WAKEMED

PROFESSIONAL PRACTICE EVALUATION POLICY (PEER REVIEW)

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PROFESSIONAL PRACTICE EVALUATION POLICY (PEER REVIEW)

1. OBJECTIVES, SCOPE OF POLICY, COLLEGIAL EFFORTS, DEFINITIONS, AND ACRONYMS

1.A ***Objectives.*** The primary objectives of the Professional Practice Evaluation ("PPE") process of each hospital affiliated with WakeMed ("Hospital") are to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) This Policy applies to all Practitioners who provide patient care services at the Hospital.

1.C ***Initial Collegial Leadership Efforts and Progressive Steps.***

(1) This Policy encourages the use of ***initial collegial leadership efforts*** by Medical Staff Leaders to address performance issues that may arise from time to time, but which are not referred for more formal review under this Policy. Such efforts may include, but are not limited to, informal discussions, mentoring, counseling, and sharing of comparative data.

There is no expectation that input from a Practitioner be obtained prior to initial collegial leadership efforts or that these efforts be documented, though documentation may be created in the discretion of the Medical Staff Leader and maintained in the Practitioner's confidential file.

(2) For matters that are reviewed under this Policy, Medical Staff Leaders shall obtain a Practitioner's input and then use defined ***progressive steps*** to address any performance issues that may be identified. As outlined in Section 4, these progressive steps include the following interventions: Informational Letters, Educational Letters, Formal Collegial Intervention, and Performance Improvement Plans.

(3) The goal of both initial collegial leadership efforts and progressive steps is to arrive at voluntary, responsive actions by the Practitioner. All such efforts are part of the Hospital's confidential performance improvement and professional practice evaluation activities.

(4) Initial collegial leadership efforts and progressive steps are encouraged, but are not mandatory. Nothing in this Policy prevents the immediate referral of a matter for review under the Credentials Policy or other applicable policy.

1.D ***Definitions.*** The following definitions apply to terms used in this Policy:

ASSIGNED REVIEWER means a Practitioner appointed by a Medical Staff Peer Review Committee, the Leadership Council, or the CPE to either: (1) serve as a consultant to the committee performing the review; or (2) conduct a review, document his/her clinical findings *in the WakeMed peer review system using the WakeMed-approved case review form,* submit the form to the committee that assigned the review, and be available to discuss his/her findings and answer questions. The functions of an Assigned Reviewer may also be performed by a standing or ad hoc committee as requested by a Medical Staff Peer Review Committee, the Leadership Council, or the CPE.

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

DEPARTMENT CHAIR means the applicable Medical Staff Department Chair (e.g., Chair of Medicine) at the Hospital.

EMPLOYED PRACTITIONER means a Practitioner who is employed by :

(1) WakeMed;

(2) Wake Specialty Physicians, LLC, WakeMed Specialist Group, LLC, and its controlled or related affiliates ("WMSP");

(3) any other WakeMed-related entity that has a formal peer review/professional practice evaluation process and an established peer review committee, as evidenced by internal bylaws or policy; or

(4) a private group that has: (a) a formal peer review/professional practice evaluation process and an established peer review committee, as evidenced

by internal bylaws or policy; and (b) information sharing provisions in a professional services contract or in a separate agreement with the Hospital.

MEDICAL STAFF LEADER means any Medical Staff Officer, Department Chair, Section Chief, or committee chair.

MEDICAL STAFF PEER REVIEW COMMITTEE means the committees that have been approved by the Medical Executive Committee ("MEC") and/or Board to perform the functions set forth in this Policy for a certain Department, specialty, service line, or other organizational unit. Medical Staff Peer Review Committees receive cases for review, obtain input from Assigned Reviewers as needed, complete theWakeMed-approved case review form in the WakeMed peer review system , and make the determinations outlined in Section 5 of this Policy. Medical Staff Peer Review Committees are formed to evaluate the quality, cost and necessity of hospitalization and health care.

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

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

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

WAKEMED COMMITTEE FOR PROFESSIONAL ENHANCEMENT ("CPE") is a multi-specialty medical review committee under North Carolina law that oversees the professional practice evaluation process, conducts case reviews, works with Practitioners in a constructive and educational manner to help address any clinical performance issues, develops Performance Improvement Plans as described in this Policy, and otherwise evaluates the quality, cost and necessity of hospitalization and health care. The CPE possesses no disciplinary authority. Only the MEC has the authority to conduct non-routine, formal investigations and to recommend restrictions of clinical privileges. The composition and duties of the CPE are described in the Medical Staff Organization and Functions Manual.

WAKEMED LEADERSHIP COUNCIL ("Leadership Council") is a medical review committee under North Carolina law that evaluates the quality, cost and necessity of hospitalization and health care and that:

(1) conducts reviews of, or determines the appropriate review process for, clinical issues that are administratively complex, as described in this Policy;

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

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

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

1.E ***Acronyms.*** Definitions of the acronyms used in this Policy are:

APP	Advanced Practice Provider
CPE	Committee for Professional Enhancement
FPPE	Focused Professional Practice Evaluation
MEC	Medical Executive Committee
MSPRC	Medical Staff Peer Review Committee
OPPE	Ongoing Professional Practice Evaluation
PIP	Performance Improvement Plan
PPE	Professional Practice Evaluation (Peer Review)

2. PPE TRIGGERS. The PPE process set forth in this Policy may be triggered by any of the following events:

2.A ***Specialty-Specific Triggers.*** Each Department shall identify adverse outcomes, clinical occurrences, or complications that will trigger PPE. The triggers shall be approved by the CPE.

2.B ***Reported Concerns.***

(1) ***Reported Concerns from Practitioners or Hospital Employees.*** Any Practitioner or Hospital employee may report to the PPE Support Staff concerns related to:

(a) the safety or quality of care provided to a patient by an individual Practitioner, which shall be reviewed through the process outlined in this Policy;

(b) professional conduct, which shall be reviewed and addressed in accordance with the Medical Staff Professionalism Policy;

(c) potential Practitioner health issues, which shall be reviewed and addressed in accordance with the Practitioner Health Policy;

(d) compliance with Medical Staff or Hospital policies, which shall be reviewed either through the process outlined in this Policy and/or in accordance with the Medical Staff Professionalism Policy, whichever the Leadership Council determines is more appropriate based on the policies at issue; or

(e) a potential system or process issue which shall be referred to the System Quality Oversight Committee (SQOC). Such referral shall be reported to the CPE. SQOC will report to CPE regarding the resolution of the issue.

(2) ***Follow-Up with Individual Who Filed Report.*** The PPE Support Staff, the Chief Medical Officer, and/or the Senior Vice President of Quality/System Chief Medical Officer should follow up with individuals who file a report when possible by:

(a) thanking them for reporting the matter and participating in the Hospital's culture of safety and quality care;

(b) informing them that:

(i) the matter will be reviewed in accordance with this Policy and that they may be contacted for additional information;

(ii) due to confidentiality requirements under North Carolina law, it is important that they maintain confidentiality and only discuss the matter with individuals who are a formal part of the review process;

(iii) due to these same confidentiality requirements, the Hospital is not permitted to disclose the outcome of the review to them, but they can be assured that a thorough review will be conducted; and

(iv) no retaliation is permitted against any individual who raises a concern and they should immediately report any retaliation or any other incidents of inappropriate conduct.

(3) ***Anonymous Reports.*** Practitioners and employees may report concerns anonymously, but all individuals are encouraged to identify themselves when making a report. This identification promotes an effective review of the concern because it permits the PPE Support Staff to contact the reporter for additional information, if necessary.

(4) ***Sharing Identity of Reporter.***

(a) ***General Rule.*** Since this Policy does not involve disciplinary action or "restrictions" of privileges, the specific identity of the individual reporting a concern or otherwise providing information about a matter (the "reporter") generally will not be disclosed to the Practitioner.

(b) ***Exceptions.***

(i) ***Consent.*** The Leadership Council may, in its discretion, disclose the identity of the reporter to the Practitioner if the reporter specifically consents to the disclosure (with the reporter being reassured that he or she will be protected from retaliation).

(ii) ***Medical Staff Hearing.*** The identity of the reporter shall be disclosed to the Practitioner if information provided by the reporter is used to support an adverse professional review action that results in a Medical Staff hearing.

(c) ***Practitioner Guessing the Identity of Reporter.*** This section does not prevent notification to a Practitioner about a concern that has been raised even if the description of the concern would allow the Practitioner to guess the identity of the reporter (e.g., where the reporter and the Practitioner were the only two people present when an incident occurred). In such case, the person or committee conducting the review will not confirm the identity of the reporter, and will pay particular attention to reminding the Practitioner to avoid any action that could be perceived as retaliation.

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

(5) ***Unsubstantiated Reports or False Reports.*** If a report cannot be substantiated, or is determined to be without merit, the matter shall be

closed as requiring no further review. False reports will be grounds for disciplinary action. False reports by Practitioners will be referred to the Leadership Council. False reports by Hospital employees will be referred to human resources.

(6) ***Self-Reporting.*** Practitioners are encouraged to self-report their cases that involve either a specialty-specific trigger or other PPE review trigger or that they believe would be an appropriate subject for an educational session as described in Section 6 of this Policy. Self-reported cases will be reviewed as outlined in this Policy. A notation should be made that the case was self-reported and that fact will be considered a positive factor in the review.

2.C ***Other PPE Triggers.*** In addition to specialty-specific triggers and reported concerns, other events that may trigger PPE include, but are not limited to, the following:

(1) identification by a Medical Staff committee or work group of a clinical trend or specific case or cases that require further review. The review and deliberations of such a committee or work group and any documentation prepared are confidential peer review information and shall be used and disclosed only as set forth in this Policy;

(2) patient complaints that are referred by the patient representative and that require physician review, as determined by the PPE Support Staff (in consultation with a CPE Co-Chair, the Chief Medical Officer, or the Senior Vice President of Quality/System Chief Medical Officer);

(3) cases identified as quality risks that are referred by the risk management department. However, confidential information generated pursuant to this Policy may not be disclosed as part of any risk management activities;

(4) unresolved issues of medical necessity referred through the utilization management committee, case management department, compliance officer, or otherwise;

(5) referrals from a serious safety event or sentinel event review team involving an individual Practitioner's professional performance;

(6) a Department Chair's determination that ongoing professional practice evaluation ("OPPE") data reveal a practice pattern or trend that requires further review as described in the OPPE Policy; and

(7) when concerns persist despite initial collegial leadership efforts, when a threshold number of Informational Letters identified in **Appendix A** is reached, or when a trend of noncompliance is otherwise identified with:

(i) Medical Staff Rules and Regulations or other policies; or (ii) adopted clinical protocols, order sets or pathways, or other quality measures.

3. NOTICE TO AND INPUT FROM THE PRACTITIONER. An opportunity for Practitioners to provide meaningful input into the review of the care they have provided is an essential element of an educational and effective process.

3.A ***Opportunity for Input.***

(1) If any questions or concerns are identified about the care provided in a case under review, the Practitioner will be notified of the questions or concerns and offered an opportunity to provide input prior to the review being completed and any final determination made. The notice to the Practitioner shall state that the requested input is required within 14 days.

(2) This prior notice and opportunity for input will always occur during the initial assessment of a case if any questions or concerns are identified, but subsequent levels of review may also seek input from the Practitioner if necessary or helpful to the review.

(3) No Educational Letter, Formal Collegial Intervention, or Performance Improvement Plan shall be implemented until the Practitioner is first notified of the specific concerns identified and given an opportunity to provide input as described in this Section. Prior notice and an opportunity to provide input are *not required* before an Informational Letter is sent to a Practitioner, as described in Section 4.A of this Policy. Also, the requirements in this Section apply only to questions or concerns that are evaluated pursuant to this Policy. This Section does not apply to questions or concerns evaluated pursuant to the Medical Staff Bylaws or Credentials Policy (e.g., where a precautionary suspension may be necessary).

3.B ***Manner of Providing Input.***

(1) The Practitioner shall provide input by meeting with the committee conducting the review, or with one or more individuals designated by the committee, if requested. The Practitioner shall also provide a written explanation of the care provided if requested to do so by the committee, responding to any specific questions posed in the request. A Practitioner is free to submit written input regardless of whether the committee has requested it.

(2) As part of a request for input pursuant to this Policy, the committee requesting input may ask the Practitioner to provide a copy of, or access to, medical records from the Practitioner's office. Failure to provide such copies or access will be viewed as a failure to provide requested input.

(3) Practitioners and individual members of the Leadership Council, a Medical Staff Peer Review Committee, or the CPE should not engage in separate discussions of a review unless the committee in question has asked the individual committee member to speak with the Practitioner on its behalf. Similarly, unless formally requested to do so, Practitioners may not provide verbal input to a member of the PPE Support Staff or to any other individual and ask them to relay that verbal input to an individual or committee involved in the review. The goal of these requirements is to ensure that all individuals and committees involved in the review process receive the same, accurate information. Finally, Practitioners must refrain from any discussions or lobbying with other Medical Staff members or Board members outside the authorized review process outlined in this Policy.

(4) Correspondence sent to the Practitioner pursuant to this Policy shall be placed in the Practitioner's confidential file. The Practitioner shall be permitted to respond in writing, and the Practitioner's response shall also be kept in the confidential file.

3.C ***Failure to Provide Requested Input.***

(1) If the Practitioner fails to provide input requested by an Assigned Reviewer within the time frame specified in the request, the review shall proceed without the Practitioner's input. The PPE Staff shall note the Practitioner's failure to respond to the request for input in the reviewer's report to the CPE regarding the assessment performed.

(2) If the Practitioner fails or refuses to attend a meeting with the Leadership Council, a Medical Staff Peer Review Committee, or the CPE (or their designees), the Practitioner's clinical privileges will be automatically relinquished until the meeting occurs.

(3) If the Practitioner fails to provide written input requested by the Leadership Council, a Medical Staff Peer Review Committee, or the CPE within the time frame specified in the request, the Practitioner will be required to meet with the Leadership Council. The purpose of the meeting is to discuss the Practitioner's obligation to participate in the review process, permit the Practitioner to explain why the information was not provided, and inform the Practitioner of the consequences of continuing to not provide the information. Failure of the Practitioner to either:

(i) meet with the Leadership Council and persuade it that the requested written input is not necessary; or

(ii) provide the requested written input prior to the meeting

will result in the automatic relinquishment of the Practitioner's clinical privileges. Such automatic relinquishment will continue until the Practitioner either meets with the Leadership Council and persuades it that the written information is not necessary or provides the requested written information.

(4) If the Practitioner fails to meet with or provide written information requested by the Leadership Council, Medical Staff Peer Review Committee, or CPE within thirty (30) days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned. (See Section 1.D for additional information about automatic relinquishment/ resignation.)

4. INTERVENTIONS TO ADDRESS IDENTIFIED CONCERNS. When concerns regarding a Practitioner's clinical practice are identified, the following interventions may be implemented to address those concerns.

4.A ***Informational Letter.***

(1) ***General.*** Minor performance issues can be successfully addressed through the use of Informational Letters, without the need to immediately proceed with more formal review under this Policy. Informational Letters are a non-punitive, educational tool to help Practitioners self-correct and improve their performance through the use of feedback. The performance issues that may lead to an Informational Letter are often referred to as "rate and rule" measures.

(2) ***When an Informational Letter May be Sent.***

(a) The Department Peer Review Committee or the CPE will identify objective occurrences for which an Informational Letter is appropriate and include them in **Appendix A**.

(b) Medical Staff Peer Review Committee Chairs may, in their discretion, determine that an Informational Letter is appropriate in other situations not listed in **Appendix A**, provided that: (i) the issue being addressed is minor in nature; and (ii) the nature of the issue is such that any input from the Practitioner, regardless of its content, would not affect the determination that an Informational Letter was appropriate (e.g., a clear violation of a Medical Staff policy for which no explanation would excuse noncompliance).

(c) Examples of the types of performance issues that may be addressed via Informational Letters include, but are not limited to, noncompliance with:

(1) specific provisions of the Medical Staff Rules and Regulations or Hospital or Medical Staff policies;

(2) an adopted protocol, without appropriate documentation in the medical record as to the reasons for not following the protocol;

(3) core or other quality measures; or

(4) care management/utilization management requirements.

(3) ***Preparation of Informational Letter.*** The PPE Support Staff shall prepare an Informational Letter reminding the Practitioner of the applicable requirement and offering assistance to the Practitioner in complying with it. A copy of the Informational Letter shall be placed in the Practitioner's confidential file. It shall be considered in the reappointment process and in the assessment of the Practitioner's competence to exercise the clinical privileges granted.

(4) ***Further Review.*** A matter shall be subject to review by the Leadership Council in accordance with Section 5 of this Policy if: (i) the threshold number of Informational Letters to address a particular type of situation is reached as described in **Appendix A**; or (ii) a trend of noncompliance is otherwise identified based on the overall number of Informational Letters sent to a Practitioner or other relevant factors, even if none of the thresholds for a particular category in **Appendix A** are met. Also, nothing in this Policy prohibits any authorized individual or committee from forgoing the use of an Informational Letter and responding to a particular incident in some other manner as warranted by the circumstances.

Informational letters may be signed by: A Department Chair, a Medical Staff Peer Review Committee Chair, a Co-Chair of the CPE, the Chief Medical Officer, or the Senior Vice President of Quality/System Chief Medical Officer. Individuals named in the preceding sentence may be copied on any Informational Letter that they do not personally sign.

4.B ***Educational Letter.*** An Educational Letter may be sent to the Practitioner involved that describes the opportunities for improvement that were identified in the care reviewed and offers specific recommendations for future practice. A copy of the letter will be included in the Practitioner's file along with any response that he or she would like to offer.

Educational letters may be sent by: The Leadership Council, a Medical Staff Peer Review Committee, or the CPE. The Department Chair and CPE will be copied on any Educational Letter that is sent to a Practitioner.

4.C ***Formal Collegial Intervention.*** Formal Collegial Intervention means a formal, planned, face-to-face discussion between the Practitioner and one or more Medical Staff Leaders. Formal Collegial Intervention only occurs after a Practitioner has had an opportunity to provide input regarding a concern. Generally, a Formal Collegial Intervention shall be followed by a communication that summarizes the discussion and, when applicable, the expectations regarding the Practitioner's future practice in the Hospital. A copy of the follow-up communication will be included in the Practitioner's file along with any response that the Practitioner would like to offer. (In contrast to conducting a "Formal Collegial Intervention," see the description of "initial collegial leadership efforts" in Section 1.C of this Policy.)

If the Leadership Council, a Medical Staff Peer Review Committee, or the CPE requests that the Practitioner attend a meeting with it or a designated individual for purposes of a Collegial Intervention, and the Practitioner fails or refuses to attend such a meeting, the Practitioner's clinical privileges will be automatically relinquished until the meeting occurs.

A Formal Collegial Intervention may be personally conducted by: One or more members of the Leadership Council, a Medical Staff Peer Review Committee, or the CPE, or these committees may facilitate a Formal Collegial Intervention by one or more designees (including, but not limited to, a Department Chair). The Department Chair, Leadership Council, and CPE may be informed of the substance of any collegial intervention, regardless of who conducts or facilitates it, and may contact the PPE Support Staff to review documentation of the intervention. Collegial intervention documentation should be included for review as part of OPPE.

4.D ***Performance Improvement Plan ("PIP").***

(1) ***General.*** The CPE may determine it is necessary to develop a PIP for the Practitioner to bring about sustained improvement in the individual's practice. To the extent possible, a PIP shall be for a defined time period or for a defined number of cases. The plan shall specify how the Practitioner's compliance with, and results of, the PIP will be monitored. One or more members of the CPE should personally discuss the PIP with the Practitioner to help ensure a shared and clear understanding of the elements of the PIP. The PIP will also be presented in writing, with a copy being placed in the Practitioner's file, along with any statement the Practitioner would like to offer.

(2) ***Input.*** As deemed appropriate by the CPE, the Practitioner may have an opportunity to provide input into the development and implementation of the PIP. The Department Chair shall also be asked for input regarding the

PIP, and shall assist in implementation of the PIP as may be requested by the CPE.

(3) ***Voluntary Nature of PIPs.*** If a Practitioner agrees to participate in a PIP developed by the CPE, such agreement will be documented in writing. If a Practitioner disagrees with the need for a PIP developed by the CPE, the Practitioner is under no obligation to participate in the PIP. In such case, the CPE cannot compel the Practitioner to agree with the PIP. Instead, the CPE will refer the matter to the MEC for its independent review and action pursuant to the Credentials Policy.

(4) ***Ongoing Assessment of PIP Results.***

(a) All PIPs will stay on the CPE's agenda and be periodically assessed by the CPE so the CPE can determine whether any modifications to the PIP are appropriate. Such modifications may include, but are not limited to, additional education, monitoring requirements, or a decision that the elements of the PIP have been satisfied and no additional action is needed. The CPE will obtain input from the Practitioner before making any modification to a PIP other than a determination that the elements of the PIP have been satisfied.

(b) Assessment of the PIP by the CPE will continue until the CPE determines that either: (i) concerns about the Practitioner's practice have been adequately addressed; or (ii) the Practitioner is not making reasonable progress toward completion of the PIP in a timely manner, in which case the CPE shall refer the matter to the MEC for its independent review pursuant to the Credentials Policy.

(c) The CPE will communicate with the Practitioner: (i) periodically regarding the Practitioner's progress under the PIP; and (ii) prior to any referral of the matter to the MEC.

(5) ***PIPs Not Disciplinary.*** PIPs are part of the Hospital's performance improvement and professional practice evaluation/peer review process. PIPs are not disciplinary in nature. Because a PIP is recommended by a non-disciplinary committee that has no authority to restrict privileges and is voluntarily accepted by the Practitioner, the PIP is not reportable to the National Practitioner Data Bank or any North Carolina licensing board.

(6) ***Participation in PIPs by Partners.*** Consistent with the conflict of interest guidelines set forth in this Policy, partners and other individuals who are affiliated in practice with the Practitioner may participate in PIPs through chart review and monitoring, proctoring, and providing second opinions. In any such instance, these individuals shall comply with the standard

procedures that apply to all other individuals who participate in the PPE process, such as the use of Hospital forms and the requirements related to confidentiality. To the extent possible, individuals who are not partners or affiliated in practice with the Practitioner will also be sought to perform these functions, consistent with the conflict of interest guidelines in this Policy.

(7) ***PIP Options.*** A PIP may include, but is not limited to, the following (used individually or in combination):

(a) ***Additional Education/CME*** which means that, within a specified period of time, the Practitioner must arrange for education or CME of a duration and type specified by the CPE. The educational activity/program may be chosen by the CPE or by the Practitioner. If the activity/program is chosen by the Practitioner, it must be approved by the CPE. If necessary, the Practitioner may be asked to voluntarily refrain from exercising all or some of his or her clinical privileges or may be granted an educational leave of absence while undertaking such additional education.

(b) ***Prospective Monitoring*** which means that a certain number of the Practitioner's future cases of a particular type will be subject to a focused review (e.g., review of the next 10 similar cases performed or managed by the Practitioner).

(c) ***Indicators Checklist*** which means that the Practitioner must (i) research the medical literature and government publications; (ii) identify evidence-based guidelines that address when a test or procedure is medically-indicated; and (iii) prepare a checklist, flow chart, or similar document that can be used to document in the medical record the medical necessity and appropriateness of a test or procedure for a specific patient.

(d) ***Second Opinions/Consultations*** which means that before the Practitioner proceeds with a particular treatment plan or procedure, the Practitioner must obtain a second opinion or consultation from a Medical Staff member approved by the CPE. If there is any disagreement about the proper course of treatment, the Practitioner must discuss the matter further with individuals identified by the CPE before proceeding further. The Practitioner providing the second opinion/consultation must complete a Second Opinion/Consultation Report form for each case, which shall be reviewed by the CPE.

(e) ***Concurrent Proctoring*** which means that a certain number of the Practitioner's future cases of a particular type (e.g., the Practitioner's next five vascular cases) must be personally proctored by a Medical Staff member approved by the CPE, or by an appropriately credentialed individual from outside of the Medical Staff approved by the CPE. The proctor must be present during the relevant portions of the operative procedure or must personally assess the patient and be available throughout the course of treatment. Proctors must complete the appropriate review form, which shall be reviewed by the CPE. Because concurrent proctoring is recommended by a non-disciplinary committee that has no authority to restrict privileges and is voluntarily accepted by the Practitioner, a PIP that includes proctoring as described in this subsection is not reportable to the National Practitioner Data Bank or any North Carolina licensing board.

(f) ***Participation in a Formal Evaluation/Assessment Program*** which means that, within a specified period of time, the Practitioner must enroll in a program approved by the CPE that is designed to identify specific deficiencies, if any, in the Practitioner's clinical practice. The Practitioner must then complete the assessment program within another specified time period. The Practitioner must execute a release to allow the CPE to communicate information to, and receive information from, the selected assessment program. If necessary, the Practitioner may be asked to voluntarily refrain from exercising all or some of his or her clinical privileges or may be granted an educational leave of absence while undertaking such formal assessment.

(g) ***Additional Training*** which means that, within a specified period of time, the Practitioner must complete additional training in a program approved by the CPE to address any identified deficiencies in his or her practice. The Practitioner must execute a release to allow the CPE to communicate information to, and receive information from, the selected program. The Practitioner must successfully complete the training within another specified period of time. The director of the training program or appropriate supervisor must provide an assessment and evaluation of the Practitioner's current competence, skill, judgment and technique to the CPE. If necessary, the Practitioner may be asked to voluntarily refrain from exercising all or some of his or her clinical privileges or may be granted an educational leave of absence while undertaking such additional training.

(h) ***Educational Leave of Absence or Determination to Voluntarily Refrain from Practicing during the PPE Process*** which means that the Practitioner voluntarily agrees to a leave of absence ("LOA") or to temporarily refrain from some or all clinical practice while the PPE process continues. During the LOA or the period of refraining, a further assessment of the issues will be conducted or the Practitioner will complete an education/training program of a duration and type specified by the CPE.

(i) ***Other*** elements not specifically listed may be included in a PIP. The CPE has wide latitude to tailor PIPs to the specific concerns identified, always with the objective of helping the Practitioner to improve his or her clinical practice and to protect patients.

Additional guidance regarding PIP options and implementation issues is found in **Appendix B**.

5. STEP-BY-STEP PROCESS. The process for PPE when concerns are raised is outlined in **Appendix C** (Flow Chart of Professional Practice Evaluation Process). This Section describes each step in that process.

5.A ***General Principles.***

(1) ***Time Frames for Review.***

(a) ***General.*** The time frames specified in this Section are provided only as guidelines. However, all participants in the process shall use their best efforts to adhere to these guidelines, with the goal of completing reviews, from initial identification to final disposition, within 120 days.

(b) ***Medical Staff Peer Review Committee Members and Assigned Reviewers.*** Medical Staff Peer Review Committee Members and Assigned Reviewers are expected to submit completed review forms to the Medical Staff Peer Review Committee, Leadership Council, or the CPE, depending on who assigned the review, within 14 days of: (i) the review being assigned; or (ii) their receipt of any requested input from the Practitioner, whichever is later.

(c) ***Medical Staff Peer Review Committees.*** Medical Staff Peer Review Committees are expected to complete their reviews within 60 days of: (i) the review being assigned to them; (ii) their receipt of the findings of a Medical Staff Peer Review Committee Member or Assigned Reviewer; or (iii) their receipt of any requested input from the Practitioner, whichever is later.

(d) ***Leadership Council.*** The Leadership Council is expected to conduct its review and arrive at a determination or intervention within 60 days.

(e) ***External Reviewers.*** If an external review is sought pursuant to Section 6.C of this Policy, those involved will use their best efforts to take the steps needed to have the report returned within 30 days of the decision to seek the external review (e.g., by ensuring that relevant information is provided promptly to the external reviewer, and that the contract with the external reviewer includes an appropriate deadline for the review).

(2) ***Request for Additional Information or Input.*** At any point in the process outlined in this Section, information or input may be requested from the Practitioner whose care is being reviewed as described in Section 3 of this Policy, or from any other Practitioner or Hospital employee with personal knowledge of the matter.

(3) ***No Further Review or Action Required.*** If, at any point in this process, a determination is made that there are no clinical issues or concerns presented in the case that require further review or action, the matter shall be closed. A report of this determination shall be made to the CPE. If information was sought from the Practitioner involved, the Practitioner shall also be notified of the determination.

(4) ***Exemplary Care.*** If the Leadership Council or CPE determines that a Practitioner provided exemplary care in a case under review, the Practitioner should be sent a letter recognizing such efforts.

(5) ***Referral to the MEC.***

(a) ***Referral by the Leadership Council or CPE.*** The Leadership Council or CPE may refer a matter to the MEC if:

(i) it determines that a PIP may not be adequate to address the issues identified;

(ii) the individual refuses to participate in a PIP developed by the CPE;

(iii) the Practitioner fails to abide by a PIP; or

(iv) the Practitioner fails to make reasonable and sufficient progress toward completing a PIP.

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

(c) ***Notice of Referral.*** The Practitioner shall be notified of any referral to the MEC.

(d) ***Review by MEC.*** The MEC shall conduct its review in accordance with the Credentials Policy.

5.B ***PPE Support Staff.***

(1) ***Review.*** All cases or issues identified for PPE shall be referred to the PPE Support Staff, who will log the matter in some manner that facilitates the subsequent tracking and analysis of the case (e.g., a confidential database or spreadsheet). The PPE Support Staff will then review the referral, with such reviews to include, as necessary, the following:

(a) the relevant medical record;

(b) interviews with, and information from, Hospital employees, Practitioners, patients, family, visitors, and others who may have relevant information. For Practitioner-specific concerns referred for review under this Policy from the serious safety event, sentinel event, or other review process, interviews and other fact-finding will be coordinated, to the extent possible, with such other review process to avoid redundancy and duplication of effort;

(c) consultation with relevant Medical Staff or Hospital personnel;

(d) other relevant documentation; and

(e) the Practitioner's professional practice evaluation history.

(2) ***Determination.*** After conducting their review, the PPE Support Staff (in consultation with the appropriate Medical Staff Peer Review Committee representative, CPE Co-Chair, Chief Medical Officer, or Senior Vice President of Quality/System Chief Medical Officer when necessary) may:

(a) determine that no further review is required and close the case (with such determinations being reviewed by the CPE as set forth in Section 5.F of this Policy);

(b) send an Informational Letter as described in Section 4.A of this Policy; or

(c) determine that further physician review is required.

(3) ***Preparation of Case for Subsequent Review.*** The PPE Support Staff shall prepare cases that require subsequent review. Preparation of the case may include, as appropriate, the following:

(a) completion of the appropriate portions of the applicable case review form;

(b) as needed, modifying the case review form to reflect specialty-specific issues, as directed by a Medical Staff Peer Review Committee, CPE Co-Chair, Chief Medical Officer, or Senior Vice President of Quality/System Chief Medical Staff Officer;

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

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

(e) identification of relevant literature.

(4) ***Referral of Case to Leadership Council, Trauma Committee, or Medical Staff Peer Review Committee.***

(a) Cases shall be referred to the Leadership Council if they are administratively complex as described in this Section or if the PPE Support Staff, in consultation with the appropriate Medical Staff Peer Review Committee Chair, CPE Co-Chair, Chief Medical Officer, or Senior Vice President/System Chief Medical Officer determines that review by the Leadership Council would be appropriate. Administratively complex cases are defined as those:

(1) that require immediate or expedited review;

(2) that involve Practitioners from two or more specialties or Departments;

(3) that involve professional conduct;

(4) that involve a Practitioner health issue;

(5) that involve a refusal to cooperate with utilization oversight activities;

(6) for which there are limited reviewers with the necessary clinical expertise;

(7) where there is a trend or pattern of Informational Letters as described in Section 4.A of this Policy;

(8) where a pattern of clinical care appears to have developed despite prior attempts at Formal Collegial Intervention/education; or

(9) where a Performance Improvement Plan is currently in effect, or where prior participation in a Performance Improvement Plan does not seem to have addressed identified concerns.

(b) Trauma cases will be referred to the Trauma Committee and reviewed as set forth in Section 5.D.

(c) All other cases shall be referred to the appropriate Medical Staff Peer Review Committee.

5.C ***Leadership Council.***

(1) ***Review.*** The Leadership Council shall review all matters referred to it, including all supporting documentation assembled by the PPE Support Staff.

(2) ***Information Sharing with Employer.*** As set forth in Section 6.M of this Policy, if the Practitioner involved is an Employed Practitioner, the Leadership Council may notify the Employer of the review and obtain its assistance in addressing the matter. In such case, a representative of the Employer may be invited to attend meetings of the Leadership Council and participate in its deliberations and interventions.

(3) ***Additional Expertise.*** The Leadership Council shall determine whether any additional clinical expertise is needed for it to make an appropriate determination or intervention. If additional clinical expertise is needed, the Leadership Council may assign the review to one or more of the following, who shall evaluate the care provided, complete an appropriate case review form, and report their findings back to the Leadership Council:

(a) a Medical Staff Peer Review Committee;

(b) an Assigned Reviewer;

(c) a committee composed of such Practitioners; or

(d) an external reviewer, in accordance with Section 6.C of this Policy.

The foregoing act on behalf of a Medical Staff committee formed to evaluate the quality, cost, and necessity of hospitalization and health care. The Leadership Council will then assess the matter and document its findings on the *Leadership Council Case Review Form*.

(4) ***Determinations and Interventions.*** Based on its own review and the findings of the other reviewers, if any, the Leadership Council may:

(a) determine that no further review or action is required;

(b) review additional cases or data related to the Practitioner to better understand any potential concerns;

(c) send an Educational Letter;

(d) conduct or facilitate a Formal Collegial Intervention with the Practitioner;

(e) refer the matter to one of the following for review and disposition:

(i) Medical Staff Peer Review Committee;

(ii) CPE; or

(iii) MEC;

(f) address the matter through the Medical Staff Professionalism Policy or Practitioner Health Policy; or

(g) refer the matter for review under the appropriate Hospital or Medical Staff policy.

In making such determinations, the Leadership Council should be guided by the Just Culture Algorithm for Physicians.

5.D ***Trauma Committee.***

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

(2) The Trauma Committee functions as a Medical Staff Peer Review Committee. Like other Medical Staff Peer Review Committees, it may address concerns that are identified through its review by sending the Practitioner an Educational Letter or by conducting a Formal Collegial Intervention. In such case, the Trauma Committee shall provide the CPE a copy of the Educational Letter or the Formal Collegial Intervention follow-up letter.

(3) If the Trauma Committee determines that a concern cannot be adequately addressed through either an Educational Letter or a Formal Collegial Intervention, it shall refer the matter to the CPE for review. The Trauma Medical Director or or designee should attend a CPE meeting to discuss the Trauma Committee's findings and answer questions.

5.E ***Medical Staff Peer Review Committees.***

(1) ***Review by Member of Medical Staff Peer Review Committee.*** When a matter is referred to a Medical Staff Peer Review Committee, an appropriate Medical Staff Peer Review Committee Member shall conduct the initial review. The Member shall either:

(a) review the case personally; or

(b) assign the review to any of the following, who shall evaluate the care provided, complete the WakeMed-approved case review form, and report his or her findings back to the Member:

(i) an Assigned Reviewer; or

(ii) a committee composed of such Practitioners.

In either case, the Medical Staff Peer Review Committee Member will prepare findings and recommendations by completing the MSPRC Case Review Form and submitting it to the Medical Staff Peer Review Committee.

(2) ***Review by Medical Staff Peer Review Committee.*** The Medical Staff Peer Review Committee will review the findings and recommendations set forth

on the MSPRC Case Review Form prepared by the Medical Staff Peer Review Committee Member. The Committee may:

(a) adopt the findings and recommendations of the Medical Staff Peer Review Committee Member as its own by approving the MSPRC Case Review Form submitted by the Member;

(b) adopt different findings and/or recommendations by completing a new MSPRC Case Review Form; or

(c) obtain additional information about a case from an Assigned Reviewer or an ad hoc committee composed of such Practitioners, then complete the *MSPRC Case Review Form.* If the Medical Staff Peer Review Committee believes an external review is necessary, the Committee will refer the matter to the Leadership Council or CPE.

(3) ***Determinations and Interventions by Medical Staff Peer Review Committees.*** Based on the findings and recommendations of a Medical Staff Peer Review Committee Member, a Medical Staff Peer Review Committee may:

(a) determine that no further review or action is required;

(b) review additional cases or data related to the Practitioner to better understand any potential concerns;

(c) send an Educational Letter;

(d) conduct or facilitate a Formal Collegial Intervention with the Practitioner; or

(e) refer the matter to the following for review and disposition:

(i) Leadership Council; or

(ii) CPE.

In making such determinations, Medical Staff Peer Review Committees should be guided by the Just Culture Algorithm for Physicians.

(4) ***Meetings of Medical Staff Peer Review Committees.*** Peer Review Committees will meet at a frequency determined by the needs of the Department or Committee Chair as long as the evaluation of peer cases are conducted within the expected 60 day timeframe.

5.F ***CPE.***

(1) ***Review of Prior Determinations.*** The CPE shall review reports from the PPE Support Staff, Leadership Council, and Medical Staff Peer Review Committees for all cases where it was determined that (i) no further review or action was required; or (ii) an Educational Letter or Formal Collegial Intervention was appropriate to address the issues presented. If the CPE has concerns about any such determination, it may:

(a) send the matter back to the Leadership Council or Medical Staff Peer Review Committee with its questions or concerns and ask that the matter be reconsidered and findings reported back to it within 14 days;

(b) supplement any intervention performed by the Leadership Council or a Medical Staff Peer Review Committee; or

(c) review the matter itself (provider input must be included in review).

(2) ***Cases Referred to the CPE for Further Review.***

(a) ***Review.*** The CPE shall consider review forms, supporting documentation, findings, and recommendations for cases referred to it by the Leadership Council or a Medical Staff Peer Review Committee.

(b) ***Information Sharing with Employer.*** As set forth in Section 6.M of this Policy, if the Practitioner involved is an Employed Practitioner, the CPE may notify the Employer of the review and obtain its assistance in addressing the matter. In such case, a representative of the Employer may be invited to attend meetings of the CPE and participate in its deliberations and interventions.

(c) ***Additional Expertise.*** The CPE may request that one or more individuals involved in the initial review of a case attend the CPE meeting and present the case to the committee. Based on its review, the CPE shall determine whether any additional clinical expertise is needed to adequately identify and address concerns raised in the case. If additional clinical expertise is needed, the CPE may:

(i) invite a specialist with the appropriate clinical expertise to attend a CPE meeting as a guest, without vote, to assist the CPE in its review of issues, determinations, and interventions;

(ii) assign the review to any Practitioner on the Medical Staff with the appropriate clinical expertise (e.g., a Medical Staff Peer Review Committee member or Assigned Reviewer);

(iii) appoint a committee composed of such Practitioners; or

(iv) arrange for an external review in accordance with Section 6.C of this Policy.

The foregoing act on behalf of a Medical Staff committee formed to evaluate the quality, cost, and necessity of hospitalization and health care.

(d) ***Determinations and Interventions.*** Based on its review of all information obtained, including input from the Practitioner as described in Section 3 of this Policy, the CPE may:

(i) determine that no further review or action is required;

(ii) review additional cases or data related to the Practitioner to better understand any potential concerns;

(iii) send an Educational Letter;

(iv) conduct or facilitate a Formal Collegial Intervention with the Practitioner;

(v) develop a Performance Improvement Plan;

(vi) refer the matter to the Leadership Council; or

(vii) refer the matter to the MEC.

In making such determinations, the CPE should be guided by the Just Culture Algorithm for Physicians.

6. PRINCIPLES OF REVIEW AND EVALUATION

6.A ***Incomplete Medical Records.*** One of the objectives of this Policy is to review matters and provide feedback to Practitioners in a timely manner. Therefore, if a matter referred for review involves a medical record (whether in the Hospital or office) that is incomplete, the PPE Support Staff shall notify the Practitioner that the case has been referred for evaluation and that the medical record must be completed within 10 days.

If the medical record is not completed within 10 days, the Practitioner will be required to meet with the Leadership Council to explain why the medical record was not completed. Failure of the individual to either:

(1) meet with the Leadership Council and convince it that the medical record is not relevant to the review; or

(2) complete the medical record in question prior to that meeting,

will result in the automatic relinquishment of the Practitioner's clinical privileges until the medical record is completed. If the Practitioner fails to complete the medical record within thirty (30) days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned. (See Section 1.D for additional information about automatic relinquishment/resignation.)

The 10-day time frame set forth in this section applies only to medical records that are necessary for a review being conducted pursuant to this Policy. The time frame set forth in this section supersedes any other time frames for the completion of medical records as may be set forth in the Credentials Policy, Rules and Regulations, or other policy.

6.B ***Forms.*** The CPE shall approve forms to implement this Policy. Such forms shall be developed and maintained by the PPE Support Staff in the WakeMed-approved peer review system, unless the CPE directs that another office or individual develop and maintain specific forms. Individuals performing a function pursuant to this Policy shall use the form currently approved by the CPE for that function.

6.C ***External Reviews.*** An external review may be appropriate if:

(1) there are ambiguous or conflicting findings by internal reviewers;

(2) the clinical expertise needed to conduct a review is not available on the Medical Staff; or

(3) an outside review is advisable to prevent allegations of bias, even if unfounded.

Obtaining an external review is within the discretion of the Leadership Council or CPE, acting in consultation with the Chief Executive Officer, Chief Medical Officer, or Senior Vice President of Quality/System Chief Medical Office. No Practitioner has the right to demand that WakeMed obtain an external review in any particular circumstance.

Those arranging for an external review shall first seek to identify an appropriate expert who is already affiliated with WakeMed. If a decision is made to obtain an external review, the Practitioner involved shall be notified of that decision and the nature of the external review. Upon completion of the external review, the Practitioner shall be provided a copy of the reviewer's report; however, information identifying the individual reviewer(s) shall be removed and the Practitioner will be informed that he/she may not attempt to contact the reviewer(s). The report of the external reviewer is a record of the committee that requested it, and will be maintained in a confidential manner as described in this Policy.

6.D ***Findings and Recommendations Supported by Evidence-Based Research/Clinical Protocols or Guidelines.*** Whenever possible, the findings of reviewers and the CPE shall be supported by evidence-based research, clinical protocols, or guidelines.

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

6.F ***Tracking of Reviews.*** The PPE Support Staff shall track the processing and disposition of matters reviewed pursuant to this Policy. The Medical Staff Peer Review Committees, Leadership Council, and CPE shall promptly notify the PPE Support Staff of their determinations, interventions, and referrals.

6.G ***Educational Sessions/Dissemination of Educational Information.***

(1) ***General Principles.***

(a) Educational sessions as described in this section, as well as the dissemination of educational information through other mechanisms, are integral parts of the peer review process and assist Practitioners in continuously improving the quality and safety of the care they provide. These activities will be conducted in a manner consistent with their confidential and privileged status under the North Carolina peer review protection law and any other applicable federal or state law.

(b) Cases that reflect exemplary care, unusual clinical facts, or would be of educational value for any other reason, shall be referred to the

appropriate Department Chair for discussion during an educational session or for the dissemination of "lessons learned" in some other manner.

(c) Medical Staff members, residents, medical students, and appropriate Hospital personnel are encouraged to participate in educational sessions in order to assess and continuously improve the care they provide.

(d) Educational sessions may also serve as a triage mechanism for the review process set forth in this Policy in certain circumstances. If any case is identified in an educational session that:

(i) may raise questions or concerns with the clinical practice or professional conduct of an individual Practitioner, and

(ii) has not already been reviewed as part of the process set forth in this Policy,

the case should be referred for review in accordance with this Policy to evaluate whether the potential concern has merit, and to address any concerns that exist. Following the conclusion of that review process, the case may be referred back to the Department Chair for purposes of conducting an educational session as described in this section.

(2) ***Rules for Educational Sessions.***

(a) For purposes of this section, "educational sessions" include morbidity and mortality conferences, and any other session conducted in a manner designed to promote quality assessment and improvement.

(b) Educational sessions will be supported and facilitated by the PPE Support Staff.

(c) Any Practitioner whose care of a patient will be reviewed in a session shall be notified at least seven days prior to the educational session. Such Practitioners shall be encouraged to attend and participate in the discussion.

(d) Information identifying specific Practitioners shall be removed prior to any presentation, unless the Practitioner requests otherwise or it is impossible to de-identify the information.

(e) All individuals who attend routine educational sessions that occur in designated specialty areas shall sign a Confidentiality Agreement annually.

(f) All attendees at an educational session will also be required to sign a confidentiality reminder for each session (e.g., as part of the sign-in process). In addition, a confidentiality reminder should be made verbally at the beginning of each session.

(g) Minutes are not required to be kept for educational sessions, but each session will have a standardized agenda that includes:

- a header in large, bold print identifying the agenda as a "Confidential Peer Review Document," and a reference to the North Carolina peer review statute (including the citation of the statute);
- the date of the educational session;
- cases reviewed (i.e., medical record numbers); and
- participants involved.

All such agendas shall be filed securely in confidential PPE Support Staff files.

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

(1) ***Documentation.*** All documentation that is prepared in accordance with this Policy shall be maintained in appropriate Medical Staff files. This documentation shall be accessible to Hospital personnel and Medical Staff Leaders and committees having responsibility for credentialing and professional practice evaluation functions, and to those assisting them in those tasks. All such information shall otherwise be deemed confidential and kept from disclosure or discovery to the fullest extent permitted by North Carolina or federal law.

(2) ***Participants in the PPE Process.*** All individuals involved in the PPE process (Medical Staff and Hospital employees) will maintain the confidentiality of the process. All such individuals shall sign an appropriate Confidentiality Agreement. Violations of this provision by Practitioners will be reviewed under the Medical Staff Professionalism Policy. Violations by Hospital employees will be referred to human resources.

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

(4) ***PPE Communications.*** Communications among those participating in the PPE process, including communications with the reviewers and the individual Practitioner involved, shall be conducted in a manner reasonably calculated to assure privacy.

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

(b) Hospital e-mail may be used to communicate between individuals participating in the professional practice evaluation process, including with those reviewing a case and with the Practitioner whose care is being reviewed. For all e-mails, a standard convention, such as "Confidential PPE Communication," shall be utilized in the subject line of such e-mail. Personal e-mail accounts or the e-mail accounts of other individuals (e.g., a Practitioner's office staff) shall not be used.

Notwithstanding this subsection, e-mail should not be utilized to present a PIP to a Practitioner. As noted previously in this Policy, one or more members of the CPE and the department chair should personally discuss the PIP with the Practitioner and present a copy to the Practitioner in person.

(c) All correspondence (whether paper or electronic) shall be conspicuously marked with the notation "Confidential Peer Review," "Confidential PPE Communication" or words to that effect. However, failure to mark documents in this manner shall not be viewed as an indication that the document is not privileged.

(d) When any correspondence is sent to a Practitioner whose care is being reviewed (whether paper or electronic), a Medical Staff Leader or PPE support staff may send a text message or make a phone call as a courtesy to alert the Practitioner that the correspondence is being sent and how it will be sent. The intent of

any such text message or phone call is to make the Practitioner aware of the correspondence and avoid any deadline being missed. Whenever such a text message or phone call is utilized, a notation to that effect should be made on the copy of the applicable correspondence maintained in the Practitioner's confidential file or in another peer review database.

(e) If it is necessary to e-mail medical records or other documents containing a patient's protected health information, Hospital policies governing compliance with the HIPAA Security Rule shall be followed.

6.I ***Conflict of Interest Guidelines.*** To protect the integrity of the review process, all those involved must be sensitive to potential conflicts of interest. It is also important to recognize that effective peer review involves "peers" and that the CPE does not make any recommendations that would adversely affect the clinical privileges of a Practitioner (which is only within the authority of the Medical Executive Committee). As such, the conflict of interest guidelines outlined in the Medical Staff Credentials Policy shall be used in assessing and resolving any potential conflicts of interest that may arise under this Policy. Those conflict of interest guidelines are summarized in **Appendix D**.

6.J ***Supervising Physicians and APP Executive Director and Advanced Practice Providers.*** A physician who is the primary supervising physician for an Advanced Practice Provider and the APP Executive Director shall be kept apprised of any concerns with the Advanced Practice Provider that are reviewed pursuant to this Policy. Without limiting the foregoing, the supervising physician will be copied on all correspondence that an Advanced Practice Provider is sent under this Policy and may be invited to participate in any meetings or interventions. The supervising physician shall maintain in a confidential manner all information related to reviews under this Policy.

6.K ***Legal Protection for Reviewers.*** It is the intention of the Hospital and the Medical Staff that the PPE process outlined in this Policy be considered patient safety, professional review, peer review, and quality assurance activity within the meaning of the Patient Safety Quality Improvement Act of 2005, the federal Health Care Quality Improvement Act of 1986, and North Carolina law. In addition to the protections offered to individuals involved in review activities under those laws, such individuals shall be indemnified and covered under the Hospital's general liability and/or directors' and officers' insurance policies when they act within the scope of their duties as outlined in this Policy and function on behalf of the Hospital.

6.L ***Delegation of Functions.*** When a function under this Policy is to be carried out by a member of Hospital management, by a Medical Staff Leader, or by a Medical

Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. However, the delegating individual or committee is responsible for ensuring the designee performs the function as required by this Policy.

6.M ***No Legal Counsel or Recordings During Collegial Meetings.***

(1) To promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner shall generally involve only the Practitioner and the appropriate Medical Staff Leaders and Hospital personnel. No counsel representing the Practitioner, Medical Staff or Hospital shall attend any of these meetings.

(2) No recording (audio or video) of a meeting shall be permitted or made. Smart phones, iPads, and similar devices must be left outside the meeting room.

6.N ***Information Sharing with Employer.***

(1) ***Scope.*** This Section applies when the Practitioner subject to a review is an Employed Practitioner (see Section 1.D for the definition of Employed Practitioner).

(2) ***Information Sharing.*** If the Practitioner involved is employed byWakeMed or Wake Specialty Physicians, LLC, WakeMed Specialist Group, LLC, and its controlled or related affiliates ("WMSP"), an appropriate WakeMed or WSP representative with employment responsibilities may be notified of the review and requested to assist in addressing the matter. If the Practitioner is employed by another WakeMed-related entity or a qualifying private group, the committee conducting the review may notify the peer review committee within that Employer and obtain its assistance in addressing the matter. In both situations, a representative of the Employer may be invited to attend meetings of the committee conducting the review, participate in discussions and deliberations, and participate in any interventions that may be deemed necessary, but shall leave the room when requested by the Chair or with the consensus of the committee. This Section is intended to supplement, not replace, any applicable Bylaw provision, policy, agreement or application form pertaining to the sharing of PPE/peer review information among WakeMed, WSP, other WakeMed-related entities, and private groups.

(3) ***Documentation and Confidentiality*.** The purpose of notifying an Employer of a review pursuant to this Section is to improve the quality of patient care. Accordingly, any information or documentation that is disclosed to the Employer or created for purposes of the review must be maintained in a confidential manner in accordance with its privileged status under the North Carolina peer review protection law. Such information should ***not*** be maintained in the employment or personnel file of the Practitioner, but rather in the Practitioner's peer review-protected file.

7. PROFESSIONAL PRACTICE EVALUATION REPORTS

7.A ***Practitioner Professional Practice Evaluation History Reports.*** A Practitioner history report showing all cases that have been reviewed for a particular Practitioner within the past two years and their dispositions shall be generated for each Practitioner for consideration and evaluation by the appropriate Department Chair and the Credentials Committee in the reappointment process.

7.B ***Reports to MEC and Board.*** The PPE Support Staff shall prepare reports at least annually showing the aggregate number of cases reviewed through the PPE process and the dispositions of those matters.

7.C ***Reports on Request.*** The PPE Support Staff shall prepare reports as requested by the Leadership Council, Department Chair, CPE, MEC, Hospital management, or the Board.

Adopted by the Cary & Raleigh Medical Executive Committees on August 3, 2021.

APPENDIX A

PERFORMANCE ISSUES THAT TRIGGER INFORMATIONAL LETTERS

This Appendix lists specific performance issues identified by the CPE that can be successfully addressed via Informational Letters rather than a more formal review. More formal review is required if a threshold number indicated below is reached within an OPPE period, or if a pattern or trend of noncompliance with Medical Staff Rules and Regulations or other policies, adopted clinical protocols, or other quality measures is otherwise identified.

This Appendix may be modified by the CPE at any time, without the need for approval by the MEC or Board. However, notice of any revisions shall be provided by the CPE to the MEC and the Medical Staff.

Medical Staff Peer Review Committee Chairs may, in their discretion, send Informational Letters for occurrences not listed below. For additional information, please see Section 4.A of the Policy.

I. Failure to Abide by Rules and Regulations

Specific Rule/Regulation	***Number of Violations Permitted Before Informational Letter Sent***	***Number of Informational Letters that Result in Review Under PPE Policy***
e.g., failure to respond to non-critical consult within 24 hours		

II. Failure to Abide by Hospital or Medical Staff Policies

Hospital/Medical Staff Policy	***Specific Requirement***	***Number of Violations Permitted Before Informational Letter Sent***	***Number of Informational Letters that Result in Review Under PPE Policy***
e.g., On-Call Policy	Failure to respond timely when on call		

III. Failure to Abide by Clinical Protocols with No Documentation as to the Clinical Reasons for Variance

Specific Protocol	***Number of Violations Permitted Before Informational Letter Sent***	***Number of Informational Letters that Result in Review Under PPE Policy***
e.g., insulin protocol		

IV. Failure to Abide by Quality Measures

Specific Protocol	***Number of Violations Permitted Before Informational Letter Sent***	***Number of Informational Letters that Result in Review Under PPE Policy***
e.g., DVT Prevention Measures		

V. Failure to Abide by Care Management/Utilization Management Requirements

Specific Requirement	***Number of Violations Permitted Before Informational Letter Sent***	***Number of Informational Letters that Result in Review Under PPE Policy***
e.g., failure to appropriately document intensity of services provided		

APPENDIX B

PERFORMANCE IMPROVEMENT PLAN OPTIONS

IMPLEMENTATION ISSUES CHECKLIST

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Note: Issues related to the development and monitoring of Performance Improvement Plans ("PIPs") are described in Section 4.D of the PPE Policy. The Implementation Issues Checklists in this Appendix may be used by the CPE to effectuate PIPs. Checklists may be used individually or in combination with one another, depending on the nature of the PIP.

A copy of a completed Checklist may be provided to the Practitioner who is subject to the PIP, so that the CPE and the Practitioner have a shared and clear understanding of the elements of the PIP. While Checklists may serve as helpful guidance to the CPE and the Practitioner, there is no requirement that they be used. Failure to use a Checklist or to answer one or more questions on a Checklist will not affect the validity of a PIP.

PIP OPTION	IMPLEMENTATION ISSUES
Additional Education/CME ***(Wide range of options)***	***Scope of Additional Education/CME*** ❑ Be specific – what type? _____ _____ ❑ Acceptable programs include: _____ _____ ❑ CPE approval required before Practitioner enrolls. ❑ Program approved: _____ ❑ Date of approval: _____ ❑ Time frames ❑ Practitioner must enroll by: _____ ❑ CME must be completed by: _____ ❑ Who pays for the CME/course? ❑ Practitioner subject to PIP ❑ Medical Staff ❑ Hospital ❑ Combination: _____ ❑ Documentation of completion must be submitted to CPE. _____ _____ ❑ Date submitted: _____ ***Additional Safeguards*** ❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges until completion of additional education? ❑ Yes ❑ No _____ _____ ***Follow-Up*** ❑ After CME has been completed, how will monitoring be done to be sure that concerns have been addressed/practice has improved? (Focused prospective monitoring? Proctoring?) _____ _____

PIP OPTION	IMPLEMENTATION ISSUES
Prospective Monitoring ***(100% focused review of next X cases (e.g., obstetrical cases, laparoscopic surgery))***	***Scope of Monitoring*** ❑ How many cases are subject to review? _____ ❑ What types of cases are subject to review? _____ _____ ❑ Based on Practitioner's practice patterns, estimated time for completion of monitoring? _____ ❑ Does monitoring include more than review of medical record? ❑ Yes ❑ No If yes, what else does it include? _____ _____ ❑ Review to be done: ❑ Post-discharge ❑ During admission ❑ Review to be done by: ❑ PPE Support Staff ❑ Department Chair ❑ Chief Medical Officer ❑ (Senior Vice President of Quality/System Chief Medical Officer ❑ Other: _____ _____ ❑ Must Practitioner notify reviewer of cases subject to requirement? ❑ Yes ❑ No Other options? _____ _____ ***Documentation of Review*** ❑ Case Review Form ❑ Specific form developed for this review ❑ General summary by reviewer ❑ Other: _____ _____ ***Results of Monitoring*** ❑ Who will review results of monitoring with Practitioner? _____ ❑ After each case ❑ After total # of cases subject to review (unless sooner discussions are necessary based on case findings)

PIP OPTION	IMPLEMENTATION ISSUES
Indicators Checklist ***(Research the medical literature, identify evidence-based guidelines addressing when a test or procedure is medically indicated, and develop a Checklist that can be included in the medical record to document medical necessity and appropriateness.)***	***Completion of the Checklists*** ❑ Checklists will be developed for the following procedures (in order of priority, if more than one): _____ _____ ❑ The Practitioner will consult with the following subject matter experts in developing the Checklists: _____ _____ ❑ The following CPE member will serve as the point of contact to assist the Practitioner with questions about the Checklists: _____ _____ ❑ The first draft of the Checklists will be submitted to the CPE by: _____ _____ ❑ The CPE will submit the Checklists to the following individuals/ committees for their review and comment, prior to final approval by the CPE: _____ ❑ The target date for final completion of the Checklists is: _____ ***Additional Safeguards*** ❑ Until the Checklists have been approved, what steps will be taken to monitor the medical necessity/appropriateness of the Practitioner's tests/procedures? _____ _____ ❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges until the Checklists have been approved? ❑ Yes ❑ No _____ _____ ***Follow-Up*** ❑ Once Checklists are completed and being used to document medical necessity/appropriateness of the Practitioner's procedures/tests for individual patients, describe the monitoring of completed Checklists that will occur (who will monitor, how often, and who will discuss with Practitioner): _____ _____

PIP OPTION	IMPLEMENTATION ISSUES
Second Opinions/ Consultations ***(Before the Practitioner proceeds with a particular treatment plan or procedure, he or she obtains a second opinion or consultation.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented as set forth in the Policy (i.e., recommended by a non-disciplinary committee with no authority to restrict privileges and voluntarily accepted by the Practitioner).)***	***Scope of Second Opinions/Consultations*** ❑ What types of cases are subject to the second opinions/consultations? _____ _____ ❑ How many cases are subject to the second opinions/consultations? _____ _____ ❑ Based on practice patterns, estimated time to complete the second opinions/consultations? _____ _____ ❑ Must consultant evaluate patient in person prior to treatment/ procedure? ❑ Yes ❑ No _____ _____ ***Responsibilities of Practitioner*** ❑ Notify consultant when applicable patient is admitted or procedure is scheduled and ensure that all information necessary to provide consultation is available in the medical record (H&P, results of diagnostic tests, etc.). _____ _____ ❑ What time frame for notice to consultant is practical and reasonable (e.g., two days prior to scheduled, elective procedure)? _____ _____ ❑ If consultant must evaluate patient prior to treatment, inform patient that consultant will be reviewing medical record and will examine patient. _____ _____ ❑ If consultant must evaluate patient prior to treatment, include general progress note in medical record noting that consultant examined patient and discussed findings with Practitioner. _____ _____ ❑ Discuss proposed treatment/procedure with consultant. _____ _____

PIP OPTION	IMPLEMENTATION ISSUES
Second Opinions/ Consultations ***(Before the Practitioner proceeds with a particular treatment plan or procedure, he or she obtains a second opinion or consultation.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented as set forth in the Policy (i.e., recommended by a non-disciplinary committee with no authority to restrict privileges and voluntarily accepted by the Practitioner).)*** ***(cont'd.)***	***Qualifications of Consultant*** ❑ Consultant must have clinical privileges in _____. ❑ Possible candidates include: _____ ❑ The following individuals agreed to act as consultants and were approved by the CPE on: _____ (date) ***Responsibilities of Consultant (****Information provided by CPE; include discussion of legal protections for consultant.****)*** ❑ Review medical record prior to treatment or procedure. ❑ Evaluate patient prior to treatment or procedure, if applicable. ❑ Discuss proposed treatment/procedure with physician. ❑ Complete Second Opinion/Consultation Form and submit to PPE Support Staff *(not for inclusion in the medical record)*. ***Disagreement Regarding Proposed Treatment/Procedure*** If consultant and physician disagree regarding proposed treatment/procedure, consultant notifies one of the following so that an immediate meeting can be scheduled to resolve the disagreement: ❑ Chief Medical Officer ❑ Senior Vice President of Quality/System Chief Medical Officer ❑ President of the Medical Staff ❑ CPE Co-Chair ❑ Department Chair ❑ Other: _____

PIP OPTION	IMPLEMENTATION ISSUES
Second Opinions/ Consultations ***(Before the Practitioner proceeds with a particular treatment plan or procedure, he or she obtains a second opinion or consultation.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented as set forth in the Policy (i.e., recommended by a non-disciplinary committee with no authority to restrict privileges and voluntarily accepted by the Practitioner).)*** ***(cont'd.)***	***Compensation for Consultant*** *(consultant cannot bill for consultation)* ❑ No compensation ❑ Compensation by: ❑ Practitioner subject to PIP ❑ Medical Staff ❑ Hospital ❑ Combination _____ _____ ***Results of Second Opinion/Consultations*** ❑ Who will review results of second opinions/consultations with Practitioner? _____ ❑ After each case ❑ After total # of cases subject to review (unless sooner discussions are necessary based on case findings) ❑ Include consultants' reports in Practitioner's quality file. ***Additional Safeguards*** ❑ Will Practitioner be removed from some/all on-call responsibilities until the second opinions/consultations are completed? ❑ Yes ❑ No _____ _____

PIP OPTION	IMPLEMENTATION ISSUES
Concurrent Proctoring ***(A certain number of the Practitioner's future cases of a particular type (e.g., vascular cases, management of diabetic patients) must be directly observed.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented as set forth in the Policy (i.e., recommended by a non-disciplinary committee with no authority to restrict privileges and voluntarily accepted by the Practitioner).)***	***Scope of Proctoring*** ❑ What types of cases are subject to proctoring? ❑ How many cases are subject to proctoring? ***Time Frames*** ❑ Based on practice patterns, estimated time to complete the proctoring? ***Responsibilities of Practitioner*** ❑ Notify proctor when applicable patient is admitted or procedure is scheduled and ensure that all information necessary for proctor to evaluate case is available in the medical record (H&P; results of diagnostic tests, etc.). ❑ What time frame for notice to proctor is practical and reasonable (e.g., two days prior to scheduled, elective procedure)? ❑ ***Procedures***: Inform patient that proctor will be present during procedure, may examine patient and may participate in procedure, and document patient's consent on informed consent form. ❑ ***Medical***: If proctor will personally assess patient or will participate in patient's care, discuss with patient prior to proctor's examination. ❑ Include general progress note in medical record noting that proctor examined patient and discussed findings with Practitioner, *if applicable*. ❑ Agree that proctor has authority to intervene, if necessary. ❑ Discuss treatment/procedure with proctor.

PIP OPTION	IMPLEMENTATION ISSUES
Concurrent Proctoring ***(A certain number of the Practitioner's future cases of a particular type (e.g., vascular cases, management of diabetic patients) must be directly observed.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented as set forth in the Policy (i.e., recommended by a non-disciplinary committee with no authority to restrict privileges and voluntarily accepted by the Practitioner).)*** ***(cont'd.)***	***Qualifications of Proctor*** *(CPE must approve)* ❑ Proctor must have clinical privileges in _____. *(If proctor is not a member of the Medical Staff, credential and grant temporary privileges.)* ❑ Possible candidates include: _____ _____ _____ ❑ The following individuals agreed to act as proctors and were approved by the CPE on _____: (date) _____ _____ _____ _____ ***Responsibilities of Proctor*** *(information provided by CPE; include discussion of legal protections for proctor)* ❑ Review medical record and: ❑ ***Procedure***: Be present for the relevant portions of the procedure and be available post-op if complications arise. ❑ ***Medical***: Be available during course of treatment to discuss treatment plan, orders, lab results, discharge planning, etc., and personally assess patient, if necessary. ❑ Intervene in care if necessary to protect patient and document such intervention appropriately in medical record. ❑ Discuss treatment plan/procedure with Practitioner. _____ _____ ❑ Document review as indicated below and submit to PPE Support Staff. ***Documentation of Review*** *(not for inclusion in the medical record)* ❑ Case Review Form ❑ Specific form developed for this PIP ❑ Other: -

PIP OPTION	IMPLEMENTATION ISSUES
Concurrent Proctoring ***(A certain number of the Practitioner's future cases of a particular type (e.g., vascular cases, management of diabetic patients) must be directly observed.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented as set forth in the Policy (i.e., recommended by a non-disciplinary committee with no authority to restrict privileges and voluntarily accepted by the Practitioner).)*** ***(cont'd.)***	***Compensation for Proctor*** *(proctor cannot bill for review of medical record or assessment of patient and cannot act as first assistant)* ❑ No compensation ❑ Compensation by: ❑ Practitioner subject to PIP ❑ Medical Staff ❑ Hospital ❑ Combination ***Results of Proctoring*** ❑ Who will review results of proctoring with Practitioner? ❑ After each case ❑ After total # of cases subject to review (unless sooner discussions are necessary based on case findings) ❑ Include proctor reports in Practitioner's quality file ***Additional Safeguards*** ❑ Will Practitioner be removed from some/all on-call responsibilities until proctoring is completed? ❑ Yes ❑ No

PIP OPTION	IMPLEMENTATION ISSUES
Formal Evaluation/ Assessment Program ***(Onsite multiple-day programs that may include formal testing, simulated patient encounters, chart review.)***	***Scope of Formal Evaluation/Assessment Program*** ❑ Acceptable programs include: _____ _____ ❑ CPE approval required before Practitioner enrolls ❑ Program approved: _____ ❑ Date of approval: _____ ❑ Who pays for the evaluation/assessment? ❑ Practitioner subject to PIP ❑ Medical Staff ❑ Hospital ❑ Combination: _____ ***Practitioner's Responsibilities*** ❑ Sign release allowing CPE to provide information to program (if necessary) and program to provide report of assessment and evaluation to CPE. _____ _____ ❑ Enroll in program by: _____ ❑ Complete program by: _____ ***Additional Safeguards*** ❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges until completion of evaluation/assessment program? ❑ Yes ❑ No _____ _____ ❑ Will Practitioner be removed from some/all on-call responsibilities until completion of evaluation/assessment program? ❑ Yes ❑ No _____ _____ ***Follow-Up*** ❑ Based on results of assessment, what additional interventions are necessary, if any? _____ _____ ❑ How will monitoring after assessment program/any additional interventions be conducted to be sure that concerns have been addressed/practice has improved? (Focused prospective review? Proctoring?) _____ _____

PIP OPTION	IMPLEMENTATION ISSUES
Additional Training ***(Wide range of options from hands-on CME to simulation to repeat of residency or fellowship.)***	***Scope of Additional Training*** ❑ Be specific – what type? _____ _____ ❑ Acceptable programs include: _____ _____ ❑ CPE approval required before Practitioner enrolls. ❑ Program approved: _____ ❑ Date of approval: _____ ❑ Who pays for the training? ❑ Practitioner subject to PIP ❑ Medical Staff ❑ Hospital ❑ Combination: _____ ***Practitioner's Responsibilities*** ❑ Sign release allowing CPE to provide information to training program (if necessary) and program to provide detailed evaluation/assessment to CPE <u>before</u> resuming practice. ❑ Enroll in program by: _____ ❑ Complete program by: _____ ***Additional Safeguards*** ❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges until completion of additional training? ❑ Yes ❑ No _____ _____ ❑ Will Practitioner be removed from some/all on-call responsibilities until completion of additional training? ❑ Yes ❑ No _____ _____ ❑ Will LOA be used for the additional training? ❑ Yes ❑ No _____ _____ ***Follow-Up*** ❑ After additional training is completed, how will monitoring be conducted to be sure that concerns have been addressed/practice has improved? (Focused prospective review? Proctoring?) _____ _____

PIP OPTION	IMPLEMENTATION ISSUES
Educational Leave of Absence or Determination to Voluntarily Refrain from Practicing during the PPE Process	❑ Who may grant a formal LOA (if applicable)? *(Review Bylaws)* _____ _____ ❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges while the PPE process continues? ❑ Yes ❑ No _____ _____ ❑ Specify the conditions for reinstatement from the LOA or for the resumption of practice following the decision to voluntarily refrain: _____ _____ ❑ What happens if the Practitioner agrees to LOA or to voluntarily refrain, but: ❑ does not return to practice at the Hospital? Will this be considered resignation in return for not conducting an investigation and thus be reportable? ❑ Yes ❑ No ❑ moves practice across town? Must Practitioner notify other Hospital of educational leave of absence or the determination to voluntarily refrain from practicing? ❑ Yes ❑ No _____ _____

PIP OPTION	*IMPLEMENTATION ISSUES*
"Other" ***Wide latitude to utilize other ideas as part of PIP, tailored to specific concerns.*** ***Examples:*** • ***Participate in an educational session at section or Department meeting and assess colleagues' approach to case.*** • ***Study issue and present grand rounds.*** • ***Design and use informed consent forms approved by CPE.*** • ***Design and use indication forms approved by CPE.*** • ***Limit inpatient census.*** • ***Limit number of procedures in any one day/block schedule.*** • ***No elective procedures to be performed after ___ p.m.*** • ***All patient rounds done by certain time of day – timely orders, tests, length of stay concerns.*** • ***Personally see each patient prior to procedure (rather than using PA, NP, or APRN).*** • ***Personally round on patients – cannot rely solely on PA, NP, or APRN.*** • ***Utilize individuals from other specialties to assist in PIPs (e.g., cardiologist experiencing difficulties with TEE technical complications mentored by anesthesiologists).***	

APPENDIX D

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Individual Reviewer Application/ Case	Committee Member					Hearing Panel	Board
			Credentials	Leadership Council or MSPRC	CPE	MEC	Investigating Committee		
Employment/contract relationship with hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N	R
Relevant treatment relationship*	Y	N	R	R	R	R	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Involvement in prior PIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R

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

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

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

N – (Red "N") means the Interested Member should not serve in the indicated role.

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

***** Special rules apply both to the provision of information and participation in the review process in this situation. See Section 8.A.3 of the Credentials Policy.

APPENDIX E

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

APPENDIX F

PEER REVIEW COMMITTEES

Department peer review committees are chaired by the department vice chair. Other peer review committee chairs are either appointed by the applicable department chair or based upon administrative position, e.g. Trauma Medical Director.

Committee Members

Peer review committee members will be recommended by the Department Chair and Committee Chair to the Leadership Council for appointment. Every Peer Review Committee must include at least three Medical Staff members in good standing, who have had privileges at WakeMed for a period of at least one year. In addition, at least one APP must be included in each PPE committee. The APP must be in good standing and have had privileges at WakeMed for a period of at least one year. Terms for committee members will be two years with staggered terms. Members can be appointed for additional terms. The PPE support staff will coordinate this transition in collaboration with the Department Vice Chair.

Committee Size

In order to maintain the confidentiality of each provider under review, it is imperative to limit the committee size. Each committee shall have a minimum of four members as outlined above. Each committee is encouraged, but not required, to seek a representative from each specialty area within their department for the peer review committee.