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Professional Practice Evaluation Policy

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CentraCare adopts the following Policy/Procedure for:

CentraCare - Monticello

PART A: OBJECTIVES, SCOPE OF POLICY, DEFINITIONS AND COLLEGIAL EFFORTS

A. The professional practice evaluation process ("PPE") has three stages: focused professional practice evaluation to confirm competence, ongoing professional practice evaluation, and focused professional practice evaluation to evaluate competence.

B. The primary objectives of PPE process are to:
    1. define prospectively, to the extent possible, the expectations for patient care and safety;
    2. establish and update the triggers for focused professional practice evaluation and the elements for ongoing professional practice evaluation that will facilitate a meaningful review of the care provided;
    3. effectively, efficiently, and fairly evaluate the care provided by practitioners, comparing it to established patient care protocols and benchmarks whenever possible; and

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

C. Duties of the Peer Review and Medical Practice Evaluation Committee are:

1. To monitor practitioner performance with the fundamental goal to promote good medical care and patient safety;
2. To conduct reviews of individual patient cases when established criteria are not met, to determine whether care was appropriate;
3. To identify and monitor trends in practitioner performance which do not meet accepted standards of patient care;
4. To work with practitioners so identified to assist them in providing evidence-based care;
5. To review complaints of practitioner conduct to promote a non-threatening, non-disruptive environment;
6. To refer cases to the Executive Committee when appropriate;
7. To identify opportunities for improvement in systems as opposed to individuals and make recommendations for appropriate changes.

D. In all stages of the PPE process, this Policy encourages the use of collegial efforts and progressive steps to address issues that may be identified. 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, and letters of counsel, education or guidance, sharing of comparative data, and performance improvement plans. All collegial efforts and progressive steps are part of the Hospital's confidential performance improvement and professional practice evaluation activities.

E. **DEFINITIONS:**

Conflict of Interest – A conflict of interest may exist if a member of the medical staff is not able to render an unbiased opinion.

Dimensions of Performance may include:

1. technical quality care
2. physician – patient relationships
3. patient safety and patient rights
4. resource utilization

5. peer and coworker relationships
6. professional responsibility for medical staff quality improvement

Focused Professional Practice Evaluation (FPPE) - The time limited evaluation of practitioner competence in performing a specific privilege. This process is implemented for all initially requested privileges and whenever a question arises regarding a practitioner's ability to provide safe, high quality care.

Ongoing Professional Practice Evaluation (OPPE) - A document summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior. The information gathered during this process is factored into decisions to maintain, revise or revoke existing privilege(s) prior to or at the end of the two-year license and privilege renewal cycle.

Peer - An individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner's performance will determine what "practicing in the same profession" means on a case-by-case basis. For quality issues related to general medical care, a physician (MD or DO) may review the care of another physician. For specialty-specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well-trained and competent in that surgical specialty. The degree of subject matter expertise required for a provider to be considered a peer for all peer reviews performed by or on behalf of the hospital will be determined by the Peer Review and Medical Practice Committee unless otherwise designated for special circumstances by the Medical Executive Committee.

Peer Review-The evaluation of an individual practitioner's professional performance by other physicians to identify opportunities to improve care.

Practitioner- For purposes of this Policy, a "practitioner" is defined as an appropriately licensed medical or osteopathic physician, dentist, podiatrist, psychologist, or allied health professional, which is privileged to attend patients at CentraCare Health – Monticello (the "Hospital").

PART B: INITIAL FOCUSED PROFESSIONAL PRACTICE EVALUATION

A. INITIAL FPPE CLINICAL ACTIVITY AND PERFORMANCE REQUIREMENTS

1. ***Development of Requirements***

   The Peer Review and Medical Practice Evaluation Committee will

recommend the clinical activity and performance requirements that will be evaluated to confirm a practitioner's competence for the core privileges and for each special privilege beyond the core that is granted. These requirements will specify the number and types of cases to be reviewed, which may differ based on a practitioner's training and experience, as well as the time frame within which the FPPE is to be completed.

2. ***Mechanism for FPPE Review***

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

   a. retrospective or prospective chart review by internal or external reviewers;

   b. concurrent proctoring or direct observation of procedures or patient care practices;

   c. discussion with other individuals involved in the care of the practitioner's patients; and/or

   d. use of alternative methods of obtaining these requirements from their active place of practice.

B. **REVIEW OF FPPE RESULTS**

1. ***Review by Peer Review and Medical Practice Evaluation Committee***

   The Peer Review and Medical Practice Evaluation Committee after review may make one of the following recommendations to the Medical Executive Committee:

   a. the FPPE process has confirmed competence and no changes to clinical privileges are necessary;

   b. some questions exist and additional review is needed to confirm competence; what additional review is needed, and the time frame for it is specified.

   c. the time period for FPPE should be extended because the individual did not fulfill clinical activity requirements, thus preventing an adequate assessment of the individual's competence. In extenuating circumstances, the time frame for FPPE may extend beyond 24 months after the initial granting of privileges if appropriate patient volumes has not been achieved to perform adequate FPPE. The committee will determine the

length of the FPPE beyond 24 months.

d. there are concerns about the practitioner's competence to exercise some or all of the clinical privileges granted, and a detailed Performance Improvement Plan that would adequately address the Committee's concerns should be implemented, or specific changes that should be made to the practitioner's clinical privileges subject to the procedural rights outlined in the Credentials Policy; or

e. the individual's clinical privileges should be automatically relinquished for failure to meet FPPE clinical activity requirements.

f. 5) Low Volume Practitioners: when the practitioner activity is low or limited at the local level, supplemental data or a letter of good FPPE standing may be requested from another CMS-certified organization where the practitioner holds the same privileges. This supplemental data or letter of good FPPE standing may not be used in lieu of a process to obtain local data but may be used when the process has been exhausted.

2. ***Review by Medical Executive Committee***

At its next regular meeting after receipt of the Peer Review and Medical Practice Evaluation Committee minutes and recommendations the Medical Executive Committee will take one of the following actions:

a. Approve the Peer Review and Medical Practice Evaluation Committee minutes and recommendation(s);

b. Refer the matter back to the Peer Review and Medical Practice Evaluation Committee for further consideration of specific questions; or

c. State its reasons for disagreement with the report and recommendation of the Peer Review and Medical Practice Evaluation 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 Medical Officer for further action consistent with the Credentials Policy.

PART C: ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

A. OPPE DATA TO BE COLLECTED

The Medical Executive Committee will approve the OPPE data to be collected for practitioners. 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 issues that are significant in terms of any of the general competencies will be considered. When possible, the thresholds for data elements will be based on relevant clinical literature.

B. OPPE REPORTS

1. ***Annual Reports***

   An OPPE report for each practitioner will be prepared annually. Quality measurements for OPPE may be used from external sources or internal CentraCare system sources approved by the Peer Review and Medical Practice Evaluation committee. Advanced Practice Providers, participating in ongoing quality monitoring, will not have annual OPPE review. The OPPE reports will be reviewed and approved annually by the Medical Executive Committee.

2. ***Review by the Medical Executive Committee***

   The Medical Executive Committee after review of a practitioners OPPE will make one of the following actions:

   a. the OPPE process has confirmed ongoing competence and no changes to clinical privileges are necessary.

   b. some questions exist and additional review is needed to confirm competence: what additional review is needed, and the time frame for it is specified.

   c. a detailed Performance Improvement Plan that would adequately address the Committee's concerns.

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

The Peer Review and Medical Practice Evaluation Committee may 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 noncompliance with:

1. Medical Staff Rules and Regulations, Medical Staff and/or Hospital policies;
2. Clinical process and outcome measures or other quality indicators required for compliance with regulatory or accreditation requirements, such as CORE measures.

In these situations, the Peer Review and Medical Practice Evaluation Committee will determine the appropriate action.

PART D: FOCUSED PROFESSIONAL PRACTICE EVALUATION TO EVALUATE COMPETENCE (FPPE)

A. TRIGGERS

FPPE may be triggered by any of the following events:

1. ***Triggers***

   May include, but are not limited to the following:

   a. identification by a Medical Staff committee of a clinical trend or specific case(s) that require further review;
   b. patient/resident or representative complaints;
   c. cases identified as litigation risks that are referred;
   d. compliance issues;
   e. sentinel events involving an individual practitioner's professional performance;
   f. OPPE data that reveals a practice pattern or trend that requires further review.
   g. Receipt of credible information suggesting one or more concerns, such as a letter from a licensing board or action by another hospital.
   h. Granting of new privileges to a current practitioner.
   i. Other quality of care issued identified through event reporting.

2. ***Reported Concerns***

   Any patient/resident or representative, practitioner or hospital employee may report concerns related to the safety or quality of care provided.

Concerns may be reported anonymously. Reported concerns will be reviewed through the process outlined in this policy. False reports will be grounds for disciplinary action, may include termination of employment or loss of medical staff membership and/or privileges.

For purposes of the review process outlined in this policy, the substance of reported concerns may be shared with the relevant practitioner, but neither the actual report, nor the identity of the individual who reported the concern, will be provided to the practitioner.

B. **STEP-BY-STEP PROCESS**

The FPPE process is used when a concern is raised via one of the triggers described above. The FPPE process is outlined below:

1. ***General Principles***
    a. The time frames specified in this Section are provided as guidelines but are not mandatory. All participants in the process will use their best efforts to adhere to these guidelines and to complete reviews of cases within the time specified.
    b. At any point in the process outlined below, information or input may be requested from the practitioner whose care is being reviewed, or from any other practitioner or hospital employee with personal knowledge of the matter.
    c. If, at any point in this process, a determination is made that there are no clinical issues or concerns presented in the case that require further review or action, the matter will be closed. A report of this determination and the reasons supporting it will be made to the MEC. If information was sought from a practitioner involved, the practitioner will be notified of the determination.

Peer Review Process

A. Triggers and related documentation will be provided for the Peer Review and Medical Staff Practice Evaluation committee for review.

B. In the event of a questionable trigger, the CMO, Chief of Staff, or Designee will be consulted to determine whether it's appropriate for further evaluation.

C. ***Peer Review and Medical Practice Evaluation Committee:***
    1. The Peer Review and Medical Practice Evaluation Committee may:
        a. determine that no further review or action is required;
        b. determine that the matter is best addressed through another

policy (e.g., Possible Impaired Practitioner Policy, Code of Conduct Policy, or Sentinel Event Policy). If such a determination is made, the committee will refer the case to the appropriate individual or committee for disposition;

c. send an educational letter;

d. conduct a collegial intervention with the practitioner;

e. send a letter of counsel;

f. refer the matter to any practitioner on the Medical Staff who has the appropriate clinical expertise to evaluate the care provided, who will complete an appropriate review form and report their findings back to the Peer Review and Medical Practice Evaluation Committee. If there is no appropriate practitioner available, outside peer review may be obtained.

g. review the information with the attributing provider by a member of the Peer Review and Medical Practice Evaluation Committee or MEC if appropriate.

D. INTERVENTIONS TO ADDRESS IDENTIFIED CONCERNS

This section describes the interventions that may be used by the Peer Review and Medical Practice Evaluation Committee or MEC 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.

In an effort to improve communication and access to information, the Peer Review and Medical Practice Evaluation Committee will record in the minutes any documentation reflecting an intervention. Appropriate documentation may be placed in the practitioner's confidential file, and it 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. ***Educational Letter***

   An educational letter may be sent to a practitioner to address specific situations (e.g., noncompliance with the Medical Staff Rules and Regulations, other policies, clinical protocols or clinical process and outcome measures or other quality indicators required for compliance with regulatory or accreditation requirements). The letter is intended to serve as a reminder to the practitioner of the applicable requirement and

offer assistance to the practitioner in complying with it.

Educational letters may be signed by the Peer Review and Medical Practice Evaluation Committee or the MEC.

2. ***Collegial Intervention***

   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 or a letter of counsel that summarizes the discussion, and when applicable, the expectations regarding the practitioner's future practice in the hospital.

   A collegial intervention may be conducted by the Chief Medical Officer, member or members of the Peer Review and Medical Practice Evaluation Committee or they may facilitate an appropriate and timely collegial intervention by other designees.

3. ***Letter of Counsel***

   A letter of counsel may be sent to the practitioner that describes the opportunities for improvement that were identified in the care or issue reviewed and offer recommendations for future practice. A letter of counsel may be sent by the Peer Review and Medical Practice Evaluation Committee or the MEC. Typically, there will be a collegial intervention prior to, or as part of, sending a letter of counsel.

4. ***Performance Improvement Plan***

   The Peer Review and Medical Practice Evaluation Committee with the MEC may determine that it is necessary to develop a Performance Improvement Plan ("PIP") for the practitioner.

   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 Peer Review and Medical Practice Evaluation Committee, the practitioner will have an opportunity to provide input into the development and implementation of the PIP.

   The PIP will be personally discussed with the practitioner and presented in writing, with a copy being placed in the practitioner's file, along with any

statement he or she would like to offer. The practitioner must agree in writing to constructively participate in the PIP. If the practitioner refuses to do so, the matter will be referred to the Medical Executive Committee for appropriate review and recommendation pursuant to the Credentials Policy.

Until the Peer Review and Medical Practice Evaluation Committee has determined that the practitioner has complied with all elements of the PIP and that concerns about the practitioner's practice have been adequately addressed, the practitioner's progress on the PIP will continue to be monitored and the matter will remain on the Peer Review and Medical Practice Evaluation Committee agenda.

A PIP may include, but is not limited to, the following:

a. ***Additional Education/CME***

   Within a specified period of time, the practitioner must arrange for education or CME of a duration and type specified by the Peer Review and Medical Practice Evaluation Committee.

b. ***Focused Prospective Review***

   A certain number of the practitioner's future cases of a particular type will be subject to a focused review (e.g., review of the next 10 similar cases performed or managed by the practitioner).

c. ***Consultations***

   Before the practitioner proceeds with a particular treatment plan or procedure, he or she must obtain a consultation from a Medical Staff member. The practitioner providing the consultation must complete a Consultation Report for each case, which will be reviewed by the Medical Peer Review and Evaluation Committee.

d. ***Concurrent Proctoring***

   A certain number of the practitioner's future cases of a particular type must be personally proctored. The proctor must be present before the case is started and must remain throughout the duration of the case or must personally assess the patient and be available throughout the course of treatment. A proctor(s) must complete the review form specified by the Peer Review and Medical Practice Evaluation Committee.

e. ***Participation in a Formal Evaluation/Assessment Program***

Within a specified period of time, the practitioner must enroll in an assessment program that is acceptable to the Peer Review and Medical Practice Evaluation Committee.

f. ***Additional Training***

Within a specified period of time, the practitioner must arrange for additional training of a duration and type specified by the Peer Review and Medical Practice Evaluation Committee. The director of the training program or appropriate supervisor must provide an assessment and evaluation of the practitioner's current competence, skill, judgment and technique to the Peer Review and Medical Practice Evaluation Committee.

g. ***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 Medical Peer Review and Evaluation Committee.

h. ***Other***

Elements not specifically listed may be included in a PIP. The Peer Review and Medical Practice Evaluation Committee 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.

For each part of the PIP, the Medical Peer Review and Evaluation Committee will define when the activity must start and when it must be completed. The Medical Peer Review and Evaluation Committee will also approve, in advance, the designated activity/ program and the practitioners or other individuals involved in the activity.

Additionally, as requested, the practitioner must execute a release to allow the Peer Review and Medical Practice Evaluation Committee to communicate information to, and receive information from, the selected program. If necessary, the Peer Review and Medical Practice Evaluation Committee may request

that a practitioner voluntarily refrain from exercising all or some of his or her clinical privileges.

E. PRINCIPLES OF REVIEW AND EVALUATION

1. *Notice to and Input from the Practitioner*

An opportunity for practitioners to provide meaningful input into the review of the care they have provided is an essential element of an educational and effective process.

a. *Notice*

No letter of counsel or PIP will be implemented until the practitioner is first notified of the specific concerns identified and given an opportunity to provide input. The notice to the practitioner will be provided by the Chief Medical Officer or member of the Peer Review and Medical Practice Evaluation Committee as designated by the committee and will include a time frame for the practitioner to provide the requested input.

b. *Input*

The practitioner may provide input through a written description and explanation of the care provided in response to any specific questions posed by the Peer Review and Medical Practice Evaluation Committee and/or by meeting in person with individuals specified in the notice.

c. *Failure to Provide Requested Input or to Attend Meeting*

i. If the practitioner fails to provide input requested by the Peer Review and Medical Practice Evaluation Committee within the time frame specified, the review will proceed without the practitioner's input. Peer Review and Medical Practice Evaluation Committee will note the practitioner's failure to respond to the request for input in the report.

ii. The practitioner's clinical privileges may be considered automatically relinquished until the practitioner provides the requested input or meets as requested. The practitioner will be given at least five days prior written notice of the request for input or the time and place of the meeting and a statement of the issues to be addressed.

d. If the provider refuses to sign the agreement for the PIP, the PIP will still be in place and filed in the practitioner's quality file.

2. ***External Reviews***

   An external review may be appropriate if:

   a. there are ambiguous or conflicting findings by internal reviewers;
   b. the clinical expertise needed to conduct a review is not available on the Medical Staff;
   c. an outside review is advisable to prevent allegations of bias, even if unfounded; or
   d. requested by a practitioner and approved by the Peer Review and Medical Practice Evaluation Committee.

   An external review may be arranged by the Peer Review and Medical Practice Evaluation Committee, in consultation with the 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.

3. ***Findings and Recommendations Supported by Evidence-Based Research/ Clinical Protocols or Guidelines***

   Whenever possible, the findings of reviewers and the Peer Review and Medical Practice Evaluation Committee will be supported by evidence-based research, clinical protocols or guidelines.

4. ***System Process Issues***

   Quality of care and patient safety depend on many factors, in addition to practitioner performance. If system processes or procedures that may have adversely affected, or could adversely affect outcomes or patient safety are identified through the process outlined in this Policy, the issue will be referred to the appropriate department and/or Peer Review and Medical Practice Evaluation Committee.

5. ***Educational Sessions***

   If a specific case is identified as part of the focused professional practice evaluation process that would have educational benefit for part or all members of the medical staff, the Peer Review and Medical Practice Evaluation Committee may direct that the case be presented in an

educational session and that members of the relevant case be invited to attend the session. The particular practitioner(s) who provided care in the case will be informed that the case is to be presented in an educational session at least seven days prior to the session and will be offered the opportunity to present the case. Information identifying the practitioner(s) will be removed prior to the presentation, unless the practitioner(s) requests otherwise. These educational sessions are considered vital to a robust, effective peer review process, and thus confidentiality and all other protections associated with this process shall be maintained.

6. ***Confidentiality***

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

   a. ***Documentation***

      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, 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 be deemed confidential and kept from disclosure or discovery to the fullest extent permitted by Minnesota or federal law.

   b. ***Participants in the PPE Process***

      All individuals involved in the professional practice evaluation process (Medical Staff members and Hospital employees) will maintain the confidentiality of the process. All such individuals will sign an appropriate Confidentiality Agreement.

   c. ***Communications***

      Communications among those participating in the professional practice evaluation process, including communications with the individual practitioner involved, will be conducted in a manner reasonably calculated to assure privacy. Telephone and direct communications will take place at appropriate times and locations, and correspondence will be conspicuously marked with the notation "Confidential, to be Opened Only by Addressee," or words to that effect.

The Medical Staff Leaders may use e-mail communication to discuss and resolve professional practice evaluation issues among and between themselves, but all communication with the practitioner whose care is being reviewed will be done verbally, in writing or electronically. In addition, all such correspondence will be conspicuously marked with the notation "Confidential, to be Opened Only by Addressee" or words to that effect.

7. ***Conflict of Interest Guidelines***

To protect the integrity of the professional practice evaluation process, all those involved must be sensitive to potential conflicts of interest. The following conflict of interest guidelines will be used in determining, whether and how, an individual can participate in the professional practice evaluation process outlined in this Policy.

a. ***Immediate Family Members***

An immediate family member (spouse, parent, child, sibling or in-law) of the practitioner whose care is being reviewed will not participate in any aspect of the review process except to provide information.

b. ***Actual or Potential Conflicts***

With respect to a practitioner whose care is under review as outlined in this Policy, actual or potential conflict situations include, but are not limited to, the following:

i. membership in the same group practice;
ii. having a direct or indirect financial relationship;
iii. being a direct competitor;
iv. close friendship;
v. a history of personal conflict;
vi. personal involvement in the care of a patient which is subject to review;
vii. raising the concern that triggered the review; or
viii. prior participation in review of the matter at a previous level.

c. ***Participation in Review Process***

i. Case Reviewers, Peer Review and Medical Practice Evaluation Committee members and MEC

If a case reviewer, member of the Peer Review and Medical Practice Evaluation Committee or member of the MEC has an actual or potential conflict as outlined in Paragraph (2) above, the nature and severity of the conflict will be considered in determining whether that individual may participate in the review process. The standards to be used are: (1) whether the conflict would prevent the individual from performing his or her assigned role in an unbiased manner; and (2) whether the conflict would be perceived by an observer to create an unfair review process. In evaluating the nature and severity of a conflict, consideration will be given to the fact that the actions of individual case reviewers will be subject to the "check and balance" of oversight by the Medical Peer Review and Evaluation Committee and/or the MEC.

Using the standards outlined above, the Peer Review and Medical Practice Evaluation Committee will evaluate potential conflicts that may occur and determine whether the person with the potential conflict should be excused from review of the matter. If a member of the Peer Review and Medical Practice Evaluation Committee is the individual with the potential conflict, the Chief Medical Officer and/or MEC will make the determination about whether a potential conflict exists and whether the person with the potential conflict should be excused.

If the matter is before the MEC, the Chairperson will evaluate the potential conflict and determine whether a potential conflict exists. Other members of the MEC may offer input about the potential conflict; however, final discretion rests with the Chairperson of the MEC in determining whether a potential conflict exists and whether the person with the potential conflict should be excused from further review of the matter.

If a determination is made that the individual should not

participate in the review, the individual may nonetheless provide information to, and answer questions posed, but will not participate in the deliberation or determination, and will be excused from any meeting during that time. This will be documented in the committee's minutes.

ii. ***Medical Executive Committee Members***

When the Medical Executive Committee is considering a recommendation that could adversely affect the clinical privileges of a practitioner, an individual who has an actual or potential conflict as outlined above may provide information to, and answer questions posed by the committee, but will not participate in the committee's final deliberation or determination, and will be excused from any meeting during that time. This will be documented in the Medical Executive Committee's minutes.

8. ***Legal Protection for Reviewers***

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

REGULATORY CITATIONS

Facility specific, none stated

REFERENCE CITATIONS

Facility specific, none stated

that have access to documents, as CentraCare cannot guarantee the relevance of these documents to external entities.

Approval Signatures

Step Description	Approver	Date
Operating Committee	Karleen Janssen: MONT EXEC ASST TO ADMINISTRATOR EX	02/2023
Medical Executive Committee	Karleen Janssen: MONT EXEC ASST TO ADMINISTRATOR EX	01/2023
Chief Medical Officer	John Hering: CCH PRESIDENT/ CMO CC MONTICELLO EX	12/2022
	John Hering: CCH PRESIDENT/ CMO CC MONTICELLO EX	12/2022