


<p>Name of Policy: Peer Review and Ongoing Professional Practice Evaluation</p> <p>Policy Number: 3364-87-27</p> <p>Approving Officer: Chief of Staff Medical Director</p> <p>Responsible Agent: Medical Director</p> <p>Scope: All University of Toledo Campuses</p>	 <p>Effective date: 09/14/05</p>
<input type="checkbox"/> New policy proposal	<input type="checkbox"/> Minor/technical revision of existing policy
<input checked="" type="checkbox"/> Major revision of existing policy	<input type="checkbox"/> Reaffirmation of existing policy

(A) Purpose

The purpose of peer review is to promote continuous improvement in the quality of care provided by the Medical Staff and Clinical Associate Staff at the University of Toledo Medical Center. The role of the Medical Staff and Clinical Associate Staff in peer review is to provide ongoing evaluations of performance to ensure effective and efficient assessments of the work of the practitioner

(B) Definitions

Peer: A peer is defined as any qualified practitioner with the appropriate training or experience to allow him/her to render an unbiased opinion on the quality or conduct of the care provided.

Peer Review: Peer review is a continuous process of review, refinement, and improvement of clinical care provided by members of the UTMC Medical Staff and Clinical Associate Staff. Appropriate standards and procedures for ongoing peer review will be established by each clinical department in conjunction with the Peer Review Committee.

(C) Responsibility

1. Each individual member of the UTMC Medical Staff and Clinical Associate Staff has the following responsibilities for peer review.
 - i. To strive to provide the best patient care possible and to continually improve one's knowledge, skills, and competence
 - ii. To provide ongoing assistance, feedback, and guidance in the professional development of one's peers.
 - iii. To provide regular and ongoing feedback and information to the Chair or Service Chief regarding personal and professional peer activities and performance either within or outside of the Department or Service.

2. Each Clinical Service Chief has a responsibility for peer review (this responsibility may be specifically delegated to individual Division Chiefs):
 - i. To provide support and resources for professional development to the faculty and to provide guidance and feedback on this development
 - ii. To provide a reasonable and consistent framework to the Department and to the Institution for identifying and addressing real and potential problems in the provision of patient care of the highest quality.
 - iii. To provide timely and complete information to the Medical Staff, the Clinical Associate Staff and its Committees regarding unresolved or recurring problems, or on events that did have or could have had important negative effects on patient care.

3. The Peer Review Committee is responsible for oversight and review of those problems or important events brought to its attention. These problems and events will generally be brought to its attention by the Clinical Service Chiefs, but may also be brought directly by any member of the Medical Staff or Clinical Associate Staff who believes that this is necessary

(D) Confidentiality

The peer review/quality assurance activities are immune to discoverability according to State of Ohio Statutes. All activities are to be kept confidential. Only authorized persons will have access to the monitoring data and/or retrieval of this information. Authorized persons include Medical Staff leaders, Hospital Administration, Medical Staff Services personnel and quality management personnel

(E) Policy and Procedure

The responsibilities of individual Medical Staff and Clinical Associate Staff members to themselves, to their peers, and to their Chairs or Service Chiefs will be carried out in a continuous and structured manner.

The responsibilities of the Chairs and Service Chiefs to individual faculty members will similarly be carried out in a continuous and structured manner, supplemented by periodic more formal reviews of performance (Ongoing Professional Practice Evaluation) according to procedures defined by the specific Department or Service, the Peer Review Committee, and as outlined in this policy. Practitioners will be assessed on their effectiveness of patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, systems based practice and professionalism. These procedures and the types of data that will be collected must be approved by the Peer Review Committee.

The Medical Staff Services Office will coordinate collection and compilation of practitioner-specific data and develop a quarterly Peer Review Report for each member of the Medical Staff and Clinical Associate Staff. The Peer Review Report and an Ongoing Professional Practice Evaluation for each practitioner will be forwarded to the appropriate Clinical Service Chief(s) for

review and completion or delegation. After review and completion by the Clinical Service Chief(s) and/or their designee(s), all Reports and Evaluations will be reviewed by representatives from the Peer Review Committee. Reports and/or Evaluations deemed problematic or raising concern will be reviewed by the Peer Review Committee at their next meeting.

Formal review procedures may also commence either with the identification of a serious problem or event by the Chair, or Service Chief, or with the bringing of such an issue directly to the Peer Review Committee by an individual member of the Medical Staff or Clinical Associate Staff. Formal records will be kept regarding the review and disposition of those problems or events that are deemed worthy of such structured review.

Examples of areas that may give rise to problems that are appropriate for review by the Medical Executive Committee are listed here. This list is not meant to be exhaustive:

- Procedural competency
- Invasive, operative, and non-invasive procedures that place patients at risk
- Blood utilization
- Medication use and monitoring
- Mortality and morbidity review
- Safety management
- Risk management
- Infection control
- Resource management (Utilization Review)
- Customer satisfaction and complaint review
- Sentinel event review
- Pathology, laboratory, or autopsy results that seriously question clinical approaches or clinical explanations for outcomes
- Assessment of patients
- Education of patients and family
- Management of information
- Leadership
- Standard of Care review
- Occurrence Reports

For problems or events that are referred to or brought to the attention of the Peer Review Committee, a formal review shall ensue. This will involve:

1. Collection and review of data regarding the problem or incident. Such data may include some or all of the following: data on processes and outcomes used to assess clinical performance, determination of the level of functioning of these processes, identification of opportunities for improvement, and review of outcomes in relation to expectations.
2. Communication to appropriate Medical Staff or Clinical Associate Staff members of findings, conclusions, recommendations, and actions taken to improve organizational performance
3. Identification of individual performance issues related to the identified problems or events. If important issues of this type are identified, the Medical Executive Committee will

be responsible for determining their use in peer review in accordance with the standards on renewing or revising clinical privileges.

For clinical events that are brought to the attention of the Peer Review Committee under this policy, and following appropriate review of the circumstances surrounding this event, the Committee shall assign the event to one of the following categories:

- Category I: A predictable event within acceptable standards of care.
- Category II: An unpredictable event within acceptable standards of care.
- Category III: An event related to a minor deviation from accepted standard of care.
- Category IV: An event related to significant deviation from accepted standard of care.
- NCE: A non-clinical event.

For any event that is considered to be Category III or IV, a letter will be sent to the practitioner involved requesting additional information. Once additional information is received, the Peer Review Committee will perform a second review to determine the final categorization. A second letter is then sent to the practitioner notifying him/her of the final category. The practitioner may appeal the category decision by requesting a review of the case by the Medical Executive Committee.

For serious problems regarding individual practitioners, or for Category III or IV events relating to individual practitioners, the following actions may be taken by the Committee:

1. Permanent records of the problem or event, and of the review of this problem or event, will be placed in the involved practitioner's peer review file for use in ongoing review and for the biannual reappointment process.
2. The practitioner may be placed on Focused Professional Practice Evaluation. This will be done if one of the following occurs:
 - i. A practitioner receives two (2) Category IV evaluations within a two-year period (the previous year and current year). Or
 - ii. A practitioner receives five (5) Category III evaluations within a two-year period (the previous year and current year). Or
 - iii. A practitioner receives one (1) Category IV and three (3) or more Category III evaluations within a two-year period (the previous year and current year)

Intensified Review will involve the following:

- i. The Medical Executive Committee will provide written notification of the Intensified Review to the practitioner.
- ii. Intensified Review will be conducted according to the procedures described in the Intensified Review Policy.
- iii. The findings of the Intensified Review will be submitted to the practitioner's Departmental Chair or Service Chief, as appropriate.

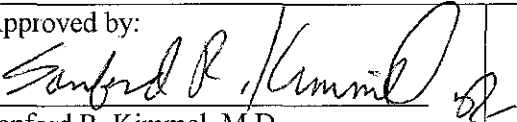
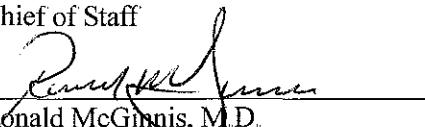
On occasion, the Peer Review Committee may request external peer review. Criteria for making a determination on whether external peer review will be obtained are as follows:

- i. A request by the Medical Staff or Clinical Associate Staff member of concern who does not believe he/she may receive an unbiased review internally.
- ii. The department cannot provide an unbiased reviewer based on issues of competitive or partnership practices.
- iii. In the case that a Clinical Service Chief or Department Chair is the subject of review, this case will be forwarded directly to MEC for consideration and assignment of external peer review if there is no unbiased expert internally.

On the basis of the recommended action of the outside expert opinion, the MEC may determine a need to limit/suspend privileges as addressed in the Medical Staff Bylaws. The Medical Staff may also work in cooperation with the reviewing agency to modify practitioner behavior in anticipation of such limitations.

(F) Communication

Findings of Departmental or Service peer review activities will be communicated within the individual medical staff departments/clinical services according to their established policies. Serious events (potential Category III and IV events) identified in such Departmental or Service reviews will be reported to the Medical Executive Committee or to its Peer Review Subcommittee.

<p>Approved by:</p> <p> Sanford R. Kimmel, M.D. Chief of Staff</p> <p> Ronald McGinnis, M.D. Medical Director</p> <p><u>9/11/08</u> Date</p> <p>Review/Revision Completed by: Medical Executive Committee</p>	<p>Policies Superseded by This Policy:</p> <ul style="list-style-type: none">• MS-027 Peer Review Process <p>Review/Revision Date: 02/21/04 05/09/07 03/25/08 07/23/08</p> <p>Next review date: 07/23/11</p>
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