FPPE-CC clinical activity and performance requirements will also specify the review mechanism to be utilized in confirming competence. The following options are available:

(1) retrospective or prospective chart review by internal or external reviewers;

(2) concurrent proctoring or direct observation of procedures or patient care practices;

(3) discussion with other individuals also involved in the care of the practitioner's patients; and

(4) review of available quality data.

2. NOTICE OF FPPE-CC REQUIREMENTS

When notified that clinical privileges have been granted, the practitioner will also be informed of the relevant FPPE-CC clinical activity and performance requirements and of his or her responsibility to cooperate in satisfying those requirements. The Credentials Committee and Medical Executive Committee may modify the FPPE-CC requirements for a particular applicant if the applicant's credentials indicate that additional or different FPPE-CC may be required.

3. REVIEW OF FPPE-CC RESULTS

A. Review by the Department Chairperson or Allied Health Committee Chairperson

Six months after privileges are granted, and at the end of any extension of the FPPE-CC time period, the relevant department chairperson or the Chairperson of the Allied Health Committee, as applicable, will review the results of a practitioner's FPPE-CC and provide a report to the Credentials Committee. The assessment and report of the department chairperson or the Chairperson of the Allied Health Committee, as applicable, will address:

(1) whether the practitioner fulfilled the clinical activity requirements;

(2) whether the results of the FPPE-CC confirmed the practitioner's competence; or

(3) if additional FPPE-CC is required to make an appropriate determination.

B. Review by Credentials Committee

Based on the assessment and report of the department chairperson or the Chairperson of the Allied Health Committee, as applicable, its own review of the FPPE-CC results, and all other relevant information, the Credentials Committee may make one of the following recommendations to the Medical Executive Committee:

(1) the FPPE-CC process has confirmed competence and no changes to clinical privileges are necessary;

(2) some questions exist and additional review is needed to confirm competence (this recommendation should also include the scope of the additional review needed and the time frame for it);

(3) the time period for FPPE-CC should be extended because the practitioner did not fulfill the clinical activity requirements and an adequate assessment of the practitioner's competence could not be performed[1];

(4) there are concerns about the practitioner's competence to exercise some or all of the clinical privileges granted and a Performance Improvement Plan ("PIP") should be designed to address concerns, or changes should be made to the practitioner's clinical privileges subject to the procedural rights outlined in the Credentials Policy; or

---

1 Although exceptions may be made for certain low-volume practitioners based on need for services in their specialties or coverage requirements, generally the time frame for FPPE-CC will not extend beyond 24 months after the initial granting of clinical privileges.

(5) the practitioner's clinical privileges should be automatically relinquished for failure to meet clinical activity requirements.

C. Review by Medical Executive Committee

At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee will:

(1) adopt the report and recommendation of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration of specific questions; or

(3) state its reasons for disagreement with the report and recommendation of the Credentials Committee.

If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing pursuant to the Credentials Policy, the Medical Executive Committee will forward its recommendation to the Chief Executive Officer for further action consistent with the Credentials Policy.

D. Review of Automatic Relinquishment Determination

(1) If a recommendation is made by the Medical Executive Committee that an individual's clinical privileges be considered automatically relinquished for failure to fulfill clinical activity requirements, the practitioner will be notified, in writing, before a report is made to the Board. The notice will inform the practitioner that he or she may, within 10 days, request a meeting with the Credentials Committee.

(2) At the meeting, the practitioner will be afforded the opportunity to explain extenuating circumstances related to the reasons for failing to fulfill the FPPE-CC requirements. No counsel will be permitted to be present at the meeting. At the conclusion of the meeting, the Credentials Committee will make a recommendation.

(3) After reviewing the Credentials Committee's recommendation, the Medical Executive Committee may make a recommendation and forward the recommendation to the Board. The decision of the Board will be final, with no right to hearing or appeal under the Credentials Policy.

PART C: ONGOING PROFESSIONAL PRACTICE EVALUATION

All practitioners who provide patient care services at the Hospital will have their care evaluated on an ongoing basis. This process is referred to as ongoing professional practice evaluation ("OPPE"). OPPE means the ongoing review and analysis of data to provide feedback and identify issues in practitioners' professional performance, if any. A flow chart of the OPPE process is set forth in **Appendix B**.

1. OPPE DATA TO BE COLLECTED

Each department, in consultation with the PPE Support Staff and the PEC, will determine the OPPE data to be collected for practitioners in that department and, where appropriate, the threshold for each data element.

The AHP Committee, in consultation with the PPE Support Staff, the PEC and relevant department chairpersons, will determine the OPPE data to be collected for members of the Allied Health Staff and, where appropriate, the threshold for each data element.

In determining the data elements to be collected, the available information system capabilities and the type of data that would reasonably be expected to reflect clinically-significant issues or concerns regarding a practitioner's professional interactions with staff, patients and families will be considered. When possible, the thresholds for clinical data elements will be based on relevant clinical literature. The OPPE data elements and thresholds will be approved by the PEC.

2. OPPE REPORTS

A. Reports

An OPPE report for each practitioner will be prepared at least every six to eight months. A copy will be placed in the practitioner's file and considered as part of the reappointment process in the assessment of the practitioner's competence to exercise the clinical privileges granted. A practitioner's OPPE report will include:

(1) performance as measured by the data elements; and

(2) the number of cases identified or referred for review and the dispositions of those cases, including the number and types of informational letters sent.

B. Review of OPPE Reports

(1) If the data on the practitioner's OPPE report are within the defined thresholds that have been established and no other issues are noted, the PPE Support Staff will provide a copy of the report to the practitioner or

notify the practitioner how to access the report. The report will indicate that it is being provided for information and for the practitioner's use in his or her patient care activities and that no response is necessary and no further review will be conducted at that time.

(2) If data on the practitioner's OPPE report are not within defined thresholds or suggest a possible concern, the PPE Support Staff will provide a copy of the report to the practitioner and will inform the practitioner that the report has been forwarded to the department chairperson for review. The practitioner will also be informed that the department chairperson will contact the practitioner if the department chairperson determines that any response or further review is required.

(3) Upon receipt of an OPPE report, the department chairperson may review the underlying cases that make up the data or other relevant information to determine if the data reflects a clinical pattern or issue that requires further review. If the data does not reflect a clinical pattern or issue that requires further review, the department chairperson will document his or her findings and include them in the practitioner's file. If the data does reflect a clinical pattern or issue, the department chairperson will notify the PPE Support Staff and proceed in accordance with Part D of this Policy.

3. NONCOMPLIANCE WITH MEDICAL STAFF RULES, REGULATIONS AND POLICIES, CLINICAL PROTOCOLS, OR QUALITY MEASURES

The PEC will identify specific situations that are conducive to being addressed with a practitioner without the need to immediately proceed with a more formal review. These situations include, but are not limited to, noncompliance with:

(a) Medical Staff Rules and Regulations;

(b) Medical Staff or Hospital policies;

(c) clinical protocols that have been approved by the Medical Executive Committee without appropriate documentation in the medical record as to the reasons for not following the protocol; or

(d) Core Measures or other quality measures.

In these situations, an informational letter reminding the practitioner of the applicable requirement and offering assistance to the practitioner in complying with it will be prepared. The letter will be signed by the department chairperson or PEC Chairperson. A copy will be placed in the practitioner's confidential file and it will be considered in the reappointment process and in the assessment of the practitioner's competence to exercise the clinical privileges granted. Issues that may result in an informational letter being sent are listed in **Appendix C**.

PART D: FOCUSED PROFESSIONAL PRACTICE EVALUATION WHEN QUESTIONS OR CONCERNS ARE RAISED

When questions or concerns are raised about a practitioner's practice, a focused professional practice evaluation will be undertaken to review the question or concern. This process is referred to as focused professional practice evaluation to evaluate competence ("FPPE-EC"). FPPE-EC is a time-limited period during which a practitioner's professional performance is evaluated. Concerns regarding a practitioner's professional conduct or health status will be reviewed in accordance with the Medical Staff Code of Conduct Policy or Practitioner Health Policy. Flow charts of the FPPE-EC process are included as **Appendix D-1** (Detailed Flow Chart) and **Appendix D-2** (Simplified Flow Chart).

1. TRIGGERS

The FPPE-EC may be triggered by any of the following events:

A. Specialty-Specific Triggers

Each department will identify adverse outcomes, clinical occurrences, or complications that will trigger FPPE-EC. The triggers identified by the departments will be approved by the PEC.

B. Reported Concerns

Adverse incidents are reported to Risk Management pursuant to Florida law. This section describes the reporting process for other concerns regarding a practitioner's clinical practice or professional conduct.

(1) Reported Concerns from Practitioners or NCH Employees

Any practitioner or NCH employee may report to the PPE Support Staff concerns related to:

(a) the safety or quality of care provided to a patient by a practitioner, which will be reviewed through the process outlined in this Policy;

(b) professional conduct, which will be reviewed and addressed in accordance with the Medical Staff Code of Conduct;

(c) potential practitioner health issues, which will be reviewed and addressed in accordance with the Practitioner Health Policy;

(d) compliance with Medical Staff or NCH policies, which will be reviewed either through the process outlined in this Policy or in

accordance with the Medical Staff Code of Conduct, whichever the Leadership Council determines is more appropriate; or

(e) a potential system or process issue, which will be referred to the appropriate individual, committee, or NCH department for review.

(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. All individuals who identify themselves will be contacted by the PPE Support Staff to confirm that the report has been received.

(3) Unsubstantiated Reports and False Reports

If a report cannot be substantiated, or is determined to be without merit, the matter will be closed as requiring no further review and will be reported to the PEC. Reports that are determined to be false may be grounds for disciplinary action.

(4) Sharing Reported Concerns with Practitioner

The substance of reported concerns may be shared with the relevant practitioner as part of the review process, but neither the actual report nor the identity of the individual who reported the concern will be provided to the practitioner. Retaliation against an individual who reports a concern will be addressed through the Medical Staff Code of Conduct.

(5) Self-Reporting

Practitioners will be encouraged to self-report their cases that involve either a specialty-specific trigger or other FPPE-EC review trigger or that they believe would be an appropriate subject for an educational session. A notation will be made that the case was self-reported.

C. Other FPPE-EC Triggers

In addition to specialty-specific triggers and reported concerns, other events that may trigger FPPE-EC 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(s) that requires further review;

(2) patient complaints that are determined through the complaint review process to require physician review;

(3) cases identified as litigation risks that are referred by the Risk Management Department;

(4) issues of medical necessity referred through the Utilization Committee, Case Management Department, Compliance Officer, or otherwise;

(5) sentinel events involving an individual practitioner's professional performance;

(6) a department chairperson's determination that OPPE data reveal a practice pattern or trend that requires further review; and

(7) a trend of informational letters regarding noncompliance with Medical Staff Rules and Regulations or other policies, adopted clinical protocols, or other quality measures as set forth in this Policy.

2. NOTICE TO AND INPUT FROM THE PRACTITIONER

(a) 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. No educational letter will be sent and no PIP will be implemented until the practitioner is first notified of the specific concerns and given an opportunity to provide input. Prior notice and an opportunity to provide input are <u>not required</u> before an informational letter is sent to a practitioner.

(b) The practitioner will also be notified when a matter is referred to the PEC or the Medical Executive Committee.

(c) The practitioner may provide input through a written description and explanation of the care provided, responding to any specific questions posed by the Leadership Council, Physician Reviewer, or PEC or by meeting in person with individuals specified in the notice.

(d) If the practitioner fails to provide input requested by the Leadership Council or the Physician Reviewer within the time frame specified, the review will proceed without the practitioner's input. The practitioner's failure to respond to the request for input will be noted in the report to the PEC.

(e) If the practitioner fails to provide input requested by the PEC within the time frame specified, the practitioner will be required to attend the next meeting of the Medical Executive Committee to discuss why the requested input was not provided. Failure of the individual to either attend this meeting 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 requested input is provided.

3. INTERVENTIONS TO ADDRESS IDENTIFIED CONCERNS

(a) This section describes the interventions that may be used by the Leadership Council or PEC when concerns regarding a practitioner's clinical practice are identified through this Policy. Interventions are not required to be taken in any particular order although typically lower level interventions will be tried first to address issues that have been identified.

(b) In an effort to improve communication, the Leadership Council, the relevant department chairperson, and the PEC will be informed of the substance of any intervention. Documentation of the intervention will be placed in the practitioner's confidential file and will be considered in the reappointment process. The practitioner will be informed that a copy of any documentation will be included in the practitioner's file along with any response that he or she would like to offer.

(1) Informational Letter

(a) For specific situations that are identified by the PEC and listed in Appendix C (e.g., noncompliance with specified Medical Staff Rules and Regulations or other policies, clinical protocols, or quality measures), the PPE Support Staff will prepare an informational letter reminding the practitioner of the applicable requirement and offering assistance to the practitioner in complying with it.

(b) If a pattern or trend of noncompliance by a practitioner is identified through informational letters, the matter will be subject to more focused review in accordance with this Policy.

(c) An informational letter may be signed by the department chairperson, the Chairperson of the Leadership Council, the Physician Advisor, or the Chairperson of the PEC.

(2) Educational Letter

(a) An educational letter may be sent to a practitioner that describes the opportunities for improvement that were identified in the care reviewed and offers specific recommendations for future practice.

(b) An educational letter may be signed by the Chairperson of the Leadership Council or the Chairperson of the PEC.

(3) Collegial Intervention

(a) Collegial intervention means a face-to-face discussion between the practitioner and one or more Medical Staff Leaders to address a question or concern that has been raised through the PPE process. Typically, a collegial intervention will be followed by an educational letter that summarizes the discussion and, when applicable, the expectations regarding the practitioner's practice in the Hospital.

(b) A collegial intervention may be conducted by one or more members of the Leadership Council, or the PEC or they may facilitate an appropriate and timely collegial intervention by other Medical Staff Leaders, including but not limited to the relevant department chairperson. The relevant department chairperson will be invited to participate in any collegial intervention involving a practitioner in his or her Department.

(4) Performance Improvement Plan ("PIP")

(a) The PEC may determine that it is necessary to develop a PIP for the practitioner. The Leadership Council may also recommend a PIP for a practitioner to the PEC.

(b) To the extent possible, a PIP will be for a defined time period or for a defined number of cases. The plan will specify how the practitioner's compliance with, and results of, the PIP will be monitored. As deemed appropriate by the PEC, the practitioner will have an opportunity to provide input into the development and implementation of the PIP. The department chairperson will also be asked for input regarding the PIP and will assist in implementation of the PIP as may be requested by the PEC. One or more members of the PEC will hand-deliver the PIP and personally discuss it with the practitioner. A PIP may include, but is not limited to, the following:

(1) Additional Education/CME

Within a specified period of time, the practitioner voluntarily agrees to arrange for education or CME of a duration and type specified by the PEC.

(2) Focused Prospective Review

A certain number of the practitioner's cases of a particular type are subject to a focused review (e.g., review of the

next 10 similar cases performed or managed by the practitioner).

(3) Second Opinions/Consultations

The practitioner voluntarily agrees to obtain a second opinion or consultation before proceeding with a particular treatment plan or procedure. The second opinion or consultation is provided by a Medical Staff member(s), or an appropriately credentialed individual from outside of the Medical Staff, approved by the PEC. The practitioner providing the second opinion/consultation will be requested to complete a Second Opinion/Consultation Report form for each case. If there is any disagreement about the proper course of treatment, the practitioner will also agree to discuss the matter further with individuals identified by the PEC before proceeding further.

(4) Concurrent Proctoring

The practitioner voluntarily agrees that a certain number of cases of a particular type (e.g., the practitioner's next five vascular cases) will be personally proctored by a Medical Staff member(s), or an appropriately credentialed individual from outside of the Medical Staff, approved by the PEC. The proctor must agree to be present during the relevant portions of the procedure or must personally assess the patient and be available throughout the course of treatment, as determined by the PEC. Proctors will be requested to complete the appropriate review form.

(5) Participation in a Formal Evaluation/Assessment Program

Within a specified period of time, the practitioner voluntarily agrees to enroll in and complete an assessment program identified by the PEC.

(6) Additional Training

Within a specified period of time, the practitioner voluntarily agrees to arrange for additional training of a duration and type specified by the PEC. The director of the training program or appropriate supervisor will be requested to provide an assessment and evaluation of the practitioner's current competence, skill, judgment and technique to the PEC.

(7) Educational Leave of Absence

The practitioner voluntarily agrees to a leave of absence, during which time the practitioner completes an education/training program of a duration and type specified by the PEC.

(8) Other

Elements not specifically listed may be included in a PIP. The PEC 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.

(c) For each part of the PIP, the PEC will define when the activity must start and when it must be completed. The PEC will also approve, in advance, the designated activity/program and the practitioners or other individuals involved in the activity.

(d) Additionally, as requested, the practitioner must execute a release to allow the PEC to communicate information to, and receive information from, the selected program. If necessary, the PEC may request that a practitioner 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 activities.

(e) The practitioner must agree, in writing, to constructively participate in the PIP. If the practitioner refuses to do so, the matter will be referred to the Medical Executive Committee for appropriate review and recommendation pursuant to the Credentials Policy.

(f) Until the PEC has determined that the practitioner has complied with all elements of the PIP and concerns about the practitioner's practice have been adequately addressed, the matter will remain on the PEC's agenda and the practitioner's progress on the PIP will be monitored. In the event the practitioner is not making reasonable and sufficient progress on completion of the PIP, the PEC may refer the matter to the Medical Executive Committee.

Appendix E contains additional guidance regarding PIP options and implementation issues.

4. STEP-BY-STEP PROCESS

This Section describes each step in the FPPE-EC process.

A. PPE Support Staff

(1) All cases or issues identified for FPPE-EC will be referred to the PPE Support Staff for review. Such reviews may include, as necessary, the following:

(a) the relevant medical record;

(b) interviews with, and information from, NCH employees, practitioners, patients, family, visitors, and others who may have relevant information;

(c) consultation with relevant Medical Staff or NCH personnel;

(d) other relevant documentation; and

(e) the practitioner's professional practice evaluation history.

(2) After conducting their review, the PPE Support Staff, in consultation with the Physician Advisor, may:

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

(b) send an informational letter; or

(c) determine that further review is required.

(3) The PPE Support Staff will prepare cases that require review. Preparation of the case may include, as appropriate, the following:

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

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

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

(d) identification of relevant literature.

(4) The PPE Support Staff will refer cases to the Leadership Council that involve or require the following:

(a) immediate or expedited review, including sentinel events;

(b) practitioners from two or more specialties or departments;

(c) a Physician Reviewer;

(d) professional conduct;

(e) a practitioner health issue;

(f) a refusal to cooperate with utilization oversight activities;

(g) a situation where there are limited reviewers with the necessary clinical expertise;

(h) a trend or pattern of informational letters;

(i) a trend or pattern of clinical care concerns; or

(j) a PIP that has not addressed identified concerns.

(5) All other cases will be referred to the appropriate Physician Reviewer, unless the PPE Support Staff, in consultation with the Physician Advisor, determines that the review should be assigned to another member of the Medical Staff who has the clinical expertise necessary to evaluate the care provided.

(6) The relevant department chairperson shall be informed of all referrals.

B. Leadership Council

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

(2) If additional clinical expertise is needed, the Leadership Council may assign the review to any of the following, who will evaluate the care provided, complete an appropriate review form, and report their findings back to the Leadership Council within 20 days:

(a) one or more of the Physician Reviewers;

(b) a department chairperson;

(c) another Medical Staff member who has the clinical expertise necessary to evaluate the care provided;

(d) an ad hoc committee; or

(e) an external reviewer.

(3) Based on its own review and the findings of any other individual who has provided a review, the Leadership Council may:

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

(b) send an informational or educational letter;

(c) conduct or facilitate a collegial intervention;

(d) refer the matter to the PEC or Medical Executive Committee for review and disposition:

(e) address the matter through the Medical Staff Code of Conduct or Practitioner Health Policy;

(f) refer the matter to the Corporate Compliance Officer; or

(g) refer the matter for review under the appropriate NCH or Medical Staff policy.

(4) As a general rule, the Leadership Council will conduct its review and arrive at a determination or intervention within 30 days.

C. Physician Reviewer

(1) The Physician Reviewer will review the medical record and all supporting documentation assembled by the PPE Support Staff.

(2) Any review will be completed within 30 days and will be documented on an appropriate review form. If the review is not completed within this time frame, the PPE Support Staff will send a reminder. If the Physician Reviewer fails to complete the review within one week of the reminder, the matter will be reported to the Chairperson of the PEC. The Physician Reviewer may consult with the relevant department chairperson, if necessary.

(3) The Physician Reviewer's findings will be reported to the PEC.

D. PEC

(1) The PEC will review reports from the Physician Advisor and the Leadership Council, for all cases where it was determined that no further review or action was required, or an informational letter, educational letter or collegial intervention was appropriate to address the issues presented. If the PEC has concerns about any such determination, it may:

(a) send the matter back to the Leadership Council or the Physician Advisor with its questions or concerns and ask that the matter be reconsidered and findings reported back to it within 14 days; or

(b) refer the matter to an individual Medical Staff member or another Medical Staff committee or NCH department for review; or

(c) review the matter itself.

(2) The PEC will review all other matters referred to it, along with all supporting documentation, review forms, findings, and recommendations. The PEC may request that one or more individuals involved in the initial review of a case attend the PEC meeting and present the case to the committee. Based on its preliminary review, the PEC will 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 PEC may:

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

(b) assign the review to any practitioner on the Medical Staff with the appropriate clinical expertise;

(c) appoint a committee composed of such practitioners; or

(d) arrange for an external review.

(3) Based on its review of all information obtained, including input from the practitioner, the PEC may:

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

(b) send an informational or educational letter;

(c) conduct a collegial intervention;

(d) develop a PIP; or

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

(4) The PEC may refer a matter to the Medical Executive Committee if:

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

(b) the individual refuses to participate in a PIP developed by the PEC;

(c) the practitioner fails to abide by a PIP;

(d) the practitioner fails to make reasonable and sufficient progress on completing a PIP;

(e) any other concern is raised that would serve as the basis for a referral under the Credentials Policy;

(f) a pattern has developed despite prior attempts at collegial intervention or prior participation in a PIP; or

(g) the matter involves a very serious incident.

PART E: GUIDELINES AND PRINCIPLES FOR REVIEW AND EVALUATION

1. INCOMPLETE MEDICAL RECORDS

(a) 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 will notify the practitioner that the case has been referred for evaluation and that the medical record must be completed within 10 days.

(b) If the medical record is not completed within 10 days, the practitioner will be required to attend a meeting of the Medical Executive Committee to explain why the medical record was not completed. Failure of the individual to either attend the Medical Executive Committee meeting or complete the medical record in question prior to that meeting will result in the automatic relinquishment of the practitioner's Medical Staff appointment and clinical privileges until the medical record is completed.

2. FORMS

The PEC will approve forms to implement this Policy. The forms will be developed and maintained by the PPE Support Staff, unless the PEC directs that another office or individual develop and maintain specific forms.

3. EXTERNAL REVIEW

(a) An external review may be appropriate if:

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

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

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

(b) An external review may be arranged by the Leadership Council or the PEC in consultation with the Chief Executive Officer or Chief Medical Officer. If a decision is made to seek an external review, the practitioner involved will be notified of that decision and the nature of the external review.

4. EVIDENCE-BASED RESEARCH, CLINICAL PROTOCOLS OR GUIDELINES

Whenever possible, the findings of reviewers and the PEC will be supported by evidence-based research, clinical protocols or guidelines.

5. TRACKING OF REVIEWS

The PPE Support Staff will track the processing and disposition of matters reviewed pursuant to this Policy. The Leadership Council, Physician Reviewers, and the PEC will promptly notify the PPE Support Staff of their determinations, interventions and referrals.

6. EDUCATIONAL SESSIONS

(a) Cases identified at any level of the review process that reflect exemplary care, unusual clinical facts, or possible system issues or, for any other reason, would be of educational value will be referred to the appropriate department chairperson. With the support of the PPE Support Staff, the department chairperson may arrange for presentation of such cases at a department meeting or other "M & M"-style educational session.

(b) The particular practitioner(s) who provided care in the case will be informed that the case is to be presented in an educational session. Information identifying the practitioner(s) will be removed prior to the presentation, unless the practitioner(s)

requests otherwise. Documentation of the educational session will be forwarded to the PEC for its review. The PEC will work with the department chairperson to disseminate lessons learned from the educational sessions as appropriate.

7. REVIEW ACTIVITIES IN HOSPITAL-BASED DEPARTMENTS

It is recognized that the medical groups that have exclusive contracts with NCH to provide hospital-based services routinely review the quality of care provided by members of their groups. Those medical groups must report to the PEC at least quarterly regarding their quality review activities and shall, to the greatest extent practicable, work with the PPE Support Staff and PEC to coordinate quality data collection to minimize duplication of effort and to allow the Hospital to meets its requirements regarding FPPE-CC, OPPE and FPPE-EC.

8. COMMUNICATION

Communications among those participating in the PPE process, including communications with the individual practitioner, will be conducted in a manner reasonably calculated to assure privacy. Correspondence (whether paper or electronic) will be conspicuously marked with the notation "Confidential Peer Review," "To be Opened Only by Addressee" or words to that effect. Substantive discussions of individual cases and reviewers' clinical findings shall not be included in e-mail. As noted previously in this Policy, any PIP that may be developed for a practitioner shall be hand-delivered and personally discussed with the practitioner. If it is necessary to e-mail medical records or other documents containing a patient's protected health information, NCH policies governing compliance with the HIPAA Security Rule will be followed.

9. CONFLICT OF INTEREST GUIDELINES

To protect the integrity of the review process, all those involved must be sensitive to potential conflicts of interest. The conflict of interest guidelines outlined in Article 8 of the Credentials Policy will be used in assessing and resolving any potential conflicts of interest that may arise under this Policy.

10. LEGAL PROTECTION FOR REVIEWERS

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

11. REPORTS

(a) A practitioner history report showing all cases that have been reviewed for a particular practitioner within the past two years and their dispositions will be generated for each practitioner for consideration and evaluation in the reappointment process.

(b) The PPE Support Staff will prepare reports at least quarterly showing the aggregate number of cases reviewed through the PPE process and the dispositions of those matters.

(c) The PPE Support Staff will prepare reports as requested by the Leadership Council, department chairpersons, Physician Reviewers, PEC, Medical Executive Committee, NCH management, or the Board.

Approved by the Medical Executive Committee on October 14, 2014.

Adopted by the Board on _____, 2014.

APPENDIX C

ISSUES THAT MAY RESULT IN AN INFORMATIONAL LETTER

This Appendix lists specific situations identified by the Practitioner Excellence Committee that are conducive to being addressed via an informational letter as set forth in the PPE Policy rather than a more formal review. Further review is required if any threshold number indicated below is reached within a six-month 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 Practitioner Excellence Committee at any time, without the need for approval by the Medical Executive Committee or the Board. However, notice of any revisions shall be provided by the Practitioner Excellence Committee to the Medical Executive Committee and the Medical Staff.

1. Failure to Abide by Rules and Regulations

Specific Rule/Regulation	*Threshold*
e.g., failure to respond to non-critical consult within 24 hours	2

2. Failure to Abide by Hospital or Medical Staff Policies

Hospital/Medical Staff Policy	*Specific Requirement*	*Threshold*
e.g., On-Call Policy	Failure to respond timely when on call	2

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

Specific Protocol	*Threshold*
e.g., insulin protocol	2

4. Failure to Abide by Quality Measures

Specific Protocol	*Threshold*
e.g., SCIP Measures	2
e.g., DVT Prevention Measures	2

APPENDIX E

PERFORMANCE IMPROVEMENT PLAN OPTIONS
(May be used individually or combined)

IMPLEMENTATION ISSUES CHECKLIST
(For use by the PEC)

TABLE OF CONTENTS

PAGE

PIP OPTION	IMPLEMENTATION ISSUES
Additional Education/CME ***Wide range of options***	***Scope of Requirement*** ❑ Be specific – what type? _____ _____ ❑ Acceptable programs include: _____ _____ ❑ PEC 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 ❑ NCH ❑ Combination: _____ ❑ Documentation of completion must be submitted to PEC. _____ _____ ❑ Date submitted: _____ ***Additional Safeguards*** ❑ Must individual 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 Requirement*** ❑ 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 Chairperson ❑ Chief Medical Officer ❑ 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

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 Requirement*** ❑ How many cases subject to second opinion/consultation requirement? _____ _____ ❑ What types of cases are subject to second opinion/consultation requirement? _____ _____ ❑ Based on practice patterns, estimated time for completion of second opinion/consultation requirement? _____ _____ ❑ Must consultant evaluate patient in person prior to treatment/procedure? ❑ Yes ❑ No _____ _____ ***Responsibilities of Practitioner*** ❑ Notify consultant when patient subject to requirement is admitted or procedure is scheduled and 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.)***	***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 PEC (or designees) on: _____ (date) _____ _____ _____ _____ ***Responsibilities of Consultant (****Information provided by PEC; 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 ❑ President of the Medical Staff ❑ PEC Chairperson ❑ Department Chairperson ❑ 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.)***	***Compensation for Consultant*** *(consultant cannot bill for consultation)* ❑ No compensation ❑ Compensation by: ❑ Practitioner subject to PIP ❑ Medical Staff ❑ NCH ❑ Combination _____ _____ ***Results of Second Opinion/Consultations*** ❑ Who will review results of second opinion/consultations with practitioner? _____ ❑ After each case ❑ After total # of cases subject to review ❑ Include consultants' reports in practitioner's quality file ***Additional Safeguards*** ❑ Will practitioner be removed from some/all on-call responsibilities until second opinion/consultation requirement is completed? ❑ Yes ❑ No _____ _____

PIP OPTION	IMPLEMENTATION ISSUES
Concurrent Proctoring ***A certain number of the practitioner's 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 Requirement*** ❑ How many cases are subject to concurrent proctoring requirement? _____ _____ ❑ What types of cases are subject to proctoring requirement? _____ _____ ❑ Based on practice patterns, estimated time for completion of proctoring requirement? _____ _____ ***Responsibilities of Practitioner*** ❑ Notify proctor when patient subject to requirement is admitted or procedure is scheduled and 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 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.***	***Qualifications of Proctor*** *(PEC must approve)* ❑ Proctor must have clinical privileges in _____. *(If proctor is not member of Medical Staff, credential and grant temporary privileges.)* ❑ Possible candidates include: _____ _____ _____ ❑ The following individuals agreed to act as proctors and were approved by the PEC (or designees) on _____: (date) _____ _____ _____ _____ ***Responsibilities of Proctor*** *(information provided by PEC; include discussion of legal protections for proctor)* ❑ Review medical record and: ❑ ***Procedure***: Be present for the relevant portions of the procedure and remain throughout 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 ❑ Specific form developed for this PIP ❑ Other: _____ _____

PIP OPTION	IMPLEMENTATION ISSUES
Concurrent Proctoring ***A certain number of the practitioner's 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.***	***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 ❑ NCH ❑ Combination _____ _____ ***Results of Proctoring*** ❑ Who will review results of proctoring with practitioner? _____ ❑ After each case ❑ After total # of cases subject to review ❑ 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 Requirement*** ❑ Acceptable programs include: _____ _____ ❑ PEC approval required before practitioner enrolls ❑ Program approved: _____ ❑ Date of approval: _____ ❑ Who pays for the evaluation/assessment? ❑ Practitioner subject to PIP ❑ Medical Staff ❑ NCH ❑ Combination: _____ ***Practitioner's Responsibilities*** ❑ Sign release allowing PEC to provide information to program (if necessary) and program to provide report of assessment and evaluation to PEC. _____ _____ ❑ Enroll in program by: _____ ❑ Complete program by: _____ ***Additional Safeguards*** ❑ Must individual agree 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 Requirement*** ❑ Be specific – what type? _____ _____ ❑ Acceptable programs include: _____ _____ ❑ PEC approval required before practitioner enrolls. ❑ Program approved: _____ ❑ Date of approval: _____ ❑ Who pays for the training? ❑ Practitioner subject to PIP ❑ Medical Staff ❑ NCH ❑ Combination: _____ ***Practitioner's Responsibilities*** ❑ Sign release allowing PEC to provide information to training program (if necessary) and program to provide detailed evaluation/assessment to PEC before resuming practice. ❑ Enroll in program by: _____ ❑ Complete program by: _____ ***Additional Safeguards*** ❑ Must individual agree 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 _____ _____ ❑ Is LOA required? ❑ 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	❑ Who may grant the LOA? *(Review Bylaws or applicable Policy)* _____ _____ ❑ Specify conditions for reinstatement: _____ _____ ❑ What happens if the practitioner agrees to LOA, but… ❑ does not return to practice at the NCH? 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? ❑ 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 PEC.*** • ***Design and use indication forms approved by PEC.*** • ***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).***	

APPENDIX F

PHYSICIAN REVIEWERS

The Leadership Council, in consultation with department chairpersons, will appoint physicians who are broadly representative of the specialties represented on the Medical Staff to serve as Physician Reviewers. In order to be eligible to be appointed and continue to serve, Physician Reviewers must:

(1) be experienced or interested in credentialing, privileging, PPE/peer review, utilization management and Medical Staff activities;

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

(3) be willing to participate in PPE training;

(4) be willing to serve a one-year term (and may be reappointed for additional terms);

(5) agree to use their best efforts to fairly and reasonably review the cases that are assigned to them and to abide by all provisions of the PPE Policy; and

(6) review the expectations and requirements of this position and affirmatively accept them.

The Physician Reviewers will review the pertinent parts of the medical record and all supporting documentation and document an assessment and findings using the specific review form provided. These forms have been developed by the PEC to facilitate an objective, consistent, and competent review of each case.

Physician Reviewers will submit completed review forms to the PEC within 30 days. A reminder will be sent if the review is not completed within this time frame.

APPENDIX G

PHYSICIAN ADVISOR

The Physician Advisor will perform the following duties and responsibilities with respect to the PPE process:

(a) consult with PPE Support Staff who support the professional practice evaluation process to determine which cases require physician review, assignment of cases requiring physician review to the most appropriate reviewer, and referral of cases involving system issues to the appropriate Hospital Department or individual for review;

(b) serve as a voting member on the Leadership Council;

(c) serve as a voting member of the Practitioner Excellence Committee;

(d) report to the Practitioner Excellence Committee regarding the cases closed without physician review and cases involving system issues;

(e) serve as a resource to physicians who are assigned cases for review, explain their responsibilities, and time frames for review, as outlined in this Policy;

(f) assist in the successful implementation of Performance Improvement Plans developed for practitioners as requested by the Practitioner Excellence Committee; and

(g) perform other duties as requested by the Leadership Council, Practitioner Excellence Committee or Medical Executive Committee.