Boulder Community Health

Medical Staff

PROFESSIONAL PRACTICE REVIEW PLAN

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SECTION 1. PURPOSE

1.1. The Governing Board of Boulder Community Health delegates authority to the Medical Staff the administration and oversight of the peer review process for Medical Staff members and Advanced Practice Professionals with clinical privileges. The Medical Staff has assigned the responsibility and authority for oversight of the peer review process to the Professional Practice Review Committee (PPRC). The authority and responsibility of the PPRC is set forth in the Medical Staff Bylaws and this Plan.

1.2. The purpose of this Medical Staff Professional Practice Review Plan (Plan) is to establish a uniform and consistent structure to:

1.2.1. Facilitate a coordinated approach to gathering data on practitioner quality and conduct from all relevant sources;

1.2.2. Provide for regular evaluation of such data and process to triage concerns and assure that they are resolved at the appropriate level;

1.2.3. Allow peer review to be conducted in a standard way throughout the hospital by practitioners who are trained and experienced in peer review; and

1.2.4. Improve patient care by enforcing standard quality and conduct criteria throughout all departments of the medical staff.

1.3. All activity conducted pursuant to this Plan is considered peer review activity and is subject to privileges and immunities attached to peer review activity under applicable state and federal laws. The results, findings, and conclusions of the performance improvement and professional practice evaluation activities conducted under this Plan are considered in the credentialing, privileging, and contract review processes of the Medical Staff.

SECTION 2. SCOPE

2.1. Practitioners who are members of the Medical Staff or are Advanced Practice Professionals who have been granted delineated clinical privileges at BCH will be subject to the requirements outlined in the Plan. The activities performed by independent licensed health care professionals under a contractual arrangement with BCH that involve direct patient care contact and/or have an impact on the outcome of patient care service are also subject to this Plan.

2.2. Nothing in this Plan is intended to limit the authority of the Medical Staff, the Medical Executive Committee or any other committee of the Medical Staff, the Governing Board or any officer of the Medical Staff or the Hospital, as such authority is set forth in the Medical Staff Bylaws.

2.3. Nothing in this Plan is intended to limit or expand the rights of Practitioners as set forth in the Medical Staff Bylaws or the rights or obligations of the Hospital or any Practitioner in any contractual or employment agreement between the Practitioner and the Hospital.

SECTION 3. DEFINITIONS

3.1. **Advanced Practice Professional** – a licensed independent mid-level practitioner who has been granted clinical privileges by the Governing Board. This includes physician assistants, advanced practice nurses, and licensed independent practitioners permitted to consult/provide services

only by written order of the attending physician.

3.2. **Department Chair** - those individuals who are appointed as chairs of the departments of the Medical Staff. For purposes of this Plan, the Medical Director of Ambulatory Quality Improvement & Population Health shall be included in the term Department Chair.

3.3. **Focused Professional Practice Evaluation -** the process by which a Practitioner's performance is reviewed by the Medical Staff based on specific concerns.

3.4. **Governing Board** – the board of directors of Boulder Community Health.

3.5. **He/his** - in this document gender is indicated as he/his and refers to both genders.

3.6. **Hospital** – Boulder Community Health, which shall include all hospital facilities and outpatient clinics owned and operated by The Community Hospital Association.

3.7. **Indicators** – those criteria established by the PPRC and approved by the MEC which are used to determine the level of review and by whom such review is conducted under this Plan.

3.8. **Leadership Council** – a body made up of the following medical staff leaders: President of the Medical Staff, Chief Medical Officer, Medical Director of Ambulatory Quality Improvement & Population Health, Chair of the Credentials Committee and Chair of the PPRC. The Director of the Medical Staff Department, the Chief Operating Officer of Physician Clinics, and the Director of the Hospital Quality Department, as invited, shall serve as ex-officio members of the Leadership Council. The Leadership Council may consult with additional individuals as necessary for a particular matter. The Leadership Council shall convene as necessary to carry out the functions assigned to it under this Plan.

3.9. **Medical Staff** – the Medical Staff of Boulder.

3.10. **Medical Staff Bylaws -** the bylaws, rules and regulations and all related manuals and policies adopted by the Medical Staff.

3.11. **Medical Staff Quality Department (MSQD)** – the unit within the Hospital's Medical Staff Department responsible for support of medical quality.

3.12. **Mortality & Morbidity Subcommittee (M&M Subcommittee)** - a subcommittee of the PPRC, to review identified morbidities or mortalities hospital wide for multidisciplinary cases or smaller departments that do not already have an M&M process in place. Composition includes Chief Medical Officer, PPRC chair, MSQD representative, the Risk Manager and a Clinical Quality representative and other providers to be determined on a case by case basis.

3.13. **On-going Professional Practice Evaluation (OPPE)** – the process by which Practitioners' performance is regularly reviewed by the Medical Staff based on established criteria

3.14. **Practitioner** – a physician, podiatrist, dentist, or Advanced Practice Professional who is credentialed through the Medical Staff.

3.15. **Professional Practice Review Committee (PPRC)** – the committee of the Medical Staff charged with the oversight of the Medical Staff peer review process as outlined in the Medical Staff Bylaws and this Plan. The PPRC shall have the composition set forth in the Medical Staff Bylaws and shall have the responsibility and authority set forth in the Bylaws and in this Plan. The PPRC reports to the Medical Executive Committee.

3.16. **Section Chiefs** – those individuals who are appointed as leaders of sections of the Medical Staff.

3.17. **Quality File** – a file maintained separate from a Practitioner's credentials file which includes quality issues identified regarding the practitioner, including activities conducted under this Plan.

SECTION 4. ORGANIZATION, STRUCTURE AND ACCOUNTABILITY OF PEER REVIEW PROCESS

4.1. The Medical Staff has a leadership role in organization performance improvement activities. When the performance of a process is dependent on the activities of one or more individuals with clinical privileges, the Medical Staff provides leadership for the process measurement, assessment and improvement activities, to include conducting appropriate peer review activities. Process improvement is performed throughout the Hospital and the Medical Staff by the departments, individuals and committee s referenced in this Plan.

4.2. Medical Staff Quality Department

Under this plan, the Medical Quality Department has the responsibility and authority, on behalf of the PPRC, to:

- 4.2.1. Collect data regarding Practitioner performance, including the data specified in Section 5 of this Plan;
- 4.2.2. Determine, based on the data collected and on guidelines established by the PPRC, whether further review or other action is required;
- 4.2.3. Send informational letters to Practitioners in accordance with guidelines established by the PPRC;
- 4.2.4. Investigate and collect additional information on matters referred to a Department Chair, Chief Medical Officer, Leadership Council, the PPRC or the MEC;
- 4.2.5. Refer matters for further review in accordance with the guidelines established by the PPRC;
- 4.2.6. Provide reports of data collected and the activities conducted under this Plan to the appropriate bodies, as provided in this Plan; and
- 4.2.7. Perform such other duties as may be requested by the PPRC, the Leadership Council, the MEC or the Governing Board.

4.3. Department Chairs/Section Chiefs/Chief Medical Officer

Department Chairs/Chief Medical Officer have the responsibility and authority under this Plan to:

- 4.3.1. Oversee the review of non-complex cases;
- 4.3.2. Take the actions authorized under this Plan;
- 4.3.3. Recommend criteria for OPPEs and provide information to the MSQD for the OPPE and FPPE process;
- 4.3.4. Provide information for and participate in initial reviews and focused review, as provided in this Plan or as requested by the PPRC; and
- 4.3.5. Perform such other duties as may be requested by the PPRC, Leadership Council, the MEC or the Governing Board.

4.4. Leadership Council

The Leadership Council has the responsibility and authority under this Plan to:

4.4.1. Oversee the review of complex cases and oversee the review of providers' professional behavior and conduct issues as may be assigned by the President of the Medical Staff or the Chief Medical Officer;

4.4.2. Take the actions authorized under this Plan.

4.4.3. Provide information, conduct reviews, and perform such other duties as may be requested by the PPRC, the MEC or the Governing Board.

4.5. Professional Practice Review Committee

The PPRC has the responsibility to ensure that peer review functions are carried out in a timely and responsible manner and in compliance with requirements as outlined in the medical staff bylaws, rules, and policies and the most current standards of The Joint Commission (TJC).

4.5.1. The PPRC has the responsibility and authority under this Plan to:

a. Oversee the practice review and improvement process for all Practitioners;
b. Establish policies, criteria, guidelines, and indicators for practice review and improvement;
c. Review and approve the forms, indicators and process for OPPEs and FPPEs for Practitioners;
d. Educate the Medical Staff regarding the practice review and improvement process;
e. Review all prior reviews and actions by the Medical Staff Quality Department, Department Chairs, Chief Medical Officer, Leadership Council or any other body conducting peer review;
f. Conduct peer review, including focused reviews in accordance with this Plan;
g. Develop and implement Practice Improvement Plans for Practitioners, in accordance with this Plan;
h. Based on reviews conducted by the PPRC, the Leadership Council, the Chief Medical Officer or the Department Chair, take such actions as authorized in this Plan;
i. Provide summary reports of its activities (to include how many practitioners are being followed by the PPRC and a general description of the issues) to the MEC and the Governing Board;
j. Perform such other duties as assigned to it under the Medical Staff Bylaws or by the MEC or the Governing Board.

4.6. Medical Executive Committee

The Medical Executive Committee shall receive periodic reports from the PPRC regarding its activities and shall approve all policies, Indicators, guidelines, OPPE/FPPE forms and related documents developed by the PPRC for the practice review and improvement process. The MEC shall have the sole authority to initiate an investigation or corrective action or recommend an adverse action, subject to the authority of the Governing Board, as set forth in the Medical Staff Bylaws. The MEC may assign portions of an investigation or a corrective action process to the PPRC for oversight, consistent with the PPRC's role in Practitioner improvement.

4.7. Governing Board

The Governing Board shall receive periodic reports from the PPRC regarding its activities, including regular review of OPPE activities. The Governing Board shall have the sole authority to take final action on adverse actions, as set forth in the Medical Staff Bylaws.

SECTION 5. DATA COLLECTION PROCESS

5.1. The following hospital departments provide information to the Medical Staff Quality Department:

5.1.1. Hospital Quality Department - information may include: core measures results, patient satisfaction results, patient safety indicators, infection rates, mortality rates, other quality measures identified by the Hospital Quality Department or requested by the PPRC, and any Practitioner issues identified in the course of quality reviews;

5.1.2. Risk management - information may include: safety events data regarding Practitioner conduct or quality and any Practitioner issues that are identified in the course of risk reviews, including without limitation, case reviews and root cause analyses;

5.1.3. Patient representatives - information may include: patient concerns or other comments regarding Practitioner conduct or quality matters and any Practitioner issues identified in the course of resolving a patient concern;

5.1.4. Organizational Analytics Department: Qlikview trending reports

5.1.5. Hospital department directors or managers - any specific concerns or issues regarding Practitioner conduct or quality;

5.1.6. Medical Staff Department Chairs, Section Chiefs or Chief Medical Officer - any specific concerns or issues regarding Practitioner conduct or quality;

5.1.7. Hospital Administration - any specific concerns or issues regarding Practitioner conduct or quality;

5.1.8. Medical Quality Department - information may include: mortality reviews, complication reviews, pre/postoperative diagnoses discrepancies, H&P quality reviews autopsy review, and others matters related to Practitioner conduct or quality identified by the Medical Quality Department or requested by the PPRC;

5.1.9. Medical Staff (Credentialing) Department: reports from external agencies regarding a Practitioner, such as notice of a civil, criminal or administrative action, investigation or settlement, and other data collected through the credentialing process;

5.1.10. Such other data as identified by the PPRC or as may be necessary for a particular review.

5.2. The MSQD shall review the collected data, and based on Indicators established by the PPRC, shall refer matters for review as set forth in Section 6 of this Plan and based on Indicators developed by the PPRC.

SECTION 6. IDENTIFICATION AND REFERRAL FOR REVIEW

6.1. <u>Informational Letters</u>

6.1.1. In the event the MSQD identifies that a Practitioner has failed to follow a rule, standard, policy, or other generally accepted practice at the Hospital (e.g., completing or updating a history and physical within 24 hours, complying with core measures, completing medical records, etc.), the Chief Medical Officer or designee may send the Practitioner an informational letter. The informational letter shall notify the Practitioner of rule, standard, policy or practice and the circumstances

under which the Practitioner did not comply and shall request that the Practitioner comply in the future.

6.1.2. A second letter on the same matter, if required, shall be sent by the Department Chair or Section Chief. If a third letter is required on the same matter, the matter shall be referred to the PPRC.

6.1.3. The Practitioner may submit a written response to an informational letter within ten days. A copy of the letter and any response from the Practitioner shall be placed in the Practitioner's Quality File.

~~6.1.4.~~ In the event a Practitioner receives three (3) informational letters (on the same or multiple matters) from the Chief Medical Officer or a Department Chair or Section Chief within a eight-month OPPE cycle, a PPRC review will be triggered.

6.1.5. Adverse occurrences or concerns regarding a Practitioner's practice or conduct related to an informational letter are concurrently referred to the Department Chair, the Section Chief, the Chief Medical Officer, the PPRC or Leadership Council, as set forth below.

6.2. Continuing Indicators

6.2.1. Indicators which reflect potential for adverse clinical outcomes or patient harm (e.g., infection rates, readmission rates, mortality rates etc.) are aggregated into quality dashboards by the Hospital Quality Department and reported to the appropriate Medical Staff committee, department or section and the PPRC.

6.2.2. Any continuing trend of such Indicators regarding a Practitioner is referred to the PPRC.

6.2.3. Adverse occurrences or concerns regarding a Practitioner's practice related to a trend are referred to the Department Chair, the Section Chief, the PPRC, or Leadership Council as set forth below.

6.3. <u>Review by Department Chair, Section Chief, Chief Medical Officer or Leadership Council</u>

6.3.1. Indicators related to an adverse clinical outcome in a specific case, or a concern related to a Practitioner's quality of care or professional conduct which creates the potential for an adverse clinical outcome are referred to the Department Chair, the Section Chief, the Chief Medical Officer or Leadership Council for initial review.

6.3.2. A matter is referred to the Department Chair, the Section Chief of the Chief Medical Officer for initial review if it does not meet the criteria for review for by the Leadership Council.

6.3.3. A matter may be referred to the Leadership Council for review if it involves any of the following:

a. a serious adverse event which requires immediate or expedited review, as determined after consultation with the President of the Medical Staff or the CMO;

b. a referral for review from any of the following: the PPRC, the MEC, the Governing Board, the CMO, the CEO or the President of the Medical Staff.

SECTION 7. INITIAL REVIEW PROCESS

7.1. When a matter is referred for review to the Department Chair, the Section Chief, the Chief Medical Officer or Leadership Council, a physician reviewer will be assigned. The physician reviewer may be the Department Chair, the Section Chief, the Chief Medical officer or a member of the Leadership Council or another physician assigned by one of the above.

7.2. A request for an initial review shall be initiated by completing a Request for Review Worksheet and returning it to the MDQ, or by the MDQ completing such form itself (Addendum A)

7.3. The MQD will be responsible for the collection of all appropriate information for the review, including, without limitation, the following:

7.3.1. A completed peer review form;
7.3.2. The original medical record(s) or safety event;
7.3.3. Copy of the Review Worksheet (Addendum B) for completion by physician reviewer;
7.3.4. Any applicable policies, standards or protocols;
7.3.5. Any other information necessary for review of the matter.

7.4. The physician reviewer will obtain additional information as necessary, complete review form and return it to the MSQD. The Department Chair, the Section Chief, the Chief Medical Officer or Leadership Council will determine the appropriate action and complete the form. If the initial review identifies concerns about the Practitioner's practice, quality of care or conduct, the Department Chair, the Section Chief, the Chief Medical Officer or a member of Leadership Council will provide verbal or written communication about the concerns to the Practitioner prior to determining the appropriate action. If the Department Chair, the Section Chief, the Chief Medical Officer or Leadership Council disagrees with the physician reviewer, the Department Chair, the Section Chief, the Chief Medical Officer or Leadership Council shall refer the matter to the PPRC, stating the reason for the disagreement. The PPRC may accept the physician review or arrange for an additional review, including but not limited to, an external review.

7.5. Based on the results of the initial review, and any guidelines established by the PPRC, the Department Chair, the Section Chief of the Chief Medical Officer shall take one of the following actions:

7.5.1. Determine that no further action is required;
7.5.2. Send an educational letter to the Practitioner;
7.5.3. Conduct a collegial intervention with the Practitioner;
7.5.4. Refer the matter to Leadership Council;
7.5.5. Refer the matter to the PPRC for a focused review; or
7.5.6. After consultation with Leadership Council, refer the matter to the MEC for investigation and/or corrective action.

The Department Chair will be informed of any action taken by a Section Chief and may take any additional action described in this Section 7.5 as the Department Chair deems appropriate.

7.6. The Department Chair, the Section Chief or the Chief Medical Officer shall document the action taken and any response of the Practitioner and provide such documentation to the MQD. The Department Chair, the Section Chief or the Chief Medical Officer will identify any educational or system issues (as defined in Section 10 of this Plan) and forward those issues to the MSQD.

7.7. Based on the results of the initial review and any guidelines established by the PPRC, Leadership Council shall take one of the following actions:

7.7.1. Determine that no further action is required;
7.7.2. Send an educational letter to the Practitioner;
7.7.3. Conduct a collegial intervention with the Practitioner;
7.7.4. Request the Practitioner to obtain a health evaluation or practice evaluation;

7.7.5. Request that the Practitioner voluntarily refrain from exercising certain privileges or performing certain procedures, pending further review;
7.7.6. Handle the matter in accordance with an applicable Hospital or Medical Staff policy (e.g., practitioner conduct or impaired practitioner policy);
7.7.7. Refer the matter to the PPRC for a focused review; or
7.7.8. Refer the matter to the MEC for investigation and/or corrective action.

7.8. Leadership Council shall document the action taken, and any response of the Practitioner and provide such documentation to the MSQD. Leadership Council will identify any educational or system issues (as defined in Section 10 of this Plan) and forward those issues to the MQD.

7.9. The MSQD shall assist the Department Chair, the Section Chief, the Chief Medical Officer or the Leadership Council in notifying the Practitioner of the results of the review and implementing the selected action. A Practitioner who is the subject of the initial review will be given the opportunity to provide a written response to the review. If the result of an initial review is that no concern is identified, notice of the review and the outcome shall be provided to the Practitioner through the OPPE process.

7.10. Documentation of the review, any action taken by the Department Chair, the Section Chief, the Chief Medical Officer or the Leadership Council, and any response by the Practitioner will be included in the Practitioner's quality file.

7.11. The PPRC shall be notified of the initial review and the action taken by the Department Chair, the Section Chief, the Chief Medical Officer or Leadership Council at the next PPRC meeting. The PPRC may take any of the following actions based on the initial review and action taken by the Department Chair, the Section Chief or Leadership Council:
7.11.1. Take no further action or review;
7.11.2. Refer the matter back to the Department Chair, the Section Chief, the Chief Medical Officer or Leadership Council for further review;
7.11.3. Conduct its own review, including a focused review.

7.12. In the event any educational or system issues (as defined in Section 10 of this Plan) are identified as a result of an initial review, the procedures described in Section 10 shall be followed.

SECTION 8. PPRC REVIEW

8.1. The PPRC has the authority to initiate review of which it is notified or any matter referred to it under this Plan. Such review may include review of the prior reviews and actions, or additional internal or external review, including but not limited to a focused review. The PPRC may take such actions authorized by this Plan and the Bylaws, other than the initiation of an investigation or corrective action. The PPRC may, however, refer a matter to the MEC for investigation or corrective action. The PPRC may also recommend administrative suspension as provided in the Investigations, Corrective Actions, Hearing & Appeal Plan in the event a Practitioner fails to cooperate with the PPRC's review or efforts to develop a Practice Improvement Plan. Such administrative suspension must be approved and initiated by those individuals authorized under the Investigations, Corrective Actions, Hearing & Appeal Plan.

8.2. <u>Focused Review</u>

8.2.1. A focused review is a review of a Practitioner's professional practice with respect to all or a portion of the Practitioner's clinical privileges. Focused reviews are conducted by the PPRC and may be initiated upon the request of the Leadership Council, Department Chair, Chief Medical Officer, MEC, Credentials Committee or Governing Board or on the PPRC's own initiative. A focused review is not an investigation or corrective action for purposes of the Medical Staff Bylaws or Investigations, Corrective Actions, Hearing & Appeal Plan. The purpose of a focused review is to assist a Practitioner in professional practice improvement in identified areas. A focused review may be initiated whenever a potential concern is identified regarding a Practitioner's conduct, quality of care or professional practice related to the Practitioner's clinical privileges. A focused review may be part of a FPPE or an OPPE or conducted as a separate review.

8.2.2. A focused review is initiated by completing a Request for Review Worksheet (Addendum A) and submitting it to the MSQD, or by the MSDQ completing such form itself. The MQD shall forward the referral to Chair of the PPRC, who shall present the referral to the PPRC at its next meeting. The PPRC Chair may initiate chart review, including external review, and/or gathering of other information prior to presenting the matter to the PPRC, as necessary to expedite the review.

8.2.3. The PPRC shall define the scope of a focused review, which may include all or a portion of a Practitioner's professional practice or the Practitioner's conduct. The PPRC may modify the scope of the review at any time, as it determines appropriate. The PPRC shall notify the Practitioner of initiation of the focused review.

8.2.4. The MSQD shall gather information for the focused review, as identified by the PPRC. Such information shall include, at a minimum, any and all prior reviews of the Practitioner. The PPRC may request any additional information it determines appropriate to evaluate the Practitioner's practice within the scope of the focused review. Such information may include, but is not limited to chart reviews, interviews of other Practitioners and staff, external evaluations of the Practitioner, and any other information the PPRC determines is appropriate to evaluate the Practitioner's practice.

8.2.5. The PPRC may request a Practitioner to obtain an external evaluation of the Practitioner's practice or health condition. The MEC shall be notified of any such request and the basis for the request. A Practitioner who fails to comply with the PPRC's request for an external evaluation shall be referred to the MEC.

8.2.6. The PPRC will give the Practitioner the opportunity to address any concerns identified by the PPRC, either in writing or, at the discretion of the PPRC, at a meeting with some or all of the members of the PPRC. A meeting with the PPRC pursuant to this Plan is not a hearing under the Investigations, Corrective Actions, Hearing & Appeal Plan, and the Practitioner shall not have the rights under the Investigations, Corrective Actions, Hearing & Appeal Plan with respect to such a meeting, including the right to have legal counsel present at the meeting. If the PPRC requests that a Practitioner meet with the PPRC and the Practitioner refuses to do so, the PPRC shall refer the matter to the President of the Medical Staff for appropriate action, which may include an administrative suspension, as provided in the Investigations, Corrective Actions, Hearing & Appeal Plan.

8.2.7. The PPRC shall assess the Practitioner's professional practice and conduct based on the information reviewed by the PPRC and in light of applicable medical standards, accreditation and regulatory standards and Hospital and Medical Staff Bylaws and policies. Based on its assessment, the PPRC will determine whether further action is

necessary to further quality of care at the Hospital. The PPRC shall notify the Practitioner of its findings and conclusions, and discuss with the Practitioner if further actions are recommended.

8.2.8. The PPRC may take any of the following actions, as it determines is necessary, based on its review and assessment and the furtherance of quality health care at the Hospital:

a. Determine that no further action is required;
b. Implement additional review or monitoring of the Practitioner's practice
c. Send an educational letter to the Practitioner;
d. Conduct a collegial intervention with the Practitioner;
e. Request the Practitioner to obtain a health evaluation or a practice evaluation;
f. Request the Practitioner to voluntarily refrain from exercising certain privileges or performing certain procedures, pending further review;
g. Handle the matter in accordance with an applicable Hospital or Medical Staff policy (e.g., practitioner conduct or impaired practitioner policy);
h. Continuing education for the Practitioner, a Section, Department or the Medical Staff;
i. Develop and implement a Practice Improvement Plan for the Practitioner;
j. Refer the matter to another Medical Staff committee or department or to a Hospital department to resolve system or process issues;
k. Refer the matter to the MEC for investigation and/or corrective action; or
l. Take such other action, other than corrective action or an adverse action (as defined in the Investigations, Corrective Actions, Hearing & Appeal Plan) which the PPRC determines is in furtherance of quality healthcare at the Hospital.

8.2.9. Any educational or system issues (as defined in Section 10 of this Plan) will be addressed pursuant to Section 10 of this Plan

8.3. Practice Improvement Plan

8.3.1. The PPRC may, as a result of a focused review, develop and implement a practice improvement plan for a Practitioner. The purpose of a practice improvement plan is to assist the Practitioner in improving his professional practice or conduct in the furtherance of quality care. A practice improvement plan may include a variety of means, including without limitation, education and training, evaluation, counseling, behavior expectations and other means to assist a Practitioner in improving his professional practice or conduct. A practice improvement plan shall be developed collaboratively with the Practitioner, to the greatest extent possible.

8.3.2. The PPRC shall monitor all practice improvement plans and may modify or terminate a practice improvement plan as it deems appropriate in furtherance of quality care.

8.3.3. The MEC will receive a summary of the practice improvement plans adopted by the PPRC. A Practitioner's compliance with a practice improvement plan will be reported to the Credentials Committee, MEC and the Board during reappointment.

8.3.4. In the event a Practitioner does not agree to a practice improvement plan recommended by the PPRC, or fails to comply with the plan as agreed, the PPRC shall refer the matter to the MEC. The Practitioner will be notified of the referral.

SECTION 9. EXTERNAL PEER REVIEW

9.1. Leadership Council, the PPRC, the MEC, the Chief Medical Officer, the President of the Medical Staff, the PPRC Chair or the CEO or his designee may refer a matter for external review whenever an external review would assist the Hospital or the Medical Staff in conducting an objective review by a qualified and independent reviewer. Instances in which external review may be appropriate include, but are not limited to:

9.1.1. Clinical expertise for a particular review is not available within the Medical Staff;

9.1.2. An actual or perceived conflict may exist due to an economic or family relationship between available reviewers and a Practitioner; or

9.1.3. Prior internal reviews resulted in ambiguous or conflicting findings/ recommendations.

9.2. If external review is indicated, the following will occur:

9.2.1. The individual referring the matter for external review shall establish the scope of the review and any budgetary limitations and time expectations.

9.2.2. The MSQD will be responsible for the oversight of the external review process.

9.2.3. Potential reviewers will be identified by, and acceptable to the chair of the body or individual requesting the review. When identifying potential reviewers' consideration will be given to a) experience and knowledge of focused professional practice evaluation process, b) competence in standards to include access to local, state and national information, and c) knowledge of statistics as appropriate.

9.2.4. The reviewer(s) may not be a member of the medical staff of BCH and must state that he has no knowledge of, or connection with, the Practitioner being reviewed.

9.2.5. Verification should be received indicating that the reviewer(s) has training, education and experience equivalent to, or greater than, that of the involved Practitioner in the particular area to be reviewed.

9.2.6. The reviewer(s) must be willing to sign a confidentiality statement and a business associate agreement, provide written conclusions within a specified time frame, and agree to discuss and defend his/her conclusions should the matter proceed to further action.

9.2.7. Whenever possible, the external reviewer will complete the review on site; if this is not feasible, records will be downloaded on to the secure external review company's website or the records will be photocopied or scanned to disc and sent via a shipping carrier that requires a signature to verify receipt.

9.2.8. Records to be reviewed will be identified by the individual or chair of the body requesting review and will include, but not be limited to an overall sample of similar cases treated by the practitioner and specific records representative of the issue, problem, question or concern.

9.2.9. The Practitioner whose cases are being reviewed will be provided an opportunity to review and comment on the external reviewer's summary of the cases. This comment period will occur prior to review by the PPRC or Leadership Council.

SECTION 10. EDUCATIONAL AND SYSTEMS ISSUES

10.1. <u>Educational Issues</u>

10.1.1. In the event a Department Chair, Section Chief, the Chief Medical Officer, Leadership Council or the PPRC identifies an issue which is appropriate for education of other Practitioners, the matter will be referred to the MSQD. The MSQD, in consultation with the individual or body who referred the matter, will arrange an appropriate educational session. The education may be provided to one or more sections or

departments, or to the entire Medical Staff. Options for educational sessions include a CME, a case review, informal presentation and discussion, on-line education or other formats appropriate to a particular issue. All members of the department, section, or Medical Staff, as appropriate, will be notified of educational sessions.

10.1.2. If the educational session involves a case which was subject to review, the Practitioner(s) involved in the case will be notified of the educational session and invited to attend. The Practitioner(s) may, but are not required to present the case at the educational session.

10.1.3. A Practitioner may be requested to attend an educational session by a Department Chair, Section Chief, the Chief Medical Officer, Leadership Council or the PPRC. If requested to attend, the Practitioner's attendance and the substance of the educational session will be included in the Practitioner's quality file. The PPRC will be notified if a Practitioner who was requested to attend an educational session does not attend.

10.1.4. The MSQD will maintain a record of the list of attendees and the contents of educational sessions.

10.1.5. The PPRC will be notified of all educational sessions conducted as a result of the review process.

10.2. System Issues

10.2.1. In the event a review conducted under this Plan identifies a Hospital or Medical Staff process or system that contributed to or has the potential to affect patient or staff safety, the matter shall be referred to the MSQD. The MSQD shall notify the CMO of the issue. The CMO shall refer the matter to the appropriate Hospital or Medical Staff leaders to address the issue.

10.2.2. The PPRC will be notified of all system issues referred to the CMO. The CMO, or other appropriate Hospital or Medical Staff leadership will report to the PPRC how the issue is being addressed. The matter will remain on the PPRC agenda until the PPRC determines that further information or action is not necessary. The PPRC will assure that the Practitioner, Department Chair, Section Chief, Chief Medical Officer and Leadership Council, as appropriate, are kept apprised of how the system issue is addressed.

SECTION 11. CONFIDENTIALITY

11.1. All files, information, documentation and discussions related to the activities conducted under this Plan are considered peer review and quality review activities and are confidential and protected under any state and federal laws for the protection of peer review and quality review activities, including without limitation, the Colorado Professional Review Act, C.R.S. §§ 12-36.5-101 et seq., the Colorado Quality Functions Statute, C.R.S. § 25-3-109; and the Federal Healthcare Quality Improvement Act, 42 U.S.C. §§11101 et seq.

11.2. All individuals involved in the activities described in this Plan will maintain the confidentiality of the information related to such activities and shall not make any voluntary disclosures of such information other than as related to the activities described in this Plan. All individuals who serve on the committees described in this Plan will sign a confidentiality statement agreeing to maintain the confidentiality of the information related to this Plan.

11.3. All documents generated by activities under this Plan will be appropriately labeled and securely maintained. Documentation may include, but is not limited to:

11.3.1. Performance data for all dimensions of performance measured for a Practitioner;

11.3.2. Correspondence to the findings and recommendations or comments regarding reviews and recommended actions;

11.3.3. Minutes of meetings during which an individual Practitioner's professional practice was discussed.

11.4. Information generated by activities under this Plan is considered peer review information and is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a Medical Staff leader or certain Hospital employees. Such individuals shall have access to the information only to the extent necessary to carry out their assigned responsibilities.

11.5. No copies of peer review documents will be created and distributed unless authorized by Hospital management or policy

11.6. All activities conducted under this Plan are considered peer review and quality review activities and are subject to all immunities and limitation of liability under any state and federal laws for the protection of peer review and quality review activities, including without limitation, the Colorado Professional Review Act, C.R.S. §§ 12-36.5-101 et seq., the Colorado Quality Functions Statute, C.R.S. § 25-3-109; and the Federal Healthcare Quality Improvement Act, 42 U.S.C. §§11101 et seq. All members of all bodies described in this Plan and all individuals who provide information to such bodies shall be immune in any civil or criminal action to the greatest extent permitted by law.

SECTION 12. PLAN REVIEW, REVISION AND AMENDMENT

12.1. This Plan will be reviewed on a biennial basis and appropriate revisions recommended by the PPRC to the MEC and Board Joint Conference Committee. Indicators and criteria will be reviewed and/or updated on an annual basis.

12.2. The PPRC shall develop such policies, procedures, forms and guidelines necessary to effectuate this Plan, including, without limitation, a conflict of interest policy applicable to the activities covered by this Plan.

12.3. The MEC and JCC shall approve this Plan and any amendments to the Plan. The MEC shall approve any policy adopted by the PPRC.

Adopted:
Professional Practice Review Committee: May 2, 2012. Revised: 1/8/2019; 11/5/2019
Medical Executive Committee: May 21, 2012. Revised: 1/22/2019; 11/18/2019
Joint Conference Committee: May 23, 2012. Revised: 1/22/2019; 11/20/2019