

**PRACTITIONER/ADVANCED PRACTICE PROVIDER
PEER REVIEW PROGRAM**

This Policy is established to define the peer review process at Dayton Children's Hospital and its provider-based locations (Hospital). The Hospital's Board of Trustees has delegated to the Professional Staff, through its committees and those committees' agents, the responsibility for evaluating, maintaining, and monitoring the quality of the Hospital's health care services. As such, whenever a Practitioner, an Advanced Practice Professional (APP),¹ a member of the Hospital's staff, or a committee engages in activities pursuant to this Policy, the individual/entity shall be acting as, or on behalf of, a Peer Review Committee (PRC) as that term is recognized in Ohio Revised Code Section 2305.25, *et seq.*

This Policy describes the committee structure and routine processes by which the Professional Staff monitors, evaluates, and improves its Practitioners' and APPs' professional performance. This Policy is not intended to be confrontational or adverse. Rather, its primary focus is educational, recognizing that early detection of concerns and a prompt response to them benefits the patient as well as the caregiver. All actions between a Practitioner/APP and PRC pursuant to this Policy shall be voluntary and informal in nature. Nothing in this Policy supersedes any provision of the Professional Staff governing documents or otherwise precludes the referral of a matter to an alternative forum (Professional Staff Executive Committee (PSEC), *etc.*) should a PRC determine such referral is appropriate. Rather, the purpose of this Policy is to describe the general routine processes that are followed for clinical Peer Review and professional practice evaluation. Further, recognizing that the purpose of this Policy is to assure quality care to patients and to resolve potential quality issues at an informal level, none of the activities provided for in this Policy are considered to be investigations antecedent to a professional review action. Rather, only the PSEC or the Board has the ability to conduct an investigation antecedent to a professional review action and to, in fact, initiate and conduct a professional review action.

I. OBJECTIVES

To provide a comprehensive framework whereby the Professional Staff can assess the quality and appropriateness of care provided by Practitioners and APPs who have been granted Clinical Privileges at the Hospital in order to:

- Improve the Quality of Care provided by Practitioners and APPs.
- Create a culture with a positive approach to Peer Review.

¹ For purposes of this Policy, the term Practitioner means a Physician, Dentist, Podiatrist, or Psychologist who is granted Privileges at the Hospital; the term Advanced Practice Professional or APP means an Advanced Practice Registered Nurse, Physician Assistant, or any other allied health professional who is granted Privileges at the Hospital pursuant to the Professional Staff process.

- Identify opportunities for Quality of Care improvement on the part of Practitioners/APPs.
- Assist in providing accurate and timely performance data for feedback to Practitioners/APPs.
- Monitor significant trends by analyzing aggregate data.
- Assure that the process for peer review is clearly defined, objective, timely, and useful.

II. DEFINITIONS

Use of Designee. Whenever an individual is authorized to perform a duty by virtue of his/her position, then the term shall also include the individual's designee.

Committee Agents. Whenever a committee is authorized to engage in an activity, the committee may designate one (1) or more agents to act on its behalf.

Focused Professional Practice Evaluation (FPPE). The focused evaluation of a Practitioner's/APP's competence in exercising a specific Privilege. This process is implemented for (1) all newly granted Privileges (initial grants as well as grants of additional Privileges during the term of an existing Privilege period); and (2) whenever a question arises regarding a Practitioner's/APP's ability to provide safe, quality care. This process is part of the Hospital's routine evaluation process and allows the Professional Staff to focus evaluation on a specific aspect of a Practitioner's/APP's performance.

Multidisciplinary Peer Review Committee (MPRC). A PRC established by the PSEC, and subject to the authority of the PSEC, that provides overall jurisdiction for the operation of the Peer Review program. To the extent additional PRCs are established, they are subject to the authority of the MPRC.

Ongoing Professional Practice Evaluation (OPPE). A documented compilation of ongoing data collected for the purpose of assessing a Practitioner's/APPs Quality of Care. The information gathered during this process factors into decisions to maintain, revise, suspend, or revoke existing Clinical Privilege(s) prior to or at the end of a designated appointment/grant cycle. This process not only allows any potential problems with a Practitioner's/APP's performance to be identified and resolved as soon as possible; but, also, fosters a more efficient, evidence-based Privilege regrant process.

Peer. An individual practicing in the same or similar profession as the individual under review with equal or greater education, training, or current competence. A determination as to who constitutes a Peer will be made on a case-by-case basis, as appropriate. All external Practitioner reviewers will be appointed to the Hospital's consulting peer review Professional Staff category (to the extent such category exists) and will agree to maintain confidentiality consistent with Ohio's peer review privilege prior to engaging in Peer Review activities.

Peer Review. A prospective, concurrent, or retrospective review of patient care, management, interaction, and/or consultation by a PRC (or one of its agents) in order to evaluate the Quality of Care provided by a Practitioner/APP. Peer Review is conducted using multiple sources of information. The individual's evaluation is based on generally recognized standards of care. Through this process, Practitioners/APPs receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

Peer Review Committee (PRC). A committee subject to the oversight of the MPRC (unless it is the MPRC) that is responsible for evaluating and improving Practitioner/APP performance as it relates to:

1. Patient care
2. Medical/clinical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. System-based practice

All members of a PRC, and individuals requested to act as an agent of a PRC, must sign a confidentiality statement, a copy of which is attached hereto as Addendum A and incorporated by reference herein, prior to engaging in peer review activities. All PRCs must follow the minutes' format, a copy of which is attached hereto as Addendum B and incorporated by reference herein.

Quality of Care. For purposes of this Policy only, Quality of Care issues related to a Practitioner's/APP's professional conduct or clinical competency.

Quality Resource Management (QRM). The Hospital department responsible for oversight, development, evaluation, and ongoing monitoring of the quality improvement, peer review, and patient safety processes and initiatives. QRM is a designated Peer Review agent of all PRCs.

III. POLICY

A. Scope. The MPRC is charged with evaluating the care provided by Practitioners/APPs at the Hospital.

1. Depending upon the scope of issues presented, the MPRC may provide such evaluation through the MPRC or it may establish PRCs that are specialty specific and that report up to the MPRC.

2. For purposes of this Policy, the assumption is that a MPRC has one (1) or more PRCs that report up to it. In the event that this is not the case, then the MPRC is responsible for the actions of the PRC as set forth herein.
 3. The composition, term, and duties of the MPRC are set forth in Addendum C attached hereto and incorporated by reference herein. The composition, term, and duties of each PRC, if any, are as set forth in the Professional Staff Organization Policy.
- B. Education. All participants in the Hospital's Peer Review program will be educated as to the responsibilities of the members and their respective committees.
- C. Manner of Activities. Peer Review activities are conducted in the following manner:
1. Cooperatively. A PRC (or agent on behalf of the PRC) may request to meet with a Practitioner/APP to discuss cases or issues under review or to request that the Practitioner/APP respond, in writing, to cases or issues under review. Practitioners/APPs are expected to reasonably participate in this process. A failure to do so will result in the matter being resolved without the Practitioner's/APP's input and will be considered in the context of whether the Practitioner/APP is acting in a professional manner consistent with his/her responsibilities pursuant to the Professional Staff governing documents.
 2. Courteously. Participants are to be courteous and respectful to each other.
 3. Impartially. Activities are to be fair, impartial, and conducted in an appropriate manner designed to protect patient safety and the integrity of the program. Activities are to be performed in good faith and without bias, prejudice, personal gain, or malice.
 4. Peer to Peer. The Peer Review program is designed to foster collegial engagement. As such, neither a PRC, nor Practitioner, nor APP shall have the right to have legal counsel present at a PRC meeting unless authorized at the PRC's sole discretion.
- D. Performance Improvement Activities. Performance improvement activities related to systemic issues are not a part of this Policy. Rather, to the extent a performance improvement issue is identified by a PRC, the issue will be referred to the appropriate Hospital committee. Correspondingly, if a Hospital committee identifies a Practitioner/APP issue, that committee will refer the matter to QRM for review and referral, as appropriate, to the MPRC or a PRC.
- E. Conflicts of Interest

1. The fact that a PRC member or PRC agent is in the same specialty as the Practitioner/APP under review does not, in and of itself, require recusal of that person.
2. In the event a Practitioner/APP believes that a PRC member/agent has a conflict of interest that precludes him/her from acting in an impartial manner, the Practitioner/APP must submit his/her objections, in writing, to the chair of the applicable PRC. The chair, at his/her sole discretion, will make the final determination as to the whether the contested individual may continue to participate.
3. A member of a PRC who is under review must be recused from participating in the peer review matter as a PRC member.

F. Confidentiality

1. Peer Review information includes all information collected for, generated by, or otherwise under the oversight of a Peer Review Committee. Peer Review information shall only be used for Peer Review purposes as that term is defined in Ohio Revised Code §2305.25, *et seq.* in the absence of a decision on the part of the Chief Executive Officer that it is appropriate for certain information to be used for alternative purposes.
2. Peer Review information shall be maintained in a secure location. Although not required as a means of assuring Peer Review protection, any or all of the following processes may be implemented as an additional means of assisting in maintaining confidentiality as deemed appropriate based upon the situation:
 - a. Identifying Practitioners/APPs by code number.
 - b. Identifying patients by code number.
 - c. Distribution of minutes and related materials at committee meetings and recollecting such minutes and related materials at the conclusion of a meeting.

IV. PEER REVIEW PROCESS

A. Identifying Cases/Issues.

1. Any person/entity may submit an incident report or otherwise notify QRM of case(s) and concerns. QRM shall then be responsible for processing the incident report consistent with Hospital policy. If the incident report involves Practitioner competency or conduct, then the process set forth in this Policy and the procedure set forth in Addendum D shall be followed.

2. QRM is responsible for identifying cases that should be referred to the applicable PRC.
 - a. In the event the Hospital only has an MPRC, all cases will be referred to the MPRC.
 - b. In the event the MPRC has one or more PRCs, the case will be referred to the appropriate PRC.
3. Case review may be triggered by any number of factors including, but not limited to: sentinel events/serious safety events, near misses, specialty specific clinical screens, benchmarks, practice patterns, professional liability cases, resource utilization data, requests for peer review, safety reports, *etc.*

V. ONGOING PROFESSIONAL PRACTICE EVALUATION

- A. Process. The Professional Staff conducts continuous ongoing quality oversight of Practitioners/APPs intended to provide useful information in the areas of patient care, professionalism, practice-based learning and improvement, interpersonal and communication skills, system-based practice, and medical/clinical knowledge. This information assists the Professional Staff, Practitioners, and APPs to identify individual practice trends that may affect patient care and safety. The data generated by OPPE is a factor in the decision as to whether to permit a Practitioner/APP to maintain Clinical Privileges.
- B. Data. Data compiled for purposes of OPPE may include, but is not limited to, the following:
 1. Review of indications for, and performance of, operative and other clinical procedure(s) performed and their outcomes.
 2. Pattern of pharmaceutical usage.
 3. Appropriateness of clinical practice patterns.
 4. Significant departures from established patterns of clinical practice.
 5. Medical assessment and treatment of patients.
 6. Morbidity and mortality data.
 7. Sentinel event data.
 8. Patient safety data.
 9. Core indicators and specialty-specific indicators as determined by the MPRC in collaboration with the applicable Professional Staff leaders.

10. Other relevant criteria as determined by the MPRC.
- C. Compilation of Data. Data may be acquired through the following:
1. Periodic chart review.
 2. Direct observation.
 3. Monitoring of diagnostic and treatment techniques.
 4. Discussion with other individuals involved in the care of each patient including consulting Practitioners/APPs, surgical assistants, nursing, and administrative personnel.
- D. Criteria.
1. Criteria are reviewed annually by the QRM after obtaining input from the Professional Staff leaders.
 2. The developed criteria is forwarded to the MPRC and then to the PSEC before being submitted to the Board for approval.
- E. Distribution.
1. The QRM generates reports that are provided to each Practitioner/APP. The goal is for reports to be issued not less than every eight (8) months. These reports are intended to reflect individual performance that can be compared to prior reports.
 2. The QRM provides Division Chiefs with the OPPE reports of each Practitioner/APP in his/her Division. In the event a Division Chief believes that an OPPE indicates concerns, the Division Chief is encouraged to meet with the affected Practitioner/APP to provide mentoring and direction. A memorandum of such meeting shall be made by the Division Chief and maintained in the Practitioner's/APP's Peer Review file. The Credentials Committee chair shall act as the Division Chief for purposes of a Division Chief's OPPE. QRM provides the OPPE reports to the applicable PRC when the data:
 - a. Establishes that thresholds have been exceeded.
 - b. Establishes that there are opportunities for improvement.
 - c. Is negative.

VI. FOCUSED PROFESSIONAL PRACTICE EVALUATION

- A. Purpose. FPPE, by its very term, is a review of a particular Practitioner/APP, and is an integral component of this Policy's routine peer review processes. At the time that a Practitioner/APP is initially granted Privileges, there is insufficient data upon which to make a determination of competency; and, therefore, a period of FPPE is implemented. In addition, even when the OPPE process is in place, the data generated may be insufficient to determine Quality of Care. As such, an FPPE implemented by the MPRC/PRC, unless it is initiated at the direction of the PSEC with an obligation to report back to the PSEC, does not constitute an investigation antecedent to a professional review action. Instead, it is part of the Peer Review Program designed to supplement data in order that appropriate determinations may be made.
- B. Grounds. An FPPE is implemented:
1. For all new grants of Privileges (initial grants as well as grants of additional Privileges during the term of an existing Privilege period).
 - a. For low volume Practitioners/APPs, an FPPE may remain in place for more than one (1) Privilege period.
 - b. For newly appointed Practitioners/APPs whose residency/training was at the Hospital, consideration will be given to using the data collected during training to satisfy the FPPE requirement.
 2. When concerns arise regarding a currently privileged Practitioner's/APP's Quality of Care.
- C. FPPE for New Grants of Clinical Privileges. The scope of the FPPE for new grants of Privileges is set forth in the applicable Clinical Privilege set. QRM monitors the completion of the requisite number of cases or other selected evaluation method. Upon completion, QRM notifies the Practitioner's/APP's Division Chief who, in turn, determines whether the FPPE has been successfully completed. A Division Chief may extend an FPPE once for a period not to exceed six (6) months. The MPRC must be notified when an individual's FPPE has been extended. If the Division Chief continues to have concerns following an extension, he/she must refer the matter to the MPRC. The Credentials Committee chair shall perform the Division Chief's duties with respect to a Division Chief's FPPE. If any concerns arise during an FPPE, the matter is handled consistent with this Policy and related Professional Staff governing documents.
- D. FPPE for Concerns Identified During a Privilege Period. An FPPE may be triggered by a PRC, the MPRC, or the PSEC when any of the following occurs:
1. Egregious single event.
 2. Pattern of concern identified pursuant to an OPPE.

3. Concerns identified by a PRC, the MPRC, or the PSEC.
4. Significant complaints by patients, Hospital staff, Practitioners, or APPs.
5. Other patterns of quality trends of concern.

E. Elements of a FPPE Based upon Concerns.

1. The establishment of an FPPE based upon Quality of Care concerns during a Privilege period is generally the responsibility of a PRC. A PRC may also refer the matter to the MPRC. An FPPE is to be designed in a manner that best provides oversight of the care being provided by a Practitioner/APP relative to the issue under review.
2. An FPPE that is managed by a PRC or the MPRC is not adverse or otherwise an investigation antecedent to a professional review action; and, therefore, does not trigger any procedural due process rights nor is it reportable to federal or state authorities.
3. An FPPE may consist of any or all of the following:
 - a. Prospective, concurrent, or retrospective case review.
 - b. Direct observation.
 - c. Proctoring.
 - d. Education.
 - e. External Peer Review.
4. In the event a PRC implements an FPPE, the Practitioner/APP will be notified, in writing.
5. Although not required, it is the expectation that the PRC will meet with the Practitioner/APP to review the reason for the FPPE and its scope.
6. A Practitioner/APP may voluntarily agree to limit the exercise of his/her Clinical Privileges during the course of an FPPE established by a PRC.

F. External Peer Review.

1. Purpose. External Peer Review is used to assure an objective and fair evaluation of the care delivered (as documented in the medical record) is afforded to the Practitioner(s)/APP(s) involved; and to resolve any issues remaining from internal Peer Review. As such, external Peer Review is considered whenever it is determined that:

- a. An internal review may not be perceived as objective or unbiased.
- b. An internal review cannot be performed due to a conflict of interest.
- c. Similarly trained Practitioners/APPs are not available to conduct a review.
- d. There is a substantial difference of opinion regarding the care provided.
- e. The review involves a new technology or procedure for which the Professional Staff does not have the requisite expertise.
- f. There is a possibility of a future professional review action.
- g. Other appropriate reason as dictated by circumstances.

2. Authority. The following have the authority to initiate an external review:

- a. The PSEC or PSEC chair (with approval of the CEO/CMO). In the event an external review is denied by the CEO/CMO, the PSEC may obtain approval from the Board.
- b. The MPRC or MPRC chair (with approval of the CEO/CMO).
- c. The Board.
- d. The Chief Executive Officer (on behalf of the Board).

A Practitioner/APP cannot require the Hospital to obtain an external peer review.

3. Qualifications. An external Practitioner reviewer must meet the qualifications of, and be an Appointee to, the Professional Staff's consulting peer review category (to the extent such category exists) as well as the following criteria:

- a. Be board certified in the specialty under review and have been engaged in the active practice of such specialty for at least five (5) years.
- b. Not have or be perceived as having a conflict of interest with the affected Practitioner/APP. Preference will be given to external

peer reviewers who have no personal relationship with the Practitioner/APP.

- c. Be able to provide a timely, written, objective opinion based on the care delivered (as documented in the medical record and pertinent related components such as radiographs, referral facility records, *etc.*). The opinion must include decision rationale, any national or organizational standards utilized, and opportunities for improvement (if any).
- d. Be willing to continue to participate in the Peer Review process through fair hearing and litigation if the matter extends to these proceedings.
- e. Such other qualifications as are deemed appropriate by the appointing committee.

G. Process Following Receipt of External Peer Review Report.

1. If the PRC that requested the review has any concerns or questions relative to the review after receipt of an external Peer Review report, the PRC is expected to follow up with the external reviewer either by letter or conversation documented by minutes.
2. Because Peer Review is part of the routine ongoing checks and balances of the Hospital's quality assessment process, a Practitioner or APP is not required to be notified of an external review. However, recognizing the value that such a report has in assessing patient care, in all but exceptional circumstances (as determined by the applicable PRC following consultation with Hospital legal counsel), the affected Practitioner/APP will be given access to the results of an external Peer Review (whether favorable or unfavorable) as well as the opportunity to participate in, or respond to, any concerns, as soon as reasonably appropriate. The Practitioner/APP is not required to be, and should not be, given a copy of the report unless the report becomes part of an investigation conducted by the PSEC that results in the initiation of the fair hearing process (or such other process as may be available for an APP). Nothing in this paragraph shall be construed as precluding the imposition of a summary suspension, pursuant to the process set forth in the Professional Staff Bylaws or APP Policy, as applicable, prior to such review if circumstances so warrant.
3. Thereafter, the applicable PRC (if not the MPRC) shall:
 - a. Close the matter.

- b. Continue with the FPPE.
 - c. Enter into a voluntary remediation agreement with the Practitioner/APP, subject to the approval of the MPRC. Refer the matter to the MPRC.
 4. If the MPRC conducts the review, the MPRC may:
 - a. Take any of the actions listed in the immediately preceding section.
 - b. Refer the matter to the PSEC. Thereafter, the process as set forth in the Professional Staff Bylaws and/or APP Policy, as applicable, shall apply.
 5. Upon completion of an external Peer Review, the determination as to what information will be shared; and when, how, and with whom, shall be decided by the MPRC (or the Board if the Board or the CEO initiated the review); provided, however, that to the extent the review establishes the need for remediation and/or corrective action, legal counsel should be brought in to assist the committee in such determination.

VII. RESULTS OF PROFESSIONAL PRACTICE EVALUATION (PPE)

- A. Based upon the analysis of the information resulting from PPE activity (FPPE or OPPE), several actions may occur including, but not limited to:
 1. Determination that the Practitioner/APP is performing in accordance with established expectations and that no action is necessary/warranted.
 2. Determination that an issue(s) exists that requires a period of FPPE.
 3. Determination that an issue(s) exists that requires informal remediation.
 4. Determination that an issue exists that requires formal corrective action.

VIII. ASSESSMENT OF PROFESSIONAL PRACTICE EVALUATION

Not less than every two (2) years, the MPRC, in conjunction with QRM, will evaluate the effectiveness of the Peer Review program and determine what changes, if any, should be made to the Peer Review process as set forth in this Policy.

IX. ACCESS TO PEER REVIEW INFORMATION

- A. Committee Activities.

1. Peer Review files are Hospital property and are maintained for credentialing, privileging, and related peer review purposes. The information maintained in these files is privileged pursuant to Ohio Revised Code § § 2305.25, *et seq.*
2. All Peer Review committee minutes are maintained as protected peer review documents. A Practitioner/APP who is under review is not entitled to access to these minutes unless they are produced as part of a fair hearing proceeding (or similar proceeding as applicable to APPs).
3. All correspondence between a Peer Review Committee and a Practitioner/APP, final determinations, related records, and related information are maintained in a Peer Review file.
4. The Hospital maintains one or more Peer Review files for each Practitioner/APP who maintains, as applicable, an appointment and/or Clinical Privileges at the Hospital. Peer Review files contain Quality of Care information including credentials, privileging, OPPE, FPPE, and other Quality of Care Data. Peer Review files may also be developed for other activities (*e.g.*, formal corrective action proceeding, *etc.*).
 - a. Consistent with Professional Staff policy, a Practitioner/APP has the right to review his/her credentials file and quality file (subject to certain information, such as references or other third party documentation, not being disclosed as determined by the Hospital).
 - b. A request to review one's credentials or quality file should be made to the Professional Staff Office. Requests should be made at least five (5) business days in advance. The review will be held at the Professional Staff Office, as applicable, in the presence of a designated Peer Review agent.
5. Peer Review information is otherwise available only to (a) authorized individuals/committees who require access to such information as part of the protected Peer Review process; or (b) appropriate accrediting/regulatory organizations.

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Professional Staff Executive Committee:

Professional Staff Chair

Date

Approved by the Board:

Board Chair

Date

ADDENDUM A

PEER REVIEW PROGRAM MEMORANDUM OF UNDERSTANDING AND STATEMENT OF CONFIDENTIALITY

Thank you for agreeing to serve as a member of a Peer Review Committee (PRC) or otherwise participate in the peer review process at the Hospital. Practitioners/Advanced Practice Professionals who participate in peer review must be viewed by their colleagues as fair, collegial, confidential, clinically competent, and professional. Peer review is ultimately the responsibility of the Hospital Board as part of maintaining the quality of medical care. The Board delegates this responsibility to the Professional Staff through the Professional Staff Chair and PSEC which, in turn, authorizes the PRCs to act. As a member of a PRC or participant in the peer review process, it is your shared responsibility in return to make sure that the peer review program is effective.

The ultimate goal of peer review is to continuously improve the skills of Practitioners and Advanced Practice Professionals with Privileges at the Hospital through identification, analysis, and practice improvement recommendations for problematic events. In order for these interventions to successfully improve patient care, the process of peer review has to be just and fair. This leads to a number of behavior expectations for members of PRCs and other peer review participants, as follows:

- Have a professional and collegial demeanor in all activities.
- Keep deliberations frank, honest, accurate, unbiased, and non-inflammatory.
- Be trustworthy. Keep the deliberations confidential the way you would expect if your case was under review.
- Seek additional input if the issue is outside the expertise of the PRC members. Sometimes determining whether or not a particular action was within the standard of care requires detailed knowledge of current practice that only a group of peers from within the involved specialty can provide.
- Do not use the peer review process to discredit, embarrass, undermine, discourage or unseat a colleague. Cases should be selected without bias.
- Do not protect a colleague or friend from peer review. If you perceive that this needs to be done, you are indicating that you believe the peer review process is either not fair; or, is being used to do something other than improve the Quality of Care. It is your obligation to bring these concerns to the PRC chair.
- If you have a conflict of interest with the Practitioner/Advanced Practice Professional being discussed, (*e.g.* competitor, partner, refers patients to you or vice-versa, financial relationship, employed in the same group, *etc.*), you are expected to disclose that conflict to the PRC. The PRC is responsible for determining whether the conflict rises to the level of precluding you from participating in the pending peer review matter. For purposes of

this Policy, the fact that Practitioners/APPs are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such Practitioners/APPs from participating in the peer review process with respect to his/her colleagues.

All peer review information is privileged and confidential in accordance with the Professional Staff Bylaws, Hospital and Professional Staff policies, and state and federal laws and regulations pertaining to confidentiality and non-discoverability. In Ohio, peer review discussions and documents are protected from discovery by Ohio law. As long as the Hospital has a prescribed process for peer review and follows that process, efforts to protect patients and improve Practitioner/Advanced Practice Professional performance cannot be used as evidence in a civil lawsuit.

To preserve the confidentiality of quality management data, it is imperative that Practitioners and Advanced Practice Professionals involved in peer review observe the following instructions in the performance of peer review:

- The case review form should never be shared with individuals who are not authorized to access this information. When the review is completed, please submit the form (either in hard copy or electronically) to the designated Professional Staff/Hospital personnel or office. The form is not to be part of the patient's medical record.
- Once the case review form is completed, making additional copies of the form is prohibited.
- Discussing peer review cases or data with other Practitioners or Advanced Practice Professionals outside of the PRC meeting is prohibited unless specifically requested by the PRC.
- Discussing any peer review case or data with anyone in a public setting is prohibited.
- Discussions of PRC reviews with Hospital employees other than those involved in the peer review or performance improvement process are prohibited.

I understand the expectations for a member of a PRC/participant in the peer review process and I agree to comply with these expectations. I further understand and agree to comply with the requirements for confidentiality of peer review deliberations. I also understand and acknowledge that failure to comply with these expectations and requirements may result in my removal as a member of a PRC/participant in the peer review process and/or may be grounds for corrective action pursuant to the Professional Staff Bylaws or APP Policy, as applicable.

NAME (Print)	SIGNATURE	DATE SIGNED

ADDENDUM B

Dayton Children's Hospital Professional Staff Multidisciplinary Peer Review Committee

Date of Meeting:

Present:

Absent:

Staff:

OLD BUSINESS

Topic:

Conclusions:

Recommendations/Action:

NEW BUSINESS

Topic:

Conclusion:

Recommendations/Action:

OTHER BUSINESS

Topic:

Conclusions:

Recommendations/Action:

There being no further business, the meeting was adjourned at _____.

Respectfully submitted:

Attest:

ADDENDUM C

Multidisciplinary Peer Review Committee

I. MPRC

A. COMPOSITION OF MPRC

1. The Multidisciplinary Peer Review Committee (MPRC) will consist of not less than eight (8) and not more than eleven (11) voting members, chosen by the Professional Staff Chair in consultation with PSEC, to include:
 - a. One individual who is on the active Professional Staff without Clinical Privileges.
 - b. One representative each from Ambulatory Care, Medicine, Surgery, Psychology/Psychiatry, and Emergency Medicine.
 - c. At-large members of the active Professional Staff.
 - d. One APP representative.
 - e. Chair and Vice-Chair of the MPRC who shall satisfy the qualifications set forth in Article I of the Professional Staff Organization Policy.
2. The Hospital CEO, Chief Medical Officer, Surgeon-in-Chief, Director of Quality Assurance and Senior Director of Surgical Services shall be *Ex Officio* members of the MPRC without vote.
3. In order to maintain continuity, initial terms will be staggered, as determined by the Professional Staff Chair, among the members (two (2), three (3), and four (4) year terms). Thereafter, members will serve three (3) year terms.
4. An MPRC member/chair may serve any number of consecutive terms if he/she continues to hold one of the positions set forth in Section (A)(1) above or is reappointed as an at-large member of the MPRC by the Professional Staff Chair.
5. Quorum, resignations, removals, vacancies, and any other procedural matter not contained herein shall be handled in the same manner as all other committees under the authority of the PSEC.

B. DUTIES OF THE MPRC & MPRC CHAIR

1. The duties of the MPRC include:
 - a. Making referrals to the PSEC or Hospital administration as appropriate.

- b. Acting as a liaison between Departments and Divisions and between the Professional Staff and Hospital administration regarding Peer Review matters.
- c. Coordinating internal/external Peer Review.
- d. Being responsible for evaluating and assisting in the improvement of Practitioner and APP performance.
- e. Conducting case reviews for the purpose of determining the appropriateness of care by Practitioners and APPs.
- f. Develop and maintain a program for recognition of peer excellence.
- g. Taking appropriate action with respect to delinquent PRC cases.
- h. Evaluating rate and rule indicators for adverse patterns, trends, and outliers.
- i. Assuring that when opportunities for improvement are identified, the appropriate individual(s) is/are notified of the issues and a reasonable improvement plan is developed.
- j. Delegating matters to the Professional Staff Health Committee, as needed, for review of reports of suspected Practitioner/APP impairment.
- k. Preparing required reports and reporting (which reporting may be by minutes) to the PSEC regularly regarding actions taken to improve care and any cases where action was not taken when requested or actions are perceived to be inadequate.
- l. Monitoring and evaluating the quality, from a peer perspective, of medical/other professional care and treatment of patients including critical, acute, chronic and ambulatory care patients.
- m. Providing oversight of medical/professional care provided by Practitioners and APPs through case reviews.
- n. Providing oversight of surgical care provided by Practitioners and APPs through case reviews including surgery indications, tissue reports, and outcomes.
- o. Assuring the implementation of a planned and systematic process for monitoring and evaluating the quality, from a peer perspective, of the medical/other professional care and treatment of surgical patients.

- p. Reviewing minutes and QA reports from other committees and designated peer review agents with respect to Peer Review matters.
 - q. Such other duties as may be assigned by the PSEC.
2. The MPRC Chair shall:
- a. Assist with the MPRC agenda, conduct the MPRC meetings, and review and sign the MPRC meeting minutes.
 - b. Work collaboratively with the Director of Quality Assurance in appropriate assignment of quality and/or behavior concerns.
 - c. Report, or delegate to a member of the MRPC to report, to PSEC regarding MPRC activities, findings, and recommendations.
 - d. Be available to assist the Division Chiefs in establishing quality metrics for their Division.

C. MEETING REQUIREMENTS

- 1. The MPRC will meet on a monthly basis and as otherwise needed at the call of the committee chair.
- 2. The MPRC will maintain a record of its proceedings and actions and will report to the PSEC.

ADDENDUM D

PRACTITIONER/APP PEER REVIEW PROCESS

1. Case identified by Quality Resource Management
 - a. Nurse reviewer
 - i. Evaluates and closes.
 - ii. Refers to a PRC member for review.
 1. Evaluates and closes.
 2. Refers to PRC for review.
 - iii. Refers to PRC for review.
2. Case evaluated by PRC
 - a. Evaluates, determines appropriate, closes.
 - b. Evaluates, issues letter out to Practitioner/APP for additional information.
 - i. If Practitioner/APP fails to respond within time requested, PRC makes determination.
 - ii. If Practitioner/APP responds, information presented is considered, and determination made.
 - c. Other than in exceptional circumstances, a determination of harm or potential harm will not be made until after the Practitioner/APP has been given an opportunity to respond.
 - i. In addition to a written response, a Practitioner/APP may request to meet with the PRC to discuss the case under review.
3. Appeal of PRC finding
 - a. The determination of the MPRC is final without an appeal process.
 - b. In the event a PRC that reports up to the MPRC has made an 'Inappropriate' finding, the Practitioner/APP may submit a written request to the MPRC to reconsider the finding. The request must specifically identify the findings with which the Practitioner/APP disagrees and the basis for such disagreement.
 - c. The MPRC may:
 - i. Review and decide the case based solely upon the written information.
 - ii. Remand the matter back to the PRC or request additional input from the PRC.
 - iii. Meet with the Practitioner/APP or the PRC.
 - d. The MPRC's decision is final.

4. Impact of determination

- a.** A case rating by a PRC or by the MPRC is not deemed adverse nor does it trigger any procedural rights pursuant to the Professional Staff Bylaws or APP Policy; rather, it is part of the ongoing informal professional practice evaluation process.