METHODIST LE BONHEUR HEALTHCARE
UNIFIED MEDICAL STAFF

PROFESSIONAL PRACTICE EVALUATION POLICY (PEER REVIEW)

Adopted by the Medical Executive Committee: November 10, 2020
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TABLE OF CONTENTS

PAGE

PAGE

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1. OBJECTIVES AND SCOPE OF POLICY

1.A ***Objectives.*** The primary objectives of the Professional Practice Evaluation ("PPE") process of Methodist Le Bonheur Healthcare are to:

(1) Establish a positive, educational approach to performance issues and a culture of continuous improvement for individual Practitioners, which includes:

(a) fairly, effectively, and efficiently evaluating the care being provided by Practitioners, comparing it to established patient care protocols and benchmarks whenever possible; and

(b) providing constructive feedback, education, and performance improvement assistance to Practitioners regarding the quality, appropriateness, and safety of the care they provide;

(2) Effectively disseminate lessons learned and promote education sessions so that all Practitioners in a relevant specialty area will benefit from the PPE process and also participate in the culture of continuous improvement; and

(3) Promote the identification and resolution of system process issues that may adversely affect the quality and safety of care being provided to patients (e.g., protocol or policy revisions that are necessary; addressing patient handoff breakdowns or communication problems).

1.B ***Scope of Policy.***

(1) This Policy applies to services provided by Practitioners at Methodist Healthcare Memphis Hospitals and Methodist Healthcare – Olive Branch Hospital (the "Hospital").

(2) The Hospital's PPE process includes several related but distinct components:

(a) The PPE process described in this Policy is used when questions or concerns are raised about a Practitioner's clinical performance. This process has traditionally been referred to as "peer review."

(b) The process used to confirm an individual's competence to exercise newly granted privileges is described in the FPPE Policy to Confirm Practitioner Competence and Professionalism (New Members/New Privileges).

(c) The process used to evaluate a Practitioner's competence on an ongoing basis is described in the Ongoing Professional Practice Evaluation (OPPE) Policy.

(d) Concerns regarding a Practitioner's professional conduct or health status shall be reviewed in accordance with the Medical Staff Professionalism Policy or Practitioner Health Policy, respectively.

(e) If a matter involves both clinical and behavioral concerns, the Chairs of the Medical Staff Leadership Council and the Committee for Professional Enhancement ("CPE") shall coordinate the reviews. The behavioral concerns may either be:

(i) addressed by the Medical Staff Leadership Council pursuant to the Professionalism Policy, with a report to the CPE; or

(ii) addressed by the CPE pursuant to this Policy, with the provisions in the Professionalism Policy being used for guidance.

2. STEP-BY-STEP REVIEW PROCESS. This section describes each step in the clinical review process. These steps are illustrated in the Flowchart of Professional Practice Evaluation Process and the CPE Case Review Algorithm, both of which are included in Appendix A to this Policy.

2.A ***Cases to Be Reviewed.***

(1) ***Specialty-Specific Triggers.*** Each Department shall identify adverse outcomes, clinical occurrences, or complications that will trigger PPE. The CPE will approve these triggers and review them periodically to evaluate their effectiveness.

(2) ***Reported Concerns.*** Any Practitioner or Hospital employee may report to the PPE Specialists concerns related to the safety or quality of care provided to a patient by an individual Practitioner. A form that may be used for this purpose (FOCUS Form – Fast and Open Communication for Unmatched Safety) is included as PPE-2 in the Professional Practice Evaluation Manual ("PPE Manual").

(3) ***Other Cases or Issues.*** Cases or issues may be identified for review through any other means, including but not limited to those described in PPE-1 in the PPE Manual (PPE Triggers That Prompt the PPE Review Process).

2.B ***Follow-up with Individuals Who Report Concerns.*** The PPE Specialists or Chief Medical Officer ("CMO") shall follow up with individuals who report concerns,

either verbally or in writing. A template Response to Reported Concerns is included as PPE-3 in the PPE Manual.

2.C ***PPE Specialists.***

(1) ***Log-in.*** All cases or issues identified for review shall be referred to the PPE Specialists, who will log the matter in some manner that facilitates the subsequent tracking and analysis of the case (e.g., a confidential database or spreadsheet).

(2) ***Fact-Finding.***

(a) The PPE Specialists will review, as necessary, the medical record, other relevant documentation, and the Practitioner's professional practice evaluation history. The PPE Specialists may also interview and gather information from Hospital employees, Practitioners, patients, family, visitors, and others who may have relevant information.

(b) For any Practitioner-specific concerns that may be referred for review from the serious safety event or sentinel event review processes, interviews and other fact-finding should be coordinated between the two processes, to the extent possible, to avoid redundancy and duplication of effort.

(3) ***Review and Determination.*** The PPE Specialists shall consult with the appropriate Clinical Specialty Reviewer ("CSR"), the Chair or a member of the CPE, or CMO if there is any uncertainty about the proper determination or review process for a case. The PPE Specialists will then:

(a) determine that no further review is required and close the case. The PPE Specialists will provide periodic reports to the CPE of cases closed pursuant to this subsection. Such reports should include the specialty-specific trigger that caused the case to be identified so the CPE can evaluate the utility of such triggers;

(b) send an Informational Letter (see Section 3 of this Policy and the Sample Informational Letter at PPE-16 in the PPE Manual for additional information on Informational Letters); or

(c) determine that further review is required.

(4) ***Preparation of Case for Further Review.*** The PPE Specialists shall prepare cases that require further review. Preparation of the case may include the following:

(a) completion of the appropriate portions of the applicable case review form (CSR Case Review Form (Individual), CSR Case Review Form (Committee), or AR Case Review Form, set forth as PPE-4.1, PPE-4.2 and PPE-5, respectively, in the PPE Manual);

(b) as needed, modifying the case review form to reflect specialty-specific issues, as may be directed by a CSR, the CPE Chair, or the CMO;

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

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

(e) identification of relevant literature.

(5) ***Referral of Case for Further Review.***

(a) ***Referrals to Medical Staff Leadership Council.*** The PPE Specialists shall refer a case to the Medical Staff Leadership Council if the case involves:

(1) a concern for which immediate or expedited review is needed;

(2) professional conduct; or

(3) a Practitioner health issue.

(b) ***Referrals to the CPE.***

(1) If a Voluntary Enhancement Plan is currently in effect, the PPE Specialists will consult with the CPE Chair to determine if the case should be referred directly to the CPE.

(2) The Medical Staff President or CPE Chair, in conjunction with the CMO, may direct the PPE Specialists to refer a case directly to the CPE if they determine that the case raises unusual or significant concerns for which direct referral to the CPE is the most appropriate review process.

(c) ***Referrals Involving Certain Complex Cases.*** If a case involves:

(1) Practitioners from two or more specialties or Departments;

(2) the CSR who would otherwise be expected to review the case; or

(3) a matter for which necessary clinical expertise is not available on the Medical Staff,

the PPE Specialists will consult with the CPE Chair or CMO regarding referral of the case. The CPE Chair or CMO will determine the appropriate review process, and may decide that two or more CSRs will review the case and complete assessments simultaneously, that an Assigned Reviewer will complete the review, or that the case will be referred to the Medical Staff Leadership Council or CPE so that an external review may be obtained. (See Section 5.A of this Policy for additional guidance on external reviews.)

(d) ***Referral to Trauma Committee.*** Trauma cases will be referred to the Trauma Committee and reviewed as set forth in Section 2.E.

(e) ***Referral to Clinical Specialty Reviewer.*** All other cases shall be referred by the PPE Specialists to the appropriate CSR. This may be the CSR at the Facility where the case occurred or the CSR at another Facility.

2.D ***Clinical Specialty Reviewer.***

(1) ***Review.*** As noted in the definition of Clinical Specialty Reviewer, the Medical Staff Leadership Council may appoint an individual or a committee to serve as a CSR for a particular Department or specialty. The review process will vary slightly depending on whether an individual or a committee is appointed.

(a) ***Individual as CSR.*** Individuals who serve as CSRs shall either:

(i) review the case, consult with an Assigned Reviewer (if needed), and complete the CSR Case Review Form (Individual) (see PPE-4.1 in the PPE Manual); or

(ii) assign the review to an Assigned Reviewer, who shall evaluate the care provided, complete the AR Case Review Form (see PPE-5 in the PPE Manual), and report his or her findings back to the individual CSR.

In all cases, the individual CSR remains responsible for completing the appropriate portions of the CSR Case Review Form (Individual) (see PPE-4.1 in the PPE Manual).

(b) ***Committee as CSR.*** When a case is referred to a committee that functions as a CSR ("CSR Committee"), a committee member designated by the chair shall either:

(i) review the case personally and complete the initial portion of the CSR Case Review Form (Committee) (see PPE-4.2 in the PPE Manual); or

(ii) assign the review to an Assigned Reviewer, who shall evaluate the care provided, complete the AR Case Review Form (see PPE-5 in the PPE Manual) as may be requested, and report his or her findings back to the CSR Committee member who assigned the review.

In all cases, the CSR Committee member will remain responsible for completing the CSR Case Review Form (Committee) (see PPE-4.2 in the PPE Manual) and submitting the form to the full CSR Committee.

The CSR Committee will review the findings set forth on the CSR Case Review Form (Committee) prepared by the CSR Committee member (see PPE-4.2 in the PPE Manual). The CSR Committee will then either adopt the member's assessment, modify that assessment, or determine to obtain additional information from the Practitioner before completing its review. These actions will be documented on the CSR Case Review Form (Committee).

(2) ***Input from Practitioner.*** If a CSR or an Assigned Reviewer has any questions or concerns about the care provided by the Practitioner, the CSR or Assigned Reviewer shall obtain input from the Practitioner prior to making any final findings. Section 4 of this Policy and PPE-9 in the PPE Manual ("Request for Input from Practitioner sent by CSR, AR, or CPE") contain additional information on obtaining input from the Practitioner.

(3) ***Determinations.*** CSRs may:

(a) with the agreement of the CPE Chair or CMO:

(i) determine that no further review is required and the case is closed;

(ii) send an Educational Letter to the Practitioner (see Section 3.C of this Policy for additional guidance on Educational Letters and PPE-18 in the PPE Manual for a Sample Educational Letter);

(iii) conduct or facilitate Collegial Counseling with the Practitioner (see Section 3.C of this Policy and PPE-19 and PPE-20 for a Collegial Counseling Checklist and a Sample Follow-up Letter to Collegial Counseling); or

(b) refer the case to the CPE for determination.

2.E ***Trauma Committee.***

(1) ***General.*** The Trauma Committee will review cases based on the criteria required for verification by the American College of Surgeons and state law. The Trauma Committee will document its findings on the appropriate case review form.

(2) ***Input from Practitioner.*** If the Trauma Committee has any questions or concerns about the care provided by the Practitioner, the committee shall obtain input from the Practitioner prior to making any final findings. Section 4 of this Policy and PPE-9 in the PPE Manual ("Request for Input from Practitioner Sent by CSR, AR or CPE") contain additional information on obtaining input from the Practitioner.

(3) ***Trauma Committee Determinations.*** The Trauma Committee may:

(a) with the agreement of the CPE Chair or CMO:

(i) determine that no further review is required and the case is closed;

(ii) send an Educational Letter to the Practitioner (see Section 3.C of this Policy for additional guidance on Educational Letters and PPE-18 in the PPE Manual for a Sample Educational Letter);

(iii) conduct or facilitate Collegial Counseling with the Practitioner (see Section 3.C of this Policy and PPE-19 and PPE-20 for a Collegial Counseling Checklist and a Sample Follow-up Letter to Collegial Counseling); or

(b) refer the case to the CPE for determination.

2.F ***Committee for Professional Enhancement.***

(1) ***Review.*** The CPE shall consider the Case Review Forms, supporting documentation, input obtained from the Practitioners involved, findings, and recommendations for all cases referred to it.

(2) ***Information Sharing with Employer.***

(a) If the Practitioner involved is employed by the Hospital, the CPE may notify an appropriate Hospital representative with employment responsibilities of the review and request assistance in addressing the matter. If the Practitioner is employed by a Hospital-related entity or a qualifying private entity, the CPE may notify a representative of the peer review committee within the Employer and request assistance in addressing the matter.

(b) The Employer is generally notified when the concern is more significant. By way of example, the CPE may choose to not notify the Employer if an Educational Letter will be sent, but may choose to involve the Employer if a Voluntary Enhancement Plan may be necessary to resolve a concern.

(c) If the Employer is notified, a representative of the Employer may be invited to attend meetings of the CPE, participate in discussions and deliberations, and participate in any interventions.

(d) Any information or documentation that may be shared with the Employer will be maintained only in a peer review-protected file at the Hospital or the Employer, and ***not*** maintained in the employment or personnel file of the Practitioner.

(3) ***Case Presentation at CPE Meeting.*** The CSR responsible for the initial assessment, an Assigned Reviewer, or the CPE Chair shall present the case to the CPE.

(4) ***Determination if Additional Expertise or Information is Required.*** The CPE or the CPE Chair 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 CPE or the CPE Chair may:

(a) invite a specialist on the Medical Staff with the appropriate clinical expertise to attend a CPE meeting (either in person or electronically) as a guest, without vote, to assist the CPE in its review of issues, determinations, and follow-up actions;

(b) assign the review to any Practitioner on the Medical Staff with the appropriate clinical expertise, with a report of the assessment back to the CPE; or

(c) arrange for an external review from an individual not on the Medical Staff in accordance with Section 5 of this Policy.

The CPE or the CPE Chair shall also determine if additional cases or data related to the Practitioner should be reviewed to better understand any potential clinical concerns, prior to the CPE making a determination.

(5) ***Input from Practitioner.*** If the CPE has any questions or concerns about the care provided by the Practitioner, the CPE may obtain additional input from the Practitioner beyond what has already been obtained, prior to making any final determinations or findings. Section 4 of this Policy and PPE-11 in the PPE Manual (Request for Additional Input from Practitioner Sent by CPE) contain additional information on obtaining input from the Practitioner.

(6) ***Determinations.*** Based on its review of all information obtained, including input from the Practitioner, the CPE may:

(a) determine that no further review or action is required. If information was sought from the Practitioner involved, the Practitioner shall also be notified of the determination. A letter that may be used for that purpose is included at PPE-14 in the PPE Manual (Notice to Practitioner That No Further Review or Action is Required When Input Had Been Requested);

(b) send an Educational Letter (see Section 3.C of this Policy for additional guidance on Educational Letters and PPE-18 in the PPE Manual for a Sample Educational Letter);

(c) conduct or facilitate Collegial Counseling (see Section 3.C of this Policy for additional guidance on Collegial Counseling and PPE-19 and PPE-20 for a Collegial Counseling Checklist and a Sample Follow-up Letter to Collegial Counseling);

(d) develop a Voluntary Enhancement Plan (see Section 3.C of this Policy for additional guidance on Voluntary Enhancement Plans and PPE-21 through PPE-27 for Voluntary Enhancement Plan Documents;

(e) refer the matter to the Medical Staff Leadership Council;

(f) refer the matter to the Medical Executive Committee; or

(g) after consultation with the Employer, refer the matter to the Employer for disposition, with a report back to the CPE regarding the action taken by the Employer. If the CPE determines the

Employer's action is insufficient, the CPE may make one of the other determinations set forth in this subsection.

In making its determination, the CPE should consult the guidance in the Case Review Algorithm set forth in Appendix A.

2.G ***Medical Staff Leadership Council.*** The Medical Staff Leadership Council is primarily responsible for addressing issues of professional conduct and health in accordance with the Professionalism Policy and the Practitioner Health Policy. However, with respect to clinical performance issues, the Medical Staff Leadership Council will review:

(1) any matter that requires immediate or expedited review given the seriousness of the issue. In such case, the Medical Staff Leadership Council will conduct a preliminary review, take any action necessary to protect patients, commence the process to obtain additional expertise if needed, and refer the case to the CSR or CPE for review under this Policy; and

(2) any other matter that may be referred to it by the CPE. By way of example and not limitation, the CPE may ask the Medical Staff Leadership Council to oversee a Voluntary Enhancement Plan that has been developed by the CPE.

If the individual under review is an Employed Practitioner, the Medical Staff Leadership Council may consult with the Employer in performing these functions.

2.H ***Time Frames for Review.***

(1) ***General.*** The time frames specified in this Section are provided only as guidelines. However, all participants in the process shall use their best efforts to adhere to these guidelines, with the goal of completing reviews, from initial identification to final determination, within 90 days.

(2) ***Assigned Reviewers.*** Assigned Reviewers are expected to submit completed AR Case Review Forms (see PPE-5 in the PPE Manual) to, or consult with, the CSR or the CPE, depending on who assigned the review, within 14 calendar days of: (i) the review being assigned; or (ii) their receipt of any requested input from the Practitioner, whichever is later.

(3) ***Clinical Specialty Reviewers.***

(a) If the CSR is an individual, the CSR is expected to complete a review within 14 calendar days of the following, whichever is later: (i) the review being assigned; (ii) their receipt of an AR Case Review Form (see PPE-5 in the PPE Manual) or other information

from an Assigned Reviewer, if applicable; or (iii) their receipt of any requested input from the Practitioner, if applicable.

(b) If the CSR is a committee, the committee member that commences the review is expected to submit the completed portion of the CSR Case Review Form (Committee) (see PPE-4.1 in the PPE Manual) within 14 calendar days of: (i) the review being assigned; (ii) their receipt of an AR Case Review Form (see PPE-5 in the PPE Manual) or other information from an Assigned Reviewer, if applicable; or (iii) their receipt of any requested input from the Practitioner, whichever is later. The CSR Committee is then expected to complete its review within 14 calendar days of the following, whichever is later: (i) its receipt of the committee member's assessment; or (ii) its receipt of any additional requested input it requested from the Practitioner.

(4) ***External Reviewers.*** If an external review is sought as set forth in Section 5 of this Policy, those involved will use their best efforts to take the steps needed to have the report returned within 30 days of the decision to seek the external review (e.g., by ensuring that relevant information is provided promptly to the external reviewer, and that the contract with the external reviewer includes an appropriate deadline for the review).

2.I ***No Further Review Required.*** Cases may be closed according to the process set forth in this Policy if a determination is made that there are no clinical issues or concerns presented in the case that require further review. If information was sought from the Practitioner involved, the Practitioner shall also be notified of the determination. A letter that may be used for that purpose is included as PPE-14 in the PPE Manual (Notice to Practitioner That No Further Review or Action is Required When Input Had Been Requested).

2.J ***Exemplary Care.*** If the CPE determines that a Practitioner provided exemplary care in a case under review, the Practitioner should be sent a letter recognizing such efforts.

2.K ***Referral to the Medical Executive Committee.***

(1) ***Referral by the CPE or the Medical Staff Leadership Council.*** The CPE (or the Medical Staff Leadership Council, if involved) may refer a matter to the Medical Executive Committee if:

(a) it determines that a Voluntary Enhancement Plan may not be adequate to address the issues identified;

(b) the individual refuses to participate in a Voluntary Enhancement Plan developed by the CPE;

(c) the Practitioner fails to abide by a Voluntary Enhancement Plan; or

(d) the Practitioner fails to make reasonable and sufficient progress toward completing a Voluntary Enhancement Plan.

(2) ***Pursuant to the Medical Staff Credentials Policy.*** This Policy outlines collegial and progressive steps that can be taken to address clinical concerns about a Practitioner. However, a single incident or pattern of care may be of such concern that more significant action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter to the Medical Executive Committee pursuant to the Medical Staff Credentials Policy or the elimination of any particular step in the Policy when deemed necessary under the circumstances.

3. OPTIONS TO ADDRESS CLINICAL CONCERNS

3.A ***General.*** This Policy and the Case Review Forms in PPE-4.1, PPE-4.2 and PPE-5 of the PPE Manual discourage the use of any scoring, leveling, or grading of cases because those practices, while traditional, foster a punitive, isolating, and destructive culture surrounding PPE activities. Instead, this Policy focuses on specific efforts to address any issues that may be identified in a constructive and educational manner and thus foster a culture of continuous improvement. As such, this Policy encourages the use of Initial Mentoring Efforts and Progressive Steps by Medical Staff Leaders in order to successfully address questions relating to an individual's clinical practice.

3.B ***Initial Mentoring Efforts.*** Initial Mentoring Efforts may include, but are not limited to, discussions, mentoring, coaching, and sharing of comparative data. There is no requirement that input be obtained prior to Initial Mentoring Efforts or that they be documented. However, brief documentation is encouraged to help determine if any pattern may be developing that would recommend a more formal response. Any documentation will be maintained in the Practitioner's confidential file. A Description of Initial Mentoring Efforts and Progressive Steps is included as PPE-15 in the PPE Manual.

3.C ***Progressive Steps.*** For matters that are reported to, or identified by, the PPE Specialists and reviewed under the PPE Policy, Medical Staff Leaders will generally use Progressive Steps to address any performance issues that may be identified. Additional information on each of the following Progressive Steps may be found in the PPE Manual. A Description of Initial Mentoring Efforts and Progressive Steps is included as PPE-15 in the PPE Manual.

(1) ***Informational Letters.***

(a) Informational Letters are intended to make Practitioners aware of an expectation or requirement. They are non-punitive, informational tools to help Practitioners self-correct and improve their performance through timely feedback.

(b) The CPE will prepare a list of objective occurrences for which an Informational Letter will be sent to a Practitioner. The list may be modified by the CPE at any time, without the need for approval by the Medical Executive Committee or Board. However, notice of any revisions shall be provided by the CPE to the Medical Executive Committee and the Medical Staff.

(c) PPE Specialists will generate an Informational Letter to be sent to a Practitioner upon the occurrence of an event which has been identified ahead of time by the CPE. The Informational Letter will be signed by the CPE Chair.

(d) A Sample Informational Letter is included as PPE-17 in the PPE Manual.

(2) ***Educational Letters.***

(a) Educational Letters describe the opportunities for improvement that were identified in the care reviewed and offer specific recommendations for future practice.

(b) Educational Letters may be sent by a CSR, with the agreement of the CPE Chair or CMO, or by the CPE.

(c) The Department Chair will be informed of the substance of any Educational Letter and may contact the PPE Specialists to review a copy of the letter.

(d) A Sample Educational Letter is included as PPE-18 in the PPE Manual.

(3) ***Collegial Counseling.***

(a) A CSR, with the agreement of the CPE Chair or CMO, or the CPE may decide that Collegial Counseling will be used to address concerns with a Practitioner.

(b) Collegial Counseling is a formal, planned, face-to-face discussion between the Practitioner and one or more Medical Staff Leaders, with the CPE designating the individuals to conduct the counseling.

(c) Collegial Counseling shall be followed by a letter that summarizes the discussion and the recommendations and expectations regarding the Practitioner's future practice in the Hospital.

(d) The Department Chair shall be informed of the substance of any Collegial Counseling and the follow-up letter, regardless of who conducts or facilitates it, and may contact the PPE Specialists to review a copy of the follow-up letter.

(e) A Collegial Counseling Checklist to help prepare for such a meeting and a Sample Follow-Up Letter to Collegial Counseling are included as PPE-19 and PPE-20, respectively, in the PPE Manual.

(4) ***Voluntary Enhancement Plan.***

(a) The CPE may develop a Voluntary Enhancement Plan to bring about sustained improvement in an individual's practice. The PPE Manual provides examples of the elements that may be included in a Voluntary Enhancement Plan. However, a Voluntary Enhancement Plan may include any activity that the CPE determines will help the Practitioner to improve. Additional guidance on Voluntary Enhancement Plans is included as PPE-21 to PPE-27 in the PPE Manual, including Voluntary Enhancement Plan Options – Implementation Issues Checklist (PPE-21) and a Voluntary Enhancement Plan Template Letter (PPE-22).

(b) If a Practitioner disagrees with the need for a Voluntary Enhancement Plan developed by the CPE, the Practitioner is under no obligation to participate in the Voluntary Enhancement Plan. In such case, the CPE cannot compel the Practitioner to agree with the Voluntary Enhancement Plan. Instead, the CPE will refer the matter to the Medical Executive Committee for its independent review and action pursuant to the Medical Staff Credentials Policy.

(c) Voluntary Enhancement Plans are not disciplinary in nature. Because a Voluntary Enhancement Plan is recommended by a non-disciplinary committee that has no authority to restrict privileges and is voluntarily accepted by the Practitioner, the Voluntary Enhancement Plan is not reportable to the National Practitioner Data Bank or any state licensing board.

3.D ***Documentation.*** Informational Letters, Educational Letters, and follow-up letters to Collegial Counseling will be placed in the Practitioner's confidential file and considered in the reappointment process.

3.E ***Confidentiality.*** All Initial Mentoring Efforts and Progressive Steps are part of the Hospital's confidential performance improvement and PPE/peer review activities. Information related to them will be maintained in a confidential manner consistent with their privileged status under state and federal law.

4. OBTAINING INPUT FROM THE PRACTITIONER

4.A ***Input Required.*** Obtaining input from the Practitioner under review is an essential element of a transparent and constructive review process. Accordingly, no Educational Letter, Collegial Counseling, or Voluntary Enhancement Plan shall be implemented until the Practitioner is first notified of the specific concerns and provides input as described in this Section. Prior notice and a request for input are not required before an Informational Letter is sent to a Practitioner. (See PPE-9, PPE-10, and PPE-11 in the PPE Manual for sample Requests for Input.)

4.B ***Manner of Providing Input.*** The Practitioner shall provide input through a written description and explanation of the care provided, responding to any specific questions posed in the correspondence to the Practitioner (e.g., email or letter). Upon the request of either the Practitioner or the person or committee conducting the review, the Practitioner may also provide input by meeting with appropriate individuals (as determined by the individual or committee conducting the review) to discuss the issues.

4.C ***Office Records.*** As part of a request for input pursuant to this Policy, the person or committee requesting input may ask the Practitioner to provide a copy of, or access to, medical records from the Practitioner's office that are relevant to a review being conducted under this Policy. Failure to provide such copies or access will be viewed as a failure to provide requested input.

4.D ***Sharing Identity of Any Individual Reporting a Concern.*** Since this Policy does not involve disciplinary action or restrictions of privileges, the specific identity of any individual reporting a concern or otherwise providing information about a matter (the "reporter") will not be disclosed to the Practitioner unless the individual consents or the information is later used to support an adverse professional review action that results in a Medical Staff hearing.

4.E ***Retaliation Prohibited.*** Retaliation by the Practitioner against anyone who is believed to have reported a concern or otherwise provided information about a matter is inappropriate conduct and will be addressed by the Medical Staff Leadership Council through the Professionalism Policy.

4.F ***Discussions Outside Committee Meetings.*** Individual members of the CPE or Medical Staff Leadership Council should not engage in separate discussions with a Practitioner regarding the review of a case unless the committee in question has asked the individual committee member to speak with the Practitioner on its behalf. Similarly, unless formally requested to do so, Practitioners may not provide verbal input to the PPE Specialists or to any other individual and ask that individual to relay that verbal input to an individual or committee involved in the review. The goal of these requirements is to ensure that all individuals and committees involved in the review process receive the same, accurate information. Practitioners must also refrain from any discussions or lobbying with other Medical Staff members or Board members outside the authorized review process outlined in the PPE Policy.

4.G ***Failure to Provide Requested Input or Attend Meeting.***

(1) ***Automatic Relinquishment for Failure to Provide Written Input or Attend Meeting.*** A Practitioner's failure to provide written input or attend a meeting when requested to do so pursuant to this Policy will result in the automatic relinquishment of the Practitioner's clinical privileges, but only if all of the following conditions are satisfied:

(a) the Practitioner is asked in writing to provide written input to, or attend a meeting with, an Assigned Reviewer, a CSR, the Medical Staff Leadership Council, or the CPE;

(b) the written request gives the Practitioner a reasonable amount of time (generally five days) to provide the written input or to prepare for the meeting; and

(c) the written request notifies the Practitioner that failure to provide the written input or attend the meeting will result in the automatic relinquishment of clinical privileges pursuant to this Policy.

See PPE-12 in the PPE Manual for a sample letter regarding Notice of Automatic Relinquishment Because of Failure to Provide Input.

(2) ***When Temporary Automatic Relinquishment Becomes Automatic Resignation from Staff.*** If a Practitioner automatically relinquishes clinical privileges pursuant to this Policy and fails to provide the requested written input or meet with the applicable individuals or committee within thirty (30) days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned. See PPE-13 in the PPE Manual for a sample letter regarding Notice of Automatic Resignation for Continued Failure to Provide Input.

4.H ***Automatic Relinquishment and Automatic Resignation Not Reportable.*** The automatic relinquishment or resignation of appointment and/or clinical privileges described in this Policy are administrative actions that occur by operation of the PPE Policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any state licensing board or agency, nor do they entitle the Practitioner to a hearing or appeal.

5. ADDITIONAL PROVISIONS GOVERNING THE CLINICAL REVIEW PROCESS

5.A ***External Reviews.***

(1) Obtaining an external review is within the discretion of the Medical Staff Leadership Council or CPE, acting in consultation with the Chief Executive Officer or CMO. No Practitioner has the right to demand that the Hospital obtain an external review in any particular circumstance.

(2) Those arranging for an external review shall first seek to identify an appropriate expert who is already affiliated with Methodist Le Bonheur Healthcare.

(3) If a decision is made to obtain an external review, the Practitioner involved shall be notified of that decision and the nature of the external review. Upon completion of the external review, the Practitioner shall be provided a copy of the reviewer's report (except that any comments related to care provided by other individuals shall be redacted).

(4) The report of the external reviewer is a record of the committee that requested it and will be maintained in a confidential manner as described in this Policy.

(5) The PPE Manual includes the following documents to assist with the use of external reviewers: PPE-6 (Letter Agreement with External Review Entity); PPE-7 (Letter Agreement with External Reviewer – Individual); and PPE-8 (Letter to External Reviewer Enclosing Information for Review).

5.B ***System Process Issues.*** Quality of care and patient safety depend on many factors in addition to Practitioner performance. If system processes or procedures that may have adversely affected, or could adversely affect, outcomes or patient safety are identified through the process outlined in this Policy, the issue shall be referred to the appropriate Hospital department or committee and/or the PPE Specialists. The referral shall be reported to the CPE and will stay on the CPE's agenda until it determines, based on reports from the Hospital department or individuals charged with addressing the system issue, that the issue has been resolved.

5.C ***Peer Learning Sessions.*** Peer Learning Sessions and the dissemination of educational information through other mechanisms are integral parts of the PPE/peer review process and assist Practitioners in continuously improving the quality and safety of the care they provide. These activities will be conducted in a manner consistent with their confidential and privileged status under the state peer review protection law and any other applicable federal or state law. Additional guidance on Peer Learning Sessions is included as PPE-31 to PPE-34 in the PPE Manual.

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

(1) ***Documentation.*** All documentation that is prepared in accordance with this Policy shall be managed in a manner reasonably calculated to assure privacy and shall be maintained in appropriate Medical Staff files. All documents (whether paper or electronic) should be conspicuously marked with the notation "Confidential PPE/Peer Review" or words to that effect, consistent with their privileged and protected status under Tennessee, Mississippi and/or federal law. However, failure to mark documents in this manner shall not be viewed as an indication that the document is not privileged.

(2) ***Verbal Communications.*** Telephone and in-person conversations should take place in private at appropriate times and locations to minimize the risk of a breach of confidentiality (e.g., conversations should not be held in Hospital hallways).

(3) ***E-mail.*** Hospital e-mail or e-mail sent through the provider quality portal may be used to communicate between individuals participating in the professional practice evaluation process, including with those reviewing a case and with the Practitioner whose care is being reviewed. All e-mails should include a standard convention, such as "Confidential PPE/Peer Review Communication" in the subject line. E-mail should not be sent to non-hospital accounts unless either: (1) the e-mail merely directs recipients to check their Hospital e-mail; or (2) the e-mail is encrypted in a manner approved by the Hospital's information systems department.

(4) ***Risk Management.*** Information that is generated pursuant to this PPE Policy may not be documented in risk management files or disclosed as part of any risk management activities.

(5) ***Participants in the PPE Process.*** All individuals involved in the PPE process (Medical Staff and Hospital employees) will maintain the confidentiality of the process. All such individuals should sign an appropriate Confidentiality Agreement. Any breaches of confidentiality by Practitioners will be reviewed under the Medical Staff Professionalism Policy. Breaches of confidentiality by Hospital employees will be referred

to human resources. The PPE Manual includes the following Confidentiality Agreements that may be used to implement this subsection: PPE-37 (Confidentiality Agreement – Medical Staff Leader); PPE-38 (Confidentiality Agreement – Assigned Reviewer); and PPE-39 (Confidentiality Agreement – Hospital Employee).

(6) ***Practitioner Under Review.*** The Practitioner under review must also maintain all information related to the review in a strictly confidential manner, as required by Tennessee and Mississippi law. The Practitioner may not disclose information to, or discuss it with, anyone outside of the review process set forth in this Policy without first obtaining the permission of the Medical Staff Leadership Council, except for any legal counsel who may be advising the Practitioner. Violations of this provision will be reviewed under the Medical Staff Professionalism Policy.

5.E ***Communications with Practitioner That Include a Deadline.*** Before any paper or electronic correspondence that includes a deadline for a response (for example, a request for input or to attend a meeting) is mailed or e-mailed to a Practitioner, a text message should be sent or a phone call should be made (or voice mail left) to alert the Practitioner that the correspondence is being sent. The intent of any such text message or phone call is to make the Practitioner aware of the correspondence so that the deadline is not missed. However, failure to send a text message or make a phone call shall not be cause for the Practitioner to miss a deadline.

5.F ***Supervising Physicians and Advanced Practice Professionals.*** Except as noted below, an appropriate supervising or collaborating physician shall be kept apprised of any concerns that are reviewed pursuant to this Policy involving an Advanced Practice Professional with whom the physician has a supervisory or collaborative relationship. Without limiting the foregoing, the supervising or collaborating physician will be copied on all correspondence that an Advanced Practice Professional is sent under this Policy and may be invited to participate in any meetings or interventions. The supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under this Policy. Notification to the supervising or collaborating physician as described in this Section is not required, or may be delayed, if the individual or committee conducting the review determines that notification would be inconsistent with a fair and effective review.

5.G ***Legal Protections.*** Practitioners have significant personal legal protections from various sources when they perform functions described in this Policy as long as they maintain confidentiality and act in accordance with the Policy. These legal protections are described in Article 7 of the Medical Staff Bylaws.

5.H ***Delegation of Functions.***

(1) When a function under this Policy is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(2) When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual as set forth above.

5.I ***No Legal Counsel or Recordings During Collegial Meetings.***

(1) To promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner shall generally involve only the Practitioner and the appropriate Medical Staff Leaders and Hospital personnel. No counsel representing the Practitioner or the Medical Staff or the Hospital shall attend any of these meetings. In their discretion, Medical Staff Leaders may permit a Practitioner to invite another Practitioner to the meeting. In such case, the invited Practitioner may not participate in the discussion or in any way serve as an advocate for the Practitioner under review, must sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

(2) Practitioners may not create an audio or video recording of a meeting nor may they broadcast it in any manner (e.g., via live streaming). If a recording is made in violation of this rule, the recording shall be destroyed. In their discretion, Medical Staff Leaders may require that smart phones, iPads, and similar devices be left outside the meeting room. In exceptional circumstances, Medical Staff Leaders or Hospital personnel may record a meeting if necessary to prepare accurate minutes or an interview summary. Once the document is prepared, however, any such recording shall also be destroyed.

5.J ***Professional Practice Evaluation Reports.***

(1) ***Practitioner PPE History Reports.*** A Practitioner history report showing all cases that have been reviewed for a Practitioner within the past two years

and their dispositions should be generated for each Practitioner for consideration and evaluation by the appropriate Department Chair and the Credentials Committee in the reappointment process. A Sample Practitioner History Report is included as PPE-42 in the PPE Manual.

(2) ***Reports to Medical Executive Committee, Medical Staff, and Board.*** The CPE shall prepare reports at least annually that provide aggregate information regarding the PPE process (e.g., numbers of cases reviewed by department or specialty; types and numbers of dispositions for the cases, including numbers of cases closed at each level of the process; listing of education initiatives based on reviews; listing of system issues identified). These reports shall be disseminated to the Medical Executive Committee, all Practitioners at the Hospital, and the Board for the purposes of reinforcing the primary objectives outlined in Section 1.A of this Policy and permitting appropriate oversight. A sample PPE Activity Summary Report to be Provided to All Practitioners, MEC, and Board is included as PPE-43 of the PPE Manual.

(3) ***Reports on Request.*** The PPE Specialists shall prepare reports as requested by the Department Chair, Credentials Committee, Medical Staff Leadership Council, CPE, Medical Executive Committee, or the Board.

5.K ***Conflicts of Interest.*** 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 CPE does not make any recommendations 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 the Medical Staff Credentials Policy shall be used in assessing and resolving any potential conflicts of interest that may arise under this Policy. Those conflict of interest guidelines are summarized in Appendix B.

5.L ***PPE Manual.*** The Medical Staff Leadership Council or CPE shall approve forms, checklists, template letters and other documents that assist with the implementation of this Policy. Collectively, these documents are known as the Professional Practice Evaluation Manual ("PPE Manual"). Such documents shall be developed and maintained by the PPE Specialists. Individuals performing a function pursuant to this Policy should use the document currently approved for that function and revise as necessary.

5.M ***Substantial Compliance.*** While every effort will be made to comply with all provisions of this Policy, substantial compliance is required. Technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

5.N ***Definitions and Acronyms.***

(1) ***Definitions.***

ASSIGNED REVIEWER means a Practitioner at any Facility who is appointed by a CSR, the Medical Staff Leadership Council, or the CPE to either: (i) serve as a consultant to the individual or committee performing the review; or (ii) conduct a review, document his/her clinical findings on the AR Case Review Form (see PPE-5 in the PPE Manual), submit the form to the individual or committee that assigned the review, and be available to discuss his/her findings and answer questions. The functions of an Assigned Reviewer may also be performed by a standing or ad hoc committee as requested by the CSR, the Medical Staff Leadership Council or the CPE.

AUTOMATIC RELINQUISHMENT/AUTOMATIC RESIGNATION of appointment and/or clinical privileges are administrative actions that occur by operation of the Medical Staff Credentials Policy and/or this Policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any state licensing board or agency, nor do they entitle the Practitioner to a hearing or appeal.

CLINICAL SPECIALTY REVIEWER ("CSR") means a Medical Staff member, an Advanced Practice Professional, or a committee (including a service-line committee) appointed by the Medical Staff Leadership Council to perform the functions set forth in this Policy for a particular Department or specialty. CSRs will be appointed for a particular Facility, but they may conduct reviews for any Facility. CSRs receive cases for review, obtain input from Assigned Reviewers as needed, complete the CSR Case Review Form (Individual) or CSR Case Review Form (Committee) (see PPE-4.1 and PPE-4.2 in the PPE Manual), and make a determination as described in Section 2.D of this Policy.

COMMITTEE FOR PROFESSIONAL ENHANCEMENT ("CPE") is a multi-specialty medical/dental peer review committee and quality improvement committee under state law that oversees the professional practice evaluation process, conducts case reviews, works with Practitioners in a constructive and educational manner to help address any clinical performance issues, and develops Voluntary Enhancement Plans as described in this Policy. The CPE has no disciplinary authority. Only the Medical Executive Committee has the authority to conduct non-routine, formal investigations and to recommend restrictions of clinical privileges. The composition and duties of the CPE are described in the Medical Staff Organization Manual.

EMPLOYED PRACTITIONER means a Practitioner who is employed by an Employer.

EMPLOYER means:

(1) the Hospital; or

(2) a Hospital-related entity or a private entity that:

(a) has a formal peer review process and an established peer review committee; and

(b) is subject to the same information sharing policy as the Hospital, or has information sharing provisions in a professional services contract or in a separate information sharing agreement with the Hospital.

FACILITY means an acute care hospital which is part of the Methodist Le Bonheur Healthcare System, or a campus of such a hospital.

MEDICAL STAFF LEADER means any Medical Staff officer, Department Chair, Associate Chair, Service Chief or committee chair.

MEDICAL STAFF LEADERSHIP COUNCIL is a medical/dental peer review committee and quality improvement committee under state law that:

(1) reviews, or determines the appropriate review process for, certain clinical issues as described in this Policy;

(2) handles issues of professional conduct pursuant to the Medical Staff Professionalism Policy; and

(3) handles issues of Practitioner health pursuant to the Practitioner Health Policy.

The Medical Staff Leadership Council has no disciplinary authority. Only the Medical Executive Committee has the authority to conduct non-routine, formal investigations and to recommend restrictions of clinical privileges. The composition and duties of the Medical Staff Leadership Council are described in the Medical Staff Organization Manual.

PPE SPECIALISTS means the clinical and non-clinical staff who support the professional practice evaluation process described in this Policy. This may include, but is not limited to, staff from the quality department, medical staff office, human resources, and/or patient safety department.

PRACTITIONER means any individual who has been granted clinical privileges and/or membership by the Board, including, but not limited to, members of the Medical Staff and Advanced Practice Professionals.

PROFESSIONAL PRACTICE EVALUATION ("PPE") refers to the Hospital's routine peer review process. It is used to evaluate a Practitioner's professional performance when any questions or concerns arise. The PPE process outlined in this Policy is applicable to all Practitioners and is not intended to be a precursor to any disciplinary action, but rather is designed to promote improved patient safety and quality through continuous improvement.

(2) ***Acronyms.***

CPE	Committee for Professional Enhancement
CSR	Clinical Specialty Reviewer
FPPE	Focused Professional Practice Evaluation
MEC	Medical Executive Committee
OPPE	Ongoing Professional Practice Evaluation
PPE	Professional Practice Evaluation (Peer Review)
VEP	Voluntary Enhancement Plan

Adopted by the Medical Executive Committee on November 10, 2020.

Adopted by the Board on November 18, 2020.

APPENDIX A

FLOWCHART OF PROFESSIONAL PRACTICE EVALUATION PROCESS AND CPE CASE REVIEW ALGORITHM

[Insert flowchart]

[Insert CPE case review algorithm]

APPENDIX B
CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Clinical Specialty Reviewer (When Conducting Initial Case Review)	Committee Member					Hearing Panel	Board
			Credentials Committee	Medical Staff Leadership Council	CPE	MEC	Investigating Committee		
Employment/contract relationship with Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N	R
Relevant treatment relationship	Y	N	R	R	R	R	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Involvement in prior VEP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R

Y ("Yes") – means the Interested Member may serve in the indicated role; no extra precautions are necessary.

Y ("Yes, with infrequent but occasional limitations") – means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Credentials Committee, Medical Staff Leadership Council, and CPE have no disciplinary authority.

In addition, the Chair of the Credentials Committee, Medical Staff Leadership Council, or CPE always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the Practitioner under review.

N ("No") – means the Interested Member should not serve in the indicated role.

R ("Recuse") – means the Interested Member should be recused, in accordance with the guidelines on the next page.

RULES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The Committee Chair or Board Chair should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member at the meeting	The Interested Member may participate in any part of the meeting that does not involve the conflict of interest situation. When the matter implicating the conflict of interest is ready for consideration, the Committee Chair or Board Chair will note that the Interested Member will be excused from the meeting prior to the group's deliberation and decision-making. Prior to being excused, the Interested Member may provide information and answer any questions regarding the following: (i) any factual information for which the Interested Member is the original source; (ii) clinical expertise that is relevant to the matter under consideration; (iii) any policies or procedures that are applicable to the committee or Board or are relevant to the matter under consideration; (iv) the Interested Member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the Medical Executive Committee prior to being excused from the meeting); and (v) how the committee or Board has, in the past, managed issues similar or identical to the matter under consideration.
STEP 3 The Interested Member is excused from the meeting	The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's or Board's deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee or Board. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making.