MEDICAL CENTER
OF LEWISVILLE

PROFESSIONAL PRACTICE
EVALUATION POLICY

Revised 2011
Horty, Springer & Mattern, P.C.
# PROFESSIONAL PRACTICE EVALUATION POLICY

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PROFESSIONAL PRACTICE EVALUATION POLICY

1. OBJECTIVES, SCOPE, AND STATEMENT OF MUTUAL EXPECTATIONS

1.A Objectives. The primary objectives of Medical Center of Lewisville’s professional practice evaluation process are to:

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

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

   (3) effectively, efficiently, and fairly evaluate the quality, appropriateness, and safety of care provided, comparing it to established patient care protocols, guidelines, and benchmarks whenever possible; and

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

1.B Scope of Policy. This Policy applies to all practitioners who provide patient care services in Medical Center of Lewisville. For purposes of this Policy, a “practitioner” is defined as a member of the Medical Staff or an allied health professional who has been granted clinical privileges.


1.C.1 Expectations for Practitioners. Practitioners are expected to:

   (a) constructively participate in the development, review, and revision of clinical protocols and guidelines pertinent to their clinical specialties, including those related to national patient safety initiatives and core measures;

   (b) comply with adopted protocols and guidelines or document the clinical reasons for variance;

   (c) abide by all responsibilities outlined in the Medical Staff Bylaws, Rules and Regulations, Credentials Policy, and other Medical Staff and Medical Center policies;
(d) constructively participate in identifying the data to be collected, reviewed and analyzed for practitioners in their specialties as part of the ongoing professional practice evaluation;

(e) constructively participate in identifying adverse outcomes, clinical occurrences, or complications in their specialties that will trigger focused professional practice evaluation;

(f) respond appropriately to educational letters and collegial interventions by modifying the behavior or practice that triggered the letter or intervention;

(g) participate constructively and cooperatively in the focused professional evaluation process and in any performance improvement plans that may be developed for the practitioner; and

(h) report, through appropriate channels, any quality of care or patient safety concerns.

1.C.2 *Expectations for Medical Staff Leaders and Medical Center Management.*

Practitioners can expect Medical Staff leaders and Medical Center management to:

(a) devote resources to the research and development of clinically sound protocols, guidelines, and quality measures;

(b) openly communicate with practitioners regarding review of their professional practice within the confines of peer review confidentiality principles;

(c) share credible comparative data and ongoing professional practice evaluation (OPPE) reports on a regular basis;

(d) use collegial, educational methods to address concerns when, in the discretion of the Medical Staff leaders and Medical Center management, such methods are consistent with patient safety and quality patient care;

(e) provide a reasonable opportunity for a practitioner to have input into the review of a particular case or cases and in the development of a performance improvement plan to which he or she will be subject; and
(f) complete the focused professional practice evaluation process in a timely and efficient manner, adhering to the time frames as outlined in this Policy and attempt, as a general guideline, to complete reviews of cases within 60 to 90 days.

2. PROFESSIONAL ACTIVITIES COMMITTEE (PAC)

2.A Composition. The Professional Activities Committee (PAC) shall consist of at least one Past Chief of Staff and five other members of the Medical Staff from the specialties of Medicine/Family Medicine, Surgery, Emergency Medicine, Pediatrics, and OB/GYN. The CEO, the Director of Quality Management, and the Director of Medical Staff Services shall be "ex officio" members of the PAC, without vote. The PAC shall also have the option of calling upon any member of the Medical Staff or other individual with clinical privileges to serve on the Committee on an ad hoc basis to provide clinical review and recommendations to the Committee, their appointment subject to the approval of the Chief of Staff. Any such ad hoc members shall be bound by the same confidentiality requirements as the other members of the PAC and shall be entitled to the same legal protections and indemnification for their activities on the PAC. Ad hoc members shall not have voting rights on the PAC.

2.B Duties. The PAC shall:

(1) oversee the implementation of this Policy;

(2) review and approve specialty-specific data elements for ongoing professional practice evaluation and specialty-specific triggers for focused professional practice evaluation that are identified by each Department;

(3) review and maintain familiarity with patient care protocols and guidelines developed by national organizations;

(4) review and approve patient care protocols or guidelines adopted by Departments and the Quality/Performance Improvement Department;

(5) identify those variances from rules, regulations, policies or protocols which do not require physician review but for which the Quality/Performance Improvement Department may send an educational letter to the practitioner involved in the case (as described in Section 3.B.2);

(6) review cases referred to it as outlined in Paragraph 5.F.2 of this Policy;

(7) develop, when appropriate, performance improvement plans for practitioners;
(8) submit reports of its actions and recommendations to the Medical Executive Committee and Board on a regular basis;

(9) review the effectiveness of this Policy at least yearly and recommend revisions or modifications as may be necessary; and

(10) oversee the Medical Center’s compliance with core measures.

3. **ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)**

3.A **Definition.** OPPE means the ongoing review and analysis of data to identify issues in practitioners’ professional performance.

3.B **OPPE Data Elements.**

3.B.1 **Specialty-Specific Data Elements.** Each Department, in consultation with the Quality/Performance Improvement Department, shall determine the OPPE data to be collected for each practitioner in that Department and, where appropriate and relevant, the threshold for each data element. In determining the data elements to be collected, the available information system capabilities and the type of data that would reasonably be expected to reflect clinically-significant issues for each specialty shall be considered. When possible, the thresholds for data elements shall be based on relevant clinical literature. The OPPE data elements and thresholds for each Department shall be approved by the PAC.

3.B.2 **Non-Compliance with Medical Staff Rules, Regulations and Policies, or Failure to Follow Clinical Protocols/Guidelines.** When cases or situations are identified in which:

(i) a practitioner failed to comply with Medical Staff Rules and Regulations or other Medical Center or Medical Staff policies; or

(ii) an adopted protocol or guideline was not followed and there is no appropriate documentation in the medical record as to the reasons for not following the protocol or guideline,

the Quality/Performance Improvement Department shall prepare an educational letter reminding the practitioner of the applicable requirement and offering assistance to the practitioner in doing so. The letter shall be signed by the Department Chair or the Chair of the PAC, a copy shall be placed in the practitioner’s confidential file, and it shall be considered in the reappointment process and/or in the assessment of the practitioner’s competence to exercise the clinical privileges granted. The number of letters sent shall be included on the OPPE report. If more than two letters
are sent during the six-month period covered by the OPPE report, the matter shall be reviewed as outlined in Section 3.C.2 of this Policy.

3.C  **Review of OPPE Data Elements.**

3.C.1  **Collection of Data.** An OPPE report for each practitioner shall be prepared at least every six months. The report shall be given to the practitioner and a copy 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.

3.C.2  **Data That Do Not Meet Thresholds.** If a practitioner’s OPPE report includes data that do not meet the defined thresholds or that otherwise may indicate a practice pattern that requires further review, the report shall be forwarded to the appropriate Department Chair. The Department Chair may review the underlying cases that make up the data or other relevant information concerning the OPPE report to determine if the data reflects any clinical pattern or issue that requires focused professional practice evaluation. If the Department Chair determines that focused professional practice evaluation is required, the process outlined in Section 5 of this Policy shall be followed.

4.  **FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) TO CONFIRM COMPETENCE (NEW MEMBERS/NEW PRIVILEGES)**

4.A  **Definition.** Focused Professional Practice Evaluation (“FPPE”) is a time-limited period during which the Medical Center evaluates a practitioner’s professional performance.

4.B  **Initially-Granted Privileges.** All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, shall be subject to FPPE. (See Appendix A: Flow Chart of FPPE Process for Initially-Granted Privileges.)

4.C  **Development of FPPE Requirements.** Each Department shall recommend the FPPE requirements needed to confirm the competence of a new Medical Staff member to exercise the core privileges in the specialties represented within the Department and for each “special” privilege outside the “core” in each specialty and how such FPPE is to be documented. The requirements shall specify a time frame for the FPPE to be completed.

FPPE requirements recommended by the Department shall be reviewed by the Credentials Committee and adopted by the Medical Executive Committee. Such requirements may include:

(1) retrospective or prospective chart review by internal or external reviewers;
2. concurrent proctoring or direct observation of procedures or patient care practices; or

3. discussion with other individuals involved in the care of the new member’s patients.

The Credentials Committee and Medical Executive Committee shall consider relevant FPPE requirements when making their recommendations regarding clinical privilege requests and may modify the FPPE requirements if an applicant’s credentials indicate that additional or different FPPE may be required.

4.D  **Notice of FPPE Requirements.** When notified that a request for privileges has been granted, the practitioner shall be informed of the above FPPE clinical activity and performance requirements and of his or her responsibility to cooperate in satisfying the FPPE requirements. In addition, the practitioner shall be informed of the requirement of fulfilling all citizenship requirements, including completion of medical records and/or emergency service call responsibilities.

4.E  **Review of FPPE Results.**

4.E.1  **Review by the Department Chair.** The Department Chair shall review the results of the FPPE and shall report to the Credentials Committee whether the practitioner fulfilled all requirements and his or her assessment as to whether the FPPE confirmed that the practitioner is competent to exercise the clinical privileges granted or if additional FPPE is required to make a determination.

4.E.2  **Review by Credentials Committee.** Based on the Department Chair’s assessment, and its own review of the FPPE results and all other relevant information, the Credentials Committee 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 FPPE is needed to confirm competence, what additional FPPE is needed, and the time frame for it (which may be coordinated by the PAC);

(c) the time period for FPPE should be extended because the individual did not fulfill the FPPE clinical activity requirements, thus preventing an adequate assessment of the individual’s competence, but in no event shall the time frame for FPPE extend beyond 24 months after the initial granting of privileges;
(d) 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 about the individual’s competence, or the changes that should be made to the practitioner’s clinical privileges subject to the procedural rights outlined in the Credentials Policy. In developing such a performance improvement plan, the Credentials Committee may request input or assistance from the PAC; or

(e) the individual’s clinical privileges should be automatically relinquished for failure to meet FPPE clinical activity requirements or other requirements of Medical Staff appointment (e.g., emergency call obligations and medical records completion), subject to the procedural rights outlined in Section 4.F of this Policy.

4.E.3 Review by Medical Executive Committee.

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:

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

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or

(3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee’s recommendation.

(b) If the recommendation of the Medical Executive Committee is either that the FPPE process has confirmed competence or that the FPPE process should be extended to permit further review, the recommendation shall be forwarded to the Board through the Chief Executive Officer.

(c) If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing in accordance with Article 7 of the Credentials Policy, the Medical Executive Committee shall forward its recommendation to the Chief Executive Officer, who shall promptly send special notice to the
applicant. The Chief Executive Officer shall then hold the application until after the applicant has completed or waived a hearing and appeal.

4.F **Hearing Rights for Automatic Relinquishment of Privileges.**

If a determination is made by the Medical Executive Committee that an individual’s clinical privileges shall be considered automatically relinquished as set forth in Section 4.E.2(e), the practitioner shall not be entitled to the hearing and appeal rights outlined in the Credentials Policy or Allied Health Practitioner Policy. Rather, the practitioner shall be entitled to the hearing rights outlined in this section.

4.F.1 **Notice.** The practitioner shall be notified in writing before a report of the automatic relinquishment is made to the Board. The notice shall inform the practitioner of the reasons for the automatic relinquishment and that he/she may request, within 10 days, a meeting with the Department Chair and the Credentials Committee and the CEO (or designee).

4.F.2 **Meeting with Department Chair, Credentials Committee, and CEO.** The individual shall have an opportunity to explain or discuss extenuating circumstances related to the reasons for failing to fulfill the FPPE or other requirements. No counsel may be present at the meeting. Minutes shall be kept.

4.F.3 **Written Report and Recommendation.** At the conclusion of the meeting, the Credentials Committee shall make a written report and recommendation. The report shall include the minutes of the meeting held with the individual. After reviewing the Credentials Committee’s recommendation and report, the Medical Executive Committee may:

(a) adopt the Credentials Committee’s recommendation as its own and forward it to the Board;

(b) send the matter back to the Credentials Committee with specific concerns or questions; or

(c) make a recommendation to the Board that is different than the Credentials Committee’s and outline the specific reasons for its disagreement.

4.F.4 **Final Board Decision.** The decision of the Board shall be final, with no right to hearing or appeal under the Credentials Policy or the Policy on Allied Health Professionals, as applicable.
5. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) WHEN CONCERNS ARE RAISED (PEER REVIEW)

5.A When Concerns Are Raised. The FPPE process shall also be conducted whenever concerns are raised about a practitioner’s clinical practice. (Concerns regarding a practitioner’s professional conduct shall be directed for review in accordance with the Medical Staff Code of Conduct.) The process for FPPE when concerns are raised is outlined in Appendix B-1 (Detailed Flowchart) and Appendix B-2 (Simplified Flowchart). This Section describes each step in that process.

5.B FPPE Triggers.

5.B.1 Specialty-Specific Triggers. Each Department shall identify adverse outcomes, clinical occurrences, or complications that will trigger FPPE. The triggers identified by the Departments shall be approved by the PAC.

5.B.2 Reported Concerns. Any practitioner or Medical Center employee may report concerns related to the safety or quality of care provided to a patient or the professional conduct of a practitioner to the Quality/Performance Improvement Department. Concerns may be reported anonymously. Such reported concerns shall be reviewed as outlined in this Section 5, unless the Quality/Performance Improvement Department determines that the concern is not related to an individual practitioner, the report cannot be substantiated, or the report is without merit.

5.B.3 Other FPPE Triggers. In addition to specialty-specific triggers and reported concerns, other events that may trigger a FPPE include, but are not limited to, the following:

(a) identification by a Medical Staff committee of a clinical trend or specific case or cases that require further review;

(b) patient complaints referred by the Patient Representative that the Quality/Performance Improvement Department determines require physician review;

(c) a Department Chair’s determination that OPPE data reveal a practice pattern or trend that requires further review;

(d) a trend of noncompliance with Medical Staff Rules and Regulations or other policies and/or failure to follow adopted clinical protocols or guidelines resulting in more than two educational letters being sent within a six-month period;
(e) cases identified as litigation risks that are referred by the Risk Management Department for focused professional practice evaluation;

(f) concerns about medical necessity referred from the Medical Center’s Compliance Officer or others; and

(g) sentinel events, as defined in the Sentinel Events Policy, if they involve an individual practitioner’s professional performance.

All matters identified for FPPE shall be referred to the Quality/Performance Improvement Department.

5.C.1 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 FPPE involves a medical record that is incomplete, the Quality/Performance Improvement Department shall notify the practitioner that the case has been referred for evaluation and that the medical record must be completed within 10 days. If the medical record is not completed within 10 days, the practitioner’s Medical Staff appointment and/or clinical privileges will be automatically relinquished until the medical record is completed.

5.C.2 Determination. After conducting its review, the Quality/Performance Improvement Department shall make one of the following determinations:

(a) No Further Review Required. If the Quality/Performance Improvement Department, in consultation with the appropriate Department Chair or PAC Chair, determines that no issue is
presented in the case and no further action or review is required, the matter shall be closed. A report of the cases closed by the Quality/Performance Improvement Department with no further review shall be provided to the PAC on a monthly basis.

(b) **Send an Educational Letter** regarding noncompliance with Medical Staff Rules and regulations, policies or adopted clinical protocols or guidelines, as described in Paragraph 3.B.2 of this Policy.

(c) **Physician Review Required.** If the Quality/Performance Improvement Department determines that a case requires physician review, it shall prepare the case for review. Preparation of the case may include, as appropriate, the following:

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

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

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

(iv) identification of relevant literature.

All prepared cases shall be forwarded to the PAC Chair for determination of the most appropriate procedure for review and evaluation.

5.D **PAC Chair Review.**

5.D.1 **Function of the PAC Chair.** The function of the PAC Chair is to triage cases and expedite the review and evaluation process by determining the most efficient and appropriate review procedure.

5.D.2 **Review and Determination.** The PAC Chair shall review all matters referred by the Quality/Performance Improvement Department, including all supporting documentation assembled. The PAC Chair may obtain any additional information he or she considers relevant, including input from the relevant practitioner, if necessary. Following that review, the PAC Chair shall make one of the following determinations:

(a) **No Further Review or Action Required.** If the PAC Chair determines that no further review or action is required, the matter shall be closed. A report of this determination shall be made to the PAC. If information was sought from the practitioner involved, the practitioner shall be notified of the PAC Chair’s determination.
(b) **Address Through Another Policy.** The PAC Chair may determine that the matter is best addressed through the Medical Staff Code of Conduct, Practitioner Health Policy, Corporate Compliance Policy, Sentinel Event Policy, or other relevant policy. If the PAC Chair makes such a determination, he or she shall refer the case to the appropriate individual or committee for disposition through the alternate policy and shall document the referral for review by the PAC.

(c) **Address Through Educational Letter.** If the PAC Chair determines that no further review or action is required, but the goal of enhancing quality of care and improving patient safety would be advanced by sending an educational letter to the practitioner involved, the PAC Chair shall compose and send the letter personally or shall facilitate having an appropriate letter sent in a timely manner. The letter shall inform the practitioner that a copy of the letter will be included in the practitioner’s file along with any response that he or she would like to offer. A copy of the letter shall be forwarded to the PAC.

(d) **Address Through Collegial Intervention.** If the PAC Chair determines that no further review or action is required, but the goal of enhancing quality of care and improving patient safety would be advanced by a collegial intervention with the practitioner involved, the PAC Chair shall conduct the collegial intervention personally or will facilitate an appropriate and timely collegial intervention. A follow-up letter shall be sent to the practitioner after the collegial intervention summarizing the discussion. A copy of the letter will be included in the practitioner’s file along with any response that he or she would like to offer. A copy of the letter shall also be forwarded to the PAC.

(e) **Further Review Required.** If the PAC Chair determines that further review of the matter is required, the PAC Chair may refer the matter to:

(i) the applicable Department Chair or Chairs;

(ii) other practitioners in the applicable Department(s) who have the appropriate clinical expertise to evaluate the care provided, who shall complete an appropriate review form, if applicable, and report their findings back to the PAC Chair within 30 days;

(iii) the PAC; or
the Medical Executive Committee if a pattern has developed despite prior attempts at collegial intervention or prior participation in a performance improvement plan, or if the matter involves a very serious incident. The Medical Executive Committee shall conduct its review in accordance with the Credentials Policy.

5.E Department Chair Review.

5.E.1 Review. In addition to OPPE clinical trends or patterns that the Department Chair identifies as requiring further review (see Paragraph 3.C above), the Department Chair shall review all matters referred by the PAC Chair. The Department Chair may request additional information or input from the practitioner whose care is being reviewed or from any other practitioner or Medical Center employee with personal knowledge of the matter. Based on this information, the Department Chair shall complete an appropriate review form and submit his or her findings to the Quality/Performance Improvement Department within 30 days of the referral. If the review is not completed within this timeframe, the Quality/Performance Improvement Department shall send a reminder and a request for immediate review to the Department Chair. If the Department Chair fails to complete the review within one week of the reminder, the matter shall be reported to the PAC Chair.

5.E.2 Assignment of Review. The Department Chair may assign the review to another practitioner in the Department who has the clinical expertise necessary to evaluate the care provided. This reviewer shall then complete an appropriate review form, if applicable, and report his or her findings to the Department Chair within 30 days.

5.E.3 Notice to and Input from Practitioner. The Department Chair may request the practitioner to provide input, but is not required to do so. The Department Chair may request the practitioner to discuss the care with the Chair, to provide a written description and explanation of the care, and/or to respond to specific questions posed by the Department Chair. The request shall provide a time frame for such input. If the practitioner fails to provide input within the time frame, the Department Chair shall proceed with the review without input from the practitioner, and shall note the practitioner’s failure in its determination and report to the PAC.

5.E.4 Determination. Following review of the case, the Department Chair shall make one of the following determinations:

(a) No Further Review or Action Required. If the Department Chair determines that no further review or action is required, the case
shall be closed. The Department Chair shall report his or her findings and determination to the PAC and, if input was sought from the relevant practitioner, shall notify the practitioner of his or her findings and determination.

(b) **Address Through Educational Letter.** If the Department Chair determines that no further review or action is required, but the goal of enhancing quality of care and improving patient safety would be advanced by sending an educational letter to the practitioner involved, the Department Chair shall compose and send the letter or shall facilitate having an appropriate letter sent in a timely manner. The letter shall inform the practitioner that a copy of the letter will be included in the practitioner’s file along with any response that he or she would like to offer. A copy of the letter shall also be forwarded to the PAC Chair.

(c) **Address Through Collegial Intervention.** If the Department Chair determines that no further review or action is required, but the goal of enhancing quality of care and improving patient safety would be advanced by a collegial intervention with the practitioner involved, the Department Chair shall conduct that collegial intervention personally or shall facilitate an appropriate and timely collegial intervention. A follow-up letter shall be sent to the practitioner after the collegial intervention summarizing the discussion. A copy of the letter will be included in the practitioner’s file along with any response that he or she would like to offer. A copy of the letter shall also be forwarded to the PAC Chair.

(d) **Further Review Required.** If the Department Chair determines that further review of the matter is required, the Department Chair shall refer the matter to the PAC, including all supporting documentation and the completed review form with his or her findings and recommendations. However, if a pattern has developed despite prior attempts at collegial intervention or prior participation in a performance improvement plan, or if the matter involves a very serious incident, the Department Chair may, in consultation with the Chief of Staff and PAC Chair, instead refer the matter directly to the Medical Executive Committee for its review and appropriate recommendation or action pursuant to the Credentials Policy.

5.F **PAC Review.**

5.F.1 **Review of Prior Determinations.** The PAC shall review reports from the Quality/Performance Improvement Department, the PAC Chair, and the Department Chairs that no further action was required or that collegial
interventions/educational letters were appropriate to address the issues presented.

If the PAC has concerns about any such determination, it may:

(a) send the matter back to the PAC Chair or Department Chair with its questions or concerns and ask that the matter be reconsidered;

(b) refer the matter to an individual Medical Staff member, another Medical Staff committee or Medical Center Department for review; or

(c) review the matter itself.

5.F.2 Cases Referred to the PAC for Further Review.

(a) Preliminary Review. The PAC shall review all other matters referred to it along with all supporting documentation. The PAC may request information from any other practitioner, Medical Center employee, or individual with personal knowledge of the matter.

(b) Additional Clinical Expertise Needed. Based on its preliminary review, the PAC shall determine whether any additional clinical expertise is needed to adequately identify and address concerns raised in the case. If additional clinical expertise is needed, the PAC may assign the review to any practitioner with the appropriate clinical expertise or to an ad hoc committee composed of such practitioners or, in consultation with the Chief Executive Officer, may arrange for an external review.

(c) External Reviews. An external review may be appropriate if:

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

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

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

If a decision is made to seek an external review, the practitioner involved shall be notified of that decision and the nature of the external review.
(d) **Notice to and Input from Involved Practitioner.**

(i) **No Further Review Required.** If, based on its initial review and any additional information obtained, the PAC determines that no further review is required, the matter shall be closed. If input had been sought from the practitioner involved at any time during the review process, or if the practitioner involved had been notified that an external review was being sought, the practitioner shall be notified of the PAC’s final determination.

(ii) **Request for Input.** If, based on its initial review and any additional information obtained, the PAC’s preliminary determination is anything other than a finding that no further review is required, it shall notify the practitioner involved of the PAC’s review and its preliminary findings. The notice shall invite the practitioner to provide input by meeting with some or all of the PAC members and/or by providing a written description and explanation of the care, and responding to any specific questions posed by the PAC. The notice shall provide a time frame for such input. If the practitioner fails to provide input within the time frame specified by the PAC, the PAC shall proceed with the review without input from the practitioner.

5.F.3 **Final Determination.** Based on its review of all information obtained, including any input from the practitioner, the PAC shall determine the appropriate course of action from the following:

(a) **No Further Review or Action Required.** If the PAC determines that no further review or action is required, the matter shall be closed. The PAC shall inform the practitioner involved of its determination.

(b) **Address Through Educational Letter.** If the PAC determines that no further review or action is required, but the goal of enhancing quality of care and improving patient safety would be advanced by sending an educational letter to the practitioner involved, the PAC will compose and send the letter itself or will facilitate having an appropriate letter sent in a timely manner. The letter shall inform the practitioner that a copy of the letter will be included in the practitioner’s file along with any response that he or she would like to offer.

(c) **Address Through Collegial Intervention.** If the PAC determines that no further review or action is required, but the goal of
enhancing quality of care and improving patient safety would be advanced by a collegial intervention with the practitioner involved, it will facilitate an appropriate and timely collegial intervention and document the collegial intervention taken. A follow-up letter shall be sent to the practitioner after the collegial intervention summarizing the discussion. A copy of the letter will be included in the practitioner’s file along with any response that he or she would like to offer.

(d) **Address Through Performance Improvement Plan (“PIP”)**. If the PAC determines that quality care and patient safety could be enhanced and the practitioner’s practice improved through a performance improvement plan, it shall develop such a plan. The performance improvement plan will be presented to the practitioner in person and in writing, and a copy will be placed in the practitioner’s file.

To the extent possible, the performance improvement plan shall be for a defined time period or for a defined number of cases. The plan shall specify how the practitioner’s compliance with, and results of, the performance improvement plan shall be monitored. As deemed appropriate by the PAC, the practitioner shall have an opportunity to provide input into the development and implementation of the performance improvement plan.

Until the PAC has determined that the practitioner has complied with all elements of the performance improvement plan and that concerns about the practitioner’s practice have been adequately addressed, the matter shall remain on the PAC’s agenda and the practitioner’s progress on the PIP shall be monitored.

A performance improvement plan may include, but is not limited to, the following (additional guidance regarding performance improvement plan options and implementation issues is found in Appendix C):

(i) **Additional Education/CME** which means that, within a specified period of time, the practitioner must arrange for education or CME of a duration and type specified by the PAC. The educational activity/program may be chosen by the PAC or by the practitioner. If the activity/program is chosen by the practitioner, it must be approved by the PAC. If necessary, the practitioner may be asked to voluntarily refrain from exercising all or some of his/her clinical privileges or may be granted an educational leave of absence while undertaking such additional education.
(ii) **Focused Prospective Review** which means that a certain number of the practitioner’s future cases of a particular type will be reviewed (e.g., review of the next 10 similar cases performed or managed by the practitioner).

(iii) **Second Opinions/Consultations** which means that before the practitioner proceeds with a particular treatment plan or procedure, he/she must obtain a second opinion or consultation from a Medical Staff member(s) specified by the PAC. The practitioner providing the second opinion/consultation must complete a Second Opinion/Consultation Report form for each case, which shall be reviewed by the PAC.

(iv) **Concurrent Proctoring** which means that a certain number of the practitioner’s future cases of a particular type (e.g., the practitioner’s next five vascular cases) must be personally proctored by a Medical Staff member(s) approved by the PAC or by an appropriately credentialed individual from outside of the Medical Staff approved by the PAC. 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. The Medical Staff member(s) who acts as proctor(s) must complete the appropriate review form, which shall be reviewed by the PAC.

(v) **Participation in a Formal Evaluation/Assessment Program** which means that, within a specified period of time, the practitioner must enroll in an assessment program identified by the PAC and must then complete the program within another specified time period. The practitioner must execute a release to allow the PAC to communicate information to, and receive information from, the selected program. If necessary, the practitioner may be asked to voluntarily refrain from exercising all or some of his/her clinical privileges or may be granted an educational leave of absence while undertaking such formal assessment.

(vi) **Additional Training** which means that, within a specified period of time, the practitioner must arrange for additional training of a duration and type specified by the PAC. The training program must be approved by the PAC. The practitioner must execute a release to allow the PAC to
communicate information to, and receive information from, the selected program. The practitioner must successfully complete the training within another specified period of time. The director of the training program or appropriate supervisor must provide an assessment and evaluation of the practitioner’s current competence, skill, judgment and technique to the PAC. If necessary, the practitioner may be asked to voluntarily refrain from exercising all or some of his/her clinical privileges or may be granted an educational leave of absence while undertaking such additional training.

(vii) Educational Leave of Absence which means that 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 PAC.

(e) Refusal of Performance Improvement Plan. The practitioner must agree in writing to constructively participate in the performance improvement plan that is developed by the PAC. If the practitioner involved in the case refuses to participate in the performance improvement plan that is developed by the PAC, the matter shall be referred to the Medical Executive Committee for appropriate review and recommendation under the Credentials Policy.

(f) Refer to the Medical Executive Committee. If the PAC determines that an educational letter, collegial intervention or a performance improvement plan may not be adequate to address the issues identified, or if a pattern has developed despite prior attempts at collegial intervention or prior participation in a performance improvement plan, the PAC shall refer the matter to the Medical Executive Committee for appropriate review under the Credentials Policy.

6. PRINCIPLES OF REVIEW AND EVALUATION

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

6.A.1 Documentation. All documentation that is prepared in accordance with this Policy shall be maintained in appropriate Medical Staff files. This documentation shall be accessible to 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 shall otherwise be deemed confidential
and kept from disclosure or discovery to the fullest extent permitted by Texas or federal law.

6.A.2 Participants in the PPE Process. All individuals involved in the professional practice evaluation process (Medical Staff and Medical Center employees) will maintain the confidentiality of the process. All such individuals shall sign an appropriate Confidentiality Agreement.

6.A.3 PPE Communications. Communications among those participating in the professional practice evaluation process, including communications with the individual practitioner involved, shall be conducted in a manner reasonably calculated to assure privacy. Telephone and direct communications shall take place at appropriate times and locations, and correspondence shall be conspicuously marked with the notation “Confidential, to be Opened Only by Addressee” or words to that effect.

6.B. Conflict of Interest Guidelines. To protect the integrity of the review process, all those involved must be sensitive to potential conflicts of interest. It is also important to recognize that effective peer review involves “peers” and that the PAC does not make any recommendation that would adversely affect the clinical privileges of a practitioner (which is only within the authority of the Medical Executive Committee). As such, the conflict of interest guidelines outlined in Article 8 of the Credentials Policy shall be used in assessing and resolving any potential conflicts of interest that may arise under this Policy.

Additional guidance pertaining to conflicts of interest principles can be found in Appendix D.

6.C Protection for Reviewers. It is the intention of the Medical Center 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 Texas law. In addition to the protections offered to individuals involved in professional review activities under those laws, such individuals shall be covered under the Medical Center’s Directors’ and Officers’ Liability insurance and/or will be indemnified by the Medical Center when they act within the scope of their duties as outlined in this Policy and function on behalf of the Medical Center.

6.D Collegial Efforts and Progressive Steps. This Policy encourages the use of collegial efforts and progressive steps to address issues that may be identified in the professional practice evaluation process. The goal of those efforts is to arrive at voluntary, responsive actions by the practitioner. Collegial efforts and progressive steps may include, but are not limited to, counseling, informal discussions, education, mentoring, letters of counsel or guidance, sharing of comparative data, and performance improvement plans as outlined in this Policy.
All collegial efforts and progressive steps are part of the Medical Center’s confidential performance improvement, OPPE, FPPE, and peer review activities. These efforts are encouraged, but are not mandatory, and shall be within the discretion of the PAC Chair, the Department Chair, and the PAC.

6.E **Findings and Recommendations Supported by Evidence-Based Research/Clinical Protocols or Guidelines.** Whenever possible, the findings of assigned reviewers and the PAC shall be supported by evidence-based research, clinical protocols or guidelines.

6.F **System Process Issues.** Quality of care and patient safety depend on many factors in addition to practitioner performance. If, during OPPE or FPPE, system processes or procedures that may have adversely affected, or could adversely affect, outcomes or patient safety are identified, the issue shall be referred to the appropriate Medical Center Department and/or the Quality/Performance Improvement Department. The shall also be reported to the PAC so that the PAC can monitor the successful resolution of these issues.

6.G **Tracking of Reviews.** The Quality/Performance Improvement Department shall track the processing and disposition of focused professional practice evaluations conducted pursuant to this Policy. The PAC Chair, Department Chair, and PAC shall promptly notify the Quality/Performance Improvement Department of their determinations and dispositions. The number of cases identified or referred for review and the dispositions of those cases shall be included on each practitioner’s OPPE report.

6.H **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 Chair(s), the PAC Chair, or the PAC 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 shall be informed that the case is to be presented in an educational session at least 10 days prior to the session. Information identifying the practitioner(s) shall be removed prior to the presentation, unless the practitioner(s) request otherwise. Documentation of the educational session shall be forwarded to the PAC for its review.

7. **PROFESSIONAL PRACTICE EVALUATION REPORTS**

7.A **Ongoing Professional Practice Evaluation Reports.** An ongoing professional practice evaluation report shall be generated for each practitioner as described in Section 3.

7.B **Practitioner FPPE History Reports.** A practitioner history report showing all cases that have been reviewed for a particular practitioner within the past 2 years
and their dispositions shall be generated for each practitioner for consideration and evaluation by Department Chair and the Credentials Committee in the reappointment process.

7.C **Reports to Medical Executive Committee and Board.** The Quality/Performance Improvement Department shall prepare reports at least biannually showing the aggregate number of cases reviewed through the FPPE process, the timeliness of the reviews, the dispositions of those matters, and, when applicable, the effect of the process on patient outcomes.

7.D **Reports on Request.** The Quality/Performance Improvement Department shall prepare reports as requested by the PAC Chair, Department Chair, PAC, Medical Executive Committee, Medical Center management, or the Board.

Adopted by the Medical Executive Committee on May 10, 2011.

Adopted by the Board of Trustees on May 24, 2011.
Appendix A: Flowchart of FPPE Process for Initially Granted Privileges (Section 4 of Policy)

**FPPE requirements**
(recommended by Departments, reviewed by Credentials Committee and adopted by MEC)

FPPE may include:
- chart review by internal or external reviewers;
- concurrent proctoring; or
- discussion with other individuals involved in the care of the practitioner’s patients

**Results of FPPE**

- Did practitioner fulfill all requirements?
- Did FPPE confirm competence?
- Is additional FPPE required?

**Department Chair**

- May request input or assistance

**Professional Activities Committee (PAC)**

- Input or assistance

**Credentials Committee**

- Assessment

**MEC**

- Adopt findings/recommendation of Credentials Committee
- Refer matter back to Credentials Committee for further consideration
- State reasons in its report/recommendation for disagreement with Credentials Committee’s recommendation

- FPPE confirms competence
- Questions exist/additional FPPE needed
- Extend time period for FPPE due to insufficient activity
- Concerns exist/develop PIP or change privileges
- Automatic relinquishment of privilege due to insufficient activity

**Chief of Staff**

- Notice of right to hearing under Credentials Policy

**CEO**

- Notice of right to hearing under Section 4F of PPE Policy

**Practitioner**

- Notice of right to hearing under Credentials Policy
Quality/Performance Improvement

1. Log in referral
2. Initial review & case preparation
3. Dispositions
   A. No issue (in consultation with relevant Department Chair and PAC Chair) — report finding to PAC
   B. Send educational letter — no immediate physician review necessary
   C. Physician review required - PAC Chair
      1. Obtain additional information, including input from practitioner, if needed
      2. Assign to colleague or conduct review personally, completing appropriate review form
      3. Dispositions
         i. No further review or action required
         ii. Report to PAC
   D. Further review required
      i. Refer to PAC
      ii. Refer to MEC (in consultation with Chief of Staff and Chair of PAC) — critical mass, serious incident, or practitioner’s failure to follow conditions of PIP

Compliance issues (e.g., medical necessity)

Reported concerns from a practitioner or Medical Center employee or Medical Staff Committee

Patient complaints referred by Patient Representative

OPPE** data outliers

Multi-Specialty Professional Activities Committee (PAC)

1. Review determinations from prior levels of review
2. Obtain additional clinical expertise from any practitioner(s) on Medical Staff or external reviewer, if needed
3. Notify practitioner of any preliminary issues/concerns and request input prior to final disposition
4. Final dispositions
   A. No further review or action required, notify practitioner
   B. Educational letter
   C. Collegial intervention — cc of follow-up letter to PAC
   D. Further review required
      i. Refer to PAC
      ii. Refer to MEC – critical mass, serious incident, or practitioner’s failure to follow conditions of PIP

Appendix B-1: Detailed Professional Practice Evaluation Process Flow Chart (Section 5 of Policy)

Possible system issues identified at ANY LEVEL shall be referred to the appropriate Medical Center department.

Any Department Chair, the PAC Chair, or the PAC may direct that a case be presented in an Educational Session.

*FPPE = Focused Professional Practice Evaluation  **OPPE = Ongoing Professional Practice Evaluation
Medical Center of Lewisville
Appendix B-2: Simplified Professional Practice Evaluation Process Flow Chart (Section 5 of Policy)

Events Triggering Review
- Specialty-specific FPPE* indicators
- Reported concerns from a practitioner, Hospital employee or Medical Staff committee
- Patient complaints referred by Patient Representative
- OPPE** data outliers
- Litigation risks
- Compliance issues (e.g., medical necessity)
- Sentinel events
- More than 2 educational letters regarding noncompliance with Rules and Regulations or Clinical Protocols/Guidelines

Possible system issues identified at ANY LEVEL shall be referred to the appropriate Medical Center department.

Any Department Chair, the PAC Chair, or the PAC may direct that a case be presented in an Educational Session.

*FPPE = Focused Professional Practice Evaluation
**OPPE = Ongoing Professional Practice Evaluation
APPENDIX C

PERFORMANCE IMPROVEMENT PLAN OPTIONS
(\textit{May Be Used Individually or in Combination})

IMPLEMENTATION ISSUES CHECKLIST
(\textit{For Use by the PAC})

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<td>Educational Leave of Absence</td>
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<td>“Other”</td>
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<tr>
<td><strong>PIP OPTION</strong></td>
<td><strong>IMPLEMENTATION ISSUES</strong></td>
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<tr>
<td><strong>Additional Education/CME</strong></td>
<td><strong>Scope of Requirement</strong></td>
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<tr>
<td><strong>Wide range of options</strong></td>
<td>☐ Be specific – what type?</td>
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<td>☐ Acceptable programs include:</td>
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<td></td>
<td>☐ PAC approval required before practitioner enrolls</td>
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<td>☐ Program approved: ________________________________</td>
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<td>☐ Date of approval: ________________________________</td>
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<td>☐ Time frames</td>
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<td>☐ Practitioner must enroll by: ______________________</td>
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<td>☐ CME must be completed by: _________________________</td>
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<td>☐ Who pays for the CME/course?</td>
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<td>☐ Practitioner subject to PIP</td>
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<td>☐ Medical Staff</td>
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<td>☐ Hospital</td>
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<td>☐ Combination: ________________________________</td>
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<td>☐ Documentation of completion must be submitted to PAC</td>
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<td>☐ Date submitted: ________________________________</td>
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<td><strong>Additional Safeguards</strong></td>
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<td>☐ Must individual voluntarily refrain from exercising relevant clinical privileges until completion of additional education? ☐ Yes ☐ No</td>
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<td><strong>Follow-Up</strong></td>
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<td>☐ After CME has been completed, how will monitoring be done to be sure that concerns have been addressed/practice has improved? (Focused prospective monitoring? Proctoring?)</td>
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<td><strong>PIP OPTION</strong></td>
<td><strong>IMPLEMENTATION ISSUES</strong></td>
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<tr>
<td>Prospective Monitoring</td>
<td>Scope of Requirement</td>
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<tr>
<td>100% focused review of next X cases (e.g., obstetrical cases, laparoscopic surgery)</td>
<td>How many cases are subject to review? __________________________</td>
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<td></td>
<td>What types of cases are subject to review? __________________________</td>
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<td></td>
<td>Based on practitioner’s practice patterns, estimated time for completion of monitoring? __________________________</td>
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</table>
| | Does monitoring include more than review of medical record?  
| | ❑ Yes ❑ No  If yes, what else does it include? __________________________ |
| | Review to be done:  
| | ❑ Post-discharge  
| | ❑ During admission  
| | Review to be done by:  
| | ❑ Quality Department  
| | ❑ Department Chair  
| | ❑ CMO  
| | ❑ Other: __________________________ |
| | Must practitioner notify reviewer of cases subject to requirement?  
| | ❑ Yes ❑ No  Other options? __________________________ |
| | Documentation of review  
| | ❑ General Case Review Worksheet  
| | ❑ Surgical Review Worksheet  
| | ❑ Medical Review Worksheet  
| | ❑ Obstetrical Review Worksheet  
| | ❑ Specific form developed for this review  
| | ❑ General summary by reviewer  
| | ❑ Other: __________________________ |
| | Results of Monitoring  
| | Who will review results of monitoring with practitioner?  
| | ❑ After each case  
| | ❑ After total # of cases subject to review
<table>
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<tr>
<th>PIP OPTION</th>
<th>IMPLEMENTATION ISSUES</th>
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<tbody>
<tr>
<td><strong>Second Opinions/Consultations</strong></td>
<td><strong>Scope of Requirement</strong></td>
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</table>
| **Before the practitioner proceeds with a particular treatment plan or procedure, he/she obtains a second opinion or consultation.** | - How many cases subject to second opinion/consultation requirement?  
|  |  
|  | - What types of cases are subject to second opinion/consultation requirement?  
|  |  
|  | - Based on practice patterns, estimated time for completion of second opinion/consultation requirement?  
|  |  
|  | - Must consultant evaluate patient in person prior to treatment/procedure?  
|  |  
|  | | ❑ Yes  ❑ No  
| **Responsibilities of Practitioner** |  
| | - Notify consultant when patient subject to requirement is admitted or procedure is scheduled and all information necessary to provide consultation is available in the medical record (H&P, results of diagnostic tests, etc.).  
|  |  
|  | - What time frame for notice to consultant is practical and reasonable? (e.g., two days prior to scheduled, elective procedure)  
|  |  
|  | - If consultant must evaluate patient prior to treatment, inform patient that consultant will be reviewing medical record and will examine patient.  
|  |  
|  | - If consultant must evaluate patient prior to treatment, include general progress note in medical record noting that consultant examined patient and discussed findings with practitioner.  
|  |  
|  | - Discuss proposed treatment/procedure with consultant.  
|
### PIP Option

**Second Opinions/Consultations**

*Before the practitioner proceeds with a particular treatment plan or procedure, he/she obtains a second opinion or consultation.*

*(This is not a “restriction” of privileges that triggers a hearing and reporting, if implemented correctly.)*

### Implementation Issues

**Qualifications of Consultant**
- Consultant must have clinical privileges in _____________.
- Possible candidates include: ____________________________
  ____________________________________________________
  ____________________________________________________
- The following individuals agreed to act as consultants and were approved by the PAC (or designees) on __________________________: (date)
  ____________________________________________________
  ____________________________________________________
  ____________________________________________________

**Responsibilities of Consultant** *(Information provided by PAC; include discussion of legal protections for consultant.)*
- Review medical record prior to treatment or procedure.
  ____________________________________________________
- Evaluate patient prior to treatment or procedure, if applicable.
  ____________________________________________________
- Discuss proposed treatment/procedure with physician.
  ____________________________________________________
- Complete Second Opinion/Consultation Form and submit to Quality Department *(not for inclusion in the medical record).*
  ____________________________________________________

**Disagreement Regarding Proposed Treatment/Procedure**
If consultant and physician disagree regarding proposed treatment/procedure, consultant notifies one of the following so that an immediate meeting can be scheduled to resolve the disagreement:
- CMO
- President of the Medical Staff
- PAC Chair
- Department Chair
- Other: ____________________________________________
  ____________________________________________________
<table>
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<tr>
<th><strong>Second Opinions/Consultations</strong></th>
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<tr>
<td><strong>Before the practitioner proceeds with a particular treatment plan or procedure, he/she obtains a second opinion or consultation.</strong></td>
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<td><em>(This is not a “restriction” of privileges that triggers a hearing and reporting, if implemented correctly.)</em></td>
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<tr>
<th><strong>Compensation for Consultant</strong> <em>(consultant cannot bill for consultation)</em></th>
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<tbody>
<tr>
<td>☐ No compensation</td>
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<td>☐ Compensation by:</td>
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<tr>
<td>☐ Practitioner subject to PIP</td>
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<td>☐ Medical Staff</td>
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<td>☐ Hospital</td>
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<td>☐ Combination</td>
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<tr>
<th><strong>Results of Second Opinion/Consultations</strong></th>
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<tr>
<td>☐ Who will review results of second opinion/consultations with practitioner?</td>
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<tr>
<td>☐ After each case</td>
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<tr>
<td>☐ After total # of cases subject to review</td>
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<tr>
<td>☐ Include consultants’ reports in practitioner’s quality file</td>
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<tr>
<th><strong>Additional Safeguards</strong></th>
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<tbody>
<tr>
<td>☐ Will practitioner be removed from some/all on-call responsibilities until second opinion/consultation requirement is completed? ☐ Yes ☐ No</td>
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<tr>
<td><strong>PIP OPTION</strong></td>
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<tr>
<td><strong>Concurrent Proctoring</strong></td>
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<tr>
<td><em>A certain number of the practitioner’s future cases of a particular type (e.g., vascular cases, management of diabetic patients) must be directly observed.</em></td>
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<td><em>(This is not a “restriction” of privileges that triggers a hearing and reporting, if implemented correctly.)</em></td>
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## Concurrent Proctoring

A certain number of the practitioner’s future cases of a particular type (e.g., vascular cases, management of diabetic patients) must be directly observed.

This is not a “restriction” of privileges that triggers a hearing and reporting, if implemented correctly.

### Qualifications of Proctor (PAC must approve)
- Proctor must have clinical privileges in ________________________.
  (If proctor is not member of Medical Staff, credential and grant temporary privileges.)
- Possible candidates include: ________________________________
- _________________________________________________________
- _________________________________________________________
- The following individuals agreed to act as proctors and were approved by the PAC (or designees) on _________________________:
  ________________________________
  ________________________________
  ________________________________

### Responsibilities of Proctor (information provided by PAC; include discussion of legal protections for proctor)
- Review medical record and:
  - **Procedure**: Be present at start of case and remain throughout procedure and be available post-op if complications arise.
  - **Medical**: Be available during course of treatment to discuss treatment plan, orders, lab results, discharge planning, etc., and personally assess patient, if necessary.

- Intervene in care, if necessary to protect patient and document such intervention appropriately in medical record.

- Discuss treatment plan/procedure with practitioner.

- Document review as indicated below and submit to Quality Department.

### Documentation of review (not for inclusion in the medical record)
- General Case Review Worksheet
- Surgical Review Worksheet
- Medical Review Worksheet
- Obstetrical Review Worksheet
- Specific form developed for this PIP
- Other: ______________________________________________________
### PIP OPTION

**Concurrent Proctoring**

A certain number of the practitioner’s future cases of a particular type (e.g., vascular cases; management of diabetic patients) must be directly observed.

This is not a “restriction” of privileges that triggers a hearing and reporting, if implemented correctly.

### IMPLEMENTATION ISSUES

**Compensation for Proctor** (proctor cannot bill for review of medical record or assessment of patient and cannot act as first assistant)

- No compensation
- Compensation by:
  - Practitioner subject to PIP
  - Medical Staff
  - Hospital
  - Combination

**Results of Proctoring**

- Who will review results of proctoring with practitioner?
  - After each case
  - After total # of cases subject to review
  - Include proctor reports in practitioner’s quality file

**Additional Safeguards**

- Will practitioner be removed from some/all on-call responsibilities until proctoring is completed?  Yes  No
<table>
<thead>
<tr>
<th><strong>PIP OPTION</strong></th>
<th><strong>IMPLEMENTATION ISSUES</strong></th>
</tr>
</thead>
</table>
| **Formal Evaluation/Assessment Program** | **Scope of Requirement**<br>☑ Acceptable programs include:  

| **Onsite multiple-day programs that may include formal testing, simulated patient encounters, chart review.** | ☐ PAC approval required before practitioner enrolls  
☐ Program approved: ____________________________  
☐ Date of approval: ____________________________ |
| | ☐ Who pays for the evaluation/assessment?  
☐ Practitioner subject to PIP  
☐ Medical Staff  
☐ Hospital  
☐ Combination: ____________________________ |
| | **Practitioner’s Responsibilities**<br>☑ Sign release allowing PAC to provide information to program (if necessary) and program to provide report of assessment and evaluation to PAC.  

| | ☐ Enroll in program by: ____________________________  
☐ Complete program by: ____________________________ |
| | **Addional Safeguards**<br>☑ Must individual agree to voluntarily refrain from exercising relevant clinical privileges until completion of evaluation/assessment program?  
☐ Yes ☐ No  

| | ☐ Will practitioner be removed from some/all on-call responsibilities until completion of evaluation/assessment program?  
☐ Yes ☐ No  

| | **Follow-Up**<br>☑ Based on results of assessment, what additional interventions are necessary, if any?  

| | ☐ How will monitoring after assessment program(any additional interventions be conducted to be sure that concerns have been addressed/practice has improved? (Focused prospective review? Proctoring?)  

| | **Onsite multiple-day programs that may include formal testing, simulated patient encounters, chart review.**<br>☑ Acceptable programs include:  

| | ☐ PAC approval required before practitioner enrolls  
☐ Program approved: ____________________________  
☐ Date of approval: ____________________________ |
| | ☐ Who pays for the evaluation/assessment?  
☐ Practitioner subject to PIP  
☐ Medical Staff  
☐ Hospital  
☐ Combination: ____________________________ |
<table>
<thead>
<tr>
<th><strong>PIP OPTION</strong></th>
<th><strong>IMPLEMENTATION ISSUES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Additional Training</strong></td>
<td><strong>Scope of Requirement</strong></td>
</tr>
<tr>
<td></td>
<td>☐ Be specific – what type?</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Acceptable programs include:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ PAC approval required before practitioner enrolls</td>
</tr>
<tr>
<td></td>
<td>☐ Program approved:</td>
</tr>
<tr>
<td></td>
<td>☐ Date of approval:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Who pays for the training?</td>
</tr>
<tr>
<td></td>
<td>☐ Practitioner subject to PIP</td>
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<td></td>
<td>☐ Medical Staff</td>
</tr>
<tr>
<td></td>
<td>☐ Hospital</td>
</tr>
<tr>
<td></td>
<td>☐ Combination:</td>
</tr>
<tr>
<td></td>
<td><strong>Practitioner’s Responsibilities</strong></td>
</tr>
<tr>
<td></td>
<td>☐ Sign release allowing PAC to provide information to training program (if necessary) and program to provide detailed evaluation/assessment to PAC before resuming practice.</td>
</tr>
<tr>
<td></td>
<td>☐ Enroll in program by:</td>
</tr>
<tr>
<td></td>
<td>☐ Complete program by:</td>
</tr>
<tr>
<td></td>
<td><strong>Additional Safeguards</strong></td>
</tr>
<tr>
<td></td>
<td>☐ Must individual agree to voluntarily refrain from exercising relevant clinical privileges until completion of additional training?</td>
</tr>
<tr>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Will practitioner be removed from some/all on-call responsibilities until completion of additional training?</td>
</tr>
<tr>
<td></td>
<td>☐ Yes ☐ No</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Is LOA required? ☐ Yes ☐ No</td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td><strong>Follow-Up</strong></td>
</tr>
<tr>
<td></td>
<td>☐ After additional training is completed, how will monitoring be conducted to be sure that concerns have been addressed/practice has improved? (Focused prospective review? Proctoring?)</td>
</tr>
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<td></td>
</tr>
</tbody>
</table>
## Educational Leave of Absence

<table>
<thead>
<tr>
<th>PIP OPTION</th>
<th>IMPLEMENTATION ISSUES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Who may grant the LOA? <em>(Review Bylaws or applicable Policy)</em></td>
</tr>
<tr>
<td></td>
<td>Specify conditions for reinstatement:</td>
</tr>
<tr>
<td></td>
<td>What happens if the practitioner agrees to LOA but …</td>
</tr>
<tr>
<td></td>
<td>- does not return to practice at the hospital? Will this be considered resignation in return for not conducting an investigation and thus be reportable?</td>
</tr>
<tr>
<td></td>
<td>- Yes  No</td>
</tr>
<tr>
<td></td>
<td>- moves practice across town? Must practitioner notify other hospital of educational leave of absence?</td>
</tr>
<tr>
<td></td>
<td>- Yes  No</td>
</tr>
</tbody>
</table>
### “Other”

Wide latitude to utilize other ideas as part of PIP, tailored to specific concerns.

**Examples:**

- Participate in an educational session at section or department meeting and assess colleagues' approach to case.
- Study issue and present grand rounds.
- Design and use informed consent forms approved by PAC.
- Design and use indication forms approved by PAC.
- Limit inpatient census.
- Limit number of procedures in any one day/block schedule.
- No elective procedures to be performed after ___ p.m.
- All patient rounds done by certain time of day – timely orders, tests, length of stay concerns.
- Personally see each patient prior to procedure (rather than using PA, NP, or APRN).
- Personally round on patients – cannot rely solely on PA, NP, or APRN.
- Utilize individuals from other specialties to assist in PIPs (e.g., cardiologist experiencing difficulties with TEE technical complications mentored by anesthesiologists).
## APPENDIX D

### CONFLICT OF INTEREST GUIDELINES

#### Levels of Participation

<table>
<thead>
<tr>
<th>Potential Conflicts</th>
<th>Provide Information</th>
<th>Individual Reviewer Application/ Case</th>
<th>Committee Member</th>
<th>Medical Executive Committee</th>
<th>Ad Hoc Investigating</th>
<th>Hearing Panel Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family member</td>
<td>Y</td>
<td>N</td>
<td>R</td>
<td>R</td>
<td>R</td>
<td>N</td>
</tr>
<tr>
<td>Employment relationship with hospital</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Partner</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>R</td>
<td>N</td>
</tr>
<tr>
<td>Direct or indirect financial impact</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>R</td>
<td>N</td>
</tr>
<tr>
<td>Competitor</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>R</td>
<td>N</td>
</tr>
<tr>
<td>History of conflict</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>R</td>
<td>N</td>
</tr>
<tr>
<td>Close friends</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>R</td>
<td>N</td>
</tr>
<tr>
<td>Personally involved in care of patient</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>R</td>
<td>N</td>
</tr>
<tr>
<td>Reviewed at prior level</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>R</td>
<td>N</td>
</tr>
<tr>
<td>Raised the concern</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>R</td>
<td>N</td>
</tr>
</tbody>
</table>
APPENDIX D

CONFLICT OF INTEREST GUIDELINES (cont’d)

Individual Reviewer Safeguards (Credentialing)
- Objective threshold criteria for appointment/privileges
- Objective review/evaluation form
- All questions/concerns referred to Credentials Committee
- Credentials Committee/MEC check and balance

Individual Reviewer Safeguards (Focused Professional Practice Evaluation) (Peer Review)
- Objective review/evaluation forms
- Objective criteria to review against
- PAC check and balance

Credentials Committee/PAC Member Safeguards
- MEC check and balance
- Credentials/PAC Chair always has discretion to recuse member in particular situation subject to the rules of recusal

Rules for Recusal
- When determining whether recusal is required, the Chief of Staff or committee chair shall consider whether the Interested Member’s presence would inhibit the full and fair discussion of the issue before the committee or would skew the recommendation or determination of the committee
- Interested Member must leave meeting room prior to committee’s final deliberation and determination but may answer question and provide input before leaving
- Recusal shall be documented in minutes
- Whenever possible, actual or potential conflict should be raised and resolved prior to meeting by committee chair and Interested Member informed of the recusal determination
- No staff member has a RIGHT to demand recusal – within discretion of Medical Staff leaders
- Choosing to refrain from participation is not a finding of actual conflict