METHODODIST HEALTHCARE - MEMPHIS HOSPITALS AND METHODIST HEALTHCARE – OLIVE BRANCH HOSPITAL

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MH-MH & MHOBH Peer Review Policies

1.0 Statement of Intent

The peer review process is designed to be educational, consistent, and to involve the practitioner (reviewee) early at the department level.

Methodist Healthcare – Memphis Hospitals (MHMH), Methodist Healthcare – Olive Branch Hospital (MHOBH), and its medical staff are responsible for the quality of care provided to the patient populations served. Methodist supports the peer review program to provide a mechanism for members of the medical staff to take an active role in activities that measure, assess, and where necessary, improve performance of practitioner practice within the organization. An additional objective of the peer review program is to provide practitioner specific data (Ongoing Professional Practice Evaluation) for use in evaluating practitioner performance and competency at appropriate intervals (i.e., at the time of reappointment as well as other appropriate times).

Goals of peer review are to:

1. Improve the quality of care provided by individual physicians;
2. Monitor the performance of practitioners who have privileges;
3. Identify opportunities for performance improvement; and
4. Monitor significant trends by analyzing aggregate data.
5. Assure that the process for peer review is clearly defined, fair, defensible, timely and useful.

Peer review should always be conducted with objectivity and without bias and with the underlying assumption that the practitioner is skilled and competent. Therefore, findings should be viewed as educational. Specific peer review data and results will be held confidential to the maximum protection afforded under applicable state and federal laws and regulations including, but not limited to, the Health Care Quality Improvement Act of 1986.

2.0 Concept Definition of Peer Review

Peer review includes concurrent or retrospective review of a health professional’s performance of clinical professional activities by peers through formally adopted procedures. It includes identification of opportunities to improve care. Peer review is used to describe review of:

- a patient record, or single event, by a group of peers, to evaluate issues that have been deemed important by the group overseeing the process;
- data, thus allowing peer reviewers to identify trends and patterns in performance; and
- events that are primarily behavior-related that may impact the quality of care rendered to patients.

Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner’s performance, rather than appraising the quality of care rendered by a group of professionals or a system. The individual’s evaluation is based on generally recognized standards of care.
3.0 Practitioner who are Subject to Peer Review

Practitioners who are subject to peer review are as follows:

<table>
<thead>
<tr>
<th>Type of Practitioner</th>
<th>Licensed Independent Practitioners (LIPs)- Membership Appointment &amp; Privileges</th>
<th>Allied Health Professionals (AHPs): Providers with Complex Privileges - Privileges Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician (M.D. or D.O.)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dentist or Oral Surgean</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Podiatrist</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Certified Registered Nurse Anesthetist</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Clinical Nurse Specialist (if deemed to be engaging in complex medical acts)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Certified Physician Assistant</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Honorary and Affiliate Staff are excluded from this process of Peer Review. Specific concerns regarding behavior will be managed in accordance with the process outlined in the medical staff bylaws and governance documents.

4.0 Key Peer Review Process Participants

4.1 Peers A “peer” is an individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner’s performance will determine what “practicing in the same profession” means on a case-by-case basis. For example, for quality issues related to general medical care, a physician (MD or DO) may review the care of another physician. For specialty-specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well-trained and competent in that surgical specialty.

4.2 Peer Reviewer(s) are member(s) of the medical staff or AHP staff, in good standing, who is/are a peer of the practitioner whose case/data is under review. When a specific case is the subject of review, individual(s) functioning as peer reviewer(s) may not have performed any medical management on the patient whose case is under review. If it is suspected that the outcome of the review may have been impacted by a competitor or partner relationship, a secondary review (internal or external) will be sought.

4.3 Reviewee is the practitioner whose case/data is under review.

4.4 External Peer Reviewer is a practitioner, who is not a current member of the medical or AHP staff, is a peer of the reviewee, has no economic relationship to the reviewee, and has no personal knowledge of the reviewee or patient. External peer reviewers may be contracted (compensated) for the peer review service. All external peer reviewers must sign a business associate agreement prior to performing peer review. These agreements are maintained on file in the medical staff office or in the legal department.
5.0 Roles and Responsibilities of Individuals and Committees Who Participate in the Peer Review Program

5.1 Medical Executive Committee (MEC) is ultimately responsible to the Board of Directors for assuring that the peer review program is carried out by its medical staff organization in accordance with the intent and procedures documented in the peer review policies.

5.2 Peer Review Oversight Committee (PROC) This is the single point of oversight for peer review regardless of where it occurs in the system. The PROC is responsible for oversight of the peer review program administered. The PROC is focused on assuring that all departments and departmental quality committees follow the process outlined in the peer review policies and that processing and outcomes between departments and hospitals are equitable. If inequities between departments (outcomes or processing) are noted, this information and supporting data will be forwarded to the MEC for appropriate action and resolution of the inequities. The PROC may also be involved in the review of practitioner specific performance issues and patterns.

The committee assures the MEC that all required peer review procedures and required program elements are effectively implemented. The PROC receives monthly peer review summaries from each department and provides guidance to department chairs regarding processes utilized, recommendations received, and actions taken.

The PROC also advises the MEC of any barriers to the conduct of efficient, effective peer review. The PROC submits monthly reports to the MEC committee summarizing systemwide peer review activities and recommendations received. The PROC also provides guidance and feedback regarding recommendations received and overall program administration to the respective departmental peer review committees.

See the medical staff committee policies for a detailed description of the PROC.

5.3 Medical Staff Departments have been established for purposes of organizing the medical staff members into groups comprised of practitioners from similar specialty or sub-specialty areas. This provides a structure for organizing practitioners into peer groups for the purpose of conducting peer review. Department chairs and any appointed vice-chairs or service chiefs oversee and facilitate peer review within their department in accordance with the procedures outlined in the peer review policies. Department chairs and Quality Committees of provider-based clinics are responsible for ensuring that the PROC receives monthly reports on the scope and results of peer review activities conducted in their department. AHP performance data shall be reviewed as appropriate by the supervising physician’s department (hereinafter “department”) who will obtain input from peers of the AHP, if needed.

5.4 QI Specialists(s) (QIS) provide staff support for the peer review program and work under the direction of Provider Quality Department. They serve in a data collection and screening capacity, prepare reports, and interact with the practitioners and
committees involved in the peer review program. They maintain the practitioner QI files, as well as a database that contains records of all case reviews and trended data. QISs may have different job titles and additional responsibilities outside of the scope of the peer review program. The title of QIS is used in this document to describe the specific functions they provide for the peer review program.

6.0 Circumstances That Require Peer Review

Peer review is conducted through ongoing, routine monitoring of both data and individual cases as part of the medical quality program. An in-depth quality review may be initiated by the department chair (or by the department vice-chair or service chief if so directed by the chair) whenever cases do not meet routine care monitoring indicator criteria or when the activities or professional conduct of any practitioner may appear to be detrimental to patient safety, to the delivery of quality patient care, or disruptive to the organization’s operation. However, initiation of in-depth quality review is not suggestive of or conclusive of wrongdoing by a practitioner and does not constitute an investigation.

The medical staff organization (through its departments and committees and confirmed by the MEC) will define the indicators and types of situations and data that will be reviewed through the peer review program. The PROC will provide consultation and feedback regarding the indicators selected.

7.0 General Procedures for Peer Review

There are two general methods for peer review utilized. The first method involves review of aggregated and trended clinical data by peers to monitor practitioner performance. The second method is assessment of clinical performance by review of individual cases. The following general procedures are utilized to perform each respective method of review. The time frames enumerated in this section are goals and create no rights with respect to the reviewee.

7.1 Review of Clinical Data:
The following characterize the process for use of clinical data in peer review:

A. Each department will define clinical data that will be useful to meet organization objectives of conducting peer review in accordance with the process outlined in this document. In addition, there may be some organization wide indicators that are selected by the MEC or PROC. The current list of indicators utilized for routine peer review monitoring is attached to this document as Section 18.0.
B. Data retrieval mechanisms for each indicator will be established by the Physician Quality Department.
C. Screening mechanisms (i.e., use of threshold criteria or performance parameters) will be established for each indicator.
D. Review mechanisms will be established by the QIS and the department chair.
E. Conclusions that are drawn from the data reviewed will be documented. For example, if data indicates that the reviewee is practicing within expected parameters then the report itself documents that conclusion and no further action is necessary. If the data or trend falls outside of expected parameters then further or a more in-depth quality review may be needed. Further review may entail activities such as obtaining additional information from the reviewee, case review or additional data collection.
7.2 Review of Cases

A. Cases may be referred for review by a committee or an individual based upon
some identified concern; or identified for review subsequent to routine indicator
monitoring when data or trends fall outside of expected parameters.

B. Each case is screened by a QIS. Exceptions to QIS screening may occur when
the circumstances of the case merit immediate and direct referral to the
department chair or president/COS of the medical staff.

C. A case review summary form is initiated by the QIS for cases that meet the
definition of a reviewable event.

D. QISs screen cases for the departments to which they have been assigned. If, in
the judgment of a QIS, the issue for which the case was referred arose due to
actions or inactions of a practitioner, the case will be referred to the PROC for
further review prior to departmental review. Summary of findings resulting from
the QIS’ review of the medical record are recorded on the case review form along
with any questions to be answered/issues to be addresses that were developed as
part of the review process. A preliminary classification is assigned by the QIS for
all cases reviewed.

E. Cases involving multiple practitioners and clinical disciplines/departments will
be directed accordingly.

F. The QIS prepares a monthly report for the PROC showing cases that were
screened and have been determined by the QIS to require no further review as
well as the remaining cases for review by the PROC.

G. The PROC reviews all cases not screened by the QISs as 0, reviews the case
summaries, preliminary scores, and questions/issues recorded on the case
summary. After review and any modifications, action is taken in accordance with
“Classifications for Case Review/Actions.”

8.0 Provision for Participation in the Review by the Reviewee

The reviewee should participate in the peer review process when notified by the department chair,
vice-chair, or service chief that an issue (either data or a specific case) is under review. The
following procedures will be utilized to provide a mechanism for participation by the reviewee.
If the reviewee is an AHP, references to “reviewee” shall be deemed to include both the AHP and
the supervising physician.

8.1 Following department review of a referred case or data where the initial concern and/or
additional concerns identified during the review cannot be resolved based on the available
documentation, a letter from the department chair or department QI committee chair will be sent
to the reviewee outlining the concerns and requesting additional information. The inquiry must
be responded to in writing within two weeks of date of letter and directed to the QIS. The
reviewee may also (in addition to the written response) request to appear in person to respond to
questions from the department QI committee and is encouraged to do so. In some cases, the
practitioner may be required to attend a meeting of the department QI committee.

8.2 If a response has not been received within the specified time frame, a second letter from the
department QI committee chair will be sent with an attachment of a copy of the initial letter of
inquiry to remind the reviewee that a response is required to resolve the issue; otherwise, the concern
will be listed as unresolved in the reviewee’s performance profile. Again, a time frame of two weeks
from date of letter will be specified. No extensions shall be granted unless due to extraordinary
circumstances (e.g. death of family member, illness of reviewee or other circumstances that create
an impossibility for the reviewee to provide a response with the time frames outlined in this section). All requests for extension must be delivered in writing to the applicable Department Chair with all supporting documentation that evidence the reviewee’s circumstances.

Otherwise, failure to respond in writing within the time period required herein shall be considered a voluntary relinquishment of privileges for all categories of practitioners other than medical staff members.

If the practitioner is a medical staff member and fails to respond within the two week period following the second letter, the practitioner will be required to meet with the department chair or department QI committee chair. The meeting request and any subsequent related activity, including, but not limited to the meeting notices, attendance requirements and consequences for failure to meet shall be conducted in accordance with the "Special Meeting Attendance Requirement" found in section 4.1E of the medical staff bylaws.

The QISs assist departments with notification of practitioners whose cases are under review. Notifications are documented by the QIS and retained in each practitioner’s QI file.
### 9.0 Classifications/Category Scores for Case Review

#### 9.1 Classification For Case Review/Actions That May Be Taken By Peer Review Oversight Committee:

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Screened by QIS. No findings identified, no further review necessary</td>
</tr>
<tr>
<td>1</td>
<td>Finding expected &amp; acceptable</td>
</tr>
<tr>
<td>4</td>
<td>Refer to GME – Housestaff Issue</td>
</tr>
<tr>
<td>5</td>
<td>Refer to Physician Wellbeing/Behavioral Issue</td>
</tr>
<tr>
<td>6</td>
<td>Refer to another clinical department/care provider (i.e., radiology, pharmacy, a particular patient care unit)</td>
</tr>
<tr>
<td>7</td>
<td>Refer to SQC / system issue</td>
</tr>
<tr>
<td>8</td>
<td>Refer to Department Peer Review Committee</td>
</tr>
<tr>
<td>9</td>
<td>Refer for Outside Peer Review</td>
</tr>
</tbody>
</table>

#### 9.2 Final Recommendations (Levels) that May be Made by a Department:

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>DESCRIPTION</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Standard of Care Met</td>
<td>No action</td>
</tr>
<tr>
<td>1b</td>
<td>Known complication-recognized and appropriately managed</td>
<td>No action</td>
</tr>
<tr>
<td>2a</td>
<td>Problem with process or documentation; no harm or adverse patient impact occurred. Causal factors may include (but are not limited to) communication failure, handoff, failure to adhere to standards/rules, knowledge or technique deficit.</td>
<td>Educational letter, track and trend. More education if significant trend</td>
</tr>
<tr>
<td>2b</td>
<td>Poor Utilization of resources</td>
<td>Letter, see peer review policies</td>
</tr>
<tr>
<td>3a</td>
<td>Departure from established pattern of clinical practice or documentation; no adverse patient impact occurred, but there was either a potential for harm or the event could be categorized as a “near miss”. Causal factors may include (but are not limited to) communication failure, handoff, failure to adhere to standards/rules, knowledge or technique deficit.</td>
<td>Letter, see peer review policies.</td>
</tr>
<tr>
<td>3b</td>
<td>Departure from established pattern of clinical practice or documentation that may have contributed to harm or an adverse patient impact. Causal factors include (but are not limited to) communication failure, standards/rules failure, knowledge or technique deficit.</td>
<td>Letter, see peer review policies.</td>
</tr>
<tr>
<td>10</td>
<td>Refer back to PROC (issues related to levels 4-7 above discovered during review/investigation.)</td>
<td></td>
</tr>
</tbody>
</table>
9.3 Preliminary Classifications that May be Assigned by a QIS:
A QIS may assign classification 0 as well as any preliminary classification (1-9) prior to submission to the PROC. Questions arising as a result of the case review and issues to be addressed shall be delineated by the QIS.

9.4 Response Requirement from Clinical & Support Areas
When the PROC requests information from clinical disciplines and support areas in pursuit of quality and performance improvement, the MEC requires a response to the PROC.

10.0 Department Quality Committee Reports

The Department Quality Committee will forward a report on all activities to the Department Chair. The Department Chair is responsible for follow-up on any peer review actions that may be required subsequent to the assignment of a score of 3 or notation of any adverse trends associated with lessor scores. The QIS will work in conjunction with the Medical Staff Services Department and the Department Chair on all peer review outcomes that require action. The QIS will forward reports to the PROC that summarize peer review activities and recommended actions on a monthly basis.

11.0 Actions That May Result From Review of Cases or Data

11.1 Department Chairs are empowered (if performance problems are deemed to be of a minor nature) to take any action determined appropriate except for those actions which would be reportable to the National Practitioner Data Bank (NPDB).

Actions, not reportable to the NPDB that may be taken by the Department Chair:

A. Order an in-depth quality review. An in-depth quality review involves additional collection of data or information regarding practitioner performance.

B. Communication with practitioner in an effort to obtain additional information.

C. Any other action that does not affect privileges or membership on the medical staff, including but not limited to:
   - request for an action plan or performance improvement plan from the individual practitioner;
   - requirement to complete additional educational activities;
   - concurrent consultation; and
   - concurrent proctoring.

D. For an initial occurrence with unintended consequences and for which the outcome is a Level “2” or “3” the Department Chair, with concurrence of the Departmental Peer Review Committee and the PROC, may recommend a reduction to a level “1a or 1b”. The practitioner must also complete an action plan that supports an improvement process in patient care or safety. This action plan should include the following:
1. The self-assessment, self-study and self-improvement activities should prevent a reoccurrence for the practitioner.

2. The practitioner should provide an educational service to the community, department peers or self, as appropriate, as approved by PROC. Examples include, but are not limited to: M&M presentation, Grand Rounds, becoming a physician champion/active participant on an existing Performance Improvement Team.

For clarification of instances when this reduction in peer review level may reasonably be offered, please refer to the “PREP Algorithm”, which is also aligned with MLH goals for a Fair and Just culture.

The opportunity to reduce an adverse Peer Review level is dependent on commitment to ongoing improvement and education. This is available only once during any provider's MLH career.

E. The Department Chair also has the option of referring the practitioner/AHP for health/well-being issues in accordance with the governance documents of the medical staff. The PROC may also recommend that a practitioner/AHP be referred.

11.2 Actions reportable to the NPDB that may be recommended to the PROC and Medical Executive Committee by the department chair include:

- Punitive suspension of appointment and/or privileges;
- Restriction of privileges;
- Reduction of privileges;
- Revocation of appointment and/or privileges;
- Any other recommendation or action that results in reducing, restricting, suspending, revocation or denial of clinical privileges or medical staff membership.

Additionally, the Department Chair may recommend a precautionary suspension to the chief of staff or CEO or designee; this is not reportable to the NPDB.

11.3 NPDB reportable recommended actions should be reviewed by the PROC (in consultation with in-house counsel) prior to submission to the MEC except when expedited processing is required due to patient safety concerns. In those cases the PROC will review the actions after the fact and provide feedback to the MEC.

11.4 The PROC receives routine reports from Departments and Quality Committees of provider-based clinics regarding peer review activity. The minutes of the PROC should indicate acceptance of reviews and actions or document different actions recommended by the PROC. Additionally, the PROC receives more detailed reports on cases where the outcome of the review required additional follow-up and/or action. A report from the PROC of all peer review activities, along with recommendations when required, is provided to the MEC on a monthly basis.
11.5 The minutes of the MEC will indicate review of reports from the PROC and recommendations received from the PROC. MEC minutes will also reflect recommendations made by the PROC to the Board of Directors as well as any actions initiated by the MEC excluding recommendations for adverse action, which will be addressed in accordance with the bylaws or credentials policies.

12.0 Timeliness
The goal of the peer review process is to complete all steps within reasonable time frames to assure that any identified quality of care issue is addressed promptly, that the individual under review has the resolution without inordinate delays, and any additional information is still readily available to support the review process. If a case is of such severity (example: sentinel event) then an expedited timeline may be requested by any administrative staff member, medical staff member, Chief Medical Officer, or Chief Quality Officer. The time frames enumerated in this section are goals and create no rights with respect to the reviewee.

12.1 Cases identified for review through retrospective record review and other data retrieval mechanisms (routine care monitors) are screened by the QIS not more than 90 days after patient discharge.

12.2 Cases referred for review by the Physician Quality Department via concerned party are screened by the QIS within 30 days of case referral. If the case occurrence is > 12 months old, the review will be completed, but any action taken should take into consideration evidence of more recent patterns.

12.3 Cases referred to the Department Vice-Chair or Service Chief or Department Quality Committee will be completed within 60 days from the date of the case being forwarded.

12.4 The PROC will receive regular reports from the Physician Quality Department regarding timeliness of case processing. The MEC will be notified of ongoing chronic delays that have been resistant to intervention. Chronic delays in case reviews not meeting above timelines will be addressed by the Medical Executive Committee.

13.0 Appeals
Because the practitioner is involved with his/her peer review case during the course of the peer review activity, the practitioner should have opportunity for his opinions on the matter(s) to be considered during the determination at the department level. The need for appeal should only arise if there is a question of fairness or improper execution of the peer review process.

In this case, an appeal may be requested in writing within 10 days of the department determination. The appeal request should document the grounds for the appeal (i.e., failure to adhere to the peer review process or unfair application of actions as a result of the review). The appeal will be heard by the PROC and the practitioner must be present to discuss his/her concerns.

14.0 External Peer Review
14.1 Circumstances which may require external peer review.
- When there is no one on the medical staff with expertise in the subject under review.
- When the PROC, MEC, executive medical staff officers, or Department Chair determines that there is no comparable internal peer (related to scope of service under review) or potential interference with the unbiased setting needed for true peer review.
- When there are conflicting recommendations from the medical staff committees or there is no strong consensus for a particular recommendation.

14.2 Approval by the PROC is required for external peer review that involves review of practitioner performance. Programmatic reviews conducted by external consultants reviewers are not required to be approved by the PROC unless the programmatic evaluation will include individual practitioner/AHP performance review.

14.3 A practitioner/AHP under review may obtain an external peer review at his/her own expense.

14.4 Referrals for external peer review will be procured and managed through the PROC in collaboration with administration.

14.5 The involved practitioner(s) will be notified in writing by the PROC that his/her case is undergoing an external review.

14.6 The results of the external review will be directed to the PROC who will disseminate the findings to appropriate groups.

15.0 Hospital Based Services
Hospital based services, such as Pathology, Radiology, Emergency Services and Anesthesia may receive referrals via the case review process described in this document. In addition, these departments implement internal quality control and improvement processes that are often performed on a daily basis. These services may from time to time have a case or case data arise for review out of their routine quality control and improvement process that merits referral for peer review. Those cases and/or data, when they arise, are to be processed as described in the peer review policies.

16.0 Ongoing Professional Practice Evaluation
Ongoing Professional Practice Evaluation (OPPE) requires the medical staff to conduct an ongoing evaluation of each medical staff member’s and Allied Health Professional’s (hereafter referred to as “practitioner”) professional performance. This demonstration of ongoing clinical and behavioral competence assures that practitioners consistently maintain acceptable performance. This process allows any potential problems with a practitioner’s performance or trends that impact quality of care and patient safety to be identified and resolved in a timely manner. OPPE also fosters an efficient, evidence-based privilege renewal process. The information resulting from the ongoing professional practice evaluation is factored into decisions to continue/maintain, limit, or revoke any existing privilege(s).

PROCEDURE:
1. The PROC and respective department chair(s) are responsible for coordinating the Ongoing Professional Practice Evaluation (OPPE) review. OPPE will be performed for all privileged practitioners on a periodic basis. For purposes of OPPE, Periodic is defined as not less frequent than every 11 months and not more often than every 6 months.

2. The type of information and process for evaluating each practitioner’s ongoing professional practice is approved by the departments and the Medical Executive Committee. The defined process is below.

3. The PROC will provide oversight when a Department Chair has concerns about a practitioner’s professional performance.

4. OPPE will be factored into recommendations to the Credentials Committee to maintain existing privileges(s), to revise existing privilege(s) or to revoke existing privilege(s), between reappointment times and either prior to, or at, the time of renewal. OPPE applies to practitioners who have privileges in the hospital and/or provider-based clinics.

5. The fact that a practitioner doesn’t “fall out” on routine screening indicator criteria does not meet the requirement for performance data review. However, zero outlier data are data and can be evidence of good performance (e.g. no returns to the OR, no complaints, etc.).

6. Reasons for zero or low volumes are taken into consideration (e.g. no longer performing the procedure, taking patients elsewhere for the procedure or privilege is typically a low volume procedure, etc.). With no volume during 2 consecutive OPPE cycles, several actions could occur, including, but not limited to:
   a. Abeyance of the privilege(s) (which shall not trigger a hearing or a NPDB report) and notifying the practitioner that if he/she wishes to reactivate it, he/she must request reactivation.
   b. Determining that zero performance should trigger a focused review (FPPE) whenever the practitioner actually performs the privilege.
   c. Determining that the privilege should be continued because the organization and/or community have need of this privilege; in this case focused review shall be triggered whenever the practitioner actually performs the privilege.

   While external data is not a substitute for OPPE, zero volume/data may trigger the requirement for a peer reference.

7. The following are examples of aggregate data reports, trends, and information that may be reviewed during OPPE. Not every practitioner will be reviewed for each indicator:
   a. Admission Activity
   b. Consult and/or procedure activity
   c. Length of Stay Data (actual and expected)
   d. Mortality Data (actual and expected)
   e. Readmissions
   f. Risk related occurrences
   g. Quality Indicator related occurrences (system indicators & one indicator as selected by each department)
   h. Outcomes including performance outcomes collected in registries
   i. Other utilization metrics, including denials
   j. Medical Records suspensions
   k. Behavior related events

8. When available, peer or benchmark comparative data will be utilized
9. For those providers without attending or admitting volume (consultants, house-based, or AHPs) the Practice Based Learning Log may be utilized in place of aggregate data reports, trends and information.

10. Administrative Review – Provider Quality will review all above documentation/data and flag the elements for specific review by the department chair (or designee) for each individual practitioner when the practitioner falls outside of criteria as defined by the PROC.

11. The PROC will periodically, but no less than once per year, reevaluate and determine the criteria threshold.

12. The department chair or designee will document pertinent findings and recommendations on the review form to include:
   a. Confirmation that the practitioner has been reviewed and is performing within desired expectations. There are no potential problems with performance or trends that would impact quality of care and patient safety; no further action is warranted. The practitioner will be evaluated again at the routine interval.
   OR
   b. Determination that an issue or question of performance exists requiring a focused evaluation (FPPE) or intensified review. See FPPE Policy, 5.
   c. Assessment of the following general competencies when data available:
      i. Patient Care
      ii. Medical Knowledge
      iii. Practice Based Learning
      iv. Interpersonal communication
      v. Professionalism
      vi. System based learning

13. The information gained by the review of the above information will be maintained in the practitioner’s Quality file.

14. Single incidents or trending of quality and safety issues that impact the safety of patients will require immediate action by the medical staff.

15. If behavior is identified as a possible issue, the Medical Staff Professional Conduct Policy will be followed as a component of OPPE or FPPE.

16. Relevant information obtained from OPPE shall be included in performance improvement activities while maintaining confidentiality.

17.0 Intensified Review

A. Based on a trend of receiving 3 “Level 3” classifications in a rolling two year time frame, the PROC and/or the Department Chair may recommend intensified review.

   Intensified review is defined as:
   • A thorough review of all quality improvement monitors, deviations from standards of care, and untoward events that have been categorized in the two years prior to being placed on intensified review (retrospective review) and for six months thereafter, and/or
   • 100% review of all relevant admissions for the next six months following the Medical Executive Committee's recommendation.

(1) The physician receives a certified letter regarding the intensified review.
(2) The findings of the intensified review are submitted to the Department Chair and the PROC for a recommendation to the Medical Executive Committee.

(3) When a practitioner's professional competency or conduct is under intensified review due to actions by the MEC or the PROC and the practitioner receives one additional Level 3 review confirmed by the PROC, the practitioner shall be placed under an automatic precautionary suspension of all clinical privileges. Such suspension shall be subject to review by the MEC for continuation, modification, or other appropriate action at its next regular meeting or at a specially called meeting.

B. In addition to intensified review, current policies for focused professional practice evaluation shall apply when practitioner competencies are in question.

18.0 Effectiveness of Program
The PROC will conduct an annual evaluation of the effectiveness of the peer review program and report on the same to the MEC. In evaluating effectiveness, the following items (among others) will be considered.

- Timeliness of peer review.
- Consistency of execution of the peer review process.
- Defensibility of peer review conclusions and actions.
- Availability of reports and documentation to support the ongoing competency process of medical or AHP staff members (i.e., reappraisal/reappointment).

Based upon the annual evaluation of effectiveness, revisions may be proposed to the peer review program to make improvements in process and outcomes. These changes will be processed in accordance with the Adoption and Revisions section of this document.

19.0 Selection and Management of Clinical Indicators
The QIS will schedule an annual evaluation of current vs. potential clinical indicator(s) for each department. The current indicator(s) will be evaluated to ensure that they provide a positive contribution to ensuring quality of care. A recommendation regarding any changes to or continuation of the use of specific indicators will be recommended to the department chair by the department quality committee. The PROC will review the recommendation and may either provide feedback and consultation to the department or forward a recommendation to the MEC.

A. System Indicators
An occurrence received in any of the following categories will be reviewed for potential peer view:

- Blood Review; criteria not met.
- Adverse drug reaction/interaction/contraindication
- Unexpected death
- Readmit with 7 days related to first admission
- Missed diagnosis
- Questionable appropriateness of MD judgment or order
- Return to ED within 48 hours
- Death within 48 hours of admission
- Operative complication: unexpected
- Post-procedure death
- Surgery secondary to complication during an invasive procedure
- Any cardiothoracic surgery with MI, cardiac arrest, neurological deficit or CNS complication (or death) within 2 days post-procedure (with anesthesia).
- APS catheter complications
- Block complications
- MI within 24 hours of procedure
- Post-procedure pneumothorax without intervention
- Emery House 24 hrs post anesthesia
- Failure of autopsy findings to correlate with terminal diagnoses
- Post operative wound infection
- Post operative vascular complication (thrombophlebitis, thrombosis, embolus)
- Unplanned admission to observation/inpatient status following same day surgery
- Other occurrence reports from Risk Management
- Other physician peer review
- Inappropriate/unprofessional conduct
- Inappropriate documentation on patient record.
- Healthcare practitioner unresponsiveness
  - After determination has been made by Medical Staff Quality staff that there is no documentation of a physician visit every 1 calendar day by the appropriately credentialed physician directing the patient care or the appropriately credentialed designated substitute physician, the occurrence and documentation will be peer reviewed and a level 3 may be assigned. Each occurrence of no physician visit may incur a possible level 3.
- Illegibility. After identification occurrences will be documented and managed in the following manner:
  - Initially, the Department Chair will provide written notification and education to the practitioner and will provide the practitioner with a copy of the occurrence.
  - The Associate Chief will address the 2nd occurrence with the practitioner with written notification.
  - With the 3rd occurrence examples and documentation of interventions will be peer reviewed with a possible level 3 assigned.
- Inappropriate H & P documentation:
  - Initially, the Department Chair will provide written notification and education to the practitioner.
  - The Associate Chief will address the 2nd occurrence with the practitioner with written notification.
  - With the 3rd occurrence examples and documentation of interventions will be peer reviewed with a possible level 3 assigned.
- Use of unapproved abbreviations. After identification occurrences will be documented and managed in the following manner:
  - Initially, the Department Chairman will provide written notification and education to the physician
  - A letter will be sent to the practitioner from the Associate Chief on the 2nd occurrence.
  - With the 3rd occurrence examples and documentation of interventions will be peer reviewed with a possible level 3 assigned.
• Failure to comply with Electronic Medical Information Rules and Regulations and Information Management Policies regarding password confidentiality:
  o Initially, the Department Chair will provide written notification and education to the practitioner.
  o The 2nd occurrence will be referred for peer review.

B. Department Specific Indicators/Triggers for Performance Improvement and Peer Review

Occurrences of these indicators/triggers will be subject to peer review.

| Anesthesia                        | 1. Prolonged recovery period > 2 hours  |
|                                  | 2. Death within 48 hours of anesthesia |
|                                  | 3. Unplanned admission to ICU following SDS procedure |
|                                  | 4. Respiratory distress/failure after surgical procedure requiring unplanned ventilator support |
|                                  | 5. Postoperative complication caused by aspiration events |
|                                  | 6. Postoperative complication caused by prolonged paralysis with unplanned ventilator support |
|                                  | 7. Anesthesia related injury to teeth or cornea |
|                                  | 8. Postoperative epidural spinal fluid leak |
|                                  | 9. Complications from regional anesthesia and steroid epidural injections |
| Cardiology                       | Covered under system wide indicators |
| Cardiothoracic                   | Covered under Evidence Based Clinical Indicators |
| Critical Care                    | 1. Non-compliance with use of Ventilator Bundle for patients ventilated > 24 hrs |
|                                  | 2. Lack of proper compliance with CVL Bundle |
|                                  | 3. ARDS patients on tidal volume ≥ 8 mL per kg preferred body weight |
| Emergency Medicine               | 1. Sepsis |
|                                  | a. Blood and Urine cultures not ordered prior to antibiotics. |
|                                  | b. Appropriate antibiotic not ordered and administered within 4 hours of presentation. |
|                                  | c. Failure to initiate IVF resuscitation. |
|                                  | d. Failure to admit to ICU versus regular/telemetry floor. |
|                                  | e. Order Lactate Level |
|                                  | 2. Compliance to the CVL bundle |
|                                  | 3. Hyperkalemia |
|                                  | a. No changes in treatment of various levels, especially if EKG changes noted. |
|                                  | b. Nephrologists’ not notified. |
|                                  | 4. Hypertension |
| Gastroenterology                 | 1. Prolonged recovery period > 2 hours post procedure |
|                                  | 2. Procedure related perforation |
|                                  | 3. Any patient dissatisfaction resulting in a formal complain |
| Internal Medicine | 1. Pneumonia management criteria not met  
2. CHF management criteria not met  
3. CVA management criteria not met |
|-------------------|---------------------------------------------|
| Neurology         | 1. Failure to consider IV Alteplase within 3 hours of stroke (CVA) onset without appropriate contraindication documented.  
2. Failure to consider Intra-arterial Alteplase within 6 hours of stroke (CVA) without appropriate contraindication documented.  
3. Failure to consider mechanical thrombectomy with the MERCI or FDA approved similar device within 8 hours of stroke (CVA) without appropriate contraindication documented.  
4. Recurrent seizures without appropriate management.  
5. Lumbar puncture performed with:  
   a. significantly elevated PT/PTT levels or  
   b. INR 1.7 or greater or  
   c. Platelet count less than 50,000.  
6. MRI ordered in the presence of cardiac pacemaker, defibrillator, or other contraindication. |
| Neurosurgery      | 1. Preoperative antibiotic given within 1 hour of skin incision  
2. Shunt infections  
3. External ventricular drain (EVD) infection  
4. Depilatory using razor instead of clippers |
| OB/GYN            | 1. Five minute apgar of 6 or less  
2. Significant birth trauma to infant  
3. Delivery of infant at term< 2500 grams by induction or C/S  
4. Primary C/S for failure to progress- Trend per MD only  
5. Primary C/S for non-reassuring tracing- Trend per MD only  
6. Uterine rupture  
7. Perinatal/Neonatal death  
8. Cardio-pulmonary arrest in OB/GYN patient  
9. Delivery unattended by MD  
10. Fracture in neonate  
11. Elective, repeat Cesarean sections/elective inductions performed prior to 39 weeks gestation  
12. Appropriate antibiotic GBS prophylaxis |
| Ophthalmology     | 1. Loss of vitreous fluid in connection with cataract surgery  
2. Loss of vision following Ophthalmologic procedure |
| Orthopedics       | 1. Failure to confirm appropriate leg/arm marked for surgical procedure.  
2. Total knee/hip protocol not met. |
| Otolaryngology    | 1. Respiratory distress/failure after surgical procedure  
2. Frontal sinus surgery in children age twelve and under |
| Pathology         | 1. Surgical Pathology QA  
2. Autopsy Clinicopathologic Correlation  
3. Autopsy turn around time  
4. Surgical Pathology turn around time  
5. Evaluation of Sypnotic Reporting Criteria  
6. Frozen section turn around time  
7. Frozen Section diagnostic accuracy  
8. Blood Utilization Review  
9. Her-2/neu IP/FISH correlation |

**Pediatric Medicine**

**Pediatric Medicine**
| Pediatric Surgery          | 1. Unplanned Transfers to a Higher Level of Care  
|                          | 2. 100% of all pediatric deaths at Le Bonheur & pediatric deaths within the system 23 weeks gestation through <13 years of age.  
|                           | **Pediatric Surgery**  
|                           | 1. Prolonged Recovery room stay >120 min  
|                           | 2. ESS < 12 years of age  
|                           | 3. Unplanned Admission of a SDS patient  
| Psychiatry                | 1. Restraints  
|                           | 2. AMA (Against Medical Advice)  
|                           | 3. Falls  
| Radiology                 | 1. Post procedure vascular complications (thrombophlebitis, thrombus, embolus)  
| Surgery                   | Covered under system wide indicators  
| Urology                   | Covered under system wide indicators  

C. Evidence Based Clinical Indicators for Performance Improvement and Peer Review

The evidence based clinical indicators are outlined in Appendix 1. These clinical indicators may be utilized for performance improvement and peer review. **Omission of (or variation from)** these quality indicators or processes without documentation of an acceptable contraindication will result in Peer Review. (See Appendix 1)
Peer Review Educational Plan (PREP) Algorithm

Unsafe Acts

Actions disregarded policy and procedures

Consequences Intended?

YES

Peer Review No PREP Available; Other restrictions to be determined

NO

Knowingly violated safe operational procedures

Were procedures available, workable, intelligible & correct?

NO

System induced error

Peer Review PREP Available

YES

TREIDED Analysis of Practitioner

NO

Possible negligent error

Trended Analysis of Practitioner?

YES

Peer Review PREP Available

NO

PEER REVIEW EDUCATIONAL PLAN (PREP) Algorithm rev 10.16.13
APPENDIX 1:
The following evidence based clinical indicators may be utilized for performance improvement and peer review. **Omission of (or variation from)** these quality indicators or processes without documentation of an acceptable contraindication will result in Peer Review.

1. **Ischemic Stroke (Adult)**
   - VTE Prophylaxis by the day of or the day after hospital admission
   - Discharge on Antithrombotic Therapy
   - Patients with Atrial Fibrillation/Flutter discharged on Anticoagulation Therapy
   - Antithrombotic Therapy by end of hospital Day 2 (from arrival)
   - LDL-c ordered within the first 48 hours of hospital arrival or measured within the past 30 days. Statin ordered at discharge for all patients with an LDL level ≥ 100, were on a statin/lipid lowering agent prior to arrival, or documented contraindication.
   - Assessed for Rehab
   - Stroke education
     - Risk factors for stroke (Nursing Default)
     - Warning signs/symptoms of stroke (Nursing Default)
     - Activation of EMS (Nursing Default)
     - Need for follow-up (Nursing Default)
     - Medications prescribed at discharge (Nursing Default)

2. **CABG**
   - Controlled postoperative blood glucose (less than or equal to 180mg/dL) in the timeframe of 18 to 24 hours after Anesthesia End Time

3. **Immunizations**
   - Influenza Immunization ordered for all patients aged 6 months or older (except patients with organ transplant during current hospitalization, patient refusal or already immunized during current season) during Flu Season - Oct. 1 – March 31 discharges

4. **Perinatal Care**
   - For Elective Deliveries and Elective Cesareans at >=37 and < 39 weeks completed gestation, clearly document gestational age and condition that justifies elective delivery/cesarean.
   - Document if the mother presented in active labor
   - Document if the mother has had a previous Cesarean and what type (ex: Classical, LUV, LUT)
   - For Cesarean Section, this population includes nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section
   - Antenatal Steroids, this population of patients at high risk of preterm delivery at >=24 and <32 weeks gestation receiving antenatal steroids prior to delivering preterm newborns
   - Health Care-Associated Bloodstream Infections in Newborns, Staphylococcal and gram negative septicemias or bacteremias in high-risk newborns
   - Exclusive Breast Milk feeding during the newborn’s entire hospitalization considering mother’s choice
5. **VTE**
   - Order appropriate VTE prophylaxis for all patients 18 years and over on the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.
   - Order appropriate VTE prophylaxis for all patients 18 years and over by the day of or day after the initial admission (or transfer) to the ICU or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer). Document orders for anticoagulation overlap therapy for patients 18 years and over with a confirmed VTE:
     - Document reason if no Warfarin is to be given.
     - Document reason if Parenteral Therapy is to be discontinued.
     - Document reason if patient is to receive less than 5 days of overlap therapy.
     - Overlap therapy should be administered for at least 5 days (patient may be discharged on both medications) with an INR greater than or equal to 2 prior to discontinuation of parenteral anticoagulation therapy, unless reason to discontinue is documented.
   - Order discharge instructions which include the following:
     - Compliance Issues (Nursing Default)
     - Dietary Advice (Nursing Default)
     - Follow-up (INR) monitoring (**Physician Default**)
     - Potential for adverse drug reactions and interactions (Nursing Default)

6. **HBIPS** (Hospital Based Inpatient Psychiatric Services)
   - Admission screening for violence risk, substance use, psychological trauma history, and at least 2 patient strengths completed within the first 3 days of admission.
   - Hours of physical restraint use.
   - Hours of seclusion use.
   - Patients discharged on multiple (2 or more) antipsychotic medications. Appropriate justification to be documented in Discharge Summary or Discharge Note (**Physician default**).
   - Post discharge continuing care plan created (MSW note).
   - Post discharge continuing care plan transmitted to the next level of care provider upon discharge.
   - Tobacco use screening. Treatment provided or offered if used tobacco in the last 12 months.
   - Influenza immunization
<table>
<thead>
<tr>
<th>Revision #</th>
<th>Document</th>
<th>Reference</th>
<th>Subject of Revision</th>
<th>Board Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original</td>
<td>Peer Review Policies</td>
<td></td>
<td>Replaces Peer Review Policy &amp; Procedure</td>
<td>March 2007</td>
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<tr>
<td>1</td>
<td>Performance Indicators</td>
<td>Department of Pediatrics / Pediatric Surgery</td>
<td>Addition of PI indicators</td>
<td>March, 2007</td>
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<tr>
<td>2</td>
<td>Recommendations from the PROC</td>
<td>9.4</td>
<td>Addition for Response Requirement from Clinical &amp; Support Areas</td>
<td>June 28, 2007</td>
</tr>
<tr>
<td>3</td>
<td>Department Specific Indicators</td>
<td>18.0, B</td>
<td>Changes to department specific indicators: Cardiology, Pathology, Psychiatry</td>
<td>June 28, 2007</td>
</tr>
<tr>
<td>4</td>
<td>Department Specific Indicators</td>
<td>18.0, B Emergency Medicine</td>
<td>Revisions to the department specific indicators for Emergency Medicine</td>
<td>December 15, 2007</td>
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<tr>
<td>5</td>
<td>Department Specific Indicators</td>
<td>18.0, B Department of GI</td>
<td>Addition of Gastroenterology Performance Indicators</td>
<td>March 27, 2008</td>
</tr>
<tr>
<td>6</td>
<td>Evidence Based Clinical Indicators</td>
<td>18.0, C</td>
<td>Revised to reflect Nursing default and the addition of LDL levels.</td>
<td>March 27, 2008</td>
</tr>
<tr>
<td>7</td>
<td>Conform with Quality and Safety Plan</td>
<td>5.2</td>
<td>Deleted section Medical Staff Quality Committee</td>
<td>August 2008</td>
</tr>
<tr>
<td>8</td>
<td>Ongoing Professional Practice Evaluation</td>
<td>16.0</td>
<td>Addition of OPPE policy to ensure compliance with recent clarification from JC.</td>
<td>November 2008</td>
</tr>
<tr>
<td>9</td>
<td>Selection and Management of Clinical Indicators – Cardiology</td>
<td>19.0, B</td>
<td>Cardiology removed the indicator “drug eluting stent criteria not met”</td>
<td>December 2008</td>
</tr>
<tr>
<td>10</td>
<td>Response Timeline</td>
<td>8.2</td>
<td>This policy delineates the timeframe for responding to peer review and specifies that no extensions will be granted except for extraordinary circumstances</td>
<td>April 30, 2009</td>
</tr>
<tr>
<td>11</td>
<td>Department Indicators</td>
<td>19.0 B - Neurology</td>
<td>Revision to Neurology Dept. indicators</td>
<td>May 28, 2009</td>
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<tr>
<td>12</td>
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<td>19.0 B - Pediatric</td>
<td>Revision to Pediatric Medicine &amp; Pediatric Surgery Dept. indicators</td>
<td>May 28, 2009</td>
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<tr>
<td>13</td>
<td>Additional Peer Review Level</td>
<td></td>
<td>An additional peer review level was proposed by the dept. of IM - Level 2b for poor resource utilization</td>
<td>June 25, 2009</td>
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<tr>
<td>15</td>
<td>GOJF Algorithm</td>
<td></td>
<td>An Unsafe Acts algorithm is provided in support of MLH Fair and Just Culture</td>
<td>June 25, 2009</td>
</tr>
<tr>
<td>16</td>
<td>CMS Indicators</td>
<td>19, C</td>
<td>Changes to the clinical indicators reflecting the current CMS and SCIP measures</td>
<td>September 24, 2009</td>
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<tr>
<td>17</td>
<td>CIDP</td>
<td>5.3</td>
<td>Removal of verbiage referencing the Committee on Interdisciplinary Practice.</td>
<td>December 10, 2009</td>
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<tr>
<td>18</td>
<td>OPPE</td>
<td>16.0</td>
<td>Clarifications of OPPE frequency and of how threshold criteria are determined.</td>
<td>January 21, 2010</td>
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<tr>
<td>19</td>
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<td></td>
<td>Changed Plan to Policies</td>
<td>November 18, 2010</td>
</tr>
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<td>20</td>
<td>Evidence Based Clinical Indicators for Performance Improvement and Peer Review</td>
<td>19.0, C</td>
<td>Pediatric Asthma Evidence Based Clinical Indicators added.</td>
<td>August 18, 2011</td>
</tr>
<tr>
<td>21</td>
<td>Circumstances That Require Peer Review</td>
<td>6.0</td>
<td>Revised word the word “facility” with Organization’s operation.</td>
<td>December 15, 2011</td>
</tr>
<tr>
<td>22</td>
<td>Ongoing Professional Practice Evaluation</td>
<td>16.0</td>
<td>Revised the OPPE Policy. 1. The PROC will provide oversight when a Department Chair has concerns about a practitioner’s professional performance. 2. For those providers without attending or admitting volume (consultants, house-based, or AHPs) the Practice Based Learning Log may be utilized in place of aggregate data reports, trends, and information.</td>
<td>November 14, 2012</td>
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<tr>
<td>23</td>
<td>Critical Care Indicators</td>
<td>19.0, B</td>
<td>Added Critical Care Department Indicators</td>
<td>December 18, 2012</td>
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<td>TYPO</td>
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<td>2.4.13</td>
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<tr>
<td>25</td>
<td>Evidence Based Indicators</td>
<td>19.0, C to Appendix 1</td>
<td>Updated and moved section to Appendix 1</td>
<td>August 14, 2013</td>
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<tr>
<td>26</td>
<td>GOJF Algorithm</td>
<td>11.0 &amp; Algorithm</td>
<td>Revised GOJF to PREP or Get out of Jail Free to Peer Review Educational Plan</td>
<td>October 16, 2013</td>
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<tr>
<td>27</td>
<td>9.2 Final Recommendations (Levels) that May be Made by a Department:</td>
<td>9.2</td>
<td>Revised Level 1 to Level 1a &amp; 1b</td>
<td>November 13, 2013</td>
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<td>28</td>
<td>Appendix 1</td>
<td></td>
<td>Updated the Clinical Indicators</td>
<td>March 31, 2014</td>
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<tr>
<td>Unification Revisions</td>
<td>Throughout the document</td>
<td></td>
<td>Changed Physician Quality Department to Provider Quality Department</td>
<td>November 19, 2014</td>
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<tr>
<td>Unification Revisions</td>
<td>Throughout the document</td>
<td></td>
<td>Changed Medical Staff Office to Medical Staff Services</td>
<td>November 19, 2014</td>
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<td>Unification</td>
<td>19.0 Selection and</td>
<td></td>
<td>The evidence based clinical</td>
<td>November 19, 2014</td>
</tr>
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</table>
| Revisions | Management of Clinical Indicators  
| C. Evidence Based Clinical Indicators for Performance Improvement and Peer Review (ADDITION) | indicators are outlined in Appendix 1. These clinical indicators may be utilized for performance improvement and peer review. **Omission of (or variation from)** these quality indicators or processes without documentation of an acceptable contraindication will result in Peer Review. (See Appendix 1) To align with MHOBH Peer Review Policies. | 2014 |
| Revision | Appendix 1 | Updated CMS measures to reflect current standards | Approved by PROC on April 1, 2015 |
| Revision | 5.3 Roles & Responsibilities | Amend to include Provider-based Clinics | December 21, 2016 |
| Revision | 11.4 Actions that May Result from Review of Cases or Data | Amend to include Provider-based Clinics | December 21, 2016 |
| Revision | 16.0 Ongoing Professional Practice Evaluation #4 | Amend to include Provider-based Clinics | December 21, 2016 |