Practitioner & Advanced Practice Provider Peer Review Policy

University Hospitals East Market Unified Medical Staff

APPLICABILITY & PURPOSE

This Peer Review Policy (Policy) applies to the University Hospitals Health System East Market[1] hospitals, including their provider-based locations (hereinafter individually and collectively referred to as "Hospital"). The Hospital Medical Staffs operate as a unified Medical Staff ("Medical Staff")

The Board of Directors of the Hospital has delegated to the Hospital Medical Staff, through its committees and those committees' members/agents, the responsibility for monitoring, evaluating, maintaining, and improving the quality of clinical care, treatment, and/or services provided by Practitioners and Advanced Practice Clinicians[2] (collectively "Providers") to patients at the Hospital. This Policy establishes the process for conducting Provider case reviews at the Hospital in a peer review protected manner pursuant to applicable Ohio laws and rules/regulations.

PEER REVEW PROCEDURE

Peer review expectations are set forth in **Addendum A-1**.

The procedure for conducting internal peer review of individual Provider cases is detailed in **Addendum A-2** along with the case review/rating form.

The procedure for requesting an external peer review of individual Provider cases is detailed in **Addendum A-3**.

The procedure for initiating and conducting a Focused Professional Practice Evaluation (FPPE) for Provider quality of care concerns is detailed in **Addendum A-4** along with the FPPE form.

PEER REVIEW COMMITTEE STRUCTURE

Routine Provider case reviews will be conducted by the Multidisciplinary Peer Review Committee (MPRC) and Specialty Peer Review Committees (SPRC), if any, that report to the MRPC. Joint Peer Review Committees (JPRC), if any, may be established in the manner set forth in **Addendum B-1**. The MRPC and each SPRC and JPRC is a Peer Review Committee (PRC).

The composition, duties, and meeting requirements for the MRPC and for each SPRC and JPRC, if any, shall be set forth in the Medical Staff Organization Policy.

SCOPE OF POLICY

Performance improvement activities related to systemic Hospital issues are not a part of this Policy. Rather, to the extent a systemic Hospital performance issue is identified by the MPRC, a SPRC, or a JPRC, the issue will be referred to the appropriate Hospital committee. Correspondingly, if a Hospital committee identifies an individual Provider performance issue, that committee will refer the matter to the MRPC. For example, if a Hospital committee is conducting a root cause analysis, the Hospital committee will refer review of a Provider's conduct/clinical care to the MRPC or appropriate SPRC or JPRC.

This Policy does not address the initial FPPE process for Practitioners and APPs granted new Privileges at the Hospital. This Policy does not address the Ongoing Professional Practice Evaluation (OPPE) process for Practitioners and APPs granted Privileges at the Hospital.

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[1] The University Hospitals Ahuja Medical Center (Ahuja), University Hospitals Geneva Medical Center (Geneva), University Hospitals Conneaut Medical Center (Conneaut), University Hospitals Regionals Medical Center dba University Hospitals Geauga Medical Center (Geauga), and each such Hospital's provider-based locations, if any, comprise the University Hospitals Health System East Market.

[2] For purposes of this Policy, the term Practitioner means a Physician, Dentist, Podiatrist, or Psychologist; the term Advanced Practice Clinician or APC means an Advanced Practice Registered Nurse, Physician Assistant, or any other health care professional who has been granted Privileges at the Hospital pursuant to the Medical Staff privileging process.

PEER REVIEW INFORMATION & ACCESS

Peer review information includes all information collected for, generated by, or otherwise under the oversight of a PRC. Peer review information shall only be used for peer review purposes as that term is defined in Ohio Revised Code §2305.25, *et seq*. in the absence of a decision on the part of the Hospital President or Chief Medical Officer, in consultation with Hospital legal counsel, that it is appropriate for certain information to be used for alternative purposes.

Peer review files are Hospital property and are maintained for credentialing, privileging, and related peer review purposes. The information maintained in these files is privileged pursuant to Ohio Revised Code §§2305.25, *et seq*.

All PRC minutes are maintained as protected peer review documents. A Provider who is under review is not entitled to access to the PRC minutes unless they are produced as part of a fair hearing proceeding (or similar procedural due process proceeding as applicable to APPs).

All correspondence between a PRC and a Provider, final determinations, and related records/documentation are maintained in a peer review file.

The Hospital maintains one or more peer review files for each Provider who is granted, as applicable, an appointment and/or Clinical Privileges at the Hospital. Peer review files contain information regarding a Provider's credentials, privileging, FPPE, OPPE, and related quality data. Peer review files may also be developed for other activities (*e.g.*, corrective action proceeding, *etc.*).

Consistent with Medical Staff policy, a Provider has the right to review his/her credentials file and quality file (subject to certain information, such as references or other third-party documentation, not being disclosed as determined by the Hospital).

A Provider does not have the right to a copy of his/her credentials or quality file unless produced as part of a fair hearing proceeding (or similar procedural due process proceeding as applicable to APPs).

A request to review one's credentials or quality file should be made to the Medical Staff Office. Requests should be made at least five (5) business days in advance. The review will be held at the Medical Staff Office, as applicable, in the presence of a designated peer review agent.

Peer review information is otherwise available only to: authorized individuals/committees who require access to such information as part of the protected peer review process; or, appropriate accrediting/regulatory organizations following consultation with Hospital legal counsel.

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the UH Ahuja Medical Executive Committee
January 21, 2026

Adopted by the UH Conneaut Medical Executive Committee
January 9, 2026

Adopted by the UH Geauga Medical Executive Committee
January 14, 2026

Adopted by the UH Geneva Medical Executive Committee
January 9, 2026

Approved by the Board
January 23, 2026

ADDENDUM A-1
PEER REVIEW EXPECTATIONS

Non-Confrontational. This Policy is not intended to be confrontational or adverse. Rather, this Policy's primary focus is remedial and educational, recognizing that early detection of concerns and a prompt response to them benefits the patient as well as the caregiver.

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

Action by (or on Behalf of) a PRC/PRC Agent(s). Whenever a Provider, a member of the Hospital's staff, or a committee engages in activities pursuant to this Policy, the individual/group shall be acting as, or on behalf of, a PRC as that term is recognized in Ohio Revised Code Section 2305.25, *et seq.* Whenever a PRC is authorized to engage in an activity, the PRC may designate one (1) or more agents to act on its behalf.

Referrals. Nothing in this Policy supersedes any provision of the Medical Staff governing documents or otherwise precludes imposition of a summary suspension or the referral of a matter to an alternative forum [*e.g.*, the Medical Executive Committee (for initiation of corrective action pursuant to the Medical Staff Bylaws or APC Policy, as applicable), *etc.*] should a PRC determine such referral is appropriate.

Cooperation Expected. A PRC (or agent on behalf of a PRC) may request to meet with a Provider to discuss cases or issues under review or to request that the Provider respond, in writing, to cases or issues under review. Providers are expected to reasonably participate in this process. A failure to do so will result in the matter being resolved without the Provider's input and will be considered in the context of whether the Provider acted in a professional manner consistent with his/her responsibilities pursuant to the Medical Staff governing documents.

Courteous/Impartial. Participants are to be courteous and respectful to each other. Activities are to be fair, impartial, and conducted in an appropriate manner designed to protect patient safety and the integrity of the program. Activities are to be performed in good faith and without bias, prejudice, personal gain, or malice.

Peer to Peer. The peer review program is designed to foster collegial engagement. As such, neither a PRC, nor a Provider shall have the right to have legal counsel present at a PRC meeting unless authorized at the PRC's sole discretion.

Impact of Determination. A case level assignment by the MRPC, a SPRC, or a JPRC is not deemed Adverse nor does it give rise to any procedural rights pursuant to the Medical Staff Bylaws or APC Policy.

Conflicts of Interest. The fact that a PRC member or PRC agent is in the same specialty as the Provider under review does not, in and of itself, require recusal. In the event a Provider believes that a PRC member/agent has a conflict of interest, the chair of the applicable PRC is notified. The PRC chair, at his/her sole discretion, will make the final determination as to whether the contested individual may continue to participate. A member of a PRC whose case is under review must be recused from participating in the peer review matter as a PRC member. Once the Provider has responded to any questions by the PRC, the Provider must be excused from the meeting while the PRC conducts its deliberations and makes its determination related to the Provider's case.

ADDENDUM A-2
INTERNAL PEER REVIEW

A. Each case referred to the applicable PRC is assigned to a "Peer" member or authorized agent of the PRC (a Peer Reviewer) for review.
   a. The Peer Reviewer must be an individual practicing in the same or similar profession (*e.g.*, Physician to Physician; APC to APC; *etc*.) as the individual under review with equal or greater education, training, and current competence. A determination as to who constitutes a Peer will be made on a case-by-case basis, as appropriate.
   b. Confirm that a Confidentiality Statement has been signed.

B. The assigned Peer Reviewer reviews the case in preparation for presentation to the applicable PRC. Upon completion of his/her review, the Peer Reviewer forwards the case to the applicable PRC for:
   a. Presentation as a consent agenda item.
      OR
   b. Review and discussion with the PRC.

C. A Provider should always be asked to provide a response whenever the initial determination is that care is anything other than "No Quality Variance."

D. If, following the Peer Reviewer's presentation of the case, the PRC determines that there are potential concerns regarding clinical care and/or professional conduct, then:

   a. The PRC sends a letter to the Provider notifying the Provider of the case review and requesting additional information.
   b. A Provider member whose case is under review is expected to respond to a request from a PRC within the time-period specified in the PRC letter requesting additional information.

E. The PRC informs the reviewed Provider, in writing, of the assigned rating, the recommended follow up action, and of the right to appeal.

F. Any action by the PRC pursuant to this Policy (*e.g.*, an FPPE for a quality concern initiated by the MPRC) that results in a limitation on a Provider's ability to exercise Clinical Privileges requires voluntary agreement on the part of the Provider.

G. In the event a SPRC or JPRC assigns a case rating of "**Major Variance from Expected Practice**," or "**Minor Variance from Expected Practice**," the Provider may submit a written appeal to the MRPC, within 60 days from the date of the SPRC or JPRC determination letter, for reconsideration of the SPRC's or JPRC's case rating. The request must specifically identify the findings with which the Provider disagrees and the basis for such disagreement. Upon receipt of a timely written appeal, the MRPC may:

a. Remand the matter back to the SPRC or JPRC or request additional input from the SPRC or JPRC;
b. Review and make a final decision based solely upon the information initially available to the SPRC or JPRC and the additional written information provided by Provider; and/or
c. Meet with the Provider and/or the SPRC or JPRC prior to making a final decision.

H. The MRPC informs the reviewed Provider, in writing, of the final assigned rating. The MRPC's decision following appeal of an initial case rating by a SPRC or JPRC is final. An initial case rating by a SPRC or JPRC that is not appealed to the MRPC is final.

ADDENDUM A-2
Internal Case Review Process for Providers

Activity	Case Review Process	Decisions/Actions	Documents *There are corresponding letters for each step in the process.
		References to PRC = the MRPC, a SPRC, or a JPRC, as applicable.	
Case Referral	Case referred to a PRC is assigned for review	Each case referred to the applicable PRC is assigned to a "Peer" member or authorized agent of the PRC (a Peer Reviewer) for review. • The Peer Reviewer must be an individual practicing in the same or similar profession (*e.g.*, Physician to Physician; APC to APC; *etc.*) as the individual under review with equal or greater education, training, and current competence. A determination as to who constitutes a Peer will be made on a case-by-case basis, as appropriate. • Confirm that a Confidentiality Statement has been signed. The assigned Peer Reviewer reviews the case in preparation for presentation to the applicable PRC. Upon completion of his/her review, the Peer Reviewer forwards the case to the applicable PRC for: • Presentation as a consent agenda item. OR • Review and discussion with the PRC.	Sign Confiden-tiality Statement
		NOTE: A Peer Reviewer only determines whether there are "concerns" or "no concerns" with respect to an assigned case. Only a PRC makes a case determination (*i.e.*, assigns a case level).	
PRC Meeting	**[No concerns from Peer Reviewer]** Case provided by Peer Reviewer to	If the Peer Reviewer has no concerns following his/her initial review, the case is presented to the applicable PRC as a consent agenda item. The PRC reviews the case summary and may ask questions of the Peer Reviewer. If, following such review, the PRC makes a determination of "**No Quality Variance**" (*i.e.*, care rendered was appropriate) then:	Form Letter #1

	PRC as consent agenda item.	• No further review is necessary; and, • The PRC informs the reviewed Provider, in writing, of the assigned rating and that the case is closed.	
PRC Meeting	**[Concerns from Peer Reviewer]** Case presented by Peer Reviewer to PRC for discussion.	If the Peer Reviewer has concerns following his/her initial review, the case is presented to the applicable PRC for review and discussion. If, following the Peer Reviewer's presentation of the case, the PRC determines that there are potential concerns regarding clinical care and/or professional conduct, then: • The PRC sends a letter to the Provider notifying the Provider of the case review and requesting additional information. • A Provider whose case is under review is expected to respond to a request from a PRC within the time-period specified in the PRC letter requesting additional information. A Provider should always be asked to provide a response whenever the initial determination is that care is anything other than "No Quality Variance."	Form Letter #2
PRC Review	**Case brought back to PRC:** After receiving a response from the Provider under review to PRC request for additional information.	Upon receipt of a timely response from the Provider whose case is under review, the case is brought back to the PRC for further review. If, following review of the Provider response, the PRC makes a determination of "**No Quality Variance**" (*i.e.*, that care rendered was appropriate) then: • No further review is necessary; and, • The PRC informs the reviewed Provider, in writing, of the assigned rating and that the case is closed.	Form Letter #3
		If, following review of the Provider's response, the PRC makes a determination of "**Minor Variance from Expected Practice**" OR "**Major Variance from Expected Practice**," then the PRC's actions can include: • Tracking and trending (*provide details regarding what is to be tracked and trended*). • Collegial discussion (*identify two (2) or more members/agents of the PRC to have the collegial discussion*).	Form Letter # #4

		• Initiating Focused Professional Practice Evaluation (FPPE) for quality concerns (*specify method*) *(subject to Addendum A-4)* • Recommending a remediation plan (*e.g.*, external counseling, internal or external education, training, *etc.*) *(provide details regarding the remediation plan).* • Requesting external peer review (*subject to Addendum A-3*) as a second opinion. • SPRC or JPRC referral to the MRPC for management. • Referral to the MEC for consideration of initiation of formal corrective action • Any other action, within the authority of the PRC, as appropriate under the circumstances (*specify other action to be taken*). Any action by the PRC pursuant to this Policy (*e.g.*, an FPPE for a quality concern initiated by the MPRC) that results in a limitation on a Provider's ability to exercise Clinical Privileges requires voluntary agreement on the part of the Provider. The PRC informs the reviewed Provider, in writing, of the assigned rating, the recommended follow up action, and of the right to appeal.	
PRC Review	**Case brought back to PRC:** <u>No response</u> from Provider to PRC request for additional information.	If <u>no response</u> is received from the Provider whose case is under review by the deadline specified in the PRC letter requesting additional information, the case is brought back to the PRC for further review. The PRC will proceed to review and rate the case based upon the information available. If the PRC makes a determination of "**No Quality Variance**" (*i.e.*, care rendered was appropriate) then: • No further review is necessary; and, • The PRC informs the reviewed Provider, in writing, of the assigned rating and that the case is closed. • The Provider is also reminded of the expectation and importance of participating in the peer review process.	Form Letter #5
		If the PRC makes a determination of "**Minor Variance from Expected Practice**" <u>OR</u> "**Major Variance from Expected Practice**," then the PRC's actions can include: • Tracking and trending (*provide details regarding what is to be tracked and trended*). • Collegial discussion (*identify two (2) or more members/agents of the PRC to have the collegial discussion*). • Initiating Focused Professional Practice Evaluation (FPPE) for quality of care concerns (*specify method*) *(subject to Addendum A-4)*	Form Letter #6

		• Recommending a remediation plan (*e.g.*, external counseling, internal or external education, training, *etc.*) *(provide details regarding the remediation plan).* • Requesting external peer review (*subject to Addendum A-3*) as a second opinion. • SPRC or JPRC referral to the MRPC for management. • Referral to the MEC for consideration of initiation of corrective action • Any other action, within the authority of the PRC, as appropriate under the circumstances (*specify other action to be taken*). Any action by the PRC pursuant to this Policy (*e.g.*, an FPPE for a quality concern initiated by the MPRC) that results in a limitation on a Provider's ability to exercise Clinical Privileges requires voluntary agreement on the part of the Provider. The PRC informs the reviewed Provider, in writing, of the assigned rating, the recommended follow up action, and of the right to appeal.	
Appeal	**[Appeal to the MRPC of SPRC or JPRC case rating]**	In the event a SPRC or JPRC assigns a case rating of "**Major Variance from Expected Practice**," or "**Minor Variance from Expected Practice**," the Provider may submit a written appeal to the MRPC, within 60 days from the date of the SPRC or JPRC determination letter, for reconsideration of the SPRC's or JPRC's case rating. The request must specifically identify the findings with which the Provider disagrees and the basis for such disagreement. Upon receipt of a timely written appeal, the MRPC may: • Remand the matter back to the SPRC or JPRC or request additional input from the SPRC or JPRC; • Review and make a final decision based solely upon the information initially available to the SPRC or JPRC and the additional written information provided by the Provider; and/or • Meet with the Provider and/or the SPRC or JPRC prior to making a final decision. The MRPC informs the reviewed Provider, in writing, of the final assigned rating. The MRPC's decision following appeal of an initial case rating by a SPRC or JPRC is final. An initial case rating by a SPRC or JPRC that is not appealed to the MRPC is final.	Form Letter #8

Note: A uniform minutes format will be established by the MRPC for use by PRCs in conducting Peer Review.

<u>Include the following in all Peer Review documentation</u> (*e.g.*, minutes, agendas, and attachments):
Privileged and confidential peer review document pursuant to Ohio Revised Code §§2305.25, *et seq.* Peer review documents are not to be copied or distributed to unauthorized individuals or entities.

<u>Note</u>: Copies of all correspondence and related documentation (other than the actual medical record) must be maintained in the Provider's quality file or other appropriate peer review file.

PEER REVIEW PROGRAM
CONFIDENTIALITY STATEMENT

Thank you for agreeing to serve as a member of a Peer Review Committee (PRC) or otherwise participate in the peer review process at the University Hospitals Health System East Market hospitals, including their provider-based locations (hereinafter individually and collectively referred to as "Hospital") The Hospital Medical Staffs operate as a unified Medical Staff ("Medical Staff").

Practitioners and Advanced Practice Clinicians (APCs) (collectively, "Providers") who participate in peer review must be viewed by their colleagues as fair, collegial, confidential, clinically competent, and professional. Peer review is ultimately the responsibility of the Hospital Board as part of maintaining the quality of medical care. The Board delegates this responsibility to the Medical Staff through the MEC which, in turn, authorizes the PRCs to act. As a member of a PRC or participant in the peer review process, it is your shared responsibility in return to make sure that the peer review program is effective.

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

- Have a professional and collegial demeanor in all activities.

- Keep deliberations frank, honest, accurate, unbiased, and non-inflammatory.

- Be trustworthy. Keep the deliberations confidential the way you would expect if your case was under review.

- Seek additional input, through a PRC-approved resource, if the issue is outside the expertise of the PRC members. Sometimes determining whether or not a particular action was within the standard of care requires detailed knowledge of current practice that only a group of peers from within the involved specialty can provide.

- Do not use the peer review process to discredit, embarrass, undermine, discourage, or unseat a colleague. Cases should be selected without bias.

- Do not protect a colleague or friend from peer review. If you perceive that this needs to be done, you are indicating that you believe the peer review process is either not fair; or is being used to do something other than improve the quality of care. It is your obligation to bring these concerns to the PRC chair.

- If you have a conflict of interest with the Provider being discussed (*e.g.*, competitor, partner, refers patients to you or vice-versa, financial relationship, employed in the same group, *etc.*), you are expected to disclose that conflict to the PRC. The PRC is responsible for determining whether the conflict rises to the level of precluding you from participating in the pending peer review matter. For purposes of this Policy, the fact that Providers are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such Providers from participating in the peer review process with respect to his/her colleagues.

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

To preserve the confidentiality of quality management data, it is imperative that Providers involved in peer review observe the following instructions in the performance of peer review:

- The case review form should never be shared with individuals who are not authorized to access this information. When the review is completed, please submit the form (either in hard copy or electronically) to the designated Medical Staff/Hospital personnel or office. The form is not to be part of the patient's medical record.

- Once the case review form is completed, making additional copies of the form is prohibited.

- Discussing peer review cases or data with other Providers outside of the PRC meeting is prohibited unless specifically requested by the PRC.

- Discussing peer review cases or data with anyone in a public setting is prohibited.

- Discussing PRC reviews with Hospital employees other than those involved in the peer review or quality assessment process is prohibited.

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

NAME (Print)	SIGNATURE	DATE SIGNED

PEER REVIEW PROGRAM
CASE REVIEW & RATING FORM

Name of Assigned Peer Reviewer: **Date Assigned for Peer Review:**

Name of Provider
Whose Case is Reviewed:

Patient Name:
Patient Date of Birth:

Patient Medical Record #: **Date of Service:**
Encounter #:
Admission Date:
Discharge Date:
UH Hospital (or provider-based facility):

Quality Management #:
Quality Indicator:

Case Summary/Outcome:

PEER REVIEWER ASSESSMENT

Date

Assigned Peer Reviewer

CASE RATING DETERMINATION

CASE RATING *(select one)*
❑ By the MRPC
❑ By a SPRC (that reports to the MRPC)
❑ By a JPRC (that reports to the MRPC)

❑ "**No Quality Variance":** Care rendered was appropriate.

❑ "**Minor Variance from Expected Practice":** Care rendered is deemed to be outside of benchmarks/established standards/standards of care; however, the variance was minor or standards of care for the case are controversial. *[See Right to Appeal below.]*

❑ "**Major Variance from Expected Practice":** Care rendered is deemed to be substantially outside of benchmarks/established standards/standard of care. *[See Right to Appeal below.]*

Notice of Right to Appeal:
If a SPRC or JPRC assigns a case rating of "Major Variance from Expected Practice," or "Minor Variance from Expected Practice," the Practitioner/APP may submit a written appeal to the MRPC to reconsider the SPRC's or JPRC's case rating. *[See Addendum A-2 regarding the appeal procedure.]*

- An initial case rating by a SPRC or JPRC that is not appealed to the MRPC is final.

[See Addendum A-2 in the Peer Review Policy and send the applicable Peer Review letter with a copy retained in the Practitioner's/APP's quality file.]

FOLLOW UP ACTION

❑ If the final case rating is "**No Quality Variance**" then the Provider is notified, in writing, of the assigned rating and the case is closed. *[See Addendum A-2 in the Peer Review Policy and send the applicable Peer Review letter with a copy retained in the Provider's quality file.]*

❑ If the final case rating is "**Minor Variance from Expected Practice**" or "**Major Variance from Expected Practice**" then the Provider is notified, in writing, of the assigned case rating, the right to appeal, and the recommended follow up action (*select one or all that apply*):

❑ Collegial discussion; identify two (2) or more members/agents of the MRPC/SPRC/JPRC to have the collegial discussion:_____.
❑ Track and trend; provide details regarding what is to be tracked and trended: _____.
❑ Initiate FPPE for quality of care concerns *(specify method)*:_____. *[The MRPC must approve an FPPE for quality of care concerns initiated by a SPRC that reports to the MRPC. A JPRC may recommend initiation of FPPE to the MRPC.] [See Addendum A-4]*
❑ Remediation plan (*e.g.*, external counseling, internal or external education, training, *etc.*) Provide details regarding remediation plan: _____.
❑ External peer review *(subject to the approval process set forth in Addendum A-3)* requested as a second opinion.
❑ SPRC/JPRC referral to the MRPC for management.
❑ Referral to the Medical Executive Committee for consideration of initiation of formal corrective action.

❑ Any other action, within the authority of the MRPC/SPRC/JPRC, as appropriate under the circumstances (*please specify*):_____.

[See Addendum A-2 in the Peer Review Policy and send the applicable Peer Review letter with a copy retained in the Practitioner's/APP's quality file.]

❑ **Hospital systemic performance improvement issue identified** (*e.g.*, nursing issue, ancillary services issues, *etc.*) and referred to _____ (*list the appropriate Hospital quality committee*).

CASE RATING AFTER APPEAL

❑ By the MRPC (following appeal of an initial case rating of "Major Variance from Expected Practice" or "Minor Variance from Expected Practice" by a SPRC or JPRC). The MRPC's decision following appeal of an initial case rating by a SPRC or JPRC is final.

❑ "**No Quality Variance":** Care rendered was appropriate.

❑ "**Minor Variance from Expected Practice":** Care rendered is deemed to be outside of benchmarks/established standards/standards of care; however, the variance was minor or standards of care for the case are controversial.

❑ "**Major Variance from Expected Practice":** Care rendered is deemed to be substantially outside of benchmarks/established standards/standard of care.

Modification of Follow Up Action:

❑ No

❑ Yes *[If so, specify the modification(s)]:* _____
_____.

[See Addendum A-2 in the Peer Review Policy and send the applicable Peer Review letter with a copy retained in the Practitioner's/APP's quality file.]

Privileged and confidential peer review document pursuant to Ohio Revised Code §§2305.25, *et seq*. Peer review documents are not to be copied or distributed to unauthorized individuals or entities.

ADDENDUM A-3
EXTERNAL PEER REVIEW

A. PURPOSE

1. External peer review is used to assure that an objective and fair evaluation of the care delivered (as documented in the medical record) is afforded to the Provider involved; and/or to resolve any issues remaining from internal peer review. As such, an external peer review should be requested (subject to appropriate approvals) whenever it is determined that:
   a. An internal review may not be perceived as objective or unbiased.
   b. An internal review cannot be performed due to a conflict of interest.
   c. Similarly trained Providers are not available to conduct a review.
   d. There is a substantial difference of opinion regarding the care provided.
   e. The review involves a new technology or procedure for which the Medical Staff does not have the requisite expertise.
   f. There is a possibility of a future professional review action.
   g. Other appropriate reason as dictated by circumstances.

B. AUTHORIZATION

1. The following have the authority to initiate and/or approve a request for an external Peer Review:
   a. The MEC or MEC chair (with approval of the Hospital President or the Chief Medical Officer)
   b. The MRPC or MRPC chair (with approval of the Hospital President or the Chief Medical Officer)
   c. A SPRC or SPRC chair (with approval of the Hospital President or the Chief Medical Officer)
   d. The Chief Medical Officer
   e. The Chief Quality Officer
   f. The Board
   g. The Hospital President (on behalf of the Board)

2. A Provider cannot require the Hospital to obtain an external peer review.

C. QUALIFICATIONS OF AN EXTERNAL PEER REVIEWER

1. All external peer reviewers must agree to maintain confidentiality consistent with Ohio's peer review privilege prior to engaging in peer review activities.

2. An external peer reviewer must meet the qualifications listed in this section and such other qualifications, if any, as provided for in the Medical Staff governing documents (modified as necessary for APCs).
   a. Be board certified in the specialty under review.
   b. Be currently engaged in the active practice of such specialty with a minimum of five (5) years of experience.

c. Not have or be perceived as having a conflict of interest with the affected Provider. External peer reviewers who have no personal relationship with the Provider will be given preference.

d. Be able to provide a timely, written, objective opinion based on the care delivered as documented in the medical record and pertinent related components. The opinion must include decision rationale, any national or organizational standards utilized, and opportunities for improvement (if any).

e. Be willing to continue to participate in the peer review process through fair hearing (or such other procedural due process as may be available for APCs) and litigation if the matter extends to these proceedings.

f. Such other qualifications as are deemed appropriate by the PRC.

3. A written agreement including a business associate agreement is required. System legal counsel must approve any written agreement submitted by an external peer reviewer.

D. PROCESS FOLLOWING RECEIPT OF EXTERNAL PEER REVIEW REPORT

1. If a PRC requested the review and has any concerns or questions relative to the review after receipt of an external peer review report, the PRC is expected to follow up with the external peer reviewer either by letter or discussion documented by minutes.

2. In all but exceptional circumstances (as determined by the applicable PRC following consultation with Hospital legal counsel), the affected Provider will be given an opportunity to review the report of an external peer reviewer (whether favorable or unfavorable) as well as the opportunity to participate in, or respond to, any concerns as soon as reasonably appropriate.

3. The Provider is not required to be, and should not be, given a copy of the report unless the report becomes part of an investigation conducted by the MEC that results in the initiation of the fair hearing process (or such other procedural due process as may be available for an APC).

4. Thereafter, the applicable PRC may proceed to take such action(s), as appropriate, in accordance with **Addendum A-2**.

ADDENDUM A-4
FPPE FOR QUALITY CONCERNS

A. GROUNDS

1. Egregious single event.
2. Pattern of concern identified pursuant to an OPPE.
3. Concerns identified by a PRC.
4. Significant complaints by patients, Hospital staff, other Providers.
5. Other patterns or quality trends of concern, which includes:
   a. Aberrant rate of complications and/or sub-optimal outcomes
   b. Deviations in the standard of care (or the perception of substandard care)
   c. Patient safety issues
   d. Unusual PASS or other incident reports
6. Non-compliance with policies critical to patient safety, clinical guidelines, or patient safety protocols, which include:
   a. Adherence to verbal orders policy
   b. Adherence to EMR documentation requirements
   c. Ensuring electrosurgical instruments are used properly to minimize fire safety
   d. Adherence to universal protocol prior to each procedure
   e. Ensuring signed consent (*e.g.*, for procedure, blood, sedation) is present prior to going to OR/procedure area or initiating procedure
   f. Ensuring arm band in place and patient identification confirmed prior to going to OR/procedure area
   g. Adherence to organ check in policy

B. AUTHORITY TO INITIATE

1. The establishment of an FPPE based upon quality concerns during a Privilege period is generally the responsibility of the MPRC. A SPRC may initiate an FPPE for quality concerns subject to approval of the MPRC. A JPRC (if any) may recommend initiation of an FPPE for quality concerns to the applicable MRPC(s). If listed in the grounds set forth in Section A above, the Chief Medical Officer with approval of the MPRC or one of the following: Chief of Staff or Chief Quality Officer may recommend initiation of an FPPE.

2. An FPPE based upon quality concerns is to be designed in a manner that best provides oversight of the care being provided by a Provider relative to the issue under review. An FPPE will not be considered an "investigation."

3. An FPPE for quality concerns may consist of any or all of the following:
   a. Prospective, concurrent, or retrospective case review.
   b. Proctoring (direct observation).
   c. Prior approval for certain procedures.
   d. Any other appropriate elements

4. In the event the MRPC or a SPRC implements an FPPE for quality concerns, the Provider will be notified, in writing.

5. Although not required, it is the expectation that the MRPC or SPRC will meet with the Provider to review the reason for the FPPE and its scope.

6. A Practitioner/APP may voluntarily agree to enter into a remediation agreement and/or to limit the exercise of his/her Privileges during the course of an FPPE for quality concerns implemented by the MRPC or a SPRC.

C. REPORTING

1. An FPPE based upon quality concerns that is managed by the MRPC or a SPRC pursuant to this Policy is not deemed Adverse and, therefore, does not give rise to any procedural due process rights pursuant to the Medical Staff governing documents nor is such FPPE reportable to federal or state authorities.

Focused Professional Practice Evaluation (FPPE) Plan for Cause

<table>
<tr><td colspan="4">Provider Name and UH Hospital (or provider-based location) where the Provider is granted clinical privileges:</td></tr>
<tr><td colspan="2">Date:</td><td colspan="2">To:</td></tr>
<tr><td>From:</td><td>[Applicable Medical Staff Peer Review Committee]

[Assigned Peer and Title]</td><td>Circle Additional Personnel involved and list their name</td><td>CMO
Hospital President
Quality Manager
Chief of Staff
Chair of Service
Chair of System
Other:</td></tr>
</table>

This FPPE Plan has been prepared for the provider indicated above ("Provider") based upon concerns regarding the Provider's [clinical practice] and/or [conduct] at _____ ("Hospital") and concerns about meeting applicable standards of performance.

Areas identified by the _____ for individual improvement are as follows:

☐ Clinical competence in _____

☐ Documentation _____

☐ Communication_____

☐ Unprofessional Conduct _____

☐ Other_____

The specific improvement required is detailed below. Consistent and sustained improvement is expected. Therefore, review of the Provider's performance in the identified area(s) will occur on a regular basis.

Action Steps:

- Conduct example: Provider will attend Vanderbilt anger management program on/before "x" date.
- Clinical example: Attend the prescribing course at Case Western on/before "x" date:

Expectations/Attainable Goals:

- Conduct example: Valid formal complaints regarding the Provider will not exceed _____ in _____ period.
- Clinical example: Demonstrate accurate prescribing as evidenced by prescriptions/orders that are complete and reflect proper drug selection, dosage, *etc.*

Monitoring Method*:*

- ☐ Chart review of ___ charts per ____.
- ☐ Review of Quality Profile
- ☐ Proctoring (direct observation by the proctor)
- ☐ Feedback meetings with the provider (see schedule below)
- ☐ Other: _____ (based upon the action steps and expectations/goals above)

Summary:
This FPPE Plan is meant to assist the Provider. The members of the _____ *[insert applicable Medical Staff PRC]* and Medical Staff leadership desire to work with the Provider, in a collegial manner, to achieve performance improvement. At the same time, the Medical Staff expects that the Provider will comply with the agreed upon FPPE Plan.

At the conclusion of the FPPE, Provider will be provided information about their FPPE Plan.

Marked improvement in the area(s) detailed above is expected. The Provider will demonstrate consistent and sustained positive performance relative to the FPPE Plan and adherence to the duties applicable to other providers granted privileges at the Hospital on an ongoing basis. The Provider's refusal or inability to do so is grounds for referral of the matter to the Medical Executive Committee for initiation of corrective action in accordance with the applicable procedure set forth in the Medical Staff Bylaws or Advanced Practice Clinician Policy, as applicable.

I *understand the FPPE Plan outlined above as it has been reviewed with me and agree to participate in the FPPE process as set forth in this FPPE Plan:*

Provider Signature_____ **Date:** _____

Printed Name: _____

Medical Staff Peer Review Representative

Signature_____ **Date:** _____

Printed Name: _____

This is a peer review protected document pursuant to Ohio Revised Code §§2305.25, et seq. This document is used by and/or prepared for use by a Peer Review Committee, within the scope and functions of a Peer Review Committee, for the purpose of reviewing professional qualifications and/or activities of health care providers pursuant to Ohio Revised Code §§2305.25, et seq. and is privileged and confidential. This document is not to be copied or distributed to unauthorized individuals or entities.

ADDENDUM B-1
JOINT PEER REVIEW COMMITTEE

A Joint Peer Review Committee (JPRC) is a PRC subject to oversight of the participating UH hospitals' MPRCs whose purpose is to conduct peer review with respect to a particular specialty or from a multidisciplinary perspective on behalf of multiple participating UH hospitals.

A. In *lieu* of an SPRC specific to the Hospital, the Medical Staff may create a JPRC consisting of Providers from both the Hospital and other UH hospitals.

1. Provider members of a JPRC must, as applicable, either have a Medical Staff appointment and/or privileges at each UH hospital participating in the JPRC; or participate in a covered entity or sign a business associate agreement for each such participating UH hospital(s) at which the Provider does not otherwise have Medical Staff appointment and/or privileges.

2. A JPRC may only be established by the approval of the Medical Executive Committee of each UH hospital that intends to participate in the JPRC.

3. A JPRC shall perform the same duties as a SPRC except as otherwise provided in this Policy.

4. A JPRC shall be subject to oversight by, and shall report to, each UH hospital MRPC for which the JPRC reviews cases.

5. A JPRC shall generate minutes that have a separate section for each participating UH hospital.