SAINT CLOUD HOSPITAL

PROFESSIONAL PRACTICE EVALUATION POLICY

TABLE OF CONTENTS

PAGE

PAGE

PAGE

PROFESSIONAL PRACTICE EVALUATION POLICY

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

1. 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.

2. The primary objectives of PPE 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 the triggers for focused professional practice evaluation and the data elements for ongoing professional practice evaluation that will facilitate a meaningful review of the care provided;

   (c) effectively, efficiently, and fairly evaluate the care 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.

3. For purposes of this Policy, a "practitioner" is defined as any individual who is a member of the Medical Staff, the Advanced Practice Provider Staff or the Medical Associate Staff at Saint Cloud Hospital (the "Hospital").

4. All practitioners who provide patient care services at the Hospital will participate in a process to confirm that they are competent to exercise the 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.

5. 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 an 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.

6. When concerns are raised about a practitioner's practice, a focused evaluation will be undertaken to evaluate the 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.

7. 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, 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. These efforts are encouraged, but are not mandatory, and will be within the discretion of the Leadership Council, the Department Chairperson, and the Practice Evaluation Committee.

PART B: FOCUSED PROFESSIONAL PRACTICE EVALUATION TO CONFIRM COMPETENCE

1. FPPE-CC CLINICAL ACTIVITY AND PERFORMANCE REQUIREMENTS

A. *Development of Requirements*

Each Department 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-CC is to be completed. The FPPE-CC requirements will be reviewed by the Credentials Committee and adopted 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; and/or

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

2. NOTICE OF FPPE-CC REQUIREMENTS

When notified that a request for privileges has 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*

The relevant Department Chairperson will review the results of a practitioner's FPPE-CC and provide a report to the Credentials Committee. The Department Chairperson's assessment and report will address each of the following:

(1) whether the practitioner fulfilled all FPPE-CC 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 Department Chairperson's assessment and report, and 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, what additional review is needed, and the time frame for it;

(3) the time period for FPPE-CC should be extended because the individual did not fulfill clinical activity requirements, thus preventing an adequate assessment of the individual's competence, but in no event will the time frame for FPPE-CC extend beyond 24 months after the initial granting of privileges;

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

(5) the individual's clinical privileges should be automatically relinquished for failure to meet FPPE-CC 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.

PART C: ONGOING PROFESSIONAL PRACTICE EVALUATION

1. OPPE DATA TO BE COLLECTED

Each Department will determine the OPPE data to be collected for practitioners in that Department 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 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. The OPPE data elements and thresholds for each Department will be approved by the Practice Evaluation Committee.

2. OPPE REPORTS

A. *Semi-Annual Reports*

An OPPE report for each practitioner will be prepared at least every eight months, effective January 1, 2016. A copy will be placed in the practitioner's file and considered in the reappointment process and 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;

(2) the number of cases identified or referred for review and the dispositions of those cases; and

(3) the number of educational letters sent, if any.

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 or concerns are noted, a copy of the report will be provided to the practitioner. 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 other possible concerns, a copy of the report will be provided to the practitioner. The report will indicate that it 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) The Department Chairperson may review the underlying cases that make up the data in a practitioner's OPPE report 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 along with the OPPE report. If the data does reflect a clinical pattern or issue, the Department Chairperson will notify the Medical Staff Office and proceed in accordance with this Policy.

(4) The time-period for OPPE should not be extended beyond eight months after the OPPE process has been initiated;

(5) non-completion of practitioner's OPPE will be sent to PEC for review and findings; if the information is not received within four months, PEC will review and determine next steps.

(6) The individual's clinical privileges will be automatically relinquished for failure to meet OPPE clinical activity requirements. At the eighth month deadline, the practitioner will receive a letter notifying them of automatic relinquishment.

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

The Practice Evaluation Committee ("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 noncompliance with:

(a) Medical Staff Rules and Regulations or other Medical Staff or Hospital policies;

(b) appropriate utilization of 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

(c) clinical process and outcome measures or other quality indicators required for compliance with regulatory or accreditation requirements, such as CORE measures.

In these situations, an educational 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/or in the assessment of the practitioner's competence to exercise the clinical privileges granted.

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

1. TRIGGERS

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*

Any practitioner or Hospital employee may report concerns related to the safety or quality of care provided to a patient. Concerns may be reported anonymously. Reported concerns will be reviewed through the process outlined in this Policy, unless the Leadership Council determines that the concern is not related to an individual practitioner, the report cannot be substantiated, or the report is without merit. False reports will be grounds for disciplinary action, including termination of employment.

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. Retaliation against an individual who reports a quality or patient safety concern will be addressed through the Medical Staff Code of Conduct Policy.

C. *Other 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 of a clinical trend or specific case or cases that require further review;

(2) patient complaints referred by the Patient Representative that require physician review;

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

(4) corporate compliance issues (e.g., medical necessity) referred through the Compliance Officer or otherwise;

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

(6) a Department Chairperson's determination that OPPE data reveal a practice pattern or trend that requires further review.

2. STEP-BY-STEP PROCESS

The FPPE-EC process is used when a concern is raised via one of the triggers described above. The FPPE-EC process is outlined in Appendix A-1 (Detailed Flowchart) and Appendix A-2 (Simplified Flowchart). This Section describes each step in that process.

A. *General Principles*

(1) 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.

(2) 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.

(3) 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 PEC. If information was sought from the practitioner involved, the practitioner will be notified of the determination.

B. *Medical Staff Office*

(1) All cases or issues identified for FPPE-EC via a trigger identified above will be referred to the Medical Staff Office to be logged in. Additionally, the Medical Staff Office, under the direction of the Vice President of Medical Affairs, will conduct a preliminary review and may consider:

(a) the relevant medical record;

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

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

(d) other relevant documentation; and

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

(2) After conducting its review, the Medical Staff Office, under the direction of the Vice President of Medical Affairs, may:

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

(b) send an educational letter; or

(c) determine that further physician review by the Leadership Council or Department Chairperson is required.

(3) The Medical Staff Office may assist in preparing cases that require further physician review. Preparation of a 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 Medical Staff Office will refer cases to the Leadership Council that involve:

(a) serious clinical issues that require expedited review;

(b) practitioners from two or more Departments;

(c) a Department Chairperson;

(d) professional conduct;

(e) a potential practitioner health issue;

(f) a pattern that appears to have developed despite prior attempts at collegial intervention/education; or

(g) a situation in which a performance improvement plan does not seem to have addressed identified concerns.

(5) All other cases will be referred by the Medical Staff Office to the appropriate Department Chairperson.

C. ***Leadership Council***

(1) Following its review, the Leadership Council may:

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

(b) determine that the matter is best addressed through another policy (e.g., the Medical Staff Code of Conduct Policy, Practitioner Health Policy, Corporate Compliance Policy, or Sentinel Event Policy). If the Leadership Council makes such a determination, it will refer the case to the appropriate individual or committee for disposition and will report its referral to the PEC;

(c) send an educational letter;

(d) conduct a collegial intervention with the practitioner;

(e) send a letter of counsel;

(f) refer the matter to the applicable Department Chairperson;

(g) refer the matter to any practitioners on the Medical Staff who have the appropriate clinical expertise to evaluate the care provided, who will complete an appropriate review form and report their findings back to the Leadership Council within 14 days;

(h) refer the matter to the PEC; or

(i) refer the matter to the Medical Executive Committee if the Leadership Council determines that this higher level of review is necessary to appropriately address an issue. The Medical Executive Committee will conduct its review in accordance with the Credentials Policy and may pursue the options set forth in either policy.

(2) The Leadership Council will keep the Department Chairperson informed of any action taken regarding a practitioner in his or her department.

D. ***Department Chairperson***

(1) The Department Chairperson will have overall responsibility for reviewing and evaluating cases referred by the Medical Staff Office or the Leadership Council.

(2) The Department Chairperson may perform the required review. In the alternative, the Department Chairperson may assign the review to one or more practitioners who have the clinical expertise necessary to evaluate the care provided or to a Department Quality Improvement Committee. Any review will be completed within 30 days and will be documented on an appropriate review form.

The review will be returned to the Medical Staff Office. If the review is not completed within 30 days of the referral, the Medical Staff Office will send a reminder. If the review is not complete within ten days of the reminder, the case will be referred to the PEC Chair, who may designate an alternate reviewer.

(3) Following review of the case, the Department Chairperson will take one of the following actions:

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

(b) send an educational letter;

(c) conduct a collegial intervention with the practitioner;

(d) send a letter of counsel; or

(e) refer the matter to or seek guidance from the Leadership Council.

E. ***Practice Evaluation Committee***

(1) The PEC will review reports from the Medical Staff Office, the Leadership Council, and the Department Chairpersons for all cases where it was determined that no further review or action was required or collegial intervention or a letter of counsel 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 Department Chairperson with its questions or concerns and ask that the matter be reconsidered;

(b) ask an individual Medical Staff member, another Medical Staff committee or Hospital 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. 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) assign the review to any practitioner on the Medical Staff with the appropriate clinical expertise;

(b) appoint an ad hoc committee composed of such practitioners; or

(c) in consultation with the Vice President of Medical Affairs, arrange for an external review in accordance with this Policy.

(3) Based on its review, the PEC may:

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

(b) send an educational letter;

(c) conduct a collegial intervention with the practitioner;

(d) send a letter of counsel;

(e) develop a Performance Improvement Plan; or

(f) refer the matter to the Medical Executive Committee if the PEC determines that this higher level of review is necessary to appropriately address an issue. The Medical Executive Committee will conduct its review in accordance with the Credentials Policy and may pursue the options set forth in either policy.

3. INTERVENTIONS TO ADDRESS IDENTIFIED CONCERNS

This section describes the interventions that may be used by the Leadership Council, Department Chairperson 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.

In an effort to improve communication and access to information, the Leadership Council, the relevant Department Chair, and the PEC will receive a copy of any documentation reflecting an intervention. This documentation will also 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.

A. ***Educational Letter***

An educational letter may be sent to a practitioner to address specific situations that are identified by the PEC (e.g., noncompliance with the Medical Staff Rules and Regulations or 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 to offer assistance to the practitioner in complying with it.

Educational letters may be signed by the Leadership Council, the Department Chairperson or the Chair of the PEC.

B. ***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 Department Chairperson, the Leadership Council, or the PEC personally or they may facilitate an appropriate and timely collegial intervention by designees.

C. ***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 offers recommendations for future practice. A letter of counsel may be sent by the Leadership Council, a Department Chairperson, or the PEC. Typically, there will be a collegial intervention prior to or as part of sending a letter of counsel.

D. *Performance Improvement Plan*

The PEC may determine that it is necessary to develop a Performance Improvement Plan ("PIP") for the practitioner. The Department Chairperson will be invited to participate in the development and implementation of a PIP.

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 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 PEC 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 matter will remain on the PEC's agenda and the practitioner's progress on the PIP will be monitored.

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

(1) *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 PEC.

(2) *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).

(3) *Second Opinions/Consultations*

Before the practitioner proceeds with a particular treatment plan or procedure, he or she must obtain a second opinion or consultation from a Medical Staff member. The practitioner providing the second opinion/consultation must complete a Second Opinion/Consultation Report form for each case, which will be reviewed by the PEC.

(4) ***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 PEC.

(5) ***Participation in a Formal Evaluation/Assessment Program***

Within a specified period of time, the practitioner must enroll in an assessment program.

(6) ***Additional Training***

Within a specified period of time, the practitioner must arrange for additional training of a duration and type specified by the PEC. 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 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.

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.

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.

(Additional guidance regarding PIP options and implementation issues is found in Appendix B.)

4. PRINCIPLES OF REVIEW AND EVALUATION

A. *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.

(1) *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 Department Chairperson, Leadership Council or Chairperson of the PEC and will include a time frame for the practitioner to provide the requested input. The practitioner will also be notified when the Department Chairperson or the Leadership Council refers a matter to the PEC.

(2) *Input*

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

(3) *Failure to Provide Requested Input or to Attend Meeting*

(a) If the practitioner fails to provide input requested by the Department Chairperson within the time frame specified, the review will proceed without the practitioner's input. The Department Chairperson will note the practitioner's failure to respond to the request for input in the report to the PEC regarding the review and determination.

(b) If the practitioner fails to provide input requested by or to meet with the Leadership Council or the PEC, 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.

B. ***Incomplete Medical Records***

One of the objectives of this Policy is to review matters and provide feedback to practitioners in a timely manner. Therefore, if a matter referred for review involves a medical record that is incomplete, the Medical Staff Office will inform the PEC Chair, who will notify the practitioner that the case has been referred for evaluation and that the medical record must be completed within 14 days. If the medical record is not completed within 14 days, or sooner as may be directed by the Chairperson of the PEC, the practitioner's clinical privileges may be automatically relinquished until the medical record is completed.

C. ***External Reviews***

An external review may be appropriate if:

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

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

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

(4) requested by a practitioner and approved by the PEC.

An external review may be arranged by the PEC, in consultation with the Vice President of Medical Affairs (or designee). 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.

D. ***Findings and Recommendations Supported by 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.

E. ***System Process Issues***

Quality of care and patient safety depend on many factors in addition to practitioner performance. If system processes or procedures that may have

adversely affected, or could adversely affect, outcomes or patient safety are identified through the process outlined in this Policy, the issue will be referred to the appropriate Hospital department and/or the Medical Staff Office. The referral will be reported to the PEC so that it can monitor the successful resolution of these issues.

F. ***Tracking of Reviews***

The Medical Staff Office will track the processing and disposition of matters reviewed pursuant to this Policy. The Department Chairperson, the Leadership Council, and the PEC will promptly notify the Medical Staff Office of their determinations, interventions and referrals.

G. ***Educational Sessions***

If a specific case is identified as part of the focused professional practice evaluation process that would have educational benefit for all members of a particular Department or for members of several Departments, the relevant Department Chairperson(s), the Leadership Council, or the PEC Chair may direct that the case be presented in an educational session and that members of the relevant Departments 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. Documentation of the educational session will be forwarded to the PEC for its review. 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.

H. ***Confidentiality***

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

(1) ***Documentation***

All documentation that is prepared in accordance with this Policy 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 Minnesota or federal law.

(2) ***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.

(3) ***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 only be via written letter. In addition, all such correspondence will be conspicuously marked with the notation "Confidential, to be Opened Only by Addressee" or words to that effect.

I. ***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.

(1) ***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.

(2) ***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:

(a) membership in the same group practice;

(b) having a direct or indirect financial relationship;

(c) being a direct competitor;

(d) close friendship;

(e) a history of personal conflict;

(f) personal involvement in the care of a patient which is subject to review;

(g) raising the concern that triggered the review; or

(h) prior participation in review of the matter at a previous level.

(3) ***Participation in Review Process***

(a) ***Case Reviewers, Leadership Council and PEC***

If a case reviewer, member of the Leadership Council, or member of the PEC 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 PEC.

Using the standards outlined above, the department chairperson will evaluate potential conflicts that occur at the department level and determine whether the person with the potential conflict should be excused from review of the matter. If the department chairperson is the individual with the potential conflict, the vice chairperson will make the determination about whether a potential conflict exists and whether the person with the potential conflict should be excused. Alternatively, the issue can be referred to the Leadership Council for resolution.

If the matter is before the Leadership Council, the Council as a whole will evaluate the potential conflict, determine whether a potential conflict exists, and determine whether the person with the potential conflict should be excused from further review of the matter.

If the matter is before the PEC, the Chairperson will evaluate the potential conflict and determine whether a potential conflict exists. Other members of the PEC may offer input about the potential conflict; however, final discretion rests with the Chairperson of the PEC 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.

(b) ***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.

J. ***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.

5. PROFESSIONAL PRACTICE EVALUATION REPORTS

A. *Practitioner History Reports*

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

B. *Reports to Medical Executive Committee and Board*

The Medical Staff Office will prepare reports at least quarterly showing the aggregate number of cases reviewed through the FPPE-EC process, the timeliness of the reviews, the dispositions of those matters, and, when applicable, the effect of the process on patient outcomes.

C. *Reports on Request*

The Medical Staff Office will prepare reports as requested by the Leadership Council, Department Chairperson, PEC, Medical Executive Committee, Medical Administration, or the Board.

Adopted by the Medical Executive Committee on July 9, 2013.

Adopted by the Board on July 17, 2013.

Revised: July 1, 2018