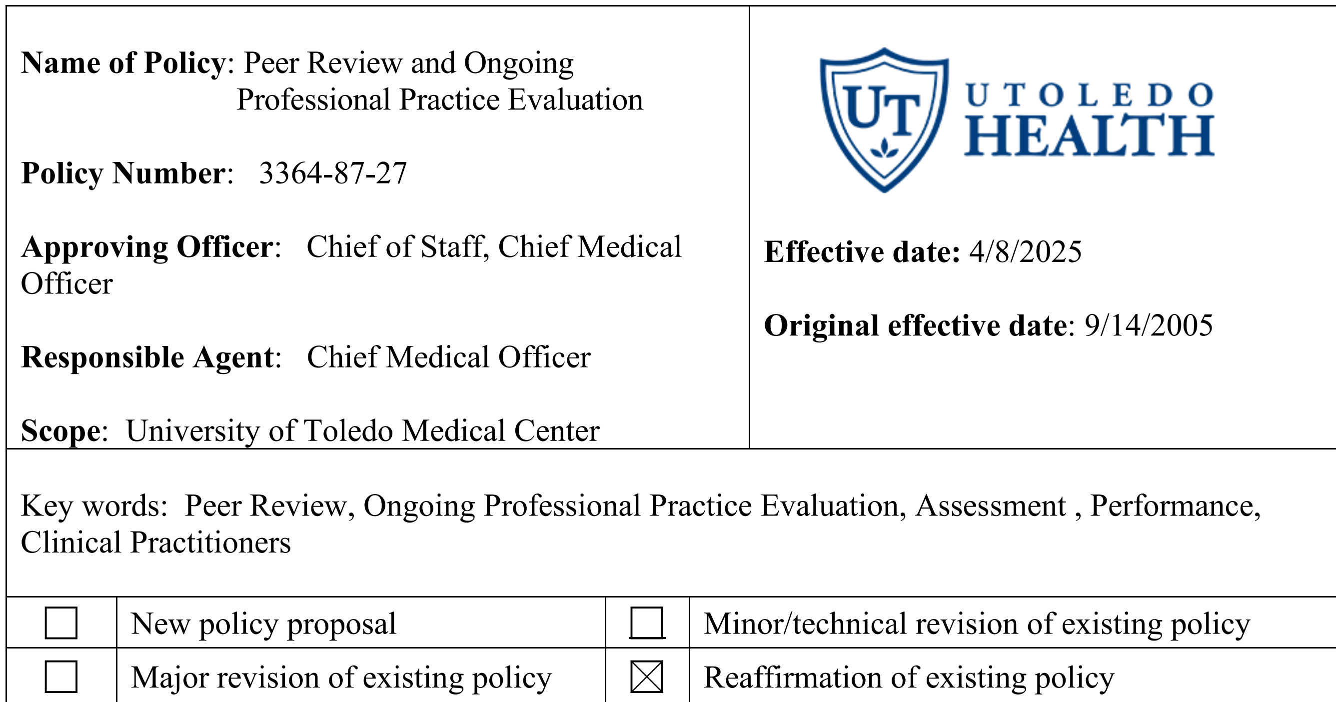

Name of Policy: Peer Review and Ongoing Professional Practice Evaluation **Policy Number**: 3364-87-27 **Approving Officer**: Chief of Staff, Chief Medical Officer **Responsible Agent**: Chief Medical Officer **Scope**: University of Toledo Medical Center	UTOLEDO HEALTH **Effective date:** 4/8/2025 **Original effective date**: 9/14/2005

Key words: Peer Review, Ongoing Professional Practice Evaluation, Assessment , Performance, Clinical Practitioners

☐	New policy proposal	☐	Minor/technical revision of existing policy
☐	Major revision of existing policy	☒	Reaffirmation of existing policy

(A) Policy

To improve the human condition, the University of Toledo promotes continuous improvement in the quality of care provided by the Medical Staff, Advanced Practice Providers (APP) and Allied Health Professionals (AHP) at the University of Toledo Medical Center ("UTMC").

(B) Purpose of the Policy

The purpose of this policy and peer review and ongoing professional review in general is to ensure effective and efficient assessment of the work of the clinical practitioners and to provide ongoing evaluations of performance.

(C) Scope

This policy applies to Medical Staff members, APPs and AHPs with clinical privileges at UTMC and University of Toledo facilities Peer Review and ongoing professional review of Residents and Fellows are handled separately and within the applicable Residency Program rules and regulations.

(D) Procedure

1. Each individual member of the UTMC Medical Staff, each APP and AHP has the following responsibilities for peer review:

    a) To strive to provide the best patient care possible and to continuously improve one's knowledge, skills and competence;
    b) To provide ongoing assistance, feedback, and guidance in the professional development of one's peers; and
    c) To provide regular and ongoing feedback and information to the Clinical 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):

    a) To provide support and resources for professional development to the Medical Staff, APPs, and AHPs, and to provide guidance and feedback on this development;
    b) 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; and
    c) To provide timely and complete information to the Medical Staff, APPs, AHPs 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, APP or AHP who believes it necessary.

(E) 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, Chief Executive Officer, Chief Medical Officer, Legal Affairs, Executive Vice President of Clinical Affairs, , UT Central Verification Office personnel and quality management personnel.

(F) Policy and Procedure

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

The responsibilities of the Clinical Service Chiefs to individual Medical Staff members, APPs and AHPs 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. Medical Staff members, APPs, and AHPs 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 and the Medical Executive Committee.

The UT Central Verification Office will coordinate collection and compilation of practitioner-specific data and develop an Ongoing Professional Practice Evaluation (OPPE) report every eight (8) months for each member of the Medical Staff, each APP and AHP. The 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, 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 Clinical Service Chief, or with the bringing of such an issue directly to the Peer Review Committee by an individual member of the Medical Staff, APP or AHP. 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 Peer Review Committee are listed here. This list is not meant to be exhaustive:

a) Questions involving procedural competency
b) Invasive, operative, and non-invasive procedures that place patients at risk
c) Blood utilization
d) Medication use and monitoring
e) Mortality and morbidity review
f) Safety management
g) Infection control
h) Resource management (Utilization Review)
i) High number of customer dissatisfaction and complaints
j) Sentinel event and standard of care review
k) Pathology, laboratory, or autopsy results that seriously question clinical approaches or clinical explanations for outcomes
l) Assessment of patients
m) Education of patients and family
n) Management of information
o) Safety Net Reports

For problems or events that are referred to or brought to the attention of the Peer Review Committee, a formal review will 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 the Medical Staff, APPs and AHPs of the 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 Peer Review Committee will be responsible for determining their use in peer review. Any actions regarding clinical privileges must be in accordance with the standards on renewing or revising clinical privileges as set forth in the Medical Staff Bylaws.

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 by the Peer Review Committee, the Committee will assign the event to one of the following categories:

Category I: An event related to a deviation from accepted standard of care.
Category II: An event that is within the accepted standard of care.

For Category I events relating to Medical Staff members, APPs or AHPs, the following actions must be taken by the Peer Review Committee:

1. The Chief of Staff will notify the practitioner and advise the practitioner of the findings of the Peer Review Committee.
2. The Medical Executive Committee must permit the practitioner to challenge the findings of the Peer Review Committee at its next regularly scheduled meeting.

For Category I events relating to individual practitioners, for serious patterns of practice the following actions *may additionally* be taken by the Peer Review Committee:

1. Place in the permanent records of the problem or event, and of the review of this problem or event, are placed by the Chief of Staff in the involved practitioner(s)' peer review file(s) for use in ongoing review and for the biennial reappointment process of the Medical Staff.

2. Require a review of the incidents or concerns of the Chief of Staff and the Clinical Service Chief with the practitioner.

3. Place the practitioner on Focused Professional Practice Evaluation and follow policy 3364-87-38.

4. Make a referral of the matter to the investigatory process under the Medical Staff Bylaws for consideration of action against the practitioner's clinical privileges

5. Request an external peer review. Consideration for making a determination on whether an external peer review will be obtained are as follows:

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

(G) Communication

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

Approved by: /s/ _______________________________ Michael Ellis, MD Chief Medical Officer 4/4/2025 _______________________________ Date /s/ _______________________________ Puneet Sindhwani, MD Chief of Staff 4/8/2025 _______________________________ Date *Review/Revision Completed by:* *Medical Executive Committee*	**Policies Superseded by This Policy:** • *MS-027 Peer Review Process* Initial effective date: 9/14/2005 Review/Revision Date: 02/21/04 05/09/07 03/25/08 07/23/08 01/26/11 06/26/13 07/01/16 07/01/19 09/22/21 11/17/21 11/17/24 4/8/2025 Next review date: 4/8/2028