BETHESDA HOSPITAL MEDICAL STAFF
PRACTITIONER/ADVANCED PRACTICE PROVIDER
PEER REVIEW PROGRAM

This Peer Review Program Policy (Policy) is established to define the Peer Review process of the Medical Staff of Bethesda Hospital (Medical Staff). The Bethesda Hospital Board of Directors (Board) has delegated to the Medical Staff, through its committees and those committees' members/agents, the responsibility for evaluating, maintaining, and monitoring the quality of health care services provided by Practitioners and Advanced Practice Providers (APPs)[1] granted Clinical Privileges at Bethesda Hospital and its provider-based locations (Hospital). As such, whenever a Practitioner, an APP, a member of the Hospital's staff, or a committee engages in activities pursuant to this Policy, the individual/entity shall be acting as, or on behalf of, a Peer Review Committee (PRC) as that term is recognized in Ohio Revised Code Section 2305.25, *et seq.*

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

I. OBJECTIVES

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

- Improve the Quality of Care provided by Practitioners and APPs.
- Create a culture with a positive approach to Peer Review.
- Identify opportunities for Quality of Care improvement on the part of Practitioners/APPs.

[1] For purposes of this Policy, the term Practitioner means a Physician, Dentist, Podiatrist, or Psychologist who is granted Privileges at the Hospital; the term Advanced Practice Provider or APP means an advanced practice registered nurse, physician assistant, or any other APP who is granted Privileges at the Hospital pursuant to the Medical Staff process.

- Assist in providing accurate and timely performance data for feedback to Practitioners/APPs.

- Monitor significant trends by analyzing aggregate data.

- Assure that the process for Peer Review is clearly defined, objective, timely, and useful.

II. DEFINITIONS

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

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

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

Medical Staff Peer Review Committee (MSPRC). This term means a PRC established by the MEC, and subject to the authority of the MEC, that provides overall jurisdiction for the operation of the Peer Review program. The Quality Assurance Committees are subject to the authority of the MSPRC.

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

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

Peer Review. This term means a prospective, concurrent, or retrospective review of patient care, management, interaction, and/or consultation by a PRC (or one of its agents) in order to evaluate the Quality of Care provided by a Practitioner/APP. Peer Review is conducted

using multiple sources of information. The individual's evaluation is based on generally recognized standards of care. Through this process, Practitioners/APPs receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their medical/clinical, technical, and interpersonal skills in providing patient care.

Peer Review Committee (PRC)[2]. This term means, for purposes of this Policy, the MSPRC and Quality Assurance Committees responsible for evaluating and improving Practitioner/APP performance as it relates to:

1. Patient care

2. Medical/clinical knowledge

3. Practice-based learning and improvement

4. Interpersonal and communication skills

5. Professionalism

6. System-based practice

All members of the MSPRC and Quality Assurance Committees, and other individuals requested to act as agents of the MSPRC or Quality Assurance Committees, must sign a confidentiality statement, a copy of which is attached hereto as Addendum A and incorporated by reference herein, prior to engaging in Peer Review activities.

The MSPRC and all Quality Assurance Committees must follow a consistent minutes' format as established by the MSPRC.

Quality Assurance Committee (QA Committee). This term means a PRC established by the MSPRC to conduct Practitioner and APP case reviews and subject to MSPRC oversight.

Quality of Care. This term means, for purposes of this Policy, issues related to a Practitioner's/APP's professional conduct or clinical competency.

Quality Department (QD). This term means the Hospital's Clinical Quality Resources Department responsible for oversight, development, evaluation, and ongoing monitoring of quality improvement, Peer Review, and patient safety processes and initiatives. The QD (and each QD Clinical Quality Specialist or "CQS") is a designated Peer Review agent of all PRCs.

[2] There are other PRCs (*e.g.*, the MEC, Credentials Committee and PEC) that do not report to the MSPRC.

III. POLICY

A. Scope. The MSPRC is charged with evaluating the care provided by Practitioners/APPs at the Hospital.

1. Depending upon the scope of issues presented, the MSPRC may provide such evaluation through the MSPRC or it may establish QA Committees, consistent with the Medical Staff governing documents, that are more specialty/ies focused. Such QA Committees shall report to the MSPRC.

2. The composition, term, and duties of the MSPRC and the QA Committees are set forth in the Medical Staff Organization Policy.

B. Education. All participants in the Hospital's Peer Review program should be educated as to the responsibilities of a PRC and its members.

C. Manner of Activities. Peer Review activities are conducted in the following manner:

1. Cooperatively. A PRC (or agent on behalf of the PRC) may request to meet with a Practitioner/APP to discuss cases or issues under review or to request that the Practitioner/APP respond, in writing, to cases or issues under review. Practitioners/APPs are expected to reasonably participate in this process. Failure to do so will result in the matter being resolved without the Practitioner's/APP's input and will be considered in the context of whether the Practitioner/APP is acting in a professional manner consistent with his/her responsibilities pursuant to the Medical Staff governing documents. Failure to respond may also result in a referral to the MEC for corrective action.

2. Courteously. Participants are to be courteous and respectful to each other.

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

4. Peer to Peer. The Peer Review program is designed to foster collegial engagement. As such, neither a Practitioner nor an APP shall have the right to have legal counsel present at a PRC meeting at which the Practitioner/APP is requested by a PRC to attend unless the PRC, in consultation with Hospital legal counsel, authorizes such presence. If a Practitioner's or APP's legal counsel is permitted to be present, the PRC shall define the scope of legal counsel's permitted activities during the meeting.

D. Performance Improvement Activities. Performance improvement activities related to systemic issues are not part of this Policy. Rather, to the extent a performance

improvement issue is identified by a PRC, the issue will be referred to the appropriate Hospital committee. Correspondingly, if a Hospital committee identifies an individual Practitioner/APP Quality of Care issue, that committee will refer the matter to the QD for review and referral, as appropriate, to the MSPRC or a QA Committee.

E. Conflicts of Interest

1. The fact that a PRC member or PRC agent is in the same specialty as the Practitioner/APP under review does not, in and of itself, require recusal of the member/agent.

2. In the event a Practitioner/APP believes that a PRC member/agent has a conflict of interest that precludes him/her from acting in an impartial manner, the Practitioner/APP must submit his/her objections, in writing, to the chair of the applicable PRC. The PRC, at its sole discretion, will make the final determination as to the whether the contested member/agent may continue to participate. In the event that a PRC member/agent is determined by the PRC to have a conflict of interest that precludes participation, the PRC member/agent must be excused while the PRC conducts its deliberation and votes.

3. A member of a PRC who is under review must be recused from participating in the Peer Review matter as a PRC member. Once the Practitioner/APP has responded to any questions by the PRC, the Practitioner/APP must be excused from the room prior to any discussion, decision(s), or vote(s) related to the Practitioner's/APP's case(s).

F. Confidentiality

1. Peer Review information includes all information collected for, generated by, or otherwise under the oversight of a PRC. Peer Review information shall only be used for Peer Review purposes as that term is defined in Ohio Revised Code §2305.25, *et seq*. in the absence of a decision on the part of the System CEO, the Chief Medical Officer, or the Associate Chief Medical Officer, in consultation with the Medical Staff President and Hospital legal counsel, that it is appropriate for certain information to be used for alternative purposes.

2. Peer Review information shall be maintained in a secure location. Although not required as a means of assuring Peer Review protection, any or all of the following processes may be implemented as an additional means of assisting in maintaining confidentiality as deemed appropriate based upon the situation:

   a. Identifying Practitioners/APPs by code number.

   b. Identifying patients by code number.

c. Distributing minutes and related materials at committee meetings and recollecting such minutes and related materials at the conclusion of a meeting.

d. Making information available only on a secure computer site.

IV. PEER REVIEW PROCESS

A. Process

1. The process for conducting individual Practitioner/APP case reviews is set forth in Addendum B attached hereto and incorporated by reference herein.

2. Any person/group may submit a report or otherwise notify the QD of case(s) and concerns. The QD shall be responsible for identifying cases that should be referred to a PRC.

a. The presumption is that cases identified for Peer Review will be referred to the appropriate specialty/ies QA Committee.

b. In the event a case involves multiple specialties or otherwise raises issues with respect to an appropriate referral, the QD will consult with the MSPRC chair.

3. Case review may be triggered by any number of factors including, but not limited to: sentinel events/serious safety events, near misses, specialty specific clinical screens, benchmarks, practice patterns, professional liability cases, resource utilization data, requests for Peer Review, safety reports, *etc.*

4. The MSPRC or QA Committee (as applicable) is responsible for generating a letter to the Practitioner/APP advising him/her of the case level determination and appeal rights, if any.

5. All QA Committee minutes (including all case level determinations) are forwarded to the MSPRC.

V. ONGOING PROFESSIONAL PRACTICE EVALUATION

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

B. Data. Data compiled for purposes of OPPE may include, but is not limited to, the following:

1. Review of indications for, and performance of, operative and other clinical procedure(s) and their outcomes.

2. Patterns of pharmaceutical usage.

3. Appropriateness of clinical practice patterns.

4. Significant departures from established patterns of clinical practice.

5. Medical assessment and treatment of patients.

6. Morbidity and mortality data.

7. Sentinel event data.

8. Patient safety data.

9. Core indicators and specialty-specific indicators as determined by the MSPRC in collaboration with the applicable Medical Staff leaders.

10. Other relevant criteria as determined by the MSPRC.

C. Compilation of Data. OPPE data may be acquired through the following:

1. Periodic medical record review.

2. Direct observation.

3. Monitoring of diagnostic and treatment techniques.

4. Discussion with other individuals involved in the care of each patient.

D. Criteria

1. OPPE criteria are reviewed annually by the QD after obtaining input from the Medical Staff leaders.

2. The developed OPPE criteria are forwarded to the applicable QA Committee for review and recommendation to the MSPRC. Following review, the MSPRC shall forward and makes its recommendation to the MEC which, in turn, shall make a final recommendation to the Board for approval.

E. Distribution

1. Individual OPPE reports are made available to each Practitioner/APP. The goal is for OPPE reports to be issued at least once every twelve (12) months. These reports are intended to reflect individual performance that can be compared to prior reports. OPPE reports are maintained in each Practitioner's/APP's applicable Peer Review file(s).

2. The QD provides the Department Chair, acting as an agent of the MSPRC or applicable QA Committee, with the OPPE reports of each Practitioner/APP in his/her Department. In the event a Department Chair believes that an OPPE indicates concerns, the Department Chair is expected to meet with the affected Practitioner/APP to provide mentoring and direction. A memorandum of such meeting shall be made by the Department Chair and maintained in the Practitioner's/APP's applicable Peer Review file. The MSPRC chair (or co-chair) shall act as the Department Chair for purposes of a Department Chair's OPPE.

3. The QD provides a Practitioner's/APP's OPPE report to the MSPRC or other applicable QA Committee when the data:

   a. Establishes that quality thresholds have been exceeded.

   b. Establishes that there are opportunities for improvement.

   c. Is negative.

VI. FOCUSED PROFESSIONAL PRACTICE EVALUATION

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

B. Grounds. An FPPE is implemented:

1. For all new grants of Privileges (initial grants as well as grants of additional Privileges during an existing Privilege period).

2. When concerns arise regarding a currently privileged Practitioner's/APP's Quality of Care.

C. FPPE for New Grants of Clinical Privileges. The assigned Peer monitors the completion of the requisite number of cases or other selected FPPE evaluation method. Upon completion, the assigned Peer notifies the Practitioner's/APP's Department Chair. The Department Chair, acting as an agent of the MSPRC, determines whether the FPPE has been successfully completed. The MSPRC chair (or co-chair) shall perform the Department Chair's duties with respect to a Department Chair's FPPE.

1. If quality concerns exist, a Department Chair may extend an initial FPPE once for a period not to exceed six (6) months. If the Department Chair continues to have concerns following an extension, he/she must refer the matter to the MSPRC.

2. For low volume providers, an FPPE may remain in place for more than one (1) Privilege period until the FPPE requirements have been met. At such time as a Department Chair determines that a low volume provider's FPPE should not be continued, he/she must refer the matter to the MSPRC.

3. If any concerns arise during an initial FPPE, the matter is handled consistent with this Policy and related Medical Staff governing documents.

D. FPPE for Quality of Care Concerns Identified During a Privilege Period. An FPPE for Quality of Care concerns may be triggered by a QA Committee, the MSPRC, or the MEC when any of the following occurs:

1. Egregious single event.

2. Pattern of concern identified pursuant to an OPPE.

3. Concerns identified by a QA Committee, the MSPRC, or the MEC.

4. Significant complaints by patients, Hospital staff, Practitioners, or APPs.

5. Other Quality of Care patterns or trends of concern.

E. Elements of a FPPE Based upon Quality of Care Concerns

1. An FPPE for Quality of Care concerns should be developed in a manner that best provides oversight of the care being provided by a Practitioner/APP relative to the issue under review. An FPPE that includes any limitations on practice, whether established by a QA Committee or the MSPRC, may only be implemented if the Practitioner/APP voluntarily agrees to participate. If the Practitioner/APP refuses to do so, the matter must be referred to the MEC. Thereafter, the process set forth in the Medical Staff Bylaws or APP Policy, as applicable, shall apply.

2. The establishment of an FPPE based upon Quality of Care concerns during a Privilege period is generally the responsibility of the MSPRC or applicable QA Committee. If a QA Committee believes an FPPE to be necessary, the QA Committee must submit the proposed FPPE to the MSPRC for its approval; provided, however, the QA Committee may implement the FPPE pending such approval. Should the MSPRC reject and/or modify an FPPE that has already been implemented, the FPPE shall be so rejected/modified as of the date of the MSPRC's action. A QA Committee may also refer the matter to the MSPRC for its determination as to whether an FPPE is appropriate.

3. An FPPE for Quality of Care concerns that is managed by a QA Committee or the MSPRC is not deemed Adverse and, therefore, does not trigger any procedural due process rights pursuant to the Medical Staff governing documents nor, in the absence of a resignation while in place, is such FPPE reportable to federal or state authorities.

4. An FPPE for Quality of Care concerns may consist of any or all of the following:

   a. Prospective, concurrent, or retrospective case review.

   b. Direct observation.

   c. Proctoring.

   d. Education.

   e. External Peer Review.

5. In the event a QA Committee or the MSPRC implements an FPPE for Quality of Care concerns, the Practitioner/APP will be notified in writing.

6. Although not required, it is the expectation that the MSPRC or QA Committee establishing an FPPE for Quality of Care concerns will meet with the Practitioner/APP to review the reason for the FPPE and its scope.

7. A Practitioner/APP may voluntarily agree to limit the exercise of his/her Privileges during the course of an FPPE for Quality of Care concerns established by a QA Committee or the MSPRC.

VII. EXTERNAL PEER REVIEW

A. Purpose. External Peer Review is used to assure that an objective and fair evaluation of the care delivered (as documented in the medical record and pertinent related components such as radiographs, referral facility records, *etc*.) is afforded to the Practitioner(s)/APP(s) involved; and to resolve any issues remaining from

internal Peer Review. As such, external Peer Review is considered whenever it is determined that:

1. An internal review may not be perceived as objective or unbiased.

2. An internal review cannot be performed due to a conflict of interest.

3. Similarly trained Practitioners/APPs are not available to conduct a review.

4. There is a substantial difference of opinion regarding the care provided.

5. The review involves a new technology or procedure for which the Medical Staff does not have the requisite expertise.

6. There is a possibility of a future professional review action.

7. Other appropriate reason as dictated by the circumstances.

B. Authority. The following have the authority to initiate an external Peer Review:

1. The MEC or MEC chair (with approval of the System CEO and Chief Medical Officer or Associate Chief Medical Officer).

2. The MSPRC or MSPRC chair (with approval of the System CEO, Chief Medical Officer or Associate Chief Medical Officer, and the Medical Staff President).

3. A QA Committee or QA Committee chair (with approval of the System CEO, Chief Medical Officer or Associate Chief Medical Officer, and the Medical Staff President).

4. The Board.

5. The System CEO (on behalf of the Board).

C. Not Required. A Practitioner/APP cannot require the Hospital to obtain an external Peer Review.

D. Qualifications. An external Practitioner reviewer must meet the following qualifications:

1. Possess skills needed at the Hospital for a specific Peer Review project or for Peer Review consultation on an occasional basis.

2. Practice either locally or in another city and/or state in which he/she has a current, valid, unrestricted license to practice and be a member of the active medical staff with privileges in good standing at an accredited hospital; OR, be a Practitioner who is a recognized expert in his/her field who has retired

from active practice at an accredited hospital within the last twelve (12) months.

3. Satisfy the Hospital's Professional Liability Insurance coverage requirements.

4. Be board certified in the specialty under review and engaged in the active practice of such specialty for at least five (5) years.

5. Not have, or be perceived as having, a conflict of interest with the affected Practitioner/APP. Preference will be given to external Peer reviewers who have no personal relationship with the Practitioner/APP.

6. Be able to provide a timely, written, objective opinion based on the care delivered (as documented in the medical record and pertinent related components such as radiographs, referral facility records, *etc*.). The opinion must include decision rationale, any national or organizational standards utilized, and opportunities for improvement (if any).

7. Be willing to continue to participate in the Peer Review process through fair hearing (or such other procedural due process proceeding applicable to APPs) and litigation if the matter extends to these proceedings.

8. Be appointed to the Medical Staff's Consulting Peer Review category (if a Practitioner) OR be covered by/subject to a Business Associate Agreement (if a Practitioner or APP).

9. Satisfy such other qualifications as deemed appropriate by the appointing committee.

10. If the external reviewer is an APP, then the requirements above shall be modified as necessary.

11. Unless appointed to the consulting peer review Medical Staff category (if a Practitioner), an external Practitioner or APP reviewer (and/or vendor that provides the external Practitioner or APP reviewer) must enter into a written agreement with the Hospital for consulting Peer Review services which agreement shall include, but not be limited to, a Confidentiality Agreement and a Business Associate Agreement (pursuant to subsection 8).

E. <u>Process Following Receipt of External Peer Review Report</u>

1. If the PRC that requested the review has any concerns or questions relative to the review after receipt of an external Peer Review report, the PRC is expected to follow up with the external reviewer either by letter or conversation documented by minutes.

2. Because Peer Review is part of the routine ongoing checks and balances of the Hospital's quality assessment process, a Practitioner or APP is not required to be notified of an external review. However, recognizing the value that such a report has in assessing patient care, in all but exceptional circumstances (as determined by the applicable PRC following consultation with Hospital legal counsel), the affected Practitioner/APP will be given access to the results of an external Peer Review (whether favorable or unfavorable) as well as the opportunity to participate in, or respond to, any concerns, as soon as reasonably appropriate. The Practitioner/APP is not required to be, and should not be, given a copy of the report unless the report becomes part of a corrective action investigation conducted by the MEC that results in the initiation of the fair hearing process (or such other procedural due process proceeding applicable to APPs). Nothing in this paragraph shall be construed as precluding the imposition of a summary suspension, pursuant to the process set forth in the Medical Staff Bylaws or APP Policy, as applicable, if/when circumstances so warrant.

3. Following an external Peer Review, the applicable PRC may:

    a. Close the matter.

    b. Initiate or continue with an FPPE, as applicable, pursuant to Section VI (D).

    c. Enter into a voluntary remediation agreement with the Practitioner/APP, subject to the approval of the MSPRC (if the agreement is with a QA Committee).

    d. Refer the matter to the MSPRC (if the matter was originally managed by a QA Committee).

    e. Refer the matter to the MEC. Thereafter, the process set forth in the Medical Staff Bylaws or APP Policy, as applicable, shall apply.

4. If an external Peer Review is requested by the MEC (or chair thereof), the MEC may either remand the matter to the MSPRC or initiate formal corrective action in accordance with the process set forth in the Medical Staff Bylaws or APP Policy, as applicable. Legal counsel may be consulted to assist the MEC with the appropriate process to be followed.

5. If external Peer Review is requested by the Board (or the System CEO as an authorized agent of the Board), legal counsel will assist the Board with the appropriate process to be followed.

6. Upon completion of an external Peer Review, the determination as to what information will be shared and when, how, and with whom, shall be decided by the PRC that obtained the external review in consultation with the Chief Medical Officer or Associate Chief Medical Officer and the Medical Staff

President (or the Board if the Board or the System CEO initiated the review); provided, however, that to the extent the review establishes the need for remediation and/or corrective action, legal counsel should be brought in to assist the PRC in such determination.

VIII. RESULTS OF PROFESSIONAL PRACTICE EVALUATION

A. Based upon the analysis of the information resulting from Professional Practice Evaluation (PPE) activity (*i.e.*, FPPE, OPPE, and case review), several actions may occur including, but not limited to:

1. Determination that the Practitioner/APP is performing in accordance with established expectations and that no action is necessary/warranted.

2. Determination that an issue(s) exists that requires informal remediation.

3. Determination that an issue(s) exists that requires a period of FPPE.

4. Determination that an issue exists that requires referral to the Medical Executive Committee for formal corrective action.

B. PPE data is considered by the Credentials Committee and the Medical Executive Committee in making a recommendation to the Hospital Board regarding Medical Staff reappointment and/or regrant of Clinical Privileges.

IX. ASSESSMENT OF PEER REVIEW PROGRAM/PROCESS

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

X. ACCESS TO PEER REVIEW INFORMATION

A. Peer Review files are Hospital property and are maintained by, or on behalf of, a PRC for credentialing, privileging, and related Peer Review purposes. The information maintained in these files is privileged pursuant to Ohio Revised Code §§2305.25, *et seq*.

B. All PRC minutes are maintained as protected Peer Review documents. A Practitioner/APP who is under review is not entitled to access to these minutes unless they are produced as part of a fair hearing proceeding (or such other procedural due process proceeding applicable to APPs).

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

D. The Hospital maintains one or more Peer Review files for each applicant requesting Medical Staff appointment and/or Privileges, each Practitioner granted Medical

Staff appointment and/or Privileges, and each APP granted Privileges at the Hospital. Peer Review files contain information regarding a Practitioner's or APP's credentials, privileging, FPPE/OPPE, Peer case reviews, and other Quality of Care data. Peer Review files may also be developed for other Peer Review activities (*e.g.*, formal corrective action proceeding, *etc.*).

1. Subject to the Medical Staff governing documents, a Practitioner/APP has the right to review his/her credentials file and quality file (subject to certain information, such as references or other third-party documentation, not being disclosed as determined by the Hospital). A Practitioner/APP does not have the right to review Peer Review files developed for other Peer Review activities except as specifically provided herein or as otherwise provided for in the Medical Staff governing documents.

2. A Practitioner/APP has the right to receive copies of any documents that the Practitioner/APP originally provided to the Medical Staff office. A Practitioner/APP does not have the right to copies of any other documents unless otherwise provided in the Medical Staff governing documents.

3. A Practitioner/APP does not have the right to a copy of his/her credentials file or quality file unless the files are produced as part of a fair hearing proceeding (or such other procedural due process proceeding applicable to APPs).

4. A request to review one's credentials file or quality file must be made to the Medical Staff Office or QD at least five (5) business days in advance with notice to the applicable Department Chair. The review will be held at the Hospital in the presence of a designated Peer Review agent.

E. Peer Review information is otherwise available only to (a) authorized individuals/committees who require access to such information as part of the protected Peer Review process; or (b) appropriate accrediting/regulatory organizations in consultation with Hospital legal counsel; or, (c) under such other circumstances as appropriate in consultation with Hospital legal counsel.

F. All court orders/subpoenas for Peer Review files shall be referred to Legal Services for follow up with the appropriate PRC (or its authorized agent).

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Executive Committee on:

Approved by the Board on:

ADDENDUM A

PEER REVIEW PROGRAM
MEMORANDUM OF UNDERSTANDING
AND STATEMENT OF CONFIDENTIALITY

Thank you for agreeing to serve as a member of a Peer Review Committee (PRC) or otherwise participate in the Peer Review process at Bethesda Hospital and its provider-based locations (Hospital). Practitioners and Advanced Practice Providers (APPs) who participate in Peer Review must be viewed by their colleagues as fair, collegial, confidential, clinically competent, and professional. Peer Review is ultimately the responsibility of the Hospital Board as part of evaluating, maintaining, and monitoring the quality of health care services provided by Practitioners and APPs granted Clinical Privileges at the Hospital. The Board delegates this responsibility to the Medical Staff through its PRCs and those committees' members/agents. As a member of a PRC or participant in the Peer Review process, it is your shared responsibility, in return, to make sure that the Peer Review program is effective.

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

- Have a professional and collegial demeanor in all activities.

- Keep deliberations frank, honest, accurate, unbiased, and non-inflammatory.

- Be trustworthy. Keep the deliberations confidential the way you would expect if your case was under review.

- Seek additional input if the issue is outside the expertise of the PRC members. Sometimes determining whether or not a particular action was within the standard of care requires detailed knowledge of current practice that only a group of Peers from within the involved specialty can provide.

- Do not use the Peer Review process to discredit, embarrass, undermine, discourage, or unseat a colleague. Cases should be selected without bias.

- Do not protect a colleague or friend from Peer Review. If you perceive that this needs to be done, you are indicating that you believe the Peer Review process is either not fair; or, is being used to do something other than improve the Quality of Care. It is your obligation to bring these concerns to the PRC chair.

- If you have a conflict of interest with the Practitioner/APP being discussed (*e.g.*, competitor, partner, refers patients to you or vice-versa, financial relationship, employed in the same group, *etc.*), you are expected to disclose that conflict to the PRC. The PRC is responsible for determining whether the conflict rises to the level of precluding you from

participating in the pending Peer Review matter. For purposes of the Peer Review Program Policy, the fact that Practitioners/APPs are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such Practitioners/APPs from participating in the Peer Review process with respect to his/her colleagues.

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

To preserve the confidentiality of Peer Review information and quality data, it is imperative that Practitioners and APPs involved in the Peer Review process observe the following instructions in the performance of Peer Review:

- The case review form should never be shared with individuals who are not authorized to access this information. When the review is completed, please submit the form (either in hard copy or electronically) to the designated Medical Staff/Hospital personnel or office. The form is not to be part of the patient's medical record.

- Once the case review form is completed, making additional copies of the form is prohibited.

- Discussing Peer Review cases or data with other Practitioners or APPs outside of the PRC meeting is prohibited unless specifically requested by the PRC.

- Discussing any Peer Review case or data with anyone in a public setting is prohibited.

- Discussing PRC reviews with Hospital employees other than those involved in the Peer review or quality/performance improvement process is prohibited.

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

NAME (Print)	SIGNATURE	DATE SIGNED

ADDENDUM B
PRACTITIONER/APP PEER REVIEW PROCESS

1. Case identified by the Quality Department who:
    a. Refers the case to the applicable QD Registered Nurse Clinical Quality Specialist (CQS) for screening. The designated CQS evaluates the case.
        i. If the case does not warrant review by a QA Committee or the MSPRC, the CQS documents and closes the case.
        ii. If the case warrants review, the CQS refers the case to a member or other authorized agent of the applicable QA Committee or MSPRC. The following situations must be referred to the MSPRC:
            - All Case Level 3 assignments by a QA Committee.
            - Three (3) Case Level 2 assignments by the same QA Committee or different QA Committees within a rolling 18-month period (based upon date of service).
            - Sentinel events involving a Practitioner/APP, regardless of case level, following review by the applicable QA Committee(s).
            - Cases that involve patient care that falls within the oversight of three (3) or more separate QA Committees following review by the applicable QA Committees.
            - Cases that involve organization-wide system or process issues following review by the applicable QA Committee(s).
            - Any case where a QA Committee or a Department Chair requests further review by (or presentation to) the MSPRC.
    b. The designated PRC member or other authorized agent reviews the case.
        i. The assigned PRC reviewer may send a Letter Seeking Information (LSI) to the Practitioner/APP whose case is being reviewed prior to the PRC meeting. In the event this occurs: (a) the PRC members/reviewer must understand that the PRC may decide that it does not agree with the reviewer's initial questions or has other questions thereby necessitating another LSI (as noted below); and (b) the LSI sent by the PRC reviewer needs to clearly state that the questions are being asked in the reviewer's capacity as a member or other authorized agent of the PRC and that the PRC may have additional questions as part of the case review process.

2. Case evaluated by the applicable QA Committee or MSPRC (See Addendum C)
    a. If the assigned PRC reviewer's recommendation is that care was appropriate, the case is placed on the "Cases Closed" list and reported to the PRC at its next meeting.
        i. If the PRC agrees with the PRC reviewer's recommendation of "care appropriate," the PRC approves assignment of Case Level 0 and closes the case. A letter regarding the case level determination may be sent to the Practitioner or APP by the PRC.

ii. If the PRC does not agree with the PRC reviewer's recommendation of "care appropriate," the PRC may, at its discretion, remove the case from the "Cases Closed" list and proceed to review and further evaluate the case.

b. If the assigned PRC reviewer determines that care was anything other than "care appropriate," the reviewer presents the case to the PRC at its next meeting.

i. Following discussion, the PRC may issue a LSI to the Practitioner/APP for additional information prior to determining the case level assignment.

- If the Practitioner/APP fails to respond to the LSI within the time specified, the PRC assigns a case level based upon the information available.
- If the Practitioner/APP responds to the LSI within the time specified, the additional information is presented, considered, and a case level assignment is made by the PRC.

ii. If, following discussion, the PRC determines that an LSI is not needed (*i.e.*, because the reviewer initially sent an LSI and the PRC has no additional questions), then the PRC will proceed to assign a case level.

iii. Following the PRC's evaluation, the Practitioner/APP is notified, in writing, of the PRC's case level determination.

c. Other than in exceptional circumstances, a determination of anything other than "care appropriate" will not be made until after the Practitioner/APP has been given an opportunity to respond.

d. In addition to a written response, a Practitioner/APP may request to meet with the PRC to discuss the case under review.

e. If the PRC that reviews the case is a QA Committee, the QA Committee may, at any time, seek direction from the MSPRC or refer a case to the MSPRC.

3. Reconsideration of a PRC case level assignment

a. In the event a QA Committee or the MSPRC (as an initial determination) has assigned a Case Level 3 or has designated three (3) individual cases as a Case Level 2 within a rolling 18-month period (based upon date of service), the Practitioner/APP may submit a written request to the applicable PRC to reconsider its decision. The request must specifically identify the findings with which the Practitioner/APP disagrees and the basis for such disagreement.

b. The QA Committee or MSPRC may:

i. Review and make its decision based solely upon the written information; or,

ii. Meet with the Practitioner/APP prior to making a final decision.

c. A reconsideration determination by the MSPRC (regarding the MSPRC's initial determination) is final.

d. A reconsideration determination by a QA Committee (regarding the QA Committee's initial determination) may either be accepted by the Practitioner/APP; or, appealed to the MSPRC pursuant to Section 4 below.

4. Appeal of a QA Committee case level assignment following QA Committee reconsideration

a. In the event the Practitioner/APP continues to dispute the decision of a QA Committee following the reconsideration process set forth in Section 3, the Practitioner/APP may submit a written request to the MSPRC appealing the QA Committee's decisions. The appeal must specifically identify the findings of the QA Committee with which the Practitioner/APP disagrees and the basis for such disagreement. The MSPRC may:

   i. Review and make its decision based solely upon the written information; or,

   ii. Remand the matter back to the QA Committee (*e.g.*, in the event of new information not previously considered by the QA Committee, *etc.*); or,

   iii. Request additional input from the QA Committee prior to making a final decision; or,

   iv. Meet with the Practitioner/APP or the QA Committee prior to making a final decision.

b. The MSPRC's decision following appeal of a QA Committee's reconsideration decision is final.

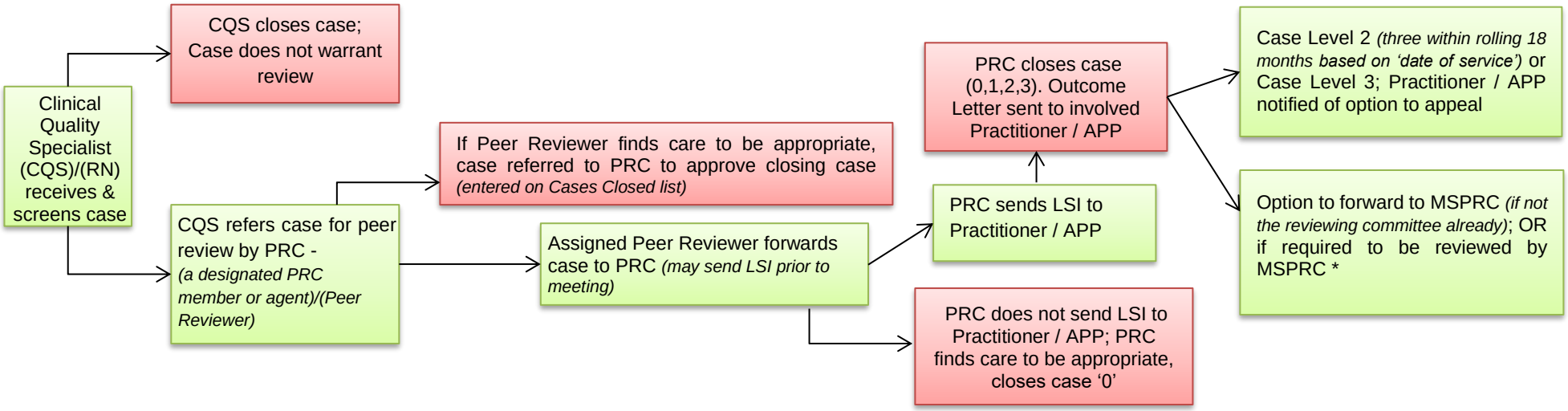
5. Impact of QA Committee or MSPRC determination

   a. A case level assigned by a QA Committee or by the MSPRC is not deemed Adverse nor does it trigger any procedural due process rights pursuant to the Medical Staff Bylaws or APP Policy; rather, it is part of the ongoing informal PPE process.

6. Responsibility of QD

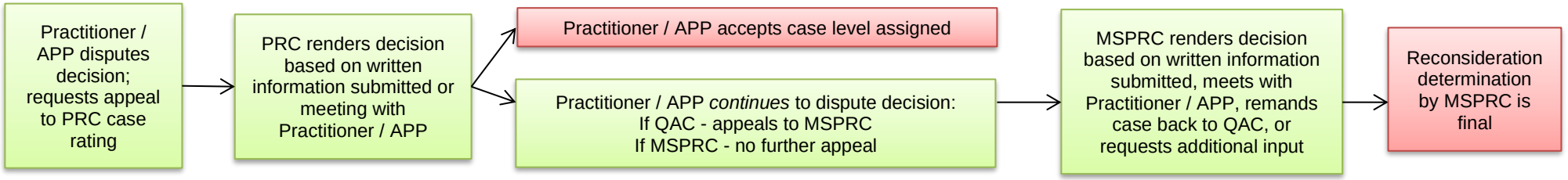
   a. The QD maintains all case review findings in its Peer Review data base.

Professional Practice Evaluation (PPE) Process



Other than in exceptional circumstances, determination of anything other than 'care appropriate' will not be made until Practitioner/APP has been given an opportunity to respond.

APPEAL of Case Level 2 (three within rolling 18 months based on date of service) or Case Level 3:



In the event of a conflict between this schematic and the Peer Review Program Policy, the Policy controls.
PRC = Quality Assurance Committee (QAC) or MSPRC
All QAC minutes are forwarded to MSPRC.

FPPE based on quality of care concerns may be initiated by the MSPRC or by a QAC subject to MSPRC approval (QAC may implement while awaiting approval).

If a case or trend warrants request for formal corrective action investigation, referral is made to Medical Executive Committee by any PRC.

***<u>These cases are always forwarded to MSPRC:</u> (Case selection determined annually)**
Case Level 3 assignments; Practitioner / APP cases with three Case Level 2 assignments within rolling 18 months based on date of service; Cases that involve patient care that falls within the oversight of three (3) or more separate QACs; Sentinel Events involving a Practitioner / APP (regardless of case level); Cases with organization-wide system or process issues; Any case where PRC or Department Chair requests further review / presentation.

Level #	Case Level Terminology	Case Level Definition
0	Care Appropriate	No clinical issues identified. Majority of peers would respond similarly under similar circumstances.
1	Improvement Opportunity	Simple (human) error(s), inadvertently doing other than what should have been done. Coaching/ education and/or trending may be appropriate.
2	Clinical Issues Identified	Care requires consideration as to whether Practitioner/APP should be provided with education, coaching, *etc.* to correct the issues identified. Trending or FPPE may be appropriate.
3	Serious Clinical Issues Identified	Care raises serious concerns of gross negligence, general incompetence, or actual intent to provide substandard care. FPPE or referral for corrective action may be appropriate.

ADDENDUM C

MEDICAL STAFF PEER REVIEW GUIDELINES

These Medical Staff Peer Review Guidelines (Guidelines) are intended to supplement the Peer Review Program Policy (Policy). To the extent there is a conflict between the Policy and these Guidelines, the Policy will control. Definitions set forth in the Policy shall have the same meaning when used herein.

The Policy encourages collegial actions to support Practitioners/APPs in their ongoing efforts to improve their own quality of care. Peer reviewers shall follow the Just Culture Algorithm included with these Guidelines. The Just Culture Algorithm recognizes that Practitioners/APPs delivering health care will occasionally make errors and that simple human error does not necessarily indicate substandard care or a substandard caregiver.

Peers are expected to conduct case reviews following the Just Culture Algorithm and considering:

1. Relevant literature and clinical practice guidelines
2. The Medical Staff governing documents and applicable Hospital and System policies
3. Opinions and views that have been expressed throughout the Peer Review process including any external Peer Review.
4. Any information or explanations provided by the Practitioner/APP under review.

The final step in the Peer Review process is for the MSPRC or a QA Committee, as applicable, to assign a case level identifying any clinical competency issue(s) and proposing remedial measure(s), as appropriate.

Case Levels

Each case reviewed by the MSPRC or a QA Committee, as applicable, must receive one of the following case level assignments:

(0) Care Appropriate/No Clinical Issues Identified

Despite the fact that the case fell out for review due to a complication (or some other question about the quality of care), it is determined that a majority of Peers would respond similarly under similar circumstances (substitution test).

(1) Improvement Opportunity:

Care shows simple errors of diagnosis, treatment, or judgement, or inadvertently doing other than what should have been done such as a slip, lapse, or mistake.

- This case level may be used for instances where a Practitioner/APP has drifted into a practice pattern that may increase the likelihood of human error and coaching/education for improvement may be appropriate.

- Trending may also be appropriate.

(2) Clinical Issues Identified

Care requires consideration as to whether the Practitioner/APP should be provided with education/coaching in order to correct the clinical issues identified.

- Trending or an FPPE for Quality of Care concerns may also be appropriate.

(3) Serious Clinical Issues Identified

Care raises serious concerns of gross negligence, general incompetence, or actual intent to provide substandard care.

- An FPPE for Quality of Care concerns or referral to the MEC for initiation of formal corrective action may be appropriate.

In addition to the case level assignment, the QA Committee or MSPRC, as appropriate, will note the following:

- Whether there are other issues of concern
- Whether there are communication/professionalism issues
- Whether there are documentation issues